Strategy for Improving the Uptake of Long-acting and Permanent Methods of Contraception in the Family Planning Program

Duration of Implementation
July 2008–June 2010
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Foreword

The Division of Reproductive Health (DRH), Ministry of Public Health and Sanitation (MOPHS), implements and monitors programs to improve the quality of the nation’s reproductive health (RH) services. The mandate of the DRH follows the Second National Health Sector Strategic Plan (NHSSPII — 2005–2010), the National Reproductive Health Policy (2007), and the National Reproductive Health Strategy (1997-2010), all of which comply with the goals of the Program of Action of the 1994 United Nations International Conference on Population and Development (ICPD), and the United Nations Millennium Development Goals (MDGs). The DRH works in collaboration with stakeholders in the RH sector to fulfill this mandate, relying heavily on evidence-based practices and approaches to design its programs.

Presently, the uptake of long-acting and permanent methods (LAPMs) of contraception is relatively low, and there is a need to increase LAPM uptake in the method mix. Given the cost and program benefits of LAPMs to the National Family Planning (FP) Programme, the DRH, with assistance from partners and technical experts, has developed the *Strategy for Improving the Uptake of Long-acting and Permanent Methods of Contraception in the Family Planning Program*. This document outlines the steps the MOPHS intends to take to revitalize LAPMs in Kenya, stimulate LAPM uptake, and standardize the intervention approaches for increasing LAPM uptake in the country.

This document will be used in conjunction with other relevant documents such as the National Contraceptive Commodities Strategy and the DRH Annual Operational Plans to assist stakeholders and LAPM providers in designing, implementing, monitoring, and evaluating LAPM service provision. It is my hope that these efforts will contribute to the overall uptake of FP services in the country and improve maternal and child health indicators.

Dr. Janet Wasiche  
Head, DRH  
September 2008
Acknowledgments

This strategy was developed in collaboration with Kenya’s LAPM Task Force, under the leadership of the Division of Reproductive Health (DRH), Ministry of Public Health and Sanitation (MOPHS). The strategy follows recommendations made at a stakeholders meeting held in November 2007 that disseminated the findings of a 2007¹ comparative assessment that documented the approaches used to promote Long-acting and Permanent Methods (LAPMs) by three projects namely AMKENI, AMUA, and ACQUIRE and their impact on method uptake.

The MOPHS would like to thank Dr. Josephine Kibaru, currently Head, Department of Family Health (formerly Head of the DRH), for initiating and supporting the strategy development process and Dr Janet Wasiche, Head, DRH for ensuring the completion of the strategy. They would also like to thank members of the Task Force for their valuable support: Dr. Bartilol Kigen, Chair and Deputy Head and Cosmos Mutunga, Programme Officer both from the DRH, Luke S. K’Odambo, National Nurses Association of Kenya, Professor J.B. Oyieke, University of Nairobi, Department of Obstetrics & Gynaecology, Mary Nyamboki, Nursing Council of Kenya, Dr. Fredrick Ndede, EngenderHealth, Ferdinand Mose, AMUA Project, Marie Stopes, Kenya, Susan Otieno, Office of the Chief Nursing Officer, and Dr. Paul Dielemans, Essential Health Services.

The family planning technical working group also provided valuable input in the development of the strategy, for which the MOPHS is most grateful. Thanks also to Dr. Alice Mutungi, a consultant who worked tirelessly in providing the required technical support towards the development of this strategy.

The MOPHS would like to thank the team of internal reviewers from the Family Health International (FHI) for their technical input: Maureen Kuyoh, Marsden Solomon, Jennifer Wesson, Rick Homan, Jennifer Liku, Jane Alaii, Monica Wanjiru, Violet Bukusi, Erin McGinn, and Christine Lasway. We would like to thank Ruth Gathu for layout and design and Deborah McGill for editorial input.

Several partners have pledged to support specific activities in the work plan for the period 2008–2010. These partners include the United States Agency for International Development, GTZ, United Nations Population Fund, Management Sciences for Health, Essential Health Services, Population Services International, EngenderHealth, the Nursing Council, Kenya Medical Services Agency, and the USAID/APHIA II projects. The MOPHS acknowledges their support in ensuring increased uptake of long-acting and permanent methods of family planning in this country.

The development of this strategy was made possible through support provided by the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPOA-00-05-00022-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

### ACRONYMS

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<th>Definition</th>
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<tr>
<td>APHIA II</td>
<td>AIDS, Population and Health Integrated Assistance Program II</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>CTU</td>
<td>Contraceptive Technology Update</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DMPA</td>
<td>Depot Medroxyprogesterone Acetate</td>
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<td>DRH</td>
<td>Division of Reproductive Health</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GOK</td>
<td>Government of Kenya</td>
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<td>GTZ</td>
<td>German Technical Co-operation</td>
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<td>IEC</td>
<td>Information Education Communication</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<tr>
<td>JHU/CCP</td>
<td>Johns Hopkins University</td>
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<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
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<td>KEMSA</td>
<td>Kenya Medical Supplies Agency</td>
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<td>KSPA</td>
<td>Kenya Service Provision Assessment</td>
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<td>LAPMs</td>
<td>Long-acting and Permanent Methods</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<tr>
<td>NCAPD</td>
<td>National Co-ordinating Agency for Population and Development (formerly NCPD)</td>
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<tr>
<td>PMO</td>
<td>Provincial Medical Officer</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>SDPs</td>
<td>Service Delivery Points</td>
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Background and Situation Analysis

Long-acting and permanent methods (LAPMs) of contraception include the intrauterine contraceptive device (IUCD), female sterilization, vasectomy, and implants. Each method has been shown to have many advantages, and research studies have demonstrated their safety and acceptability.

Although the use of modern contraceptive methods in Kenya has risen steadily over the years, trends show a general increase in the use of short-acting methods and a decline in the use of LAPMs. According to the 1993, 1998, and 2003 Kenya Demographic and Health Surveys (KDHS), depot-medroxyprogesterone acetate (DMPA, or Depo-Provera) had the greatest increase in use—from 7 percent in 1993 to 15 percent in 2003. Thus, DMPA remains the most widely used method and the most preferred future method (47 percent) among married women. At the same time, the use of female sterilization (bilateral tubal ligation) decreased from 5.5 percent to 4.5 percent during the same period, and the use of IUCDs declined from 4.2 percent to 2.5 percent among currently married women ages 15 to 49 years, according to the KDHS [2003]. Vasectomy use remained low and isolated (NCPD et al., 1994, NCPD et al., 1999, CBS et al., 2004).

Despite a low rate of use, LAPMs are more effective at preventing pregnancy than short-acting methods. LAPMs are more convenient to clients and have better compliance than the short-acting methods, since the client does not need to remember to use them or to visit family planning (FP) clinics frequently for method re-supply or administration.

For example, results from one study revealed that IUCD users had the fewest compliance problems and the lowest discontinuation rates during a twelve-month period of use, as compared to users of Depo-Provera and oral contraceptive pills (Sekadde-Kigondu, Mwathe, and Ruminjo, 1996; FHI, 2007). The continuation rates for Jadelle, the two-rod contraceptive implant, were reported to be 88 percent and 42 percent after one and five years, respectively (Sivin, Nash and Waldman, 2002), whereas the continuation rates for oral contraceptives and injectables are 60 percent to 70 percent after one year, respectively (Ali and Cleland, 1995). LAPMs have high user satisfaction rates, which were reported to be 85 percent for IUCD users (Sekadde-Kigondu, Mwathe, and Ruminjo, 1996) and 97 percent for users who chose female sterilization (Ruminjo and Lynam, 1997).

When choosing a method FP clients needs to appreciate the effectiveness of a method in preventing a pregnancy. Implants and IUCDs represent effective FP options for couples who do...
not want children in the near future. LAPMs such as implants and IUCDs offer long-term effectiveness and reversibility, with effectiveness lasting three to twelve years, depending on the method chosen (WHO, JHU/CCP, 2007). On the other hand, surgical contraception (i.e., vasectomy and female sterilization) is the only method that offers highly effective, permanent protection from unintended pregnancies for couples who have achieved their desired family size. Vasectomy is simple to perform, safe, and usually has no complications (FHI, 2007a). Both sterilization and IUCDs may also be used in the immediate postpartum period, as they are safe to the mother and do not affect milk production (WHO, 2004).

LAPMs are appropriate methods for all people, including those infected with HIV. For instance, there are very few medical conditions that would restrict an individual's eligibility for surgical contraception. Also, among HIV-positive women, IUCD insertion did not significantly alter the prevalence of shedding HIV-1 infected cells, which indicates that using an IUCD with a condom may be an appropriate method for HIV-positive women wishing to avoid pregnancy (Richardson, Morrison, Sekadde-Kigondu et al, 1999).

When total medical expenses are considered, LAPMs offer great cost-effectiveness over time. The IUCD, vasectomy, and implants are considered the three most cost-effective methods when used for at least three years (FHI, 2007b). In addition, investing in FP, including LAPMs, has been reported to be an economical way to meet the United Nations Millennium Development Goals (MDGs)\(^2\). For example, it has been estimated that investing enough money in FP to fill the unmet need would result in savings of three times the amount needed to meet five different MDGs.

However, despite their many advantages, the general decline in use of LAPMs in Kenya continues. Several factors may have contributed to this drop, including limitations by health facilities to offer these methods, inadequate knowledge of advantages and benefits, myths and misperceptions, provider bias, and weak or absent public-private sector partnerships. Past studies found several reasons for the decline in IUCD use, such as poor quality of care, fear of HIV acquisition and transmission, poor product image, provider bias and deteriorating skills, shifting client preferences, and decline in health infrastructure (Stanback J, Omondi O, 1995; FHI, MOH/Kenya, 2005; MOH/Kenya, 2008).

The capacity to provide LAPMs in Kenya has been quite low compared to the capacity to provide short-acting methods. In addition, there has been inadequate promotion of LAPM

\(^2\) Source: Morehead, S and Talbird, S. *Achieving the Millennium Development Goals: The contribution of fulfilling the unmet need for family planning*. May 2006
methods, as indicated in the findings of the Kenya Service Provision Assessment survey (KSPA) of 2004. Nearly nine out of ten health facilities surveyed were found to offer short-acting methods, such as combined oral contraceptive pills, progestin-only injection, and the male condom. On the other hand, an LAPM such as surgical contraception (male or female) was offered by only 5 percent of the facilities surveyed. Only 13 percent of those facilities offered implants, even though 50 percent had them. The implication here is that there is need to enable those facilities which have the implants actually offer the service (NCAPD et al., 2005).

Weak or nonexistent public-private sector partnerships also contribute to the decline in LAPM use in Kenya. Many private-sector initiatives are short term, with little or no ownership by the MOPHS or target communities, and are not necessarily systems-oriented, which negatively affects sustainability of the initiatives. On the other hand, most public-sector quality-improvement initiatives do not involve the private sector. Public-private sector partnerships are more likely to result in successful, cost-effective, and sustainable programs. In the comparative assessment of LAPMs in Kenya by FHI, in collaboration with MOPHS and partners (EngenderHealth and AMUA project), it was reported that participation by the private sector in the AMUA project resulted in capacity building and motivation of the providers, as well as enhanced supply of contraceptive commodities for the private sector. In addition, sustained implementation of some interventions continued even after some projects ended (MOH/Kenya, 2007).

The declining utilization of LAPMs is occurring when Kenya's total annual cost of all contraceptive commodities is projected to increase from US$16.7 million in 2004 to US$21.7 million in 2015, an increase that will only maintain the current prevalence rates and method mix. Kenyan policy-makers are concerned about how to maintain and expand RH services when national and development partner support are not meeting anticipated commodity needs.

Response

To arrest the decline in the use of LAPMs in Kenya, and address the constraints of maintaining and expanding RH services in resource-constrained settings, the MOPHS and partners launched intensive efforts aimed at enhancing the use of these methods. Such interventions included task shifting for implant provision, revitalization of IUCDs, revision of the FP guidelines to highlight LAPMs and the introduction of service delivery, capacity building, and demand-creation interventions in selected districts (through AMKENI, AMUA, and ACQUIRE), among others. The LAPM interventions through AMKENI, AMUA, and ACQUIRE targeted private and

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3 Based on a forecast done using the EngenderHealth Reality Tool. The forecast used the CPR and method mix from the 2003 DHS, UN projections for the number of women of reproductive age 2003-2015 in Kenya, and ran a projection assuming no change in the CPR/method mix. See www.engenderhealth.org for more information about the tool.
public sector providers and featured activities, some of which addressed LAPMs only, while others addressed all modern contraceptive methods. However, all interventions employed holistic models incorporating activities that targeted advocacy, supply, and demand.

In early 2007, FHI, in collaboration with MOPHS and partners (EngenderHealth and AMUA project) carried out a comparative assessment to document the approaches used in the provision of LAPMs by the AMKENI, AMUA, and ACQUIRE projects, their outcomes, and their impact on LAPM uptake. The findings indicated that while all three projects made progress in promoting contraceptive methods, no single element stood out as a determinant of LAPM provision. However, with regard to enhancement of uptake of LAPMs, it was evident that good outcomes entailed capacity building, demand creation, public-private sector partnerships, commodity security, and sustainability.

After the assessment, in November 2007, the DRH hosted a meeting for stakeholders to review the results and develop consensus on a national strategy to further revitalize LAPMs. The participants concluded that the MOPHS should continue implementing both innovative interventions to increase LAPM utilization and also the recommendations and lessons learned from the comparative assessment. Thus, the MOPHS LAPM Revitalization Strategy was developed based on input from stakeholders and endorsed by the MOPHS Family Planning Working Group.
The LAPM Revitalization Strategy

Goal

The strategy’s overarching goals are to establish a sustainable FP program with a balanced method mix of both long- and short-acting contraceptive methods and to promote the uptake of these methods. Our focus will be to expand the provision of quality LAPM services and to educate communities about the importance of LAPMs in child spacing and in improving the health of mothers, newborns, and families, consequently facilitating client uptake in both the public and private sectors of health care.

Objectives

To ensure availability of high-quality LAPM services, the strategy seeks to:

- Equip health workers with knowledge and skills on LAPM provision
- Increase awareness, knowledge, and acceptability of LAPMs in the communities
- Increase funding and commitment for procurement of LAPM commodities by the Government of Kenya (GOK)
- Strengthen the reporting system and commodity distribution of LAPM commodities and supplies
- Strengthen public-private sector partnerships

Approach

The stakeholders meeting of November 2007 recommended that the LAPM revitalization strategy for the MOPHS be based on the following themes, taking into consideration the evidence from the assessment:

1. Capacity building
2. Demand creation
3. Logistics management (i.e., security and distribution of supplies/commodities and equipment)
4. Public-private sector partnerships
5. General sustainability of the interventions

The stakeholders further identified the steps necessary for the development of each thematic area, the goals and objectives, and the key actions required, as discussed in the following section (see also Appendix 1 for the complete list generated by the stakeholders).
Theme 1: Build Capacity to Improve the Quality of LAPM Services

For providers to offer quality LAPM services, it is important that they have up-to-date knowledge and skills, as well as positive attitudes. However, they face challenges such as maintaining a trained work-force in health facilities. For example, most facilities suffer when trained providers choose to transfer, or when skilled providers move to other departments or facilities where their LAPM skills are not required, not to mention staff moving to other organizations or to other countries. Other challenges include provider bias based on personal beliefs about LAPMs and religious and cultural barriers.

Objective

The objective is to equip health workers (both pre- and in-service) with up-to-date knowledge, skills, and positive attitudes on provision of LAPMs for all potential users (i.e., during nulliparous, interval, or immediate postpartum periods). To achieve this, the MOPHS will provide leadership and work together with partners and other stakeholders to undertake the following capacity-building actions:

Priority Action I — Determine the specific needs for LAPM training, capturing regional disparities

Key Activities:
- Develop a data collection tool (produce draft, pre-test, and modify)
- Conduct a needs assessment (collect and analyze data, and write report)
- Share findings with the stakeholders (include health-care providers that do not provide LAPMS in order to facilitate client counseling and referral) and design the way forward

Priority Action II — Conduct training of trainers and service providers

Key Activities:
- Design training (conceptualize and plan training intervention, develop learning goals and objectives, and create training schedules)
- Develop or adapt/adopt training materials (print and electronic) and learning activities/instructional methods
- Train trainers and providers

Priority Action III — Evaluate training

Key Activities:
- Develop a monitoring and evaluation plan that includes activities, indicators, logistics, and a budget
- Develop data collection tools and conduct an evaluation
Note: The development of an evaluation plan and data collection tools will be carried out alongside the training design.

♦ Share the report with stakeholders (including the providers and administrators), and design the way forward

**Theme 2: Increase the Use of LAPMs by Creating Demand for Them**

Community members are important to the uptake and continuation of LAPM use. However, promoting LAPMs in a community is hampered by challenges: myths and misconceptions; religious and cultural barriers; providers’ concerns and biases about LAPMs; providers’ influence over the methods clients choose. To create demand and increase LAPM uptake, these challenges need to be addressed.

**Objective**

To increase community awareness, knowledge, and acceptability of LAPMs in line with the National RH community strategy, this objective seeks to garner community ownership, support, and participation. The MOPHS, its partners, and other stakeholders will undertake the following priority actions:

**Priority Action I — Identify the factors influencing the use/non-use of LAPMs**

**Key Activities:**

♦ Review existing research evidence on factors influencing the use of LAPMs
♦ Review feedback received from the LAPM national stakeholders meeting
♦ Review and prioritize identified barriers to LAPM use

**Priority Action II — Implement culturally appropriate behavioral change communication (BCC) to enhance the acceptability and use of LAPMs**

**Key Activities:**

♦ Review existing LAPM/FP IEC materials, and adopt those that are culturally appropriate to particular communities and specific target groups, or develop new ones
♦ Test IEC materials and modify, as necessary
♦ Distribute IEC materials

**Priority Action III — Implement community sensitization and mobilization activities for LAPMs**

**Key Activities:**

♦ Organize and conduct targeted community sensitization activities for LAPMs
♦ Identify community events, such as chiefs’ barazas, weddings, religious gatherings, clubs (i.e., for youth, women), and entertainment places to promote LAPMs
♦ Use existing channels such as health facilities and the CHWS[Community Health Workers] to disseminate information

Theme 3: Ensure the Security and Distribution of Commodities, Equipment, and Supplies for Wider Availability of Method Choices to Increase the Use of LAPMs
Inadequate contraceptive commodities, supplies, and equipment limit the variety of methods available to clients and fewer choices inhibit client uptake. The Kenya government’s low budgetary allocations to the health sector, as well as many competing RH priorities in this sector, reduce the ability of the MOPHS to provide commodity security. However, the MOPHS has developed the National Contraceptive Commodities Security Strategy 2007–20124 (MOH/Kenya, 2007), and this section will borrow heavily from the recommendations in that document.

Objective
Ensure the security of commodities/supplies and the equipment necessary for the provision of a complete method mix, and improved LAPM services. To achieve this objective, the MOPHS, its partners, and other stakeholders will undertake the following priority actions:

Priority Action I — Lobby for increased funding of and commitment to procurement of RH commodities by the GOK
   Key Activities:
   ♦ Lobby budgetary officials in the Ministries of Health and Finance to increase the budget for procurement of RH commodities, particularly IUCDs, implants, and consumables for sterilization

Priority Action II — Strengthen the reporting system
   Key Activities:
   ♦ Assess the reporting system, identifying weaknesses
   ♦ Share the findings with stakeholders, and design a plan to respond to the system’s weaknesses

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**Priority Action III** — Enhance partnerships between the logistics units of DRH and Kenya Medical Supplies Agency (KEMSA) in order to strengthen the distribution of RH commodities

**Key Activities:**
- Sensitize DRH and KEMSA staff on timely distribution of RH commodities, including LAPMs
- Enhance communication between DRH and KEMSA
- Improve KEMSA’s delivery of RH commodities (including LAPMs)

Arrange for DRH and KEMSA to conduct a joint supervision on the distribution of RH commodities

**Theme 4: Advance Public-Private Sector Partnerships**

The private sector plays a major role in the provision of LAPMs and other contraceptive services, as about 50 percent of contraceptive users obtain their services from this sector. Their participation in activities to improve the provision of LAPM services is crucial.

To extend LAPM services in order to reach more clients, public-private sector partnerships should be strengthened. However, there are some challenges. Nongovernmental organizations, faith-based organizations, and private medical-training institutions have priorities for implementation in place, and these may differ from those of the MOPHS. In addition, many donor-funded interventions are short-term, with very few targeting the private sector. Also, most quality-improvement activities by the public sector leave out the private sector. These challenges need to be addressed for partnerships between the public and private sectors to be successful in their efforts to promote and provide LAPMs.

**Objective**
Strengthen the capacity of the public and private sectors to plan and implement LAPM interventions jointly in order to achieve wider coverage of the target audience and sustainability. To promote public-private sector partnerships, the MOPHS and stakeholders will undertake the following priority actions:
Priority Action I — Organize the planning and implementation of LAPM interventions so that public- and private-sector agencies conduct them jointly

**Key Activities:**
- Convene a joint (public and private sector) meetings to plan for the design, implementation, monitoring, and evaluation of complementary interventions for LAPMs
- Facilitate the development of integrated work plans for LAPM interventions including contraceptive commodity supply between the public and private sectors
- Hold all-inclusive forums to share information gathered from the implementation process
- Include private providers in MOPHS-organized CTUs and in supervisory visits to facilities

Priority Action II — Link the LAPM interventions of the public and private sectors to improve service delivery

**Key Activities:**
- Foster sensitization between (and agreement by) public and private sectors on joint priority actions of the strategy, in order to promote the uptake of LAPMs and to avoid the duplication of effort and waste of resources
- As much as possible, have individual facilities implement LAPM activities within their existing RH services and structures

Priority Action III — Disseminate data and information on LAPMs to both the public and private sectors

**Key Activities:**
- Package and disseminate information gleaned from LAPM research and implementation to public and private stakeholders
- Provide technical assistance to stakeholders to develop strategies needed to address issues identified in the research

Theme 5: Ensure the Sustainability of Interventions to Improve the Quality of LAPM Services

Although the contraceptive prevalence rate in Kenya increased steadily for many years, it has stagnated for the past decade, and the unmet need for FP has remained unacceptably high—at 24 percent in 1998 and 24.5 percent in 2003 (NCPD et.al., 1999; CBS et al., 2004). Some of the factors that are reported to contribute to this stagnation include limited availability of these methods in health facilities; poor quality of care; fear of HIV infection and transmission; poor product image; inadequate provider knowledge
Evidence from the 2007 Comparative Assessment of LAPMs shows that even after the project ended, the provision of IUCDs and implants in AMUA and ACQUIRE project sites continued to increase. However, in the AMKENI project sites, the provision of IUCDs approached near baseline levels (MOH/Kenya, 2008). There are prevailing challenges to sustained LAPM interventions. These include inadequate RH and MOPHS budgets, a workforce that is unmotivated and too small, the inability of clients to afford payment for services, and low demand within communities for LAPM services.

Objective
Put in place effective sustainability measures to ensure the continued availability of high-quality LAPM services at all health-service delivery points (SDPs). To maintain LAPM uptake through high-quality service-delivery interventions over a sustainable period, the MOPHS, its partners, and other stakeholders will undertake the following priority actions:

Priority Action I — Strengthen staff training, deployment, and supportive supervision

Key Activities:
- Establish appropriate levels of staffing as well as effective and appropriate frequency of continuing professional development (CPD) activities and supervision
- Deploy at least two trained staff in each SDP, and ensure their retention at the FP clinic
- Institutionalize CPD at the facility level (e.g., on-the-job training [OJT]) and provide tools and other support for necessary for support supervision
- Create and obtain budget for staffing, training/updates, and supervision

Priority Action II — Create an adequate budget line for RH (including LAPMs), commodities, and equipment

Key Activities:
- Ensure good reporting
- Forecast demand for different contraceptive methods, in order to make budget estimates more accurate
- Pursue the registration of low-cost but effective methods (e.g., Sino implants)
Priority Action III — Use existing MOPHS structures for the delivery of LAPM services

Key Activities:

♦ Facilitate ownership of the program by the District Health Management Team (DHMT) and other stakeholders (including community members), and make sure that district work plans include LAPM activities beyond the intervention periods

♦ Conduct forums/seminars for DHMT and stakeholders (including community members) to share ideas and feedback, from the design stage of the intervention through to the intervention’s conclusion

A summary of the recommended work plan follows.
## Implementation Plan

**Theme 1: Build Capacity to Improve the Quality of LAPM Services**

### 1.1. Action to be achieved/addressed: Conduct a training needs-assessment

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<th>Responsibility</th>
<th>Lead</th>
<th>Support</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
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<tr>
<td>Develop data collection tool (produce draft, test, and modify)</td>
<td>DRH</td>
<td></td>
<td>MOPHS</td>
<td>3 weeks</td>
<td>Stationery, computers</td>
<td>Technical experts, funds, allowances, transport, fuel</td>
<td>Copies of finalized data collection tools</td>
</tr>
<tr>
<td>Collect data</td>
<td>Provincial &amp; district RH coordinators</td>
<td></td>
<td>DRH, MOPHS</td>
<td>4 weeks</td>
<td>Questionnaires, checklists, recording devices</td>
<td>Technical experts, funds, allowances transport, fuel</td>
<td>Data available from the assessment sites</td>
</tr>
<tr>
<td>Analyze data</td>
<td>Provincial &amp; district RH coordinators</td>
<td></td>
<td>DRH, MOPHS</td>
<td>2 weeks</td>
<td>Software, Computers</td>
<td>Technical experts, funds</td>
<td>Compiled findings from the assessment</td>
</tr>
<tr>
<td>Write report</td>
<td>Provincial &amp; district RH coordinators</td>
<td></td>
<td>DRH, MOPHS</td>
<td>1 week</td>
<td>Stationery, Computers</td>
<td>Technical experts, funds</td>
<td>Copies of report</td>
</tr>
<tr>
<td>Conduct workshop to share findings with stakeholders</td>
<td>Provincial &amp; district RH coordinators</td>
<td></td>
<td>DRH, MOPHS</td>
<td>1 day</td>
<td>Stationery, Computers, Overhead/LCD projector</td>
<td>Technical experts, funds</td>
<td>Workshop proceedings</td>
</tr>
<tr>
<td>Design way forward</td>
<td>Provincial &amp; district RH coordinators</td>
<td></td>
<td>DRH, MOPHS</td>
<td>0.5 days</td>
<td>Stationery, Computers, Overhead/LCD projector</td>
<td>LAPM stakeholders, technical experts</td>
<td>Copy of document detailing the way forward</td>
</tr>
</tbody>
</table>
## Implementation Plan

### 1.2. Action to be achieved/addressed: Train trainers and providers

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design training</strong> (conceptualize and plan training intervention, develop learning goals and objectives, create training schedules)</td>
<td>Regional RH trainers</td>
<td>1 week</td>
<td>Stationery, computers</td>
<td>Technical experts, funds</td>
<td>Training plan detailing learning goals, objectives, and schedules</td>
</tr>
<tr>
<td><strong>Adapt/develop training materials</strong> (print and electronic) and learning activities/ instructional methods</td>
<td>Regional RH trainers</td>
<td>2 weeks</td>
<td>Stationery, computers</td>
<td>Technical experts, funds</td>
<td>Copies of facilitator and trainee manuals, each containing relevant information</td>
</tr>
<tr>
<td><strong>Train trainers</strong></td>
<td>Regional RH trainers</td>
<td>1 week</td>
<td>Stationery, computers, overhead/LCD projector, flipchart, markers, skills lab</td>
<td>Technical experts, funds</td>
<td>• No. of training workshops conducted • Workshop proceedings, No. of TOTs trained</td>
</tr>
<tr>
<td><strong>Train providers</strong></td>
<td>TOTs</td>
<td>PMOs, MOPHS</td>
<td>1 week per group</td>
<td>Stationery, Computers, Overhead/LCD projector, Flipchart, Markers, Skills lab</td>
<td>Technical experts, TOTs, Funds</td>
</tr>
</tbody>
</table>
# Implementation Plan

## 1.3. Action to be achieved/addressed: Evaluate training

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop (alongside the training design) an evaluation plan that includes activities, indicators, logistics, and budget</td>
<td>DRH coordinator, MOPHS</td>
<td>2 weeks</td>
<td>Stationery, computers</td>
<td>Technical experts, funds</td>
<td>Copies of completed evaluation plan</td>
</tr>
<tr>
<td>Develop data collection tools</td>
<td>DRH coordinator, MOPHS</td>
<td>1 week</td>
<td>Stationery, computers</td>
<td>Technical experts, funds</td>
<td>Copies of finalized data collection tools</td>
</tr>
<tr>
<td>Conduct evaluation/ collect data</td>
<td>PMO/ DMOH, DRH, MOPHS</td>
<td>Throughout training period, 4 weeks, 6 months, yearly</td>
<td>Data collection tools, stationery, computers</td>
<td>Technical experts, funds</td>
<td>Hard data from the assessment sites</td>
</tr>
<tr>
<td>Analyze data</td>
<td>PMO/ DMOH, DRH, MOPHS</td>
<td>1 week</td>
<td>Stationery, computers, overhead/LCD projector, flipchart, markers, skills lab</td>
<td>Technical experts, funds</td>
<td>Compiled findings from the assessment</td>
</tr>
<tr>
<td>Write evaluation report</td>
<td>PMO/ DMOH, DRH, MOPHS</td>
<td>1 week</td>
<td>Stationery, computers</td>
<td>Technical experts, funds</td>
<td>Copies of report</td>
</tr>
<tr>
<td>Share report with stakeholders (including providers and administrators)</td>
<td>PMO/DMOH, DRH, MOPHS</td>
<td>1 day</td>
<td>Stationery, computers, overhead/LCD projector, flipchart, markers, skills lab</td>
<td>Technical experts, funds</td>
<td>Workshop proceedings</td>
</tr>
<tr>
<td>Design activities to inform/improve based on evaluation report</td>
<td>PMO/DMOH, DRH, MOPHS</td>
<td>0.5 days</td>
<td>Stationery, computers</td>
<td>DRH stakeholders</td>
<td>Copy of document detailing the way forward</td>
</tr>
</tbody>
</table>
Implementation Plan

Theme 2: Increase the Use of LAPMs by Creating Demand for Them

2.1. **Action to be achieved/addressed: Identify factors influencing the use and non-use of LAPMs**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Lead</th>
<th>Support</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>Partner facilitator</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop data collection tools (produce draft, test, and modify)</td>
<td>DRH/ DMOH PMO</td>
<td>MOPHS</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Copies of finalized data collection tools</td>
</tr>
<tr>
<td>Collect data</td>
<td>DMOH/ PMO</td>
<td>DRH</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Hard data from the assessment sites</td>
</tr>
<tr>
<td>Analyze data and write report</td>
<td>DMOH/ PMO</td>
<td>DRH</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Compiled findings from the assessment, copies of the final report</td>
</tr>
<tr>
<td>Conduct workshop and share findings with stakeholders (including providers and community representatives)</td>
<td>DMOH/ PMO</td>
<td>DRH</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Workshop proceedings</td>
</tr>
<tr>
<td>Stakeholders to design the way forward</td>
<td>DMOH/ PMO</td>
<td>DRH</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Copy of document detailing the way forward</td>
</tr>
</tbody>
</table>

**Note:** In Kenya, the action outlined on this page has already been accomplished. However, for any FP program to improve the uptake of LAPMs this action is a necessity.

**Key**

NA = Not applicable in Kenya at the moment.
## Implementation Plan

### 2.2. Action to be achieved/addressed: Adapt, adopt, and develop culturally appropriate IEC materials

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop draft IEC materials culturally</td>
<td>DRH/PMO/DMOH</td>
<td>1 year</td>
<td>Existing/draft IEC materials</td>
<td>Technical experts, funds, institutional capacity</td>
<td>Copies of draft IEC materials</td>
</tr>
<tr>
<td>appropriate to particular community and specific target group</td>
<td>MOPHS/partners /stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test and modify the IEC materials, as necessary</td>
<td>DRH/PMO/DMOH</td>
<td>8 weeks</td>
<td>Draft IEC materials</td>
<td>Technical experts, funds, institutional capacity</td>
<td>Copies of printed IEC materials</td>
</tr>
<tr>
<td></td>
<td>DRH/partners/stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Distribute the IEC materials                    | PMO/DMOH                                | One year   | Copies of the different IEC materials | DRH/MOPHS staff at all levels, CBDs, health educators, funds | • No. of copies of IEC materials distributed  
• Proportion of each specific target audience reached  
• No. of forums in which IEC materials were distributed |
### Implementation Plan

#### 2.3. Action to be achieved/addressed: Implement community sensitization and mobilization activities for LAPMs

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
</table>
| Identify community groups and specific targeted community activities, and organize and conduct targeted community sensitization seminars on LAPMs | DRH/PMO/DMOH, regional RH coordinators, MOPHS, other stakeholders | 1 year     | IEC materials, media briefs | Funds for production of more IEC materials, fuel, staff allowances         | • No. of seminars conducted  
• Proportion of target groups reached                                   |
| Leverage existing community events, such as chiefs’ barazas, weddings, religious gatherings, clubs (e.g. for youth, women), entertainment places | DRH/PMO/DMOH, regional RH coordinators, MOPHS, other stakeholders | 1 year     | IEC materials, media briefs | Funds for production of more IEC materials, fuel, staff allowances         | • No. of events where leveraging took place  
• Proportion of target groups reached                                    |
Implementation Plan

Theme 3: Ensure the Security and Distribution of Commodities, Equipment, and Supplies for Wider Availability of Method Choices to Increase the Use of LAPMs

3.1. **Action to be achieved/addressed:** Increase funding of and commitment to the procurement of RH commodities by Government of Kenya and its partners

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobby budgetary officials in the Ministries of Health and Finance to increase budgetary allocation for procurement of RH commodities</td>
<td>DRH</td>
<td>Stakeholders</td>
<td>12 months</td>
<td>Advocacy materials (e.g., policy and media briefs)</td>
<td>Technical experts, funds, personnel</td>
</tr>
<tr>
<td>Enhance collaboration and coordination of partners involved with commodity security</td>
<td>Heads of DRH/KEMSA</td>
<td>MOH</td>
<td>Throughout implementation period</td>
<td>Stationery, computers, overhead/LCD projector, flipchart, markers</td>
<td>Technical experts, funds, stationery</td>
</tr>
<tr>
<td>Pursue registration of low cost but effective methods (e.g., implants) through advocacy and lobbying</td>
<td>DRH/Pharmacy and Poisons Board</td>
<td>MOH</td>
<td>1 year</td>
<td>Stationery, advocacy briefs</td>
<td>Technical experts, funds</td>
</tr>
</tbody>
</table>
Implementation Plan

3.2. Action to be achieved/addressed: Strengthen the reporting system

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare, draft, and test data collection tools, collect and analyze data,</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>write report, and share findings with stakeholders</td>
<td>Lead Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design a plan to train health workers on a reporting system for contraceptives, including LAPMs (i.e., on importance and how to carry out reporting)</td>
<td>DRH and KEMSA</td>
<td>Stakeholders</td>
<td>3 months</td>
<td>Stationery, computers, overhead/ LCD projector</td>
<td>Technical expert, funds, transport,</td>
</tr>
</tbody>
</table>
| Conduct training highlighting importance and methodologies of reporting for contraceptives (including LAPMs) | DRH and KEMSA           | Stakeholders | 12 months                       | Stationery, computers, overhead/ LCD projector, flipchart, markers | Technical expert, funds, transport | • No. of training workshops conducted  
  • Workshop proceedings  
  • No. of personnel trained |
| Forecast demand for services for efficient budgeting (i.e., ensure good reporting) | DRH/ Pharmacy and Poisons Board | MOPHS/ Ministries of Economics and Planning | Annually | Stationery, computers | Technical experts, funds | • Projected amounts of commodities and supplies  
  • Timely orders of commodities and supplies |

**Note:** In Kenya, the action outlined on this page has already been accomplished. However, for any FP program to improve the uptake of LAPMs this action is a necessity.

**Key**

NA = Not applicable in Kenya at the moment.
### Implementation Plan

3.3. **Action to be achieved/addressed: Enhance partnerships between the logistics units of DRH and KEMSA in order to strengthen the distribution of RH commodities**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
</table>
| Sensitize DRH and KEMSA staff on timely distribution of RH commodities, including LAPMs | Heads of DRH/ KEMSA     | MOPHS                 | Stationery, computers, overhead/LCD projector, flipchart, markers | Technical experts, funds   | • No. of sensitization seminars conducted  
• Proportion of target group sensitized                                                      |
| Ensure cross-representation of DRH and KEMSA in each organization’s meetings | Heads of DRH/ KEMSA     | MOPHS                 | Stationery, computers, overhead/LCD projector, flipchart, markers | Technical experts, funds   | No. of meetings with cross-representation (i.e., DRH and KEMSA meetings where both KEMSA and DRH are represented) |
| Strengthen logistic information systems and enforcement of delivery of RH commodities to facilities, in accord with KEMSA’s service charter | Heads of DRH/ KEMSA     | MOPHS                 | Stationery, computers                       | Technical experts, funds, transport | • Plan for delivery of RH commodities included in KEMSA’s service charter  
• Copy of the above plan shared with DRH  
• No. of times service charter has been used, according to plan in delivery of RH commodities |
| Conduct joint supportive supervision                                       | Heads of DRH/ KEMSA     | MOPHS                 | Stationery                                  | Funds, transport            | Proportion of planned supervisory events conducted                                         |
**Implementation Plan**

**Theme 4: Advance Public-Private Sector Partnerships**

4.1. **Action to be achieved/addressed: Strengthen public-private sector joint planning and implementation of LAPM interventions to avoid duplication and waste**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead</strong></td>
<td><strong>Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct joint planning for public and private sector interventions for LAPMs</td>
<td>DRH, PMO, DMOH/facility in-charges, private sector</td>
<td>MOPHS, private sector parent institutions, partners</td>
<td>6 months</td>
<td>MOPHS annual RH/FP plans, stationery, computers, overhead projectors, markers, flipcharts</td>
<td>Transport, funds, technical experts at initial stages</td>
</tr>
<tr>
<td>Employ complementary implementation of LAPM interventions by the public and private sectors</td>
<td>DRH, PMO, DMOH, private sector</td>
<td>MOPHS, private sector parent institutions, partners</td>
<td>1 year</td>
<td>Equipment, Records materials (e.g., registers)</td>
<td>Transport, fuel, technical experts, funds</td>
</tr>
<tr>
<td>Hold all-inclusive forums for sharing information gleaned from the implementation process</td>
<td>DRH, PMO, DMOH, private sector</td>
<td>MOPHS, private sector parent institutions, partners</td>
<td>Every quarter, 6 months, annual</td>
<td>Reports of monitoring and evaluation information from facilities, districts, and provinces, stationery, reporting devices</td>
<td>Transport, fuel, funds, technical experts</td>
</tr>
</tbody>
</table>
## Implementation Plan

### 4.2 Action to be achieved/addressed: Improve the links between the LAPM interventions of the public and private sectors to improve service delivery

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
</table>
| Sensitize public and private sectors and secure their agreement to joint priority LAPM activities | DRH, PMO, DMOH, private sector | 6 months   | Annual RH/FP plans, stationery, computers, overhead/LCD projectors, markers, flipcharts | Funds, fuel, transport | • Copies of proceedings of sensitization and planning meetings  
• Copies of agreements on joint plans  
• Copies of joint plans |
| Implement LAPM activities within existing RH/FP services and structures (e.g., including private-sector service providers in the MOPHS-organized trainings, such as the CTUs) | PMO, DMOH, private sector | Annual     | Annual RH/FP plans, commodities, equipment, skills lab | Technical experts, funds, fuel, transport | Copies of reports of the MOPHS trainings that included private practitioners in their CTU trainings |
## Implementation Plan

### 4.2. Action to be achieved/addressed: Share information/data on LAPMs between the public and private sector to nurture strengths and close any gaps, in order to improve performance

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package information for LAPM program implementation</td>
<td>PMO, DMOH, private sector</td>
<td>Monthly, quarterly, annually</td>
<td>Records materials (e.g., registers, forms), stationery, computers</td>
<td>Technical experts, Stakeholders, Funds, Fuel/Transport</td>
<td>Copies of returns from sites</td>
</tr>
<tr>
<td>Hold all-inclusive forums to share information on the implementation process</td>
<td>DRH, PMO, DMOH, private sector</td>
<td>Every quarter initially, then bi-annually</td>
<td>Compiled information from facilities, districts, and provinces, stationery, reporting devices</td>
<td>Technical experts, stakeholders, funds, fuel, transport</td>
<td>Proceedings of the forums</td>
</tr>
<tr>
<td>Hold all-inclusive forums to design the way forward and close gaps</td>
<td>DRH, PMO, DMOH, private sector</td>
<td>Every quarter initially, then bi-annually</td>
<td>Packages of summary information, conclusions and recommendations, stationery, reporting devices</td>
<td>Technical experts, stakeholders, funds, fuel, transport</td>
<td>Copy of the forums’ documents outlining the way forward</td>
</tr>
</tbody>
</table>
## Implementation Plan

### Theme 5: Ensure the Sustainability of Interventions to Improve the Quality of LAPM Services

**Action to be achieved/addressed:** Strengthen the deployment and training of staff

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect data using facility staff inventories and other means to establish adequate staffing levels, frequency and effectiveness of CPDs and supervision</td>
<td>DRH MOPHS</td>
<td>12 months</td>
<td>Questionnaires, checklists, recording, devices computers, stationery</td>
<td>Funds, transport, technical experts</td>
<td>• Documented staffing levels and gaps&lt;br&gt;• Documented CPD/supervision practice, strengths, and gaps</td>
</tr>
<tr>
<td>Advocate for deployment of at least 2 trained staff in each SDP, and ensure retention of those trained in areas/units providing LAPM services</td>
<td>PMO/ DMOH MOPHS</td>
<td>6 months</td>
<td>Staff inventory, stationery, computers, incentives</td>
<td>Technical know-how for: - updating data and payroll - rational training incentives, funds</td>
<td>• Staff inventory showing presence of at least 2 trained staff on LAPMs at each SDP&lt;br&gt;• Staff inventory showing retention of trained staff in LAPM provision areas/units for at least 5 years</td>
</tr>
<tr>
<td>Enhance partnership of MOPHS and partners in staff deployment at SDPs</td>
<td>PMO/ DMOH MOPHS</td>
<td>6 months and annually</td>
<td>Staff inventory with updated data and payroll, stationery</td>
<td>Willingness and action, stakeholders</td>
<td>Staff inventory showing partner-trained staff taken/to be taken over by MOPHS</td>
</tr>
<tr>
<td>Institutionalize CPDs--e.g., on-the-job training (OJT)-- and support supervisors</td>
<td>PMO/ DMOH, DRHTSTs (provincial trainers) MOPHS, stakeholders</td>
<td>At least once per fiscal year</td>
<td>Computers, recording devices and materials, skills laboratory, stationery</td>
<td>Technical experts, funds, fuel, transport,</td>
<td>• Documented plan for CPDs&lt;br&gt;• Reports of CPDs and supervisory events completed</td>
</tr>
<tr>
<td>Create and obtain budget for staffing, training/updates, and supervision</td>
<td>DRH/ PMO/ DMOH MOPHS, stakeholders</td>
<td>Planned supervision, quarterly, sporadic</td>
<td>Stationery, computers</td>
<td>Funds, skills lab</td>
<td>Inclusion of staffing, training/updates, and supervision line items in the facility operational budget</td>
</tr>
</tbody>
</table>
Work Plan Matrix

5.1. Action to be achieved/addressed: Encourage ownership of the program by DHMT and other stakeholders

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time Frame</th>
<th>Materials/ Tools</th>
<th>Resources</th>
<th>SMART Markers of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobby and advocate the DHMT and other stakeholders (including community members) and secure ownership of LAPM interventions and inclusion in the district work plans beyond the intervention periods</td>
<td>Lead: DMOH, PMO, DRH</td>
<td>Support: MOPHS, stakeholders</td>
<td>July – December, 2008</td>
<td>Computers, stationery, overhead projector</td>
<td>Funds for snacks/meals during meetings</td>
</tr>
</tbody>
</table>

- No. of lobbying/advocacy events
- Documented inclusion of activities in the district work plans

| Conduct forums/seminars for DHMT and stakeholders (including community members) to share approaches, successes, challenges (and strategies to mitigate the challenges) from the design stage of the intervention through to its conclusion | Lead: Facility in-charge, DMOH, PMO, DRH | Support: MOPHS, stakeholders | Quarterly at first, then every 6 months | Computers, stationery, overhead/LCD projector flipchart, markers | Funds for snacks/meals during meetings |

- No. of forums/seminars conducted
- Summary proceedings of forums/seminars
REFERENCES


Appendix 1: List of activities generated from brainstorming session with stakeholders

During the stakeholders’ meeting of November 2007, the five thematic areas determined as the critical areas in an LAPM revitalization strategy included capacity building, creation of demand creation LAPMs, contraceptive security, sustainability, and public-private partnerships. The stakeholders then set the goal for each theme, listed the objectives and steps towards achieving the goals, brainstormed the key actions required to achieve the objectives, prioritized the three most important actions, and identified specific activities required to achieve each of the actions. Listed below are the important activities for each theme area for the MOPHS, partners, and other stakeholders. These activities are crucial to sustain the provision of high-quality LAPM services and thus to increase the use of these methods.

Theme 1: Capacity Building
Important actions to the theme area are;
1. Identification of training needs
2. Training TOTs and providers
3. Update on FP methods
4. Evaluation of training
5. Harmonization of training curriculum
6. Identification of training sites
7. Identification of training resources
8. Training follow-ups and facilitative supervision (for training and implementation)
9. Strengthening provider counseling skills

Theme 2: Demand creation
Important actions to the theme area are;
1. Developing and implementing appropriate IEC & BCC materials
2. Developing and using creative BCC media programs
3. Community mobilization & sensitization on LAPM
4. Identifying factors influencing the use of non-LAPM
5. Promoting advocacy of LAPM at community and national level
6. Launching of LAPM at community level

Theme 3: Contraceptive security
Important actions to the theme area are;
1. Increasing funding and commitment for procurement of RH commodities
2. Government and stakeholder to lobby for more funds
3. Increasing budget for contraceptives
4. Strengthening reporting system
5. Capacity building of health workers on logistics management
6. Hastening dissemination of the RH data tools
7. Strengthening distribution of RH commodities by KEMSA
8. Sensitizing KEMSA staff on RH commodities by KEMSA
9. KEMSA to conform to service charter
10. Joint supportive supervision for KEMSA and DRH

**Theme 4: Private-public partnerships**
Important actions to the theme area are;
1. Provision of consistent and up-to-date information to public and private sectors
2. Stakeholder participation in meetings/forums and activities to promote their buy-in
3. Basket funding of LAPM interventions
4. Joint planning by public and private sector representatives
5. Dissemination of data and information on LAPM to public and private sectors
6. Integration of LAPM interventions by public and private sectors
7. Facilitation of availability of LAPM from MOPHS to private providers

**Theme 5: Sustainability**
Important actions to the theme area are;
1. On job training of clinical officers, nurses, doctors
2. Advocate deployment of at least two trained staff per facility
3. Address issue of legal/policy revision to enable safe practice
4. Create linkages between health facilities on referral system
5. Reinforce community mobilization
6. Advocacy through community resources as part of community focus strategy
7. Dedicated and sufficient budget line for commodities and equipments
8. DHMT forum for ownership for effective sustainability and create functional logistic system