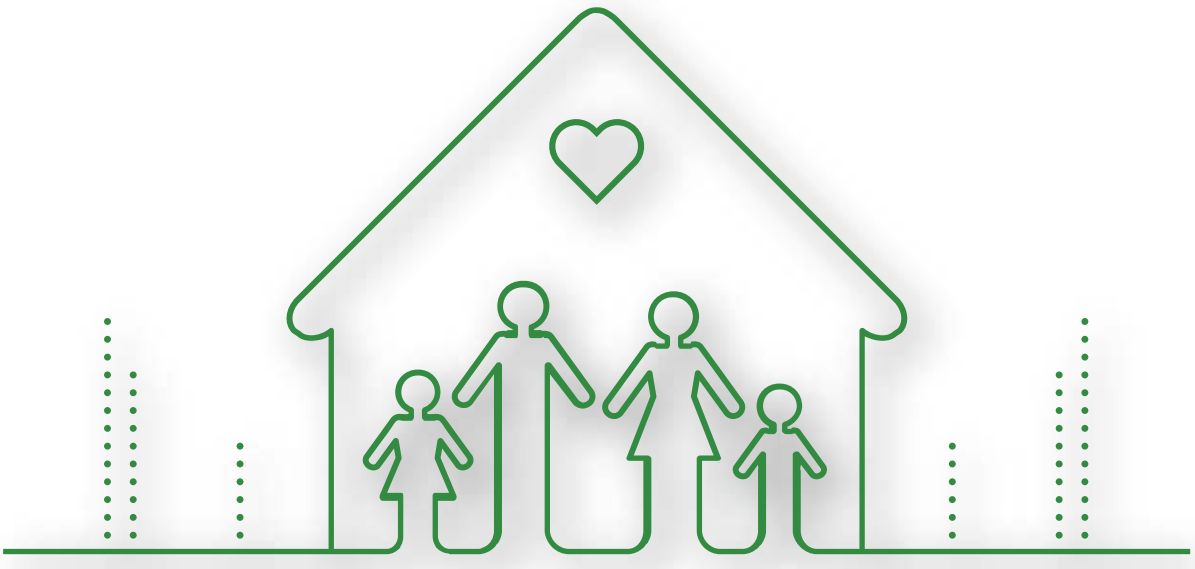
REPUBLIC OF KENYA

COUNTY GOVERNMENT OF NANDI

DEPARTMENT OF HEALTH SERVICES

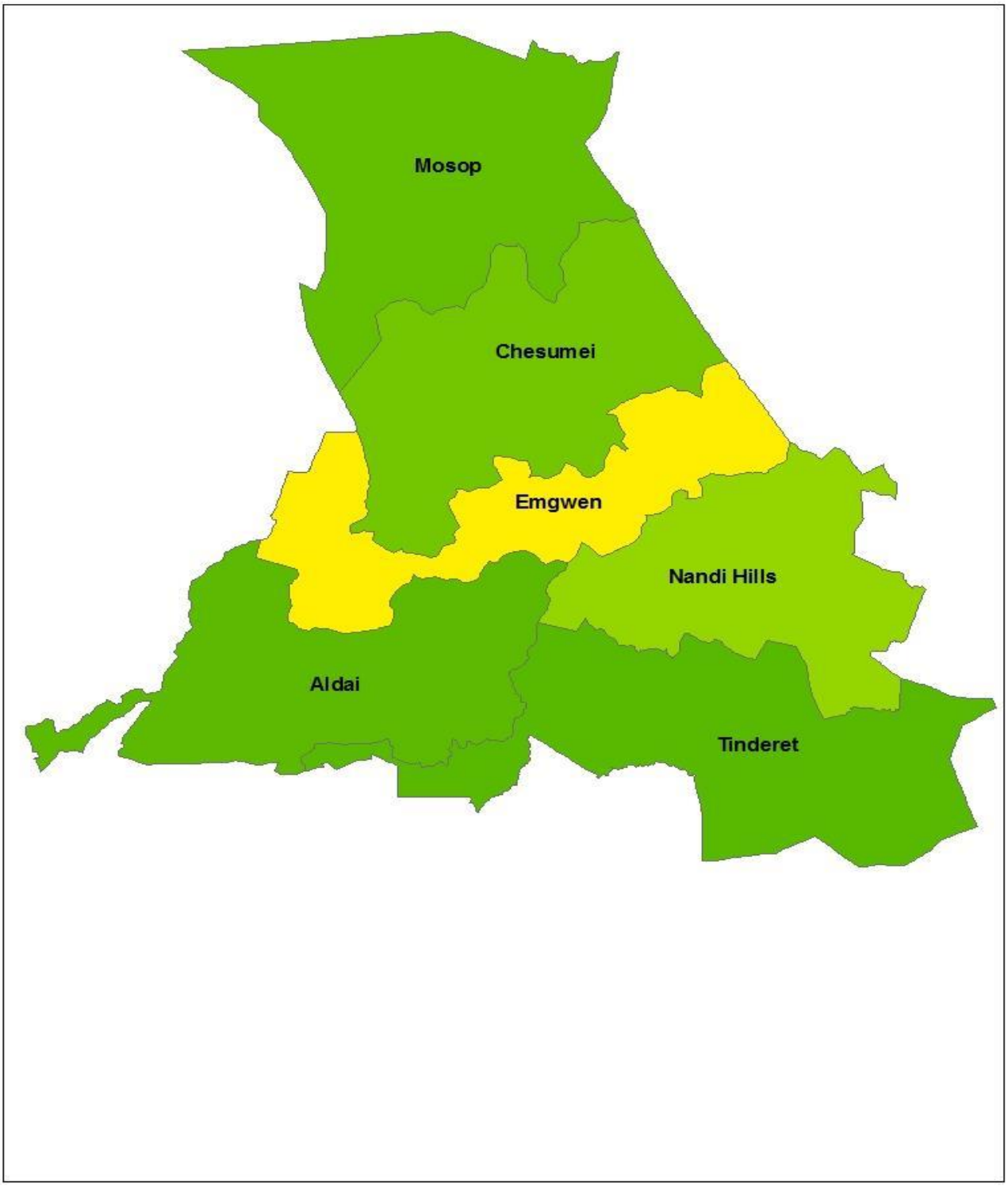
FAMILY PLANNING COSTED IMPLEMENTATION PLAN

2016 / 17 - 2020 / 21



NANDI COUNTY FAMILY PLANNING COSTED IMPLEMENTATION PLAN

MAP OF NANDI COUNTY



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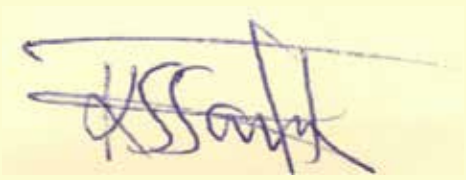
FOREWORD

The Family planning Costed Implementation Plan (CIP), 2017–2022 gives directions to ensure significant improvement in overall status of health in Nandi County in line with the County Integrated Development Plan (CIDP), the Health Sector Plan, the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030, and other global commitments. It demonstrates the health sector's commitment, under the county government leadership, to ensuring that the county attains the highest possible standards of health, in a manner responsive to the needs of the population.

This plan is designed to be comprehensive focusing on identifying the gaps in reproductive and family planning needs and to develop strategies to address the same. It focuses on ensuring equity, people centeredness, participatory approach, efficiency, a multi-sectoral approach, and social accountability in the delivery of reproductive healthcare services. The plan embraces the principles of protecting the rights and fundamental freedoms of specific groups of persons, including the right to health of women of reproductive age, young people, male and people with special needs.

The plan was developed through a participatory process involving all stakeholders in health including county departments and agencies; development partners (multilateral and bilateral) and implementing partners (faith-based, private sector, and civil society). The detailed strategies, specific programmes and packages will be elaborated in this five-year plan.

It is my sincere hope that under the devolution system of government, all the actors in health in the county will rally around this plan to ensure that we all progressively move towards the realization of the right to health and steer the county towards the desired health goals.



HE Governor

Nandi County

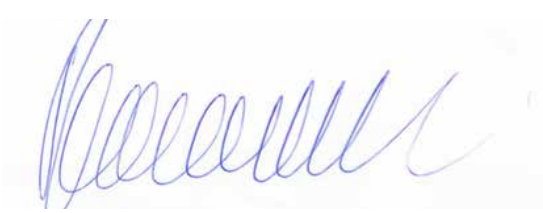
PREFACE

The plan has been developed to provide a framework for the management and service delivery in the health sector. This plan shall be used together with other government policies to ensure consistency in its application in filling the gaps identified. The policy document will be useful to the Department of Health and Sanitation in fulfilling its constitutional mandate of providing quality health services which are accessible, acceptable, affordable, sustainable, equitable and responsive to the reproductive/family planning health care needs of citizens.

Service delivery in the health sector needs to be up-scaled throughout due to the ever emerging challenges in health care delivery. In order to address these challenges, there is need for a combined approach in handling health issues in the county by all stake holders. One such approach is to ensure that the identified gaps and strategies are conclusively addressed by all partners to help the county have a healthy population.

The plan provides guidance on the institutional framework for management of service delivery in the health sector. It also outlines the mechanisms for monitoring, evaluation and reporting for accountability of health service delivery.

I have no doubt that the diligent implementation of this plan will play an important role in supporting the effective provision of health services as envisaged in the CIDP and other County and National health guidelines.



County Executive Committee member
Department Of Health and Sanitation
Nandi County

ACKNOWLEDGEMENT

The development of this plan was accomplished through the concerted efforts of the CHMT, SCHMT and HMT with the guidance from department of planning who assisted in a variety of ways towards the completion of this document.

Foremost we thank HE The Governor, CEC and the Chief Officer of Health for their continued support and guidance in the development of this plan.

I also acknowledge the consultant Mr. Cosmas Mutua for his guidance through the process, DSW through Mr. Mark Gachagua, MSK through Mr. David Obuya for financial and technical support, and other partners.

As I conclude, I call upon all the partners involved to implement this plan in a coordinated and synergized manner to avoid duplication and wastage of resources.

Director Of Health

Nandi County.


BEYOND ZERO

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome	M&E	Monitoring & Evaluation
AWP	Annual Work Plan	MMR	Maternal Mortality Ratio
AYSRH	Adolescent and Youth Sexual Reproductive Health	MOH	Ministry of Health
CDC	County Director of Health	MOU	Memorandum of Understanding
CEC	County Executive Committee Member		
CHEWs	Community Health Extension Workers	NASCOP	National AIDS and STI Control Programme
CHMT	County Health Management Team	NCPD	National Council for Population and dev.
CHVs	Community Health Volunteers	NGO	Non-Governmental Organizations
CIDP	County Integrated Development Plan	OJT	On Job Training
CIP	Costed Implementation Plan	PAC	Post Abortion Care Kit
CME	Continuous Medical Education	PHC	Population and Housing Census
CPR	Contraceptive Prevalence Rate	PHOs	Public Health Officers
CRH	County Reproductive health Coordinator		
CYP	Couple Year Protection	PSK	Population Service KenyaS
DHIS	District Heath Information System	PWD	People with Disability
DMPAs	Depot Medroxyprogesterone Acetate	PWUD	People Who Use Drugs
DQA	Data Quality Assurance	QI	Quality Improvement
DRH	Division of Reproductive Health	SDG	Sustainable Development Goals
DSW	Deutsche Stiftung Weltbevölkerung	SDPs	Service Delivery Point
eMTCT	Elimination of Mother to Child Transmission	SOPs	Standard Operating Procedures
FBO	Faith Based Organization	STI	Sexually Transmitted Infection
FP	Family Planning	SW	Sex Workers
GDP	Good Dispensing Practice	WRA	Women of Reproductive Age
HIS	Health Information Systems	TB	Tuberculosis
HIV	Human Immunodeficiency Virus	TFR	Total Fertility Rate
HRH	Human Resource for Health	TNA	Training Needs Assessment
HSS	Health Systems Strengthening	TOT	Trainer of Trainer's
ICT	Information Communication Technology	TWG	Technical Working Group
IEC	Information Education & Communication	UN	United Nations
KDHS	Kenya Demographic Health Survey	UNFPA	United Nations Population Fund
LAPMs	Long Acting and Permanent Methods	URC	University Research Council
MCPR	Modern Contraceptive Prevalence Rate	WHO	World Health Organization

OPERATIONAL DEFINITIONS OF TERMS

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

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

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

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

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

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

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

Elimination of Mother-To-Child Transmission (eMTCT): refers to the elimination of transmission of HIV from a HIV-positive woman to her child during pregnancy, labour, delivery and/or breastfeeding.
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Environment the surroundings or conditions in which a person, animal, or plant lives or operates, the natural world, as a whole or in a part.

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

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

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

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

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

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

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

Modern Contraceptive Methods: include female sterilization, male sterilization, oral hormonal pills,

the intrauterine device (IUD), injectables, implants, male condoms, female condoms, Lactational Amenorrhea Method (LAM.

Traditional Methods: include rhythm and withdrawal.

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

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

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

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

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

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

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

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

CHAPTER ONE: INTRODUCTION

1.1 COUNTY BACKGROUND

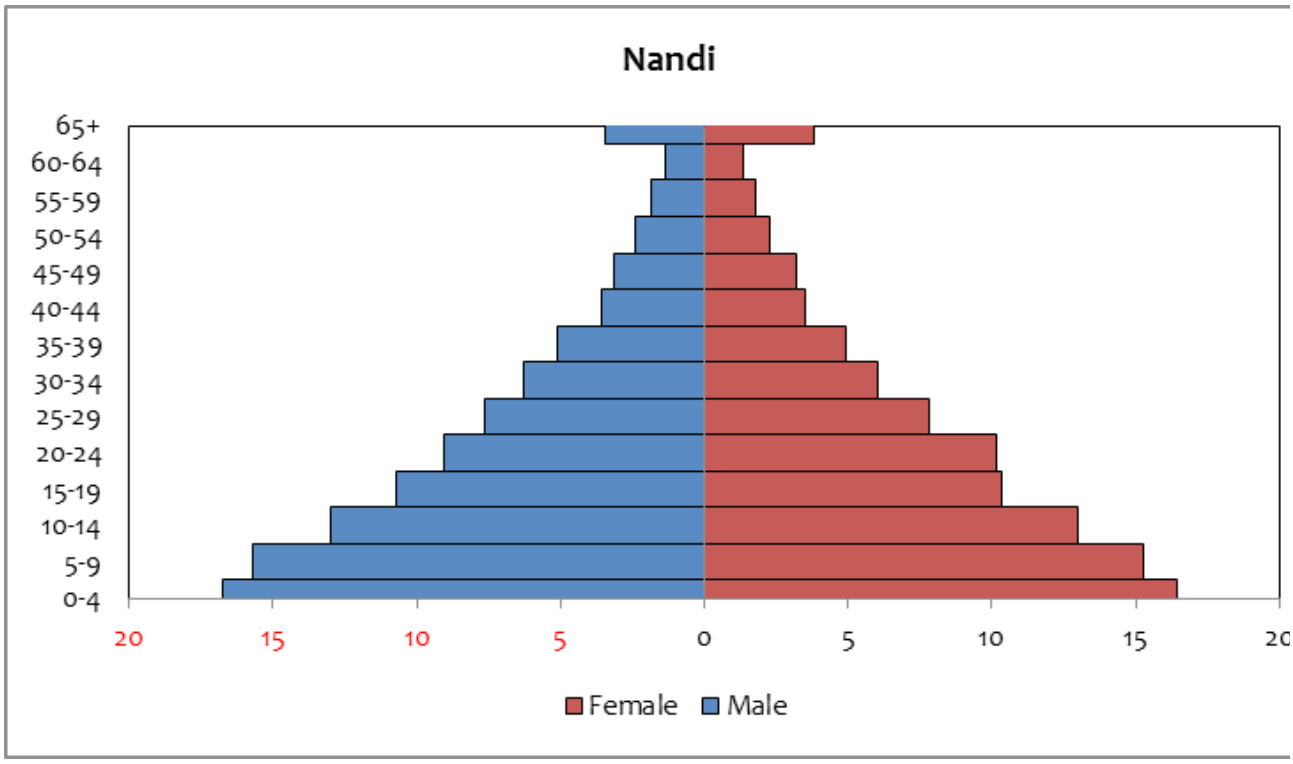
Nandi County is one of the 47 counties in the country and it borders Uasin Gishu to the north, Baringo & Kericho counties to the East, Kisumu County to the South and Vihiga & Kakamega counties to the West. The county is mainly divided into two ecological zones i.e highlands & lowlands predisposing it to varied climatic and socio –economic conditions.

The main agricultural activities practiced include tea growing, subsistent farming, sugar cane plantation along lower escarpment, coffee, Dairy farming among other activities.

The Nandi county population is 975213 (2017) as projected from the 2009 population census living in an area of 2884.4 sq. km .The population structure is composed of 31695 children under 1 year, 160911 children under 5 years, 415441 under 15 years and 235903 women of child bearing (WRA) ages. The annual population growth rate is estimated at 3% and total fertility rate of 4.

The county has six sub counties namely; Aldai, Chesumei, Emgwen, Mosop, Nandi Hills and Tinderet with a population ratio of 1:1 and a population density of 257 per km^2. Life expectancy stands at male 58 years and female 60 years. The poverty index is 47%.

1.2 NANDI COUNTY POPULATION PYRAMID



1.3 RATIONALE FOR AND USE OF THE FP-CIP

The Nandi County FP-CIP is the guide for all FP programming for the county government across all sectors, development partners, and implementing partners. Nandi'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 Nandi'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 Nandi 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 Department of Health (DOH) 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 DOH ultimately accountable for their achievement. All other sectoral departments should work in tandem with the DOH 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 DOH budget requests for FP programmes. It also provides guidance to the DOH and partners to prioritise the funding and implementation of strategic priorities.

- **Mobilize resources:** The FP-CIP should also be used by the County Government Of Nandi (CGN) and its partners to mobilize needed resources. The plan details the activities and budget required to implement a comprehensive FP programme, and as such, the DOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP and conduct advocacy to mobilize 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. Partners to mobilize needed resources. The plan details the activities and budget required to implement a comprehensive FP programme, and as such, the DOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP and conduct advocacy to mobilize funds from development partners to support any remaining funding gaps.

1.4 THE DEVELOPMENT PROCESS

Nandi County began developing its Family Planning Costed Implementation Plan, 2017–2022 (FP-CIP) in the third quarter of 2017, with support initiated by Deutsche Stiftung Weltbevölkerung (DSW) supported by a facilitator.

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

The plan and activity matrix was presented in various forms to expert groups throughout the process including various partners and DOH experts across technical areas.

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

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

1.5 KEY PRINCIPLES OF THE FP-CIP

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

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

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

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

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

CHAPTER 2: SITUATIONAL ANALYSIS

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

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

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

2.2 FP 2020

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

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

The summit aimed to ***"mobilize global policy, financing, commodity and service delivery commitments***

to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020."

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

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

- Increasing the demand and support for family planning
- Improving supply chains, systems, and service delivery models
- Procuring the additional commodities.
- Fostering innovative approaches to family planning challenges
- Promoting accountability through improved monitoring and evaluation

2.3 SUSTAINABLE DEVELOPMENT GOALS (SDGS)

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

- 3.1- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.7- By 2030 ensure universal access to sexual and reproductive health care services, including family Planning, information and education and the integration of reproductive health into national strategies and programmes.

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

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

2.4 NATIONAL CONTEXT

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

Table 1: Main constitutional provisions and impact on Health

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

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

1. Provide leadership and management of the county health teams, planning, development and monitoring of County health services in compliance with the national standards.

2. County level prioritization of health investments, setting and reporting on relevant targets and coordination of all actors in the county health systems.

3. Provide guidance on health facilities within the county in implementing health service tariffs and benefits.

4. Development and management of referral services within the county health systems and other referral health facilities.

5. Conduct County studies including operational research to inform decision making in health service delivery at all levels.

6. Provision of emergency medical and ambulance services in the County.

7. Provision of County pharmacy services and county health facility services.

8. Provision of preventive, promotive and rehabilitative services to the County.

9. Strengthen inter County and national health services collaboration.

10. Facilitate and coordinate the role of non-state actors in the county health system focusing on county priorities and ensure their compliance with the national policy and regulatory requirements; and

11. To facilitate capacity building for health care workers and the community in the county.

2.5 FAMILY PLANNING TRENDS IN KENYA

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

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

The public sector is the major source of contraceptive methods in Kenya, providing contraception to 60 per cent of current users. Within the public sector, 24 per cent of users obtain their methods from government dispensaries, 20 per cent from government hospitals, and 16 per cent from government health centers. 34per cent of modern contraceptive users obtain their methods from the private medical sectors, mainly from private hospitals/clinics (21%) and pharmacies (10%).

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

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

2.6 UNMET NEED FOR FAMILY PLANNING

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

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

Total demand for family planning is higher among women aged 35-39 (89%), However, it is lower among younger women (15-19) and those older (45-49) (each 61%). Demand for family planning does not vary much by urban-rural residence; however, there are wide variations by region. North Eastern has the lowest demand (33%) and Eastern the highest (83%). Women with no education (47%) and women in the lowest wealth quintile (60%) have a lower demand than their more educated or wealthier counterparts.

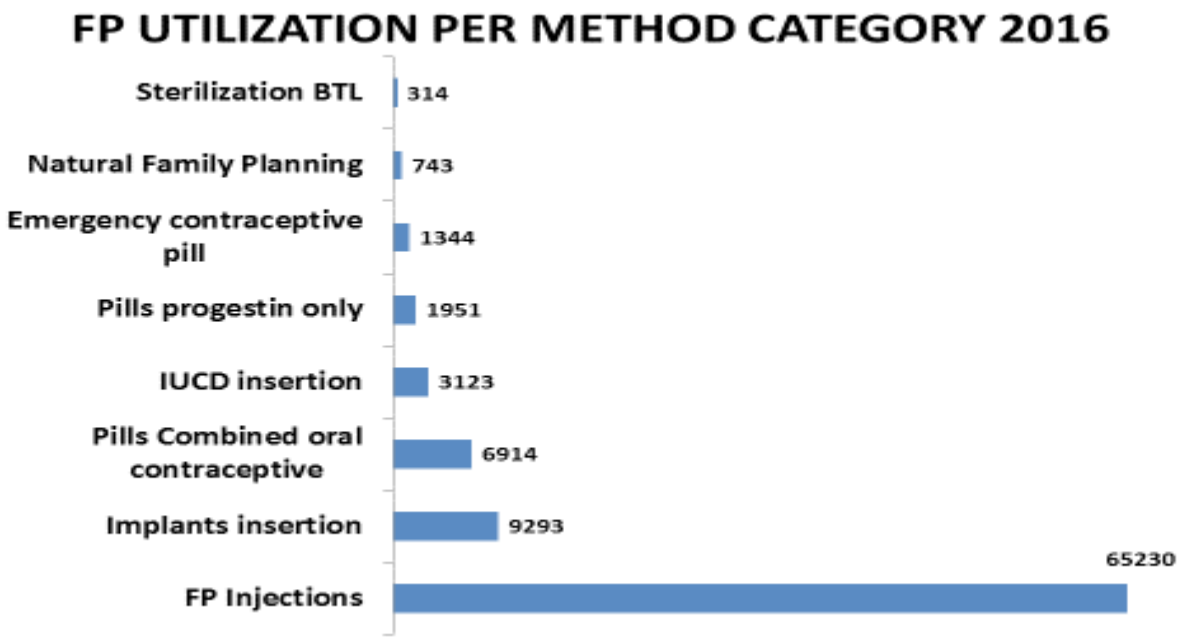
2.7 GENERAL OVERVIEW OF FAMILY PLANNING IN NANDI COUNTY

Medical facilities are inadequate in terms of the number of health centers and the services provided to the local population. The current life expectancy is 59 years with a population growth rate of 3% and a total fertility rate of 4 children per woman. Population density is 257 per square kilometer, and covers an area of 2884.4 sq km. About 40% of the population live below poverty line. It is served by 174 Health facilities, of which 6 are hospitals, 168 primary care facilities and 36 community units. The doctor population ratio is 1:30000 while the nurse population 1:2500. This is way below the minimum threshold of 1 doctor per 10 000 population that was established by WHO as necessary to deliver essential maternal and child health services.

No. of Health Facilities in Nandi County and Percentage Coverage of FP as per DHIS

SUB COUNTY	PUBLIC	FBO	PRIVATE	NO. OF CUs	TOTAL	FP COVERAGE %
Aldai	26	2	1	4	33	34.4
Chesumei	20	3	7	9	39	42.3
Emgwen	18	3	3	0	24	36.7
Mosop	20	5	2	8	35	39.2
Nandi Hills	13	1	23	7	44	59.8
Tinderet	19	1	1	8	27	36.2
Nandi County	116	15	37	36	204	42.4

2.8 FAMILY PLANNING UPTAKE BY METHODS



2.9 FACTORS AFFECTING FAMILY PLANNING AND THE MITIGATION MEASURES

Several factors were identified as reasons for low uptake of family planning services in Nandi county hence poor FP indicators. They are as listed below with proposed mitigation measures.

FACTORS	MITIGATION MEASURES
Accessibility to FP services for instance health facilities are far apart	Outreach services to the unreached areas Open up more facilities
Cultural factors value of boy child, patriarchal society polygamy ,Religion	Community awareness on FP Community participation FP services Women empowerment
Myths and misconceptions on FP utilization	Give correct information on FP Male involvement in FP services
Hidden Cost of FP services	Budgeting of FP commodities including non-pharmaceuticals
Health care personnel offering FP services	Capacity building,motivation,employ more staff
Inconsistent supply of FP commodities	Proper quantification and forecasting of FP commodities Storage facilities
Client/staff attitude and preference towards FP services	Create awareness Customer care relationship
Age of clients	Create awareness
Workload	Employ more staff
Inadequate skills of staff on FP E.g insertion of coil, removal of IUCD,BTL	Capacity building and regular updates/ mentorship/OJT Trainings on sign language and braille.
Inadequate information on FP services	Strengthen ACSM

Inadequate community involvement and participation	Strengthen existing CHUs and establish more CHUs
FP policy	Domestication and dissemination of FP policy
FP Side effects	Sharing of information and seek alternative methods
Lack of political support	Sensitize them on FP Advocacy targeting politicians
Low male involvement	Bring males on board by sensitizing them on need of FP

2.10 POPULATIONS WITH SPECIAL NEED FOR FAMILY PLANNING

TARGET POPULATION	REASONS
Youth and Adolescence	Sexually active Teenage pregnancies, unsafe abortions Misuse of E pill
PLWHIV	Stigma (Low integration of services)
MAPS(MSM, Saw millers	Sexually active high cases of abortion
Tea casual workers	Social economic status
PLWD	Access to services and information
Marginalized communities e.g. ogiek, terik	Lack of information and accessibility of the service
Religious groups	Resistance to FP
Male	Resistance to FP
Politicians	Advocating for more population of children

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

STRENGTHS	OPPORTUNITIES
• Existing trained staffs in FP • Commodity security • Availability of reporting system • Existing infrastructure • Community strategy • Existing policy guidelines • Existing referral and linkage system • Adoption of technology • Good partner leverage/coordination • Good coordination and teamwork • Dedicated staff • Conducive working environment	• Existing Partners • Affirmative action – Beyond Zero, FMS, Linda Mama, • Subsidized education • Technological advancement • Improved road network • Political goodwill
WEAKNESS	**THREATS**
• Uncoordinated Partners activities • Inadequacy of resources- Equipment, workforce • Push system supply of commodities at sub county • Inadequate storage space • Lack of youth friendly services/drop-in centres • Poor male involvement • Inadequate advocacy • Lack of FP budget line in the county • Lack of FP data submission from the private facilities • Lack of IEC materials and job aids • Demotivated staff • High staff turn over • Poor staff attitude	• Political leaning • Duplication of partner activities • Myths and misconceptions • Political pronouncements • Recurring medical strikes • Cultural beliefs • Food insecurity • Sexual and Gender Based Violence • Geographical inaccessibility • Poor terrain • Unreliable and inadequate donor support • Illiteracy • Poverty level • Technological access still a problem

2.12 PESTEL ANALYSIS

The PESTEL highlights the importance of identifying trends and anticipating changes in a variety of environments. A clear understanding of the environment could influence an organization's vision as well as whether and how to alter their strategy. It can help an organization to (re)position itself in a dynamic context.

DOMAIN	POSITIVE	NEGATIVE
Political	Existence and increasing number of women politicians who will be FP champions Politicians investing and prioritizing in building the hospitals(Governors manifesto) Employment and absorption of health staff Local legislative structure;	Non employment and motivation of technical staff Lack of FP prioritization in the budget High turnover of staff as a result of change in county political leadership Negative political pronunciation towards FP
Economical	• Tea zones, large scale farming of maize, sugar cane, milk hence generating income for the county. • County revenues: ensure that the county can invest in health facilities that provide FP services • Conducive investment platforms	High dependence on agricultural revenue Huge gap between the rich and the poor. The very poor seek unsafe abortions. Tea zones owned by foreigners
Social Cultural	• Value in girl child education • Comparatively high access to FP info and services • Large youthful population in Nandi county	• Low of male involvement in FP • Male chauvinism • Wrong beliefs on FP (myths and misconceptions) • Value for boy child. Desire to get a boy resulting to large families and low uptake of FP

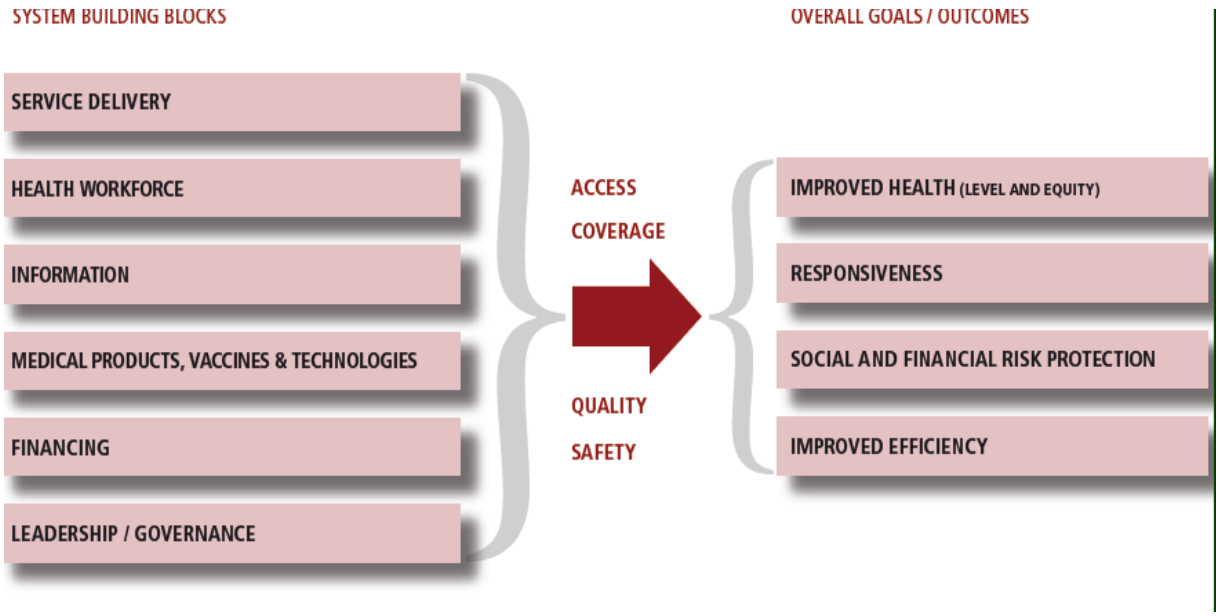
DOMAIN	POSITIVE	NEGATIVE
Technological	• Large number of people own mobile phones • Many homes connected to electricity • Presence of local radio and TV stations sharing info on FP in the local dialect • High use of social media platforms • M&E systems available to track availability of FP commodities	• Inadequate medical equipment • Downtime of equipment • Poor network coverage in some areas (cellular)
Environmental	• Renovation of health facilities • Conducive climate for FP commodities storage	• Hilly terrain • Inaccessible road network
Legal	• Constitution safeguarding health • CIDP • Policy guidelines available	• Lack of county specific policies on FP • Poor implementation of existing policies

CHAPTER 3: HEALTH SYSTEMS STRENGTHENING FOR IMPROVED FAMILY PLANNING INTERVENTIONS

3.0 STRENGTHENING HEALTH SYSTEMS

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

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



Pillar 1: Service delivery:

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

Pillar 2: Health workforce:

Health workforce includes having trained service providers working with the right attitude, knowledge and skills. The staff should have the necessary commodities (such as medicines, disposables, and reagents), equipment, and adequate financing, to perform their jobs. Recognition and support for the vital roles played by community champions, community organizations and lay workers, thus strengthening the community systems is critical to avoiding demoralized staff that could lead to a high turnover.

Pillar 3: Information systems:

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

Pillar 4: Supply of medical and health products:

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

Pillar 5: Financing

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

Pillar 6: Leadership and governance:

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

Pillar 7: Advocacy:

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

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 Nandi 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 40% and increase the modern contraceptive prevalence rate (mCPR) to 68 % among women of reproductive age in Nandi County by 2022.

Strategic Objectives:

1. To increase utilization of FP services by 50% by 2022 in Nandi County.

2. To increase the capacity of the Health care work force in FP by 50% by 2022.

3. To improve availability, quality and use of data for decision making by 2022.

4. To have a specific budget line for FP by 2019

5. To eliminate stock out of FP commodities in all health facilities in Nandi County by 2019.

4.1 IMPLEMENTATION PLAN

PILLAR 1: Service delivery

Aim: 1. To increase access and utilization of quality family planning services.

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Male involvement.	Increased male participation in RH/FP interventions.	Identify, engage and train 1500 male FP champions	No of male champions trained in FP	Training manual Finances	Annually	Training manual Activity reports
		Hold 360 dialogue meetings in the sub-counties	No. of dialogue meetings held	Resource person Finances IEC materials	Monthly	Activity report Participants list
		Hold 360 Public Barazas	No. of public barazas held	Resource person Finances IEC materials	Monthly	Activity reports
		Recognition of 150 male partners	No. of males rewarded	Rewards Finance	Annually	Meeting reports Award list
Service integration	Increased access to FP services at all service provision points	Integrate FP services in 35 CCC sites	No. of CCCs providing FP services	Finance Commodities Reporting tools HR	Annually	Monthly /Progress report
		Integrate FP services in 160 ANC,	No. of ANC clients reached with FP messages	Reporting tools HR Finances	Monthly	Monthly report Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Integrate FP services in the 25 CHUs,	No. of CUs providing FP services	HR Finances IEC Materials	Monthly	Monthly report Progress reports
		Integrate FP services in the 160 GBV clinics,	No. of GBV clinics offering FP Services	HR Finances IEC Materials	Monthly	Monthly reports Progress reports
		Integrate FP services in the 160 PNCs,	No. of PNC providing FP services	HR Finances IEC Materials	Monthly	Monthly reports Progress reports
		Integrate FP services in the 160 PAC,	No. of PAC providing FP services	HR Finances IEC Materials Commodities	monthly	Monthly report Progress report
		Integrate FP services in the 160 MAT,	No. of MAT offering FP services	Commodities Equipment Rep0rting tools Finances HR	Monthly	monthly reports progress report
		Integrate FP services in the 160 Youth friendly clinic ,	No. of YFS providing FP services	commodities Rep0rting tools Finance HRC	Monthly	monthly report progress report
		Integrate FP services in the 60 Inpatient,	No. of inpatient unit offering FP services	commodities Reporting tools Finances HR	Monthly	monthly report progress report
		Integrate FP services in the 160 outpatient,	No. of outpatients units offering FP services	commodities Rep0rting tools Finances HR	Monthly	monthly report progress report
		Integrate FP services in the 160 Cervical cancer screening sites,	No. of cervical cancer screening sites offering FP services	commodities Rep0rting tools Finances HR	monthly	monthly report progress report

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Scale up uptake of long term family planning methods- sensitize 160 staff	No of clients receiving LARC	commodities Rep0rting tools Finances HR		progress report
		Train 30 TOTs on RH/FP	No. of TOTs trained	Training manual HR Finances	Annually	progress report
		Train 300 HCWs on LARC	No of HCWs trained on LARC	Training manual HR Finances	Annually	progress report
		Conduct 1440 integrated outreaches in all sub counties especially hard to reach areas (12 integrated outreaches per sub-county per quarter)	No. of outreaches conducted	commodities Rep0rting tools Finances HR	Monthly	Monthly outreach reports progress reports
		Provision of FP services for 6000 people with disabilities for 5 years	No. of PWD accessing FP services	commodities Reporting tools Finances HR	Monthly	Monthly reports Progress reports
		Provision of FP services for 200 FSWs	No of FSWs accessing FP services	commodities Reporting tools Finances HR	Monthly	Monthly reports Progress reports
		Provision of FP services for 100 MSWs	No. of MSWs accessing FP services	commodities Reporting tools Finances HR	Monthly	Monthly and progress reports
		Provision of FP services for 100 truck drivers	No of truck drivers reached	commodites Reporting tools Finances HR	Monthly	Monthly and progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Provision of FP services for 5000 tea pluckers	No of tea pluckers reached	commodities Reporting tools Finances HR	monthly	Monthly and progress reports
		Establish 48 CUs	No. of CUs established and operational	Finances Resource persons	Annual	Progress report
		Recruit 3000 CHVs	No of CHVs recruited	Finances Resource persons	Annually	progress report
		Train 1500 community health volunteers on FP.	No of CHVs trained on FP	Training manual Finances Resources people	Quarterly	Quarterly training report
		Conduct 175,200 health talks in all the facilities.	No of health talks conducted	HR IEC materials Finances	Daily	Activity report
		Conduct Comprehensive health sex education in 964 primary schools	No. of health talks held	Commodities Reporting tools Finances HR	Quarterly	Progress reports
		Conduct Comprehensive health sex education in 249 secondary schools	No. of health talks held	commodities Reporting tools Finances HR	Quarterly	Monthly reports
		Conduct Comprehensive health sex education in 20 tertiary institutions	No. of health talks held	commodities Reporting tools Finances HR	Quarterly	Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Enhancing service delivery systems and structures	Increased access to age appropriate reproductive health care	Establish 12 Functional youth-friendly centers that offer age appropriate reproductive health care (two per sub-county)	No of youth friendly services established and functional	Finances Commodities IEC material HR ICT equipment	Annual	Progress reports
		Strengthen one existing youth-friendly centers that offer age appropriate reproductive health care	No of youth friendly centers strengthened	Finances Commodities IEC material HR ICT equipment	Quarterly	Quarterly report Progress report
		Train 1213 teachers(primary and secondary) on Adolescent youth sexual reproductive health	No of teachers trained on AYSRH	Training manual Finances HR	Quarterly	Quarterly reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Community mobilization, education and empowerment	Increased community awareness on AYSRH	Train 1000 parents and guardians on Adolescent youth sexual reproductive health	No. of parents/guardians trained on AYSRH	Training manual Finances HR	Quarterly	Quarterly reports
		Train 1000 religious leaders on Adolescent youth sexual reproductive health	No of religious leaders trained on AYSRH	Training manual Finances HR	Annually	Progress reports
		Train 500 opinion leaders on Adolescent youth sexual reproductive health	No of opinion leaders trained on AYSRH	Training manual Finances HR	Annually	Progress reports
		Train 150 peer educators on Adolescent youth sexual reproductive health	No of peer educators trained on AYSRH	Training manual Finances HR	Annually	Progress reports
		Conduct 400 live local radio talk shows on FP	No of TV/radio show	Finances Resource persons	Monthly	Progress report
		Conduct 100 road shows	No of road shows conducted	Finances Resource persons	Monthly	Progress report
		Conduct 120 youth sporting/magnet theatre/diva night	No of youth events conducted	Finances Youth IEC materials Resource persons	Monthly	Progress report
		Establish 650 health clubs in learning institutions	No of health clubs established in learning institutions	Finance Resource persons Teachers	Annually	Progress reports
		Strengthen 200 learning institution health clubs	No of health clubs strengthened in learning institutions	Finance Resource persons Teachers	Quarterly	Quarterly reports Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Commodity Structure	Reduced stock outs.	Train 500 health care providers on forecasting and quantification of the RH/FP Commodities annually.	No of healthcare providers trained on F&Q	Training manual Resource persons Finance	Annual	Progress report
		Conduct 125 routine forecasting and quantification meetings of the RH/FP Commodities annually	No of routine F&Q for RH/ FP commodities conducted	HR Finances F&Q tools	Annually	F&Q reports Progress reports
		Scale up the commodity management system to all health facilities in the county to improve reporting for the RH/FP commodities to 100%	% ofTimely reports and updated inventory	HR Reporting tools Finance	Monthly	Monthly reports
		Equitable distribution/redistribution of the RH/FP commodities- establish 7 redistribution tems	No of functional redistribution teams Updated commodity inventory	Redistribution tools Finances HR	Quarterly	Quarterly reports Progress reports
		Strengthen 250 storage facilities for RH/FP and other commodities in the major health facilities in the County.	No of health facilities with RH/FP stores Updated stock inventory	Stock control cards Finances HR	Quarterly	Quarterly reports Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Improved Structures	High quality services provided at all levels.	Renovate and equip 18 health facilities in hard to reach areas.	No. of facilities renovated and equipped in hard to reach areas	Finances BQs	Annually	BQ reports Progress reports
		Equip 7 health facilities with incinerators,	No of incinerators built and installed	BQs Finances HR	Annually	BQ and progress reports
		Equip 250 health facilities with waste bins	No of waste bins bought	Finances Procurement plan HR	Annually	Progress report
		Equip 250 health facilities with liners	No of liners bought	Finances Procurement plan HR	Quarterly	Progress report
		Equip 250 health facilities with IPC buckets	No of IPC buckets purchased	Finances Procurement plan HR	Quarterly	Progress report
	Strengthen service delivery for RH for PWDs	Conduct 5 assessments to establish health facilities that are not disability friendly in the county.	No of facilities assessed	HR Finance	Annually	Assessment reports
		Construct ramps – 28 disability friendly	No of ramps built	BQs HR Finance	Annually	BQ reports and progress report
		Construct 28 railed walkways disability friendly structures.	No of railed walkways built	BQs HR Finance	Annually	BQ reports and progress report
		Construct 28 sanitation facilities which are disability friendly.	No of sanitation facilities built	BQs HR Finance	Annually	BQ reports and progress report
		Purchase and distribute 300 Wheel chairs	No of wheelchairs purchased	Finance	Annually	Progress reportsS

PILLAR: 2. Health workforce

Aim: To improve the capacity of healthcare workforce to provide family planning services and information at all levels.

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
1. Human resource management	Increased/adequate number of skilled service providers.	Conduct annual FP staff capacity gaps and needs assessment at the County.	No of staff identified with training gaps No of assessments done	Finance TNA tool HR	Annually	Assessment reports Progress report/ staff returns
		Recruit RH/FP service providers based on the needs assessment.	Number of new staff recruited	Finance HR	Annually	staff returns
		Deploy RH/FP service providers based on the needs assessment	Number of staff deployed	Finance HR	Annually	staff returns
		Train 500 health care providers on FP.	Number of staff trained on FP	Finance Training manual HR	Annually	staff returns Progress report
		Conduct OJT and mentorship to 300 service providers on FP	hNo of OJTs/mentorship done	Training manual Finances HR	Quarterly	Quarterly reports Supervision reports
		Motivation of 18 best facilities regarding RH/FP service per year.	No of facilities rewarded	Finances HR	Annually	Award scheme progress reports
		Reward and recognition of 18 best performing HCWs on RH/FP per year	No of HCWs rewarded Reward system in place	Finances HR	Annually	Award scheme progress reports
		Strengthen 120 in-service training and mentorship approaches for RH/ FP service providers based on HRH norms and standard.	No of in-service forums held	Training manual Finances HR	Quarterly	Staff returns Progress reports
		Disseminate 40 updates on RH/ FP policies, guidelines, registers, manuals regularly.	No of RH/FP policies, guidelines, registers, manuals disseminated	Resource persons Policy documents Finance	Quarterly	Dissemination/ meeting reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Engage existing training institutions for 40 capacity building and training workshops on RH/ FP.	No of MOUs with training institutions No of capacity building and trainings done	Resource persons Finance Training manuals	Quarterly	meeting reports MOUs
		Conduct annual staff appraisal.	No of staff appraised	Appraisal forms	Quarterly/ Annually	Appraisal reports
		Conduct 125 RH/FP performance review meetings.	No of review meetings done	Finance Review system/ tool Personnel	Quarterly	Progress reports Review meeting reports
2. Capacity Building	Increased human resources capacity for AYSRH initiatives	Train 500 service providers in delivery of non-discriminatory AYSRH education and services	No of in-service providers trained in AYSRH	Training manual Finances HR	Quarterly	Staff returns Progress reports
	Improved provider competency in offering FP services.	Train 30 service providers on sign language.	No of service providers trained on sign language	Training manual Finances HR	Quarterly	Staff returns Progress reports
		Train 150 PHOs on FP advocacy	No of PHO trained on FP advocacy	Training manual Finances HR	Quarterly	Staff returns Progress reports
		Identify and Recruit 1500 CHAs	No of CHAs recruited	Finances Resource persons	Annually	Progress reports
		Train 1000 CHAs on FP advocacy	No of CHAs trained on FP advocacy	Training manual Finances HR	Quarterly	Staff returns Progress reports
		Train 20 health promotion officers, on FP advocacy	No of Health promotion officers trained on FP advocacy	Training manual Finances HR	Quarterly	Staff returns Progress reports
		Train1500 CHVs on FP bi-annually	No of CHVs trained on FP advocacy	Training manual Finances HR	Quarterly	Staff returns Progress reports

PILLAR: 3. Information (Research, Monitoring, Evaluation & Reporting)

Aim: Enhance availability of quality FP data and use at all levels of healthcare for decision making

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
1. Dissemination of tools	Increased availability of all reporting tools	Quantify data reporting tools required	No of data reporting tools quantified	Finance Personnel Quantification tool	Annually	Quantification reports Progress reports
		Procure 10 health data reporting tools per facility	No of data reporting tools procured	Finance Personnel Procurement plan	Annually	Progress reports
		Distribute data reporting tools to all levels of care	No of data reporting tools distributed	Finance Personnel Data tools	Quarterly	Quarterly reports Progress reports
2. Supportive supervision	Improved data quality	Provide data collection and reporting tools across all levels of care.	No of data collection and reporting tools provided	Finance Personnel Data tools	Quarterly	Quarterly reports Progress reports
		Train 500 Service providers and health managers on Data management	No of service providers trained on Data management	Finance Personnel Data tools	Annually	Quarterly reports Progress reports
		Conduct 140 data Review meetings/ DQAs.	No of data review meetings conducted	Finance Personnel Data tools	Quarterly	Quarterly reports Progress reports
		Deploy electronic medical record system in the major hospitals and dispensaries in the County.	No of electronic medical systems deployed	Finance Personnel Electronic systems	Annually	Progress reports
		Conduct 4 data support supervision at the County level annually	No of support supervisions done	Finance Personnel Supervision tools	Annually	Progress reports
		Conduct 24 data support supervision at the Sub-county level annually	No of support supervisions done	Finance Personnel Supervision tools	Annually	Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Develop quarterly 124 FP score cards/ fact sheets	No of FP score cards/ fact sheets developed	Finance Personnel	Annually	Progress reports
		Conduct 50 FP data review meetings at CU level annually.	No of FP data review meetings conducted	Finance Personnel Data review tools	Annually	Progress reports
3. Data review meeting	Increased use of data for decision making	Train 1200 Service providers and health managers on Data demand and use.	No of Service providers trained in data use No of health managers trained on Data demand and use.	Finance Personnel Data review tools	Annually/ Quarterly	Quarterly reports Progress reports
		Conduct RH/FP data analysis in each Sub County.	No of data analysis done	Finance Personnel Data analysis tools	Annually	Progress reports
		Develop action plans in the county.	No of action plans developed	Finance Personnel POA	Annually	Progress reports
		Review implementation of action plans in the county	No of review meetings done	Finance Personnel TOR	Quarterly	Quarterly reports Progress reports
4. Capacity building	Increased number of skilled personnel on data management	Conduct 360 Continuous Medical Education.	No of CMEs done	Finance Personnel Training manual	Monthly	Monthly reports Progress reports
		Development of County research agenda	Research agenda developed	Finance Personnel	Annually	Progress reports
		Disseminate to stakeholders the 10 County RH research agendas	No of dissemination meetings done	Finance Personnel	Annually	Progress reports
5. Operational research	Increases uptake of operational research to support the decision-making process	Set up research team in the County.	No of research team set up	Finance Personnel Research agenda	Annually	Progress reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Identify areas of research (research needs) within RH/FP component.	No of areas identified	Research agenda	Annually	Progress reports
		Identify health care workers research needs and skills gaps	No of HCW identified	Finance Personnel	Annually	Progress reports
		Capacity build health care workers on basic research methods.	No of HCWs trained on basic research methods	Finance Personnel Training manual	Annually	Progress reports
		Budget for operational researches on the areas of RH/FP	A specific budgetline on operational researches on the areas of RH/FP	Finance Personnel	Annually	Progress reports
		Conduct 65 ASRH health research partner's forum.	No of ASRH health research partner's forums held	Finance Personnel	Biannually	Progress reports
		Conduct 200 RH/FP service evaluations at the health facilities	No. of facilities evaluated	Finance Personnel	Biannually	Progress reports
6. Information and technology	Increased use of IT systems and structures for information sharing	Develop a website for the department of health	A functional health website	Finance Procurement plan FP Documents	Annual	Progress report IT Plans
		Develop and utilize digital platforms for sharing SRH information	A functional SRH digital platform in place	Finance HR	Annual	Progress report
		Support production and dissemination of 100,000 RH/FP IEC materials at all levels.	No of IEC materials produced and disseminated	**Finances** **HR**	Annual	Progress reports
		Set up m-health platform for FP services at the community level.	A functional m-health platform	Finance HR ICT equipment	Annual	Progress report
		Conduct 120 system reviews (EMR and m-health) quarterly	No of reviews (EMR and m-health) conducted	Finance HR ICT equipment	Quarterly	Progress report

PILLAR: 4. Medical products, vaccines and technologies

Aim: Increase availability of quality FP commodities

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
1. Supply chain management	Increased availability of contraceptives	Participating in the National Forecasting & Quantification exercise.	No of national forecasting and quantification exercise participated	Human resource, Finance, Vehicles	Annually	Quantification and Forecasting reports
		Conduct 474 F&Q activity in the County	No. of F&Q activities conducted	Human resource Finance Data	Annually	Training reports
		Conduct quarterly ordering & distribution/ redistribution of RH/FP	No of ordering , distribution and redistribution done	Human resource Finance Ordering tools	Quarterly	Order sheets Delivery notes
		Conduct supervision	No of facilities supervised No of supervision conducted	Human resource Finance	Quarterly	Supervision reports Supervision checklist and schedules
		5.Monthly reporting	No of reports submitted FP commodities purchased	Finance HR Finance	Monthly	Monthly FCDRR
		6. Purchase of FP commodities		HR Finance Commodities	Quarterly	Order sheets Delivery notes

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
2. Resource mobilization	Increased resources for FP initiatives	Conduct 1 Family planning Stakeholder mapping	No of stakeholders mapped	Human resource Finance	Annually	Mapping reports
		Develop and share Budgets with FP stakeholders	Budget developed and shared	HR Finance	Annually	Attendance list Attendance list, Stakeholders meeting reports
		Conduct one sensitization meeting with political leaders	No of sensitization meetings with political leaders	HR Finance	Annually	Report, participants list
		Conduct 1 youth led advocacy meetings on FP prioritization in county budget	No of youth led advocacy meetings on FP prioritization in the county budget	HR Finance	Annually	Meeting report, attendance list
		Conduct 2 trainings on proposal writing to 30 health workers	No of trainings carried out on proposal writing	HR Finance	BI-Annually	Meeting report. Attendance list
		Conduct one proposal development meeting for 30 health workers	No of proposal development meetings carried out	HR ,Finances	Annually	Meeting report, proposals developed
		Support 1 reproductive health budgeting meeting between CHMT and MCAs health and budget committee	No of reproductive health budgeting meeting between CHMT and MCAs health and budget committee	HR Finance	Annually	Meeting report, attendance list
		Conduct 2 follow up meetings on FP budget allocation	No of follow up meetings on FP budget allocation carried out	HR Finance	Annually	Meeting report attendance list

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
3. Quality control	Increased availability of quality FP products	Sensitize 150 SDPs on Good storage practices	No of SDPs sensitized on good storage practices	HR , Finances, training manuals	Monthly	Training report
		Carry out Products inspection to 150 facilities	No of facilities inspected	HR, financial resources	Quarterly	Inspection reports Reports
		Pharmacovigilance (Monitoring on drugs procurement)	No. of Pharmacovigilance supervisions out	HR, Finances , reporting tools	Monthly	Meeting report, attendance list
		Hold quarterly drug, medicine and therapeutic committee meeting	No of drugs , medicine and therapeutic committee meeting	HR , Finances	Quarterly	Reports
		Establish 7 appropriate commodity storage areas.	No of appropriate commodity storage areas established	HR, Finances	Annually	BQ,Inspection Reports
		Conduct quarterly redistribution activities in the county	No of redistribution activities carried out	HR , Finances	Quarterly	Report

Aim: Increase allocation & timely disbursement of FP funds

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Advocate for itemized budget on FP	Inclusion of FP budget line in the county health budget.	Conduct 5 program based budget training for 45 managers	No of health managers trained on PBB	HR, Finance	Annually	Reports
		Conduct 1 joint AWP meetings of CHMT members, Health Executive & The County Treasury	No of joint AWP meetings of CHMT members, Health Executive & The County Treasury carried out	HR, Finance	Annually	Reports
		Conduct 6 joint AWP meetings of SCHMT members	No of AWP meetings of SCHMT members,	HR, Finance	Annually	Reports
		Conduct 2 meetings to advocate for inclusion of FP budget line of 50 MCAs & CHMT, SCHMT	No of meetings to advocate for inclusion of FP budget line of 50 MCAs & CHMT, SCHMT	HR, Finance	Bi- Annually	Reports
	Increased resources for FP	Conduct 1 Stakeholder meetings of 50 (County Assembly Health committee, MOH, CSOs).	No of stakeholders meeting carried out	HR , Finance	Annually	Reports
	Increased partnerships for FP funding.	Conduct 1 stakeholders forums of 30 members at Sub county level to develop proposals and solicit for FP funding	No of stakeholders forum conducted	HR, Finances	Annually	Reports
		Conduct 1 meeting of 30 CHMT & Partners to share the approved health budget & AWP	No of meetings with CHMT and partners carried out	HR, Finances	Annually	Reports
		Conduct 1 meeting to sign an MOU between the Dept. of Health and the Partners	No of MOUs signed	HR, Finances	Annually	Reports, signed MOUs

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
	Increase financing for AYSRH initiatives	Carry out a baseline survey on AYSRH Solicit for AYSRH funding from partners through 1 stakeholders forums Conduct one youth led meeting of CHMT & Partners to share the approved health budget & AWP Conduct one youth led stakeholder meeting with members of County Assembly Health committee,	One baseline survey carried out No of stakeholders forum No of youth led meetings held No of youth led meetings with MCAs health committee	HR, Finances HR, Finances HR , Finances HR, Finances	Annually Annually Annually Annually	Reports Reports Reports Reports

PILLAR 6: Leadership and governance

Aim: Increase number of County & Sub County level FP Champions

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
Leadership and governance for FP	Increased policy formulation and adaptation	Conduct 3 workshops to develop/ domesticate relevant RH/FP and ASRH policies, guidelines and strategies.	Number of RH/FP and ASRH policies domesticated	HR. Finance	Quarterly	Policy documents, Baseline report
		launch RH/FP and ASRH policies, guidelines and strategies	Number of policy documents launched	HR. Finance	Annually	Policy documents domesticated/ developed
		Conduct 6 meetings to disseminate RH/FP and ASRH policies, guidelines and strategies	No. of dissemination meetings conducted	HR, Finance	Annually	Reports, attendance list and minutes
		Quarterly review meetings for RH/FP and ASRH policies implementation	No. of review meetings held	HR, Finance	Quarterly	Reports, attendance list and minutes
	Increased leadership and coordination for FP strategies in the County	Conduct 4 RH/FP and AYSRH support supervision in the county	No. of support supervisions conducted	HR, Finance	Quarterly	Supervision Reports
		Conduct consultative meetings to mainstream FP strategy in the CIDP	No. of consultative meetings held	HR, Finance	Annually	Minutes and reports
		Conduct 7 meetings to sensitize community structures (county health board, hospital boards, facility health committees and community health committees) on FP	No. of sensitization meetings held	HR, Finance	Annually	Minutes and reports

PILLAR: 7. Advocacy

Aim: Strengthen stakeholder involvement, political commitment and investment in advocacy for FP

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
1. Build capacity of FP stakeholders	Strengthened multi-sectoral coordination and networking, partnership and community partnerships	Conduct 1 Stakeholder mapping	No of partners identified	Funds personnel	annually	Database/ matrix
		Establish &Train 30 FP TWG members	No of TWG members trained No of TWG meetings held	Funds Personnel Training materials	Annually	report
		Conduct 4 Stakeholder meetings (FBOs, CORPs, Media, Admin, MOE, Youth & Gender, CHMT	No of meetings held	funds	quarterly	reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
2.FP Awareness	Increased FP awareness among stakeholders	Conduct 1 meeting to sensitize stakeholders on FP/RH and ASRH related policies and guidelines	No of meetings held	Funds Personnel policies	quarterly	reports
		Conduct 1 workshop to design & develop FP/RH and ASRH related IEC materials and documentary.	No of FP/RH and ASRH IEC materials developed	Funds Personnel consultant	Annually	IEC materials
		Pretest the developed IEC materials	No of materials pretested	Funds personnel	Annually	IEC materials
		Production of 10000 IEC materials	No. of materials printed	Funds	Annually	IEC materials
		Conduct 4 meetings to disseminate & distribute the IEC materials.	No of dissemination meetings No of IEC materials distributed	Funds IEC materials	continuous	reports
		Erect billboards in 2 major sub county towns	No of billboards erected	funds	Annually	billboards
		Conduct 6 road shows to create awareness on FP	No of road shows conducted	Funds IEC materials	Bi-annually	reports
		Identify, map out and meet leaders and decision-makers to inform and engage them on the need to support FP/RH activities	No of meetings held No of pledges given	Funds Policy documents AWP	quarterly	reports
		Commemoration of World Contraceptive Day	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		Commemoration of World Condom Day	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		Commemoration of Intl Youth Day	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		Commemoration of World Population Day	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		Commemoration of Intl Women's Day	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		Strengthen integration of family planning awareness into other programmes/services	No of programmes/services integrating FP services	FP commodities IEC materials Trained personnel	continuous	reports

STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	INPUTS	FREQUENCY	DATA SOURCE
		Strengthen integration of family planning awareness into other sectors	No of sectors integrating FP services	FP commodities IEC materials FP policy	continuous	reports
		1.Identification of FP champions 2.Orientation of FP champions	FP champions in place	Funds Personnel IEC materials	continuous	Reports
	Advocate for elimination of barriers that hinder young people's access to RH information and services	1. Conduct an assessment to identify barriers 2.Develop targeted FP messages to demystify myths and misconceptions on FP 4.Conduct 2 dialogue sessions and focused group discussions 4.Develop/customize FP e-platform for the youth	No of young people, facilities and CUs reached No of FP messages developed No of dialogue sessions conducted e-platform developed	Funds Tools Personnel consultant	Annual Annually	Gap analysis report Targeted FP messages Report e-platform
FP advocacy for hard to reach population	Increased FP awareness and uptake among hard to reach population	1. Develop targeted FP messages to demystify myths and misconceptions on FP 2. Conduct 4 dialogue sessions with religious leaders (catholic, Muslim, miracle church)	No of FP messages developed No of dialogue sessions conducted	Funds Personnel Funds Personnel IEC materials	Annually quarterly	IEC materials Report
2. Media advocacy	Increased media coverage	Conduct 1 media assessment to identify popular media houses Conduct 1sensitization meetings with popular media stations in FP/ RH and ASRH programmes Conduct 4 meetings to develop FP/ RH and ASRH messages Conduct 1 meetings to develop Pre-recorded media programs, talk shows and radio spots Airing of 4 recorded messages Conduct quarterly feedback meetings	No. of popular media houses identified No of meetings held No of meetings held Availability of FP/RH and ASRH messages No of meetings held Availability of FP/RH and ASRH pre-recorded media programme No. of media sessions aired No of meetings held List of participants	Funds Personnel Tools Funds Personnel IEC materials Funds Personnel Funds Personnel Funds Funds personnel	Annually Annually Annually Quarterly quarterly quarterly	Report FP/RH messages Reports Reports FP/RH and ASRH reports Reports Reports Reports

CHAPTER 5: RESEARCH, MONITORING & EVALUATION

5.0 INTRODUCTION

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

A mid-term evaluation of this CIP will be carried out in 2019, and an end-term evaluation in 2022. This will be soon after the release of the results of the National Population and Housing Census and the Kenya Demographic and Health Survey, that are both expected in 2019. The results will be compared with the baseline data used in this strategy that has primarily been drawn from the KDHS, 2014 and the estimates from the PHC. The targets for both the mid-term and end-term evaluations are provided in the table below.

5.1 EXPECTED RESULTS

Table 4: Key Performance Indicators and Targets for the Strategy

PILLAR	Key Performance Indicators (KPIs)	Baseline 2016/2017	Mid-term 2018/19	End-term 2022
1. Service Delivery	% of women of reproductive age receiving any family planning methods	49.4	53	60
	Total Fertility rate (TFR)	4	3.4	3.
	% of women with unmet need of FP between 15-49 years	50.6	47	40
	# of facilities offering LARCs	18	40	90
	# of facilities offering Youth Friendly FP services	0	2	6
	Number of adolescent accessing FP services (10-14 yrs.)	1134	1800	3000
	Number of adolescent accessing FP services (15-19 yrs.)	3811	4500	6000
	Number of teenage pregnancies	6220	4500	3000
	% of contraceptive Prevalence Rate, Modern Methods (mCPR)	59	62	68
	# of health facilities offering Adolescent friendly services	0	2	6
	# of comprehensive integrated outreaches conducted by facilities	108	224	1440
	# of health workers trained on FP LMIS	25	80	160
	# of health workers mentored on LMIS	0	180	400
	# of facilities offering integrated health services	146	148	150

2. Health workforce	# of health care providers with sign language skills	1	5	30
	# of nurses recruited	110	120	150
	# of doctors recruited	5	8	10
	#. of clinical officer recruited	0	10	20
	No. of Health care workers trained on LARC	250	310	400
	# of CHVs trained on FP	0	300	1500
	# of CHEWs trained on FP	0	180	300
	# mentorship and follow up visits on FP by CHMT	4	150	300
	# of mentorship and follow up visits on FP by SCHMT	0	150	300
	# of health promotion officers, PHOs & CHEWs capacity built	0	90	300
	# of dialogue meetings held at the CHU level	26	190	400
	No. of health care workers trained on data for decision making	0	270	600
	# of surveys conducted among special groups on FP.	0	1	5
	# of facilities using revised FP M&E tools.	165	170	180
	% of facilities submitting timely FP reports.	83	92	100
	% of facilities submitting FP reports monthly	92	96	100
	No. of facilities with active QI teams.	2	6	10
	% of facilities visited by the CHMT during support supervision	75	85	100
	# of CUs with CHVs trained in community based information system management	0	20	36
	# of county Data review meetings	1	8	20
	No. of data review meetings with the facilities at sub counties	66	90	120
	# of operational researches carried out	0	2	4
4. Medical Products, vaccines and technologies	% of facilities reporting no stock out of FP commodities	70	85	100
	% of health workers trained on commodity management.	10	50	160
	% of facilities with LMIS tools	100	100	100
	% of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	100	100	100
	% of secondary/tertiary SDPs with at least 3 modern methods of contraception available on day of assessment	100	100	100

5. Health Financing	Availability of a costed FP plan	0	1	1
	% financial allocation for implementation of the costed FP plan	0	30	70
	% of FP budget utilization on FP (Burn rate)	0	90	100
6. Leadership and governance	# of FP specific stakeholder committee forums held	0	20	120
	#. of MOUs done with FP current implementing partners	4	6	10
	# of TWGs members trained on FP	1	10	17
7. Advocacy	# of stakeholders mapped on FP	15	17	20
	# of FP TWG meetings held	3	9	20
	#. of champions advocating for FP	60	90	120
	#. of policy formulated or /and adapted	0	1	3
	#. of FP advocacy messages developed and disseminated to media	0	4	12

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 in 2019, will also be used in the end line evaluation. The main data collection tools and techniques will include the DHIS. Listed in the table below are tools that are currently in use and of importance to FP.

Table 5: Current Reporting Tools and Registers Used for FP

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

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 system are protected from deliberate bias or manipulation for political or personal reasons.

5.4 DATA FLOW

Routine data will be generated from the community units and taken up to the facility level. The facilities will submit their data to the 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 form of reports, supervision and such forums from the CHMT downwards to the facilities and community units, and these shall be utilized. All relevant information received from the National level will be channeled down to the County mainly through the CHMT. The flow of data will include data for services as well as for commodities, and will be utilized for decision making. The communication between CHMT and MoH is one of collaboration.

CHAPTER 6: PARTNERSHIP AND FINANCING

6.0 INTRODUCTION

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

This chapter further seeks to cost the CIP, with the hope that it will be included as a stand-alone budget line within the county health budget in 2018/19FY. The costing helps to guide the allocation of these funds. With a clear budget, the partners can also identify areas that they can offer support, aligned to their core business. The successful implementation of this strategy will therefore be dependent upon the collaborative efforts and synergies of all the stakeholders and actors, led by the County Health Team.

6.1 STAKEHOLDERS ANALYSIS

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

Table 6: Stakeholders in Nandi 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	Marie Stopes Kenya	Service provision FP advocacy Social marketing
	DSW Kenya	FP Budget analysis and advocacy
Private sector	Private health facilities	Partnerships and service delivery
FBOs	Faith Based health facilities	Service delivery
Others	Community FP champions	Awareness creation and community mobilization
	Community	Mobilization, Consumers.

6.2 SUMMARY BUDGET

INTERVENTION AREA	Total Year 1	Total Year 2	Total Year 3	Total Year 4	Total Year 5	Total Cost
Pillar 1: Service Delivery						
Male Involvement	59,142,800	63,282,796	67,712,591	72,452,473	77,524,146	340,114,807
Service integration						
Awareness creation						
Community mobilization						
Pillar 2: Health Workforce						
Human Resource Management	46,282,900	49,522,703	52,989,292	56,698,542	60,667,440	266,160,878
Capacity Building						
Pillar 3: Information						
M&E Strengthening	27,570,800	29,500,756	31,565,808	33,775,415	36,139,694	158,552,475
Operational research						
Pillar 4: Medical Products, Commodities and Supplies						
Supply chain management	21,484,450	22,988,361	24,597,546	26,319,375	28,161,731	123,551,464
Resource mobilization						
Commodities						
Quality Control						
Pillar 5: Health Financing						
Resource Mobilization	6,320,500	6,762,935	7,236,340	7,742,884	8,284,886	36,347,545
partnership						
Pillar 6: Leadership and Governance						
Profiling of FP partners	3,736,900	3,998,483	4,278,376	4,577,863	4,898,313	21,489,936
Capacity Building of FP Partners						
Pillar 7: Advocacy						
Advocacy for FP funding	10,792,100	27,957,602	29,914,634	32,008,658	34,249,264	134,922,259
Awareness creation						
Media advocacy						
GRAND TOTAL	175,330,450	204,013,636	218,294,588	233,575,211	249,925,475	1,081,139,364

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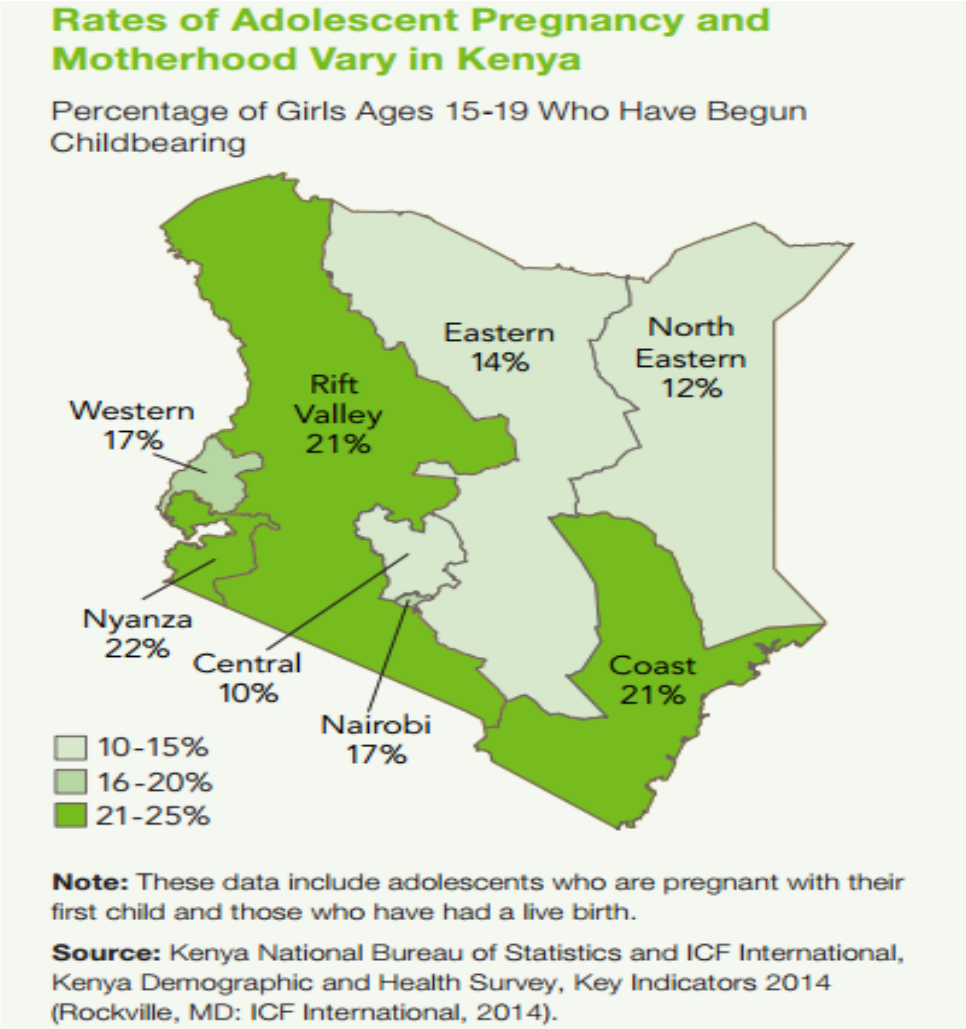
ANNEXES

Annex 1: National Health Work Force Staffing Needs

STAFF CATEGORY	Sub categories	Total staff needs	Norms/ 10,000 persons	
			By staff category	By sub categories
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		0.3
	X-ray technician	0		-
	Radiographer	753		0.2
	Radiologist	576	0.6	0.1
Environmental health staff	Public Health Officers	4,229		1.0
	Public Health Technicians	2,662	1.6	0.6
Community staff	Trained Community Health Worker	120,886		27.5
	Social Health Worker	3,528	28.3	0.8
Rehabilitation specialists	Occupational Therapists	704		0.2
	Physiotherapists	1,768	0.6	0.4
Management staff	Health Records and Information Officer	4,071		0.9
	Health Records and Information Technician	0		-
	Medical engineering technologist	413	1.2	0.1
	Medical engineering technician	825		0.2
Administrative staff	Drivers	7,252		1.6
	Clerks	8,661		2.0
	Cleaners	11,890		2.7
	Security	9,718		2.2
	Accountants	3,846		0.9
	Administrators	4,330		1.0
	Cooks	6,503	12.6	1.5
	Secretaries	3,362		0.8
General support staff	Casuals	2,593		0.6
	Mortuary attendants	749		0.2
	Patient attendants	7,858	2.5	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

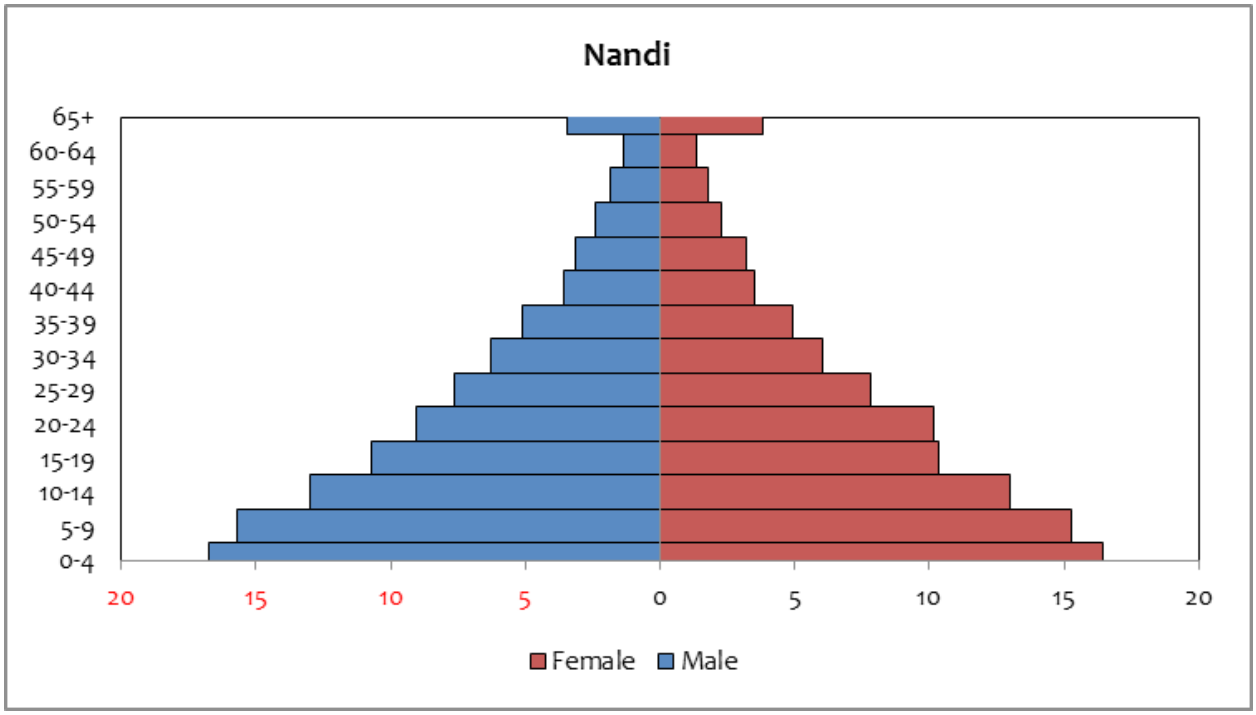
Method mix is not expected to change significantly between 2011 and 2017. However, female condoms are expected to contribute 0.5% of methods used in 2017 up from 0% in 2011. Pills are expected to decline by 0.1% from 16.6% in 2011 to 16.5% in 2017 and Vasectomy by 0.3% to 0% in 2017.

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

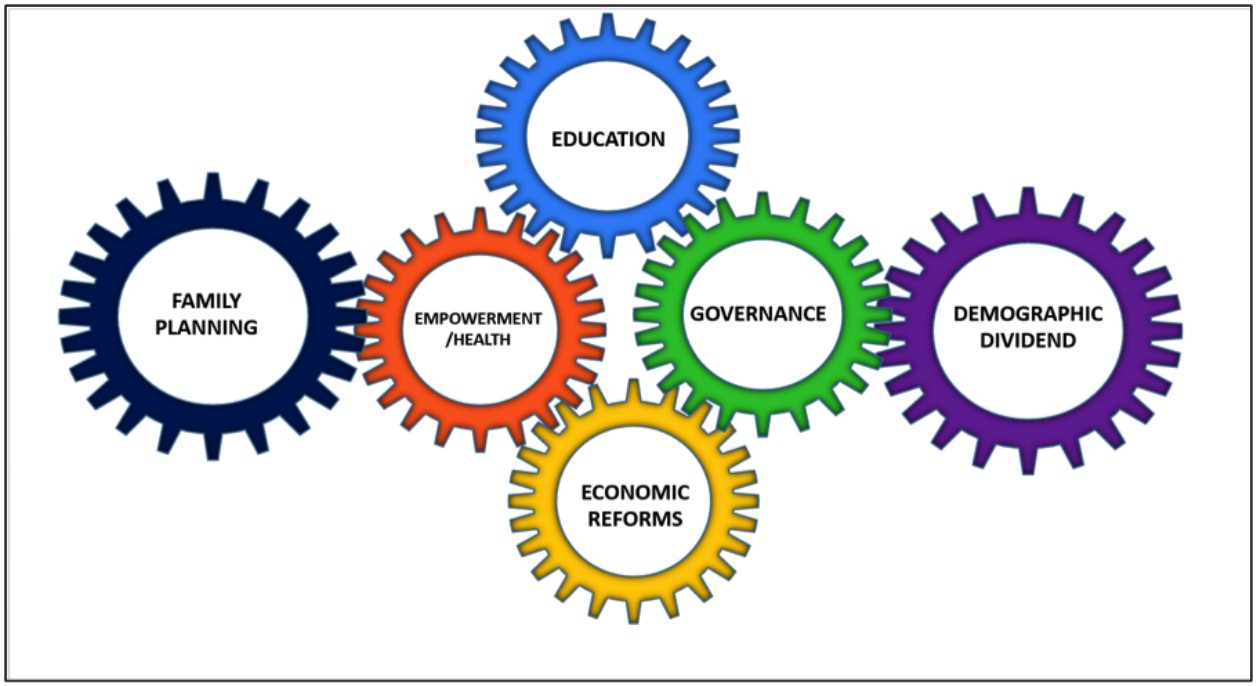
ANNEX 5: Sustainable Development Goals

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

ANNEX 6: Population Pyramid by Age and Gender

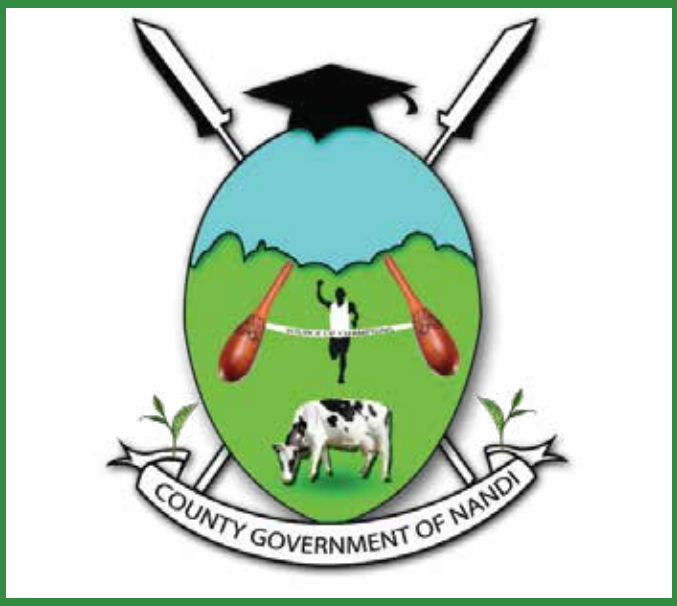


ANNEX 7: Demographic Dividend Investment Wheels



ANNEXE 8: LIST OF FP-CIP DEVELOPMENT TEAM

NAME	ORGANIZATION/DEPARTMENT
Ruth Koech	Nandi C.E.C
Arusei Kosgei	MOH-Chief Officer
Dr. Joseph Kangor	County Director of Health
Christine Andalo	County Reproductive Health Coordinator
Caleb Ikutu	County Records Health Officer
Dr. Andrew Kisang	County Pharmacist
Mark Too	County Health Accountant
David Obuya	Marie Stopes Kenya
Felix Kimutai	Nandi Youth Bunge
Nicholas Kibet	Nandi Youth Bunge
Chrisantus Mulindo	MOH CCHSC
Jane Samoei	MOH CHPO
Lilian Mulama	MOH-SCPHN
Edward Ndiwa	MOH-SCPHN
Flomenah Tero	MOH-SCPHN
Emily Kurgat	MOH-SCPHN
Rachel Jebet	MOH-SCPHN
Baiywo Caroline	MOH SCPHN
Dr. Hassan Kosi	MOH-SCMOH
Imam Rajab Kipkorir	Imam Kapsabet Mosque
Maxmillah Chemutai	Nandi County Youth Bunge
Dr. Chepkwonyi Richard	MOH-SCMOH
Margaret Yego	MOH-Nursing Officer
Joseph Biwott	MOH-SCHRIO
Shadrack Tarno	NCCSN
Ezekiel Kisorio	MOH-SCHRIO
Julius Sang	Red Cross
Lilyanne Limoh	MOH-SCHRIO
Lucy Kandie	MOH-SCHRIO
Valentiene Jerono	NCPD
Moses Ouma	Regional Coordinator NCPD
Dr. Wandera Wanyonyi	MOH-SCMOH
Rev. Peter Rono	Reverend
Dr. Terer Erick	MOH Medical supplies
Sally Kemboi	MOH-CNO
Mark Wanjohi	DSW
Cosmas Mutua	Lead facilitator



County Government of Nandi

Department of Health Services

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