Ministry of Public Health and Sanitation

Reproductive Health Communication Strategy Implementation Guide

for Family Planning, Adolescent and Youth Sexuality and Reproductive Health Rights, and Maternal, Neonatal, and Child Health

2010-2012

USAID FROM THE AMERICAN PEOPLE

Ministry of Public Health and Sanitation

Reproductive Health Communication Strategy Implementation Guide

for Family Planning, Adolescent and Youth Sexuality and Reproductive Health Rights, and Maternal, Neonatal, and Child Health

2010-2012

USAID
FROM THE AMERICAN PEOPLE

Family Health
Afya Ya Jamii
DIVISION OF REPRODUCTIVE HE

Contents

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of the C-Change project, and do not necessarily reflect the views of USAID or the United States Government.

ACRONYMS

AMREF	African Medical Research Foundation
ANC	Antenatal care
APHIA	AIDS, Population, and Health Integrated Assistance Project
AYSRHR	Adolescent and Youth Sexuality and Reproductive Health Rights
BCC	Behavior change communication
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community-based organization
C-Change	Communication for Change
CHW	Community health worker
DHP	Department of Health Promotion
DRH	Division of Reproductive Health
FBO	Faith-based organization
FHOK	Family Health Options Kenya
FP	Family planning
GOK	Government of Kenya
IEC	Information, education, and communication
KDHS	Kenya Demographic and Health Survey
KfW	German Development Bank
LAPM	Long acting and permanent method
M&E	Monitoring and evaluation
MOPHS	Ministry of Public Health and Sanitation
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal, and child health
MDG	Millennium Development Goal
NASCOP	National AIDS and STD Control Program
NCAPD	National Coordinating Agency for Population and Development
NOPE	National Organization of Peer Educators
PATH	Program for Appropriate Technology for Health
PLHIV	People Living With HIV and AIDS
PRB	Population Reference Bureau
PSI	Population Services International
RH	Reproductive health
SBCC	Social and behavior change communication
TWG	Technical Working Group
WHO	World Health Organization

Foreword

This document provides the broad framework for communications that supports the implementation of Kenya's National Reproductive Health (RH) Strategy. This implementation guide seeks to facilitate the coordinated and systematic roll-out of the strategy at all levels and to stimulate dialogue. The guide also seeks to build and sustain institutional and multisectoral support towards the achievement of the Government of Kenya's reproductive health/family planning (RH/FP) goals, through advocacy, behaviour change, and social mobilization. The implementation guide prioritizes three key thematic areas: family planning; adolescent and youth sexual and reproductive health; and maternal, neonatal, and child health. The guide's overall purpose is to ensure coordination and synergy of social and behavior change communication (SBCC) in RH/FP programming and that it is consistent, set the stage for scale and impact, and define a common measurement for success.

The guide was a collaborative effort of various partners and stakeholders and the Division of Reproductive Health of the Ministry of Public Health and Sanitation. It was developed and produced with support from the United States Agency for International Development (USAID) through the C-Change Project. I wish to take this opportunity to thank all those who contributed to its development and production.

Dr. S. K. Shariff
Director of Public Health and Sanitation
Ministry of Public Health and Sanitation

Dr. Francis M. Kimani
Director of Medical Services
Ministry of Medical Services

Acknowledgements

This implementation guide was developed through a consultative process that engaged many individuals and organizations. The Ministry of Public Health and Sanitation (MOPHS) would like to recognize all those involved in producing it. The Division of Reproductive Health (DRH) provided oversight and guidance, and special thanks go to Ann Njeru for her leadership and technical assistance. We recognize the important role of USAID, which provided funding and technical assistance through the Communication for Change (C-Change) Project.

Several organizations and partners provided invaluable contributions through the RH Communication Technical Working Group and as individual partners. Among others, these include the Department of Health Promotion (DHP), the National Coordinating Agency for Population and Development (NCAPD), World Health Organization (WHO), GTZ, Population Services International (PSI), FHI, African Medical Research Foundation (AMREF), Marie Stopes International, Pathfinder International, Program for Appropriate Technology for Health (PATH), the German Development Bank (KfW), Family Health Options Kenya (FHOK), and EngenderHealth. To all who contributed in one way or another to the development and production of this document, we say thank you.

Dr. Shiphrah Kuria
Head, Division of Reproductive Health
Department of Family Health
Ministry of Public Health and Sanitation

SECTION I

Introduction

Family planning (FP), maternal, neonatal, and child health (MNH), and sexual and reproductive health (RH) for adolescents and youth are fundamental elements of the RH Communication Strategy for Kenya (2010–2012). These are key areas to address for Kenya to make progress on Millennium Development Goals (MDGs) and Vision 2030.

Recently, the Government of Kenya (GOK) and donors agreed to bolster RH/FP programs and services to ensure the country meets the goals ahead, including the 2015 target set by the Ministry of Public Health and Sanitation (MOPHS) of increasing contraceptive prevalence from 46% to 56%.

Social and behavior change communication (SBCC), which includes advocacy, social mobilization, and individual behavior change, is vital to Kenya's achievement of the MDGs and Vision 2030. SBCC is a crucial component in changing social norms; addressing myths and misconceptions; and improving knowledge, attitudes, and practices of Kenyans with regard to RH/FP and MNH. Without normative changes, increased uptake of available RH services cannot be achieved.

A number of GOK policy documents place a strong emphasis on the important role of SBCC in improving RH/FP behaviors and health outcomes. The list includes the *National Reproductive Health Policy for Kenya, National Reproductive Health Strategy* (2009–2015), *RH Communication Strategy* (2010-2012), *Youth Reproductive Health Policy, FP guidelines for service providers, and Roadmap for Maternal and Newborn Health.*

PURPOSE OF THE IMPLEMENTATION GUIDE

The overall purpose of this implementation guide is to:

- ensure coordination and synergy of RH/FP SBCC programming
- ensure consistent SBCC on RH/FP
- set the stage for scale and impact
- define a common measurement for success

The implementation guide thus outlines the roles and activities of the GOK and partners at national, regional, and county levels. Developed through a consultative process with the RH Communication Technical Working Group (TWG) and partners, the guide will assist stakeholders working in RH/FP to develop SBCC programs and activities that are aligned with the RH Communication Strategy.

WHO SHOULD USE THE GUIDE

This implementation guide is based on current implementation and coordination structures of the MOPHS, though these will change when Kenya's new constitution, with its focus on counties, is operationalized.

The target populations for the guide are:

- provincial health management teams
- district health management teams
- APHIA Plus partners implementing RH/FP activities
- coordinating agencies
- civil society organizations, including NGOs, CBOs, and faith-based organizations (FBOs)
- community networks
- private providers

SECTION II

The Roll-Out Plan

The RH Communication Strategy will be implemented in accordance with the National Reproductive Health Policy and the National Reproductive Health Strategy (2009–2015). The strategy is managed and coordinated by the Division of Reproductive Health (DRH) of the MOPHS at the national level, and by provincial and district health management teams at their respective levels.

The TWG will provide the central technical review and coordinating mechanism for national SBCC activities, and will provide input to SBCC materials developed under the Communication Strategy. The TWG's members are national-level stakeholders implementing the national strategy, along with representatives of donors, international NGOs, and other development partners providing technical assistance and other resources.

At the national level, the DRH will collaborate with the Department of Health Promotion (DHP) in providing oversight and supportive supervision to teams of implementing partners working at provincial and district levels in the regions. Within the regions, DRH is represented by provincial and district RH coordinators and DHP by health promotion officers.
To implement this strategy in a concrete and meaningful way, this guide details the steps that need to be taken at national, provincial, and district levels.

AT THE NATIONAL LEVEL

Coordinate and Plan

To implement a comprehensive RH Communication Strategy, a clear coordination and monitoring mechanism needs to be developed to oversee proposed activities. The TWG, led by the DRH, will coordinate the national SBCC program, messages, materials, formats, and indicators for the MOPHS. The following government institutions, international NGOs, and bilateral and multilateral donors are currently members of the TWG:

- Division of Reproductive Health (DRH)
- Department of Health Promotion (DHP)
- National Coordinating Agency for Population and Development (NCAPD)
- National AIDS and STD Control Program (NASCOP)
- United States Agency for International Development (USAID)
- United Nations Population Fund (UNFPA)

- United Nations Children's Fund (UNICEF)
- Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
- World Health Organization (WHO)
- C-Change
- Population Services International (PSI)
- FHI
- Pathfinder International
- EngenderHealth
- JHPIEGO
- Population Council

The TWG will work with key national stakeholders to:

- determine SBCC message priorities for national campaigns
- harmonize the messages and materials of stakeholders
- provide input on timelines and deliverables of SBCC programs
- obtain input and commitment from national stakeholders on SBCC program components
- coordinate the responsibilities, tasks, and contributions of stakeholders
- ensure that the SBCC campaign is implemented at provincial and district levels
- ensure that the SBCC program is monitored and evaluated as part of partner activities in each province
- set standards and guidelines on RH/FP communication
- conduct fundraising and research related to RH communication

Implement and Develop

Based on the recommendations of the TWG, the MOPHS, DRH, and DHP developed a national media campaign, including media messages and materials. Key national partners, including C-Change and the Health Communication and Marketing Project, collaborated with the MOPHS to harmonize RH/FP messages and generate the campaign.

Currently, the national campaign's RH/FP SBCC materials for men and women include radio spots, posters, billboards, general information leaflets for use at health facilities, and health-provider job aids. Materials for youth include posters, magazine ads, flyers, radio programs, and an online component. All materials were launched in November 2010, and will be subsequently distributed to partners during workshops to ensure correct understanding of the SBCC program.

To ensure that program activities reflect the priorities of the RH Communication Strategy, national partners will participate in TWG and submit their tailored SBCC materials to its review.

National partners will also collaborate with the MOPHS on SBCC program components and contribute technical support in areas identified by the TWG.

Monitor and Evaluate

The DRH/MOPHS will develop national indicators and a monitoring and evaluation (M&E) plan for the SBCC program. The MOPHS, through FP/RH communication working groups, will also monitor media messages and analyze data from the most recent Kenya Demographic and Health Survey (KDHS) as a baseline for the campaign.

RH COMMUNICATION MANAGEMENT SECRETARIAT

To promote sustainability and effectively implement the RH Communication Strategy, it is anticipated that a Management Secretariat will be established to coordinate the affairs of the TWG. Among its roles and responsibilities, the Secretariat will:

- coordinate the planning and implementation of activities in the RH Communication Strategy and the reporting of these activities to the Head of DRH
- be responsible for networking with all partners, government agencies, private providers, and FBOs involved in RH communication to ensure maximum support to DRH in implementing the strategy
- record decisions of the TWG and inform activity planning
- serve as editor of SBCC materials, the DRH newsletter and web site, and initiate communications through other channels identified in the RH Communication Strategy
- take the lead in M&E of SBCC projects and programs that are guided by the RH Communication Strategy
- report on the results of the strategy, in accordance with guidance from the TWG and the Head of DRH

AT REGIONAL LEVELS

At regional and county levels, the MOPHS will work with APHIA Plus and other national and provincial partners to coordinate regional implementation of the national campaign.
The MOPHS will organize regional SBCC working groups that will:

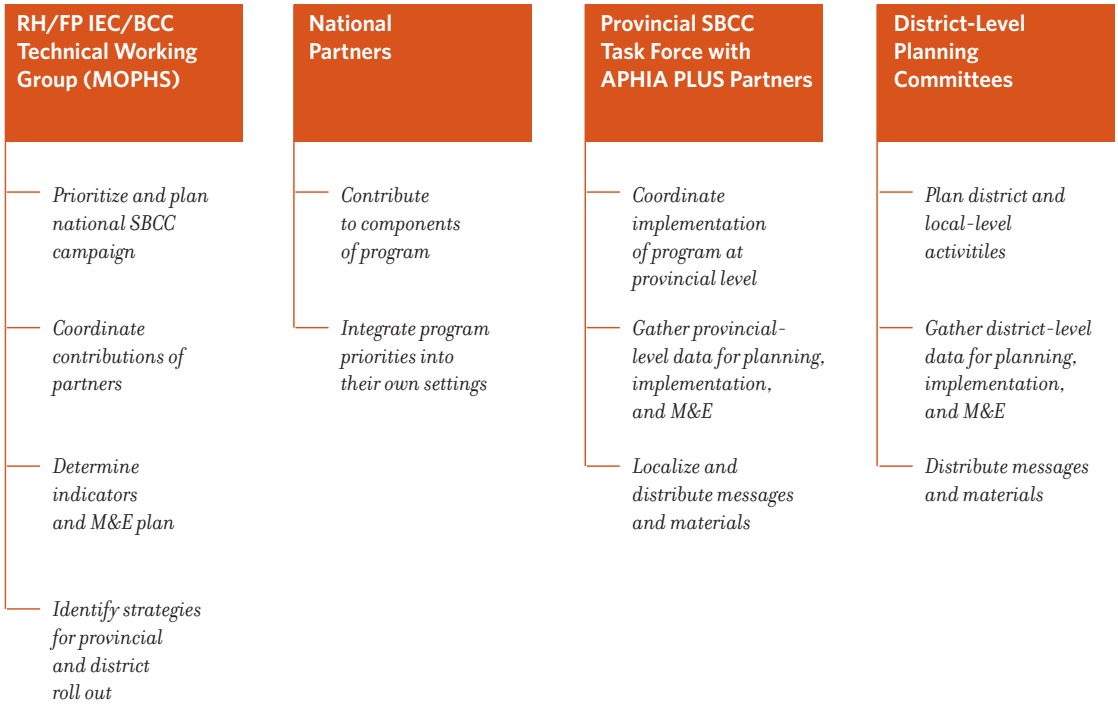
- coordinate the implementation of the national program with provincial MOPHS and partners
- gather provincial-level data for planning and implementation
- convene provincial (regional) workshops to tailor RH/FP messages to provincial needs and localize product messages and materials

- identify resources available to adapt, print, and distribute materials in local languages, as appropriate, in coordination with implementing partners
- coordinate M&E and the collection of data

AT DISTRICT LEVELS

District-planning committees of the MOPHS will be assisted by APHIA Plus and other partners to implement district-level SBCC program activities. These committees will

- plan for district and local-level activities
- conduct local SBCC planning workshops with APHIA Plus provincial partners to share SBCC priorities and campaign components
- gather district-level data for planning and implementation
- distribute SBCC materials and messages
- develop M&E plans and tools for collecting data



SECTION III

Guiding

The RH Communication Strategy outlines the following guiding principles for planning, designing, implementing, monitoring, and evaluating SBCC interventions for RH/FP in Kenya:

Results-oriented: The effectiveness of an SBCC effort will be ultimately determined by the health outcomes. Increased knowledge, approval, and adoption of healthy norms or behaviors should be verified by research.

Science-based: SBCC planning will use accurate data and theory to inform and guide activities.

Client-centered: A client-centered approach involves clients in determinations of their health needs and engages them in the process of shaping messages that address those needs.

Participatory: Clients should be involved throughout the communication process, including in program design, implementation, and evaluation.

Benefit-oriented: Clients must perceive the benefits of adopting the targeted behavior.

Linked to services: Health promotion efforts should be directed towards specific services and enhance self-efficacy and community empowerment.

Multi-channeled: The use of complementary channels or ways to reach target audiences has been shown to increase the effectiveness of SBCC.

Technical quality: SBCC should aim for high-quality messaging and products.

Advocacy-related: SBCC should target individual and policy levels to influence social and behavior change.

Expanded to scale: SBCC is effective when successful efforts can be scaled up.

Programmatically sustainable: SBCC programs should aspire to create sustainable social change.

Cost effective: SBCC resources should be focused towards a combination of the most cost effective channels.

SECTION IV.

Moving From Strategy to Implementation

The following sections outline the steps that implementing partners should follow in designing and developing effective SBCC interventions at national, provincial, and county levels.

SBCC has three characteristics.

1. SBCC is an interactive, researched, and planned process aimed at changing social conditions and individual behaviors. This process includes five steps:
   - Understanding the Situation
   - Focusing & Designing Your Strategy
   - Creating Interventions & Materials
   - Implementing & Monitoring
   - Evaluating & Replanning

The steps of the planning process (or C-Planning, illustrated on the left) draw on previous ones and contribute to subsequent ones. C-Planning provides the structure for the rest of this guide.

SOURCE: Adapted from Health Communication Partnership, P-Process Brochure, CCP at JHU (2003); McKee, Manoncourt, Chin, Carnegie, ACADA Model (2000); Parker, Dalrymple, and Durden, The Integrated Strategy Wheel (1998); AED, Tool Box for Building Health Communication Capacity (1995); National Cancer Institute: Health Communication Program Cycle (1989).

2. SBCC uses a socio-ecological model, which examines several levels of influence to find the "tipping point" for change:
   - the individual "self" most affected by the issue
   - immediate influencers, such as family, peers, and community
   - access to and quality of services, products, and providers
   - overall barriers or support produced by an enabling environment, such as policies, politics and religion

Each level and the actors therein are influenced by their information, motivation, and ability to act, values (i.e., attitudes and beliefs), and social/gender norms. Analysis based on data and this model determines where to focus efforts that have the biggest impact.

3. SBCC operates through three key strategies:
   - advocacy
   - social mobilization
   - behavior change communication

SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

SECTION V.

Understanding the Situation—What Do the Data

UNDERSTANDING THE SITUATION

Understanding the situation is the first step in any communication effort. This requires looking at the effects of problem or issue and its direct and indirect causes, defining people who are directly affected and those influencing them, examining their context, and assessing existing research about the problem or issue.

KENYA'S POPULATION GROWTH

Kenya's population has grown rapidly since 1948, increasing from 5.4 million to the current estimate of 40 million. It is projected to increase to 65 million by 2030 (NCAPD 2008). High population growth has resulted in a youthful population and built-in momentum for future growth. Even with declining fertility, the youth bulge means that there will still be a large number of women of child-bearing age in the future.

Kenya's RH/FP programs have evolved over time, reflecting a range of GOK policy frameworks, strategies, and service guidelines for providers. Despite these milestones, many issues continue to be a challenge.

FERTILITY TRENDS

Kenya's average total fertility rate in the 1970s rose rapidly, reaching 8 children per woman. After a period of sharp decline the 1980s and early 90s, this rate was 4.7 children per women. It stagnated until the early 2000s, and saw a modest decline to 4.6 children per women in the 2008/9 KDHS. The age of women at first birth has continued to decrease, and currently one in four has had her first child before age 19.

AWARENESS AND KNOWLEDGE OF FP METHODS

High awareness and knowledge of FP methods has not translated into high contraceptive prevalence rates. Though 95% of the population reported knowledge of at least one method of FP, the contraceptive prevalence rate across the country is only 46%. This rate is below the national target, and there are huge regional variations.

Socio-cultural beliefs and practices, gender dynamics, poor male engagement, and weak health management systems continue to impede the demand for and utilization of RH/FP services.

UNMET NEED FOR FP/RH SERVICES AND MATERNAL MORTALITY

Unmet need for FP remains high. Of the 63% of Kenyans with unmet FP needs, 60% are in rural areas and 74% are in urban areas. The unmet need for FP among youth ages 15–24 is 30%, and there is a large unmet need for FP among people living with HIV (PLHIV). Approximately 55% of currently married couples who do not use FP say they intend to use it in the future, and another 27% want to wait at least two years before the birth of their next child.

According to the 2008/09 KDHS, Kenya's maternal mortality ratio (MMR) is high, at 488 maternal deaths per 100,000 live births, well above the 2015 MDG target of 147 per 100,000. While the vast majority of women receive some antenatal care (ANC) from a skilled provider, only 15% reported they had made the recommended ANC visit by their fourth month of pregnancy, In addition, only 43% had learned about the signs of pregnancy complications during an ANC visit.

More than half of Kenya's births occur at home, and 43% occur in a health facility—32% in public-sector facilities and 10% in private-sector facilities. The most commonly given reason for not going to a facility to give birth—by 42%—was distance and a lack of transportation. An additional 21% said they did not think a visit to a facility was necessary.

Only 44% of births in Kenya are assisted by a skilled provider (i.e., a doctor, nurse, or midwife); 28% are assisted by a traditional birth attendant; 21% by untrained relatives or friends; and 7% occur with no assistance. More than half of the women surveyed did not have a postnatal checkup. Approximately 13% of all maternal deaths occur among adolescents, mainly as a result of complications of unsafe abortions.

USE OF MODERN CONTRACEPTIVE METHODS

Although the use of modern contraceptive methods has risen steadily in Kenya, trends show a general increase in the use of short-acting methods and a decline in the use of long-acting and permanent methods (LAPMs). According to the 1993, 1998, and 2003 KDHS, use of Depo-Provera increased from 7% in 1993 to 15% in 2003. Injectables remain the most widely used LAPM and is the future method preferred by 47% of married women. During the same period among currently married women ages 15–49, female sterilization (bilateral tubal ligation) decreased from 5.5% to 4.5%, and IUD use declined from 4.2% to 2.5% , according to the 2003 KDHS.

According to the 2008/9 KDHS, while use of any FP method is 46%, modern methods account for 39%. Injectables and pills are the most popular modern methods, and account for 22% and 7% respectively. Traditional methods (rhythm and withdrawal) account for 6%.

ANALYSIS OF AUDIENCES AND THEIR CONTEXTS

A socio-ecological model (see graphic on page 9) is applied to further understand the context of population groups most affected. This model allows an analysis of how an individual is influenced by peers, family, and community, and by the overall enabling environment. Individuals' health behaviors are also influenced by the information they receive, their motivation, their ability to act, and prevailing social and gender norms. The socio-ecological model helps to define audiences who are most affected by an issue or problem and their direct and indirect influencers (also known as primary, secondary, and tertiary audiences). It helps analyze their context, and enables program designers to choose appropriate strategies to ignite change at different levels.

SBCC interventions should target a segmented audience. Segmentation is a process of identifying unique groups of people within a larger population. These groups share similar interests and needs relative to the behavior to be promoted, and are likely to respond similarly to a given communication. Segmentation requires going beyond the traditional demographics (age, education, location) to personalization, including giving each of the audience profiles a name. Target groups include people directly affected, people directly influencing them, and people indirectly influencing them.

People Directly Affected

- Women of reproductive age
- Men of reproductive age
- Adolescents and youth

People Directly Influencing People Who Are Directly Affected

Community and Social Networks

Evidence has shown that RH/FP uptake is also linked to community and social network support. Using social mobilization interventions, the following should be targeted:

- Faith-based networks
- Traditional networks
- Women and men's organizations
- Workplaces
- People with special needs and those with disabilities

Community and Opinion Leaders

Using advocacy interventions, key leaders need to be convinced that RH/FP requires community resources and are fundamental to the quality of life of members of their communities. The following should be among those targeted:

- Traditional leaders
- Political leaders
- Faith-based leaders
- Private-sector leaders

Service Providers

The knowledge, abilities, and attitudes of service providers, health workers, and pharmacists have been shown to have a great impact on utilization of RH/FP services. The following groups should be included in SBCC RH/FP interventions:

- Service providers at health facilities
- Pharmacists
- Community-level health workers
- Volunteers

People Indirectly Influencing People Who Are Directly Affected

Multisectoral Leaders (Ministries) and Policymakers

Policymakers at all levels need to embrace the need for sustained FP programming. At national and regional levels, it is critical to integrate FP SBCC into other development sectors, including the following:

- Education
- Agriculture
- Gender and children's services
- Culture and social services
- Youth

COMMUNICATION AND FP/RH UTILIZATION

Utilization of RH/FP services is influenced by a range of issues, including gender, cultural norms, knowledge, attitudes, and access to services. Developing appropriate SBCC programming and more targeted communication messages requires an understanding of the underlying determinants for positive RH/FP behaviors for each audience, as well as the perceived benefits of changed behaviors. Knowing this information contributes to more targeted communication messages and programs.

It is also essential to collect information on barriers to uptake of RH services and to conduct further qualitative formative research, using key informant interviews and focus group discussions with carefully segmented audiences. Barriers should be addressed in the corresponding communication objectives.

The following tables reference the thematic areas and audiences in the RH Communication Strategy. They are illustrative, and may change after formative research in specific geographic locations. In the examples to follow, the objectives also reflect cross-cutting factors from the socio-ecological model including information, motivation, ability to act and norms.

Table 1a. Thematic Area 1- Family Planning

TARGET POPULATION: Women of Reproductive Age			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of FP services and uptake of modern contraceptive methods, especially LAPMs, to delay first birth or space children at least 2 years apart	• Health concerns and fear of side effects of modern methods • Misconceptions and myths about effectiveness of methods • Fear of reproach for women discussing FP with their partners • Perception that FP leads to increased promiscuity	• Allows families to devote more resources to each child • Allows mother to devote more time to each child • Allows more time to be spent on education and working outside the home • Improves the health of mother and child	• Increase in number of women who report talking to a health worker about FP methods and ask about side effects • Increase in number of women who can identify more than one modern contraceptive method, particularly LAPMs

Table 1a. Thematic Area 1 - Family Planning *(continued)*

TARGET POPULATION: Women of Reproductive Age			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of FP services and uptake of modern contraceptive methods, especially LAPMs, to delay first birth or space children at least 2 years apart *(continued)*	• Desire to prove ability to have children • Practice of achieving a family size equal to that of their parents • Desire for a son if family has only daughters • Perception of negative attitudes of health workers • Lack of confidence about the benefits of child spacing or limiting the number of children • Lack of accessibility of FP methods • Religious and traditional beliefs	• If using a condom, prevents HIV infection • Allows peace of mind when having sex	• Increase in number of women who understand the effectiveness, reliability, and safety of modern contraceptive methods, particularly LAPMs • Increase in number of women who report talking to their partners about FP • Increase in the number of women who report they believe that use of modern contraceptive methods is widespread in the community • Increase in the number of women who have encouraged someone to use a modern contraceptive method • Increase in number of women who report positive provider-client interaction on RH/FP at health facilities • Increase in number of women who feel confident that using FP to space their children at least 2 years apart or limit their number will improve their quality of life and the health of their families • Increase in number of women who report they know where to access FP methods • Increase in the number of women who report they know how to use modern contraceptive methods • Increase in number of women who approve of the use of modern contraceptive methods for child spacing and limiting the number of their children

Table 1b. Thematic Area 1 - Family Planning

TARGET POPULATION: Men of Reproductive Age			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of FP services and uptake of modern contraceptive methods to delay birth of first child or space children at least 2 years apart	• Negative associations with talking about FP and sex • Belief that it is a woman's responsibility to prevent pregnancy • Perception that FP leads to increased promiscuity • Misconceptions and myths about effectiveness of modern methods • Negative attitudes of health workers • Lack of confidence about the benefits of child spacing or limiting the number of children • Distance to a health facility/accessibility of FP methods • Desire for a son if family has only daughters • Religious and traditional beliefs	• Allows families to devote more resources to each child • If using a condom, prevents HIV infection • Allows peace of mind when having sex	• Increase in number of men who report talking to their partners about FP • Increase in the number of men who report they believe that use of modern contraceptive methods is widespread in the community • Increase in number of men who approve of the use of modern contraceptive methods for child spacing and for limiting the number of their children • Increase in number of men who report talking to a health worker about FP methods • Increase in number of men who can identify more than one modern contraceptive method, particularly LAPMs • Increase in number of men who understand the effectiveness, reliability, and safety of modern contraceptive methods, particularly LAPMs • Increase in number of men who report positive provider-client interaction on RH/FP at health facilities • Increase in number of men who feel confident that using FP to space their children at least 2 years apart or limit their number will improve their quality of life and the health of their families • Increase in number of men who report they know where to access FP methods and how to use them

Table 1c. Thematic Area 1 - Family Planning

TARGET POPULATION: Adolescents and Youth			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of RH/FP services • Increased ability to negotiate sexual behavior • Delayed childbearing	• Lack of youth-friendly services and clinics • FP methods not accessible • Negative attitudes of health workers • Negative association with talking about FP and sex • Belief that it is a woman's responsibility to prevent pregnancy • Misconceptions and myths about contraception • Fear of side effects of modern methods • Lack of confidence about the benefits of RH/FP services • Religious and traditional beliefs • Lack of self-efficacy to negotiate sexual behavior	• Allows young women to focus on education because they will not get pregnant • If using a condom, prevents HIV infection Allows peace of mind when having sex	• Increase in number of youth who report knowledge of RH/FP services available • Increase in number of youth who report they know where to access FP methods and how to use them • Increase in number of youth who report positive provider-client interaction on RH/FP at health facilities • Increase in number of youth who report talking to their partners about FP • Increase in number of youth who report talking to a health worker about FP methods and asking about side effects • Increase in number of youth who feel confident that seeking RH/FP services to delay childbearing will allow them to pursue their dreams and have a higher quality of life • Increase in number of youth who can identify more than one modern contraceptive method • Increase in the number of youth who report they believe that use of RH/FP services is widespread in their peer groups • Increase in number of youth who are able to choose an appropriate contraceptive method for themselves • Increase in number of youth who are able to be assertive and negotiate sexual behavior

Table 1d. Thematic Areas 1, 2 and 3: FP/Adolescents and Youth/MNH

TARGET POPULATION: Service Providers			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Positive provider-client encounters at all levels of service delivery	• Too many patients and not enough time to counsel each one properly • Biases regarding RH/FP • Low pay and lack of motivation	• More consistent attendance of clients at health facilities • Clients ask more questions and more likely to adhere to guidance provided	• Increase in number of providers who have the interpersonal communication skills to counsel patients on FP • Increase in number of providers who practice positive interpersonal communication skills during FP service delivery • Increase in number of providers who report counseling patients on RH/FP services and methods • Increase in number of providers who report counseling patients on the importance of ANC visits and skilled attendants at childbirth • Increase in number of providers who believe that they are helping their patients to improve their quality of life and health of their families by using RH/FP services and methods • Increase in number of providers who provide accurate information on the effectiveness and side effects of modern contraceptive methods • Increase in number of providers who become a trusted source of FP information and services • Increase in number of providers who believe that fellow providers are trusted sources of FP

1e. Thematic Area 1 and 2 - FP/Adolescents and Youth

TARGET POPULATION: Community Leaders			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increase in quality and accessibility of RH/FP services within communities • Increased integration of RH/FP information and services into youth social and economic development programs	• Lack of confidence about the benefits of RH/FP services for communities • Religious and traditional beliefs • Competing issues and resources	• Improved economic growth, with fewer dependent young people and more adults in the workforce • Less burden on social services and less demand for water, food, education, healthcare, housing, transportation, and jobs	• Increase in number of community leaders who believe that RH/FP programs help their communities to improve their quality of life and the health families • Increase in the number of community leaders who understand the components of effective RH/FP programs and how to support them in their communities • Increase in the number of community leaders who believe that there is a demand for RH/FP in their communities • Increase in the number of community leaders who believe their fellow community leaders support RH/FP programs • Increase in the number of community leaders who become advocates for provision of better quality and more accessible RH/FP services • Increase in the number of community leaders who become champions of RH/FP programs for youth

Table 2a. Thematic Area 3: MNH

TARGET POPULATION: Women of Reproductive Age			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of ANC and skilled attendance during delivery • Increase in prompt healthcare for complications of delivery (emergency obstetric care services) and unsafe abortions • Increased use of exclusive breastfeeding for six months after delivery	• Lack of knowledge about when ANC visits should begin and how many are necessary • Lack of confidence about benefits of skilled attendants during delivery • Lack of knowledge regarding postpartum care and warning signs • Long distance to a health facility and lack of transport • Cost of giving birth in a facility • Health provider attitudes Lack of confidence about the benefits of breastfeeding and how long it should be continued • Religious and traditional beliefs • Lack of male involvement in decision-making on RH issues	• Improves health of mothers and their children • Reduces major causes of maternal deaths, such as excessive bleeding, obstructed labor, high blood pressure, and infections • Helps mothers to make adequate preparations and delivery plans	• Increase in the number of women who feel confident that seeking a minimum of four ANC visits during pregnancy will improve their health and the health of their babies • Increase in the number of women who seek ANC as soon as they know they are pregnant • Increase in the number of women who plan to deliver their babies at a health facility and have a transportation plan • Increase in the number of women who think the benefits of ANC and delivering at a health facility outweigh the costs • Increase in the number of women who report positive provider-client interaction on RH • Increase in the number of women who know warning signs after delivery and when to seek the help of a health provider • Increase in number of women who feel confident that visiting a trained midwife within 48 hours after delivery will improve their health and the health of their babies • Increase in the number of women who feel confident that breastfeeding exclusively for six months will improve the health of their babies • Increase in the number of women who speak to their partners about RH issues • Increase in the number of women who believe that positive RH behaviors are widespread in the community

Table 2b. Thematic Area 3 - MNH

TARGET POPULATION: Men of Reproductive Age			
Desired Changes	Perceived Barriers	Perceived Benefits	Communication Objectives
• Increased utilization of ANC and skilled attendants during delivery • Increase in prompt healthcare (emergency obstetric care services) for complications of delivery and unsafe abortions	• Long distances to a health facility and lack of transport • Cost of health facility • Health provider attitudes • Belief that RH issues are a woman's responsibility • Religious and traditional beliefs	• Improves the health of mothers and babies	• Increase in the number of men who believe that attendance at ANC visits and birth at a health facility will improve the health of mothers and babies • Increase in the number of men who have a transportation plan for getting their partners to a health facility before delivery • Increase in the number of men who feel the benefits of ANC and delivery at a health facility outweigh the costs • Increase in the number of men who report positive provider-client interaction on RH • Increase in number of men who speak to their partners about RH issues • Increase in the number of men who accompany their partners to health facilities for ANC and delivery services • Increase in the number of men who know warning signs after delivery and when to seek the help of a skilled health provider • Increase in the number of men who believe that positive RH behaviors are widespread in their communities

SECTION VI.

Focusing and Designing—What Approach and Media Mix Do We Use?

FOCUSING & DESIGNING

In this step, the strategic approach and positioning for a comprehensive campaign is decided, along with an appropriate and mutually reinforcing channel mix. The strategic approach allows target audiences to recognize all strategies and activities as a coherent campaign.

Communication interventions in FP, MNH, and adolescents and youth—three key thematic areas of the RH Communication Strategy—should address desired changes and communication objectives. Success will be achieved through targeted, evidence-based SBCC campaigns that are designed according to best-practice principles and that improve knowledge, create demand, and ensure utilization of available services.

STRATEGIC APPROACH AND BRANDING OF KENYA'S FP, YOUTH, AND MNH CAMPAIGNS

The audience analysis above enables us to choose an appropriate strategy mix to address the barriers identified during the first step of C-Planning. A wellness approach was selected for Kenya's current mass media campaigns in RH/FP, MNH, and adolescent and youth sexual and reproductive health.

The overarching theme of the national FP campaign targeting women and men of reproductive age is *Jipangie Maisha Poa (Plan for a Good Life)*. This theme was chosen to help women and men personalize FP responsibility and link FP services with a good quality of life for people who plan to space their children and limit their number.

The overarching theme of the FP/RH campaign targeting youth is *Don't Take Chances, Take Control*. This theme was chosen to encourage young people to make decisions about their reproductive and sexual health. It conveys the key message in a short, catchy phrase that is easy to remember. It is a call to action for youth to seek contraceptive information and services in order to avoid unplanned pregnancy. The message was informed by DHS data(2009) that indicate that 30% of youth ages 15–24 have unmet needs for FP/RH.

The overarching theme of the MNH campaign targeting women of reproductive age is *Give Your Baby a Healthy Start*. This was chosen as a positive appeal to women to take responsibility for giving their children a healthy beginning. It was informed by data in the DHS survey that indicate that only 15% of Kenyan women had the recommended ANC visit by the fourth month of pregnancy (DHS 2009).

A PHASED APPROACH

RH/FP communication implementation will be done in phases, targeting specific audiences, identifying strategic opportunities for repositioning RH/FP, and contextualizing communication elements to different regions. For example, interventions can be implemented in a few counties before they are scaled up to an entire province. They can also target a specific age segment, then target others.

For example, the first phase of the FP campaign targeted youth ages 18–24 and women and men ages 25–35. The main message for men and women focused on spacing children at least two years apart and promote visits to a health facility for RH/FP advice.

The second phase could address obstacles and barriers to FP uptake. Using social mobilization, advocacy, and behavior change strategies, it could promote the safety and reliability of modern FP methods, as outlined in the implementation framework. This phase could also promote the use of LAPMs.

The TWG would determine the subsequent phasing, based on agreed-upon guidelines and national priorities.

OPPORTUNITIES FOR REPOSITIONING FP

The National Leaders' Conference and post-conference events will provide opportunities at national and regional levels to reposition RH/FP. The following were the objectives of the conference in November 2010:

- review the implementation of the population policy
- collectively identify and propose ways of addressing population challenges
- identify leaders' roles in the implementation of population and development programs at all levels, communicating exactly what advocacy actions are expected of conference participants when they return to their workplaces and homes
- inform and shape the development of a national population plan of action
- make recommendations for the next decade, including repositioning FP

A comprehensive plan of action was developed that included the identification of post-conference activities into which communications on RH/FP can be integrated. This platform can be used to follow up on the CARMMA conference and continue communication on MNCH. The TWG, in collaboration with key partners and stakeholders, will determine other opportunities to reposition RH/FP at all levels.

CHANNEL MIX

Interviews and focus groups provided the following information on preferred channels for each target audience and the channel mix for each audience segment. The research also guided the development of the implementation matrix see on page 28.

CHANNEL	AUDIENCE
Radio spots	Women, Men, Youth
Posters	Women, Men, Youth
Billboards	Women, Men
Leaflets	Women , Men, Youth
Health provider job aids	Service providers
Magazine ads	Youth
Online component	Youth

SECTION VII.

Creating—What Communication Messages and Materials Do We Use?

CREATING MESSAGES AND MATERIALS FOR CHANGE

In this step, messages and materials are created. Creative briefs are drawn up, taking into account the information gathered in the previous steps, including messages that address identified obstacles.

Also at this stage, concept testing and pretesting are undertaken to ensure that messages and materials are appropriate and relevant to their intended audiences and evoke appropriate responses.

The GOK considers RH/FP to be issues that critically affect the health and development of Kenya. The themes and key messages for FP, adolescent and youth, and MNH campaigns are listed below. In addition to these key themes, communication programming emphasizes dual protection, including use of dual contraceptive methods.

KEY MESSAGES OF THE FP CAMPAIGN *JIPANGIE MAISHA POA (PLAN FOR YOURSELF A GOOD LIFE)* TARGETING WOMEN AND MEN AGES 25–35

- Spacing your children at least two years apart is key for a healthy and prosperous family.
- Modern family planning methods are safe and reliable.
- Use a modern family planning method to delay pregnancy or space births.
- Talk to your partner about a modern family planning method of your choice.
- Visit a health facility for more information and family planning services.

KEY MESSAGES OF YOUTH RH CAMPAIGN *DON'T TAKE CHANCES, TAKE CONTROL* TARGETING YOUTH AGES 18-24

- It is okay to learn about various modern methods of contraception to take control of your life and prevent unwanted pregnancies.
- Several modern methods of contraception exist, and each has its own benefits and limitations.
- It is important to visit a health provider for counseling on appropriate methods.
- Only condoms can protect you from sexually transmitted diseases.
- It is important to delay child bearing.
- It is important to delay sexual debut.

KEY MESSAGES OF THE MNCH CAMPAIGN *GIVE YOUR BABY A HEALTHY START AND NO ONE SHOULD DIE WHILE GIVING LIFE* TARGETING WOMEN OF REPRODUCTIVE AGE

- Visit a health facility as soon as you know you are pregnant.
- Make at least four focused antenatal care visits during your pregnancy.
- In case you deliver at home, visit a health facility within 48 hours after the delivery.
- Plan to deliver your baby at a health facility.
- Breastfeed the baby 30 minutes after delivery.
- Breastfeed your baby exclusively for six months, and thereafter introduce other complimentary feeding
- Keep the baby warm after delivery.
- Wash your hands before handling the baby.

SECTION VIII.

RH/FP Communication Implementation Matrix

IMPLEMENTING AND MONITORING

The fourth step of C-Planning is to develop an implementation plan to turn your plans into action. The implementation plan should tie your activities to your objectives, give a time frame, and allocate budget and responsibilities. Process indicators are also an important component to continuously monitor your activities, re-plan and revise as necessary.

INTRODUCTION

The implementation guide priorizes activities to be conducted over the next two years in the three thematic areas: FP; adolescent and youth sexuality and reproductive health rights (AYRHR), and MNCH.

The implementation matrix outlines:

- strategies
- broad activities
- materials
- implementers
- process indicators
- indicative budget
- timelines

THEMATIC AREA 1: FAMILY PLANNING

Objective 1: Implement multimedia behavior change communication, social mobilization, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote use of FP services and contraceptive choice and increase the use of LAPMs.

Objective 2: Implement SBCC capacity strengthening activities among health providers to address health-provider barriers to uptake of FP services, especially LAPMs.

Matrix 1: Family Planning

Advocacy For Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
1.1. Hold consultative forums with political leaders on increased resource allocation and support for FP services at national and county levels	• Fact sheets for county-level leaders • Video on ENGAGE Model •Presentation on Kenya leading the way	NCAPD DRH/DHP PRB C-Change APHIA Plus	# of consultative forums conducted # of fact sheets developed, produced, and disseminated	1,200,000		
1.2. Hold meetings with parliamentary committees on health	• ENGAGE Model • Presentation on Kenya leading the way • The NCAPD RAPID model	NCAPD DRH/DHP PRB APHIA Plus	# of parliamentary committee meetings conducted	500,000		
1.3. Hold consultative forums with religious leaders to advocate for support for FP services at national and county levels	• Fact sheet for FBOs • Advocacy kit for county leaders	NCAPD DRH/DHP APHIA Plus PRB	# of consultative forums on FP for religious leaders # of fact sheets for FBOS	1,500,000		
1.4. Conduct FP stakeholder forums at national, county, and community levels on support for FP goals and actions	•Fact sheets	NCAPD DRH/DHP APHIA Plus PRB	# of FP stakeholder forums conducted # of fact sheets developed and disseminated	600,000		

Matrix 1: Family Planning *(continued)*

Advocacy For Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
1.5. Build capacity of the media to advocate for FP through briefings with editors, training in FP, media briefing kits, field visits, and development and dissemination of TV/ radio programs	• Media kits • FP training guide for journalists • Fact sheet for briefings with editors	NCAPD DRH/DHP PRB C-Change Internews APHIA Plus	# of media briefings conducted # of media kits developed and produced # of briefing kits developed for editors	1,000,000		
1.6. Support local leaders and opinion leaders, and village health committees to become FP champions	• Advocacy kit for county leaders	NCAPD DRH APHIA Plus PRB C-Change	# of forums for local and opinion leaders # of advocacy kits developed for county leaders	2,000,000		
1.7. Conduct regular FP advocacy performance review meetings	• Performance review tools	DRH/DHP NCAPD APHIA Plus PRB C-Change	# of advocacy performance review meetings conducted # of performance review tools developed	500,000		
1.8 Develop FP advocacy standard indicators and tools	• Standard FP advocacy indicators tools	DRH/DHP NCAPD	# of workshops to develop FP advocacy indicators # of advocacy indicators tools developed and disseminated	1,000,000		

Matrix 1: Family Planning *(continued)*

Social Mobilization and Behaviour Change Communication for Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
2.1 Conduct a workshop to develop standard messages for FP campaigns and interventions to be used at all levels for priority target audiences	• Workshop modules and tools for message development	DRH/DHP C-Change UNFPA JHPIEGO PSI APHIA Plus UNFPA UNICEF WHO	# of workshops conducted # of messages developed	1,000, 000		
2.2. Conduct interpersonal communication activities and outreach at community levels among target audiences to provide comprehensive messages on RH/ FP, including through household visits by community health workers (CHWs) and volunteers, Interactive community theatre activities, and community dialogue sessions	• Standard kit for CHWs: flip chart on MNH, T-shirt, guidelines, FP SBCC materials • Community theater tools: leaflets on FP, community mobilizer booklets • Community dialogue discussion cards • Low cost, easy-to-read leaflets • Clinic videos • Key chains	DRH/DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of CHW kits developed and produced # of community theatre tools developed and produced # of community dialogue cards developed and produced # of videos developed and produced	5,000, 000		
2.3 Conduct FP mass media campaigns both at National media and local stations	• Radio spots encouraging desired behaviors and addressing barriers to uptake of services • TV spots encouraging desired behaviors and addressing barriers to uptake of services	DRH/DHP APHIA Plus JHPIEGO Pathfinder International UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of radio campaigns conducted # of TV spots developed and aired # of TV and radio programs aired # of newspaper	30,000,000		

Matrix 1: Family Planning *(continued)*

Social Mobilization and Behaviour Change Communication for Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
2.4 Arrange for outdoor advertising	• Billboards • Wall branding • Posters • Banners	DRH/DHP APHIA Plus C-Change JHPIEGO Pathfinder International	# of billboards in different locations # of posters produced and disseminated # of banners developed and produced	8,500,000		
2.5 Conduct targeted FBO activities: outreach to churches and mosques	• Fact sheets for FBOs	DRH/DHP APHIA Plus C-Change JHPIEGO Pathfinder International Inter-religious Council	# of fact sheets developed and disseminated	800,000		
2.6 Conduct activities for special groups and hard-to-reach populations	• Leaflets for special groups and hard-to-reach populations	DRH/DHP APHIA Plus C-Change JHPIEGO Pathfinder International	# of leaflets developed and produced	800,000		
2.7. Establish alliances, partnerships, and networks focusing on SBCC for FP	• Leaflets • Fact sheets	DRH/DHP APHIA Plus	# of leaflets and fact sheets # of alliances, partnerships, and networks	500,000		
2.8. Support women's and men's groups/ clubs to integrate FP with activities	• Guidelines/ protocols for integrating FP SBCC into non-health programs	DRH/DHP APHIA Plus	# of guidelines developed # of groups integrating FP activities	300,000		

Matrix 1: Family Planning *(continued)*

Capacity Strengthening for Health Providers and SBCC Practitioners on Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
3.1 Capacity strengthening for FP partners and health promotion and RH officers on BCC	• SBCC capacity strengthening modules and tools for RH/ SBCC practitioners	DRH/DHP C-Change UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF APHIA Plus	# of capacity strengthening assessments and workshops conducted	1,000,000		
3.2. Capacity building for health providers on interpersonal communication skills	• Training curriculum on interpersonal skills • Job aid on Interpersonal Communication skills	DRH/DHP UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of interpersonal communication skills workshop conducted # of job aids developed and produced	1,000,000 500,000		
3.3 Capacity strengthening for CHEWS, CHWs, and CBD on FP/RH SBCC	• SBCC capacity strengthening modules and tools for community-level implementers	DRH/DHP C-Change APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# SBCC workshops for community-level implementers # of modules and tools developed and implemented	4,000,000		
3.4 Develop SBCC M&E plan with key FP indicators to be used at all levels	• SBCC M&E plan and monitoring tools	DRH/DHP C-Change APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of M&E workshops conducted # of M&E frameworks and monitoring tools developed, produced, and disseminated	1,500,000		

Matrix 1: Family Planning *(continued)*

Capacity Strengthening for Health Providers and SBCC Practitioners on Family Planning						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
3.5. Strengthen SBCC research on FP-related issues to inform programming	• SBCC research protocols on FP-related issues, such as fears and misconceptions and other barriers to uptake of services	DRH/DHP C-Change APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of SBCC FP research studies conducted and results disseminated	1,500,000		
3.6. Capacity strengthening on documentation, dissemination, and utilization, of evidence-based SBCC practices	• Guidelines on documentation, dissemination, and utilization of SBCC best practices	DRH/DHP UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF	# of workshops on documentation and dissemination of SBCC FP best practices	1,500, 000		
3.7. Develop materials for health providers on FP/RH	• Reference guides on contraceptives • Job aids • Booklets • Brochures • Flip charts • Wall charts	DRH/DHP Engender Health JHPIEGO APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ	Reference guides developed and produced Booklets, brochures, flipcharts, and wall charts developed and produced	3,000,000		
Sub Total: KSH 69,200,000						

THEMATIC AREA 2: ADOLESCENT AND YOUTH SEXUALITY AND REPRODUCTIVE HEALTH RIGHTS (AYSRHR)

Objective: Implement multimedia behavior change communication, social mobilization, and advocacy interventions to promote provision of adequate information and ensure universal access to AYSRHR services by youth.

Matrix 2: Adolescent and Youth Sexuality and Reproductive Health Rights (AYSRHR)

Advocacy for AYSRHR						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
1.1. Conduct AYSRHR stakeholder forums on advocacy at national, county, and community levels	• Presentation on ASRH advocacy issues • Fact sheet	DRH/DHP APHIA Plus PATHFINDER UNICEF GIZ PSI UNICEF	# of AYSRHR stakeholder forums conducted	1,000,000		
1.2.Advocate for the establishment of functional youth-friendly corners in all health facilities offering AYSRHR services	• Guidelines for setting up and delivering youth-friendly services	DRH/DHP APHIA Plus PATHFINDER UNICEF GIZ PSI UNICEF	# of workshops to develop guidelines on youth-friendly corners # of functional youth-friendly corners offering AYSRHR services	1,500,000		
1.3. Advocate for establishment of youth empowerment centers in each county and support them to integrate AYSRHR information	• SBCC materials for youth	NCAPD Ministry of Youth and Sports DRH APHIA Plus GIZ PSI	# of youth-friendly AYSRHR SBCC materials developed # of advocacy meetings held	500,000		
1.4. Engage the media as partners in advocating for AYSRHR by briefing editors, training and arranging field visits for journalists , developing media kits, and developing of TV/ Radio programs	• Media kits • Editorial briefing kits • Guide for journalist training	DRH/DHP APHIA Plus PSI INTERNEWS PSI UNICEF	# of media briefings held # of journalists and editors trained on AYSRHR # of field visits conducted by journalists and feature stories aired	2,000,000		

Matrix 2: Adolescent and Youth Sexuality and Reproductive Health Rights (AYSRHR) *(continued)*

Advocacy for AYSRHR

Broad activities	Materials	Implementers	Process indicators	Indicative budget (KSH)	Year 1		Year 2	
1.5. Conduct regular advocacy performance review meetings for AYSRHR partners and stakeholders	• Advocacy performance review guidelines	DRH/DHP APHIA Plus PSI UNICEF	AYSRHR performance reviews workshops and guidelines developed and disseminated					

Behaviour Change Communication and Social Mobilization for AYSRHR

Broad activities	Materials	Implementers	Process indicators	Indicative budget (KSH)	Year 1		Year 2	
2.1 Conduct print and electronic mass media campaign to provide information and improve access to AYSRHR services	• Radio spots • TV spots • TV and radio programs • Newspaper columns/ adverts	DRH/DHP GIZ PSI FHI APHIA Plus	# of mass media campaigns conducted on AYSRHR	27,000, 000				
2.2 Conduct campaigns via internet and mobile phones to provide information and improve access to AYSRHR services	• Messaging for mobile phones • Facebook • Twitter • Hotlines	DRH/DHP GIZ PSI FHI APHIA Plus	# of mobile phone, Facebook, Twitter and hotline campaigns conducted	2,000,000				
2.3 Organize community-community based activities, including interactive theatre, road shows, and peer education	• Guides on interactive and magnet theatre Peer education guides	DRH/DHP GIZ PSI APHIA Plus	# of the community interactive theatre performances # of peer education activities # of road shows and other community-based activities	4,000, 000				
2.4 Support schools to establish and run AYSRHR clubs	• Guidelines for AYSRHR clubs in schools • IEC materials	APHIA Plus Ministry of Education PTAs	# of functional AYSRHR clubs in schools	800,000				

Matrix 2: Adolescent and Youth Sexuality and Reproductive Health Rights (AYSRHR) *(continued)*

Behaviour Change Communication and Social Mobilization for AYSRHR						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
2.5. Organize school-based competitions that engage adolescents and youth to disseminate AYSRHR information	• Curricula and guidelines for integrating AYSRHR into school programs	DRH APHIA Plus Min of Education	# of workshops on SBCC AYSRHR curricula integration # of school-based AYSRHR activities	800,000		
2.6 Arrange for outdoor advertisements that promote the concept of AYSRHR for youth	• Billboards • Wall branding • Posters • Banners	APHIA Plus Local authorities DRH/DHP GIZ PSI	# of outdoor advertisements (billboards, wall branding, posters, banners)	2,000,000		
2.7 Integrate AYSRHR services into a package of youth-friendly services	• Print materials on youth-friendly services	DRH/DHP PSI NASCOP NOPE APHIA Plus	# of youth-friendly AYSRHR materials developed & disseminated	1,000,000		
2.8. Advocate for establishment of alliances, partnerships and networks focusing on AYSRHR	• Leaflets • Fact sheets	APHIA Plus DRH/DHP PSI NASCOP NOPE	# of AYSRHR alliances, partnerships, and networks formed # of AYSRHR advocacy meetings held	500,000		
SUB-TOTAL: KSH 43,100,000						

THEMATIC AREA 3: MATERNAL, NEONATAL AND CHILD HEALTH (MNCH)

Objective 1: Implement multi-media behavior change communication, social mobilization, and advocacy interventions that reachurban, peri-urban, and rural women of reproductive age and promote skilled attendance during delivery and increase awareness of the importance of seeking prompt healthcare for delivery complications.

Objective 2: Implement SBCC capacity strengthening activities among health providers to address health-provider barriers that affect access to MNCH services.

Matrix 3: Maternal, Neonatal and Child Health

Advocacy for MNCH						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
1.1. Engage parliamentary health committees, including KEWOPA	• Fact sheets on maternal health • Advocacy kit for leaders	# of MNCH fact sheets and advocacy kits developed and produced	# of MNCH fact sheets and advocacy kits developed and produced	500,000		
1.2. Conduct MNCH stakeholder forums at national, county, and community levels to advocate for SBCC for MNCH-related issues	• Advocacy kit for county leaders • Presentation on MNCH advocacy issues • Fact sheet	DRH/DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus Save the Children - UK	# of county leaders advocacy kits and fact sheets developed and produced	1,000,000		
1.3. Engage the media as partners in advocating for increased and accurate reporting on MNCH by briefing editors, training and organizing field visits for journalists , and developing media kits and TV/radio programs	MNCH media kits • Briefing kits for editors on MNCH • Training guide for journalists on MNCH	DRH/DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus Save the Children UK	# of MNH media kits developed and produced # of training guides for journalists # of workshops for journalists	2,000,000		
1.4. Conduct regular MNCH advocacy performance review meetings	• Performance review guides	DRH/DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus Save the Children UK	# of MNCH advocacy review meetings	500,000		

Matrix 3: Maternal, Neonatal and Child Health *(continued)*

Behaviour Change Communication and Social Mobilization for MNCH						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
2.1. Conduct mass media campaign on MNCH to increase access to information and services.	• Radio spots • TV spots • Documentary on MNCH testimonials • TV and radio programs • Newspaper columns/ adverts	DRH DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK AMREF Save the Children UK	# of radio and TV campaigns conducted # of TV and radio programs supported # of internet and mobile phone campaigns	20,000,000		
2.2. Conduct interpersonal communication activities and outreach at community level s among target audiences to provide comprehensive messages on MNCH, including through household visits by CHW, CBD, community health volunteers and Interactive MNH community theatre activities, and MNCH community dialogue sessions	• Standard CHW kit: flip chart on MNH, T-shirt , guidelines, IEC materials on MNH • Community theater tools: leaflets on MNCH, booklets for community mobilizers • MNCH community dialogue discussion cards • Low cost, easy-to-read leaflets on MNCH	DRH DHP UNFPA GIZ JHPIEGO Engender-Health APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK Save the Children UK	# of CHW kits on MNCH developed and produced # of MNCH community theatre tools developed and produced # of MNCH community dialogue cards developed and produced # of MNCH videos developed and produced	5,000,000		

Matrix 3: Maternal, Neonatal and Child Health *(continued)*

SBCC Capacity Strengthening for MNCH						
Broad activities	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (KSH)**	**Year 1**	**Year 2**
3.1 Conduct a workshop to develop standard messages for MNCH campaigns to be used at all levels	• Workshops on message development • Development of training modules, and tools	DRH, DHP UNFPA JHPIEGO Engender-Health APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF Save the Children UK	# of message development workshops conducted	1,000,000		
3.2 Develop, produce and disseminate standard MNCH messages at all levels	• Posters • Fact sheets • Job aids • Leaflets • Booklets • Give aways; stickers, caps, umbrellas etc	DRH DHP UNFPA JHPIEGO Engender-Health APHIA Plus UNFPA UNICEF WHO Marie Stopes FHOK GIZ AMREF Save the Children UK	# of posters, fact sheets, job aids, leaflets, booklets, and giveaways developed, produced, and disseminated	2,000,000		
SUBTOTAL: KSH 32,000,000						

Grand total: KSH 144,300,000

SECTION IX.

Evaluation and Replanning—How Do We Measure Success?

As illustrated in the implementation matrix, a common set of indicators will be measured by the MOPHS/DRH to ensure that joint progress is being made on RH/FP, MNH, and adolescent and youth issues.

EVALUATION AND REPLANNING

In the final stage of C-Planning, it is important to learn from the experiences of the program and use this learning to guide the next round of work.

However, research and evaluation is not something that happens only at the end of the process. It is relevant throughout—for example, in the gathering of baseline information, the setting of measurable communication objectives, and in the monitoring of implementation plans.

As stated earlier, the TWG will work with key national stakeholders to ensure that the SBCC program is monitored and evaluated as part of partner activities.

REFERENCES

Ministry of Public Health and Sanitation (2010). *Reproductive Health Communication Strategy - 2010–2012.*

Ministry of Public Health and Sanitation (2007). *National Reproductive Health Policy.*

Ministry of Public Health and Sanitation (2009). *National Reproductive Health Strategy-2009–2015.*

Ministry of Public Health and Sanitation (2009). *FP guidelines for Service Providers.*

Ministry of Public Health and Sanitation (2009). *Roadmap for Maternal and Newborn Health.*

National Council for Population and Development (2008). *Youth Reproductive Health Policy.*

Government of Kenya (2008/9). *Kenya Demographic Health Survey.*

Ministry of state for planning and national development and vision 2030 (2007). *Kenya Vision 2030 the popular version.*

Notes: