

DEVELOPMENT ASSISTANCE PLAN

21p.

POPULATION/HEALTH SECTOR

ASSESSMENT

II. C. U.S. ASSISTANCE TO POPULATION/HEALTH

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II.C. U.S. ASSISTANCE TO POPULATION/HEALTH

SUMMARY OF SECTOR ASSESSMENT

Demography

Analysis of census data from censuses conducted in 1948, 1962, and 1969 show that Kenya's population has doubled from about 5.4 million in 1948 to 10.9 million people in 1969. In 1973 the population was estimated at 12.5 million. The population growth rate has also risen from an estimated 2.0 - 2.5 percent in 1948 to 3.3 percent in 1969 and a probable 3.5 percent in 1974.

The principal reasons for this rapid growth are Kenya's fertility rate of 7.6 children per woman (one of the highest rates in the world), falling mortality rates and lengthened life expectancy at birth, and the extreme youthfulness of Kenya's population (about half are under 15 years of age). Given the continuation of these trends, the population may approach an annual growth rate of 4 percent and may double within 20 years or less.

Such trends are not normally amenable to rapid change, and even under the most optimistic assumptions Kenya's population may exceed 20 million in the year 2020: Under varying assumptions the pattern might approximate the following: A - 34.3 million if the fertility rate remains at 7.6; B - 28.1 million if the rate falls to 4 by 2000; C - 26.2 million if the rate decreases to 3, and D - 24.3 million if the rate declines to 2. However, even these projections show Kenya's population doubling by the end of the century.

Distribution of population in Kenya is closely related to rainfall patterns with 80 percent of the people living on the 18 percent of the land considered suitable for cultivation. Population densities in some of these "high potential" agricultural areas are now 400 - 500 persons per square kilometer and the areas of high density as well as densities per square kilometer are increasing. The most striking feature of the spatial distribution of the rural population, however, is the extent of sparsely populated areas, covering over half of the country and all having a serious moisture deficit.

Kenya's population is affected by two main streams of internal migration -- from rural, high density population areas to urban centers and from these same major rural centers to commercial farming areas in

the former "White Highlands". The latter is due to post-independence efforts to resettle African farmers on land once "reserved" for expatriates. Such migration principally involves the young and persons in their early maturity, although there is evidence of a strong return migration to home areas among adults over 45.

Migration to urban areas while having a significant impact on urban population size, will not significantly affect the size of the rapidly growing rural population. This selective migration adds to rural problems by leaving behind the uneducated, the very young, the very old, and a disproportionate number of women. The 1969 census showed about 525,000 rural households headed by women of which about 400,000, or one-third of all rural households, might be those whose male heads had migrated to towns.

Because of the inability of urban and high potential rural centers to employ all those who might migrate there, a migratory trend which may become increasingly important is movement from densely populated farming areas onto Kenya's under-populated marginal and semi-arid lands. Such a movement could contribute little over the long-term to Kenya's agricultural production while hastening the process of environmental deterioration already underway as a result of drought, erosion and overgrazing.

The urban population in Kenya was estimated to be 1.2 million in 1973 and growing at about 7.1 percent although that rate is expected to increase. By the end of the century urban centers may have to accommodate about 9 million people, nine times the 1969 population and, therefore, to cope with the environmental and social problems accompanying rapid urbanization.

The socio-economic implications of Kenya's rapid population growth are serious, reflecting concern over the obstacle such growth presents to development rather than concern over the country's ability to support a larger population. One area of socio-economic development particularly sensitive to population growth is GDP per capita. As described in the "Development Overview" section, Kenya has made impressive achievements in raising both GDP and GDP per capita since independence. However, aggregate figures for the country at large mask significant rural and sectoral differences. This is particularly true in the rural sector where 90 percent of the population lives but which had significantly lower improvements in income due to lower than average GDP growth combined with higher than average rates of population change. Even under the IBRD's most optimistic projections rural farm incomes may only grow by 2.8 percent during the 1974-78 Development Plan period.

Given the existing population size and composition, the labor force is expected to double to a total 7.6 million by 1990 and may approximate 11 million by the end of the century, depending on the fertility rate. While the labor force may, thus, be growing at about 3.6 percent per year, employment during 1972-1978 may only increase by 3.2 percent.

The Government of Kenya is committed to the principle that every child has the right to have access to seven years of basic education. The primary school-age population is now over 2.1 million children and growing at about 4 percent per year. Enrollments, therefore, will rise to about 3.2 million children during 1974-1978. The secondary school-aged population now totals 1,080,000 of which only 8 percent are enrolled. With this group estimated to increase to 1.4 million by 1978 and enrollments to increase to 112,000 by that year, the percentage enrolled will remain unchanged from the current figure. Expenditures for elementary education alone account for 53 percent of all educational spending proposed during the Plan period, and if current trends in educational budgets continue, these expenditures could take up over 80 percent of the Central Government budget by 1990.

A fourth socio-economic factor affected by population growth is food production. Using a conservative estimate of the population growth rate (3.3 percent), the demand for food has been projected to more than double by the year 2000 and to nearly triple if the existing fertility rate remains unchanged. Just to maintain existing nutrition levels increases in food production must keep pace with population growth. Given the scarcity of productive land in Kenya and Kenya's population growth, productive land per capita can only decline.

Health Situation and Services

In 1969 there were a total of 10 million known cases of illness, almost one for every Kenyan, principally classifiable into the following categories: upper respiratory tract infections and gastro-enteritis, environmental-caused illnesses (water-borne, parasitic or other sicknesses), communicable diseases, nutritional deficiencies, and problems associated with pregnancy and child birth. If the total number of cases increases as projected to 16 million in 1984, they could consume almost three-quarters of the present capacity of Kenya's health services.

Health services in Kenya are provided by the Central Government, local authorities, church missions, industrial health units, and private institutions and individuals. In 1970 the Government took over administration of most public sector health services when local authorities were unable to meet rising demand, and the church system, which provides about 30 percent of all hospital beds and some paramedical training, is now being integrated within the Government network.

The Kenya health delivery system is heavily oriented toward provision of curative care through a network of provincial, district and sub-district hospitals, the distribution of which is highly uneven among the various provinces. In 1973 there were 132 hospitals having a total of 14,430 beds, and the national bed/population ratio was 1.15 beds per 1,000 population.

Alongside the hospital network is the rural health system based on health centers, sub-centers, and dispensaries, also offering primarily curative care and some preventive services. Attendance at rural health facilities is chiefly by women and children while male patients constitute a significant proportion of those cared for at hospitals on both an in-patient and out-patient basis.

A study of the rural health system by the Ministry of Health (MOH) and the World Health Organization (WHO) in 1972 ("Proposal for the Improvement of Rural Health Services and the Development of Rural Health Training Centers in Kenya," referred to henceforth as the "MOH/WHO Proposal") found the existing rural health system highly inadequate. The major reasons cited for the various problems was the 1970 takeover of the local health system by the MOH which was then, and still is, unable to cope with all the ramifications and requirements of such an extensive additional burden. The basic problems identified by the MOH/WHO team were:

- Severe shortages of staff with shortfalls among various paramedical personnel needs ranging from 21-to-24 percent, with at least 54 percent of rural dispensaries lacking graded staff, and with 400 Harambee (self-help) facilities unopened because staff were unavailable.
- Serious administrative deficiencies resulting in a high degree of inefficiency and ineffectiveness.

The MOH/WHO Proposal provides a lengthy listing of the administrative deficiencies. Briefly summarized, they included:

- Differentiating among various types of facilities on the basis of staffing; yet staffing varied from place to place and time to time.
- No fixed or functional relationship between types of facilities so that ratios of population served varied considerably and services were generally limited to a three-to-four mile radius around each facility.
- Lack of coordination of services within and between individual facilities.

- Lack of a sense of common purpose among staff.
- Lack of leadership at all levels of the health system.
- Ad hoc coverage by mobile units.
- Inadequate and poorly defined technical, operating and administrative procedures.
- Deficiencies in equipment, transport and sanitation at health facilities.

According to MOH personnel, many of these problems still exist, particularly those involving coordination, communications and reporting, supervision, supportive services, and staff discipline.

Contributing factors to administrative problems are the lack of training for medical and paramedical staff in management skills and an organizational system within the MOH which leads to duplication of effort and overlapping responsibilities, particularly with regard to the complex of activities which form part of the totality of rural health services.

To improve the quality of health care available to Kenya's rural population and to extend the coverage of such services the Ministry and WHO proposed an ambitious 10-year master plan for rural health to be fully implemented by 1984. Goals of the program are:

- To increase the number of rural health facilities and to staff them adequately in order to achieve a higher density and more even distribution of delivery points.
- To provide services as part of an integrated rural health unit framework.
- To adjust staffing so as to ensure a uniform, high standard of services.
- To promote and protect family health.
- To improve administration and efficiency of the rural health system.

Improved staffing is the key focus of the Proposal through expansion of training to meet staff shortages, particularly for enrolled and community nurses, and through provision of special training for rural health paramedical staff at a network of six provincial rural health training centers. These staff will receive 13 weeks training at the Centers following completion of their basic paramedical training. NORAD and UNICEF are to assist in development of the RHTC's which are to begin operating in 1976.

The financial requirements of the Program are heavy, and a significant portion are to be met from foreign aid sources. Total capital costs for new and/or renovated rural health facilities were estimated to approximate a maximum of \$50.4 million while recurrent expenditures for rural health were projected to rise from \$3.9 million in 1972/73 to \$9.1 million in 1984/85 for a total cost over the period of \$88.3 million. Additional funding was estimated for expanded training facilities -- \$1.75 million for construction and \$9.5 million, recurrent costs, during 1972/73 - 1984/85.

Family Planning In Kenya

Family planning activities were first initiated in 1955 by local groups in Nairobi and Mombasa. The impetus for family planning was to make people aware of, and to provide them with, modern contraceptives to enable them to avoid unwanted pregnancies. In 1961 the two organizations joined to form the Family Planning Association of Kenya (FPAK) which in 1962 became the first affiliate from Tropical Africa of the International Planned Parenthood Federation (IPPF).

Since 1967 when the Government officially launched its national family planning program, the role of FPAK has changed from provision of clinical services to providing information-education services in support of the national program. The FPAK information, education and communication (IE&C) efforts stress person-to-person contacts through its 73 field educators (three of whom are now males) distributed among all seven provinces and Nairobi. In addition to the field worker program, FPAK also participates in special exhibitions, prepares materials for use by mass media, operates three mobile cinema vans, publishes a quarterly journal, and conducts seminars to educate special groups, such as teachers, extension workers, Members of Parliament, and other national and local leaders, about family planning.

The IPPF, a significant contributor of financial support to FPAK, operates seven mobile teams providing clinical family planning/maternal-child health services at various sites throughout Kenya. IPPF also supports the only facility in Kenya for training family planning workers.

Several other private groups are active in Kenya, chiefly in the IE&C field. These include the National Christian Council of Kenya and the World Assembly of Youth, both of which are supported either directly or indirectly by AID/Washington grants. A third organization is the UN/FAO-assisted Programs for Better Family Living which is attempting to educate government and other personnel working in rural areas about the relationship of family size to community and family welfare and to improve coordination among such groups.

Both the Nairobi and Mombasa City Councils operate family planning clinics. The NCC now has 39 such facilities and annually accounts for 15-20 percent of all family planning acceptors in Kenya.

Official Government interest and involvement in this field was a direct outgrowth of the 1962 census findings and the consequent realization of their implications for economic development. The 1965 policy statement of Kenya's national goals and development philosophy identifies rapid population growth as one of two major constraints to achieving development objectives. In 1965 at the Government's request a team from the Population Council in New York conducted a survey and made recommendations for establishing a national family planning program. The Government accepted the Report, launched the National Family Planning Program in 1967 (the first sub-Saharan African country to do so), and in 1968 opened the first Government-sponsored family planning clinic in Nyeri.

Since these beginnings the number of family planning clinics has increased to 300 (out of 900 health service points) operating mostly on a part-time basis. Family planning acceptors have risen steadily from 6,359 in 1967 to probably 60,000 in 1973. Unfortunately, the overall acceptance rate among women of child-bearing age is a low 2.2 percent, and about 80 percent of all acceptors of contraceptive methods "drop out" of the program during their first year of use.

The Government family planning program, like rural health activities, has been limited by severe staff shortages affecting both its provision of clinical services and its IE&C efforts. The Ministry of Health Education Unit has been responsible for producing various types of materials and audio-visual aids, but output has been limited by insufficient staff and an inadequate facility, and the results of a recent PBFL evaluation of the HEU-developed family planning calendar indicate materials may be ineffective in conveying the intended message about family planning to the general public.

Despite the fact that family planning is widely and openly discussed in Kenya, there continues to be a great lack of knowledge among the population at large about this subject, about contraception and about human reproduction. Then, too, large families are still valued in Kenya, and actual family size corresponds closely to desired family size, i.e. six children.

Because of the Government's interest, its positive actions regarding family planning, and Kenya's openness to external assistance, there has been a significant degree (possibly a surfeit) of donor involvement in this area. For example, in 1971 80 percent of family planning services were provided by expatriates. By 1973, however, this specific situation had been alleviated such that Kenyans provided most services.

In addition to donor involvement there is also extensive activity in the family planning/population field in Kenya carried out by ministries other than Health, by private organizations, and by the University. The vast number of bodies active in Kenya in this area makes essential close coordination of their efforts.

Because of developments and problems encountered in the initial stages of the national program, the Government drafted in 1972 a plan for an expanded and more effective national five-year family planning program. That plan was reviewed and revised by the IBRD and a five-year program covering FY 1975-1979 subsequently proposed for support by several donors under the leadership and coordination of the MOH. The program is to focus directly on manpower and management constraints.

The Five-Year Family Planning Program is closely related to, and integrated with, the goals and activities to be implemented under the 10-year rural health plan. The specific family planning objectives of the Program are:

- 1) Establishment of 400 full-time family planning/maternal-child health (FP/MCH) service points and 190 part-time outlets.
- 2) Training and deployment of 400 Community and/or Enrolled Nurses (EN/CN's), 46 Provincial and District Nurse Trainer/Supervisors and Family Planning Field Officers, and 800 Family Planning Field Workers.
- 3) Training and deployment of 55 tutors to staff CN training schools.
- 4) Extension of the coverage of health education and family planning materials.

The demographic objectives of the Program are to recruit 640,000 new family planning acceptors during 1975-1979 in order to reduce the crude birth rate of 43 per 1,000 and the rate of population increase to about 3 percent.

Achievement of the two sets of objectives will be supported by construction of various training and rural clinic facilities, a new HEU building, and a National Family Welfare Center (NFWC) to serve as the Program's central headquarters. The national program is to be administered by the NFWC through the MOH structure for administering health services. The NFWC will be headed by a Director who is also the MOH Deputy Director of Medical Services/Family Planning. He will be assisted by a Deputy and the heads of the four NFWC divisions -- clinical services, information and education, training, and evaluation and

research. The Program will receive policy guidance and overall coordination from a high-level Interministerial Working Committee. Technical advice and guidance will be furnished by four Advisory Working Committees, one for each NFWC division. Together the committees and the divisions will be responsible for overseeing a much expanded effort in each of their areas involving the MOH, other ministries, the University, and private organization personnel. One aspect of this effort will be development of a Population Studies and Research Center at the University of Nairobi to carry out research in broad, population-related subjects which can be of use to the national program.

Total cost of the Five-Year Family Planning Program was estimated at \$38.8 million of which \$14.3 is to come from the GOK and the remainder from seven donors -- the IDA, Denmark, West Germany, Norway, Sweden, the UN Fund for Population Assistance, and AID. The bulk of the expenditures are to be for local costs (\$29.1 million), principally occasioned by the growth in MOH recurrent costs attributable to Program activities. The increased recurrent costs for family planning will mean an average growth in the Ministry's recurrent budget estimated at 11.3 percent per year.

Family Planning/Health in the 1974-78 Development Plan

Both the Five-Year Family Planning Program and the 10-year rural health effort were included in the Plan essentially as they were described above. The Plan period corresponds to Phase I of the rural health program so that those implementation targets were adjusted accordingly.

The Plan's presentation makes clear how closely the GOK sees the inter-relationship of the two programs and their mutually reinforcing nature. However, the Plan gives principal emphasis to population growth within the broader context of socio-economic development and justifies the family planning program on that basis. The family planning program as it is presented also is to continue the basic principles under which Government has operated its national program since 1967:

- 1) The Program is an integral part of efforts toward social and economic development.
- 2) The Program is linked to MCH services.
- 3) The Program is wholly voluntary.
- 4) The Program emphasizes spacing of births rather than limitation of numbers.

Significant funding is proposed for both programs during 1974-1978. The Plan projects total health expenditures and financing at about \$274 million of which about \$104 million should benefit rural health activities. About \$23.4 million of the latter amount is for family planning. Even though the health allocations remain heavily oriented toward hospital and curative care, the rate of increase in expenditures for preventive programs is much higher.

A comparison of Plan funding proposals with the 1974/75 budget estimates gives mixed evidence as to GOK intentions. While training estimates are increased over the 1973/74 approved budget levels and those for the rural health program exceed the Plan figures, funding and personnel for family planning fall below Plan estimates and program needs if the NFWC is to be launched in a timely fashion and to fulfill the role assigned to it. This situation may be remedied if there should be a supplementary budget allocation approved later this fiscal year.

Constraints

There are four constraints which will affect the Government's ability to reach the ambitious goals of both the family planning and rural health programs over the next five years and ultimately to affect Kenya's population growth rate. Two of these affect both programs while the other two relate solely to family planning:

1. Limited manpower availabilities and capabilities to carry out expanded health/family planning programs.
2. Limited organizational and managerial abilities within the MOH and NFWC to enable them to implement and carry out both programs efficiently, effectively and in a manner which will ensure achievement of program targets and objectives in a timely fashion.
3. Lack of general knowledge and acceptance of either the concept of family planning or contraception.
4. Limited ability of expanded family planning services provided through a Government health system to have a significant effect on the Kenyan population problem within the relatively short-time frame of five-to-ten years without resort to non-institutional means of distributing contraceptives more widely.

KENYA'S POPULATION SECTOR

The population/family planning sector is an extremely important one for Kenya -- a fact widely recognized by Government planners as well as donors. The size and rate of growth of the population has significance for attainment of many of the country's development objectives -

increased and more equitable distribution of income, particularly among rural people; increased output, and an improved standard of life in rural areas.

Given the dimensions of the problem posed by rapid population growth, AID has assigned Kenya a high priority for population/family planning assistance. In an AID/W exercise to identify countries requiring priority attention, Kenya ranked fifteenth on a list of 96 countries world-wide, and fourth on the list of African countries after Nigeria, Zaire, and Tanzania.

The Five-Year Family Planning Program to be implemented during 1975-1979 is basically sound. It attempts to focus on the key constraints of staffing, management, and family planning education although its probable success in solving the second of these is unclear. Certainly, the five-year program offers a means by which to address population concerns in a manner acceptable to the Government and Kenyans at large. Because of the program's close relationship to the parallel Government plan for improving rural health services, the two activities taken together make the most efficient use of available human and financial resources.

One may ask whether the family planning program is fully adequate to the task before it. Based on the 1974/75 budget estimates, funding and personnel requirements to initiate the program have not yet been fully forthcoming. Whether this is a valid indication of an inadequate GOK commitment is questionable. With the adverse balance of payments situation facing Kenya in FY 1974-FY 1975 (at a minimum) and the resultant financial restraints placed on the Government, the shortfalls may be attributable in large part to these other factors. Similarly, they may also reflect to some degree the administrative problems of the Ministry of Health. The Government of Kenya has a long history of support for family planning, both in words and deeds, going back to the 1962 census, and this has occurred even though individual members of Government may publicly express reservations.

The delays in authorizing NFWC positions - only one (the Director) of the six key leadership posts has been filled and only one other authorized -- combined with first-year funding shortfalls from Plan projections means there will be delays in achieving program objectives. These delays may be compounded by the managerial problem identified by the IBRD as being common throughout Government ministries -- the lack of staff skills for 1) conceptualizing a project as being a unit of both related and distinct actions occurring in a certain sequence and requiring certain resources to be available and preparatory steps to be carried out, and which, taken together, result in achievement of pre-determined objectives and, then, 2) following through to see that things actually happen and that problems are identified as they arise and are resolved promptly.

Our concern is that with such delays, the resulting lengthened disbursement periods, and the inevitable associated frustrations, some of the donor funds originally earmarked for the Five-Year Program will be diverted to other assistance activities. The Mission is aware of some family planning aid agreements between the GOK and other donors under which such diversion is possible. In the short run before the Program is fully under way, this may be a useful administrative device for donors to keep funding pipelines low; however, the longer-term implications could be serious if such "diversions" are not later restored.

To place the GOK Five-Year Family Planning Program in perspective, one must view its impact upon reducing population growth in association with the stimulus to growth resulting from improved rural health services. For example, of every 1,000 pregnancies in Kenya, an estimated 110 do not result in live births, thus giving a foetal wastage rate of 11 percent. For each 1,000 live births, an estimated 120 infants die during their first year of life for an infant mortality rate of 12 percent. Finally, it is estimated that 15 to 20 percent of all children born alive die before the age of five. If these rates are halved by 1984 as proposed, the projected number of surviving infants in that year (771,811 out of 868,864 pregnancies) will exceed by 72,000 the number who would have survived at current mortality rates. To compensate for this, the family planning program will need to avert about 77,000 births in 1984 just to keep pace with population growth attributable solely to decreases in foetal and infant death rates. The Government is fully aware of this phenomena.

Considerations such as the above as well as the proven slowness of health institution-based family planning services in affecting population growth are behind the ILO/UNDP statement quoted on page 214 of the Sector Assessment. In Kenya's case, certain "givens" affect the Government's choice of the type of program to be followed:

- Kenya's population growth is attributable to a continuing high birth rate, falling death rates, and lengthened life expectancy. The only ones of these which it might be acceptable to curb is births.
- Immigration is a negligible contributor to population growth so that a ban on immigration is useless. Forced mass emigrations or programs to encourage voluntary emigration of numbers significant enough and over a long enough period to affect population growth would be impracticable at a minimum and only a short-term solution since the birth rate in the population remaining would still be high.

- For any family planning program to affect population growth by the 1980's, work must begin now.

To address the problem of altering population growth through lowering birth rates means that in voluntary programs, such as Kenya's (which has to be the case for AID to be able to provide assistance), the decision by a couple to practice contraception is subject to influence by a host of considerations -- personal, familial, social, economic, religious, cultural and so on. Therefore, the starting point for any program is to offer family planning services and the knowledge and means of fertility limitation to the entire population of reproduction age. This would seem to be the first priority action and the one which Kenya is taking.

Making services available can be expected to achieve some positive results. The numbers of people visiting family planning clinics and evidence from other sources indicate there is unmet demand for family planning services although this is not large or intense. Meeting this demand should have a small and (just) visible impact on the birth rate. Whether this will, in turn, affect the population growth rate will depend on the magnitude of the reduction and the changes occurring simultaneously in the death rate. If it does affect the growth rate, chances are the change will be small, but in Kenya even a slight turn downward in the growth rate or even a halt to the upward trend would be significant.

The second priority in a program limiting births should be to alter the demand for children and to instill in the population the value of the two-child family. In light of the principles under which Kenya operates its family planning program, this is not yet conceived as being a direct part of the GOK effort. In fact, according to the Development Plan, the IBRD project proposal, and other sources, the Government presently sees such a change as resulting from socio-economic development. This the GOK is to bring about through the entirety of its development activities.

AID ASSISTANCE STRATEGY

AID's family planning assistance to Kenya has been embodied in two bilateral activities -- the continuing and multi-faceted Population Dynamics Project and the new Family Planning Project -- and about eight active and two recently completed AID/Washington centrally funded activities. As a result, the program has been very diffuse and diverse, directing assistance to Government activities in demography, clinical services and IE&C, to information-education and clinical programs conducted by various private and church groups, and to various research activities at the University.

While having minimal impact on the Government program and its goals, many of the centrally funded efforts have placed a severe burden on the Mission in its attempts to oversee project implementation, to maintain liaison with local contacts, and to carry out actions requested by AID/W. This stretching of limited Mission staff resources may also have diverted attention from the Population Dynamics project, two of whose elements have been relatively unsuccessful. It should be stressed, however, that the problems encountered with the Health Education (Sub-project 141.1) and Vihiga Family Planning (141.3) activities are principally the result of inadequate provision of counterparts and staff by the MOH in the case of the former and inadequate pre-planning and project implementation by the Ministry and AID in the latter instance. (In contrast, the PopLab sub-project (141.2), at the Ministry of Finance and Planning's Central Bureau of Statistics, has been comparatively successful.)

With the new Family Planning Project about to begin implementation -- a six year effort covering FY 1975 - FY 1980 and estimated to cost \$3.5 million per the PROP -- it is important that the Mission clearly define its priorities and organize so as to make it possible for this project to address effectively the problems of Kenya's rapid population growth.

Because the successful implementation of the Government's Five-Year Family Planning Program is crucial for achievement of development objectives and for limiting Kenya's population growth, the Mission believes the central focus and first priority among its population/health assistance efforts should be the new Family Planning Project, which is to provide support for various components of the GOK Program (see below for brief description of AID project activities). The magnitude and scope of the AID and GOK efforts alone would call for such an emphasis. Then, too, AID's performance with this project may well have implications for future requests for U.S. assistance in this sector.

However, another project aspect which requires considerable attention is close coordination and liaison with the six other participating donors in order to ensure timely availability of inputs, to minimize duplication and overlap, and to prevent their working at cross-purposes. While responsibility for such coordination and leadership has been assigned to the Ministry of Health, its ability to follow through at the moment is severely limited. Therefore, for the short-run at least, responsibility for coordination will devolve upon the donors themselves. In carrying out this task the Mission feels the lead should be taken by the UNFPA, but AID must still support that organization's efforts and maintain close contacts with the other donors.

As the Family Planning project becomes active, two of the Population Dynamics sub-activities are to be absorbed within it, leaving only the Poplabs portion of this project to continue under this heading. New bilateral assistance efforts will be kept to a minimum and selected for their direct support to the Government family planning program and for their contribution to achieving the objectives of the AID Family Planning Project. Two proposals which the Mission is now considering and which meet these criteria are assistance to the Ministry of Health to improve its administrative and management capabilities, and to the University of Nairobi to establish the Population Studies and Research Center. The former is considered particularly crucial in light of the severity of the management constraint facing the MOH family planning and rural health programs.

One further area where the Mission may wish to become involved at some future time is commercial distribution of contraceptives. Whether AID assistance should more appropriately be provided directly through a bilateral project or indirectly through an AID/W grant to an intermediate institution is presently a moot point which shall have to be considered before any agreement to assist is reached. While the Ministry of Health has experimented with a pilot commercial distribution program for condoms and the Ministry has expressed some interest in an expanded effort, the policy decision to go ahead has not been made nor, to the Mission's knowledge, has the idea been widely discussed within Government.

Of the AID/W centrally funded activities the Mission believes the following are high priority 1/ and deserving of continued support because of their relevance for, and contribution to, the Central Government family planning program:

- African Data for Decision Making (Dualabs)
- Remote Sensing Census Project
- Downstate Medical Center training activities for Nurse Supervisor/Trainers in family planning 2/
- University of North Carolina assistance to health training institutions to develop family planning curricula and improve teaching methods 2/
- Chogoria Hospital (FPIA)

1/ Projects are not listed in order of priority although together they fall into that category.

2/ Exact project titles not known.

A sixth such high priority activity was the Legal Aspects of Population Studies Project which has recently been completed.

The remaining AID/W projects are in a lower priority category. Most of these are useful and have merit in themselves and, therefore, should continue to presently scheduled termination dates unless further review and/or evaluation indicate otherwise or unless future developments in Kenya's family planning program warrant their earlier termination or their continuation. (An example of the latter case might be the University Overseas Population Intern Program under which only one intern may still be in Kenya. This activity might really make a significant contribution after the NFWC Evaluation and Research Division begins operating or when the Population Studies and Research Center is established.

The centrally funded project which should be terminated immediately is the Association for Voluntary Sterilization, Inc., grant from AID/W financing) to a staff member of the University Medical School to enable him to learn techniques and to perform male and female sterilizations as voluntarily requested by the patients. Sterilization is legal and allowable under Kenyan law. The basis for this recommendation is the two-year hiatus caused by the grantee's accepting a Population Council fellowship in the U.S. (which may have been made possible through another AID/W grant!).

For the short-term, i.e. until the Mission's new and proposed bilateral activities are underway and running smoothly, the Mission proposes a moratorium be placed on any new starts of AID/W centrally funded activities either proposed at AID/W's initiative or the initiative of AID/W grantees and U.S. intermediate institutions. This proposal is made to enable the Mission to direct its staff resources to the high priority activities identified above and to on-going efforts.

Over the longer term the Mission proposes to utilize AID/W funded projects as needs arise and as these are appropriate to the objectives of AID's population/health assistance to Kenya. In order to foster improved coordination of all donor activities in this sector, to avoid overburdening limited GOK staff capabilities, and to support MOH leadership of Kenya's family planning program, the Mission believes that such new activities should be the subject of an official request transmitted to AID by the GOK implementing agency, i.e., the Ministry of Health, the University, etc., through the External Aid Division, Ministry of Finance and Planning. (This is the standard procedure for transmitting all assistance requests which has been agreed upon with the GOK.)

In Part IV of the DAP the Mission has made recommendations regarding staffing which, along with certain proposals above, should relieve somewhat the workload of the Mission Population Officer. Additionally, the USAID has just completed a revision of Mission guidance on responsibilities of Project Managers. As part of the effort to improve management, project support officers are identified from Program Office staff to work with and backstop individual Project Managers. The IDI scheduled to arrive at the end of CY 1974 has been assigned this responsibility for population activities.

As can be seen from the above, there are certain central themes running through the Mission's strategy for this sector, many of which are common to its activities, both bilateral and centrally funded.

- Close coordination with the GOK and other Kenyan entities active in this field.
- Close coordination with other involved donors.
- Improved management.
- A focus on the Government program so that AID can provide maximum support to achievement of its objectives.
- Better integration of Mission and AID/W activities of they can be mutually reinforcing.

With this reorientation the AID/Kenya program in population/health should be providing assistance in the specific fields of training for Kenyan staff, management, information-education, demography, and supportive research. While this may appear to be an extensive range, it should be pointed out that all but demography are directly included within the MOH-NFWC five-year program. The Mission does not propose to broaden that range by involvement in activities in biological/chemical research, genetics, contraceptive manufacture, construction of facilities, or advanced techniques of fertility regulation.

Continuing Bilateral Projects

1. Population Dynamics - Health Education

This sub-activity of the Population Dynamics Project has provided two U.S. direct-hire and PASA (HEW) advisory staff, training for Kenyan staff, and equipment to the MOH Health Education Unit to enable the Unit to design and produce family planning educational materials. The U.S. personnel have also participated in the planning and conducting of training programs in family planning and health education for students

at the Medical Training Center and for similar seminars and short courses held throughout Kenya. A five-year plan for developing the HEU during 1972-1978 was prepared but never implemented due to budget limitations and lack of follow-through by the Ministry. Many of the provision of this plan were incorporated in the recommendations made re the HEU in the five-year family planning program, and continued support the HEU will be provided for about another 18 months under the new Family Planning Project to begin in FY 1975. When that project is initiated, this Population Dynamics sub-activity will be terminated, and personnel and other assistance transferred to the new project.

2. Population Dynamics - Poplabs

In the third year of an estimated five-year project life, this activity is to assist in establishment of a Demographic Studies Unit in the Central Bureau of Statistics, Ministry of Finance and Planning. The Unit will give Kenya the capability to measure vital statistics on a continuing basis and to monitor population growth and its rate of change. In connection with this objective, AID assistance will help determine the most cost-effective method for collecting data on births and deaths in Kenya and will begin a program of demographic analysis using existing data plus that collected by project activities. The sub-project is implemented through a contract with the University of North Carolina which has provided a U.S. statistician/demographer for the Unit, training for Kenyan staff, some commodities, and local costs in support of the Unit's operations.

3. Population Dynamics - Vihiga Family Planning

Begun in FY 1973 and originally scheduled to end June 30, 1974, the Vihiga Family Planning sub-project was to conduct an experimental program to test methods of delivering family planning services in rural areas. The program was considered one of several efforts under way as part of the Special Rural Development Project supported by the Mission in the Vihiga/Hamisi Division (see DAP Section II.B.). The project was conceived in the field with minimal participation or understanding of central MOH staff and, consequently, has never received effective direction, staff or other inputs from the Ministry. AID support consisted of contraceptives and financing for local costs of this GOK-implemented project. The activity is now being reassessed by the Ministry of Health which may recommend reformulation and continuation so that the research objectives can be realized and utilized by the national five-year program. If this should occur, this sub-activity, too, shall be transferred to the new project.

New Bilateral Projects

1. Family Planning

Submitted to AID/W last April and still awaiting approval at the time of this writing, this project will assist the Government to carry out its Five-Year Family Planning Program. As described in the PROP, the project's objectives and output targets are essentially those of the GOK program summarized earlier in this section and set forth in more detail in the Sector Assessment.

AID personnel inputs will include: two personnel for the HEU (previously provided under the Population Dynamics project); short-term advisors as needed by the HEU or NFWC, and short-term advisors to assist in training Kenyan trainers of nurses and field workers and teaching staff of the HEU. Over 20 percent of the total AID project cost will go for participant training for about 106 Kenyan family planning staff, including Provincial and District Medical Officers, Provincial (Nurse) Matrons, Nurse Supervisor/Trainers, Family Planning Field Officers, NFWC staff, HEU staff, and Nurse Tutors.

The largest portion of AID financing will be for MOH and NFWC recurrent costs of operating the five-year program. Such support will reimburse the GOK for actual expenditures and will be provided on a declining basis over time as the Government picks up an increasing share of such costs. Finally AID shall finance equipment for the HEU, the NFWC, clinical equipment for the fixed and mobile family planning service points, and colored condoms to supplement contraceptives provided by the other donors. Total cost of all inputs was projected in the PROP at \$3.5 million during FY 1975 - 1979.

The Mission believes that provision of assistance under this project must be tied to Government performance in implementing the five-year program. Thus, the actual total AID funding provided may fall short of the estimated total in light of recent developments regarding authorization of MOH and NFWC staff, etc. Should circumstances warrant, however, the Mission would also recommend -- for certain project components -- increased funding for training, assuming qualified NFWC and MOH staff are available, and for additional assistance to the HEU.

2. Health Management

Purpose of this project would be to improve the managerial and administrative capability of the Ministry of Health so as to

facilitate implementation of the family planning and rural health programs. Given the interrelationships of these two programs, it would not be possible or practicable to attempt to focus only on improving the management of one of them. Because of the "health" component of the project, the Mission assumes that AFR health funds will be needed rather than earmarked population monies.

Subject to initial survey in FY 1975 to assess the problems in more detail and to design the project, the Mission now believes the activity might involve 1) provision of long and short-term training for MOH staff in health-related administration-management subjects, 2) provision of short-term personnel to do special studies of particular management problems as requested by the MOH and then follow up visits by these specialists as needed to assist the MOH in implementation of improved procedures, and 3) assistance to enable local institutions, such as the Kenya Institute of Administration, to provide training and/or consultancy services in this field to the MOH and NFWC. This latter component may be provided by a grant to KIA to develop such a capacity or by financing for an MOH contract with KIA for these services.

The project should begin FY 1976 and run for about three years, at the end of which there should be a major evaluation to assess project results and impact and to determine whether results justify conclusion as scheduled or continued assistance, either as set forth in the original project design or in some revised form.

3. Population Studies and Research Center

This project was originally developed by the Population Council; however, certain problems with their proposal and the belief this project ought to be more directly controlled by the Mission given the project's close relationship to the national program resulted in a Mission decision to provide assistance directly. As indicated in the Sector Assessment, the Center, a part of the University of Nairobi, will conduct and supervise on behalf of the NFWC in-depth population research having a broader scope and implications than the service-centered studies of NFWC and the vital statistics and census work of the CBS and Office of the Registrar General. The Center will also train researchers in demography and population at the post-graduate level and, thus, provide high-level manpower for an expanded national population program.

As presently conceived, the Center will bring together faculty in sociology, geography, economics, anthropology, demography, and medicine to conduct research into population-related subjects within those disciplines. It will also promote interdisciplinary and inter-faculty cooperation among the University Faculties of Arts, Medicine, Agriculture, Veterinary Medicine, Design and Development, and the Institute of Development Studies.

AID assistance would include financing for research and fellowships and, possibly, some advisory assistance in setting up the Center and in developing a link with a "sister" U.S. university. No capital construction would be financed.

Centrally Funded Activities

1. African Data for Decision Making

Under a contract with Dualabs initiated in FY 1974 two advisors are provided to the CBS to install improved computer program packages for use by the CBS in analyzing demographic data and making the results available for use by Government decision makers.

2. Remote Sensing Census Project

Also initiated in FY 1974 under a PASA with the U.S. Bureau of the Census, this project will demonstrate the utility of satellite imagery for developing census estimates and monitoring changes in population distribution throughout Kenya. This latter effort may have particular relevance for some of the environmentally and drought-related agriculture activities proposed in Section II.A. U.S. assistance includes periodic, short-term TDY advisors, equipment, and training for four staff of the Kenya Land Survey as well as satellite imagery from the U.S. Earth Resources Technology Satellite (ERTS).

3. Downstate Medical Center - Downstate is providing training in family planning clinic techniques for six Nurse-Midwife Supervisor/Trainers now in the U.S. Upon the completion of their training and return to Kenya they will prepare curricula, organize, and conduct training courses for EN's, CN's and other Nurse Supervisor/Trainer's to pass on the techniques learned in the U.S. TDY assistance will be provided by Downstate staff to assist with this second phase of the activity.

4. University of North Carolina

This project assists Kenyan health training institutions to develop family planning curricula and to improve teaching methods. Four TDY advisors have been in Nairobi during the last month in connection with the project. UNC has also reportedly provided training for some U.S. advanced degree graduates in population by financing their research in Kenya or their attachment to local FP agencies.

5. Chogoria Hospital

Family Planning International Assistance (FPIA) is providing financial assistance to Chogoria Hospital to enable this church-operated institution to incorporate family planning services and education into

its health program and those of its 11 satellite rural FP/MCH clinics. This hospital is the only such facility in the area and in addition to health care provides training for paramedical staff. These activities are now being initiated with staff being trained and accreditation being obtained from the MOH.

6. Legal Aspects of Population Studies in Kenya

A member of the University's Law Faculty completed in August compilation of a compendium of Kenya law as it relates to fertility and behavior. His report is now being distributed by the University and should provide various ministries and Parliament with important information on the incentives and disincentives provided by Kenya law to adoption of family planning. The study was financed by an AID/W grant to the Smithsonian Institution.

7. Family Life Education

FPIA also provides financing to the National Christian Council of Kenya to enable it to carry out family planning education for young church members and teachers. NCKK is also developing "sex education" or "family life" curricula for use in secondary schools. This project will be evaluated in October 1974 at the Mission's request. Assuming no major, unresolvable problems are identified, the Mission believes the project should continue to its scheduled completion date.

8. Population Seminars for Youth

The World Assembly of Youth in a program similar to that of the NCKK conducts seminars, essay contests, conferences, etc., to inform and educate young people about the importance of family planning. Kenya is only one of several countries participating in this program. Coordination with NCKK is achieved through joint meetings and sharing of schedules.

9. Female and Male Sterilization

Funded through the Association for Voluntary Sterilization, Inc., this one-year project was to develop female sterilization procedures on an out-patient basis and to determine if male sterilization has any popular appeal in Kenya. The activity was to have been implemented by a Kenyan member of the University Faculty of Medicine based at Kenyatta Hospital; however, before implementation could begin, he accepted a Population Council fellowship for two years of study in the U.S.

10. Population Services International

Terminated in July at the Mission's insistence, this two-year project implemented through a contract with PSI was a social marketing experiment to test the feasibility of operating a commercial distribution program for condoms using existing local commercial outlets. While the project appeared to have had some encouraging results re the feasibility of such a commercial distribution effort, the contractor gave principal attention to the commercial sales program and did not follow through on the research aspects of the project. PSI also did not pay enough attention to explaining the program to local leaders in the test area and developing a base of local understanding and support. The Mission understands PSI has received MOH sanction to continue operating its commercial program in Kenya although USAID does not know what are its current sources of financial backing.

Two other AID/W-funded activities have operated in Kenya in the past. A Post-Partum IUD Experiment, financed by a grant from the Pathfinder Fund, was to develop information on acceptance of IUD's by mothers immediately following delivery at a local hospital. The second was the Advanced Techniques for Fertility Management Project which provided one-month's training at Johns Hopkins University for two Kenyan doctors in advanced methods of regulating fertility, including sterilization and abortion. With the recent AID Policy Determination on abortion, the Mission assumes this project has been discontinued.