THE KENYA FAMILY PLANNING ADVOCACY TOOLKIT

NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT

DECEMBER 2023

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT
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National Council for Population and Development (NCPD)
The Chancery Building, 4th Floor, Valley Road
P.O. Box 48994-00100, Nairobi, Kenya
Tel: 020 2711600/1
Fax: 254-20-271-6508
Mobile: +254 724 256 202/735 700 204
Email: info@ncpd.go.ke
Facebook: @NCPDfacebook
Twitter: @NCPD_Kenya
Website: www.ncpd.go.ke

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LIST OF ACRONYMS

AWP	Annual Work Plan
AYSRH	Adolescents and Youth Sexual Reproductive Health
BETA	Bottom-Up Economic Transformation Agenda
CBEF	County Budget and Economic Forum
CBO	Community-Based Organization
CDH	County Director of Health
CECM	County Executive Committee Member
CHA	Community Health Assistant
CHMT	County Health Management Team
CHP	Community Health Promoter
CHS	Community Health Strategy
CIP	Costed Implementation Plan
CIDP	County Integrated Development Plan
CME	Continuous Medical Education
CoG	Council of Governors
CRF	County Revenue Fund
CSO	Civil Society Organization
CYP	Couple Years of Protection
DD	Demographic Dividend
DIP	Detailed Implementation Plan
DMS	Director of Medical Services
FBO	Faith-Based Organization
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
GBV	Gender-based Violence
GDP	Gross Domestic Product
GESI	Gender Equity and Social Inclusion
GOK	Government of Kenya
HIP	High Impact Practices
HRM	Human Resources for Health
IEC	Information, Education, and Communication
ICPD	International Conference on Population and Development

LIST OF ACRONYMS

IMR	Infant Mortality Rate
IUD	IntraUterine Device
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
KNBS	Kenya National Bureau of Statistics
mCPR	modern Contraceptive Prevalence Rate
MDA	Ministries, Departments and Agencies
Mand E	Monitoring and Evaluation
MOH	Ministry of Health
MSP	Multi-Sectoral Platform
MTEF	Medium-Term Expenditure Frameworks
NCPD	National Council for Population Development
NGO	Non-governmental Organization
NHIF	National Health Insurance Fund
NTEP	(Ministry - The) National Treasury and Economic Planning
PCHE	Per-Capita Health Expenditure
PESTEL	Political, Economic, Social, Technology, Economic, and Legal (framework)
PFM	Public Finance Management (Act of 2012)
PHC	Primary Health Care
PIIM	Power Influence/Interest Matrix
POA	(ICDP) Programme of Action
PPP	Public-Private Partnership
PTA	Primary Target Audience
RH	Reproductive Health
RNI	Rate of Natural Increase
SAGAs	Semi-Autonomous Government Agencies
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SDEP	State Department for Economic Planning
SDGs	Sustainable Development Goals
STA	Secondary Target Audience
STI	Sexually Transmitted Infection

LIST OF ACRONYMS

SWG	Sector Working Group
SWOT	Strengths, Weaknesses, Opportunities, and Threats (framework)
TAP	Target Audience Profiling
TAS	Target Audience Segmentation
TFR	Total Fertility Rate
TMA	Total Market Approach
TSP	Task Sharing Policy
TTA	Tertiary Target Audience
U5MR	Under Five (years) Mortality Rate
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USD	United States Dollar
UNFPA	United Nations Population Fund
WHO	World Health Organization
WRA	Woman/Women of Reproductive Age

GLOSSARY OF TERMS

Advocacy - is a series of strategic and interconnected actions that aim to bring about positive changes in the policy, legislative, funding or regulatory environment, and in the implementation of policy at national or county levels.

Contraception - encompasses all methods used to prevent pregnancy, including: condoms, emergency contraception, fertility awareness methods (e.g. Standard Days Method), implants, injectables, intrauterine devices (IUDs), the lactational amenorrhea method (LAM), oral contraceptives, tubal ligations, and vasectomies.

Demographic Dividend – refers to the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents

Family Planning (FP) - refers to the full range of fertility and contraceptive policies and services that allow people to determine the number and timing of pregnancies, including the voluntary use of methods for preventing pregnancy

Healthy Timing and Spacing of Pregnancies (HTSP) - HTSP is an approach to Family Planning that helps women and families delay, space, or limit their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children. HTSP works within the context of free and informed choice and considers fertility intentions and desired family size.

Information, Education, and Communication (materials, activities, etc.) (IEC) - As per the World Health Organization (WHO), "IEC refers to a public health approach aimed at changing or reinforcing health-related behaviours in a target audience, concerning a specific problem and within a predefined period of time, through communication methods and principles."

Unmet Need for Family Planning - refers to women "who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour."

Rate of Natural Increase (RNI) - expressed as a percentage, is derived by subtracting the Death Rate from the Birth Rate. The difference is the annual rate of population growth without accounting for migration

Infant Mortality Rate (IMR) - is the annual number of deaths of infants (under age of 1 year) per 1,000 live births

Total Fertility Rate (TFR) - is the average number of children a woman would have assuming that current age-specific birth rates remain constant throughout her childbearing years (age 15 to 49 years).

Contraceptive Use - refers to the percentage of currently married or "in-union" women of reproductive age (WRAs) who are using any form of contraception.

Power-Influence/Interest Matrix (PIIM) - is a project management tool that has been adopted in Advocacy to aid in Stakeholder Analysis. It is an important tool because it improves the intervention's focus, efficiency, and effectiveness, by refining the selection criteria of partners to be co-opted into the Advocacy Coalition, and thus helps in managing expectations and improving communications.

FOREWORD

This toolkit aims to provide a one-stop resource for family planning (FP) advocacy. The toolkit will provide stakeholders with the necessary information and tools to act and provide voice and agency to women and girls in need of contraceptives.

The Toolkit is designed to target key decision-makers and influencers in FP funding, policy and legal framework at national and county levels. FP is a socio-economic agenda for the country. This FP toolkit is designed to focus attention of advocates, partners, stakeholders, policy-makers, and decision-makers on the implementation of FP as an effective strategy for achieving the country's socio-economic goals. By providing strategic direction of the FP agenda, the toolkit allows advocates to have a common voice based on evidence to support advocacy for policy and funding response. The toolkit is therefore an important pathway to expanding access to FP in line with SDGs Target 3.7: "By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."

This Toolkit will be utilized by FP advocates in government at the national and county level, Civil Society Organizations (CSOs), Development Partners, the Private Sector Actors, underserved groups, communities, and individuals. This Advocacy Toolkit aims to equip FP advocates with resources, and relevant information required to effectively analyze the FP ecosystem, prioritize issues, plan for, and implement effective advocacy interventions to influence relevant policies and funding for FP. The toolkit also provides descriptions of key advocacy concepts, approaches, and tools, and explains how advocates can employ them to improve the effectiveness of advocacy efforts and guarantees desirable outcomes. The toolkit also provides insights on key actors in the FP/RH space and pointers on how to engage them.

It is my expectation that the FP advocates will use this tool kit as guided with an aim of having efficacious advocacy in the family planning arena.

Dr. Bashir Issak
Director
Directorate of Family Health

ACKNOWLEDGEMENT

The National Council for Population and Development (NCPD) was bestowed with the responsibility of coordinating the development of the Family Planning Advocacy Tool Kit.

The Council would like to acknowledge the team that was drawn from Government (Ministry of Health, Division of Reproductive and Maternal Health and NCPD), non-state actors (Marie Stopes Kenya, Clinton Health Access Initiative (CHAI), Sexual Reproductive Health Rights Alliance, International Centre for Reproductive Health (ICRH), and Pathfinder) and Development Partners (USAID and UNFPA) who took part in the development of the advocacy tool kit. Your dedication and commitment to develop such a detailed Family Planning Advocacy Tool Kit is highly appreciated.

Special appreciation goes to Axis Health Analytics lead Dr. Urbanus Kioko for leading the process together with Bildad Mwanga and Vincent Odiara. The evidence and communication of the information has contributed to providing water tight evidence on the various socio-economic issues raised and addressed in the Tool Kit.

We are grateful to many other stakeholders who greatly improved the kit through a stakeholder validation forum that was held in December 2023. The toolkit development, editing, finalization and printing would not have been possible without the immense financial and technical support from USAID through Momentum Global and Country Leadership Programme of JHPIEGO, Clinton Health Access Initiative and the United Nations Population Fund (UNFPA). We hope that this kit will guide the family planning advocacy efforts in Kenya.

Dr. Mohamed A. Sheikh
Director General,
National Council for Population and Development

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> ...the information has contributed to providing water tight evidence on the various socio-economic issues raised and addressed in the Tool Kit.

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01
INTRODUCTION

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1.1. ABOUT THIS TOOLKIT

This toolkit aims to provide a one-stop resource for family planning (FP) advocacy. The toolkit will provide stakeholders with the necessary information and tools to act and provide voice and agency to women and girls in need of contraceptives. It contains a collection of resources for effective FP advocacy that can be used across different FP contexts and settings.

1.2. WHO IS THE TOOLKIT DESIGNED FOR?

The Toolkit is designed to target key decision-makers and influencers in FP funding, policy and legal framework at national and county levels. It will be utilized by FP Advocates in government at the national and county level, Civil Society Organizations (CSOs), Development Partners, the Private Sector Actors, underserved groups, communities, and individuals. The FP Advocates will target the following key audiences, which include the following decision makers and influencers:

Table 1: A breakdown of key actors in the FP space in Kenya to be targeted for FP Advocacy

PRIMARY TARGET AUDIENCES	RELEVANCE
The Chair and Members Committee on Health (National Assembly, The Senate and County Assembly)	Are critical to the advancement of the FP agenda by providing leadership for legal/policy change, prioritization and approval of budget for FP and also oversight roles
The Chair and Members of the Budget and Appropriations Committee (National Assembly, Senate and County Assembly)	Are the foremost legislative decision-makers in the financing of FP commodities and services that should be prioritized and targeted for FP advocacy

PRIMARY TARGET AUDIENCES	RELEVANCE
The Council of Governors (CoG), Health Committee of CoG, Committee of CECM, Chief Officers' of Health	Support by the CoG is vital for the advancement of the FP agenda. Its members hold great sway in the prioritization and allocation of resources to FP. The CoG is responsible for: Intergovernmental Coordination; Prioritization and allocation of resources for FP; and ensuring allocated budget is availed
The CS, PS, DG-Health, Ministry of Health	Responsible for charting strategic direction and providing leadership for the advancement of the FP agenda in the country
The CS, PS, The National Treasury and Economic Planning (NTEP)	Are critical decision-makers in the resourcing of proposed FP interventions
Executive Office of the President	Pivotal in the coordination of all activities requiring the support of, and/or assent of the Presidency
The Development Partners and Foundations (Funders)	Have been central actors, providing funding and technical support for the advancement of FP in Kenya
SECONDARY TARGET AUDIENCES	**ROLE**
The Private Sector	Are critical partners in the delivery of FP products in the country and portend unexplored potential as a viable resource for FP financing
Civil Society Organizations (CSOs)	Provide an aggregation platform and powerful voice for individuals, groups, and communities to advance their own FP agenda
Regulatory and Professional Bodies	Responsible for quality and standards in FP. They also a part of the planning, implementation, and oversight of FP interventions
FP Advocates and Champions	Are powerful FP ambassadors that have access to high offices and decision-makers. Their endorsement can help to rapidly build support and momentum for FP advocacy effort
The Media (social and mainstream)	The media is a powerful advocacy tool that can be used to inform and change perceptions of both the public and critical decision-makers in the FP space
Research and Academic Institutions	Are a credible source of empirical evidence (data) for decision-making in FP

1.3. GOAL

Improve the overall health and social-economic status of the Kenyan populace by ensuring universal access to quality, equitable, accessible, and affordable family planning information, commodities and services

1.4. ADVOCACY OBJECTIVES

- To strengthen the legal and policy enabling environment for Family Planning (FP) in Kenya by addressing specific barriers, gaps, and inconsistencies in the existing regulations and policies
- Increase the annual allocations for the FP commodity financing by a minimum of 20% each year for the next 5 years at both the national and county levels

1.5. PURPOSE OF THE FAMILY PLANNING ADVOCACY TOOLKIT

The Family Planning Advocacy Toolkit aims to equip FP Advocates with resources, and relevant

information required to effectively analyze the FP ecosystem, prioritize issues, plan for, and implement effective Advocacy interventions to influence relevant policies and funding for FP.

1.6. HOW TO USE THE FAMILY PLANNING ADVOCACY TOOL KIT

This toolkit is a concise, easy-to-use reference resource for advocates conducting FP Advocacy campaigns. The document is divided into Six Chapters, namely: *1)* Introduction, *2)* Situational Analysis *3)* What is Advocacy? *4)* Evidence-Based Advocacy for FP, *5)* Stakeholder Analysis, *6)* Monitoring and Evaluation. The toolkit has a Preamble Section consisting of *i)* Foreword, *ii)* Acknowledgement, *iii)* Table of Contents, *iv)* List of Figures, v) Operational Definitions and lastly, *v)* List of Acronyms. There is also an Epilogue Section consisting of *i)* References Segment and *ii)* Annexes, which domiciles templates, tools, and infographics that advocates will need for planning and implementing FP Advocacy.

The toolkit also provides descriptions of key advocacy concepts, approaches, and tools, and explains how advocates can employ them to improve the effectiveness of advocacy efforts and guarantees desirable outcomes. The toolkit also provides insights on key actors in the FP/RH space and pointers on how to engage them. Chapter 4 of the toolkit provides factual evidence for making pro-FP arguments and the corresponding "calls to action". The structure of the document presupposes that many FP advocates may require to only reference specific sections of the toolkit, and it's thus designed in topical segments for quick reference.

1.7. RATIONALE

In recognition of the country's responsibility towards global and regional commitments, the GOK has prioritized and invested heavily in healthcare as one of its four core pillars of its transformative *Bottom-up Economic Transformation Agenda (BETA)*. This commitment is important because it will ensure that gains achieved over the years through strategic health programmeming will be sustained in the foreseeable future. Kenya is a signatory to the global level *Sustainable Development Goals (SDGs)* agenda which in part, emphasizes attainment of universal access to Sexual and Reproductive Health (SRH) services, and the integration of RH into other national strategies and programmes. Kenya is also a signatory to the Abuja Declaration that committed countries to increasing Health Sector Financing to 15% of their total national budget. Kenya was among the 179 countries from around the globe that signed on the *1994 International Conference on Population and Development Programme of Action (ICPD PoA)* committing specific country targets for vital FP/RH indicators such as increased financing of FP commodities from domestic resources in order to eliminate disparities in access to quality FP services, as evidenced by unmet need for FP, currently at 14% for married women and 19% for sexually active unmarried women. These commitments are in line with the African Union (AU) Agenda 2063 that proposes to focus on Sustainable Development, Growth, Equality, Human Capital Development, Gender Development and Youth Empowerment.

FP is a socio-economic agenda for the country. This FP toolkit is designed to focus attention of advocates, partners, stakeholders, policy-makers, and decision-makers on the implementation of FP as an effective strategy for achieving the country's socio-economic goals. By providing strategic direction of the FP agenda, the toolkit allows advocates to have a common voice based on evidence to support advocacy for policy and funding response! The toolkit is therefore an important pathway to expanding access to FP in line with SDGs Target 3.7: "By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."

There is ample evidence in support of the premise that FP is one of the best and most cost-effective investments to ensure the health and well-being of women, children, and communities. As part of its economic transformation strategy, Kenya was the first country in sub-Saharan Africa to adopt FP as a national policy leading to the creation of a national family planning programme that has been among the most successful in the region. Its commitments to the Global and Regional FP/RH agenda are precisely crystallized in the Kenya FP2030 commitments, which, among other things, proposes to:

- *Increase domestic financing for FP commodities to cover 100% of the country's requirements) by 2026*
- *Ensure sustained availability of FP commodities to the last mile*
- *Increase mCPR for married women from 58% to 64% by 2030*
- *Reduce the unmet need for FP for all women from 14% to 10% by 2030*

Kenya's BETA blueprint is cognizant of the changing donor landscape and the need to shift RH/FP financing from the current model that is heavily donor-dependent to a sustainable model that draws on domestic sources.

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...the toolkit allows advocates to have a common voice based on evidence to support advocacy for policy and funding response!

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02
SITUATION ANALYSIS

A comprehensive situation analysis of family planning in Kenya should always be the foundation for any evidence-based policy and programme development. To obtain the most accurate and current information, it is essential to refer to the latest publications and reports from reputable sources like the KDHS, Kenya Population and Housing Census, and FP2030.

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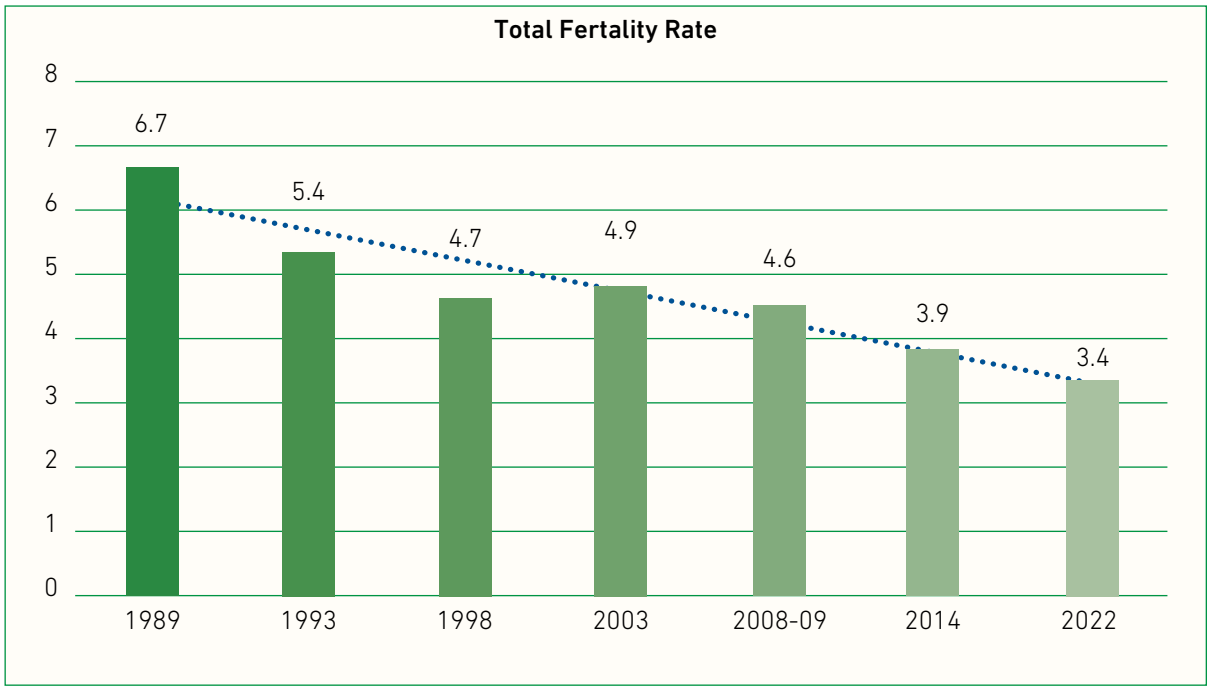
2.1. DEMOGRAPHICS AND HEALTH

Between 2009 and 2019, Kenya's population increased by 2.3%, from 38.6 million to 47.6 million (KNBS, 2019). On average, the country's Population Growth Rate (PGR) of 2.9%, recorded between 1999 – 2009, declined significantly to a PGR of 2.3%, which was recorded in the period 2009 – 2019. The decline in the population growth rate is mirrored by the decline in fertility rates. Between 2003 and 2014, fertility declined from an average of five (5) to four (4) children per WRA (women of reproductive age, 15- 49 years).

The graph below shows the trend of Total fertility rate from 1989. The graph shows that Total fertility rate has been declining, which mirrors the observed increase in the mCPR.

Figure VI: A chart showing the decline in Total Fertility Rates in Kenya from 1989 - 2022



Source: KDHS 1989, 1993,1998,2003,2008-09,2014 and 2022

The above trends are good indicators that Kenya is on the right path to achieving a demographic dividend. In 2017, Kenya launched its **"Demographic Dividend Roadmap"** that is expected to guide the country in making strategic investments in health, education and training, economic and governance sectors, aimed at harnessing the potential of a young population to accelerate socio-economic development that would ultimately lead to a better quality of life for the citizenry.

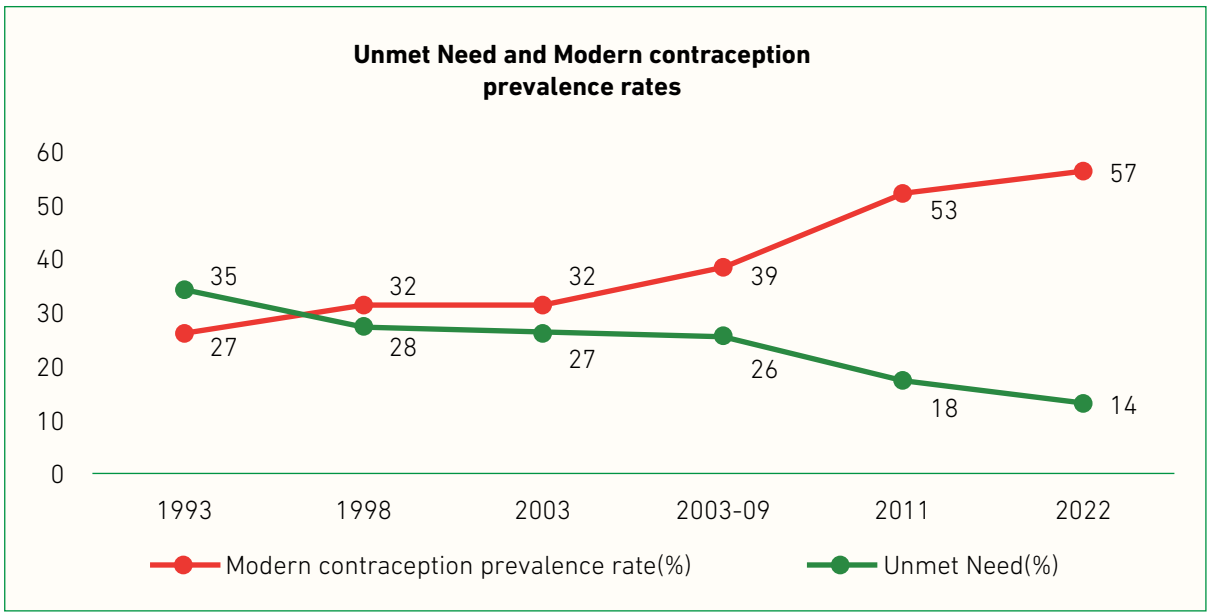
2.1.1. TRENDS IN UNMET NEED FOR FP and mCPR AT NATIONAL LEVEL

Unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting). Specifically, women are considered to have an unmet need for spacing if they are:

- *Pregnant with a mistimed pregnancy*
- *Postpartum amenorrhoeic for up to two years following a mistimed birth and not using contraception*
- *At risk of becoming pregnant (fecund), are not postpartum amenorrhoeic, are not using contraception, and either do not want to become pregnant within the next two years or are unsure if or when they want to become pregnant*

From previous KDHS data, Figure 13 (below) shows the trends of unmet need versus the modern contraceptive prevalence rate (mCPR) between 1993 and 2022. The graph shows that the use of modern contraception has increased significantly, from 17.9% in 1989 to 57% in 2022. During the same period, unmet need for FP declined from 35% in 1993 to 14% in 2022. This is a clear indicator that the increase in modern contraception use has contributed to the reduction in unmet need for contraception by 21% in the last 20 years.

Figure VII: A line graph showing the inverse correlation between mCPR and Unmet Need for FP

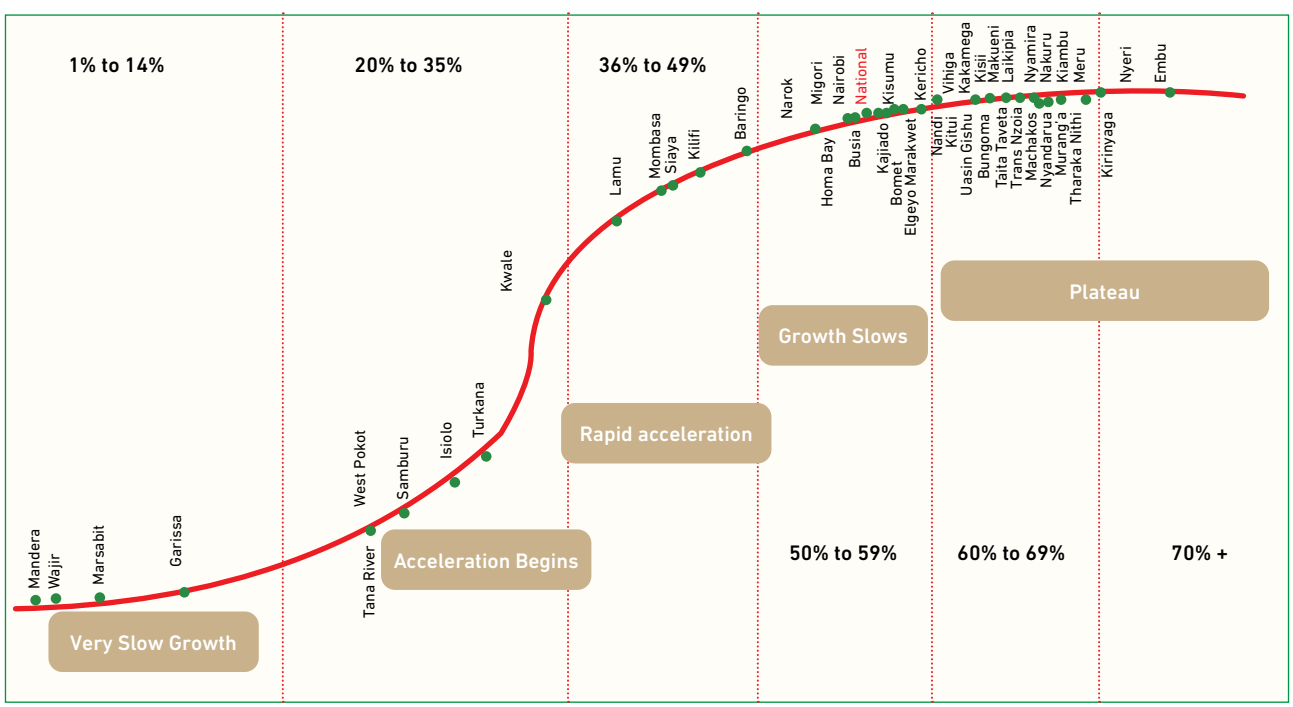


Source: KDHS 1993, 1998, 2003, 2008-09, 2014 and 2022

2.1.2. UNMET NEED FOR FP and mCPRs IN KENYAN COUNTIES

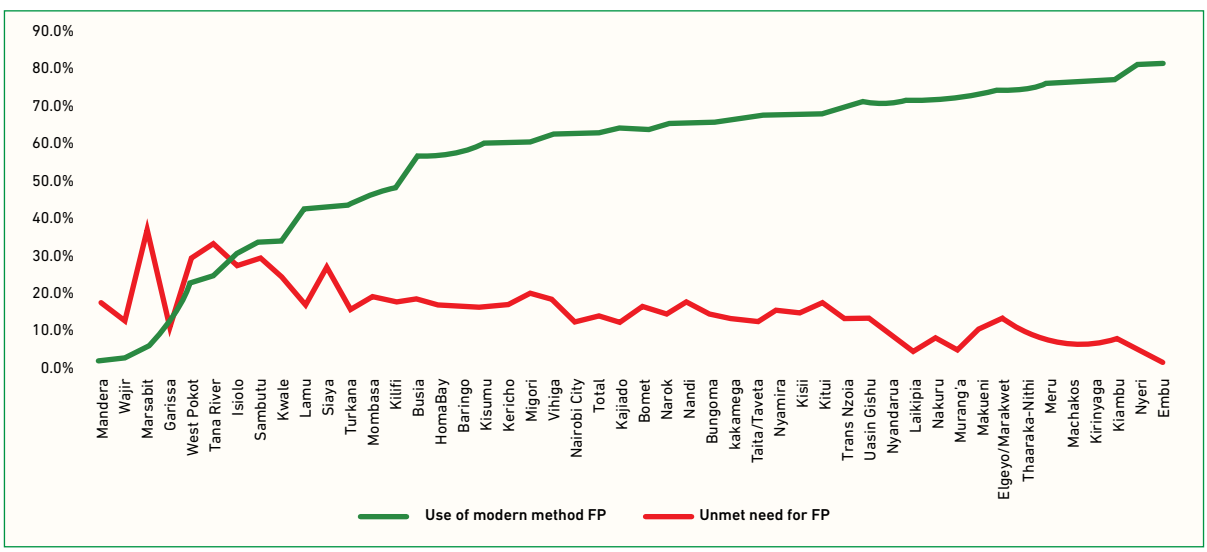
According to KDHS data in 2022, counties in Arid and Semi-Arid Lands (ASAL) counties of Mandera (1.8%), Wajir (2.8%), Marsabit (5.6%), Garissa (11.1%), West Pokot (23.2%), and Tana River (23.2%) have the lowest mCPRs in the country. Conversely, counties located in the densely populated central highlands, upper, and lower eastern posted the highest mCPRs, with Embu leading with (75.2%), followed by Kirinyaga (70.8%), Nyeri (70.5%), Meru (69.7%), and Kiambu (68.2%). Figure 14 (below) depicts the distribution of mCPR in Kenyan counties in an S-curve, and provides pointers for recommended advocacy interventions that correspond with the counties' position on the S-curve continuum

Figure VIII: Chart showing the S-curve of mCPR in counties across Kenya



Interpretation of the S-curve (*Pg. 10*) - What it means for FP programmes priorities		
During this stage efforts are needed to change social norms around FP, stimulate demand, and establish infrastructure and providers to deliver quality FP services	During this stage it is important to make sure there are no barriers to services by ensuring contraceptive availability, high-quality services, and continued demand generation. It is also during this stage that counties want to achieve and maintain rapid growth to maximize their ability to transform their population and benefit from the demographic dividend.	Efforts at this stage should prioritize equity in mCPR among different sub-groups to ensure that no one is left behind. Programmes should focus on long-term sustainability, continued improvements in service quality, and expanding the range of methods available.
Interpretation of the S-curve - What it means for Goal-setting		
Since mCPR will not have much change annually, programmes should focus on precursor indicators that signify changes in demand for FP and increased access through system expansion	At this stage realistic, but ambitious mCPR goals should be established.	At this stage, rather than focusing on further growth, goals and objectives should be focused on equity indicators and government financial commitments.

Figure IX: *A graph showing the negative correlation between mCPR and Unmet Need across counties in Kenya*



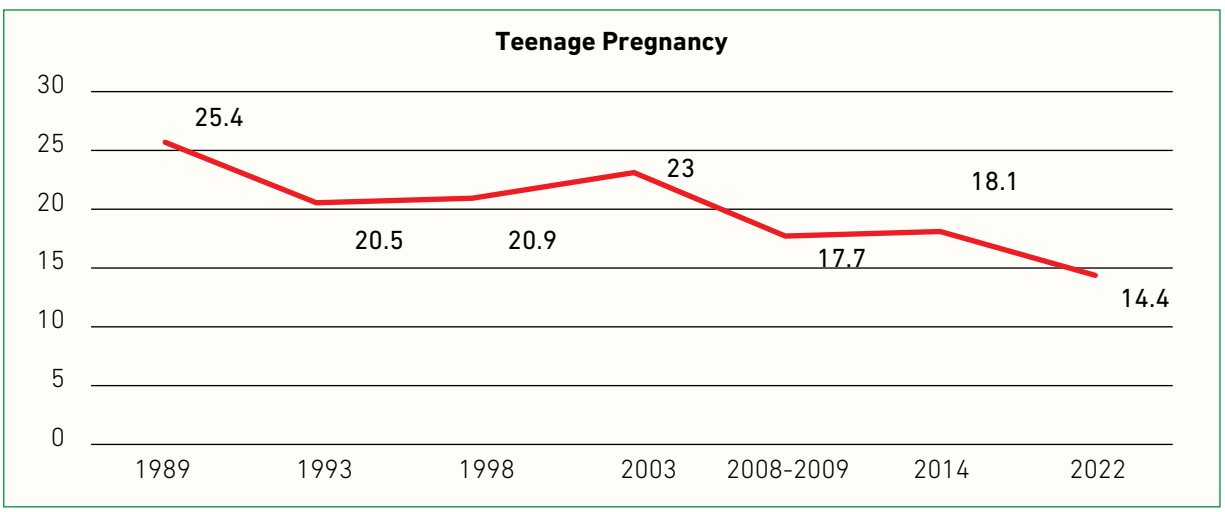
Source: *KDHS 2022*

The above graph shows that counties with higher CPR also have lower unmet need for FP. For example, Embu county has the highest CPR of 75.2% and lowest Unmet need of 2.2% while counties like Mandera, Marsabit and West Pokot with the lowest CPR have the highest unmets needs for FP.

2.1.3. TRENDS IN ADOLESCENT PREGNANCY RATES IN KENYA

From the KDHS data collected over the years (1989, 1993, 1998, 2003, 2008-09, 2014, and 2022), teenage pregnancy has been alarmingly high. Teenage pregnancy has negative consequences on the life of the girl such as dropping out of school, early marriages and unemployment. Although teenage pregnancy rates have dropped over the years from 25.4% in 1989 to 14.4% in 2022, more effort is still needed to further bring down the rate. The Government of Kenya (GOK) is committed to reducing the pregnancy rates among adolescent girls from the current 14% to 10% by 2025 (FP2030).

Figure X: *A line graph showing the drop in Teenage Pregnancy Rates (TPR) in Kenya between 1989 and 2022*



Source: KDHS 1989, 1993, 1998, 2003, 2008-09, 2014 and 2022

2.1.4. TRENDS IN MATERNAL MORTALITY RATES IN KENYA

The progress in family planning has contributed to the reduction of maternal, infant and child mortality. According to KDHS 1998, 2003, 2008/09 and 2014 surveys, the maternal mortality rate (MMR) declined from 590 in 1998 to 414 per 100,000 live births in 2003. In 2008/09 KDHS, the MMR increased to 520 and again declined to 362 in 2014 with a further decline to 355 per 100,000 live births in 2019. Infant mortality rate declined from 77 per 1000 live births in 2003 to 39 in 2014 and further to 32 per 1000 live births in 2022. Under five mortality declined from 115 per 1000 live births in 2003 to 52 in 2014 and further to 41 per 1000 live births in 2022.

With family planning, proper spacing is achieved and mothers are able to bring up healthy children reducing the infant and under five mortality deaths.

2.2. LEGAL AND POLICY ENVIRONMENT

Kenya is a signatory to a number of key global and regional commitments that prioritize RH/FP as an important strategy for the attainment of socio-economic progress, among them the Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs,), the International Conference on Population and Development Programme of Action (ICPD PoA) and FP2020. In keeping with its international commitments, Kenya has successfully enacted/developed robust legal and policy frameworks to guide the delivery of RH/FP programmes in the country leading to the afore-mentioned achievements in FP.

The Sessional Paper No. 10 of 1965 is cited as the first ever policy in Kenya that attempted to link the health and well-being of its citizenry to the sustained socio-economic progress of the country. Over the years, Kenya has enacted/developed numerous legal/policy frameworks, including revisions to existing ones, in a bid to respond to the ever-changing health needs and socio-economic dynamics of its populace. Moreover, strategic plans have also been developed at both national and county levels, and regularly revised in order to operationalize the provisions prescribed in the said legal/policy frameworks that honour constitutional

obligations, political promises, and international and regional commitments entered into by the GOK on behalf of its people.

Below are some of the key international, regional and national commitments by the GOK that speak to FP and may be referenced by advocates to anchor their FP advocacy agenda for increased investments in FP and the auxiliary policy changes required for the delivery of quality FP services and achievement of strategic targets as set in the governments' commitments to its people and partners.

DOCUMENT	DESCRIPTION AND OBJECTIVES OF FRAMEWORKS	SOURCE
SDG Framework	Sustainable Development Goal (SDG) indicator 3.7.1 specifically outlines the desirable outcome of FP programmes, i.e. "Proportion of women of reproductive age (aged 15-49 years) who have their need for FP satisfied with modern methods". FP contributes directly or indirectly to SDGs 1, 2, 3, 4, 5, 8, 10, 11, 12 and 13.	UNITED NATIONS *(Jan. 2015)*
ICPD25	In 2019, Kenya made 17 commitments as part of the ICPD25 framework to be achieved by 2030. These included: Increased Health Sector Financing, Universal Access to high-quality RH/FP services, Increased Demand and Utilization of FP Services, Eliminating Teenage Pregnancies, Increased Medium Term Expenditure Frameworks (MTEF) Budgetary Allocations for Population Programmes, Resource Allocation for FP commodities, and Sustainable Policies/Legal Environment to support the delivery of quality RH/FP programmes.	GOK *(Nov. 2019)*
Constitution of Kenya	Article 43(a) The constitution guarantees every person the right to the highest attainable health standard including Reproductive Health Services	GOK *(Aug. 2010)*
Kenya Vision 2030	Kenya Vision 2030 makes reference to the MDGs and recognizes elements of RH (e.g. reduction in infant, child and maternal mortality and improvement in maternal health) as foundational standards for a healthy productive populace that is a prerequisite for the attainment of the desired socio-economic growth/goals that are detailed in the document. In this sense, the document provides a blueprint for long-term investments in health.	GOK *(Jun 2008) (Pgs. 1, 5)*
Bottom Up Economic Transformation Agenda)	The BETA Plan outlines GOK's commitment to set aside seed funding of Kshs 100 billion to co-fund strategic health programmes including: HIV, Tuberculosis, Malaria, and RH/FP.	GOK *(Jul 2023)*
Kenya FP2030 commitments	FP2030 sets out Kenya's FP/RH targets to be achieved by 2030. They include: Increase mCPR for married women from 58% to 64%; Reduce the unmet need for FP for all women from 14% to 10%; Ensure sustained availability of FP commodities to the last mile; and Reduce pregnancy among adolescent girls (15-19 years) from 14% to 10% by 2025.	GOK *(Nov 2021)*
The National Reproductive Health Policy (2022 - 2032)	Aimed at accelerating FP/RH progress in Kenya in line with SDGs (3,5,10). Addresses inequalities in accessing quality reproductive health services and unique needs of marginalized populations e.g. PWDs, adolescents, and persons in humanitarian/fragile settings. Also addresses bottlenecks and structural weaknesses in the health system e.g. HRH, technology, data, research, partnerships, etc.	GOK (MOH) (Jul 2022)

DOCUMENT	DESCRIPTION AND OBJECTIVES OF FRAMEWORKS	SOURCE
National Adolescent Sexual and Reproductive Health Policy (2015)	This framework aims to improve access to ASRH information and services by promoting an enabling socio-cultural and legal environment for the delivery of SRH information and services to adolescents, increasing gender equity, strengthening inter-sectoral coordination and collaboration and supporting adolescent participation and leadership in SRH planning and programmeming at all levels.	GOK (MOH) (Jun 2015)
Kenya FP Costed Implementation Plan (2021 - 2024)	The Kenya FP CIP is the third installment under the Kenya Health Policy 2014–2030. It sets out the strategic direction, the areas of investment, the implementation framework and the resources that are required in the National Family Planning Programme between 2021 and 2024. The CIP, among other things, provides a unified implementation roadmap for FP; Defines budgetary requirements for the FP programme; Provides a framework for inclusive participation of multiple stakeholders; Guide the mobilization of resources from government, development partners and private sector; Provide a framework to guide the development of county-level FP-CIPs	GOK (MOH) (Oct. 2021)
The Health Act of 2017	This Act provides for the right of every citizen to access quality RH services, including safe, effective, affordable, and acceptable FP services	
Kenya Health Policy (2014 - 2030)	The Kenya Health Policy 2014 to 2030 recognizes FP as a strategic reserve for public health commodities and advocates for ensuring access for all people to their preferred contraceptive methods as part of advancing human rights	
The Sessional Paper No. 3 of 2012 on Population Policy for National Development	This framework identifies rapid population growth and a youthful population structure as key issues that will pose challenges in the realization of Vision 2030. FP is at the centre of Kenya's commitment to create a system to achieve Universal Health Coverage (UHC) that is based on subsidized Primary Health Care (PHC) to include preventive, promotional and curative services as envisioned in the "Afya Bora Mashinani."	
MOU between GOK and its FP Development Partners	This Memorandum of Understanding (MOU) between GOK and its Development Partners forms part of the frameworks for the enabling environment for FP. The MOU aims to gradually increase domestic financing for FP commodities in the ratios 1:1.5 in the year 2019/2020, 1:1 in the year 2020/2021, 1:1 in the year 2021/2022, 1:1 in the year 2022/2023, 1:0.5 in the year 2023/2024, 1:0.25 in the year 2024/2025 and 1:0 in the year 2025/2026.	

2.3 HUMAN RESOURCES FOR HEALTH (HRH)

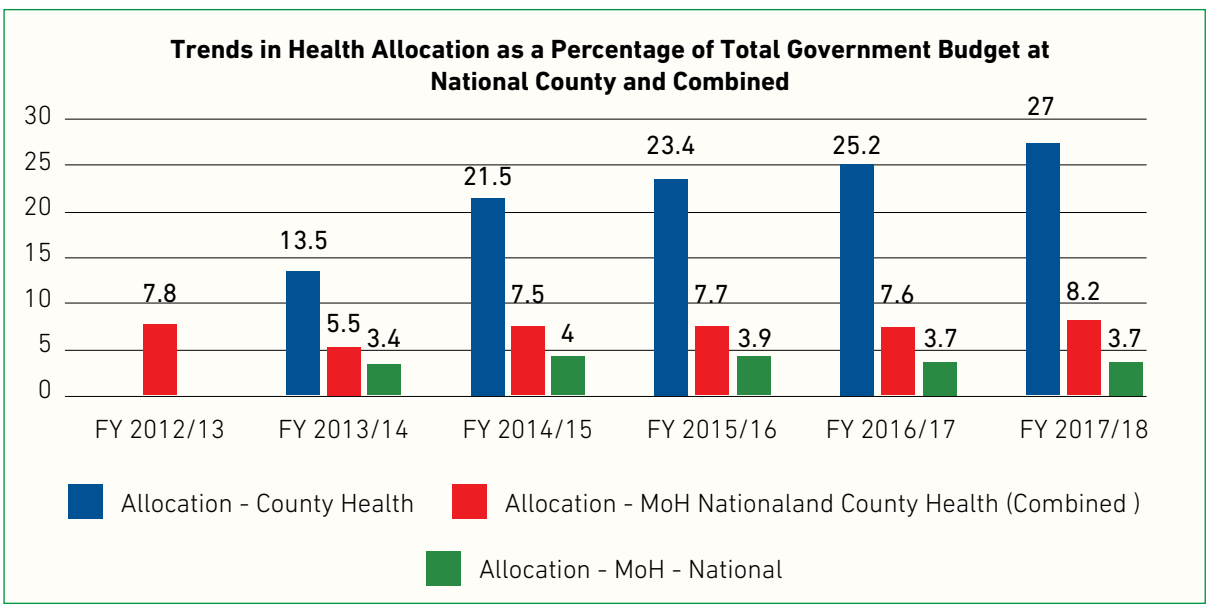
Kenya is experiencing a dire health workforce shortage particularly in specialized healthcare workers to cater for the rapidly growing need for specialized health care (MOH Training Needs Assessment report (2015). The particular challenge for FP is the limited ability of the deployed workforce to competently offer up to date comprehensive counselling services and the full range of FP methods (both short and long term). The verdict on short-term stop gap measures such as task-shifting are yet to prove their effectiveness in solving the current HRH deficit experienced in public healthcare facilities.

FP2030 expressly identifies the HRH gap in the delivery of quality FP services and it proposes "To enhance the capacity of HRH to provide FP information and services while also focusing special attention on the under-served, vulnerable and hard to reach populations, including those in emergency and humanitarian contexts. Towards this end, both the national and county governments should prioritize training of specialized cadres, competent at providing the comprehensive FP services.

2.4.FINANCING AND PARTNERSHIPS FOR FAMILY PLANNING IN KENYA

Domestic Financing in FP commodities has largely remained low with much of the funding coming from development partners such as USAID, UNFPA, BMGF and other Donors. Nevertheless, the government of Kenya has also funded FP services in Kenya through the budgetary allocation to counties. Before devolution, there was a dedicated budget line for FP commodities. Devolution transferred most of the health services delivery to counties including FP services rendering the national level budget line for FP commodities obsolete. The chart below shows the budget allocation to health services.

Figure XII: *A chart showing absolute budgetary allocations to health*



Source: Source: Ministry of Health, 2017; National and county health budget analysis

The FP programme is funded through these allocations to health at both National and County levels which have remained relatively constant for a number of years ranging between 7.5% in 2014/15 to 8.2% in 2017/18. Advocates of FP programmes should also broadly target increased health allocation since it has leveraged on the amount available to finance FP services while at the same time advocating for increased FP allocation from the available health budget.

Donors also contribute to FP financing in Kenya. The GoK signed an MOU with them to gradually increase domestic financing for FP commodities by the ratios 1:1.5 in year 2019/2020, 1:1 in the year 2020/2021, 2021/2022, and 2022/2023, and by 1:0.5 in 2023/2024, 1:0.25 in 2024/2025 and 1:0 in 2025/2026. This ratio is designed in a way that GOK will fully fund the entire financing needs for FP commodities by 2026.

Despite this agreement with donors, GoK did not disburse any funds in the financial year 2022/2023 against a requirement of Kes 2.2B resulting in a funding gap of Kes 2.2B. In the 2023/2024 FY, GOK allocated Kes 1 Billion against a requirement of Kes 2.7 billion resulting in a funding gap of Kes 1.7 Billion. The total funding requirement for FP commodities for year 24/25 is Kes 4.06B, according to NCPD projections. Development partner's commitment is Kes 731 million which will be pegged to the government honoring its commitment. The total funding gap expected from the government in year 24/25 is Kes 3.3B.

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...the national and county governments should prioritize training of specialized cadres, competent at providing the comprehensive FP services.

REPUBLIC OF KENYA

NCPD

03
WHAT IS ADVOCACY?

3.1. DEFINITION

Advocacy is a series of strategic and interconnected actions that aim to bring about positive changes in the policy, legislative, funding or regulatory environment, and in the implementation of policy at national or county levels.

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3.2. PRINCIPLES OF FAMILY PLANNING ADVOCACY

a. **Clarity of purpose** refers to the state of having a clear and well-defined understanding of the advocacy goal(s), objectives and/or intentions. It guides the advocacy team (or coalition) in its decision-making and actions, prioritization, and aligning efforts toward a common goal.

b. **Independence** refers to the principle that advocates should operate free from any undue influence, conflict of interest, or bias. This principle emphasizes that advocates should act in a manner that prioritizes the best interests of their "client(s)" or the causes they support, without being swayed by external pressures, personal gain, or conflicting loyalties. Independence is important because it builds trust, and promotes credibility and integrity of the advocacy efforts.

c. **Confidentiality** refers to the ethical and legal obligation to safeguard sensitive information shared by clients or stakeholders. Advocates must ensure that the information provided to them remains private and is not disclosed to unauthorized parties. Commitment to confidentiality fosters trust and open communication between advocates and clients, allowing for more effective representation and support.

d. **Empowerment** means enabling individuals or groups to gain the knowledge, skills, resources,

and agency (confidence) to assert their rights and make informed decisions. It involves advocating for, and providing support that helps marginalized groups to speak for themselves. The goal of empowerment in advocacy is to promote self-determination and autonomy, allowing individuals and communities to have a stronger voice and greater control over their own circumstances.

e. **Flexibility** in advocacy refers to the ability of the advocacy team/coalition to adapt their strategies and tactics to effectively respond to changing circumstances and challenges as the circumstances evolve. Being flexible enables advocates to navigate unexpected obstacles, seize opportunities, and remain resilient in pursuit of their goals and objectives

f. **Transparency and Accountability** involves openly and honestly communicating the actions, decisions, and outcomes of advocacy efforts to both the rights' holder, duty bearers, and stakeholders. It requires the advocacy team/coalition and stakeholders to provide clear information about their activities, finances, and decision-making processes. This commitment enables stakeholders to assess the effectiveness of advocacy efforts, and ensures that resources are used responsibly in pursuit of the desired outcomes.

g. **Inclusion - Marginalized Groups** (e.g. People with Disabilities) are integral to society and their unique needs and perspectives are important considerations in order to ensure equitable access to FP for all

3.3. TYPES OF ADVOCACY

Advocacy can be categorized based on the target audience and the approaches used. There are two broad types of Advocacy:

a. **Political Advocacy** this refers to the strategic and interconnected actions that bring positive change at the political level decision making process.

b. **Technical Advocacy** includes the strategic and interconnected actions that aim to bring about positive changes at the technical level of decision-making processes.

3.4. APPROACHES TO FAMILY PLANNING ADVOCACY

a. **Financial Advocacy** involves conducting audits of public finances and holding responsible entities/persons to account to ensure that the public gets its value for money

b. **Legislative Advocacy** focuses on enacting laws/policies.

c. **Administrative Advocacy** involves meeting heads of administrative departments and sharing information, data and stories about one's Advocacy Agenda that can help them make informed administrative decisions.

d. **Evidence-based Advocacy** involves conducting empirical research or a critical analysis of available data and packaging outputs into appropriate formats for dissemination to intended audiences.

e. **Media (Social and Mainstream)** Advocacy is a powerful tool with a wide reach that can be used to create news, educate audiences, cultivate relationships, and capitalize off breaking news.

f. **Legal Advocacy** involves litigation (filing suits), usually to request the courts to repeal a law, stop a law from being enacted, or seek the court's interpretation on the grounds that the law has been misinterpreted.

g. **Peer-to-Peer Advocacy** describes interpersonal engagements between individuals from a shared background, that employ a shared understanding and social capital to advocate for change

h. **Grassroots (Community) Advocacy** involves mobilizing the public to support an advocacy agenda.

3.5. FACTORS TO CONSIDER WHEN PLANNING FOR FP ADVOCACY

When embarking on any FP Advocacy intervention, the following factors should be taken into consideration:

a. **Time:** Is a crucial factor in any advocacy intervention. It's essential to establish clear timelines for the development and dissemination of your advocacy materials.

Consider the urgency of the issue at hand, such as prevailing family planning challenges or impending policy decisions including the timing of the delivery of the advocacy message

b. **Cost:** Advocacy is an expensive intervention and there is a need to consider budgetary implications and plan for resource mobilization

c. **Target audience:** Map out the audiences for the FP advocacy

d. **Social, economic and cultural context:** refers to the comprehensiveness of messaging, ensuring that it addresses the nuanced aspects of cultural, social, and economic considerations

e. **Sustainability:** Beyond the immediate impact, consider the long-term sustainability of the FP advocacy agenda.

3.6. TOOLS AND CHANNELS FOR EFFECTIVE FAMILY PLANNING ADVOCACY

The section outlines and defines some of the key Advocacy Tools (i.e. communication materials) that advocates will find relevant when conducting FP advocacy. They include:

a. **Policy Statements** are official documents that articulate an official position on FP policies or issues.

b. **Policy Briefs** are concise documents (one or two pages) that present key information, analysis, and recommendations related to a specific policy issue that decision-makers can use to arrive at a decision.

c. **Technical Briefs** are detailed documents that serve as a foundation for evidence-based advocacy, providing in-depth analysis, evidence, and technical information on specific FP issues.

d. **Media Advisory/Kit** (s) are collections of materials provided to media outlets to facilitate accurate coverage of FP issues. The kit may contain tools like fact sheets, press releases/statements, images, videos and audio recordings.

e. **Reports** are a compilation of findings based on evidence-based data. Infographic(s) are visual representations of data commonly employed in reports or presentations to simplify complex concepts into an easily understandable logical summary that enhances clarity of data when engaging stakeholders.

f. **Brochures and Fact Sheets:** Brochures are printed materials that provide concise information about FP services, products, benefits, and resources. Fact Sheets on the other hand are brief documents that provide concise and factual information about FP issues, often used to educate policymakers and decision-makers.

g. **Documentaries** are short videos or documentaries that highlight personal stories, testimonials, or statistics to raise awareness and advocate for family planning.

Digital channels (*Websites, Microsites, Blogs, Microblogs, Apps, Emails, etc.*) are gaining popularity as affordable, effective, and highly interactive mediums that may be employed by advocates to host FP Advocacy content and tools.

3.7. STEPS FOR CONDUCTING EFFECTIVE FAMILY PLANNING ADVOCACY

There are several advocacy frameworks that have been effectively employed by FP advocates over the years, such as the SMART Advocacy framework and the Rights-Based FP Model. Invariably, most of the popular Advocacy models currently in use consists of the following nine (9) basic steps:

STEP 1: Situation Analysis (Understanding the Landscape)

The FP situation varies across various counties, contexts, and settings. Thus, it is essential to find out what is happening in the particular setting(s) of the advocacy activities under question, in order to focus effort on specific problems, and to build on existing strengths. This toolkit recommends the use of the PESTEL model (Annex 2 for illustration as the standard framework for analyzing contexts.

STEP 2: Establish an Advocacy Team

It helps to have a group of committed individuals who are willing to work on advocacy activities. This group can take charge of planning, identifying partners, and coordinating the activities of the advocacy campaign. Committee members could include staff from the main implementing institution

as well as FP researchers, members of relevant professional associations or reproductive health technical committees, and representatives of partner organizations dedicated to strengthening family planning services. Ideally, committee membership should also include members of the audiences to be reached.

STEP 3: Identify Advocacy Goal(s), Objectives, and Expected Outcomes

Being clear about your Advocacy objectives and expected outcomes is crucial for a well-organized advocacy strategy. In most cases, the advocacy objective(s) are usually different from the programme objectives, in that they reflect what can be achieved through advocacy efforts targeting decision-makers (and those that influence them) with relevant research and information communicating research and information to decision-makers and those that influence them. For the purposes of this FP Advocacy Toolkit, the advocacy objectives are focused on promoting changes in the policy environment and mobilizing resources that ultimately affect family planning services and use.

STEP 4: Conduct a Stakeholders Analysis

When identifying target audiences, it is helpful to segment them into Primary, Secondary, and Opposition audiences. The Primary Target Audience (PTA) are those who will ultimately make the policy or financial decisions. They may include high-level policy-makers such as politicians, ministers of health or finance, or decision-makers at the national or county level.

The Secondary Target Audience (STA) are all the individuals or groups that have access to and can directly influence the attitudes, positions, and decisions of policy-makers and/or any other relevant decision-makers required to effect desired change(s). They may include multi/bi-lateral donors, partners, women's groups, FP champions/ ambassadors, opinion leaders, community and religious leaders, etc. The `Antagonists' are an important subgroup of the STA that must always be considered and planned for.

The academia, researchers, academics, professional associations, and the media are often included into the Tertiary Target Audience (TTA) category. The TTA may have some vested interests in FP, or even indifferent to the FP agenda, but still concerned about the outcome(s) of the intervention. The TTA can be employed to amplify the width, depth, and reach of conversations. The TTA may also be co-opted into the FP discussion to give expert opinion, fact-check arguments and data/evidence presented or even articulate the perspectives and concerns of the silent voices in society

STEP 5: Coalition-Building, Networking and Enlisting Champions

Through coalition-building and networking, larger audiences can be sensitized and triggered to add their voices and resources to a common FP agenda, and create grassroots support for FP that will sustain the momentum of the FP advocacy intervention. FP champions and influential leaders in society should be engaged because of their power to influence decision-makers, thereby achieving desired objectives.

STEP 6: Developing a Detailed Implementation Plan (DIP)

Once the objectives, target audiences, messages, communication channels, and activities have been identified, specify the people and organizations that are responsible for each activity. List what is needed to accomplish each objective/task e.g., people, funds, time, materials, and venues. (see DIP Template in the Appendix). This is helpful in allocating responsibility, creating synergy, and providing a basis for tracking progress and evaluating the success of the FP advocacy intervention. As a rule of thumb, normal advocacy work plans do not normally extend beyond one year. This is because priorities often change from one year to the next and new opportunities for advocacy do regularly arise. It is also important to remember that human and financial resources are usually limited, so the number of activities planned should be both reasonable and doable within the allotted time. It may be wise to delay a planned activity if the attention of the target audience(s) is diverted due to circumstances such as a natural disaster, riots, elections, or a major policy event on a different issue.

STEP 7: Developing, Tailoring and Pretesting Messages

While some of the advocacy messages may be of universal importance (e.g., family planning saves lives), most messages must be crafted for each audience. What might be persuasive for a women's group leader may not work with a finance minister, or vice versa, for example. The general rule is that messages and communication channels should be tailored to suit the concerns and educational levels of the different audiences. A basic communication

principle is that family planning advocates should know their audiences well. Conducting focus group research and interviews on family planning issues with representatives of the various audiences, and pretesting the messages and their formats with them before launching the advocacy activities is time well invested. The channel should be carefully selected so as to maximize the likelihood of reaching particular people.

STEP 8: Implement, Monitor, and Evaluate

At all points during the implementation of the interventions, the core advocacy team should closely monitor the progress toward achieving the set objectives and expected outcomes. If an activity is less than successful, the committee members should find out why and adjust its course as needed so that the advocacy effort will become increasingly effective with time. An evaluation plan should be an integral part of the overall work plan, and should be developed with the participation of all the coalition partners. Committee members should measure both the performance outputs (were all the activities implemented, delivered, and on time?) and also the outcomes (Did the activities bring about the desired change?).

STEP 9: Capture Results and Manage Knowledge

Knowledge management (KM) is the process of capturing, organizing, storing, and sharing an organization's collective knowledge and information to facilitate its effective use for decision-making, problem-solving, learning, and innovation. KM involves creating systems and practices that help the core FP team and its coalition partners make the best use of its knowledge assets, which may include documented information and also tacit knowledge held by individuals in the organization. KM is absolutely important to Advocacy, because it helps in guiding decision-making and the design of future Advocacy interventions. It is also important to remember that, in keeping with the globally acceptable advocacy tenets of accountability, transparency, and justice, the advocacy team should plan for, and execute, dissemination forums

3.8. UNDERSTANDING AND MAPPING OUT THE CHANGE PROCESS

3.8.1. INSTITUTIONAL LEVEL STRUCTURES AND DECISION-MAKING MECHANISMS

Decisions to introduce, amend, or implement policy are guided by evolving needs, informed by new research/data, or even new technologies/ products that introduce efficiencies into the system. Alternatively, pressure from right-holders and their advocates may catalyze the need for policy change(s).

In order to successfully advocate for relevant policy changes, FP advocates must first understand institutional decision-making mechanisms and processes and how the said high-level national decisions move to become law/policy before being cascaded to lower levels for implementation. Institutional culture, values, and practice has a huge bearing on the types of law/policies that will be enacted/developed and how they are implemented.

This toolkit focuses particular attention on official government mechanisms/offices recognized in law and charged with the roles of enacting/developing relevant guiding frameworks and by the same authority, given the mandate to implement the said frameworks, including planning for and allocation for requisite resources for implementation of legal/ policy prescriptions

National Level Mechanisms

At the national level, policy decisions may be handed down from either the Legislative (Senate and National Assembly), as Acts of Parliament (Bills, Statutes) or the Executive Arms of Government in the form of Executive Orders. Interpretations by the Judiciary may also give rise to jurisprudence that is functional and operationally part of the compendium of enforceable laws and regulations in a country.

Technocrats within GOK are required to operationalize the decisions by the Legislature, Executive or Judiciary by developing subsidiary legislation, policy frameworks, Standard Operating Procedures (SOPs), circulars, that provide guidance for implementing legal/policy decisions. Particular offices are also mandated in law to provide resources for implementation of high-level legal/ policy decisions.

Table 2: The roles of national level mechanisms in resourcing and creating an enabling environment for FP programmes

NATIONAL MECHANISMs	ROLES
The Executive (Presidency)	• Executive Orders/Circulars have the force of policy • Setting the national agenda (e.g. BETA - prioritizes health as one of the primary pillars for economic transformation)
The Judiciary	• Upholding and interpreting the constitution and laws related to RH/FP and women's rights • In the absence of local precedents, uses international Jurisprudence to shape policy direction which in turn influences the enabling environment for RH/FP
The Legislature - The National Assembly and The Senate *NB. The Health Committee and the Budget and Appropriations Committee do play leading roles in the formulation of policy and the budgeting process*	• Review of existing frameworks - may result in amendments or even abolishment of archaic legal/policies • Enactment of relevant legal/policy frameworks that influence delivery of FP services • Oversight Roles • Spearheading Public Participation • Debating Government Plans, Budgets and Voting on the same • The Senate represents the interests of the counties and ensure that the devolved functions (e.g. Health, including RH/FP) are adequately resourced
The National Treasury and Economic Planning	• Formulating and implementing Fiscal Policies • Preparing the Annual National Budget; Sets budget ceilings • Ensures that expenditures are aligned to national priorities. • Coordinates the budgeting process • Issues economic analysis/forecasts - guides budgetary decisions
Ministry of Health	• Assess funding and develop budget proposals based on need • Formulating budget proposals for health services including FP • Uses evidence to propose and formulate health policies, guidelines, and strategies aligned with international best practice but tailored to meet specific needs/goals of Kenya • Lead - coordination and development of national health policies • Cascading national policies to the devolved level of government • Coordinate with other national ministries, county governments, partners and international agencies to ensure effective implementation of policies and programme
National Council for Population and Development	• Engages in research, consults with relevant stakeholders, and conducts data analysis to inform policy decisions • Advocacy, public education, resource mobilization, and M and E of population programmes including FP
Auditor General	• Provides objective and independent assessment of government finances and programmes at all levels • Audits expenditures - ensures transparency, accountability, and compliance with financial regulations and policies • Auditor General's findings can identify inefficiencies and financial mismanagement which informs budgeting process and helps policy-makers to make informed decisions • Findings can lead to policy recommendations

NATIONAL MECHANISMs	ROLES
Sector Working Groups (SWGs)	• Platform for coordination and consensus-building among key players in the healthcare sector including FP • Coordination and development of sector-specific plans and budgets • Collective forum for the identification and prioritization of needs, allocation of budgets, and mobilizing of resources (for FP)

County Level Mechanism

The Constitution of Kenya 2010 describes County Governments as the devolved level of government with devolved powers and functions including the authority to manage and implement specific functions and services within their respective counties. Management of the devolved health function does require resourcing and operational policies (enabling environment) at county level. The following are some of the key actors and mechanisms involved in shaping policy and making critical financial decisions at county level that affects the implementation of FP programmes.

***Table 3:** County level mechanisms and their roles in resourcing programmes and creating an enabling environment for FP*

COUNTY MECHANISMS	ROLES
Council of Governors	• Collaborates with national government to ensure that resources are equitably allocated to counties in a manner that reflects the needs of their constituents (including RH/FP needs) • Stewards policy discussions that have a bearing on RH/FP • Provides a powerful voice (advocate) for the rights of citizens, including access to quality healthcare and RH/FP services.
County Assembly *NB: The Health Committee and The Finance and Budget Committee of the County Assemblies play a significant role in the formulation of relevant policies and allocation of resources to health programmes including RH/FP*	• Represent the interests and priorities of their constituents - i.e. policies and resources reflect the priorities and needs of constituents • Contextualize and pass legislation to operationalize national policy at county level • Debating county government Plans, Budgets and voting on the same (approval or rejection) • Spearheading Public Participation • Oversight Roles
The County Executive *Includes: The Governor, Deputy Governor, County Secretary, CEC Member for Planning, CEC Member for Health; Chief Officers for planning and Health*	• Responsible for Executive Functions e.g. administration of the health function - responsible for the resourcing and implementation of relevant policies and programmes (e.g. RH/FP) • Collaborates with the County Assembly to ensure adequate allocation of resources to health programmes • Collaborate with healthcare agencies (e.g. KEMSA, NHIF) to ensure adequate and effective utilization of resources

COUNTY MECHANISMS	ROLES
County Health Management Team (CHMT)	• Responsible for assessment of county health needs and use data to guide budgetary proposals and policy recommendations • Have a significant voice in the allocation of resources and can effectively influence the prioritization, planning and allocation of resources to FP programmes (can champion or be targeted for FP advocacy); responsible for coordinating county planning processes • Coordinate with the County Executive, partners and other stakeholders to ensure FP programmes are adequately resourced • Provide insights/evidence and make recommendations that inform the adaptation of national policies to county context • Oversee the implementation of FP programmes in counties
Sub-County Health Management Team (SCHMT)	• Responsible for assessing and addressing specific health needs at sub-county levels • Participate in the development of the County Integrated Development Plans (CIDPs), Annual Development Plans (ADP), and the Annual Work Plans (AWPs) and can therefore influence allocation of resources to FP programmes • Collaborate with CHMT, partners, and other stakeholders at their level to ensure that FP policies and programme resource allocations are responsive to the needs of the sub-counties • Oversee the implementation of FP programmes at the sub-county level and can therefore influence allocation of resources to FP programmes
Multi-Sectoral Platforms (MSP)	• Are unofficial county forums that coordinate stakeholders to discuss and make recommendations on Policy, County Priorities and Integrated Plans, Resource Mobilization, including monitoring and evaluation.

3.8.2. INSTITUTIONAL PRACTICE

The decision-making processes consist of several steps, including: Policy Development, Research, Stakeholder Consultation (sometimes, Public Participation), and Risk Assessment. A review of Legal, Statutory, Policy, and Regulatory (Standards) may also be necessary to ensure compliance. The Constitution of Kenya (2010) expressly lays down "Public Participation" requirement in all decision-making and governance matters of public concern. Depending on the nature and scope of policy and/or financial decisions, it may be necessary to gather input from, and involve relevant stakeholders (donors, partners, regulatory bodies, professional bodies, community leaders/members) in the decision-making processes. In summary, the following factors should be considered when making critical decisions on matters of policy and finances:

- **Legal and Regulatory Requirements:** Organizations must adhere to applicable laws and regulations, which can necessitate policy changes or updates.
- **Stakeholder Input, Public Opinion and Community Pressure:** Input from stakeholders, including the public, employees and advocacy groups, can influence decision-makers and shape policy in a way that ensures that their expectations and needs are adequately catered for.
- **Economic Considerations:** Financial constraints, budgetary concerns, and cost-benefit analyses can influence whether a policy is implemented and to what extent.
- **Organizational Culture and Values:** The organization's mission, values, and culture may guide policy decisions to align with its overall objectives and principles.

3.8.3. INDIVIDUAL BEHAVIOUR

Many elected leaders and political appointees may advocate for policies that align with their ideologies and campaign promises, and their behaviour can reflect their personal experiences, beliefs and

values. Another case in point would be religious positions on matters of FP/RH; there are many instances and in-country examples where religious leaders have opposed certain FP/RH interventions. It is important to consider their points of view because of the large constituency they represent. In such cases, it is necessary for advocates to adopt a "negotiation and compromise" approach.

3.8.4. BUDGETING CYCLE AND PROCESSES AT NATIONAL AND COUNTY LEVELS

The Budget and the Budget Process is anchored in the Constitution of Kenya, 2010 and is governed by the provisions of The Public Finance Management (PFM) Act, 2012. Under the PFM Act, the National Treasury is required to prepare key documents for approval by Cabinet and Parliament within stipulated timelines provided for in above-mentioned frameworks. Sector Working Groups (SWGs) are therefore required to adhere to the said statutory provisions and are required to document all stakeholder engagements while attaching evidence of the said activities as annexure to the Sector Reports to comply with the public participation requirement.

SWGs are responsible for formulation and prioritization of sector budget proposals and is the only recognized avenue for bidding for resources. Ministries, Departments and Agencies (MDAs) are therefore required to fully participate in the relevant Sector and bid for resources within the available ceilings. No spending proposal will be factored in the budget unless approved and considered within the SWGs.

Figure I: *Flow-chart showing the Budgeting Process at the National and County levels of government*

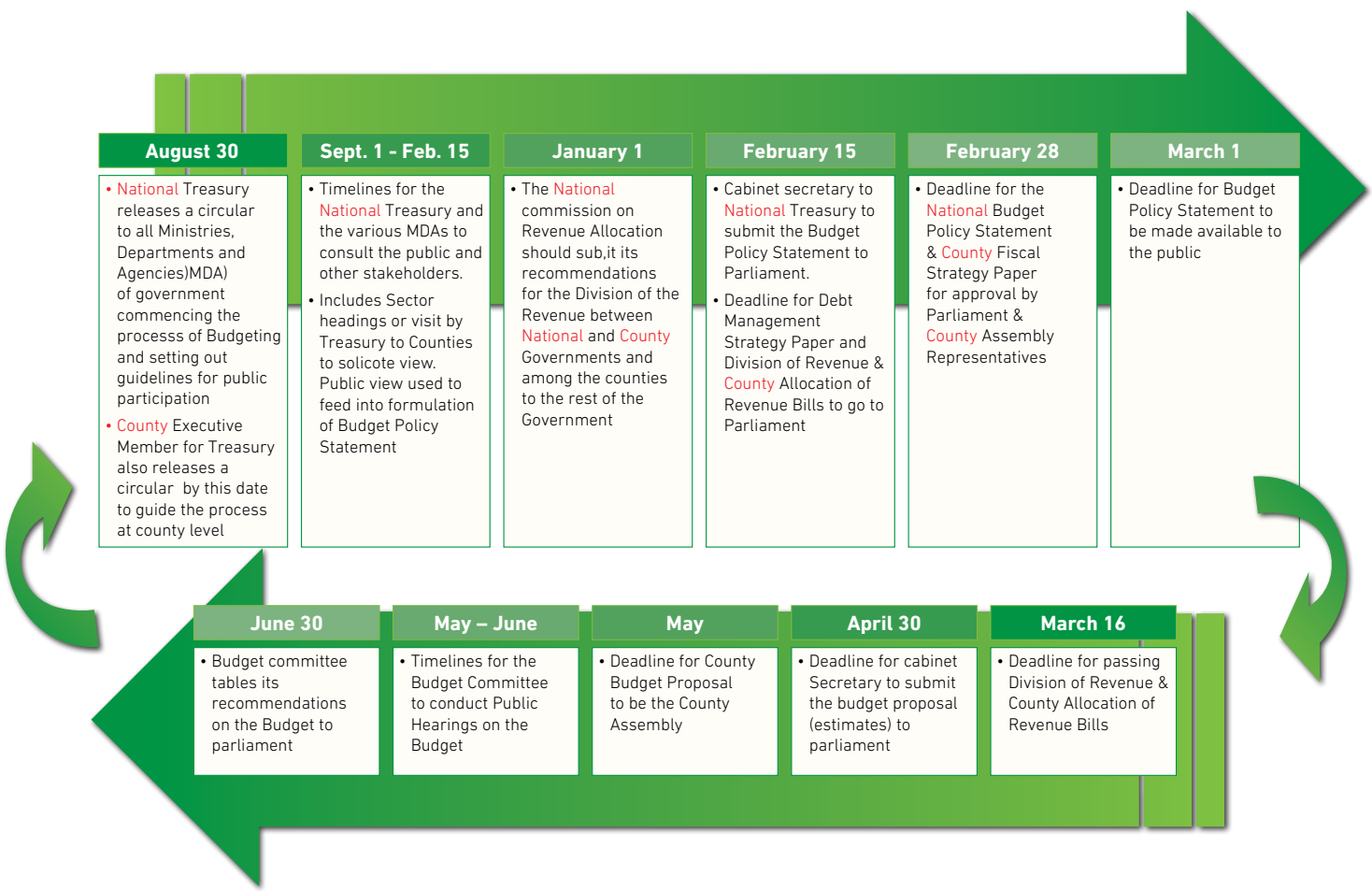


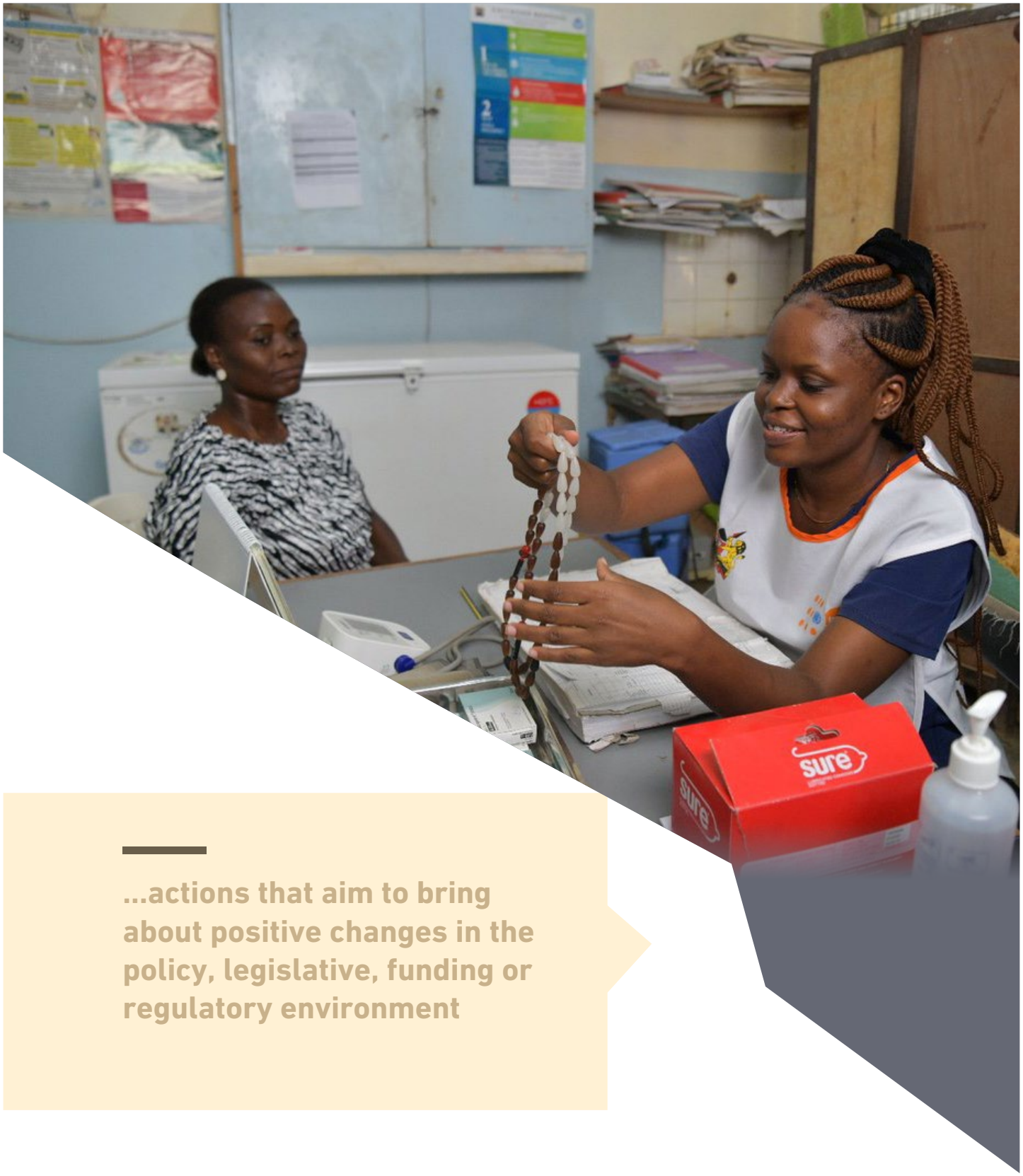
Figure II: *Opportunities for Advocacy and Potential Entry during the National Budgeting Process/Cycle*

STAGE	OPPORTUNITIES FOR ENTRY & ADVOCACY ENGAGEMENT
Pre-Budget Phase	• Identify key advocacy priorities related to healthcare, including Family Planning (FP) and reproductive health. • Engage with stake holders, civil society organizations, and experts to develop evidence-based recommendations. • Advocate for the inclusion of these priorities in the budget by submitting proposals to relevant government bodies
Budget Formulation Phase	• Collaborate with government ministries and committees such as the health committee to influence budgetary allocations for healthcare, FP, and RH programs. • Participate in public consultations and budget hearings to present your case and raise awareness of the importance of your priorities. • Provide data and research to support your advocacy efforts demonstrating the impact of these programs on public health and development.
Budget Approval Phase	• Advocate for the approval of budgets that reflect your healthcare and FP priorities. • Engage with members of the national assembly, including through meetings, briefings and public campaigns to secure their support.
Budget Implementation Phase	• Monitor the implementation of the budget to ensure that allocated funds are spent effectively and efficiently. • Advocate for transparency and accountability in the use of resources for healthcare programs including FP.
Mid-Year Review Phase	• Engage in the mid-year budget review process to address any issues or adjustments needed to support healthcare and FP initiatives.
Audit & Evaluation Phase	• Collaborate with the auditor general and oversight committees to review how funds have been used and whether healthcare and FP programs have achieved their intended programs.
Post-Budget Phase	• Continue advocacy efforts to ensure that healthcare, FP and RH programs remain on the national agenda • Evaluate the impact of advocacy efforts on budget allocations and outcomes and adjust strategies as necessary for the next budget cycle.
Year-Round Engagement	• Maintain year-round engagement with policymakers, civil society organizations and stakeholders to build support for your healthcare and FP advocacy goals. • Utilize media and public awareness campaigns to sustain momentum and inform the public about the importance of these programs.

Figure III: *Opportunities for Advocacy and Potential Entry during the County Planning and Budgeting Process*

30TH AUGUST – 30TH APRIL BUDGET FORMULATION	**30TH AUGUST** • Preparation and consolidation of budget estimates • Development of priorities (CIDP, ADP, AWP)	• Participate in DWG – Intro FP Budget Line • Sensitization – Citizens participate in CBEF
	1ST SEPTEMBER • Preparation & Tabling of ADP to County Assembly (CA) • Plan must be made public within 7 days of approval	• Work with key stakeholders & MOH officers to ensure FP inclusion in AWPs
	28TH FEBRUARY • Submission of County Fiscal Strategy Paper • Setting of Budget Ceilings, Priorities refined	• Opportunity to influence prioritization of FP into the county budget estimates
	30TH APRIL • Submission of County Budget Estimates + Supporting Documents to CA by CECM for Finance	• Opportunity for FP Advocacy at SWG & CBEF meetings with MCAs
30TH APRIL – 30TH JUNE APPROVAL (DEBATING & AMMENDMENTS)	**MAY – JUNE** • Budget & Appropriation Committee conducts public Hearings on Budget Estimates	• Citizens' participation at Public Hearings • FP Advocates can also participate here
	30TH APRIL – 30TH JUNE • CA amends and/or approves the Budget Estimates	• Engage MCAs; Advocate for prioritization of FP & allocation of required resources
	JUNE • Submission of County Appropriation Bill to CA for debate and approval	• Participate in Public Hearings by the Budget & Appropriation Committee
	30TH JUNE • Deadline for the enactment of the County Appropriation Bill that authorizes spending in new financial year	• Participate in Public Hearings • Lobby MCAs to prioritize & fund FP
	JUNE – SEPTEMBER • Finance Bill Table at CA, debated & approved • Finance bill must be passed in 90 days from 30th June	• Participate in Public hearings conducted by the Finance Committee of the CA
IMPLEMANTATION	**30TH OCTOBER** • One month to the end of every quarter – County Treasurer submits to CA a financial/non-financial performance report	• Review/ input – Quartely implementation Reports by CBEF & Controller of Budgets
AUDIT & EVALUATION	**1ST JULY – 30TH JUNE (FISCAL YEAR)** • Executive prepares Budget Implementation & Quartely Report: Auditor General audits counties. CA provides Budget oversight of spending	• Review/input – Auditor General's Reports; ensure spending on FP matches priorites • Social Accountability – oversight on funds

ACRONYMS in Fig 6: CA = County Assembly; CBEF= County Budget and Economic Forum; MCA = Member(s) of the County Assembly; CECM = County Executive County Member; (CIDP, ADP, AWP, SWG have been defined in earlier sections of this document)



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...actions that aim to bring about positive changes in the policy, legislative, funding or regulatory environment

REPUBLIC OF KENYA

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04
EVIDENCE-BASED ADVOCACY FOR FAMILY PLANNING

Evidence-Based Advocacy means advocating in a targeted, evidence-based and professional manner while measuring the impact and outcomes of the advocacy work. Designing and delivering evidence-based FP advocacy is aimed at strengthening the capacity of advocates with tools and frameworks for influence. This section of the FP Advocacy Toolkit addresses the complexity of the demographic dividend by linking age structure with social and economic development, enabling policy makers to quantify the changes that would be required to successfully achieve a demographic dividend. It does so by allowing customization of the design to multiple scenarios that depict how the combined power of multisectoral policy investments can generate a demographic dividend that would not be possible under the status quo.

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During assessment, the FP Advocate will identify:

- The factors inhibiting and/or promoting utilization of data and evidence research by policymakers
- The areas for capacity strengthening on FP Advocacy
- The knowledge and skills gaps in evidence-based FP advocacy for different audiences

The rapid assessment can be conducted through focus group discussions with evidence-based advocacy coalition members to give their reflections on the research used in FP advocacy.

4.1 SOCIO-ECONOMIC BENEFITS OF FAMILY PLANNING SERVICES

This section of the toolkit is to assist advocates in the family planning field in their efforts to promote policy dialogue on the health, social, and economic benefits of increasing access to family planning services. It is expected that the evidence will enable the advocates to present relevant arguments to promote family planning and birth spacing in their particular settings. The evidence on the link between family planning and macro-level socioeconomic impacts (health, education, economy, demographic dividend, urbanization, GDP and agriculture), and family planning and maternal and infant mortality and morbidity was estimated using three models:

i. DemProj-projects the population for the country by age and sex, based on assumptions about fertility, mortality, and migration;

ii. FamPlan- projects family planning requirements needed to reach national goals for addressing unmet need or achieving desired fertility. It uses assumptions about the proximate determinants of fertility and the characteristics of the family planning programme (method mix, source mix, discontinuation rates) to calculate the cost and the number of users and acceptors of different methods by source;

iii. RAPID- projects the social and economic consequences of high fertility and rapid population growth for such sectors as labor, education, health, urbanization, and agriculture. The evidence generated is supposed to raise awareness of the importance of fertility and population growth as factors in social and economic development.

4.1.1. FAMILY PLANNING AND THE DEMOGRAPHIC DIVIDEND

The demographic dividend (DD) provides an economic rationale for a country to increase access to and use of family planning methods. To realize DD, family planning efforts need to be combined by a decrease in the fertility rate, reduction in infant mortality rate, sound economic policies and improvements in health status and educational achievement.

The Facts and Evidence

Increasing use of modern contraceptives prevalence from 58 in 2022 to 64 in 2030 (see figure 8) would reduce the country's total fertility rate (TFR) from 3.4 in 2022 to 2.76 in 2030, the proportion of the population under age 0-14 will begin to decline (see figure xx) relative to the adult working-age population (generally ages 15 to 64) and dependency ratio will decline from 0.68 in 2022 to 0.6 in 2030. The decline in this ratio will set the stage for smaller families, who now have more resources to invest in the health, education, and well-being of each child. With fewer people to support, the country will experience a window of opportunity for accelerated economic growth. The country's GDP is projected to increase from KES. 12.098 Trillion in 2022 to KES. 21.930 Trillion in 2030) and per capita income will increase from KES. 221,281 in 2022 to KES. 343,488 in 2030. Achievement of these benefits must be backed by appropriate social and economic policies and good governance.

Table 4: Evidence of accelerated family planning on demographic dividend

	Total Fertility Rate	Population 0-14	Population aged 15-64	Population aged 65+	Dependency Ratio – (Male + Female)	Gross Domestic Product (GDP)	GDP per Capita
2022	3.4	20,519,958	32,587,888	1,565,638	0.68	12,098,200,000,000	221,281
2023	3.32	20,676,026	33,541,061	1,619,126	0.66	13,005,565,000,000	232,962
2024	3.24	20,823,748	34,508,202	1,682,726	0.65	13,989,110,853,125	245,457
2025	3.16	20,965,363	35,473,606	1,755,848	0.64	15,055,780,555,676	258,892
2026	3.08	21,112,929	36,427,432	1,834,500	0.63	16,213,193,685,893	273,354
2027	3	21,270,771	37,362,860	1,918,637	0.62	17,469,716,196,550	288,920
2928	2.92	21,438,420	38,277,122	2,008,331	0.61	18,834,537,774,406	305,715
2029	2.84	21,611,652	39,171,065	2,103,625	0.6	20,317,757,624,140	323,860
2030	2.76	21,783,877	40,048,783	2,204,204	0.6	21,930,479,635,556	343,488

The Call to Action

The policy-makers should provide a conducive FP policy environment which strengthens resource allocation and FP investments. This will sustain the FP gains already made and harness the demographic dividend.

4.1.2 FAMILY PLANNING AND FOOD SECURITY

The Facts and Evidence

Family planning has a direct effect on food security through its impact on population growth, which determines the size of a country's population and consequently the demand for food and services. The country's population is projected to rise from 54 million in 2022 to approximately 63 million in 2030, which will significantly increase the demand for food particularly in parts of the country already experiencing food insecurity. Access to contraception and practicing healthy birth spacing will help reduce the gaps projected between demand for food and crops produced. Expanded access to and use of family planning can play a major role in reducing population growth, and significantly improve child health and nutrition outcomes. When parents have smaller families, they are better able to invest in the health, nutrition, and education of each child. This has been referred to as the quality-quantity tradeoff.

The Call to Action

Support investments and policy change to improve access to FP as a strategy for mitigating food insecurity particularly in counties already experiencing food insecurity.

4.1.3. FAMILY PLANNING AND AGRICULTURE

The Facts and Evidence

Agriculture has been and still is the backbone of Kenya's economy directly contributing up to 33% of the Gross Domestic Product (GDP). The sector provides livelihoods for more than 40% of the nation's total population and at least 70% of its rural population. Uncontrolled population explosion has a negative effect on available arable land which in turn reduces productivity leading to food shortage. Modelling results show that the current population growth rate will reduce arable land available per capita from the current 0.12 HA in 2022 to 0.1HA by 2030, which will lead to a 42% reduction in the production of major (food) crops by 2030.

The Call to Action

Policy-makers should support strategies that expand awareness and dispel misconceptions that lead to hesitancy around family planning utilization. Decision-makers, planners and funders should consider FP as a potential food security strategy.

4.1.4. FAMILY PLANNING AND EDUCATION

The Facts and Evidence

To grow the country's economy, both boys and girls must have access to education. In particular, girl's education—at the secondary level—will help delay marriage and first pregnancy and directly contribute to socioeconomic development. To sustain the window of opportunity arising from demographic dividend, the government should also invest in human capital through education. Modelling evidence shows that primary school enrolment will marginally increase from 93 per cent in 2022 to 95 per cent by 2030. Enrolment in secondary school will increase from 57 per cent in 2022 to 70 per cent by 2030. The evidence also shows that the teacher-student ratio is 47:1. This is significantly higher than the UNESCO-recommended ratio of 25 students per teacher for primary schools and the Kenya recommended ratio of 40 students per teacher.

Table 8: *Family Planning and Education*

	Children of Primary School Age	Primary Students	Enrolment Rate	Children of Secondary School Age	Secondary Students	Enrolment rate
2022	10,797,222	10,041,416	93%	5,173,180	2,936,297	57%
2023	10,797,056	10,068,255	93%	5,255,632	3,070,077	58%
2024	10,787,818	10,086,610	94%	5,322,372	3,197,149	60%
2025	10,788,666	10,114,374	94%	5,369,358	3,314,236	62%
2026	10,812,597	10,163,841	94%	5,391,558	3,417,170	63%
2027	10,873,048	10,247,848	94%	5,388,758	3,504,579	65%
2028	10,996,448	10,391,643	94%	5,369,967	3,581,231	67%
2029	11,144,871	10,559,765	95%	5,348,355	3,655,333	68%
2030	11,298,700	10,733,765	95%	5,335,594	3,734,916	70%

The Call to Action

The policy-makers and advocates must support efforts to increase use of family planning as a necessary investment to get the demographic dividend.

4.1.5. FAMILY PLANNING AND POVERTY

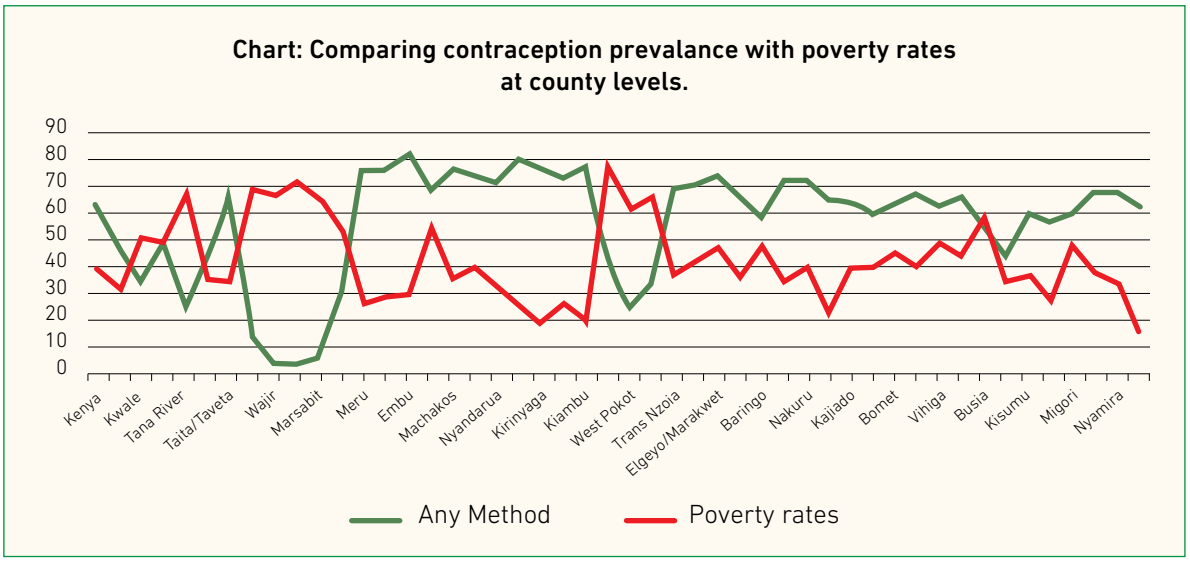
The Facts and Evidence

There is a trend between poverty levels and contraception use. The poorest counties tend to have the lowest prevalence of modern contraception. Examples from a few selected counties indicate some degree of correlation between poverty levels and low contraceptive use: CPR in Wajir: 3% versus poverty rate of 66.3; Marsabit (CPR 5.9% versus poverty rate 65.9), Mandera (CPR 2.1 versus poverty rate of 71.9), Mombasa (CPR 46.7 versus poverty rate of 31.8) and Meru (CPR 76 versus poverty rate 26.3).

The Call to Action

Given that a higher CPR is correlated with lower poverty levels, FP programmes should be integrated in relevant policies for a concerted implementation to impact poverty levels in the country.

Figure V: *Chart showing inverse correlation between mCPR and poverty rates in Kenyan counties*



4.1.6. FAMILY PLANNING AND URBANIZATION

The Facts and Evidence

Total population in major urban cities is projected to increase from around 16.4 million in 2022 to 19.2 million by 2030. The number of urban youth aged 12-25 years is projected to increase from 4.9 million in 2022 to 5.5 million by 2030. As a result, urban cities will not be able to keep up with increased demand for environmental, health, and educational services, not to mention the employment, housing, and transportation needs of a population that may double in size in less than 10 years. About 21.2% of the total population in Kenya live in informal settlements, often without access to sanitation and safe drinking water. Because of these unhealthy conditions, rapid population growth will exacerbate the health problems in urban areas.

Table 9: *Growth in urban population and urban youth (aged 12-25)*

	Total Urban Population	Urban Youth (Aged 12-25)
2022	16,402,045	4,960,732
2023	16,750,864	5,075,212
2024	17,104,402	5,177,554
2025	17,458,444	5,266,766
2026	17,812,458	5,343,217
2027	18,165,680	5,407,686
2028	18,517,162	5,461,624
2029	18,865,904	5,506,481
2030	19,211,060	5,540,744

Call to action

Policy makers and planners should ensure that family planning services in urban areas is a high priority, especially since the majority of urban residents in the country live on less than US$1.5 per day.

4.1.7. FAMILY PLANNING AND THE ENVIRONMENT (CLIMATE CHANGE)

The Facts and Evidence

Total population is projected to reach 63.71 million by 2030. Both population growth and climate change contribute to natural resource depletion, such as soil erosion, deforestation, and reduction of fresh water supplies. Growing populations increase demand for these diminished natural resources, furthering environmental degradation and posing political challenges for equitable resource allocation. This growth will worsen the threats posed by climate change in a number of ways. It will lead to resource depletion, economic insecurity, and decreased overall health.

Call to Action

To deal with demographic stresses in climate change mitigation and adaptation efforts policy-makers and planners must support family planning interventions that address social, economic, and environmental challenges for sustainable development.

4.1.8.FP, UNMET NEED, AND BIRTH SPACING IMPACTS ON INFANT MORTALITY RATES

Family planning remains one of the most cost-effective public health measures available in developing countries because its benefits go beyond population management. Use of family planning is necessary to reduce unmet need, achieve optimal birth spacing, reduce Infant mortality and Under five mortality rates and improve child health and survival. In 2022, 14.1 percent of married women in Kenya had an unmet need for family planning. These women would like to delay, space, or limit their child bearing but are currently not using any method of contraception. Unmet need for family planning can lead to infant mortality rates and abortion-related deaths.

The Facts and Evidence

Accelerated use of modern contraceptives would reduce unmet need for family planning from 14.1 percent in 2022 to 11.3 per cent in 2030. Infant mortality rate (IMR) would decline from 32 (per 1000 live births) in 2022 to 24.3 (per 1000 live births in 2030. The under-five Mortality Rate (U5MR) will decline from 41 (per 1000 live births in 2022) to 33.2 per 1000 live births by 2030.

Table 4: *Unmet need, Infant Mortality Rate and Under 5 Mortality Rate*

	Percent Unmet Need	Infant mortality rate (per 1000 live births - Male Female)	Under 5 mortality rate (per 1000 live births - Male/ Female)
2022	14.1	32	41
2023	13.8	25.5	34.1
2024	13.4	24.9	33.8
2025	13.1	26	35.7
2026	12.7	26	35.1
2027	12.4	25.5	34.5
2028	12	25	34
2029	11.7	24.6	33.7
2030	11.3	24.3	33.2

Call to Action

The decision and policy makers should support interventions that support contraceptive security plans to ensure uninterrupted access to a variety of contraceptive methods. They should support comprehensive family planning programmes.

4.1.9. UNINTENDED PREGNANCIES, ABORTIONS, AND MATERNAL DEATHS AVERTED

Use of modern contraceptives helps women and families prevent unintended pregnancies and unwanted births, allowing the country to pace development with population growth. This enables the country to expand health care, build schools, and develop infrastructure and employment opportunities as the population grows.

The Facts and Evidence

Accelerated use of modern family planning methods from 58% to 64% by 2030, will avert around 2.4 million unintended pregnancies, and that if women were not using contraception, there would have been more unintended pregnancies by 2030. The country would also avert 62,900 maternal deaths by investing in modern contraceptive methods compared to a scenario of low or no investment. In addition, Kenya would prevent 5,784,126 (cumulative, 2022-2030) more unsafe abortions by accelerating expanded access to and use of modern methods by 2030.

Kenya would save an additional 2,138 mothers' lives by investing in modern methods compared to a scenario of low effort and investment

Table 5: *Unwanted pregnancies averted, maternal deaths averted and unsafe abortions averted due to FP*

	# of unwanted pregnancies averted due to use of mCPR	Maternal deaths averted	Unsafe abortions averted
2022	1,850,490	5,990	550,706
2023	1,926,500	6,236	573,326
2024	2,003,929	6,486	596,369
2025	2,081,970	6,738	619,594
2026	2,160,129	6,991	642,854
2027	2,237,927	7,242	666,007
2028	2,315,156	7,492	688,990
2029	2,391,800	7,740	711,800
2030	2,468,005	7,986	734,478
Cumulative, 2022–2030	**19,435,906**	**62,900**	**5,784,126**

Call to Action

The policy makers should support efforts to scale up contraceptive use to prevent maternal deaths by allowing women to delay motherhood, avoid unintended pregnancies and subsequent abortions.

4.1.10. SAVINGS IN HEALTHCARE COSTS

The Facts and Evidence

The country will save millions in a year in healthcare costs by accelerating use of modern contraceptives. Savings are projected to increase from KES 9.2 billion in 2022 to KES 12.3 billion in 2030.

Figure IV: *Chart showing the incremental savings in healthcare costs due to investments in FP*

Call to Action

Policy makers should support investments in family planning so as to achieve savings in health care costs for investments in health service and improved health service delivery

4.1.11. MODERN CONTRACEPTIVE USE

Currently, 14% of married women in Kenya aged 15-49 have an unmet need for family planning, which limits their ability to prevent unintended pregnancies and plan their families. The country's commitment objective is to increase mCPR for married women from 58% to 64% by 2030 and reduce unmet need for family planning for all women from 14% to 10% by 2030. Increasing access to family planning will increase use of mCPR from 57% in 2022 to 64% by 2030 and increase the percentage of women estimated to have their demand for family planning met with a modern method of contraception from 73.75 in 2022 to 77.88 in 2030. Accelerated use of family planning would also increase total users of modern contraceptive methods from 4,992,973 in 2022 to 6,659,144 in 2030.

Table 6: *Modern Contraceptive Prevalence - Percentage demand satisfied with modern methods*

	Modern Contraceptive Prevalence Rate (mCPR)	Percent of demand satisfied with modern methods	Total users of modern methods of contraception
2022	57	73.75	4,992,973
2023	58.75	74.28	5,198,061
2024	59.5	74.8	5,406,978
2025	60.25	75.33	5,617,548
2026	61	75.85	5,828,436
2027	61.75	76.36	6,038,351
2928	62.5	76.87	6,246,727
2029	63.25	77.38	6,453,527
2030	64	77.88	6,659,144

Call to Action

Policy makers, planners and key development partners should support sustained availability of family planning commodities to the last mile, and support increased domestic financing for family planning commodities to cover 100% of the requirements by 2030. Efforts should also be made to enhance the capacity of human resources for health (HRH) to provide family planning information and services while also focusing special attention on the under-served, vulnerable, and hard-to-reach population including vulnerable populations in the country.

4.2. A SUMMARY OF THE BENEFITS OF FAMILY PLANNING

Available evidence suggests that a low Fertility Rate leads to manageable Population Growth Rate which in turn yields an array of environmental, social, and economic benefits such as:

- *Reduces pressure on land use, thereby slowing rural-urban migration*
- *Helps to improve employment opportunities and ensure food security*
- *Allows for greater investment in education, health services, and job creation*
- *Improves family welfare because through savings on income that can then be optimally invested in good education of fewer children, better nutrition, and better healthcare*
- *Contributes to lower maternal and infant mortality because it reduces unintended pregnancy and allows for longer spacing between births*
- *Enables couple/families to plan when and how many children they will have*

4.3. WHAT CAN BE DONE? (RECOMMENDATIONS FOR ACTION)

Policymakers

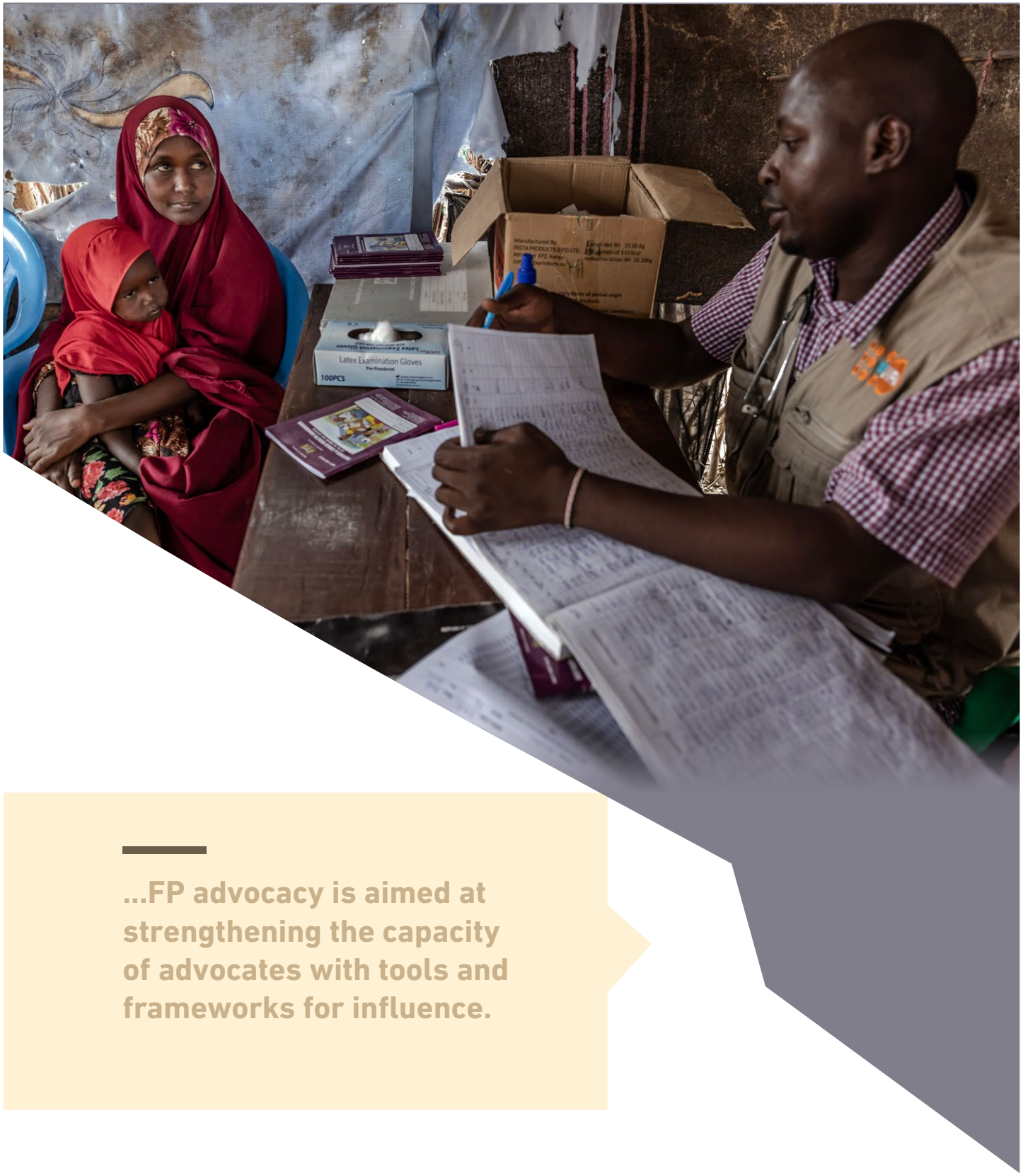
- *Support a comprehensive RH strategy that guarantees universal access to FP information and services*

National and County Health Officers

- *Scale up successful strategies to equitably extend the reach of FP interventions (information and services) to the last mile, thereby make long-term FP methods more widely available*
- *Ensure continuous availability of contraceptive supplies at all service delivery points*
- *Engage private sector providers and community members in the provision of FP services and information*

Civil Society Leaders and Media Representatives

- *Educate the public on the implications of rapid population growth*
- *Dispel misconceptions about family planning methods*



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...FP advocacy is aimed at strengthening the capacity of advocates with tools and frameworks for influence.

05
STAKEHOLDER ANALYSIS

It is essential for the advocacy team to identify individuals, groups, organizations, and institutions with interest in FP with a view to engage them in the advocacy process. Relevant information required to accurately analyse the power and influence of stakeholders includes: areas of specialization, level and spheres of influence, allies and antagonists, organizational values and culture, geographical and administrative extent of operations, scope of current and past projects, decision-making processes, effective strategies/tactics, past experiences working with partners, and even contact details.

Armed with this information, the Advocacy team then conducts a Power-Influence / Interest Matrix Analysis which will help in focusing effort by prioritizing which partners to onboard for the intervention, their strengths and role(s) and the level of engagement required for the partnership to bear fruit. This chapter outlines the process of stakeholder analysis and its significance in shaping advocacy strategies.

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5.1. TARGET AUDIENCE SEGMENTATION AND PROFILING

Target Audience Segmentation (TAS) - Advocacy requires prior knowledge of the target audience based on demographics, and behavioral attributes and/or any other defining characteristic. This segmentation helps those undertaking advocacy to achieve the following:

- *Deliver insights that help Advocacy teams to (re) align their desired/present strategies to the on-ground realities and evolving circumstances*
- *Helps to identify opportunities and critical agenda items to be addressed in future for future advocacy interventions*
- *Support the prioritization of competing agenda items and enables optimal decision making*
- *Supports rational budgeting and resource allocation decisions*

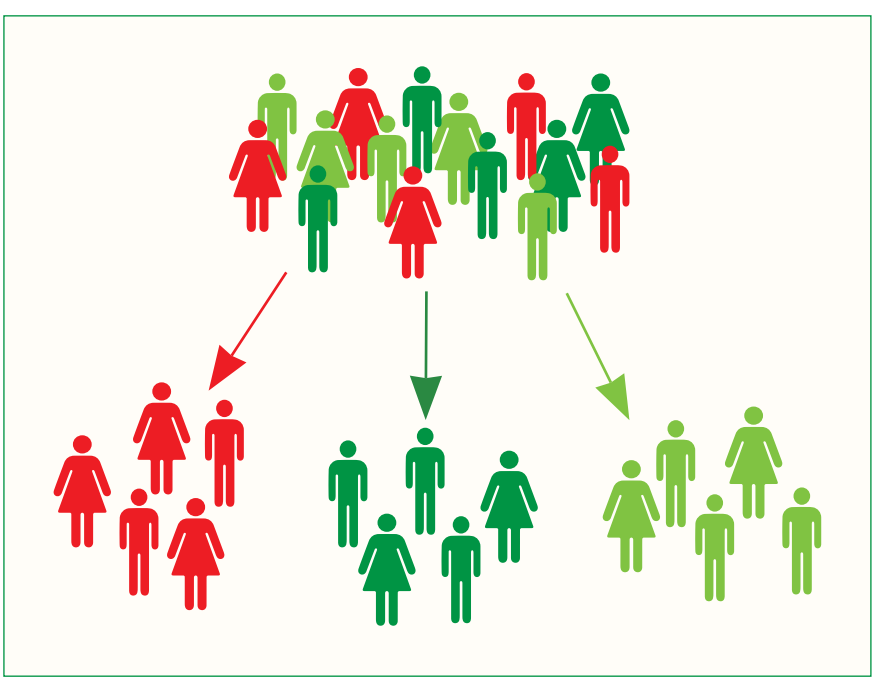
Primary Target Audience (PTA) - The PTA is defined as the prime target/recipient(s) of the advocacy "ask" that has the latitude, agency, power and resources necessary to deliver the greatest impact or the desired outcome(s) when correctly targeted with the advocacy intervention. The PTA for any advocacy intervention is usually dictated by the goal(s) of the advocacy intervention. By clearly defining the end-goal, the team can easily narrow down to the PTA.

Secondary Target Audience (STA) - The STA is a person or entity, usually a confidante, a close ally or a respected figure of authority, with unrestricted access to the PTA and preferably commands their attention of and/or wields unqualified influence over the subject. Although the STA is not the primary decision-maker, he/she/they has the power to drum up interest and support for the Advocacy Agenda

Tertiary Target Audience (TTA) - is a person, group or entity, who may have vested or indifferent interest in the advocacy agenda, but is still concerned about the outcome(s) of the intervention. The TTA can be employed to amplify the width, depth, and reach of conversations. TTAs may be co-opted into Advocacy interventions to fact-check arguments, point out blind spots, introduce divergent opinion(s), or even articulate the perspectives and concerns of the muted voices of society that lack the agency to speak up.

Prioritization and Mapping - After segmenting the broader target audience in smaller subgroups with peculiar characteristics of interest to the intervention, one may choose to create a visual map that illustrates the different audience segments with labels (identifiers) for attributes. The prioritized segments, selected based on the goal(s), objectives and potential impact of planned advocacy action, are conspicuously highlighted.

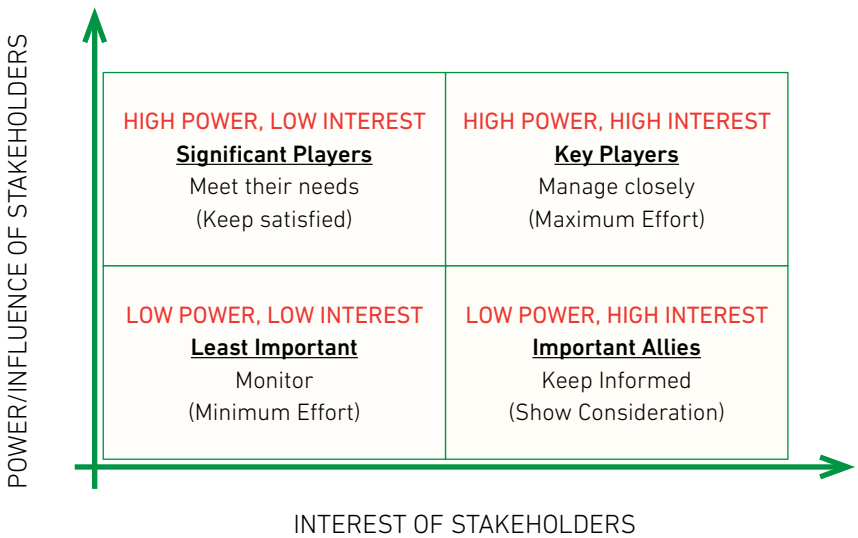
Figure XIII: *An illustration of a Prioritization Map, highlighting relevant target audience segments (TAS)*

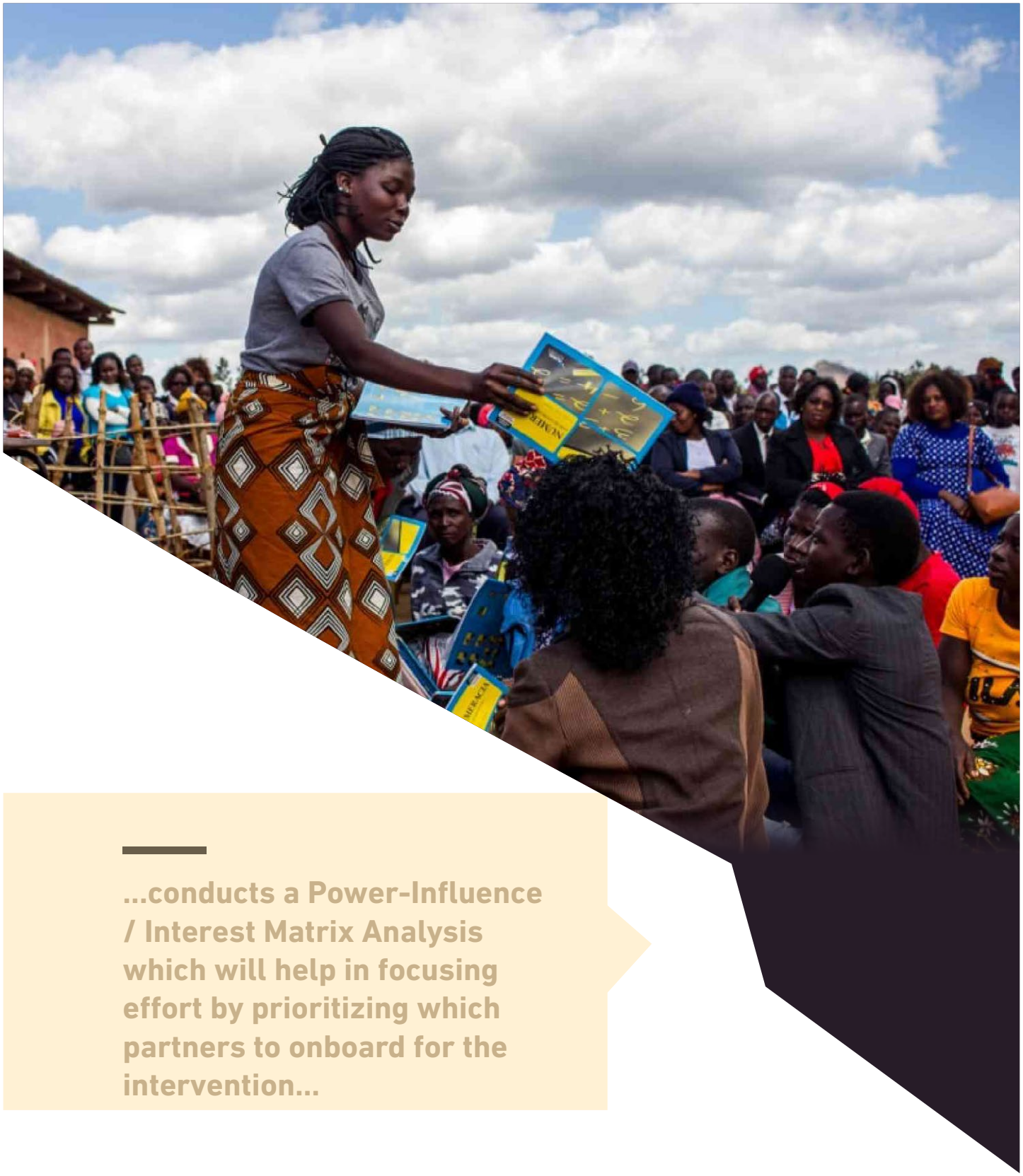


5.2. THE POWER INFLUENCE/INTEREST MATRIX (PIIM)

Power Analysis is both an important Advocacy process required to gain a deeper understanding of various stakeholders operating in one's ecosystem and also a critical decision-making model that helps a team to narrow down on their options for partnerships and focus their efforts in engaging a few influential partners that will contribute most to their course and yield the biggest impact. Also known as the Power/Interest Grid, the Power-Influence/Interest Matrix (PIIM) is used by advocates to categorize, rank, and prioritize stakeholders on the basis of the power and influence they wield (influence), and the level of interest that should be invested in managing different partnerships. Below is an illustration of the PIIM Matrix:

Figure XIV: *Diagram depicting the Power-Interest/Influence Matrix*





...conducts a Power-Influence / Interest Matrix Analysis which will help in focusing effort by prioritizing which partners to onboard for the intervention...

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06
MONITORING AND EVALUATION

Effective advocacy requires ongoing Monitoring and Evaluation (M&E). This chapter offers insights into how to effectively conduct M and E activities. It includes the development of a **Detailed Implementation Plan (DIP)** and an appendant **M and E Plan** to assess the progress and impact of Advocacy efforts.

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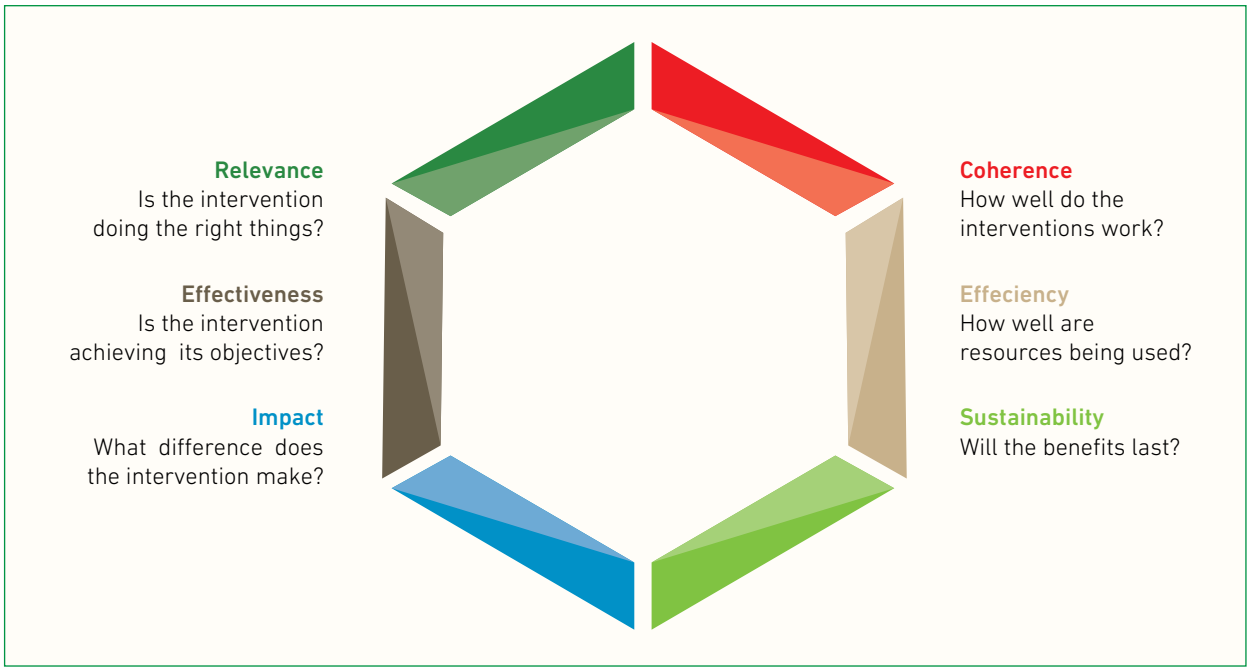
6.1. DEFINITION

Monitoring and Evaluation for Advocacy is the systematic and ongoing process of collecting, analyzing, and assessing relevant data and information to measure the progress, impact, and effectiveness of advocacy initiatives aimed at influencing policies, practices, and public opinion, with the ultimate goal of achieving social and political change in a transparent and accountable manner.

6.2. KEY CONSIDERATIONS WHEN DEVELOPING AN M&E PLAN FOR FP ADVOCACY

When developing an M&E Plan, the Advocacy team should brainstorm and consider the factors outlined in the illustration below:

Figure XV: *An illustration of the key considerations and constituent elements of a comprehensive M&E plan*



6.3. STEPS IN DEVELOPING AN M&E PLAN FOR FP ADVOCACY

Step 1: Identify FP Advocacy Goals and Objectives

The first step to creating an M&E plan is to identify the programme goals and objectives. Goal refers to the overall impact that the FP advocacy work sets to accomplish. Defining programme goals starts with answering three questions:

a. What problem is the programme trying to solve?

b. What steps are being taken to solve that problem?

c. How will programme staff know when the programme has been successful in solving the problem?

Answering these questions will help identify what the programme is expected to do, and how staff will know whether or not it worked. For example, if your organization is starting a FP commodity financing project or policy advocacy work to employ community health workers in distributing FP commodities at community level, goal would look like these:

- GOAL 1: **Improve the enabling environment for FP by addressing legal and policy barriers**
- GOAL 2: **Increased GOK financing of FP programme to Kenya Shillings 30 million by 2030**

Objectives are developed after goal setting. The objectives make the goal to be more realistic in implementation and they contribute towards achievement of the overall goals. Example of objectives that contribute to each of the above goals are;

- OBJECTIVE 1: **To strengthen the legal and policy enabling environment for Family Planning (FP) in Kenya by addressing specific barriers, gaps, and inconsistencies in the existing regulatory frameworks and policies**
- OBJECTIVE 2: **Increase the annual funding for the FP commodities by a minimum of 20% each year for the next 5 years, with the aim of reaching a total annual budget of USD 30M by 2030**

Objective must be SMART and coherent with the goal they are contributing to.

Step 2: Identify and design activities

For each of the goals and objectives set, activities are developed that contribute to the goal and the objective. The activities must be SMART. Example of activities that speak to the Goals and their objective could be:

- Goal 2: **Objective 1: Activity 1: By January of 2026, support parliament to pass legislations that cures barriers, gaps, and inconsistencies in existing legislation and align it to the existing need in the country**
- Goal 1: **Objective 2: Activity 1: Develop an investment case for FP programme domestic financing by June 2024**

Step 3: Develop indicators for the Goals, Objectives, and Activities

Indicators are used to measure whether you have achieved the planned activities, objectives and goals. Each goal, objectives and activities developed must have corresponding indicators to measure it.

Once the programme's goals, objectives and activities are defined, it is time to define indicators for tracking progress towards achieving those goals. Programme indicators should be a mix of those that measure processes, or what is being done in the programme, and those that measure outcomes.

Process indicators track the progress of the programme. They help to answer the question, "Are activities being implemented as planned?" Some example of process indicators based on the above activities are

- *Number of investment cases developed*

Outcome indicators track how successful programme activities have been at achieving programme objectives and goals. They help to answer the question, "Have programme activities made a difference?" Some examples of outcome indicators based on the above goals and objectives are:

- *Amount of funding in Kenya shillings committed to FP commodities by Parliament*
- *% increase in the amount of FP commodities financing from domestic sources*
- *No. of policies developed that enhance the delivery of FP programmes*

The table below gives more details on indicators:

Table 11: Types of Advocacy Indicators (based of the Logframe Model for M&E)

TYPE	DESCRIPTION OF INDICATOR(S)	EXAMPLES
1. **Input Indicators**	• These are used to monitor the level of resources available for planned interventions and should give an early alert should there be any logistical challenges that might limit the effectiveness of the intervention. • They include: money, time, staff, expertise, methods, and facilities the organization commits to the advocacy intervention	• *No. of staff dedicated to FP Advocacy intervention* • *Amount of money spent on hosting FP advocacy sessions* • *Amount of time spent on intervention as a percentage figure of the total planned time*
2. **Output Indicators (also referred to as Activity or Process Indicators)**	• These are usually numerical counts of actions or products resulting from direct (planned) activities of an intervention. • Activity indicators provide a good way of tracking whether a project or intervention is being delivered as planned and will highlight any potential challenges that may be encountered e.g. delays.	• *No. of meetings held* • *No. of people reached* • *No. of IEC materials developed* • *No. of radio spots aired*

TYPE	DESCRIPTION OF INDICATOR(S)	EXAMPLES
3. Outcome Indicators	• Outcomes are measurable changes within an ecosystem/population as a direct result of the activities/ interventions conducted • Outcome indicators speak to the objectives of the said intervention/ project.	• *No. of policies developed that enhance FP programmes* • *Percentage increase in budgetary allocation towards FP* • *Actual amount(s) of resources expended on FP commodities*
4. Impact Indicators	• These are quantitative or qualitative metrics that are used to determine long-term (usually over several years) changes due to the sustained effort of a project or intervention. • These changes mostly speak to the goal (purpose) of a project or intervention, and are commonly determined using population-based surveys.	• *Percentage change in mCPR (from 58% - 64% by 2030)* • *Percentage reduction in unmet need for FP in all women (from 14% - 10% by 2030)* • *Percentage reduction among adolescent girls, 15 -19 years (from 14% - 10% by 2025)* • *Increased domestic financing for FP commodities (to cover 100% of the requirements - USD 30M, by 2026)*

Step 4: Define Data Collection methods, Timelines/ Frequency and Responsibility

After creating monitoring indicators, it is time to decide on methods for gathering data and how often various data will be recorded to track indicators. This should be a conversation between programme staff, stakeholders, and donors. These methods will have important implications for what data collection methods will be used and how the results will be reported. Examples of data collection methods include but are not limited to focused group discussions, interviews, use of pre-designed questionnaires, and desktop review.

The source of monitoring data depends largely on what each indicator is trying to measure. The programme will likely need multiple data sources to answer all of the programming questions.

Step 5: Create an Analysis Plan and Reporting Templates

Once all of the data have been collected, someone will need to compile and analyse it to fill in a results table for internal review and external reporting to stakeholders. This is likely to be an in-house M&E manager or research officer for the programme.

The M&E plan should include a section with details about what data will be analyzed and how the results will be presented. Do research staff need to perform any statistical tests to get the needed answers? If so, what tests are they and what data will be used in them? What software programme will be used to analyse data and make reporting tables? Excel? SPSS? These are important considerations.

Another good thing to include in the plan is a blank table for indicator reporting. These tables should outline the indicators, data, and time period of reporting. They can also include things like the indicator target, and how far the programme has progressed towards that target.

Step 6: Reporting, Usage, Learning and Adaptive Management

M&E data provides a reliable basis for tracking progress and assessing the effectiveness and impact of Advocacy initiatives. Additionally, it enables the Advocacy team(s) to make informed decisions based on real-time information, and continuously refine their strategies which ultimately enhances the effectiveness and efficiency of their interventions. The reports produced should be tailored to the recipient audiences. Sometimes, it may be more effective to use abridged document formats such as Fact Sheets, Technical Briefs, and Infographics, instead of full-length reports

6.4. DEVELOPING A DETAILED IMPLEMENTATION PLAN (DIP)

It is always necessary for an Advocacy Team to create a DIP at the beginning of their intervention to help in tracking all the different components and activities of their work. An adapted GANTT CHART (Annex 4) is the standard model used for creating a DIP. Some of the critical elements that are contained in the DIP are:

a. Objective(s)

b. Milestones

c. Activities/Tasks

d. Responsibility

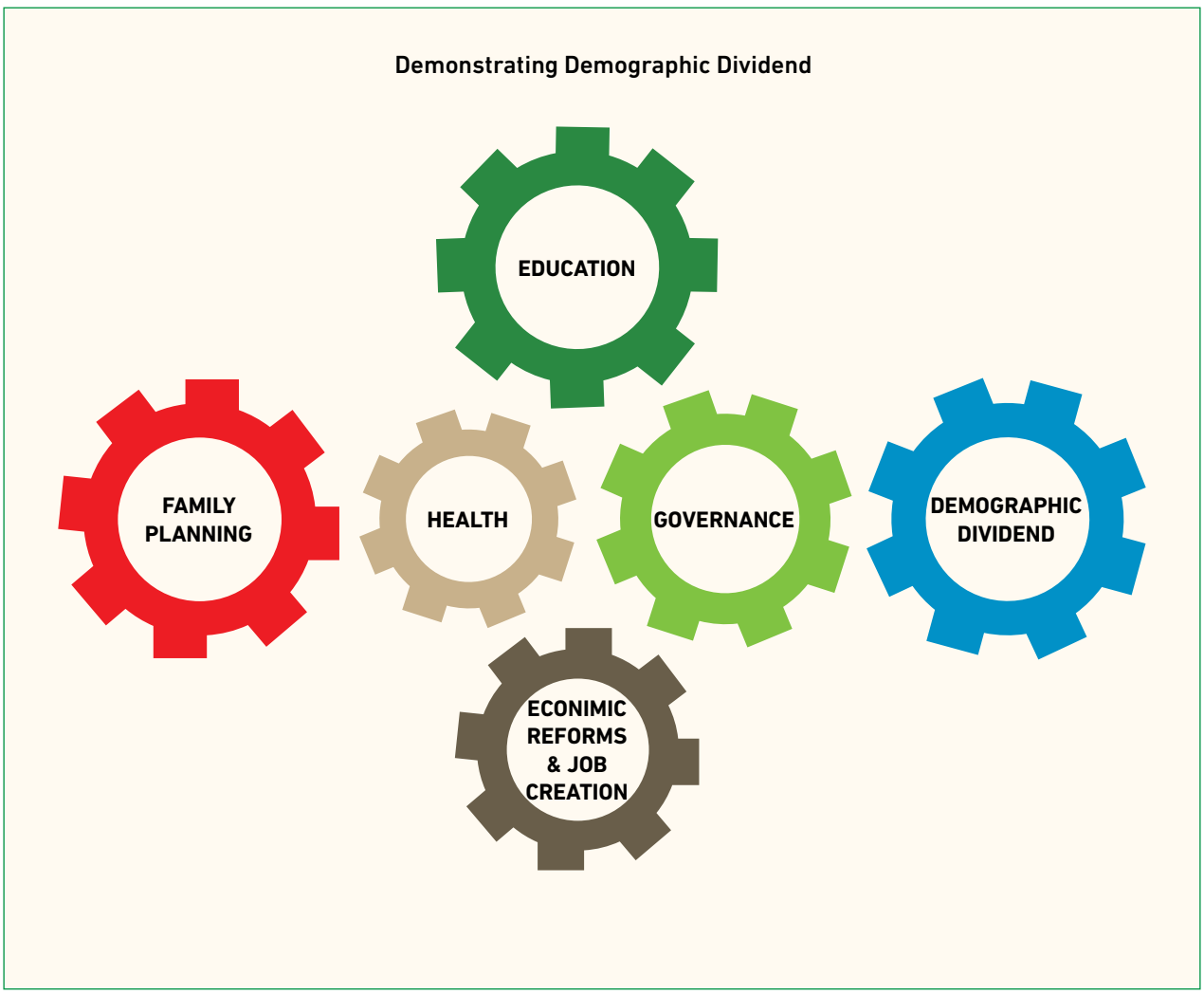
e. Duration of Activities (Start/End Dates)

f. Inputs (resources required)

g. Status of activity

h. Targets based on Advocacy indicators

i. Evidence of completed work (means of verification)



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ANNEXES

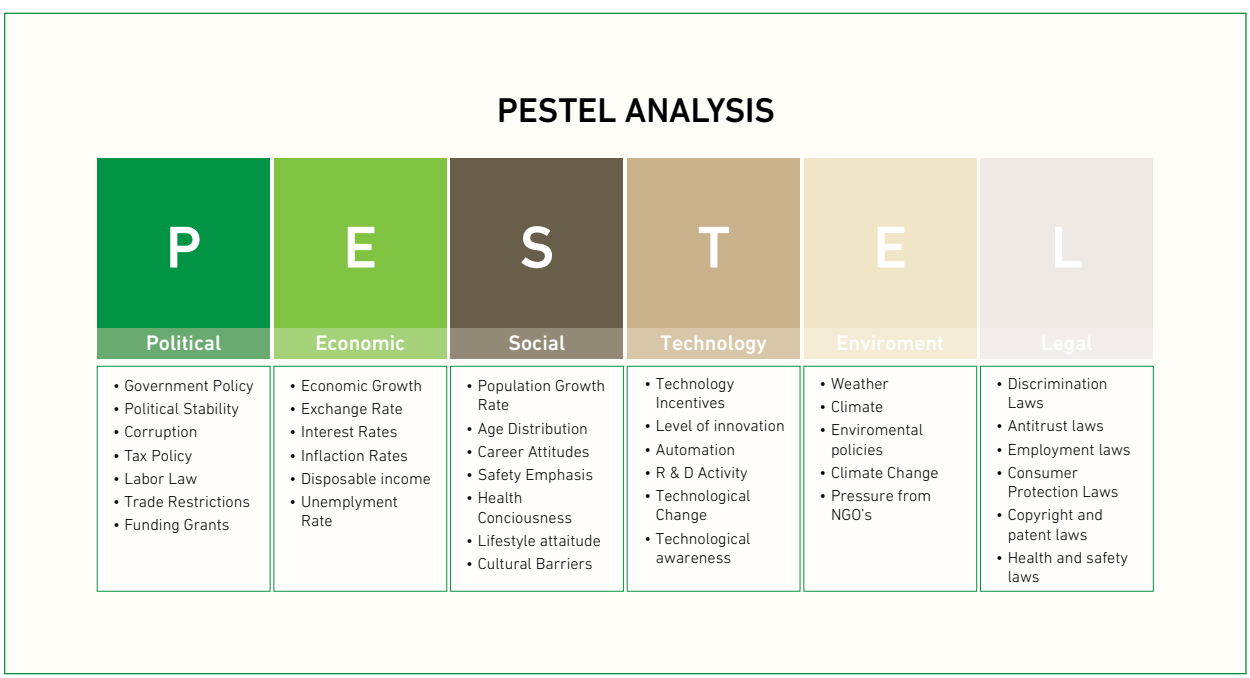
ANNEX 1: SAMPLE ADVOCACY MATRIX

Table 12: Communication Matrix template for planning and tracking Advocacy Communication Plans

OBJECTIVE 1: **Enabling Environment** - By Dec. 2024, catalyze the development, enactment, of relevant policy changes in support of increased investments in FP					
TARGET AUDIENCES	KEY MESSAGES	TACTICS and STRATEGIES	CHANNELS and MATERIALS	RESOURCES and BUDGETS	INDICATORS and EVIDENCE
PTA					
STA					
TTA					
OBJECTIVE 2: **Financing** - By Dec. 2024, advocate for improved financial allocations towards FP commodities (in line with government commitments					
TARGET AUDIENCES	KEY MESSAGES	TACTICS and STRATEGIES	CHANNELS and MATERIALS	RESOURCES and BUDGETS	INDICATORS and EVIDENCE
PTA					
STA					
TTA					

ANNEX 2: THE PESTEL MODEL (FOR ANALYZING CONTEXTS)

Figure XVI: *PESTEL Framework for analyzing the FP landscapes (Stakeholder Analysis)*



ANNEX 3: EVIDENCE FOR FP ADVOCACY (FROM MODELLING)

Figure XVII: *Family planning, vs Infant mortality rate and under 5 mortality rate*

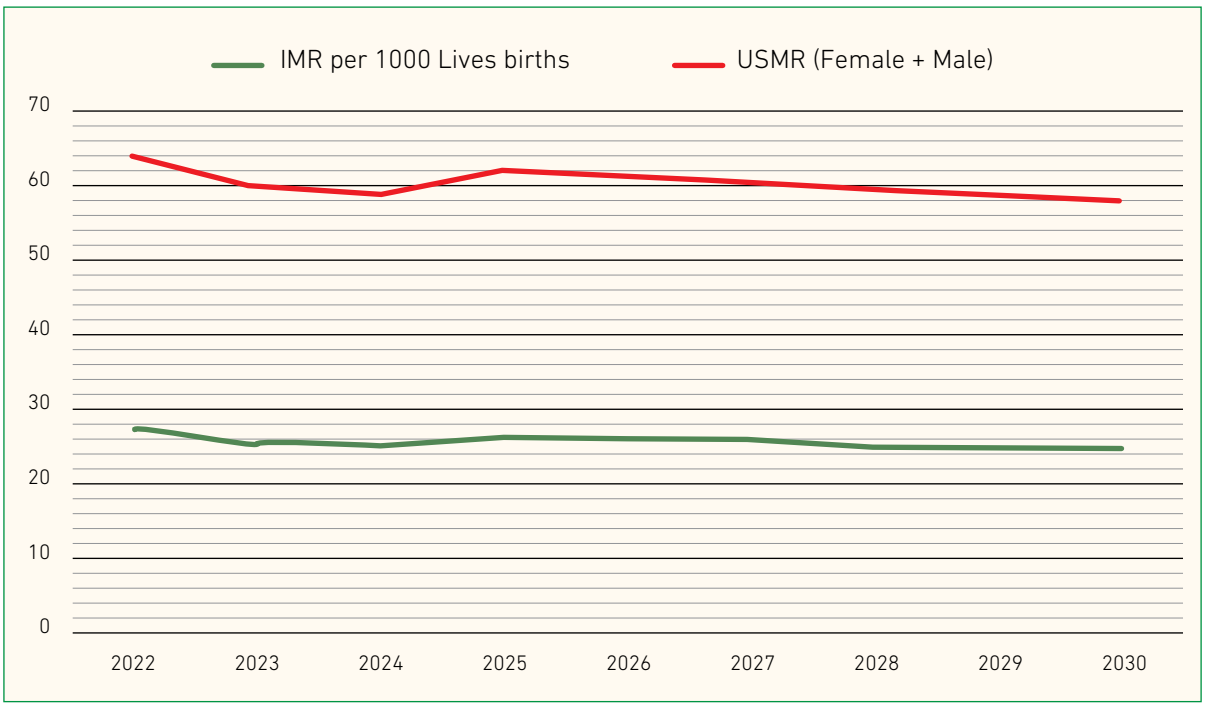


Figure XVIII: *Family Planning Vs Dependency Ratio*

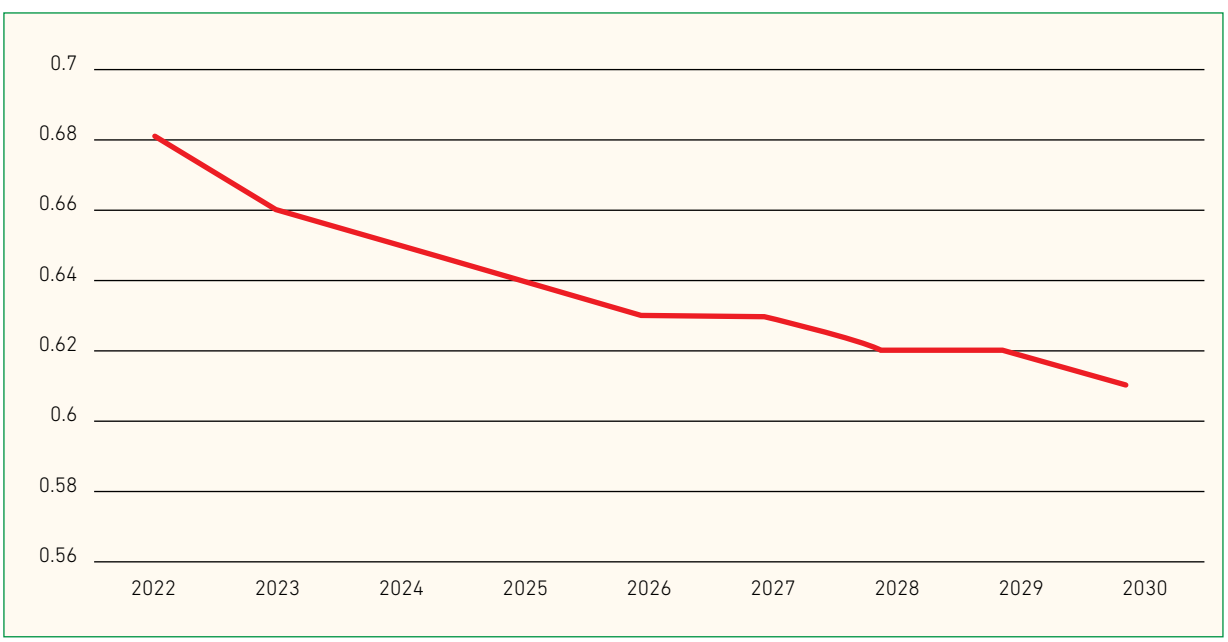
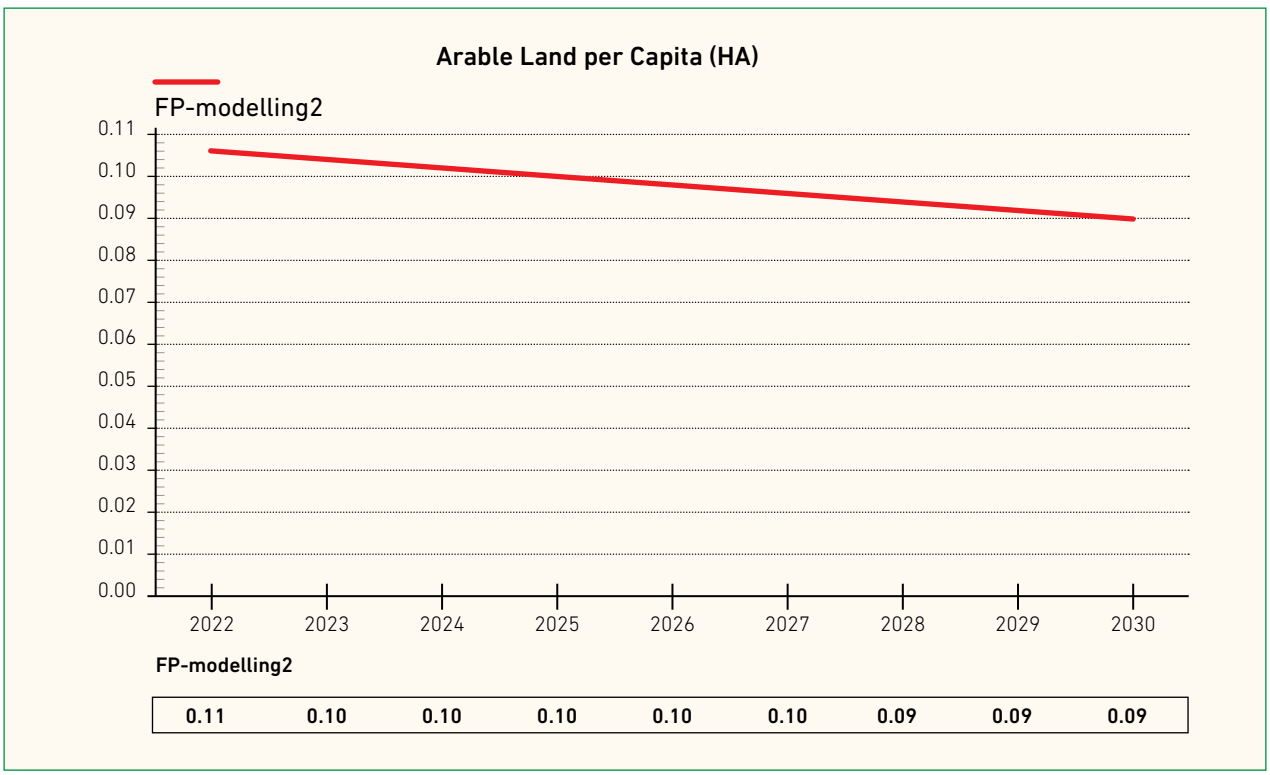
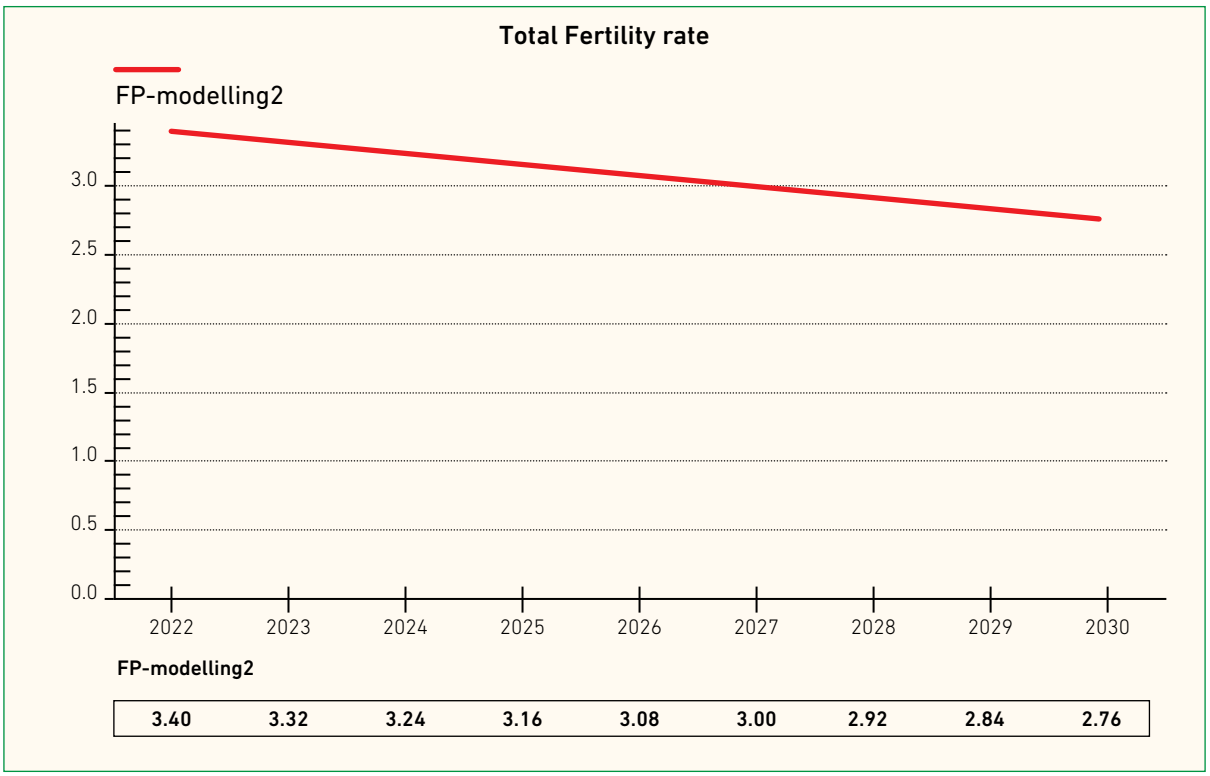


Figure XIX: *Relationship between population growth and arable land per capita*



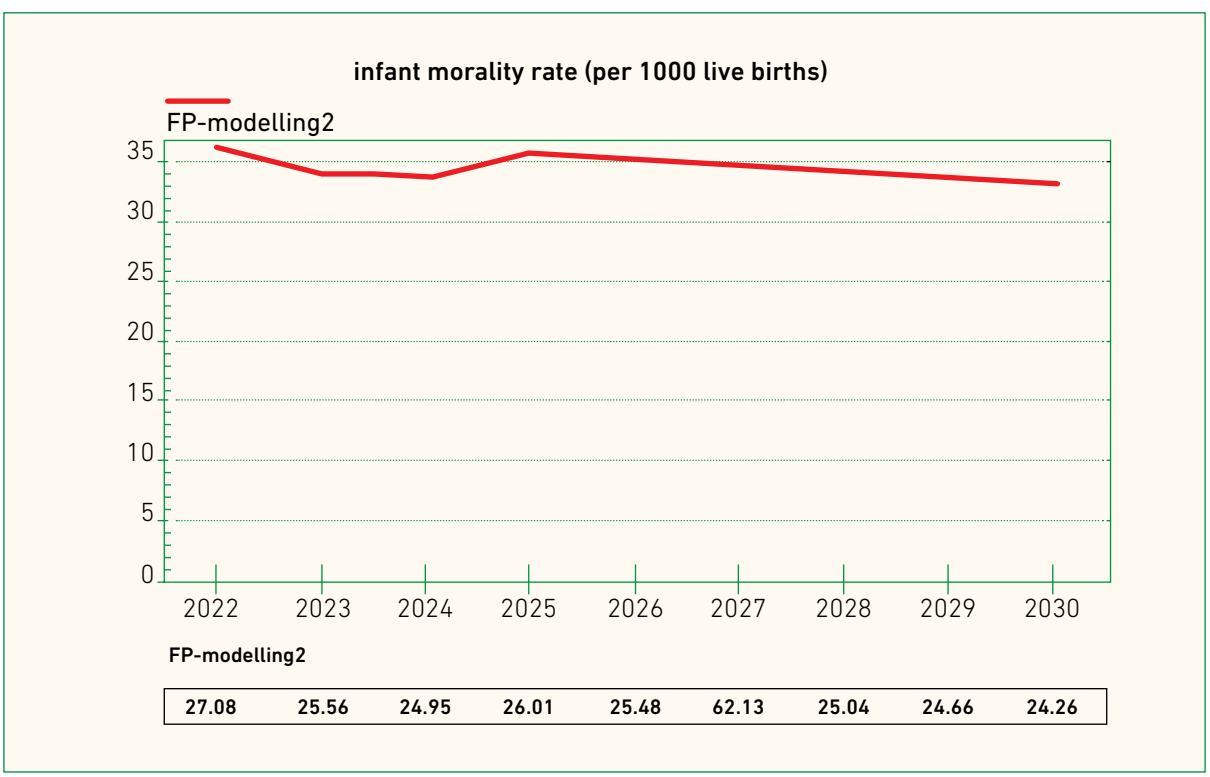
FP-modelling2								
0.11	0.10	0.10	0.10	0.10	0.10	0.09	0.09	0.09

Figure XX: *Total Fertility Rate*



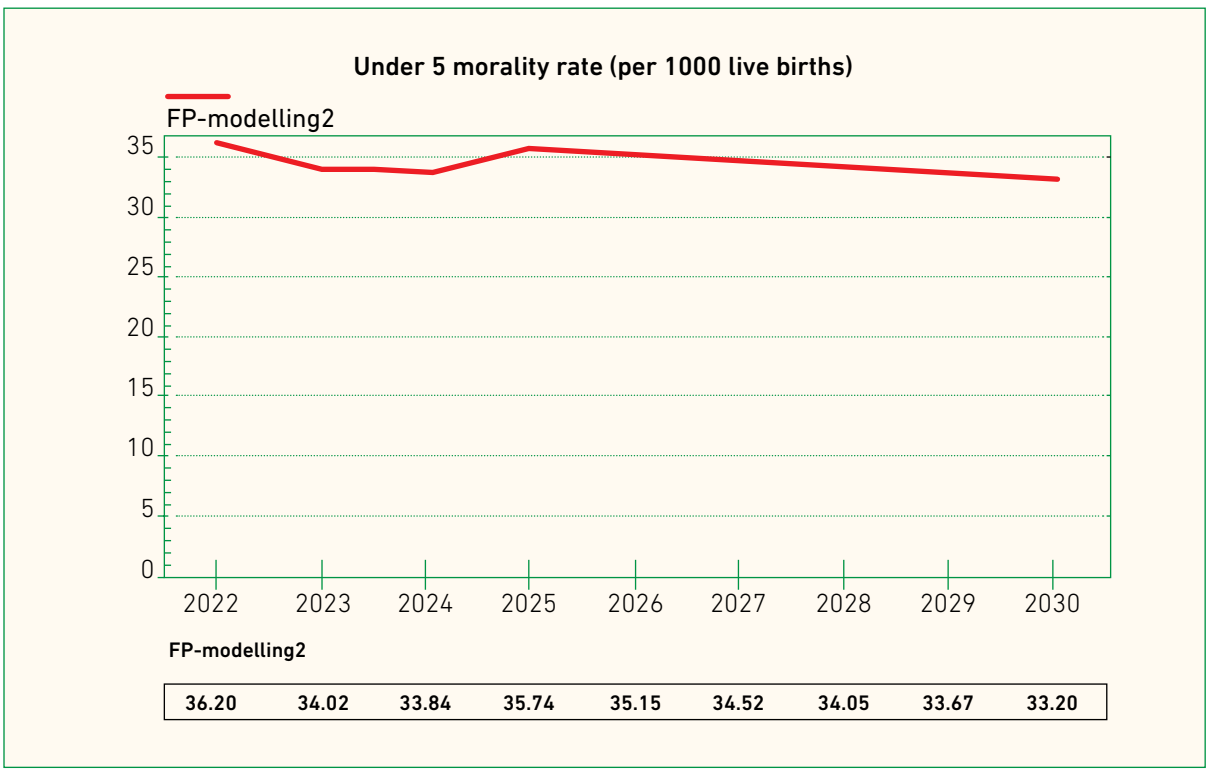
FP-modelling2								
3.40	3.32	3.24	3.16	3.08	3.00	2.92	2.84	2.76

Figure XXI: *Family planning and Infant Mortality Rate*



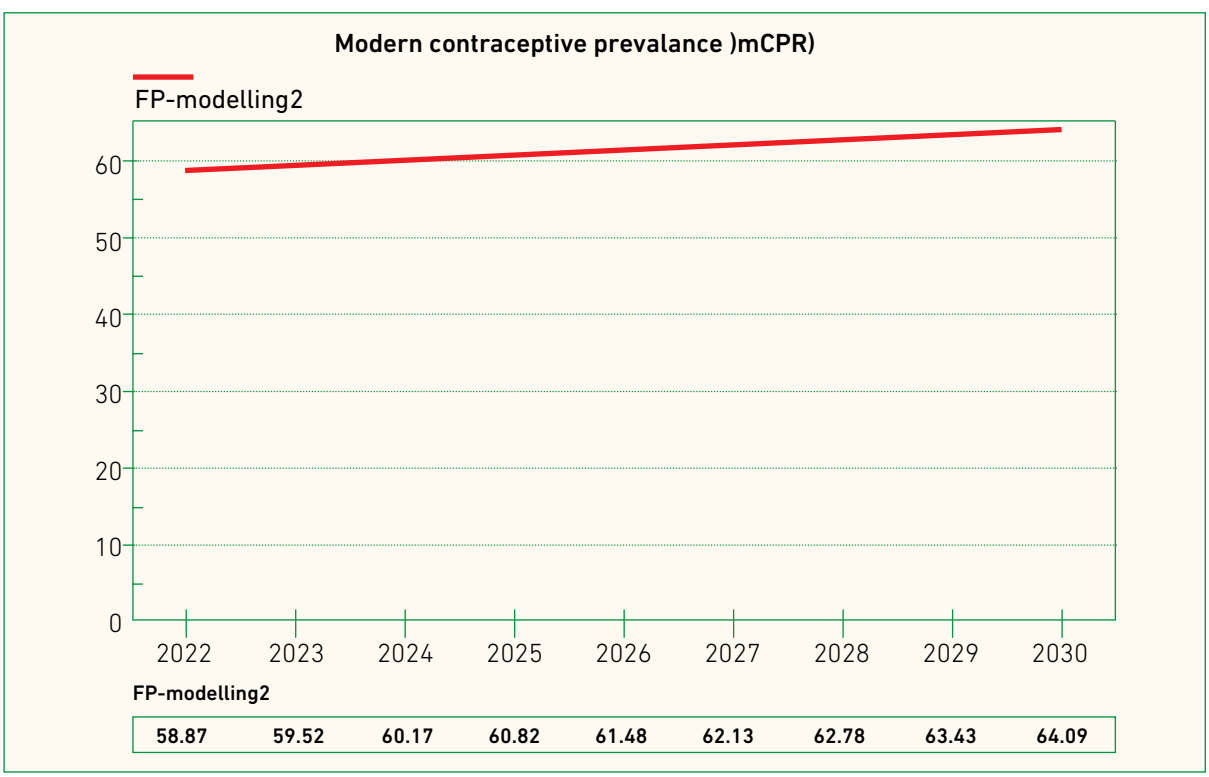
FP-modelling2								
27.08	25.56	24.95	26.01	25.48	62.13	25.04	24.66	24.26

Figure XXII: *Family planning and under five mortality rate*



FP-modelling2								
36.20	34.02	33.84	35.74	35.15	34.52	34.05	33.67	33.20

Figure XXIII: *Modern Contraceptive Prevalence Rate*



FP-modelling2								
58.87	59.52	60.17	60.82	61.48	62.13	62.78	63.43	64.09

ANNEX 4: SAMPLE GANTT CHART (DETAILED IMPLEMENTATION PLAN)

Table 14: *Ample Gantt Chart (Detailed Implementation Plan)*

DETAILED IMPLEMENTATION PLAN - FAMILY PLANNING ADVOCACY																			
	OBJECTIVE 1:	MONTH 1				MONTH 2				MONTH 3				RESPONSIBLE (PERSON/ ENTITY)	INPUTS	TARGETS	EVIDENCE	STATUS
MILESTONE 1: Foundational and Onboarding of Partners		W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4					
Activity 0.1	Inception Meeting with partners: Hold initial planning meeting with NCPD focal persons	x																
Activity 0.2	Draft and Share "Inception Report" with the refined SOW, DIP and Budget for NCPD's approval	x																
Activity 0.3	Drafting & Signing of FP Advocacy MoU: Workshop to refine Advocacy Objectives & Draft MoU		x															
MILESTONE 2: To conduct Landscape & Stakeholder Analysis to inform content and design of Advocacy Toolkit																		
Activity 1.0	Inception Meeting with partners: Prepare interview tools, Protocols, Training Guides		x	x	x													
Activity 1.1	Desk Review: Conduct Desk Review to mop out all the relevant action in Kenya(4 Counties) and Ethiopia (2 districts)			x	x													
Activity 1.2	Conduct Power/Interest Assesment: Use Desk Review data to conduct a power/Interest Assessment				x	x												
Activity 1.3	Rapid Appraisal Workshops: Facilitate one-day cluster workshop with key actors to validate/refine Report					x	x											
Activity 1.4	Training Research Assistants: Conduct two-day training for RAs who will be conducting the In-depth interview						x	x										
Activity 1.5	Conduct In-depth Interviews: Provide oversight during fieldwork (In-depth Interviews)							x	x	x	x							
Activity 1.6	Conduct Photo-voice Exercise: Provide oversight to field teams during the photo-voice exercise								x	x	x							
Activity 1.7	Analyze Data: Use Nvivo to analyze qualitative data from in-depth interviews and derive insights from the same									x	x	x						
Activity 1.8	Prepare and share final Landscape & Stakeholder Report: Prepare final Landscape & Stakeholder Analysis Report										x	x	x					
MILESTONE 3: To conduct a co-creation workshop to develop advocacy Toolkit, prototype it and dissemination and implementation																		
Activity 2.0	Preparation for workshop: Prepare Interview Tools, protocols, Training Guides												x					
Activity 2.1	Conduct workshop: Conduct co-creation workshop to Develop Advocacy Tools for five target counties																	
Activity 2.2	Training of ToT: Training ToT who will who will Pilot/ Prototype Advocacy Toolkit																	
Activity 2.3	Prototyping Advocacy Toolkit: Conduct Prototyping exercise in 5 target Counties																	
Activity 2.4	Drafting of Final Advocacy Toolkit: Drafting of ratified Advocacy Toolkit																	
Activity 2.5	Design and Contextualization of Advocacy Toolkit: Graphics and Translation work on final approved toolkit																	
Activity 2.6	Dissemination of Advocacy Toolkit: Support Country Teams to prepare for & Disseminate Advocacy Toolkit																	
Activity 2.7	MEAL Support: Technical support for MEAL during implementation																	
Activity 2.8	Technical Support Coordination and Iterations: Prepare the final report with recommendations (Plan)																	

ANNEX 5: LIST OF CONTRIBUTORS

SNo	CONTRIBUTORS NAME	ORGANIZATION
1.	Anna Mwanaisha	Access To Medicines Platform
2.	Annastacia Kumola	USAID
3.	Beatrice Okundi	National Council for Population and Development (NCPD)
4.	Bildad Mwanga	Axis Health Analytics and Policy Analysis
5.	Charity Koronya	UNFPA
6.	Christabel Were	DSW-K
7.	Diana Kivuti (In memoriam)	NCPD
8.	Dorothy Okemo	Access To Medicines Platform
9.	Dr. Albert Ndwiga	MOH/Division of Reproductive and Maternal Health (DRMH)
10.	Dr. Ramwaka Nyadziwa	SRHR Alliance
11.	Dr. Urbanus Kioko	Axis Health Analytics and Policy Analysis
12.	Febronne Achieng	AMREF/ Motion Tracker
13.	Festus Kisamwa	Marie Stopes Kenya
14.	Irene Wangui	UNFPA
15.	Jane Wanjaria	NCPD
16.	Joseph Kitipai	NCPD
17.	Joshua Okeyo	Clinton Health Access Initiative
18.	Judy Amina	SRHR Alliance
19.	Lucy Kimondo	NCPD
20.	Margaret Mwaila	NCPD
21.	Margaret Odera	NCPD
22.	Mark Okundi	Marie Stopes Kenya
23.	Maurice Oduor	NCPD
24.	Melanie Olum	ICRH-K
25.	Pamela Adhiambo	RHNK
26.	Pamela Onduso	Pathfinder
27.	Sharon Atieno	Pathfinder
28.	Vincent Odiara	Axis Health Analytics and Policy Analysis

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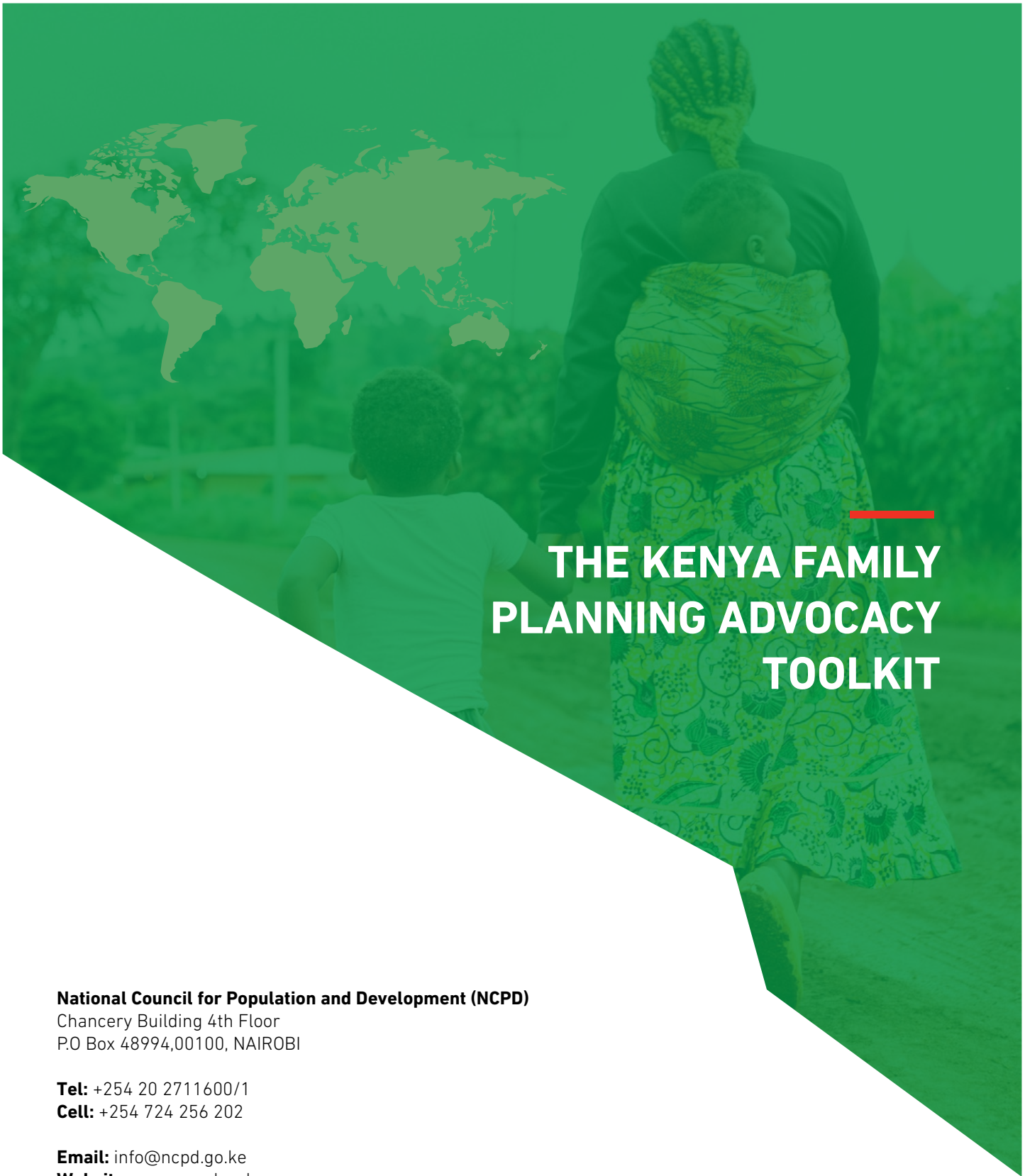
SNo	ORGANIZATIONS IN VALIDATION MEETING
1.	Amref Health Africa
2.	Clinton Health Access Initiative
3.	Council of Governors Secretariat
4.	DSW-Kenya
5.	FP2030 Hub
6.	Living Goods
7.	National Council for Population and Development
8.	Palladium/Propel
9.	PS-Kenya
10.	Reproductive Health Network of Kenya (RHNK)
11.	SRHR Alliance
12.	UNFPA
13.	USAID
14.	USAID/Afya Ugavi



THE KENYA FAMILY PLANNING ADVOCACY TOOLKIT

National Council for Population and Development (NCPD)
Chancery Building 4th Floor
P.O Box 48994,00100, NAIROBI

Tel: +254 20 2711600/1
Cell: +254 724 256 202

Email: info@ncpd.go.ke
Website: www.ncpd.go.ke

REPUBLIC OF KENYA

9 789914 450255

@NCPD_Kenya
https://ncpd.go.ke/