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PROJECT PAPER
KENYA FAMILY PLANNING II
PROJECT 615-0193

AUTHORIZED: AUGUST 13, 1982

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/KENYA

FROM: Satish P. Shah, Chief, Projects Division *SPS*

SUBJ: Kenya Family Planning II
Project 615-0193

Date: 10 August 1982

PROBLEM:

Your approval to authorize a grant of \$4,000,000 from Section 104 of the Foreign Assistance Act 1961, as amended, (Population and Health) to the Government of Kenya for the Family Planning II (Project 615-0193); and for a source/origin procurement waiver for two vehicles.

AUTHORITY:

Pursuant to Delegation of Authority No. 140, effective June 9, 1982, you have the authority to authorize any project that does not exceed \$20,000,000, does not present significant policy issues, does not require issuance of waivers that may only be approved by the Assistant Administrator for Africa or the Administrator, and does not have a life project in excess of ten years. The Project falls within these limitations.

A. Project Description

Kenya's population growth rate of 4% is recorded as the highest in the world. It has been gradually increasing over the past several decades, with serious negative implications for the success of Kenya's broad-based plans for national socio-economic development. Studies and experience have shown that traditional patterns of child spacing among Kenyan families are disappearing in the face of rapid socio-economic change, and that modern family planning methods are being increasingly utilized as a means to achieve such spacing. The lack of availability of efficiently delivered modern family planning services, however, is seen as an important constraint to increasing widespread adoption of

effective methods of spacing. Another constraint is the lack of community support for and appropriate knowledge of family planning. Such support is considered essential to promote decisions to limit family size, as well as to space births, and so realize development benefits which elude families with very high family size ideals.

The goal of this project is to reduce the rate of population growth in Kenya. The purpose of the project is to build an institutional capability at the national level to address the two basic constraints to effective child spacing and family size limitation. The first constraint is lack of widespread availability of efficiently delivered modern family planning methods. The second constraint is very high family size preferences which are supported by the socio-cultural context in which most families live. Until present socio-cultural conditions and attitudes change, it is unlikely that significant numbers of families who could benefit will take the initiative to plan and limit their family size.

The proposed project is part of an Integrated Rural Health and Family Planning Project. This Government of Kenya initiated activity is supported by seven donors, with overall coordination provided by the World Bank. It follows a five-year Maternal Child Health/Family Planning Project (1974-1979), but has a broader, interministerial, multi-sectoral scope. Scheduled for startup in July 1982, it has a duration of three years, with funding of \$61 million provided through June 1985. A second phase (separate project) would follow from July 1985 to June 1988 based on an appraisal scheduled for 1984. AID's participation in the first three year activity will be concentrated on reducing Kenya's birth rate through: (1) generating a demand for family planning services and preference for smaller family size and (2) providing more effectively delivered family planning services.

The IRH/FP project is organized in two parts. Part A addresses the problem of creation of demand for family planning through establishment of an interministerial National Council on Population and Development (Council) to be supported by the World Bank, UNFPA, UK, the Government of Kenya and AID. AID will provide support to the establishment of the Council and a Secretariat to implement the directives of the Council. It will also support specific discrete subproject demand-creation activities initiated by Kenya private and public organizations and approved by the Council.

The second part, Part B, will provide support to the Ministry of Health in expanding the availability and improving the quality of rural health and family planning services.

Activities will include construction of rural health facilities, training, provision of commodities, transport and health education. Donors assisting are the World Bank, SIDA, Danida, UK, UNICEF and AID. AID is participating selectively in Part B and will finance family planning training which will directly support attainment of the Family Planning II Project objectives.

B. Financial Summary

The Family Planning II Project represents AID's contribution to the multidonor Government of Kenya Integrated Rural Health and Family Planning Project which will have a total estimated cost of \$61,300,000. AID's contribution to the IRH/FP project is \$4,000,000: \$3,000,000 for Part A activities and \$1,000,000 for Part B activities. Support for Part A is aimed at developing the institutional capability of the National Council on Population and Development. AID will finance the first two year's operating costs of the Council, and three years' costs of nine family planning information and education subprojects to be implemented by private and government organizations.

Under Part B, AID will contribute to the subproject activity which deals with the family planning service delivery training of the Ministry of Health's 900 Enrolled Community Nurses and 270 Clinical Officers.

The Government of Kenya contribution to the activities supported by AID include \$1,059,000 for Part A and \$295,000 (for family planning training activities) in Part B.

C. Social, Technical and Economic Considerations

The analyses presented in the Project Paper show the project to be socially, technically and economically feasible. The paper draws on extensive analysis of previous related activities in Kenya, and elsewhere in the world (including explicit use of lessons learned in the development of the successful approach to family planning in Indonesia). The IRH/FP Project follows the earlier multidonor Government of Kenya-supported Maternal Child Health/Family Planning Project 1974-1979, and specifically takes into account the lessons learned from that effort. The recognition of the need for a two part approach that provides for a nationwide effort to promote demand for services through subprojects implemented by Kenya institutions should result in socially and technically sound promotion of family planning ideas and practices.

Provision of the supply of family planning services through a national integrated rural health and family planning service delivery approach will result in similarly socially sound and technically efficient means for AID to support an increase in effective use of family planning methods. The economic analysis finds the funding of subprojects (to be implemented by local agencies) and family planning training, (to be utilized by the current cadre of MOH Clinical Officers and Enrolled Community Nurses) to be highly cost effective.

The AID grant will not include any activities which will directly affect the environment; thus environmental concerns are not an issue.

The human rights situation in Kenya has not changed since FY 1981, and no further review by the Department of State's Bureau of Human Rights and Humanitarian Affairs is required.

D. Conditions and Covenants

One initial condition precedent and two additional conditions precedent to disbursement have been identified as noted in the Project Authorization.

No specific problems are anticipated in negotiating the Project Grant Agreement. The Government of Kenya has worked closely with the donors involved in the multidonor effort of which Family Planning II is a part, and the donors themselves have demonstrated strong commitment to a well-integrated project design, implementation and evaluation effort. The Government has reviewed and approved the modifications in the Integrated Rural Health and Family Planning project which have emerged following the joint multidonor appraisal mission, and it is anticipated that AID and the GOK will be able to sign the Project Agreement shortly after the date of authorization.

E. Waiver Requested

Authorization is requested for a source/origin procurement waiver from Geographic Code 000 to Geographic Code 935 for two minibuses with an approximate value of \$24,500. A detailed justification for this waiver is provided in Annex I of the Project Paper, (also included in Tab C).

F. Committee Action and Congressional Notification

A Project Review was held on June 3, 1982. The project was recommended for authorization with certain modifications. The proposed modifications have been made.

The CN expired on August 9.

G. Implementation

USAID/Kenya's Division of Health Nutrition and Population will have responsibility for project monitoring under the direction of the USAID Director and with the assistance of the Projects Division and REDSO/EA.

There will be separate arrangements for the implementation of Parts A and B of the IRH/FP Program. For Part A, the actual information and education activities will be carried out by the participating agencies, both governmental and non-governmental. Coordination and monitoring, common support activities, the preparation of overall annual work plans, procurement of goods for NGOs, progress reports, reimbursement applications and the transfer of funds will be carried out by the National Council's Secretariat. The Secretariat's chief executive, the Director, will be appointed as Project Director, Part A, and will report to the Permanent Secretary in the Office of the Vice President and Ministry of Home Affairs. Each of the participating government agencies will be responsible for the procurement of its own goods and services.

Part B of the IRH/FP Program will be carried out by the MOH, with the NGO component carried out jointly by the MOH and NGOs. Although the MOH project components will be carried out by existing MOH units, a strong IRH/FP Core Project Unit has been established for (1) the monitoring and supervising of Part B activities; (2) keeping Part B project accounts; (3) preparing Part B disbursement and reimbursement applications; and (4) preparing Part B progress reports for donors. The Director of the IRH/FP Core Project Unit will also be the Project Director, Part B, and will report to the Director of Medical Services. An MOH Steering Committee will oversee the implementation of Part B components and to solve any problems of intra-ministerial coordination that may arise in the course of project implementation.

The training Division of the National Family Welfare Center will have the primary responsibility for the implementation of the in-service family planning training for Enrolled Community Nurses and Clinical Officers. The NFWC will be assisted by the Chief Nursing Officer's staff, the IRH/FP Core Project Unit and staff at Enrolled Community Nursing Schools located at Meru, Thika, Kisumu, Mombasa, and Nyeri. The ECN training will require 8 weeks of theoretical and practical instruction, while the CO training will require one week of theoretical training. The practical training will take place in MCH/FP clinics within hospitals and health centers located in the vicinity of the 5 ECN schools.

The implementation plan has been reviewed by the Project Committee and is believed to be realistic and should be accomplished within the three year time frame of the project.

The project demonstrates satisfactorily that the requirements of Section 611 (a) of the Foreign Assistance Act have been met; project funding is based on reasonable cost estimates, derived from sound financial and technical analyses, and is adequate to achieve planned outputs.

The USAID/Kenya Project Officer is Spence Silberstein.

RECOMMENDATIONS:

That you sign the attached Project Authorization, and thereby approve:

a) the proposed project at a life of project level of \$4,000,000; and

b) the source/origin waiver requested in Annex I of the Project Paper (also included in Tab C) for project vehicles.

Director's Decision: _____

Approved: Allison B Hemick

Disapproved: _____

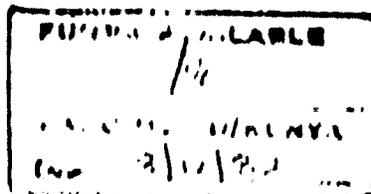
Date: 13 Aug 1982

Attachments:

- Tab A - Project Authorization
- Tab B - Project Paper
- Tab C - Source/origin waiver for vehicles

Drafted: NGreeley/SPShah:pao

Clearances: HNP:SS Silberstein Sm
 HNP:RB Bratanak RB
 PROG:WLeifen W
 RLA:GHannon GH
 RSA:ALaemmer AL
 EXO:JGreenough JG
 RPMC:RHorn RH



Approved: _____
 Date: _____

PROJECT AUTHORIZATION

Name of Country: Kenya
Name of Project: Family Planning II
Number of Project: 615-0193

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning Project Phase II (the "Project") for the Government of Kenya (the "Grantee") involving planned obligations of not to exceed \$4,000,000 in Grant Funds in a one year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project.

2. The Project will assist the Grantee to establish an institutional capability at the national level to implement effective birth spacing and limitation of family size in Kenya by financing the costs of technical assistance; training and observation tours; and commodities and other support costs.

3. The Project Grant Agreement which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Source and Origin of Goods and Services.

Goods and services, except for ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the Republic of Kenya and the United States, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent

The Grant Agreement shall contain conditions precedent to disbursement in substance as follows:

(1) Prior to any disbursement, or the issuance of any commitment documents under the Grant Agreement, the Grantee shall furnish in form and substance satisfactory to A.I.D. statement of the name of the person holding or acting in the office of the Government of the Grantee as specified in the Representatives Section of the Grant Agreement, and of any additional representatives, together with a specimen signature of each person specified in such statement.

(2) Prior to any additional disbursements or the issuance of any additional commitment documents under the Grant Agreement to finance costs:

(i) relating to an interagency program for Information and Education on Population and Development (Part A of the Project), the Grantee shall, except as A.I.D. may otherwise agree in writing, submit to A.I.D., evidence that the Office of the Vice -President and Ministry of Home Affairs has filled the position of Director, Deputy Director and all five professional positions in the Secretariat of the National Council on Population and Development with full-time, experienced and qualified staff; and

(ii) relating to a program of Rural Health and Family Planning services (Part B of the Project), the Grantee shall, except as A.I.D. may otherwise agree in writing, submit to A.I.D. in form and substance satisfactory to A.I.D., evidence that the Ministry of Health has established a Core Project Unit and has filled all key positions with full-time, experienced and qualified staff.

c. Covenants.

The Grant Agreement shall set forth an understanding providing in substance as follows, except as A.I.D. may otherwise agree in writing:

(1) The Secretariat of the National Council of Population and Development shall submit for A.I.D. approval an annual work plan and budget at least 30

days prior to commitment of any expenditures for that year.

(2) The Ministry of Health shall keep all key positions in the National Family Welfare Center filled with full-time staff whose qualifications and experience shall be acceptable to A.I.D.

(3) The Ministry of Health shall submit for A.I.D. approval by September 30, 1982, time-phased plans for in-service family planning training of 900 Enrolled Community Nurses and 270 Clinical Officers who will be assigned to Rural Health Facilities of the Ministry of Health. The plans should include but not be limited to, dates and locations of training, numbers of trainees and trainers, anticipated onward assignment of each trainee and estimated costs.

(4) The Ministry of Health shall submit for A.I.D. approval by December 31, 1982, a detailed time-table for conversion of all Government Rural Health Facilities not functioning as full-time Maternal and Child Health/Family Planning Service Delivery Points (SDPs) into full-time SDPs, and for their conversion into limited SDPs supplying non-pharmaceutical contraceptives and resupplying oral contraceptives.

d. Waiver.

Notwithstanding paragraph (a) above, and based upon the justification contained in Annex I of the Project Paper, I hereby approve a source/origin waiver from A.I.D. Geographic Code 000 (United States) to Code 935 (Special Free World) to permit procurement of two minibuses with a total approximate cost of \$24,500; find that special circumstances exist to waive the requirements of Section 636(i) of the Foreign Assistance Act of 1961, as amended; and certify that the exclusion of procurement from Free World countries other than the cooperating country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

Date: 13 August 1982

Allison B. Herrick
Allison B. Herrick
Director, USAID/Kenya

Clearances: HNP:SSilberstein *ms*
HNP:RBritanak *ms*
PROG:WLefer *ms*
RLA:GBisson (draft)
RSA:ALaemmerzahn *ms*
EXO:JGreenough *ms*
RFMC:RHenrich *ms*

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET	1. TRANSACTION CODE <input checked="" type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____ DOCUMENT CODE 3
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2. COUNTRY/ENTITY KENYA	3. PROJECT NUMBER 615-0193
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4. BUREAU/OFFICE AFR 06	5. PROJECT TITLE (maximum 40 characters) FAMILY PLANNING II
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6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 07 31 81	7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY <u>82</u> B. Quarter <u>4</u> C. Final FY <u>82</u>
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8. COSTS (\$000 OR EQUIVALENT \$) =						
A. FUNDING SOURCE	FIRST FY <u>82</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	0	4000	4000	0	4000	4000
(Grant)	(0)	(4000)	(4000)	(0)	(4000)	(4000)
(Loan)	(0)	(0)	(0)	(0)	(-)	(-)
Other U.S. 1.						
Other U.S. 2.						
Host Country	0	1354	1354	0	1354	1354
Other Donor(s)						
TOTALS	0	5354	5354	0	5354	5354

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PH	400	400	0	0	0	4000	0	4000	0
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 430 440 450 460 420	11. SECONDARY PURPOSE CODE 440
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12. SPECIAL CONCERN CODES (maximum 2 codes of 4 positions each) A. Code DEL PVON TNG B. Amount 120 180 100	
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13. PROJECT PURPOSE (maximum 450 characters)

To establish an institutional capacity within the GOK to implement effective birth spacing and limitation of family size in Kenya.

14. SCHEDULED EVALUATIONS MM YY MM YY MM YY Interim 07 20 81 07 20 81 Final 07 01 82	15. SOURCE/ORIGIN OF GOODS AND SERVICES <input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify) _____
---	---

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (Page 1 of 6 page 17 Amendments)

17. APPROVED BY Signature: <i>William R. Kowak</i> Title: DIRECTOR USAID/KENYA	Date Signed: MM DD YY 07 13 82	18. DATE DOCUMENT RECEIVED IN AID/AC, OR FOR AID/AC DOCUMENTS, DATE OF DISTRIBUTION MM DD YY _____
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FAMILY PLANNING II

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 - 2. Profiles of Participating Agencies**
- H. AID Project Statutory Checklist**
- I. Waiver**
- J. World Bank - Kenya Staff Appraisal of an Integrated Rural Health and Family Planning Project Report No. 3409-KE, April 14, 1982.**

(iii)

Project Design Team:

Ned Greeley, USAID/Kenya	-	Project Design Officer and Social Analyst
Richard Greene, USAID/Kenya	-	Program Economist
Satish Shah, USAID/Kenya	-	Financial Analyst
Spencer Silberstein, USAID/Kenya	-	Population Officer and Member of World Bank Integrated Rural Health and Family Planning Joint Appraisal Team
Gary Bisson, REDSO/EA	-	Legal Advisor/REDSO

Project Review Committee:

Charles Costello	-	Chairman and Acting Director, USAID/Kenya
William Letea	-	Program Officer
John W. Stattery	-	Chief, Health, Nutrition Population Division
John Greenough	-	Executive Officer
Thomas Bebout	-	Deputy Director, Regional Financial Management Center
Arthur Laemmerzahl	-	Supply Advisor, Regional Development Services Organization

ABBREVIATIONS:

CBS	-	Central Bureau of Statistics
CO	-	Clinical Officer
CDSS	-	Country Development Strategy Statement
DANIDA	-	Danish Agency for International Development
ECN	-	Enrolled Community Nurse
FHFE	-	Family Health Field Educator
FP	-	Family Planning
FPAK	-	Family Planning Association of Kenya
GOK	-	Government of Kenya
HIS	-	Health Information Service
I&E	-	Information and Education (Family Planning)
INTRAH	-	International Training in Health Program University of North Carolina
IRH/FP	-	Integrated Rural Health and Family Planning Project
IUD	-	Intrauterine Device
KFS	-	Kenya Fertility Survey
MCH/FP	-	Maternal Child Health/Family Planning
MOA	-	Ministry of Constitutional Affairs
MOCHA	-	Ministry of Constitutional and Home Affairs (now changed to MOCA and MOHA)
MOF	-	Ministry of Finance
MOH	-	Ministry of Health
MOHA	-	Ministry of Home Affairs
NFWC	-	National Family Welfare Center
NGO	-	Non-Governmental Organization
NORAD	-	Norwegian Agency for International Development
OC	-	Oral Contraceptive
PSRI	-	Population Studies and Research Institute
PVO	-	Private and Voluntary Organization
RHF	-	Rural Health Facility
SDP	-	Service Delivery Point
SIDA	-	Swedish International Development Authority
TBA	-	Traditional Birth Attendant
UK	-	United Kingdom
UNICEF	-	United Nations Children's Fund
UNFPA	-	United Nations Fund for Population Activities

I. SUMMARY AND RECOMMENDATIONS

A. Project Description

Kenya's population growth rate of 4% is recorded as the highest in the world. It has been gradually increasing over the past several decades, with serious negative implications for the success of Kenya's broad-based plans for national socio-economic development. Studies and experience have shown that traditional patterns of child spacing among Kenyan families are disappearing in the face of rapid socio-economic change, and that modern family planning methods are being increasingly utilized as a means to achieve such spacing. The lack of availability of efficiently delivered modern family planning services, however, is seen as an important constraint to increasing widespread adoption of effective methods of spacing. Another constraint is the lack of community support for and appropriate knowledge of family planning. Such support is considered essential to promote decisions to limit family size, as well as to space births, and so realize development benefits which elude families with very high family size ideals.

The goal of this project is to reduce the rate of population growth in Kenya. The purpose of the project is to build an institutional capability at the national level to address the two basic constraints to effective child spacing and family size limitation. The first constraint is lack of widespread availability of efficiently delivered modern family planning methods. The second constraint is very high family size preferences which are supported by the socio-cultural context in which most families live. Until present socio-cultural conditions and attitudes change, it is unlikely that significant numbers of families who could benefit will take the initiative to plan and limit their family size.

The proposed project is part of an Integrated Rural Health and Family Planning Project.¹ This Government of Kenya initiated activity is supported by seven donors, with overall coordination provided by the World Bank. It follows a five-year Maternal Child Health/Family Planning Project (1974-1979), but has a broader, interministerial, multi-sectoral scope. Scheduled for startup in July 1982, it has a duration of three years, with funding of \$61 million provided through June 1985. A second phase (separate project) would follow from July 1985 to June 1988 based on an appraisal scheduled for 1984. AID's participation in the first three year activity will be concentrated on reducing Kenya's birth rate through: (1) generating a demand for

1. See Annex J for the World Bank document, "Kenya: Staff Appraisal of a Rural Health and Family Planning Project".

family planning services and preference for smaller family size, and (2) providing more effectively delivered family planning services.¹

The IRH/FP Project is organized in two parts. Part A addresses the problem of creation of demand for family planning through establishment of an interministerial National Council on Population and Development (Council) to be supported by the World Bank, UNFPA, UK, the Government of Kenya, and USAID. USAID will provide \$3 million to support establishment of the Council and a Secretariat to implement the directives of the Council. It will also support specific discrete subproject demand-creation activities initiated by Kenyan private and public organizations and approved by the Council.

The second part, Part B, will provide support to the Ministry of Health in expanding the availability and improving the quality of rural health and family planning services. Activities will include construction of rural health facilities, training, provision of commodities, transport and health education. Donors assisting are the World Bank, SIDA, Danida, UK, UNICEF, and USAID. USAID will provide \$1 million to support family planning training for Enrolled Community Nurses and Clinical Officers. USAID, therefore is participating selectively in the IRH/FP project by providing support to activities which directly affect achievement of the project goal and purpose.

B. Summary Findings

The analyses completed as part of the Project Paper effort have concluded that the proposed design is technically, socio-culturally, economically, financially, and environmentally sound. Plans for completion of administrative organization, for project implementation, for monitoring and evaluation are feasible. The role of the USAID project vis-a-vis other donors and the GOK is clearly documented. The relationship of each to the other during the implementation phase including the obligations of each are charted in detail in this paper. USAID's involvement includes responsibility for project appraisal for a possible follow on activity in 1985; however, any subsequent commitment will be contingent upon progress achieved during this phase.

-
1. In this paper, "IRH/FP Program" refers to the proposed two phased six year effort, "IRH/FP Project" to the multidonor GOK supported three year activity, and "project" refers to AID's activities within the IRH/FP Project and titled as Family Planning II.

C. Recommendations

1. It is recommended that a grant of \$4.0 million be made to the Government of Kenya for the three year project to achieve the purposes described in this paper.

2. A source/origin waiver from AID Geographic Code 000 (United States) to code 935 (Special Free World) for two vehicles (approximate value \$24,500) is recommended. See Annex I.

II. BACKGROUND

A. The Problem

Kenya's current population, estimated to be 17.5 million, is growing at an annual rate of 4 percent. This rate of population growth will double Kenya's population in 18 years, and if current levels of fertility remain constant and mortality continues to decline along its recent trend, there will be 38.6 million Kenyans by the year 2000. Kenya's population growth rate is influenced by increasing fertility as well as declining mortality. The total fertility rate, an estimate of the average number of children born to women during their reproductive years, has increased from 6.8 in 1962 to 7.6 in 1969 and to 8.1 in 1977. There were substantial declines in mortality, particularly infant and childhood mortality, during the same period. Infant mortality has declined from 119 in 1969 to 87 in 1977, although there are great variations within the different regions of Kenya. These data suggest that Kenyan women will average 8.1 live births during their reproductive years and that 9 percent of the children will die before their first birthday.

Although Kenyan child survivorship is high for sub-Saharan Africa, approximately one of every three Kenyans who dies is below the age of five compared to about one in twelve in developed countries. There is clearly room for improvement in infant and child survivorship and likelihood of further declines in mortality levels. Table 1 provides a comparison of recent census data. Figure 1 compares the data graphically, and includes a projection for population growth through the year 2025 which illustrates the alarming dimensions of the population problem in Kenya.

Table 1

<u>Year</u>	<u>Population</u>	<u>Crude Birth Rate</u>	<u>Crude Death Rate</u>	<u>Population Growth Rate</u>
1962	8,636,000	50	20	3.0%
1969	10,943,000	50	17	3.3%
1979	15,291,000	53	14	3.9%

KENYA

Birth Rates, Death Rates, and Rates of Natural Increase, 1950 - 1978

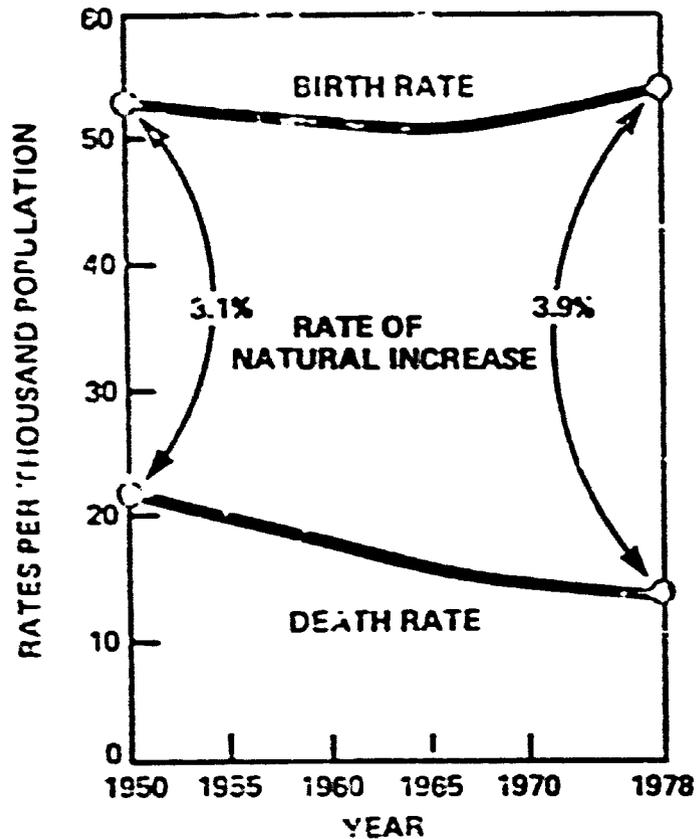
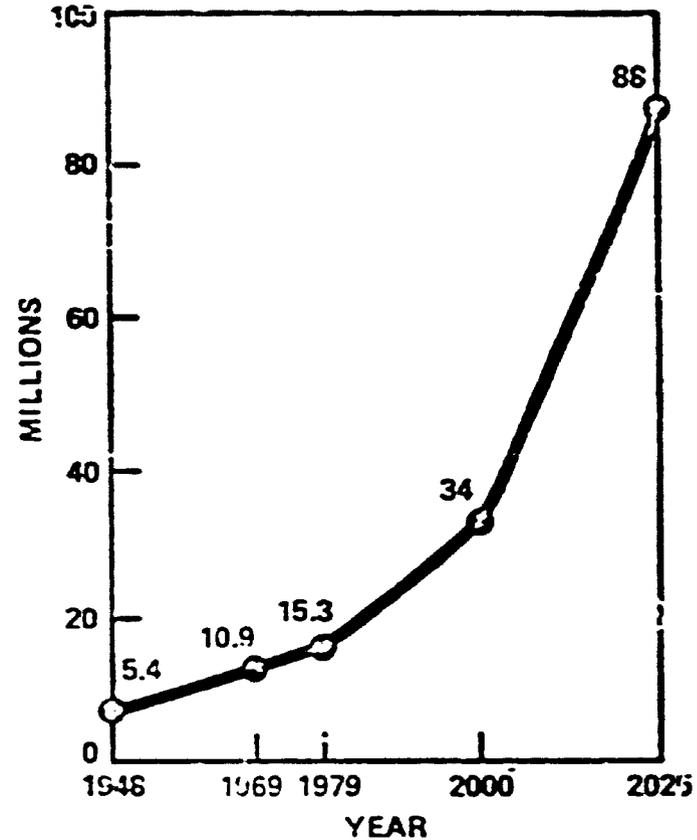


Figure 1

Population Growth, 1948 - 2025

Assuming a Constant Growth Rate



Source: Futures
Group Rapid
Presentation - Kenya

The combination in Kenya of the current high level of fertility with rapidly declining mortality is virtually unprecedented in demographic history. Kenya has the highest recorded population growth rate of any country in the world. Analysis of data from the 1977/78 Kenya Fertility Survey indicates that there is the probability of even higher fertility with continuing declines in such traditional fertility-limiting practices as prolonged lactation and polygamy, unless the practice of family planning increases.

Demographic trends have relevance to both socio-economic development and family welfare. Per capita income is not only affected by population size, but also by its rate of growth and age distribution. A high rate of population growth implies that a higher level of investment is required to achieve a given increase in per capita income. An estimated 49.9 percent of the Kenyan population is under 15 years of age, and a high dependency ratio such as Kenya's implies that there are fewer producers relative to consumers.

The present very rapid population growth retards Kenya's socio-economic development in three main ways:

- 1) by increasing pressure on land and other natural resources, and thus tending to reduce output per capita;
- 2) by increasing unemployment and underemployment, and
- 3) by requiring a greater proportion of public expenditure to be devoted to meeting basic needs.

Kenya's two basic resources are people and land. A sustainable balance between Kenya's population and land resources must be maintained if development objectives are to be realized. Good land is in very short supply. Only 18.6 percent of Kenya's total land area is arable land fit for sustained agricultural production. High and medium potential land per capita in Kenya has declined from .91 hectares in 1969 to .62 hectares in 1979 and is projected to decline to .40 hectares by 1989. Kenya's limited resource base and rapidly growing labor force make the creation of off-farm employment essential. Kenya will be extremely hard pressed, however, to find the resources to create jobs through massive investments in small industries or rural enterprises while at the same time providing social services to a growing, nonproductive dependent population. The rural economy is already constrained by high population densities and fragmentation of arable land. There simply is not enough arable land to employ even a fraction of the additional estimated 9.6 million Kenyans who will enter the labor force between 1978 and 2000.

A further important consequence of rapid population growth is the increased public expenditure required to meet basic needs for education, health, water, and housing. Government has set itself ambitious targets for the extension of basic social services to all Kenyans by the year 2000. These targets are not likely to be met because Government will have to greatly increase public expenditures even to provide social services to the same percentage of Kenyans now receiving them.

B. Previous Interventions

Voluntary associations began to promote family planning in Nairobi and Mombasa as early as the mid-1950's. In 1956 the Government set up a unit for family planning as part of the Maternal and Child Health Program in the Ministry of Health (MOH). Kenya thus became the first country in sub-Saharan Africa to formulate a population policy and to establish a National Family Planning Program.

Early in 1971 Government requested the World Bank's help in preparing a five-year plan to strengthen the MOH's MCH/FP services. Over the next two years Bank Missions helped the Government prepare a plan which became the 1974-79 MCH/FP Program financed by the Government of Kenya, the World Bank, the United Nations, the Governments of Sweden, Denmark, Germany, and the United Kingdom, and USAID.

The main constraints addressed under this program were: (1) a shortage of adequately trained paramedical personnel to deliver MCH/FP services; (2) weak FP information and education activities; and, (3) lack of a MOH unit for planning, monitoring, and evaluating the MCH/FP Program.

USAID/Kenya contributed \$2.3 million to the multi-donor Maternal and Child Health/Family Planning Program through the bilateral Family Planning Project (615-0161). The USAID contribution included: short-term technical assistance; participant training in population/family planning for over 60 Ministry of Health (MOH) employees; audio-visual equipment for the MOH's Health Education Unit (HEU); MCH/FP equipment for MCH/FP Service Delivery Points; office equipment for the National Family Welfare Center (NFWC); and staff support for additional personnel at the NFWC, HEU and MOH rural health facilities.

The goals of the 1974-79 MCH/FP Program were a reduction in the population growth rate from 3.3 percent to 3 percent and an unquantified improvement in the health of mothers and children. Although MCH/FP Program activities did not have their anticipated impact on fertility, the impact on maternal and child health was encouraging. The numbers of visits for antenatal and child welfare

services grew steadily during the MCH/FP Program. A majority of pregnant women (about 65 percent) and a smaller but growing percentage of children are utilizing MCH services. Although it is difficult to prove causality, there were substantial declines in infant mortality during the period of the MCH/FP Program. In contrast, the MCH/FP Program never reached 3 percent of the married women of reproductive age with family planning services, and the program was not successful in reducing the annual rate of population growth from 3.3 percent to 3 percent. Despite the efforts made, the rate climbed to an alarming 3.9 percent by 1979.

The 1974-79 MCH/FP Program was extensively evaluated and a number of lessons were learned that influenced the design of Government's Integrated Rural Health and Family Planning Program, the multi-donor successor to this first MCH/FP Program. These lessons are documented in the External Mid-Term Review Mission's Reports--World Bank Report No. 1713-KE; World Bank Project Performance Audit Report and Completion Report; Staff Appraisal of an Integrated Rural Health and Family Planning Program (Annex J); and, the USAID/Kenya "Project Evaluation Summary".

First, the MCH/FP Program concentrated heavily on the supply side of family planning although available evidence clearly suggests that the main constraint to the reduction of fertility levels in Kenya is the almost universal desire for large families. The designers of the MCH/FP Program assumed that sufficient demand for FP services already existed or would be created by Family Planning Information and Education activities under the project to attain 640,000 new FP acceptors. In light of widespread popular attitudes favoring high fertility, as revealed by the 1977/78 Kenya Fertility Survey and the meager FP I&E activities which were actually implemented by the MOH, the assumption appears to have been seriously unrealistic in retrospect. Thus a lesson learned is the need for greater emphasis on activities designed to affect family size norms and attitudes about family-size preferences and family planning.

Second, it is clear that donor agencies supporting the MCH/FP Program overestimated the level of GOK commitment to reduction of the rate of population growth and provision of FP information and services. For example, lack of commitment seriously affected the establishment and operation of the National Family Welfare Center, the unit established to provide FP training, information and education, research and evaluation, and expanded MCH/FP clinical services. The unit never managed to obtain the degree of autonomy or influence within the MOH necessary to carry out its mandate--the spearheading of the National Family Planning Program. Another example was the take-over of the MOH hostel designed to house FP trainees by medical students at Kenyatta Hospital. A second lesson learned is the need for GOK, in particular the MOH, commitment to be in evidence from the outset.

Third, the MCH/FP Program relied excessively on the MOH as the sole agency to achieve its objectives. The MOH's management deficiencies and lack of commitment to FP led to the failure to utilize the resources of the strengthened MOH Health Education Unit to mount a significant mass communication program, and therefore resulted in an inadequate quality and quantity of FP information and services. There was no serious attempt by either the GOK or donor agencies to involve other Government agencies or the private sector in the attainment of the MCH/FP Program objectives. The third lesson learned is the need to develop a broad multi-sectoral program which would generate wide community cooperation and political support, and would institutionalize mechanisms to encourage and coordinate the implementation of FP activities by Government and nongovernment agencies.

C. USAID Approach to the Population Sector.

In USAID's view, the exceptionally high and possibly increasing population growth rate is probably the single most critical issue in Kenya's development. In recognition that Kenya's 4 percent annual rate of population growth adversely affects almost every development sector of the economy, the reduction of the population growth rate is one of the three principal objectives of the U.S. Assistance Program to Kenya as identified in the Country Development Strategy Statement (see USAID/Kenya 1984 CDSS pp 34-35). It is closely related to USAID's principal health objective which is the reduction of infant and child mortality. In USAID's view, Kenyan families will not lower their fertility aspirations until they perceive that child survivorship is increasing. USAID, through its experience with three bilateral population projects over the past dozen years, acknowledges that there are formidable constraints to be overcome. USAID is actively involved in the population sector because of the gravity of the population problem and because public and private Kenyan agencies have welcomed U.S. population assistance.

In light of the constraints and experience previously gained in Kenya and elsewhere, it is USAID strategy to place emphasis upon creation of demand for family planning through private and public sector activities while continuing to support private and public systems for the delivery of family planning services. USAID recognizes that demand for family planning services is relatively minimal, that it is not evenly dispersed among all families but rather found under certain conditions, and that the availability and quality of services is crucial to sustained effective use.

Funding the bilateral Family Planning II project proposal will directly support USAID's broad-based but selective approach while responding to the Government's request for assistance in its multi-donor-funded Integrated Rural Health/Family Planning Project

of which Family Planning II is an integral, but distinct part. The proposed project provides \$3 million for the Interagency Information and Education Program on Population and Development to address demand creation through selected public and private sector activities. The remaining \$1 million is directed at training to improve the quantity and quality of family planning service delivery by Ministry of Health personnel.

This approach is seen as an efficient means to address the constraints identified, while supporting the major government-initiated Integrated Rural Health/Family Planning Project. For comparative purposes, Table 2, below summarizes AID's contribution in relation to the other donors, and the GOK.

Table 2

SUMMARY FINANCIAL PLAN
\$ in Thousands

<u>Donor</u>	<u>Interagency Information and Education Program</u>	<u>Rural Health Services</u>	<u>Total</u>	<u>X</u>
AID	3,000	1,000	4,000	6.9
World Bank	4,800	18,200	23,000	39.4
SIDA	-----	9,800	9,800	16.8
Danida	-----	8,500	8,500	14.6
ODA	100	1,100	1,200	2.1
UNICEF	-----	700	700	1.2
UNFPA	600	-----	600	1.0
GOK	3,000	7,500	10,500	18.0
				<u>100.0</u>
GOK (Taxes & Duties)	<u>100</u>	<u>2,900</u>	<u>3,000</u>	
TOTAL	<u>11,600</u>	<u>49,700</u>	<u>61,300</u>	

In addition to the resources that will be provided to Kenya through the bilateral Family Planning II Project, substantial resources will be transferred to Kenya through centrally-funded Population and Family Planning activities and USAID-funded Population and Family Planning Operational Program Grants. Centrally-funded grantees and contractors are expected to involve themselves in areas such as commercial retail sales of contraceptives, community-based family planning delivery and delivery of FP information and services to hotel, factory, and plantation workers. USAID will develop activities with both Kenyan and U.S. PVOs interested in implementing innovative approaches to the delivery of health and FP information

and services. This will not only provide FP information and services to groups that desire them, but also demonstrate to policy-makers that there is demand for family planning when services are delivered in an appropriate manner.

USAID's current Health Planning and Information Project, Kitui Rural Health Project and other non-FP components of the multi-donor IKH/FP Project will help strengthen the planning and management systems of the MOH and promote allocation of relatively greater resources to promotive and preventive rural health services. The Kitui Rural Health Project will attempt to achieve most of the IRH/FP Project objectives in a single district and is closely related to the IRH/FP Project. The Population Studies and Research Institute (PSRI), a recipient of USAID funding for the past five years, will continue to perform most of the analysis on Kenya's population situation. PSRI is expected to assist the National Council on Population and Development through research and evaluation activities linked to the Interagency Information and Education Program. Analysis carried out at PSRI provided a significant amount of the information utilized in preparation of this project paper.

The most significant of USAID's efforts, however, will be the Family Planning II Project. USAID believes that FP information and services, when delivered in a sensitive and culturally appropriate manner, will find acceptance among Kenyans from many walks of life. Kenyans, particularly those benefiting from the consequences of rapid socio-cultural changes, will support FP when they better understand the benefits. USAID, however, does not believe that current trends in fertility are going to decline dramatically over the next few years. A more reasonable short term aim is for the leveling off of the current increasing rate. Thus the proposed project, while clearly the most appropriate for current conditions, is one which can succeed without achieving dramatic change. The constraints to be addressed are too numerous and deep-seated to be overcome quickly.

III. PROJECT DESCRIPTION

A. Goal and Purpose

The goal of the project is to reduce Kenya's birth rate. Current statistics suggest that Kenyan women will average 8.1 live births during their reproductive years. This figure is up from an estimated 7.6 in 1969 and 6.8 in 1962. In the near term, family size is expected to increase further as changes in family patterns such as decreased duration of breast-feeding result in increased exposure of women to pregnancy. Although the gradually increasing birth rate may not decline during the three year period of the project, we would expect to see certain trends which indicate an eventual downturn. These include a decline in the rate of increase in the birthrate and increased use of contraceptives to space births and achieve smaller family size.

Assuming a favorable conclusion of this project, a second phase will follow. By the end of the second phase, a decline in the birth rate from 53 to 47 per thousand will indicate that the program goal will have been achieved.

The purpose of the project is to build up an institutional capability at the national level which will improve the performance of the National Family Planning Program. To promote demand for family planning and preference for smaller family size, the Kenyan Government, has established a National Council on Population and Development. This body, with supporting units, will assume the major responsibility for information and education efforts to effect the decline in the birth rate. As one of its first acts, the Council will create a relatively small but innovative subproject funding program aimed at identifying and supporting a range of different activities to promote demand for smaller family size. Institutions from both the Government and non-government sectors will participate in the information and education program. By the end of the three years, Phase I, various institutions with financial and other assistance from the Secretariat will have implemented an estimated 30 information and education subprojects.

On the supply side, the Ministry of Health will take responsibility for developing with donors much more effective and widespread family planning services as part of the integrated rural health delivery program. The overall program includes support to the Ministry of Health and to non-government health-related institutions, mainly church based. AID is targeting its funds on training of family planning service providers in order to increase the number of MOH service delivery points. By the end of the three year project, the current contraceptive prevalence rate of 4% will be 7%; there will be 328,000 new acceptors of family planning services recorded, and 224,000 continuing users.

B. Strategy

The basic strategy of the project is to harness resources in both the public and private sectors to increase the demand for and use of effective methods. USAID's assistance to both parts of the IRH/FP Project will provide for exceptionally efficient use of population funds, as they will be complemented by other resources aimed at achieving the same and/or related ends. In Part A the aim of the Council is to enlist participation of a range of existing institutions to initiate population-related activities. In Part B the MOH, with donor assistance, will be improving and extending all rural health services thus improving the context for extension of family planning service delivery.

A related strategy is to recognize the economic and socio-cultural conditions supporting the persistence of very high fertility and to target resources to reach families in specific

contexts in a systematic, selective manner. Within the project, emphasis will be on increasing access to knowledge and practice of family planning nationwide to develop a critical mass of opinion and practice supporting program goals. A second related approach will be a nationwide attempt to identify and remove barriers affecting acceptability of family planning ideas and practices. In particular, deep-seated values supporting large family size and widely prevalent attitudes eroding current contraceptive usage will be addressed. A third approach will recognize the diversity of economic circumstances and family life styles in Kenya, and mount a series of studies and campaigns tailored for specific population groupings. Such an approach will take into account the current low level of demand for contraceptives to achieve smaller family size, while focusing specifically on promising categories of users which can be identified and reached through systematic means. It also takes into account the multiple reasons for use of contraception (spacing, disease avoidance) as well as recognizing alternatives and complementary means for achieving a reduction in the birth rate (e.g. though promotion of prolonged breast-feeding practices, women's group activities, social security programs, etc.). An important addition to the present approach will be the inclusion of an explicit emphasis on promotion of family planning to achieve smaller family size.

In order to explore thoroughly the potential for demand creation, the approach of the Council will be as wide-reaching as feasible. The unit implementing the information and education program will actively seek to develop activities in the public and private sectors. It will encourage innovation and flexibility. Particularly in the initial stages, however, its staff will be required to assist actively in the preparation of project plans for implementation, monitoring and evaluation of subprojects. Learning and applying lessons from initial projects will be a critical task of the Council.

It is essential that a broad-based information and education program be supported by a similarly widespread network of family planning services. USAID will provide its share of assistance to this end by assuming responsibility for selective training of MOH family planning service providers. In this way, USAID will play a significant role in both parts of the IRH/FP Project.

C. Project Timing and Components

1. Overview

The Integrated Rural Health and Family Planning Program is a six year phased effort with a first phase scheduled for implementation July 1, 1982 through June 30, 1985. At present all donors including USAID are committing resources only for implementation of the first phase. Participation in the second

phase is contingent on the findings of a joint donor appraisal planned for the end of Phase 1.

The IRH/FP Program consists of two components which have been outlined above. Part A addresses the creation of demand for smaller family size and family planning practices, and Part B includes activities designed to strengthen the provision of rural health and family planning services. USAID's contributions to both components are discussed below. The details of the contributions of the other donors and the GOK are discussed in the Joint Appraisal Report included as Annex J. Essentially donor contributions for Part A complement USAID's by providing support of a similar nature to the Interagency Program for Information and Education. Donor contributions for Part B, the Rural Health/Family Planning Service Delivery component, include support for construction and equipping of new service delivery points for both MOH and non-government facilities, training and education activities, commodities, equipment, salaries, drugs, technical assistance, and vehicles.

2. Part A

An Interagency Program for Information and Education on Population and Development in Kenya

The Government of Kenya approved establishment of the National Council on Population and Development in early 1982. Table 3 depicts the Council organization. The Council is composed of representatives of the private and public sector and a Secretariat. The Council sets policy and approves the plan of work to be carried out by a number of private and public sector agencies. The Secretariat will assist these participating institutions with funding, technical assistance, and supporting services in the development and implementation of discrete activities. The full Council will meet only a few times annually. Most decisions will be taken on its behalf by the five-member Executive Committee comprising representatives of two public agencies, two private agencies, and the Secretariat.

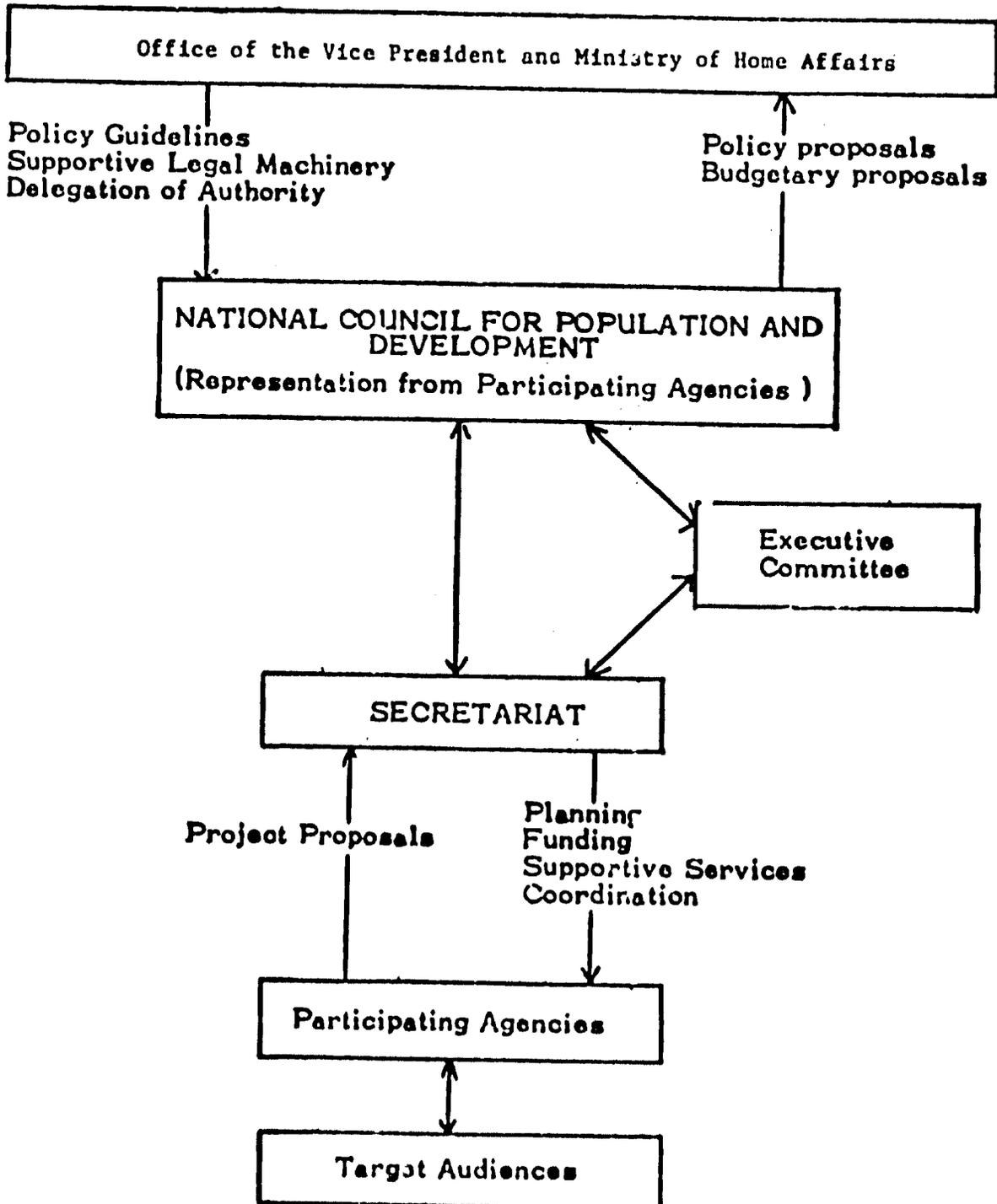
The Secretariat is the basic unit for implementation of Council business. It includes the following 17 full-time positions:

- a) professional and technical staff (7),
- b) administrative staff (3), and
- c) secretarial and other support staff (7).

The Council, acting through its Secretariat, will determine the scope and direction of the Interagency I&E Program, review private and public sector proposals, approve budgets, coordinate and support Kenyan agencies implementing the program, and liaise with donor agencies funding the program. It will play a central role in the management of Interagency I&E Program finances. Funds for the

Table 3

Recommended Organizational Structure for the Interagency Information and Education Programme on Population and Development in Kenya



Council's Secretariat and for the private and public implementing agencies will be included in the budget of the Council's host ministry (Office of the Vice President and Ministry of Home Affairs). Based on annual agreements, funds would be periodically transferred to the implementing agencies. The Council will prepare progress reports, reimbursement applications and all other required documentation for the funding agencies. Funds for Part A activities to be implemented by Government agencies will be included in the agencies' own budgets.

The institutional development of the newly approved Council and its Secretariat will be a major undertaking in its own right. Detailed terms of reference must be drawn up, but it is already clear that the Secretariat will have a variety of crucial functions including:

- 1) Program planning and formulating overall priorities and strategies with the guidance and approval of the Council;
- 2) Initiating ideas for specific activities and responding to those initiated by operating/implementing agencies;
- 3) Negotiating agreements with operating/implementing agencies for specific projects;
- 4) Providing technical assistance to help strengthen project proposals;
- 5) Arranging and contracting for technical assistance or other services or materials required by operating agencies, for example: baseline measurement, planning or facilitating evaluation of projects, audio-visual aids for training, curriculum development;
- 6) Monitoring the progress of projects carried on by implementing agencies;
- 7) Helping to plan and arrange for the systematic evaluation of all projects and feedback to the agency whose project is being evaluated;
- 8) Designing and contracting for the operation of a large-scale, continuing mass media program;
- 9) Budget allocation control and accounting of funds provided by Government or obtained by Government from external donors for I&E activities;
- 10) Assistance with equipment procurement and maintenance;
- 11) Liaison with District Development Committees and other local groups to facilitate local level coordination of I&E activities;

- 12) Continuing contact with external donor agencies for support for the Interagency Information and Education Program; and
- 13) Periodic reporting to donors, the Council, and the nation on progress being made.

The Secretariat will require technical assistance, training and observation tours, commodities (vehicles, office furniture, office equipment, audio-visual equipment), and other cost support (salaries and allowances, office rental, travel and per diem, support for training/workshops, and subcontracts for research, evaluation, and mass media activities). The success of the Interagency I&E Program will be largely dependent on how well the Secretariat performs its functions. Considerable external support will be required to facilitate the process.

In essence, the Interagency I&E Program has two distinct components for donor assistance. The first component is the institutional development of the National Council on Population and Development. The second component is the funding of I&E activities to be implemented by private and public sector organizations. Although donor agencies must give advance approval to the annual workplan of the Council, which will include the I&E proposals that have been endorsed by the Council, it is clear that donor agencies must rely to a very great extent on the preparations made by the Council's Secretariat.

The Government has identified a number of deficiencies which constrain the effectiveness of current I&E activities. These include:

- a) Absence of a mechanism for coordinating I&E activities of private and public agencies;
- b) Relative neglect of certain key audiences (especially men, youth in schools, professional, and leadership groups);
- c) Over-emphasis on health aspects and neglect of other important aspects of family size/population growth;
- d) Inadequate attention to opportunities for FP motivation of target audiences in MCH clinics and maternity wards;
- e) Inadequate scope, quantity, and pretesting of I&E materials;
- f) Limited use of radio and other mass media;

- g) Insufficient use of extension workers outside the health sector and various nonformal education programs; and
- h) Ineffective use of schools for education in population dynamics, family life, and health.

In recognition of the above deficiencies, the major objectives the Council has set include but are not limited to the following:

- a) To create a climate of opinion in favor of a strong population program by making people from all walks of life aware of the seriousness of the population problem;
- b) To induce professional, religious, and other influential groups to encourage the public to accept family planning;
- c) To encourage couples to reduce their family size aspirations and to practice family planning;
- d) To provide potential and actual family planning users with information about family planning;
- e) To encourage medical and paramedical personnel to provide effective family planning services; and
- f) To prepare youth for responsible parenthood.

To achieve these objectives, the Council will initiate a series of campaigns, each using a variety of approaches aimed at a variety of audiences, which will include the following message categories: awareness, population information, legitimation, contraceptive information, motivation and reassurance. All available channels of communication will be utilized to the extent feasible. The essential elements of the program are interpersonal communications, the use of mass media, education and training activities, and evaluation. Among the necessary supporting activities are: training to provide manpower for the varied activities of the program (design, testing and production of print and audio-visual materials and teaching aids); use of commercial resources; program-oriented research; documentation; and administrative services.

A proposed indicative program consisting of 16 separate activities to be implemented by six private and two public organizations will begin during the first year. Information including the proposed subproject selection guidelines and profiles of potential participating agencies to be funded by AID are included

in Annex G. In selecting proposals for the indicative program from among those submitted by potential private and public implementing agencies, priority has been given to activities that fill obvious gaps. In order to provide the Council with some flexibility during the first year of the program, funds equivalent to 10 percent of its estimated cost would be reserved for activities not in the indicative program which may be added during the course of the year. Only the first year's work program has so far been planned in detail and for each of the subsequent years the Council would draw up an annual workplan and budget for approval by the financing agencies. During the first year USAID will fund the operating costs of the National Council's Secretariat and 9 activities to be implemented by NGOs as described below:.

(a) Family Planning Association of Kenya (FPAK):

- (i) Private Medical Practitioners: for one workshop to be organized by FPAK during the first year to encourage private doctors to offer FP services.
 - (ii) I&E Program for Members of Parliament: for a workshop to inform MPs about, and to enlist their support for, Kenya's population program.
 - (iii) Training of Traditional Birth Attendants (TBAS): for training of 320 TBAs a year in rural health and FP services, and support for supervisory and training staff.
 - (iv) In-service Training in I&E for FPAK Staff: to conduct in-service courses in I&E for its own field educators, senior management, and clerical staff who have considerable contact with the public.
 - (v) Production of Support Materials for Field Use: to provide for the designs, pre-testing and production of materials for use by FPAK's field educators.
 - (vi) Evaluation of On-going I&E Programs: to carry out or sub-contract evaluations of its lay educator and youth programs with a view to requesting the Council to finance expansions of these programs.
- (b) Kenya Catholic Secretariat: Family Life Education Program: to increase understanding of the population program among Catholics and to educate couples in the ovulation method of FP which has been found to be acceptable to Catholic couples because of its similarity to traditional child spacing methods.

- (c) Protestant Churches Medical Association: Adolescent Health and FP I&E Program: to develop materials and provide workshops for school personnel and religious leaders to encourage PCMA members to reach in- and out-of-school youth in their areas.
- (d) Salvation Army: FP-I&E Program: to carry out a program aimed primarily at men with the help of male workers who would be recruited and trained by trainer/supervisors and Salvation Army health staff, who would provide FP services.

3. Part B Improvement of Rural Health and Family Planning Services

The Ministry of Health is responsible for the implementation of Part B of the IRH/FP Program. Although Part B includes assistance to the private sector (both church-related and non-church-related), the total financing will be included in the MOH budget. The improvement of rural health and family planning services to be undertaken in Part B is clearly related to the family planning demand creation activities in Part A and includes a wide variety of activities designed to improve both the quantity and quality of rural health and family planning services.

A complete description of all Part B activities of the IRH/FP Program can be found in the World Bank publication entitled, "Staff Appraisal of a Rural Health and Family Planning Project" (Annex J). The following paragraphs include a discussion of the family planning components of the IRH/FP Project.

Part B of the project will substantially increase the availability of FP services in rural areas by increasing the number of RHF's offering FP services and widening the range of RHF personnel trained to provide such services. According to the Kenya Fertility Survey (KFS) travel times to a facility offering FP services averaged 68, 40, and 10 minutes for rural, urban, and metropolitan residents of Kenya. As of mid-1980, out of a total of 830 MOH RHF's, 250 (156 health centers, 21 health subcenters, and 73 dispensaries) offered daily MCH/FP services and were classified as Service Delivery Points (SDPs). A further 136 MOH RHF's (5 health centers, 3 health subcenters, and 128 dispensaries) offered part-time MCH/FP services, usually provided by mobile teams. The remaining 444 or 53 percent of the MOH RHF's offered no FP services at all. The situation is particularly acute at the dispensary level. Although 85 percent of MOH rural health centers offer full-time FP services and an additional 3 percent offer part-time FP services, only 12 percent of MOH dispensaries offer full-time FP services and an additional 20 percent offer part-time FP services. Two-thirds of MOH rural dispensaries offer no FP services at all. Moreover, less than one percent of non-government RHF's offer daily services. In particular, the considerable potential for FP service delivery by the church-related health institutions has not been realized to date.

The specific activities to be funded under the IRH/FP Project to address these constraints are listed below. AID is funding the first activity listed:

In-service training for rural health facility personnel, including comprehensive theoretical and practical family planning training for Enrolled Community Nurses and Clinical Officers;

Deployment of additional Enrolled Community Nurses (ECNs), Clinical Officers (COs) and other paramedical personnel to rural health centers and dispensaries;

Establishment of a new ECN Training School and a new CO Training School and upgrading of three church-related Enrolled Nursing Schools;

Establishment of a new system of drug logistics to improve availability of drugs and contraceptives at RHEs;

Establishment of a new program of community-based health services including nonclinical resupply of contraceptives;

Establishment of an additional 300 MCH/FP full-time Service Delivery Points (SDPs) at MOH rural health centers and dispensaries;

Establishment of an additional 30 MCH/FP full-time SDPs at Protestant and Catholic RHEs;

Improvement of the capabilities of the National Family Welfare Center (NFWC) through short-term technical assistance, fellowships and observation tours, salary support for additional staff, vehicles, equipment and FP research and evaluation activities;

Provision of contraceptives for private and public sector family planning activities;

Improvement, upgrading and limited new construction of MOH and church-related rural health centers and dispensaries;

Provision of additional transport including 1200 bicycles, 115 motorbikes, 21 cars, and 4 motorboats to increase mobility of MOH and church-related RHE staff and 24 ambulances for referrals to provincial and district hospitals;

Establishment of 6 maintenance and training workshops for vehicles, equipment, and buildings and establishment of a Central Maintenance Unit at the Ministry of Health;

Consolidation and improvement of health data collection and processing including FP service statistics; and

Expansion of health education activities through in-service training and increased production of health education materials.

In USAID's view, the principal constraint to the expansion of FP services at RHF's has been the shortage of paramedical staff trained in FP for assignment to RHF's. In order to convert an additional 300 MOH RHF's, chiefly at the rural dispensary level, to full-time MCH/FP SDP status, USAID is funding the in-service FP training of 900 Enrolled Community Nurses (ECNs) and 270 Clinical Officers (COs) during 1982-85. (It is planned that an additional 300 MOH RHF's would be converted into full-time MCH/FP SDP status during the 1985-87 phase of the IRH/FP Program. By the end of 1987, all MOH RHF's should be functioning as full-time MCH/FP SDPs.)

Since the oral contraceptive (OC) is the most widely accepted FP method (approximately 70 percent of new FP acceptors choose OCs), most FP clients need to visit a RHF at least once every three months for resupply. Even in RHF's offering daily FP services, frequently only one nurse is trained to provide FP services, and she is on leave (annual, sick, maternity, or training) on the average of four months in the year. If no trained FP service provider is present in the facility, no FP services are offered and the FP client must travel great distances to another facility. It is not surprising that FP acceptance is extremely low and that the FP discontinuation rate for methods requiring frequent resupply is extremely high.

In recognition that the shortage of ECNs trained in FP constrains the delivery of FP services, the MOH has recently introduced new policies governing the distribution of contraceptives. Other paramedical staff at RHF's, i.e., Clinical Officers, Family Health Field Educators (FHFES), Patient Attendants, and ECNs untrained in FP, will now be allowed to supply nonprescription contraceptives (condoms, foams, and jellies) and to resupply OCs. The new policy would allow RHF's without an ECN fully trained in FP to become limited MCH/FP SDPs able to supply nonclinical contraceptives and to resupply orals until they can be assigned ECNs qualified to insert IUDs and to prescribe orals. As community-based health services are initiated, volunteer community health workers will be allowed to supply nonprescription contraceptives. See Table 4 for summary of contraceptive availability by type of facility and cadre of health personnel authorized to provide them.

At present, although ECNs are responsible for FP services at RHF's, their basic training at nursing schools does not adequately cover clinical aspects of FP and, therefore, needs to be

Table 4:

CONTRACEPTIVE AVAILABILITY

	<u>New Prescription of Oral Contraceptives</u>	<u>Oral Contraceptive Resupply</u>	<u>IUD Insertions</u>	<u>Nonprescription Contraceptives - Including Natural Family Planning</u>
Health Center	ECN trained in FP CO trained in FP	ECN CO PHPE Patient Attendant	ECN trained PP	ECN CO PHPE Patient Attendant
Dispensary	ECN trained in FP	ECN PHPE Patient Attendant	ECN trained in FP	ECN PHPE Patient Attendant
Community-Based Programs	-	ECN PHPE Patient Attendant	-	ECN PHPE Patient Attendant CHW

Footnote: Pharmacies can resupply oral contraceptives and provide nonprescription contraceptives. Rural shops (dukas) often stock nonprescription contraceptives. Voluntary Surgical Contraception and Depo-Provera available only through physicians at selected private and public hospitals.

supplemented by in-service FP instruction. The Training Division of the MOH's National Family Welfare Center currently trains about 120 ECNs in eight-week, in-service FP courses annually. During the three-year project period USAID will assist the NFWC to expand its training output to 900 ECNs (annual average of 300) and assist the NFWC to initiate in-service FP training for 90 Clinical Officers annually.

Clinical Officers are in charge of rural health centers and directly supervise the ECNs who provide FP services. The CO's basic training needs strengthening in obstetrics and in family planning. With USAID assistance the NFWC will initiate a new program for in-service FP training of COs that would allow them to prescribe oral contraceptives and to supervise the FP services rendered by ECNs more effectively.

The NFWC will be responsible for planning and assisting district health authorities to present in-service FP training to other categories of rural health staff. Patient attendants at RHPs, ECNs who have not attended NFWC's in-service FP course and FHPEs will receive short-term on-the-job training in FP that will allow them to resupply oral contraceptives. This training will be conducted by district rural health staff.

Because of the NFWC's pivotal role in family planning there is considerable emphasis within the IRH/FP Program on strengthening its institutional capabilities. As mentioned above, USAID will concentrate on FP in-service training which is the responsibility of the NFWC's Training Division. The MOH has already filled the positions of the NFWC Director, Administrator and Head of the Information and Education Division. The MOH has agreed to fill key vacant posts at the NFWC including those of the Heads of the Training and Clinical Services. Additional new posts will be created within each of the NFWC's divisions to allow the NFWC to cope with its enlarged responsibilities.

Other donors will provide funds for approximately three person-years of short-term consultant services for the NFWC. There will be funding of up to \$40,000 annually for FP-related operations research studies on topics proposed by the NFWC. The MOH will set up an Evaluation and Research Committee to approve study topics and select contractors in connection with this and other research and evaluation financed by the IRH/FP Program. Donors will provide ample supplies of contraceptives for both private and public agencies which deliver FP services. There will be funds for FP participant training and observation tours to view FP activities in other countries.

4. Natural Family Planning

In both Parts A and B of the IRH/FP Program instruction in natural family planning methods will be provided to those Kenyans

who desire it. The Kenyan Catholic Secretariat's proposal for a Family Life Education Program has been included in the Part A indicative program and will be financed by USAID. This activity is designed to increase understanding of the population problem among Catholics and promote the education of couples in the ovulation method.

Catholic health institutions will be strengthened under Part B of the program and will provide instruction in natural family planning methods within the context of MCH services.

The in-service family planning training for ECNs and COs which will be financed by USAID will include both artificial and natural family planning methods. USAID recognizes that natural family planning methods are desirable for both Catholics who do not wish to utilize artificial methods for religious reasons and for others who find natural family planning methods more suitable than artificial methods. Family planning services should be completely voluntary and the choice of method should be left to the individual. Other institutions in addition to Catholic institutions will be encouraged to include natural family planning methods among the FP methods offered.

D. Project Inputs and Outputs

Within Part A of the IRH/FP Project USAID will provide \$3 million in assistance to the National Council on Population and Development. The output will be a fully staffed and functioning Secretariat of the National Council. There will be a system for identifying, prioritizing, monitoring, and evaluating activities to be implemented by private and public agencies with the Council's funding. Approximately 30 private and public subprojects will be implemented over the life of the project. The Secretariat will require inputs of technical assistance, training and observation tours, commodities (vehicles, office furniture, office equipment, and audio-visual equipment), and other cost support (salaries and allowances, office rental, travel and per diem, support for training/workshops, and subcontracts for research, evaluation and mass media activities). Agencies implementing individual subprojects will utilize Secretariat resources as well as funds for subproject operating costs. USAID funds will support the operating costs of the Secretariat and provide seed money for financing subprojects as described in Section IV. E. "Financial Plan".

Within Part B of the IRH/FP Project USAID will provide \$1 million to finance the in-service FP training of 900 Enrolled Community Nurses (ECNs) and 270 Clinical Officers. There will be salary support for 8 additional trainers, procurement of training

materials and 2 vehicles and payment of travel costs and per diem expenses associated with the training courses. Technical assistance will be provided through the centrally-funded INTRAH Program. The in-service FP training will provide trained manpower to staff 300 dispensaries, health subcenters and health centers capable of serving as SDPs for FP activities.

Other donors will construct, renovate or upgrade the physical facilities of RNFs, provide salary support for additional paramedical staff, procure MCH/FP equipment and supply drugs and contraceptives. Donor inputs of technical assistance, training, salary support and commodities will result in a National Family Welfare Center which is fully staffed with adequately trained and well-qualified family planning professionals. Current professional vacancies (the Heads of the Clinical Services and Training) will be filled and 14 additional positions will be established and staffed.

E. Beneficiaries

There are two basic categories of beneficiaries: recipients of the family planning information and education activities provided under Part A; and, recipients of the family planning services and related activities provided under Part B.

The primary beneficiaries of the Information and Education Program can be divided into four main types of audiences. Identification of these audiences is guided by the need to focus efforts on individuals, families or groups which have common socio-economic, occupational, or religious concerns, for example, in order to maximize informal group interaction, reinforcement of individual learning, and to promote self-sustaining local initiative. Note that the prime beneficiaries will be reached through several channels and most of the Kenyan population will be reached at the minimum through mass media.

- The four basic beneficiary types are as follows:
- 1) Policy and decision makers and opinion leaders.
These include public officials at all levels, with special emphasis placed on Members of Parliament.

Others include senior civil servants, clergy, leaders of women's groups, medical doctors, and senior social workers, labor and cooperative leaders, business and industrial leaders, university and college teachers and ranking members of the military.

- 2) Married or Otherwise Sexually Active Adults of Reproductive Age.

Although women have to date received the major attention of family planning information and

education, increased efforts are necessary. To alter present attitudes an approach focusing on existing functional groups in specific geographic communities will be utilized with supplementary messages beamed at the general public.

Men, as well as national leaders and youth of both sexes, have been singled out as having been largely neglected in past research and information as well as education activities. In a recent study, only one-third of a sample of men interviewed stated their willingness to use family planning to stop having children. Other research has indicated that under conditions of economic hardship men with at least primary level education are as receptive to family size limitation as their wives.

- 3) School children at all levels and of both sexes and out-of-school youth who may or may not be sexually active.

In a 1978 study of university students, the students were found to have a high level of awareness of various family planning methods, but many reported they did not receive sex education from parents because "parents are Christians" or from teachers because the curriculum does not allow it. The inclusion of population and family life education in the school curriculum is a proposed feature of the current program.

- 4) Providers of health and family planning information and services, including extension workers in all development areas and writers and program designers in the mass media.

The beneficiaries of Part B of the project include both those involved in service delivery--an estimated 1,170 paramedical health workers will receive USAID-financed training under the project--and the recipients of services.

Analysis of uncorrected 1979 census data indicated that there were 3,349,000 women in the reproductive ages of 15-49. As an estimated 5% of the women are infertile and very few are celibate, the overwhelming majority of all women in the age group 15-49 are exposed constantly to the risks of pregnancy. This includes unmarried women as this group accounts for an estimated 20% of all first births (Mosley, Werner, and Becker 1981:14).

Given the high fertility of Kenyan women, it would seem that the best place to implement a vigorous family planning program is at MCH/FP service delivery points. Currently married women average a live birth every 30 months throughout their married lives and the majority have contact with clinics. In 1978, for example, an estimated 65% of all pregnant women visited antenatal clinics at least once, and almost 70% visited a clinic at least once for child welfare services. Thus over a three year period, a concentrated clinic-based effort could reach two-thirds of all childbearing women.

The percentage of women likely to seek family planning services, however, is likely to be a small minority of the total. One analysis of the 1977/78 Kenya Fertility Survey presents a four part typology of all ever married women which illustrates the variety of fertility related attitudes and behavior in Kenya.

TABLE 5 FAMILY PLANNING ATTITUDES PLUS PRACTICES AMONG EVER MARRIED WOMEN, KFS 77/78

	<u>EVER USED AN EFFICIENT METHOD OF CONTRACEPTION</u>	<u>NEVER USED AN EFFICIENT METHOD OF CONTRACEPTION</u>	<u>TOTALS</u>
DESIRED LESS THAN SIX CHILDREN	MODERN 4.4% (n = 277)	TRANSITIONAL 19.8% (n = 1247)	24.2% (n = 1524)
DESIRED SIX OR MORE CHILDREN	TRANSITIONAL 8.2% (n = 517)	TRADITIONAL 67.6% (n = 4269)	75.8% (n = 4786)
	<u>12.6%</u> (n = 794)	<u>87.4%</u> (n = 5516)	<u>100.0%</u> (n = 6310)

Source: Dow and Werner 1982:19

The Typology shows a very small group (4.4%) who report truly efficient fertility regulating behavior, and a very large group (67.6%) who are very pronatal. The in-between categories of family planning innovators (8.2%) who desire six or more children, and those women who have never tried contraceptives (19.8%), are clearly the most promising regarding participation in the IRH/FP project.

Other analysis of the KFS data have identified some of the common characteristics of the users. These include:

- 2.1% married women with no education were users as contrasted to almost 19% among women with more than four years of education;

--16.2% of married working women were users, as opposed to 3.8% not currently working;

--11.5% of married women living in urban areas were users; in rural areas only 3.6% were users;

--4.1% of women in monogamous marriages were users as contrasted to 2.8% in polygamous marriages;

--8.3% of married Kikuyu women were users as contrasted to 2.5% among Luo, 3% among Luhya, 4.4% among Kamba (after Mosley and Werner, 1980).

Men are far less promising potential beneficiaries of a MOH service delivery effort. Men rarely visit health facilities and are often perceived by wives as being hostile to family planning. A more successful strategy to reach men is likely to be through community-based distribution activities, social or commercial marketing programs (not provided for under this project) and private clinics.

Indirect beneficiaries of the project will be the families of contraceptive users, to the extent that spacing and family size limitation improve the environment of the family and general welfare. Benefits will also accrue to non-users to the extent that a reduction in the overall birth rate reduces the strain on resources expended to meet basic human needs. A further elaboration of project beneficiaries is included in the Social Analysis Section IV C. and the Social Analysis Annex C.

IV. PROJECT ANALYSES

A. Technical Feasibility

The IRH/FP Project, and USAID's contribution to it, are fully feasible from the technical perspective. All aspects of the project have been developed following extensive analysis of previous efforts and careful appraisal of project design. A brief summary of the steps taken in the process of project development for both Part A and B are included below.

1. Part A

Philip Mbithi, the then Chairman of the Sociology Department of the University of Nairobi, and Lyle Saunders, a distinguished U. S. expert in FP communications were commissioned by the Government of Kenya to produce a program proposal entitled, "An Interagency Programme for Information and Education on Population and Development in Kenya." In February 1980, the Ministry of Economic Planning and Development organized a workshop for 90 persons representing more than 30 private and public Kenyan

agencies to review the draft consultancy report. The recommendations of the workshop participants were incorporated into the final version of the report which appeared in April 1980.¹

Following the workshop participating Kenyan agencies were asked to submit specific projects they would like to undertake. An outline giving guidelines and a suggested format for project preparation was provided to each agency. Eleven agencies presented 37 proposals for consideration. The consultants' final report included summaries of each proposal and recommendations about their eventual funding. Full descriptions of each proposal are included in the annex to the consultants' report.

In October and November of 1980, the World Bank organized a joint appraisal mission to study the feasibility of Parts A and B of the IRH/FP Program. The team consisted of 12 technical specialists provided by 6 donor agencies, USAID/Kenya being represented by the Population Officer. The findings of the team are presented in the World Bank Appraisal Report, Annex J.

During the joint appraisal mission, the team and Kenyan counterparts reviewed the Saunders-Mbithi report to determine the feasibility of the proposals and finalized the design of the Part A activities. Sixteen of the 37 proposals were judged to be of high priority and ready for implementation during the first year of the IRH/FP Program. Nine of these are to be funded by USAID. The institutional capability of the agencies submitting the proposals was assessed, as part of proposal review. The proposed activities under Part A were deemed to be technically feasible.

The technical approach to be followed under Part A combines interpersonal communications, extensive use of mass media, education and training activities, institutional development and research and evaluation. The underlying assumption is that a comprehensive FP I&E Program can ultimately influence Kenyan attitudes and practices related to fertility. The targets for the program will be social groups and communities whose collective beliefs and values largely determine what their members think and do. The design relies heavily on indigenous organizations, and on existing expertise currently available in the public, non-governmental and commercial sectors. In fact, several of the subprojects proposed for first year implementation are expansions of current activities which are being successfully carried out by the participating agencies. The Secretariat of the Council will be staffed by highly qualified professionals with expertise in the relevant technical disciplines. The approach is well-grounded in communications theory, reflects a thorough understanding of Kenya's

1. Copy of the report is available in the HNP Division, USAID/Kenya.

socio-cultural and institutional setting, and has been strongly influenced by similar activities in other countries, notably Indonesia. USAID believes that Part A is technically feasible.

2. Part B

Part B of the IRH/FP Program was prepared by the Ministry of Health with the technical assistance of resident donor-financed professionals and consultants provided by the World Bank. The 1980 joint appraisal mission reviewed the activities proposed under Part B to determine their feasibility, and together with Kenyan counterparts sharpened the scope of the activities to make them financially and administratively feasible, and finalized the design of Part B.

USAID/Kenya is to fund only the in-service FP training of 900 Enrolled Community Nurses and 270 Clinical Officers under Part B. The training will be carried out under the technical supervision of the Training Division of the National Family Welfare Center of the MOH. The Division has carried out similar training for more than 1000 ECNs since 1974. The INTRAH Program of the University of North Carolina organized a Training of FP Trainers Workshop in 1981 for NFWC trainers to upgrade communications skills, introduce new teaching methodologies and to review the existing training curriculum. INTRAH and the Chief Nurse's Office of the MOH initiated a series of workshops in November 1981 to address the need for strengthening the teaching of FP at schools of nursing and to improve FP supervisory skills of District Public Health Nurses. An estimated 280 nurse tutors will be trained in teaching and management skills in MCH/FP. Although the Training Division of the NFWC will be responsible for the implementation of the in-service FP training of 900 ECNs, the theoretical training will take place at schools of nursing.

The FP training is specifically linked to the FP tasks to be performed by ECNs and COs in rural health facilities. The training includes both theoretical and clinical aspects of FP service delivery. The training involves no technological innovation regarding the tasks to be performed by ECNs.

Although the COs have not previously received in-service FP training, the level of new technology to be absorbed is minimal (prescription of oral contraceptives) and certainly within the capability of this cadre. USAID concludes that Part B is technically feasible.

B. Administrative Feasibility

1. Part A

The National Council on Population and Development will coordinate efforts in population information and education, including the programs proposed under Part A. The Permanent Secretary in the

Office of the Vice President and Ministry of Home Affairs is responsible for organizing the National Council. To facilitate the process, an Interministerial Committee comprising representatives of the Ministries of Health, Basic Education, Higher Education, Economic Planning and Development, and Finance; the Office of the President, and the National Council for Science and Technology is meeting regularly.

There are a number of steps that must be taken to institutionalize the newly approved Council. The first is to establish the Council's Secretariat which in turn can facilitate the remaining steps in the institutionalization process. Government has identified a highly qualified team of consultants to develop detailed terms of reference of the Secretariat and a workable model for the Council based on Kenyan and international experience.

The consultants will begin work in June, 1982, and are expected to accomplish the following:

- a) Analyze the tasks to be performed by each professional and administrative member of the Secretariat staff, determine the required qualifications and experience, and develop detailed job description;
- b) develop managerial and organizational procedures to be followed by the Secretariat in performing its assigned functions; and
- c) develop a model for the National Council and indicate how the various elements will relate to each other.

The Office of the Vice President and Ministry of Home Affairs will utilize the consultant's report to recruit the staff of the Secretariat. The Secretariat has the status of a regular department in a Government ministry, and as such it can have its own budgets and operate its own programs. A proposal for funding the Secretariat and the information and education activities in the first year of Part A has been submitted to the Ministry of Finance for inclusion in the FY 1982/83 budget. The budget request includes full funding of these subprojects at the levels specified in the World Bank Appraisal Report. Funding for the Secretariat and for activities in Part A to be carried out by NGOs will be included in the budget of the Office of Vice President and Ministry of Home Affairs. As soon as the Secretariat becomes operational, funding arrangements can be concluded between the Secretariat and agencies implementing Part A of the first year indicative program. Funding for Part A activities to be carried out by other Government ministries will be included in the budgets of those ministries.

The members of the Council can be appointed at any time without approval from Cabinet or Parliament. The Interministerial Committee will advise the Office of Vice President and Ministry of

Home Affairs on the composition of the Council. In the interim period before the Council members are appointed, policy directives for the Secretariat will be issued by the Office of Vice President and Ministry of Home Affairs. Although specific criteria for Council membership have not yet been formulated, it is anticipated that a broad spectrum of interests would be represented, including all major agencies, public and private, with a direct interest in population and development matters.

Although the National Council on Population and Development is a new institution, it will be organized based on an understanding of organizations having similar functions in country. The National Council of Science and Technology is likely to be one model to which the consultant team will refer in making detailed plans for the Council. A second, less successful but still relevant institution is the National Council of Social Services. These two are particularly appropriate, as one of the members of the consultant team has experience of each as its chief executive.

A key concern of the consultant team is establishment of a selection process for subproject funding which ensures selection of agencies fully capable of subproject implementation and monitoring. The proposed structure for the Council intentionally separates the resource allocation and evaluative functions from the technical and facilitative function. The salaried professional members of the Secretariat will likely be linked to technical committees and subcommittees composed of non-salaried outside experts and technical representatives of participating agencies. The Secretariat will play a technical and facilitating role related to the design, implementation and evaluation of subprojects. Decisions related to the selection, re-design and termination of subprojects will be made by the Council on the recommendations of the technical committees and subcommittees. Under the proposed structure, the Secretariat should be able to maintain a high degree of professional autonomy.

The selection and retention of dedicated professionals in the Secretariat is the key to the Council's success. The Council is not only a mechanism for funding subprojects, but also will have the institutional capacity to facilitate, coordinate and assist agencies who wish to design and implement activities. At this time a number of the interested agencies lack the capacity to develop activities without outside assistance. The Secretariat will need to assess the capacity of each of these and help the agency to build capacity in areas of weakness. For the first round of small project funding, agencies have been selected which clearly have the required institutional capacity to implement and monitor the approved subprojects.

USAID is satisfied that Government's commitment to establishment of the Council is irrevocable and that the--admittedly preliminary--plans for the Council are administratively feasible. USAID and the other donors, however, are providing support with the full knowledge that development of the Council will be a challenging and possibly time-consuming process.

2. Part B

The Family Planning II project purpose related to Part B is to help improve the Ministry of Health's institutional capacity to deliver effective family planning services. The MOH will establish an IRH/FP Steering Committee comprising the Permanent Secretary (Chairman), the Director of Medical Services, the Chief Nursing Officer, the Deputy Secretary for Development, and the Director of the Core Project Unit to provide policy guidelines and to review at least once quarterly the progress of Part B. The MOH will also establish an IRH/FP Core Project Unit composed of a Project Manager, Deputy Project Manager, six professional staff and fifteen support staff.

The duties and functions of the IRH/FP Core Project Unit include:

- a) Provide day to day management of Part B activities;
- b) Account for expenditures;
- c) Maintain a financial management and control system;
- d) Prepare disbursement and reimbursement applications;
- e) Prepare project reports;
- f) Provide technical assistance and supervision to the MOH departments with project implementation responsibilities;
- g) Provide guidance on procedures and policies related to implementation;
- h) Set up teams to plan, implement and evaluate IRH/FP activities; and
- i) Monitor progress of each MOH department in implementation.

The National Family Welfare Center has the primary responsibility for the family planning services component of the IRH/FP Program. The NFWC will have the following major functions:

- a) Establishment and improvement of MOH/FP Service Delivery Points;

- b) Training of Enrolled Community Nurses in family planning;
- c) Training of Clinical Officers in family planning;
- d) Information and Education activities in family planning-linked to Part A;
- e) Evaluation and research in family planning-linked to the Health Information System; and
- f) Training of other cadres in family planning.

The NFWC was established in 1974 to plan and support the activities of Government's 1974-79 MCH/FP Program. The World Bank Project Performance Audit Report on the Kenya First Population Project (Credit 468-KE) fully documents the shortcomings of the NFWC and the underlying causes. The report concluded that: "The NFWC never became adequately linked to its institutional environment and thus lost potential means of support and influence. It was never provided with, or was shorn of essential resources such as staff, buildings and vehicles; until at the end of the project it is no longer a viable organization for directing (the) national population effort" (World Bank Project Performance Audit Report 1981:19). The MOH with the encouragement and support of donor organizations is attempting to strengthen the institutional capacity of the NFWC through the family planning services component of the IRH/FP Program.

The World bank Audit Report further indicated: "The most serious effect on the project came from the lack of a full-time, relatively independent director. As a result, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out the role envisaged, and the principal task of directing NFWC activities fell to the deputy directors, who were changed three times over the life of the project and themselves received little support" (Ibid:11).

The MOH has recruited a full-time, senior Director of the NFWC. In response to donor concerns about key professional vacancies at the NFWC, the MOH has agreed to fill existing vacancies and to establish additional NFWC positions. This involves the assignment of additional professional and administrative staff to the NFWC. The assignment of administrative personnel allows the NFWC Director the authority to incur expenses and will result in greater autonomy for the NFWC. In addition, donor agencies will provide consultant support, participant training and observation tours to strengthen the institutional capacity of the NFWC. The MOH intends that the IRH/FP Core Project Unit will support and assist the NFWC to carry out its responsibilities. The donors including USAID are committed to the effective running of the NFWC, and will continue to provide it with the necessary support.

The NFWC organizational structure is headed by a Director and Deputy Director and consists of the following divisions and functions:

- a) Administrative and Planning Division: responsible for the day to day administrative activities such as transport, accounts and purchasing of equipment and supplies;
- b) Clinical Service Division: responsible for monitoring the quality of MCH/FP services and determining manpower, equipment and supply requirements; also responsible for coordinating the phased expansion of MCH/FP SDPs;
- c) Training Division: responsible for training the necessary manpower to deliver family planning services;
- d) Information and Education Division: responsible for the promotion of family planning services through I&E activities; works closely with the health Education Unit and the National Council; and participates in training of health cadres in family planning; and
- e) Evaluation: coordinates family planning operational research and evaluation in cooperation with the Health Information System.

USAID will assist the NFWC Training Division in training 900 Enrolled Community Nurses and 270 Clinical Officers through short-term, in-service family planning courses. The aforementioned World Bank Audit Report concluded that the NFWC Training Division achieved most of its training targets under the MCH/FP Program. The report states, "In spite of the difficulties of role clarity and lack of informational support the result of the training can be seen as one of the highlights of the project."

The Training Division is staffed by nurse-trainers with considerable experience in training health cadres in family planning. The Training Division trained 950 Enrolled Community Nurses in family planning during the MCH/FP Program. Most of the staff are former USAID participants. Eight additional nurse-trainers are to be funded by USAID under this project to handle the expanded training responsibilities. The AID-funded INTRAM Program has provided and will continue to provide technical assistance to both the NFWC and schools of nursing through in-country workshops. USAID believes that the NFWC Training Division and the schools of nursing have the capacity to accomplish the in-service family planning training to be supported by USAID.

C. Social Soundness Analysis

1. Introduction

There are three documents which address the prospects for a successful national family planning program from the social perspective. These include the basic planning document for Part A of the project entitled, "An Interagency Programme for Information and Education on Population and Development in Kenya" (Lyle Saunders and Philip Mbithi, April 1980); the "Evaluation of the Socio-Cultural Impact of the MCH/FP Programme on Rural Populations" (Shem Migot-Adholla, April 1981) prepared for the Operation Evaluations Department of the World Bank, and the Social Analysis, Annex C of this paper. All of these documents served as resources for the design of the project, and substantiate the fundamental social soundness of the basic assumptions, purposes, and strategies of the approach.

An effort designed to support a national GOK multidonor project, USAID's proposed contribution is eminently sound in the social context. It is based on extensive experience and analysis. It is also designed to directly support the key interrelated activities of promotion of smaller family size preferences among appropriate segments of the Kenyan population and improvement of the ability of the MOH to expand delivery of efficient family planning services. The relevance of this particular strategy is analyzed in detail in the documents referred to above. This summary analysis addresses the major social soundness concerns, with emphasis placed on the critical issues for each.

2. Context

Kenya, like most of the countries of sub-Saharan Africa, is predominantly rural and agricultural and only just beginning to move beyond the phase of the population transition when infant and maternal mortality rates are declining and fertility rates are increasing. At this point among most Kenyan families, desired family size is extremely high, actual size is high, and use of efficient family planning to limit family size is correspondingly low. Many features of Kenyan society support high fertility, these are analyzed in Annex C. Despite a general context supporting high fertility, however, there are important processes underway which point to a significant emerging demand for family planning in both urban and rural settings. The demand is often related to birth spacing requirements, and to reduction of completed family size from very large (e.g. 8 or 9 children) to large (e.g. 6 to 7 children). Nonetheless a trend to small family size is discernable under certain economic and socio-cultural conditions, and although the purposes for which families use effective contraception are varied, they do support the goals of the project.

3. Socio-Cultural Feasibility

There are several reasons why the proposed project has a high degree of socio-cultural feasibility. It is a second phase activity and so is able to benefit from previous experience. It is the product of a collaborative effort which has profited from consultants (such as Saunders and Mbithi) who are exceptionally well qualified to help design a socially appropriate program for Kenya. It has had the benefit of one of the most extensive national programs for the generation of social statistics found in sub-Sahara Africa. It has been designed with a very flexible component of small project funding which will enlist a wide range of local institutions in efforts to promote family planning and smaller family size preferences in accordance with local economic and socio-cultural conditions.

One of the most important features of the project from the social perspective is the degree to which the design takes into account the fact that ultimate decisions and behavior regarding contraceptive use and birth limitation will occur in the family setting. Effective family planning will be the outcome of by-and-large "rational" decisions as taken by family members, and as conditioned by a wide range of concerns such as perception of the family planning program, community sanctions, ethnic and historical rivalries, etc. At present, most recent studies show that a number of conditions must be met before a family becomes actively involved in effective family planning. The program design, with its flexible structure and wide-ranging multisectoral focus, will be able to mobilize a range of resources to identify and promote conditions favorable to family planning practice.

4. Participation

In MCH/FP the degree of commitment of MOH service delivery staff, national leadership, and potential clients was found to be relatively disappointing. The proposed USAID project will focus directly on improving the capability and commitment of the Ministry of Health service delivery staff; this has been identified in a number of studies as an important problem. Establishing the National Council on Population and Development in the Office of the Vice President and Ministry of Home Affairs is a sign of commitment at the highest level of national leadership. While full participation in achieving the goals of the program will still be conditioned by the political and ethnic constraints discussed in Migot-Adholla's paper, for example, recent public statements by the President, and his clear interest in the viability of the program, will serve to increase participation at the national level.

A key purpose of Part A of the program is to generate participation of institutions, communities and groups throughout

Kenya. Such participation is expected to achieve significant multiplier effects among the populations involved. As organizations such as Maendeleo ya Wanawake, the Protestant Churches Medical Association and the Family Planning Association of Kenya receive support, they will be able to generate substantial interest in family planning across the countryside in the communities and among the types of families who are most likely to be furthest along in the transition towards smaller family size preferences. The participating organizations will generate involvement of local leadership and community-based institutions. Frequently, they will be introducing family planning information and education in an integrated multisectoral context (e.g. through support to income-generating women's groups, or family life education). Through such approaches, socio-cultural and other localized concerns will be taken into account.

An important characteristic of the program will be concerted effort to involve men in the program, in both Part A and B activities. Men are viewed from a number of perspectives as being suspicious of family planning purposes and practices and thus a constraining influence on the participation of their wives. In a recent pair of surveys*, for example, men interviewed (n = 825) reported an average desired total of 8.66 children. A comparable sample of women (n = 1329) desired an average of 8.04 children. These totals are relatively similar and suggest common views across sexes. When the same sample of women was queried about their perception of their husbands' attitude towards family planning, however, the pattern of their responses substantiated the need for a special focus on men to improve family attitudes and participation. For example, only 19.6% of all women thought their husband would approve of family planning to stop having children, while the remaining women either thought their husbands would disapprove (51.3%) or did not know what their husband's position would be (29.1%) (Dow and Werner draft 1982:15). It is likely that one means to increase the participation of women and families in the family planning program will be to increase efforts to promote more favorable attitudes among men.

* Carried out by Dow and Werner in 1981, the study utilized a subsample from the Central Bureau of Statistics sampling frame. The results reported herein are from their draft paper entitled: "Perception of Family Planning and the Family Planning Program Held by Rural Kenyan Women - 1982".

5. Beneficiaries

A beneficiary profile of recipients of information and education and family planning services is provided in Section III E. This topic is also covered in detail in Annex C.

A key concern in AID policy is the role of women. Clearly women assume a major role in this project and efforts will be directed to their husbands as well as themselves to promote their involvement. A second issue related to general AID policy is the degree to which benefits are directed at the better-off segments of the society, at the expense of or resulting in the omission of attention to poorer, needier families. There is no doubt that the families most likely to alter fertility patterns as a result of AID's involvement in the IKH/FP Project are those who are from the better-advantaged communities in terms of access to productive employment, education, social amenities, and health and family planning services. Earlier adoptors are likely to be families experiencing the kinds of internal changes which result from the benefits of modernization.

A desire for smaller family size however does not necessarily occur first in the wealthiest families. In the case of Kenya, one can argue that those who are sufficiently involved in the process of modernization to experience high aspirations for both parents and children, but who are constrained by inflation and other circumstances are most likely to want smaller families. The families in the middle strata who are feeling the economic pinch may well be more receptive to the program than those much better-off. In sum, for the project to succeed there is no question that the focus must be on the families benefiting from socio-economic change. An unavoidable consequence of this approach is that AID-provided resources will only benefit poorer families in more indirect ways, over the long term.

A further implication of this approach is that the project will continue to cater to a wide variety of needs. For example, provision of family planning as a means for spacing (particularly as a replacement for breast-feeding) and as a means to alter large family desires only slightly is an important characteristic of the proposed approach. To ensure that the project provides benefits to as wide a range of the population as possible, it must continue to serve, as expressed in one paper, as a cloak of many colors (Dow and Werner 1982). A too narrow focus on an approach which is solely or primarily aimed at promoting fertility reduction, might harmfully restrict the desired range of intended beneficiaries.

6. Impact

The evidence from various sources (the most recent being the Dow and Werner 1981 national study referred above) makes it clear that present trends in Kenya are not conducive to a rapid increase in effective family planning. Significantly, most Kenyan families and communities have yet to undergo the kind of changes which encourage the transition to smaller family size. The strength of the proposed project is that it will identify and support the kinds of institutions and families involved in the processes promoting rapid family change at the local level, as well as supporting training to improve the delivery of effective services. This is an efficient approach to achieving impact in an exceptionally complex context; the results, however, will be slow in realization.

D. Economic Feasibility

A detailed Economic Analysis, included in Annex D, demonstrates economic feasibility of the combined rural health and family planning project. The economic feasibility of the essential component parts of the IRH/FP Project are assured once least-cost criteria have been investigated for those components and found to be met. These include components funded by AID under Family Planning II. Because of the requirement for an integrated approach to family planning and rural health in Kenya, however, it is not conceptually possible to determine the marginal effect on total IRH/FP Project outputs of AID expenditures.

Out of a total AID funding package of \$4 million under the Family Planning II Project, \$3 million will be used to finance operating costs of the National Council on Population and Development and the costs of nine subprojects to be implemented by private organizations. This AID funding will provide just over one-quarter of the total support required for the Interagency Information and Education Program on Population and Development whose function will be to promote understanding and demand for family planning services (Part A of the overall program). USAID's recently approved CDSS adopts a strategy which places emphasis upon creation of demand for family planning through public and private sector activities. Such an emphasis derives in part from in-depth evaluation of previous family planning efforts in Kenya which suggest that the main constraint to the reduction of fertility levels in Kenya is the widespread desire for large families. Although no portion of a truly integrated program of family planning can be deemed more important than any other, USAID is channeling three-quarters of its Family Planning II assistance into demand creation, which it believes will be essential to proper utilization of the much larger sums being spent elsewhere

in the program on expanding overall FP supply. The remaining one-quarter of the funds (\$1 million) supplied through Family Planning II will provide financing for family planning training for 900 Enrolled Community Nurses and 270 Clinical Officers (Part B of the overall program). These personnel are the basic front line workers in expanding family planning supply in Kenya, and their confidence, competence and motivation will be essential elements in demand creation and in the continuity of user acceptance of family planning techniques as well.

Family Planning II, Part A expenditures contribute to least-cost implementation of the overall family planning program by underwriting essential coordination mechanisms and expanding the role of private organizations in creating demand for family planning services. Past evaluation studies strongly endorse the necessity of institutionalizing a mechanism to encourage and coordinate the implementation of POP/FP activities among the MOH, other government ministries, and private sector agencies. The National Council on Population and Development is designed to fill this need for a coordinating body which is capable of directing a broad multisectoral approach requiring wide community cooperation and political support while avoiding duplication of effort or waste of funds. Forty percent of Family Planning II, Part A expenditures will go toward funding the Council and seeing that this need for coordination is met.

Family Planning II seeks to implement the current CDSS strategy of increasing the involvement of the private sector in family planning activities in order to more fully utilize this sector's relatively high level of motivation and efficiency in use of funds. The remaining 60 percent of AID-financed Part A expenditures will be utilized to increase support for such organizations as the Family Planning Association of Kenya, the Salvation Army, the Protestant Churches Medical Association, and the Kenya Catholic Secretariat. USAID experience and analysis suggest that least-cost achievement of FP goals is enhanced when assistance can be selectively targeted and channeled through well-organized existing institutions familiar with and sensitive to the needs of the people they serve.

Finally, with regard to Family Planning, Part B expenditures, USAID believes that a least-cost approach to increasing FP supply is fully supported by expenditures to provide training in family planning techniques to MOH personnel. This is particularly so in light of the magnitude of other FP expenditures likely to be made for construction, transportation, supplies, and so on. Least-cost approaches have been adopted in every case in the training programs themselves by relying on in-country, in-service upgrading of existing staff as opposed to overseas, academic training of new-hire personnel. In sum, Family Planning II is found to be economically sound and economically feasible

since it funds essential features of an economically sound rural health and family planning program in a fully cost-efficient manner.

E. Financial Plan

The following tables present the financial plan for this project. Table 6, the Overall Financial Plan, shows the costs of AID, GOK, and other donor inputs; Table 7 shows the costs of various project activities (Part A and B) financed by AID; and Table 8 shows the costs of various activities (Part A and B) financed by the Government which can be directly attributed to the project financed by AID. Detailed cost breakdowns of each component as estimated by the World Bank for its Integrated Rural Health and Family Planning Project are included in the World Bank Report (see Annex J.)

Out of the total Part A cost of \$11,500,000, AID's contribution of \$3,000,000 is expected to finance the first two year's operating costs of the National Council on Population and Development and three years' costs of nine subprojects to be implemented by private and governmental organizations, and other donors or GOK will finance the third year cost of the National Council for Population and Development. It should be noted that there has been an agreement between the donors and GOK regarding financing for the first year only. However for subsequent two years, the Council would draw up an annual work plan and budget for approval by the financing agencies. As a member of the multidonor team, USAID can assume that there will be only minor changes in the annual workplan and budget for activities financed by AID. Under Part B whose total cost is estimated at \$46,800,000, AID will contribute \$1,000,000 for the subproject activity which deals with the training of Ministry of Health's 900 Enrolled Community Nurses and 270 Clinical Officers. The training will be managed by National Family Welfare Center. Other donors and GOK will finance the remaining costs as shown on Tables 6, 8, and Annex J.

A summary of costs financed by AID and GOK (GOK's costs are attributed to project activities for which AID is making contribution) is as follows: (All local currency costs)

	<u>Part A</u>	<u>Part B</u>	<u>Total</u>
AID	\$3,000,000	\$1,000,000	\$4,000,000 (74.7%)
GOK	<u>\$1,059,000</u>	<u>\$ 295,000</u>	<u>\$1,354,000</u> (25.3%)
Total	\$4,059,000	\$1,295,000	\$5,354,000 (100%)

TABLE 6

OVERALL FINANCIAL PLAN
\$ in Thousands

PART "A"

INTERAGENCY INFORMATION AND EDUCATION PROGRAM ON POPULATION AND DEVELOPMENT

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
1. A.I.D.	\$ 1,353	1,080	567	3,000
2. World Bank (IDA)	300	1,500	3,000	4,800
3. UNFPA		300	300	600
4. UK - ODA	100			100
5. GOK	<u>1,000</u>	<u>1,200</u>	<u>800</u>	<u>3,000</u>
Total Cost--Part "A"	\$ 2,753	\$4,080	\$4,667	\$11,500

PART "B"

RURAL HEALTH SERVICES

1. A.I.D.	320	326	354	1,000
2. World bank (IDA)	2,600	6,600	9,000	18,200
3. SIDA	1,200	4,300	4,300	9,800
4. DANIDA	400	2,900	5,200	8,500
5. UNICEF	200	200	300	700
6. UK - ODA	300	800		1,100
7. GOK	<u>1,000</u>	<u>2,700</u>	<u>3,800</u>	<u>7,500</u>
Total Cost Part "B"	6,020	17,826	22,954	46,800
Total (A + B)	8,773	21,906	27,621	58,300
Add taxes and duties				<u>3,000</u>
Total				\$61,300

TABLE 7

PROJECT COSTS FINANCED BY A.I.D.

PART "A"

INTERAGENCY INFORMATION AND EDUCATION PROGRAM ON POPULATION AND DEVELOPMENT

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
1. National Council on Population and Development				
(a) Furniture	(15,700)	(1,000)		(16,700)
(b) Office equipment	(24,600)	(10,100)		(34,700)
(c) Audio-visual equip.	(70,600)	(70,600)		(141,200)
(d) Staff salaries	(111,700)	(121,300)		(233,000)
(e) Vehicle Operating cost.	(24,000)	(28,400)		(52,400)
(f) Other Operating Costs (rent, office supplies, allowances, etc.)	(258,400)	(209,200)		(467,600)
Subtotal (1)	(505,000)	(440,600)		(945,600)
10% Price Contingencies/Yr.	(50,500)	(88,100)		(138,600)
10% Physical Contingencies	(55,500)	(52,300)		(107,800)
Total (1)	<u>611,000</u>	<u>581,000</u>		<u>1,192,000</u>
2. Family Planning Association of Kenya (FPAK)				
(a) Kits for JBA	(3,400)	(3,400)	(3,400)	(10,200)
(b) Staff salaries	(23,100)	(23,100)	(23,100)	(69,300)
(c) Vehicle Operating cost	(11,400)	(11,400)	(11,400)	(34,200)
(d) Other costs (workshops, seminars, training, supplies, etc)	(326,800)	(116,800)	(116,800)	(560,400)
Subtotal (2)	(364,700)	(154,700)	(154,700)	(674,100)
10% Price Contingencies/Yr.	(36,400)	(31,000)	(46,400)	(113,800)
10% Physical Contingencies	(40,900)	(18,300)	(20,900)	(80,100)
Total (2)	<u>442,000</u>	<u>204,000</u>	<u>222,000</u>	<u>868,000</u>

PART "A" - CONTINUED

INTERAGENCY INFORMATION AND EDUCATION PROGRAM ON POPULATION AND DEVELOPMENT

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
5. Salvation Army				
(a) Service equipment	(1,300)	(300)	(300)	(1,900)
(b) Staff salaries	(16,700)	(16,700)	(16,700)	(50,100)
(c) Vehicle Operating costs	(41,600)	(41,600)	(41,600)	(124,800)
(d) Other Operating costs (training, travel, etc.)	(12,400)	(12,400)	(12,400)	(37,200)
Subtotal (5)	(72,000)	(71,000)	(71,000)	(214,000)
10% Price Contingencies/Yr.	(7,200)	(14,200)	(21,300)	(42,700)
10% Physical Contingencies	(7,800)	(8,800)	(8,700)	(25,300)
Total (5)	<u>87,000</u>	<u>94,000</u>	<u>101,000</u>	<u>282,000</u>
6. Overall Contingencies	<u>20,000</u>	<u>20,000</u>	<u>7,000</u>	<u>47,000</u>
7. Evaluation			45,000	45,000
TOTAL PART "A" COSTS	<u>1,353,000</u>	<u>1,080,000</u>	<u>567,000</u>	<u>3,000,000</u>

PART "B"

RURAL HEALTH SERVICES

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
(In-service Family Planning Training of Enrolled Community Services and Clinical Officers)				
1. audio-visual equipment	(4,900)			(4,900)
2. Vehicles (2 mini buses)	(24,500)			(24,500)
3. Staff salaries	(31,800)	(31,800)	(31,800)	(95,400)
4. Other Operating Costs (course materials, per diem, travel)	(203,200)	(207,700)	(207,700)	(618,600)
Subtotal	(264,400)	(239,500)	(239,500)	(743,400)
10% Price Contingencies/Yr.	(26,600)	(47,900)	(71,800)	(146,300)
10% Physical Contingencies	(29,000)	(28,600)	(31,700)	(89,300)
Subtotal Part "B" Costs	<u>320,000</u>	<u>316,000</u>	<u>343,000</u>	<u>979,000</u>
Evaluation		10,000	11,000	21,000
TOTAL PART "B" COSTS	<u>320,000</u>	<u>326,000</u>	<u>354,000</u>	<u>1,000,000</u>
TOTAL PROJECT COSTS (AID)	<u>1,673,000</u>	<u>1,406,000</u>	<u>921,000</u>	<u>4,000,000</u>

PART "A" - CONTINUED

INTERAGENCY INFORMATION AND EDUCATION PROGRAM ON POPULATION AND DEVELOPMENT

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
5. Salvation Army				
(a) Service equipment	(1,300)	(300)	(300)	(1,900)
(b) Staff salaries	(16,700)	(16,700)	(16,700)	(50,100)
(c) Vehicle Operating costs	(41,600)	(41,600)	(41,600)	(124,800)
(d) Other Operating costs (training, travel, etc.)	(12,400)	(12,400)	(12,400)	(37,200)
Subtotal (5)	(72,000)	(71,000)	(71,000)	(214,000)
10% Price Contingencies/Yr.	(7,200)	(14,200)	(21,300)	(42,700)
10% Physical Contingencies	(7,800)	(8,800)	(8,700)	(25,300)
Total (5)	<u>87,000</u>	<u>94,000</u>	<u>101,000</u>	<u>282,000</u>
6. Overall Contingencies	<u>20,000</u>	<u>20,000</u>	<u>7,000</u>	<u>47,000</u>
7. Evaluation			45,000	45,000
TOTAL PART "A" COSTS	<u>1,353,000</u>	<u>1,080,000</u>	<u>567,000</u>	<u>3,000,000</u>

PART "B"

RURAL HEALTH SERVICES

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
(In-service Family Planning Training of Enrolled Community Services and Clinical Officers)				
1. Audio-visual equipment	(4,900)			(4,900)
2. Vehicles (2 mini buses)	(24,500)			(24,500)
3. Staff salaries	(31,800)	(31,800)	(31,800)	(95,400)
4. Other Operating Costs (course materials, per diem, travel)	(203,200)	(207,700)	(207,700)	(618,600)
Subtotal	(264,400)	(239,500)	(239,500)	(743,400)
10% Price Contingencies/Yr.	(26,600)	(47,900)	(71,800)	(146,300)
10% Physical Contingencies	(29,000)	(28,600)	(31,700)	(89,300)
Subtotal Part "B" Costs	<u>320,000</u>	<u>316,000</u>	<u>343,000</u>	<u>979,000</u>
Evaluation		10,000	11,000	21,000
TOTAL PART "B" COSTS	<u>320,000</u>	<u>326,000</u>	<u>354,000</u>	<u>1,000,000</u>
TOTAL PROJECT COSTS (AID)	<u>1,673,000</u>	<u>1,406,000</u>	<u>921,000</u>	<u>4,000,000</u>

TABLE 8

PROJECT COSTS FINANCED BY G.O.K.

PART "A"

INTERAGENCY INFORMATION AND EDUCATION PROGRAM ON POPULATION AND DEVELOPMENT

GOK's contribution is expected to be for the purchase of vehicles and support to subproject activities as identified in the World Bank Report No. 3409-KE (see Annex J). The GOK's contribution is estimated at \$3,000,000 (excluding taxes and duties), as shown in Table 6. Of the total, \$1,059,000 can be attributed to AID project financing as follows:

GOK contribution attributable to AID
 = GOK Part A total contribution (\$3,000,000) X
 AID Part A total contribution (\$3,000,000)
 divided by total donor contribution
 (\$8,500,000).

PART "B"

RURAL HEALTH SERVICES

GOK's contribution directly attributable to activities financed by AID is mainly for the operating cost of two vehicles and the cost of salaries including housing allowance for Enrolled Community Nurses (300 No. per year) and Clinical Officers (90 No. per year). These costs are as follows:

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
(a) Operating cost of 2 vehicles @ \$20,800 per year/vehicle	(13,600)	(13,600)	(13,600)	(40,800)
(b) Salary of 300 Enrolled Community Nurses @ \$1,550/year for 10 days training/year.	(38,500)	(38,500)	(38,500)	(115,500)
(c) Salary of 90 Clinical Officers @ \$3,000/year for 10 days training/year.	(22,500)	(22,500)	(22,500)	(67,500)
Subtotal	(74,600)	(74,600)	(74,600)	(223,800)
10% Price Contingencies/Year	(7,400)	(14,800)	(22,400)	(44,600)
10% Physical Contingencies	(8,000)	(8,200)	(9,200)	(25,400)
Total	90,000	98,100	106,700	295,000

Total GOK contribution (PART A AND PART B) = \$1,354,000

F. Recurrent Cost Implications

GOK contributions to the three-year IRH/FP Project will be financed under several budget headings. Part A expenditures to finance activities of the National Council on Population and Development and of various NGO's will appear in the budgets of the Office of the Vice-President and the Ministry of Home Affairs. Part A expenditures associated with activities to be carried out by other governmental agencies will be allotted to the budgets of those agencies. The impact of the IRH/FP Project on the budgets of the Office of the Vice-President and the Ministry of Home Affairs is difficult to estimate with precision at this time. Effective February 25, 1982, the Office of the Vice-President and the Ministry of Finance were made independent of one another. On the same date, the Ministry of Home Affairs and the Ministry of Constitutional Affairs were also separated from one another. Separate line item projections for the Office of the Vice-President and for the Ministry of Home Affairs have not yet become available for the forward budget years. It may be noted however, that Part A expenditures amount to only about 29 percent of the GOK's costs during the first three year of the program, that such expenditure will be spread among a number of GOK ministries and agencies, and that placement of the National Council under the Office of the Vice-President is an indication of significant GOK support for the program as a whole.

The majority (71 percent) of IRH/FP Project costs during the first three years relate to Part B and would have to be included in the MOH budget. As indicated in the table above, the total cost to the GOK of Part B would rise from 0.9 percent of the MOH budget in 1981/82 to 3.1 percent in 1983/84. Moreover, operating and maintenance costs arising from Part B activities would continue to rise to an estimated level of \$12.5 million in FY 1987/88 (at 1981 prices) equivalent to 8.5 percent of the projected MOH budget at that time.

Incremental operating and maintenance costs arising from the IRH/FP Project would represent 25.6 percent of the increment in the budget of the MOH in 1982/83, 14.9 percent of the increment in 1983/84, and 33.8 percent of the increment between 1983/84 and 1987/88. (31.2 percent, 18.3 percent and 41.7 percent of the increments in the Recurrent Budget respectively). Relevant subvotes of the MOH budget under which these types of expenditures would normally be classified comprised 24.3 percent of the MOH's recurrent budget in FY 1980/81. Other developmental activities in the period outside the program under these subvotes are expected to be of relatively minor magnitude. As a result, implementation of the IRH/FP Project implies only a modest shift in the composition of expenditures within the MOH's recurrent budget for a high priority effort, indicating overall financial feasibility. Similar calculations can be made for the AID-funded component of the overall program, Family Planning II. As indicated in Table 9, the

Table 9

RECURRENT COST IMPLICATIONS FOR GOM BUDGET*
(THOUSAND US DOLLARS, ** 1981 PRICES)

	1981/82 (Budget)	1981/83 (Forwarded Budget)	1983/84 (Budget Ceiling)	1984/85	1985/86	1986/87 Projected***	1987/88
Total GOM Budget	1,655,260	1,732,000	1,800,000	1,876,000	1,951,040	2,029,082	2,110,245
Office of IP and MOP	58,158	—	—	—	—	—	—
MOOYA	41,818	—	—	—	—	—	—
MOR	107,368	114,000	121,400	130,800	136,032	141,473	147,132
- Research	85,566	91,000	97,000	104,800	108,992	113,352	117,886
- Development	21,802	23,000	24,400	26,000	27,040	28,122	29,246
IRB/TP							
Total GOM Cost	2,000	3,900	4,600	—	—	—	—
Part A	1,000	1,200	800	—	—	—	—
Part B	1,000	2,700	3,800	—	—	—	12,500
Part B Share of MOR Budget	0.9%	2.4%	3.1%	—	—	—	8.5%
Incremental GOM Cost	2,000	1,900	700	—	—	—	—
Part A	1,000	200	- 400	—	—	—	—
Part B	1,000	1,700	1,100	—	—	—	8,700
Part B Share of MOR Budget Increment	—	25.6%	14.9%	—	—	—	33.8%
FP 11 (ACD)							
Total GOM Cost	443	522	369	—	—	—	—
Part A	353	424	282	—	—	—	—
Part B	90	98	107	—	—	—	—
Part B Share of MOR Budget	0.1%	0.1%	0.1%	—	—	—	—
Incremental GOM Cost	443	79	- 133	—	—	—	—
Part A	353	71	- 142	—	—	—	—
Part B	90	8	9	—	—	—	—
Part B Share of MOR Budget Increment	—	0.1%	0.1%	—	—	—	—

Notes:

- * GOM Fiscal years, July 1 - June 30.
- ** Conversion at nominal rate of 2 US \$ = 1 Kf.
- *** Assuming minimum GDP growth of 4 percent per year, constant ratio of Budget expenditures to GDP, and MOR share of total Budget constant at 7.0 percent during 1984/85 and beyond.

Source:

Ministry of Finance. Forward Budget 1981/82-1984/85.

FP II component by itself implies added MOH expenditures totalling only 0.1 percent of the average and incremental MOH budget expenditures during 1981/82 - 1983/84.

G. Environmental Concerns

According to Section 216.2 of Agency's procedures stated in 22CFR Part 216, an Initial Environmental Examination, Environmental Assessment and Environmental Impact Statement are not required for programs involving nutrition, health care or population and family planning services if they do not include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.). The AID Grant does not include any activities which could directly affect the environment.

V. IMPLEMENTATION ARRANGEMENTS

A. Implementation Plan

1. Government of Kenya

There will be separate arrangements for the implementation of Parts A and B of the IRH/FP Program. For Part A, the actual information and education activities will be carried out by the participating agencies, both governmental and non-governmental. Coordination and monitoring, common support activities, the preparation of overall annual work plans, procurement of goods for NGOs, progress reports, reimbursement applications and the transfer of funds will be carried out by the National Council's Secretariat. The Secretariat's chief executive, the Director, will be appointed as Project Director, Part A, and will report to the Permanent Secretary in the Office of the Vice President and Ministry of Home Affairs. Each of the participating governmental agencies will be responsible for the procurement of its own goods and services.

Part B of the IRH/FP Program will be carried out by the MOH, with the NGO component carried out jointly by the MOH and NGOs. Although the MOH project components will be carried out by existing MOH units, a strong IRH/FP Core Project Unit has been established for (1) monitoring and supervising of Part B activities; (2) keeping Part B project accounts; (3) preparing Part B disbursement and reimbursement applications; and (4) preparing Part B progress reports for donors. The Director of the IRH/FP Core Project Unit will also be the Project Director, Part B, and will report to the Director of Medical Services. An MOH Steering Committee will oversee the implementation of Part B components and to solve any problems of intra-ministerial coordination that may arise in the course of project implementation.

The Training Division of the National Family Welfare Center will have the primary responsibility for the implementation of the in-service family planning training for Enrolled Community Nurses and Clinical Officers. The NFWC will be assisted by the Chief Nursing Officer's staff, the IRH/FP Core Project Unit and staff at Enrolled Community Nursing Schools located at Meru, Thika, Kisumu, Mombasa, and Nyeri. The ECN training will require 8 weeks of theoretical and practical instruction, while the CO training require 1 week of theoretical training. The practical training will take place in MCH/FP clinics within hospitals and health centers located in the vicinity of the 5 ECN schools.

Detailed descriptions of implementation arrangements can be found in World Bank Report, Annex J. The time-phased implementation schedules related to Part A and B activities to be financed by USAID are included in Annex B.

2. USAID/Kenya

The Health, Nutrition and Population Division has responsibility for project implementation. The Population Officer is the project officer of Family Planning II. The Projects Division will provide necessary support as part of overall project management function.

B. Procurement Plan

It is anticipated that all goods and services procured under the project will be contracted directly by the National Council on Population and Development and the implementing agencies for the subprojects for Part A and the Ministry of Health for Part B. The procuring agencies will be required to follow AID procedures as set forth in Handbook 11.

It is further anticipated that all services and goods will be procured locally.

C. Evaluation Plan

The evaluation of Part A activities is the responsibility of the National Council on Population and Development. The National Council's Secretariat will evaluate or enter contractual arrangements to evaluate each of the subproject activities implemented by participating agencies. Implementation of Part A activities will be based on annual plans and budgets to be prepared by the Secretariat and approved by the funding agencies. Starting with the first project year, all potential implementing agencies will submit proposals to the National Council for

activities they propose to carry out the following year. The Council will assess, rank and consolidate these proposals based on the funds available, the agencies' performance in implementing Part A activities in the previous year, and policy guidelines issued by the Council's Executive Committee.

The National Council, in addition to periodic evaluation, will monitor the progress of the Part A subprojects. Those subprojects found not to be achieving their intended impact will be re-designed with the assistance of the National Council or terminated. USAID and other donor agencies will meet annually with the National Council to review progress during the past year and develop a financing plan for the following year's Part A activities. In addition, the World Bank will organize Donor Supervision Missions at least every six months to formally review the status of project implementation of both Parts A and B. The World Bank will organize a Joint Appraisal Mission at the end of the second project year to evaluate Phase I of the IRH/FP Program and assess the activities planned for Phase II. USAID/Kenya will prepare a Project Evaluation Summary (PES) following the Joint Appraisal Mission on both Parts A and B. There will be a final USAID evaluation of Parts A and B at the conclusion of Phase I. The evaluation will document changes in knowledge, attitude and practice of family planning in order to assess the impact of IRH/FP Program activities during Phase I.

Part B monitoring and evaluation will be the responsibility of the MOH's IRH/FP Core Project Unit, assisted by other MOH units as appropriate. USAID/Kenya intends to arrange a special evaluation by outside consultants of the in-service family planning training of ECNs and COs during the second project year. The NFWC and the Health Information System will propose operational research and evaluation activities related to family planning services. The activities will be undertaken by the NFWC, the HIS or by contracted consultants.

The HIS will collect and analyze family planning service statistics. Data related to the outputs of in-service family planning training, expansion of MCH/FP Service Delivery Points and staffing of MCH/FP SDPs will be maintained by the NFWC. The service statistics will serve as an indicator of IRH/FP Program impact.

The USAID final evaluation will follow standard practice in utilizing the Logical Framework (Annex A) as the evaluation guide. A supplemental list of performance characteristics and critical assumptions for consideration by the evaluation team are included in Annex A.

Measurement of demographic change will be the responsibility of the Central Bureau of Statistics. The CBS intends to undertake a National Demographic Survey of 80,000 households during 1983. A contraceptive prevalence survey module developed by Westinghouse Health Systems will be administered to a subsample of approximately 6,400 women aged 15-49 years. It is anticipated that contraceptive prevalence surveys will be implemented every 2-3 years to measure impact of LRH/FP Program activities.

D. Conditions and Covenants and Negotiating Status

1. Conditions Precedent to Disbursement - Part A

The Office of the Vice-President and Ministry of Home Affairs has filled the positions of Director, Deputy Director and all five professional positions in the Secretariat of the National Council on Population and Development with full-time staff whose experience and qualifications shall be acceptable to USAID.

Part B.

The Ministry of Health has established a Core Project Unit and has filled all key positions with full-time staff whose experience and qualifications shall be acceptable to USAID.

2. Covenants - Part A

The Secretariat of the National Council on Population and Development shall submit for USAID approval annual workplan and budget at least 30 days prior to commitment of any expenditures for that year.

Covenants - Part B

1. The Ministry of Health shall keep all key positions in the National Family Welfare Center filled with full-time staff whose qualifications and experience shall be acceptable to USAID.
2. The Ministry of Health shall submit for USAID approval by September 30, 1982, time-phased plans for in-service family planning training of 900 Enrolled Community Nurses and 270 Clinical Officers who will be assigned to Rural Health Facilities of the Ministry of Health. The plans should include but

not be limited to, dates and locations of training, numbers of trainees and trainers, anticipated onward assignment of each trainee and estimated costs.

3. The Ministry of Health shall submit for USAID approval by December 31, 1982, a detailed time-table for conversion of all Government Rural Health Facilities not functioning as full-time Maternal and Child Health/Family Planning Service Delivery Points (SDPs) into full-time SDPs, and for their conversion into limited SDPs supplying nonpharmaceutical contraceptives and resupplying oral contraceptives.

3. Negotiating Status

During the period of March 29-April 4, 1982, negotiations on the Integrated Rural Health and Family Planning Project took place between the Government of Kenya and the World Bank. Representatives of other donor agencies participating in the financing of the IRH/FP Project including AID were present as observers. Agreement was reached on the IRH/FP Project components to be financed, the proposed financing to be provided by Government and each donor agency, and donor conditions for financial participation. On May 6, 1982, the World Bank announced its approval of a \$23 million International Development Association Credit for the IRH/FP Project. The Government of Kenya and all donor agencies are in basic agreement, although individual agreements must be negotiated. There are no substantive issues between Government and USAID/Kenya which would prevent the signing of a Project Agreement for Family Planning II.

FAMILY PLANNING II PROJECT 615-0193
PROJECT DESIGN SUMMARY LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Program of Sector Goal:</u> <u>The broader objective to which this project contributes:</u></p>	<p><u>Measures of Goal Achievement:</u></p>	<p><u>Assumptions of achieving goal targets:</u></p>	<p><u>Assumptions of achieving goal targets:</u></p>
<p>To reduce the birth rate.</p>	<p>1. The gradually increasing birth rate may not decline during the life of the project but certain lead indicators that it may turn down will include:</p> <ul style="list-style-type: none"> - decline in the rate of increase in the birth rate - increased desire for limitation of family size through use of family planning methods - increased spacing of births among families using FP - reduction in adolescent pregnancies 	<p>1. Demographic data monitoring and evaluation system</p> <p>2. Project Statistics</p> <p>3. Demographic Survey (in 1983)</p>	<p>1. Government support for family planning to space births and limit size increases.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Project Purpose:</u>	<u>Conditions that will indicate purpose has been achieved. End-of-Project status.</u>		<u>Assumptions for achieving purpose:</u>
To establish an institutional capacity within the JCK to implement effective birth spacing and limitation of family size in Kenya.	<p>1. 30 FP information and evaluation activities identified and being implemented.</p> <p>2. Council and Secretariat performance reflects a high degree of: (a) agreement and commitment to institutional objectives; (b) breadth and depth of professional knowledge relevant to attainment of objectives; (c) interdisciplinary coordination and professional effectiveness in selecting, planning, implementing and evaluating subproject activities.</p> <p>3. (82) (83) (84) New FP acceptors: 87000 109000 132000 Continuing FP Users: 146000 185000 224000 Contraceptive Prevalence (Modern Methods): 5% 6% 7%</p>	<p>1. Project monitoring and evaluation.</p> <p>2. 1983 contraceptive prevalence survey.</p>	<p>1. Government strongly supports the National Council and its purposes.</p> <p>2. The economic and socio-cultural context of many Kenyan families does not significantly constrain emerging preferences for smaller family size.</p> <p>3. The terms of service for trained personnel will be sufficient that they return to and remain in positions for which they are trained.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Project inputs:</u>	<u>Implementation Target</u> <u>(Type & Quantity)</u>		<u>Assumptions for providing Inputs:</u>
Inservice and incountry training	1. 900 ECNs and trained 270 COs trained	1. GOK and project financial and training records.	1. Personnel available for training.
Cash contribution to the National Council on Population and Development.	2. \$3 million		2. GOK completes staffing of the National Council. National Council prepares adequate yearly budget and workplan in timely fashion.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Project Outputs:</u>	<u>Magnitude of Outputs:</u>		<u>Assumptions for achieving outputs:</u>
Fully staffed and functioning National Council on Population and Development.	1. System for generating, identifying, prioritizing, selecting, funding and evaluating information and education activities in place and operating effectively.	1. Project reports, monitoring and evaluation.	1. Sufficient number of paramedical staff will be motivated for assignments to rural service delivery points.
Additional Dispensaries Health Centers, and sub-centers capable of serving as service delivery points for family planning activities.	2. Nine activities funded by AID.	2. Site visits	2. Other donor components (contraction, equipment and supplies) will be forthcoming on a timely basis.
	3. Full family planning capability (trained personnel, equipment supplies) at an additional:		
	300 dispensaries, health centers and sub-centers		

Annex A

Supplemental Project Performance Characteristics and Assumptions

I. Conditions that will indicate the project purpose has been achieved.

A. Organizational Viability of National Council's Secretariat

- 1. Doctrine or philosophy is generally known by insiders, by clients and by donors.**
 - a. Secretariat's mandate is clearly articulated and is consistent with GOK and donor community perceptions.**
 - b. Secretariat's top management shows higher degree of agreement on doctrinal elements than do persons at lower end of organizational structure.**
- 2. Program content is sufficient and necessary to sustain the organization and to justify its cost.**
 - a. Program is consistent with doctrine and is in demand by clients.**
 - b. Organization has ability to adapt to its changing environment while remaining on course consistent with its major objectives.**

B. Institutional Capability of National Council's Secretariat

- 1. Interdisciplinary staff of Secretariat performs tasks in highly professional manner with both private and public sector clients.**
 - a. Planning, implementation and evaluation tasks reflect the interrelationship of various disciplines.**
 - b. Policy and planning tasks reflect a balanced outlook of varied disciplines toward both private and public sectors.**
 - c. Staff composition represents varied disciplines recruited on a continuing basis to keep the ranks up to ceiling**

2. National Council provides planning and policy guidance that serves to stimulate design and implementation of FP (Family Planning) programs in the private and public sectors.
 - a. Staff coordinates, collects, and disseminates FP research findings that are applicable to Kenya specific localities.
 - b. Staff provides guidance in design, monitoring, redesign and evaluation methods to private sector entities pursuing FP activities.
 - c. National Council is perceived as the intellectual leader for Kenya's FP movement and is valued for its policy guidance in research and innovative FP programs in Kenya
- C. National Council's professional staff capability
1. Secretariat's professional staff are well versed in state-of-the-art matters concerning demographic, sociological, and FP program data.
 2. Leadership is conversant with peer group researchers and practitioners of FP programs both inside and outside of Kenya.
 3. Staff are well versed in all facets of FP field activities in Kenya.
 4. Staff is able to analyze, recommend for refinement or to disapprove program proposals based on appropriate economic, sociological and financial criteria.
 5. Staff is oriented towards the solution of field problems with ability to train, advise and otherwise work with private sector organizations and Government departments to develop, design, implement and evaluate FP programs.
- D. Organizational capability and viability
1. Results of a capable and viable organization are evident in the quality selection and application of criteria for financing successful FP activities.
 2. Successful programs reflect a substantial increase in new FP acceptors using modern methods.

3. Feedback system between field program and National Council is operative and effective.
 4. A climate of opinion is created favorable to the FP program.
- E. Important assumption: the GOK, by virtue of its investiture of the National Council in the Office of the Vice President and Ministry of Home Affairs, will provide it the mantle of respectability, prestige and financial support that it requires.

II. Project Outputs and Magnitude of Outputs

- A. Fully staffed and functioning National Council with trained staff in place.
1. Staffing pattern developed and gazetted for 27 full-time positions.
 2. Job descriptions prepared and approved by Directorate of Personnel.
 3. Availability and adequacy of development and recurrent vote for National Council.
 4. Staff recruited, sent off to training or being trained on-the-job.
- B. Internal processes and operational procedures developed and adopted by National Council.
1. Operational systems for identifying, prioritizing and financing FP programs in place.
 2. Personnel and recruitment procedures in place.
 3. Review and approval criteria for external proposals developed.
 4. Extension function to private sector groups developed and procedures in place.

Annex B

Implementation Schedules

PART A

- 2/82 1. Cabinet approves establishment of National Council.
- 2/82 2. Office of Vice President and Ministry of Home Affairs assigned responsibility for National Council.
- 3/82 3. Office of Vice President and Ministry of Home Affairs and participating Ministries submit 1982/83 budget estimates to Treasury.
- 5/82-
7/82 4. Consultants recommend detailed terms of reference and operating procedures for National Council.
- 6/82 5. Government budgets 1982/83 funds for Part A.
- 7/82 6. Office of Vice President and Ministry of Home Affairs prepares sessional paper on National Council.
- 7/82 7. Office of Vice President and Ministry of Home Affairs appoints professional and administrative staff for Secretariat.
- 7/82 8. USAID/Kenya Director approves Family Planning II Project Paper.
- 8/82 9. AID/W allots FY 82 funding.
- 8/82 10. Government and USAID/Kenya sign Project Agreement.
- 9/82 11. USAID/Kenya and Office of Vice President and Ministry of Home Affairs initiate Part A procurement actions.
- 9/82 12. Office of Vice President and Ministry of Home Affairs rents office space for the National Council's Secretariat.

- 9/82 13. Government appoints membership of the National Council, the Executive Committee and technical committees.
- 9/82 14. Parliament considers the sessional paper and approves the National Council.
- 10/82 15. National Council becomes operational.
- 10/82 16. National Council and non-governmental participating agencies sign agreements for 1982/83 Part A activities.
- 10/82 17. Participating agencies begin implementation of Interagency Information and Education Program.
- 1/83 18. Each participating agency submits quarterly statements of account to National Council.
- 2/83 19. National Council consolidates quarterly statements of account and submits first reimbursement voucher to USAID.
- 3/83 20. The National Council submits a draft plan for 1983/84 Part A activities to USAID.
- 4/83 21. Government and Part A donors meet to discuss 1982/83 performance, consider annual plan for 1983/84 and draw up financing plan.
- 4/83 22. Quarterly statements of account.
- 4/83 23. National Council submits second reimbursement voucher to USAID.
- 5/83 24. Office of Vice President and Ministry of Home Affairs and participating Ministries submit 1983/84 budget estimates to Treasury.
- 6/83 25. Government budgets 1983/84 funds for Part A.
- 7/83 26. Quarterly statements of account.
- 8/83 27. National Council submits third reimbursement voucher to USAID.
- 8/83 28. National Council and non-governmental participating agencies sign agreements for 1983/84 activities.

- 8/83 29. Participating agencies begin implementation of second year Interagency Information and Education Program activities.
- 9/83 30. USAID and National Council initiate procurement actions.
- 10/83 31. Quarterly statements of account.
- 11/83 32. National Council submits fourth reimbursement voucher to USAID.
- 12/83 33. The GOK Controller and Auditor General prepares report on audited project accounts.
- 12/83 34. National Council sends annual financial report to USAID.
- 1/84 35. Quarterly statements of account.
- 2/84 36. National Council submits fifth reimbursement voucher to USAID.
- 3/84 37. National Council submits a draft plan for 1984/85 Part A activities to USAID.
- 4/84 38. Government and Part A donors meet to discuss 1983/84 performance, consider annual plan for 1984/85 and draw up financing plan.
- 4/84 39. Office of Vice President and Ministry of Home Affairs and participating Ministries submit 1984/85 budget estimates to Treasury.
- 4/84 40. Quarterly statements of account.
- 5/84 41. National Council submits sixth reimbursement voucher to USAID.
- 6/84 42. Government budgets 1984/85 funds for Part A.
- 7/84 43. Quarterly statements of account.
- 8/84 44. National Council submits seventh reimbursement voucher to USAID.
- 8/84 45. National Council and non-governmental participating agencies sign agreements for 1984/85 activities.

- 8/84 46. Participating agencies begin implementation of third year Interagency information and Education Program activities.
- 9/84 47. USAID and National Council initiate procurement actions.
- 9/84 48. Donor Appraisal of Integrated Rural Health/Family Planning Program, Phase II - Review of Phase I.
USAID prepares PES.
- 10/84 49. Quarterly statements of account.
- 11/84 50. National Council submits eighth reimbursement voucher to USAID.
- 12/84 51. The GOK Controller and Auditor General sends report to USAID on audited project accounts.
- 12/84 52. National Council sends annual financial report to USAID.
- 1/85 53. Quarterly statements of account.
- 2/85 54. National Council submits ninth reimbursement voucher to USAID.
- 3/85 55. National Council submits draft plan for 1985/86 Part A activities to USAID for financing under IRH/FP Program, Phase II.
- 3/85 56. USAID submits PID for Family Planning III to AID/W.
- 4/85 57. Government and Part A donors meet to discuss 1984/85 performance, consider annual plan for 1985/86 and draw up financing plan.
- 4/85 58. Office of Vice President and Ministry of Home Affairs and participating Ministries submit 1985/86 budget estimates to Treasury.
- 4/85 59. Quarterly statements of account.
- 5/85 60. National Council submits tenth reimbursement voucher to USAID.
- 6/85 61. Government budgets 1985/86 funds for Part A.

- 7/85 62. Quarterly statements of account.
- 8/85 63. USAID Director approves Family Planning III Project Paper.
- 8/85 64. National Council submits eleventh reimbursement voucher to USAID.
- 8/85 65. National Council and non-governmental participating agencies sign agreements for 1985/86 activities.
- 10/85 66. AID/W allots FY 86 funding.
- 10/85 67. Government and USAID sign Family Planning III Project Agreement.
- 10/85 68. Quarterly statements of accounts.
- 11/85 69. National Council submits twelfth reimbursement voucher to USAID.
- 12/85 70. The GOE Controller and Auditor General sends report to USAID on audited project accounts.
- 12/85 71. National Council sends annual financial report to USAID.
- 1/86 72. USAID prepares final Pkb.

PART B

- 3/82 1. MOH submits 1982/83 IRH/FP budget estimates to Treasury.
- 3/82-6/82 2. MOH fills existing vacancies at the NFWC.
- 5/82 3. SIDA management consultants initiate indepth review of MOH's organizational structure and administrative procedures. MOH to prepare a timetable for implementation of consultants' recommendation.
- 6/82 4. Government budgets 1982/83 funds for Part B.
- 7/82 5. MOH establishes IRH/FP Steering Committee.
- 7/82 6. MOH appoints Project Director of Part B and assigns full-time staff to the IRH/FP Core Project Unit.
- 7/82 7. USAID/Kenya Director approves FP II Project Paper.
- 8/82 8. AID/W allots FY 82 funding.
- 8/82 9. Government and USAID/Kenya sign Project Agreement.
- 9/82 10. USAID/Kenya and MOH initiate Part B procurement actions.
- 9/82 11. MOH appoints eight additional nurse-trainers to be financed by USAID.
- 9/82 12. Project Director of Part B submits to USAID time-phased plans for in-service family planning training of ECNs and COs including dates, locations, numbers of trainees, numbers of trainers and estimated cost.
- 12/82 13. The MOH prepares a detailed timetable for conversion of all Government RHPs not presently functioning as MCH/FP SDPs into full SDPs, and for their interim conversion into limited SDPs supplying non-medical contraceptives and resupplying oral contraceptives.

- 12/82 14. The MOH sets up a system to show the number, type and posting by specific facility of rural health staff.
- 12/82 15. The MOH conducts a study of the causes of ECN and CO student attrition and possible remedies, and of the feasibility of shortening ECN training.
- 12/82 16. The MOH selects locations for new CO, ECN and maintenance training schools and appoints architects to prepare designs.
- 12/82 17. The MOH concludes a survey of existing RHF's to determine locations of dispensaries to be improved and upgraded, new dispensaries and housing to be built, together with designs and cost estimates.
- 12/82 18. Location will be identified for 30 NGO MCH/FP Service Delivery Points, 3 nursing schools and three rural health centers to be upgraded.
- 2/83 19. Project Director of Part B consolidates quarterly accounts for Part B and submits first reimbursement voucher to USAID.
- 3/83 20. The MOH submits 1983/84 IRH/FP budget estimates to Treasury.
- 4/83 21. Donor Supervision Mission.
- 5/83 22. Project Director of Part B consolidates quarterly accounts and submits second reimbursement voucher to USAID.
- 6/83 23. The MOH establishes seven provincial and 51 district Health Education Officers' posts.
- 6/83 24. Government budgets 1983/84 funds for Part B.
- 6/83 25. Government engages a qualified institution to conduct a fertility and mortality study.
- 8/83 26. Project Director of Part B consolidates quarterly accounts for Part B and submits third reimbursement voucher to USAID.

- 11/83 27. Project Director of Part B consolidates quarterly accounts for Part B and submits fourth reimbursement voucher to USAID.
- 12/83 28. The GOK Controller and Auditor General prepares report on audited project accounts.
- 12/83 29. The Project Director of Part B sends an annual report summarizing all Part B financial transactions to USAID.
- 2/84 30. Project Director of Part B consolidates quarterly accounts for Part B and submits fifth reimbursement voucher to USAID.
- 2/84 31. Special Evaluation of ECN and CO in-service FP training.
- 3/84 32. MOH submits 1984/85 IRH/FP budget estimates to Treasury.
- 4/84 33. Donor Supervision Mission.
- 4/84 34. Project Director of Part B consolidates quarterly accounts for Part B and submits sixth reimbursement voucher to USAID.
- 6/84 35. Government budgets 1984/85 funds for Part B.
- 6/84 36. MOH concludes study on the options for financing the expanding supply of drugs.
- 8/84 37. Project Director of Part B consolidates quarterly accounts for Part B and submits seventh reimbursement voucher to USAID.
- 9/84 38. Donor Appraisal of IRH/FP Program, Phase II - Review of Phase I. USAID prepares PES.
- 11/84 39. Project Director of Part B consolidates quarterly accounts for Part B and submits eighth reimbursement voucher to USAID.
- 12/84 40. The GOK Controller and Auditor General prepares report on audited project accounts.
- 12/84 41. Project Director of Part B sends an annual report summarizing all Part B financial transactions to USAID.

- 2/85 42. Project Director of Part B consolidates quarterly accounts and submits ninth reimbursement voucher to USAID.
- 3/85 43. The MOH submits the 1985/86 IRH/FP budget estimates to Treasury.
- 3/85 44. USAID/Kenya submits Family Planning III PID to AID/W.
- 4/85 45. Donor Supervision Mission.
- 5/85 46. Project Director of Part B consolidates quarterly accounts for Part B and submits tenth reimbursement voucher to USAID.
- 6/85 47. Government budgets 1985/86 funds for Part B.
- 8/85 48. Project Director for Part B consolidates quarterly accounts for Part B and submits eleventh reimbursement voucher to USAID.
- 8/85 49. USAID/Kenya Director approves Family Planning III Project Paper.
- 10/85 50. AID/W allots FY 86 funding.
- 10/85 51. Government and USAID/Kenya sign Family Planning III Project Agreement.
- 11/85 52. Project Director of Part B consolidates quarterly accounts for Part B and submits twelfth reimbursement voucher to USAID.
- 12/85 53. The GOK Controller and Auditor General prepares report on audited project accounts.
- 12/85 54. Project Director of part B sends an annual report summarizing all Part B financial transactions to USAID.
- 1/86 55. USAID/Kenya prepares final PES.

SOCIAL ANALYSIS

A. Introduction

At 4%, Kenya's population growth rate is among the highest in the world. The high rate is the result of two basic demographic trends: the death rate and the fertility rate. Improved education for women, improved nutrition, effective malaria control, and other health-related developments have supported a steady and substantial decline in mortality. This declining death rate is the trend which sets Kenya off from most other African countries, which have similarly high fertility rates, but which have not yet achieved the dramatic turndown, particularly in infant mortality, found in Kenya.

Improved health conditions in Kenya have also had significant direct effects on fertility. The proportion of childless women, for example, has declined considerably over recent years.¹ An estimated 14% of women over age 40 were childless in 1962. This figure dropped to 4.3% in the late 1970's, primarily due to a reduction in sterility through effective treatment of venereal diseases and also through a decline in fetal losses due to malaria control.

B. The Context of High Fertility

An analysis of fertility increase in Kenya can begin by examining changes in the total fertility rate, (defined as the number of live births had by a woman reaching the end of her reproductive cycle). This rate has steadily increased, as shown in Table 1.

TABLE 1. TOTAL FERTILITY BY TIME PERIOD

<u>Period</u>	<u>Total Fertility Rate</u>
1941 - 1945	6.1
1946 - 1950	6.6
1951 - 1955	6.6
1956 - 1960	7.0
1961 - 1965	7.5
1966 - 1970	7.7
1971	7.9
1972	8.0
1979	8.1

Source: (Hania 1979:3 Table 3; 1979 census.)

I. Essentially all women in Kenya marry, so celibacy is not a consideration (Mualey, Werner and Becker 1981:3).

This increase is fueled by the extremely high value placed on children in Kenya, and fits a pattern of high population growth seen throughout Sub-Saharan Africa. For the average Kenyan family, desired family size has kept step with fertility potential. In 1967, for example, a survey among women showed that desired fertility was 6 children; in a survey of similar women (age 15-49) in 1977-78, desired fertility was 8 (Dow and Werner, 1981:276).

There are practical, largely rational, reasons for high and growing fertility among Kenyan families. The most important is the decline in indigenous practices such as breast-feeding and polygamy which limited births in traditional society. Also important is the rural socio-economic context in which Kenyan families live. Eighty percent live in dispersed rural homesteads and most rely on labor-intensive technologies (hoe cultivation, pedestrian transport, individual portage of fuel and water) to meet basic human needs. Agriculture, the basic means of livelihood, is domestically organized. Many farm tasks fall to the women and children of the family, and in many instances the burden has increased under the impact of what has been called "partial modernization".

The status of women is very low, and there are very few alternatives to the demanding roles of mother and wife in rural areas. Most women spend their lives working in agriculture. Wage jobs are held by very few (20% of all wage jobs in the country). Access to some primary school education is relatively high and increasing, but women with a few years of education report higher fertility than either those women with no education, or with complete primary education or higher. The few years of education are associated with the kind of partial modernization which effects, for example, a reduction in length of breastfeeding and an increase in awareness of good health practices, but not a desire to space births or limit family size significantly.

In many communities the need for children's labor has increased under the tighter economic situation which forces all family members to work, both on- and off-farm. Children provide farm labor, especially during peak seasons, and perform household tasks such as fetching firewood and water, caring for younger siblings and assisting in food preparation. They are especially called upon for family support when men are away working or when women spend time in cash-earning activities. Their contribution to the family is considered by most parents to be of greater value than the resources required to raise them (Dow and Werner, 1982b). The reverse perception, that children are a net burden on the family, has been associated with declining fertility in several African countries (Caldwell 1977; Handwerker 1977). Although average size of holdings on the fifth of the country which is endowed with good agricultural land is diminishing, the perception remains that the remaining land and urban opportunities offer an adequate economic base for the next generation.

Other factors supporting high fertility in Kenya stem from the circumstance that attitudes, values, and practices associated with family fertility and fertility regulations are changing very slowly. In most Kenyan cultures, for example, strong negative sanctions are placed on the counting of children (and livestock). Under these circumstances, parents are reluctant to assess the number, costs, and benefits of children. To do so implies the adoption of a number of foreign concepts, without which it is difficult to even discuss the value of fertility limitation. Furthermore, the extended family system is widespread, rendering the calculation of family size and the contribution of family members to family well-being far more complex and inappropriate than in societies where the nuclear family is the norm.

The high value placed on many children has not been diminished by the wide-reaching changes in family patterns and conditions of recent decades. The risks of parenthood, for example, are still keenly felt by parents, the precipitous decline in infant mortality notwithstanding.¹ Men continue to express a preference for many sons, for they are expected to protect the homestead in times of danger as well as provide social security during old age. Politicians, too, are reluctant to commit themselves publicly to fertility control measures. Ethnic rivalries as well as fear of conservative elements in their constituencies render most politicians very cautious in the family planning area. Common prohibitions on communication about sexual matters between adjoining generations (eg. child/parent, parent/grandparent) reinforce traditional beliefs and inhibit the spread of scientific information on topics such as menstruation and sexual intercourse, which in turn significantly limits acceptance and continuation of contraceptive use.

It is also possible that the repetitive sounding of a population growth rate alarm by population analysts over the past fifteen years has had a negative effect overall. A related point is that those who make decisions in Kenya, from the national level

1. It can be argued that fear of child loss remains because even though infant mortality has declined precipitiously, births have also increased precipitiously. Thus the contemporary parent may be aware of as many infant deaths in the community today as his/her grandparent was two generations ago.

to the family, are those with a relatively small stake in the outcome of high fertility and with a considerable stake in avoiding the negative consequences associated with supporting fertility limitation. The politician, the Ministry of Health official, the religious leader, and the male household head in most circumstances are far more likely to be threatened by the implications of fertility limitation than by rapid population growth.

C. Indigenous Constraints on Fertility

While traditional societies in Kenya all experienced high death rates, most observed cultural practices which served to regulate fertility as well. Typically breast-feeding and prolonged sexual abstinence were practiced following birth; other practices such as the maintenance of separate living and sleeping quarters for husband and wife, polygamy and prohibition of sex for the uncircumcised and those in mourning also limited the period when a woman was at risk of pregnancy.

In addition, there were among many groups specific cultural norms which sanctioned gaps of two or three years between births. Among the agricultural Meru and the nomadic pastoralist Galla, the period during which an adult fecund woman could appropriately bear children was socially defined, and limited to the years when she held the status of "mother," as opposed to uncircumcised "girl" or elderly "grandmother". In these groups, the concepts of child spacing and family size limitation were explicitly endorsed, and the period of socially acceptable childbearing was considerably restricted (Greeley 1977 and Prins 1953). In other groups, such as the agricultural Kikuyu, there were virtually no cultural constraints on childbearing. In most ethnic groups, however, child spacing in association with breast-feeding was accepted as desirable and even enforced by social sanctions (Holmes 1972).

In contemporary Kenya, most of the community-sanctioned practices which constrained fertility are gradually losing their effectiveness. Two traditional practices, prolonged breast-feeding and polygamy, are still prevalent, and both continue to have a significant although largely unintended constraining effect on fertility.¹ In fact, it is the combined

1. Recent analysis of a national study undertaken in 1981 indicated that on the average women desire more children than what they will achieve based on their own estimates of breastfeeding practices and birth intervals. (Dow and Verneer, 1982c.)

effect of both these practices which has the most important limiting effect on current fertility; the current level of modern contraception use is so low that it is not possible to detect an effect on the overall fertility rate (Mosley, Werner and Becker 1981:11).

The impact of a decline in duration of breast-feeding on fertility is most clearly seen in comparing the relative effects of different levels of education on birth intervals. According to Mosley, Werner and Becker (1981) there is a 2.2 month decline in the average duration of breast-feeding among women with 5-8 years of education resulting in a 25% reduction in the delay return of menstruation. The average duration of breast-feeding is 17 months, which in turn is associated with 12 months of delay in menstruation (lactational amenorrhea). Older women breast-feed longer and younger women for shorter periods. Since 97% of all women breast-feed their babies, the limiting impact on fertility is almost universal. It has been calculated that if this considerable degree of breast-feeding in Kenya were to decline to the very brief intervals seen in western societies, a rise of 25 percent in the overall fertility rate could result if not compensated by other means such as effective use of contraceptives (Ibid.) As the overall trend in Kenya is for a reduction in the duration of the breast-feeding interval as a result of a number of modernizing factors, there is a strong likelihood that the mean birth interval of 30 months will decrease. Without compensating effects fertility will therefore increase.

The average birth interval is one approach to understanding fertility dynamics; another is the average likelihood that an individual woman will have another birth. Marital status is important here. A continuously married woman in Kenya, with an average birth interval of 30 months, could expect 9.6 births over a 30 year reproductive life (age 15-44). The difference between this estimate, and the total Kenya fertility rate estimate of 8.1 live births, is a function of the proportion of a woman's potential reproductive life that she spends in marriage. The type of union also has an effect. (The material in this paragraph is from Mosley, Werner and Becker 1981:12) Twenty percent of men in Kenya are polygamous and approximately 10% of the wives are in polygamous unions. The fertility among women in polygamous unions is 11% lower than among wives in monogamous marriages, mainly due to polygamy (separate living arrangements and personal preferences may reduce coital frequency).

In general, there is believed to be a trend in Kenya towards fewer polygamous marriages due to the effects of modernization, Christian teachings and reduction in infertility

among women. The proportions of better educated men who still take at least one additional wife, however are relatively high. Among the wives in the Kenya Fertility Survey whose husbands were in professional or clerical occupations, for example, 27% and 25% respectively reported being in a polygamous union (Mosley, Werner and Becker 1981: Table 5). The implication of this relatively high percentage is that despite its conservative character; polygamy remains a desirable practice in Kenya even among the more modernized segment of the population. Its continued practice will likely constrain fertility among polygamously married women who are less likely to use effective contraceptives than those in monogamous unions.

In sum, traditional practices which are for the most part unconnected with the desire to limit or space births are the main factors limiting fertility in Kenya. Both of these practices--breast-feeding and to a lesser extent polygamy--are declining in the face of rapid socio-economic change. The dynamics of this change are also fueling wide-reaching changes in family life styles and opportunities which in turn are associated with decisions to limit family size. The processes by which these changes occur however, are highly complex, and vary considerably across regions, ethnic groups, rural and urban settings, and degrees of socio-economic attainment. Table 3 portrays a range of variables to illustrate the variation in fertility patterns among married women of the major ethnic groups. Note that despite the variation, there are some identifiable patterns which indicate a trend towards greater regulation of fertility among groups more fully involved with the processes of modernization.

Those groups with a lower marital fertility rate have prolonged breast-feeding, relatively less monogamy, and tend to reside in metropolitan areas. The group having lowest fertility, the Coastal Mijikenda, come from an area where mortality is high. A further significant factor for the Coastal Mijikenda and Luo of Nyanza is a higher level of infecundity related to poor health, which in turn is associated with polygamy. The two groups having highest fertility report relatively short breast-feeding intervals, very little metropolitan residence, and virtually no use of effective contraceptive methods. The groups having fairly high fertility, but also experiencing more sustained involvement with modernizing processes like urbanization and education, (Kikuyu, Luhya, and Kamba), also report relatively higher use of contraceptive methods. It is likely at least among the Kikuyu sample that use of contraceptives is effectively compensating for the relatively low degree of breast-feeding and polygamy which constrain fertility in the other groups. Not only is the duration of breast-feeding the shortest among the groups but the average effect of polygamously married women on overall fertility among the Kikuyu sample is slight. The average marital fertility rate, however, is still among the highest in Kenya.

TABLE 3.

RELATIONSHIP BETWEEN ETHNIC IDENTITY, LOCATION AND VARIOUS FERTILITY INDICATORS

	MFR*	Breast-feeding months	Polygamous Married %	Effective Contraceptive Use %	Women With No Schooling %	Metro-politan %
Talenjio (Ethi 98%) ¹	386	16	23	2	59	.03
Elize (Nyassa 57%)	361	17	33	1	62	1
Chimoio (Central 60%)	342	14	12	8	36	8
Luanda (Western 80%)	337	16	35	3	48	6
Metro-Inha (Eastern 97%)	335	18	22	9	46	1
Luanda (Eastern 78%)	322	18	26	4	46	9
Loe (Nyassa 64%)	285	17	43	2	55	9
Mititanda (Coast 92%)	217	23	39	2	89	20

*MFR - Marital Fertility Rate - the number of women per 1000 having a live birth in the last 12 months.

Source: Mosley, Garner and Becker, 1961.

1. % of ethnic group in Province of origin.

D. Voluntary Fertility Control

The discussion so far has focussed on the main factors constraining the already exceptionally high growth rate in Kenya. The significance of these factors rests in the fact that they have had an impact on family fertility which is by and large unintended. The desire for large families remains very strong for most Kenyans, and most attempts to use effective contraceptive methods have been aimed at sustaining existing fertility patterns, particularly child spacing, rather than limiting family size. In many instances existing fertility patterns are a departure from traditional patterns of prolonged spacing, in others they do include efforts to limit family size to 6 or 7 children rather than to 8 or more or to refuse to limit family size at all. Desired family size among women is over 8 children, and only 4 percent of Kenya's families currently use an effective contraceptive method.

Issues of access to family planning services and the quality of such services are also relevant to current fertility patterns. Although initiated in 1967, the National Family Planning Program has received strong criticism for failing to mount an effective information, education and service delivery program. Family planning statistics from the most recent years analyzed (1978 and 1979) point to an actual decline in the rate of new acceptors of family planning methods (World Bank, 1982).

Based on present conditions and impact to date it is likely that the best the family planning program will achieve is a stabilization of the current overall fertility rate. A reduction in the overall fertility rate will not likely be evidenced in the near term, without the kind of dramatic turn around in attitudes towards fertility and family size and access to health and family planning services found in a few select countries in Asia and Latin America.

Nonetheless, the lack of promising alternatives to the promotion of small family size ideals and voluntary use of effective contraception requires examination of the potential that family planning offers within the Kenyan context. Table 4 presents findings related to family planning knowledge, attitude, and practices for two time periods (1966-77 and 1977-78), based on interviews with currently monogamous married African women age 15-49, in rural areas, and in Nairobi (urban areas). The overall conclusion is that while (modern) use of contraceptives has increased significantly, particularly in urban areas, knowledge of has not in the rural areas, nor has the desire to use contraception to limit family size. The discouraging implication is that "the greater contraceptive use observed in the more recent

study is intended to facilitate, by spacing, the achievement of genuinely higher fertility aspirations" (Dow and Werner 1981:276-277).

A recent study (Dow and Werner 1982c) carried out in 1981 supports this pessimistic view. Men interviewed in a national sample (n = 825) reported desiring a total of 8.66 children. In the comparable sample of women (n = 1329) average desired children was 8.04 children. These figures omitted the considerable percentage of non-numeric pronatal responses (for example "as many as possible"). These totals are relatively similar, and suggest common views supporting high fertility for both sexes and thus do not imply domination of the husband (*Ibid*). The average age of women in this national sample was 34.4 years; the average number of births was 6.06 births (*Ibid*: 3).

Additional findings of this study support the view that current preference and practice of exceptionally high fertility is a fairly stable phenomenon, not likely to change significantly in the near future. Analysis of actual birth intervals of the sample compared with desired levels of fertility, for example, indicate that women want more children than they are likely to have given present practices which delay births, such as breast-feeding. Thus demand for children still exceeds supply (*Ibid*: 50). Similarly, as in earlier studies, the preference for family planning use is to delay births, not to stop having them. Of men interviewed, for example, 55% approved of their wife using family planning methods to delay births; however only 31% approved of use to stop having births, (Dow and Werner 1982b). Women in the sample displayed a negative view of husband preferences. Only 19.6% of women interviewed in the sample (n=1329) thought their husbands would approve of use of family planning, while the remaining women either thought their husbands would disapprove (51.3%) or did not know what their husbands' position would be (29.1%) (Dow and Werner 1982c: 14).

TABLE 4.

KAP Findings for Ever-Married Women Age 14-49

1967 and 1977/78 (Age Standardized)

<u>Variable</u>	<u>Rural 1967</u> <u>(N = 744)</u>	<u>Rural 1977/78</u> <u>(N = 5,519)</u>	<u>Urban 66-67</u> <u>(N = 200)</u>	<u>Urban 77-78</u> <u>(N = 210)</u>
Percent of women who mentioned knowledge of any contraceptive method without probing.	53.0	47.5	45.0	59.9
Percent who had ever used any contraceptive method.	10.3	30.8	2.0	45.5
Percent who had ever used at least one modern method.	NA	10.8	0.7	33.7
Percent of women who are current users.	6.3	8.4	---	----
Present Fertility	3.8	3.9	2.6	2.8
Desired Fertility	6.0	8.0	5.8	5.8
Percent of Women who want no more children.	29.6	17.0	23.0	19.2

Source: Dow and Werner 1981, pg. 274, 276.

E. Family Planning Innovators

Although the trend toward effective family planning is weak, there are sufficient data to allow a characterization of the kinds of women and families who are now, or are likely to be, the leaders in a gradual transition to smaller family size. Table 5 divides all the respondents of the Kenya Fertility Survey into four basic categories, organized in relation to use of effective contraceptive methods and number of children desired. Note most women (67%) still retain a traditional perspective towards fertility, and that almost two-thirds of women ever using effective contraception are doing so to achieve large family preferences.

Family planning innovation is thus of several types; not only do a percentage of women with traditional family size preferences use effective contraception, but also a significant portion of women not using effective contraception nevertheless want less than six children. A closer look at the "modern" women who want fewer than 6 children and have also used effective contraception indicates the positive impact of development on family planning use. Urban residence, educational attainment, occupational status of husband, and monogamous marriage are all positively related to adoption (Dow and Werner 1982a:15-17). Household size is also related, a smaller (presumably more nucleated) unit being more likely to be innovative than a larger, presumably more extended family.

A key variable in this analysis is age, as it is the younger generation which appears most favorably disposed towards maintaining smaller family size norms. Never-married women (most are under age twenty-five and unmarried) are more likely to want fewer than 6 children than currently married women, and it is likely that this cohort may well use effective contraceptives to a greater extent than their elders when married. Since unmarried mothers constitute 5-10% of all smallholder households, these may be a group upon which to focus in pilot family planning efforts.

Table 5:

DISTRIBUTION OF EVER-MARRIED WOMEN WITHIN
 TYPOLOGY CELLS

	Ever used an efficient method of contraception (+)	Never used an efficient method of contraception (-)	Totals
	Modern (++)	Transitional (+-)	
Desired Fewer Than 6 Children (+)	277 ^a (18.2) ^b (34.9) ^c (4.4) ^d	1247 (81.8) (22.6) (19.8)	1524 (24.2)
	Transitional (-+)	Traditional (--)	
Desired 6 or More Children	517 (10.8) (65.1) (8.2)	4269 (89.2) (77.4) (67.6)	4786 (75.8)
Totals	794 (12.6)	5516 (87.4)	6310

a. Count c. Column percent
 b. Row percent d. Total percent

Source: Dav and Werner 1982:11

A detailed analysis of the relationships between women's socio-economic background and style of fertility, however, reveals considerable variation in the specific ways modernization is affecting desired family size, effective contraceptive use, and fertility behavior. Level of education, as mentioned above, is generally related to increased contraceptive use; however, women with 1-4 years of primary education have higher fertility than those with either less or more education. One key question in this regard is to what extent young women with some education will adopt effective contraception in the future, and thus compensate for the effects of reduced breast-feeding. According to Dow and Werner in the study referred to in Table 5, the birth interval is longest in the "modern" block, (34 months) indicating the positive effect of contraceptive use on the very small sample of women involved, and second longest (31 months) among the other small proportion of married women using effective contraceptives yet not wanting to limit children to less than 6. Among women not using efficient contraception, the average birth interval was 29 months (Dow and Werner 1982a:21).

We can classify the innovators as being those whose use of contraception is unusually high, and those for whom there is evidence of conscious steps to reduce family size. These include: urban residents, the highest income and occupational classes, the best educated women, women with wage employment, and those from ethnic groups and social classes which were the first to, and still are the most likely to, adopt western family lifestyles. Although the categories are quite disparate, there are reasons to believe that similar processes are operating in each case to change fertility. These are reviewed below.

Urban-rural fertility differences are relatively large. Kenya Fertility Survey data show that women in Nairobi or Mombasa have a total fertility rate 2.5 births lower than that of rural women. Current contraceptive use is much higher in urban areas (19 percent) than in rural areas (8 percent) (Kenya Fertility Survey 1:102,140), although, as already pointed out, the effects of increased contraception are partially offset by decreased duration of breast-feeding, possibly disease-related sterility, and unreported abortions (Mosley, Werner and Becker 1981: 32).

Both higher education and husbands' employment in white collar and professional categories tend to correlate with decreased breast-feeding, but among the best educated women, and especially among those who also have husbands in the most modern occupational category, higher levels of contraceptive practice more than offset the decrease, and there is a net decline in fertility (*Ibid*:1981:51). There is a dramatic increase in knowledge of, ever use of, and current use of contraception among each incremental group of educated women (Kenya Fertility Survey 1:140).

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Although the proportion of women in Kenya who are working in a wage or salaried job is small--7 percent of women in the Kenya Fertility Survey sample, for example--these women have a fertility level 15 percent lower than other women, and a (modern) contraceptive use rate which is greater than four times that of those not working (Mosley, Werner and Becker 1981:24). Working women breast-feed only slightly less than the average Kenyan woman (Kenya Fertility Survey I:67).

An extremely important question but as yet to be fully addressed is the probability that a significant percentage of the country's rural smallholder families will soon adopt modern family fertility desires and practices. The tabular material presented above shows that the determinants for various family fertility patterns in rural areas operate in widely varying ways. It appears that rural households most likely to adopt smaller family size preferences and practices are those in which economic and health conditions reduce the risk and increase the cost of many births. Research to date suggests that rural families falling within the middle category of income, who have strong modern aspirations, who are sufficiently involved in the cash economy to experience the effects of inflation, who have a (probably long standing) perception of land pressure, who have access to health and family planning services, and who belong to an ethnic group which traditionally has maintained norms supporting child spacing, are those which are likely to be innovators (Greeley 1977; Kabwegyere 1976). These characteristics are particularly salient for male decision-making.

They also support research findings from Ghana (Oppong, 1968) and analysis of recent Kenya data (Dow and Werner 1982b) that suggest a connection between changing economic relationships within the extended family and a trend towards fewer desired children. Under this model, an "open" family is one "in which polygamy, fostering of children by nonparental kin, management and ownership of property by groups of siblings etc. are prevalent. Thus, for example, aunts and uncles act as mothers and fathers and financial cooperation is often closer among kin than between spouses" (Oppong 1968: 616). In this environment, the level of income and other resources of a married couple are not likely to have an impact on desired family size as there is no concept of closure, of limitation of parental responsibility to the immediate family of children and parents, for example. In families which have moved away from the open conjugal family style, when resources are less likely to be shared across siblings (e.g. in educating nephews, sharing property etc.), there is more likely to be reason to limit family size. Often the emergence of this style is promoted by participation of several generations of a family in western-based institutions such as schools and Christian churches. These factors may reinforce husband-wife communication, a desire to fully educate children, and a desire for achievements in the modern sector for family members of both sexes.

Preliminary analysis of the recent Kenya study cited above indicates that there is a trend towards greater closure of families in rural areas, as regards propensity to support siblings and their family needs, (Dow and Werner 1982b). This trend may well signal a significant change in family life styles which intervenes between changes in broad structural variables such as educational level and rural urban residence on the one hand and family size and family planning attitudes. It is relevant to note, however, that the characteristics of a related model of family change associated with changes in family fertility patterns have not been found in the preliminary analysis. This model, developed by Caldwell (1977), Handwerker (1977) and others, emphasizes the importance of changes in patterns of resource allocation and family expectations and responsibilities as preceding changes in fertility. Under this model, it is not simply increases in education, or income, or urban experience that matter, but a change in obligation patterns within the family from "what children owe parents to what parents owe children". Previous research in rural Kenya has showed the commitment of many middle aged men to prolonging and enhancing their own reproductive potential through polygamy rather, for example, than investing in education for their children (Levine 1975). In the recent Dow and Werner Study, a series of questions were asked to measure the degree to which parents were significantly increasing their commitments to their children as predicted in the model. No trend in this direction has been identified (Dow and Werner 1982b).

F. Family Planning Services

Provision of family planning information and materials has been the responsibility of the Ministry of Health since the Government announced that family planning would be an integral part of maternal and child health services in 1966. Prior to that time, as early as 1955 in the metropolitan areas, family planning was promoted by voluntary organizations in the private sector (World Bank, 1982:15). By the standards of Sub-Saharan Africa, Kenya's family planning program has been a substantial one. In 1980 there were 621 facilities offering FP services within the National Family Planning Program.

Staff competence is also an issue. The criticism has been levelled that staff are frequently delinquent in follow-up of visitors and in some cases both unable and unwilling to even answer questions about contraceptive side-effects (Mott and Mott 1980:32; Migot-Adholla 1981).

The result is a situation which has been characterized as an "extremely hopeless environment for family planning" (Migot-Adholla 1981:13). In 1975, the number of family planning first visitors was 53,500, in 1977 it was 72,000. In 1978, however despite the steadily increasing population growth rate, the number fell to 62,400. In 1979 it was 62,800 and preliminary figures for 1980 indicate a 10% drop in user rates from 1979. This decline, however, may in part be attributable to fewer units reporting. According to a World Bank Analysis, "It appears that the decline in new acceptor rates is a national phenomenon; except for Nairobi the number declined almost everywhere" (World Bank 1982:17). About eighty-four percent of all clinics offering family planning services are government owned, two percent are run by the Family Planning Association of Kenya and the remainder by the local authorities and church organizations. Despite the extensive role played by church organizations in delivery of medical services, involvement in family planning service delivery is similar to that of the Family Planning Association of Kenya.

Despite the existence of an extensive family planning program, however, actual trends in acceptance are not promising; rather they reflect the trends of increasing fertility and desire to increase family size discussed above. Of the women who know of family planning source, for example, only 13 percent are using a contraceptive. This rate is the lowest of any country with the exception of Pakistan (Mott 1981:33). Performance of the Family Health Field Educators (FHFE) is low, with each having recruited only about 15-18 new family planning acceptors per year. Other educational efforts too have been minimized, with minimal impact. It is significant however that a recent study has found that current perceptions of the goals and intentions of the national family planning program do not in themselves constitute a major obstacle to greater use (Dow and Werner 1982c).

It is not unlikely that some of shortcomings in the program itself have served to limit the spread of family planning, and so encourage a rise in fertility. Reasons for this center around limitations in the availability, reliability, and quality of services. Clinics are unevenly dispersed and poorly located, open infrequently or part-time, are short-staffed and short of materials, and are lacking in privacy and amenities. Average travel times to a family planning clinic, for example, are 68, 40, and 30 minutes for rural, urban, and metropolitan areas respectively (World Bank 1982: 15). A recent study evaluating the impact of rural access roads on development in Kenya, for example, has found indications that improved rural roads access is positively associated with a reduction in desired family size and an increase in knowledge and approval of the use of contraceptive methods (Beshkok and Dow 1982: 110).

G. Alternative to a Government Fertility Planning Program

Private profit-making family planning activities in Kenya have been limited, and largely confined to the urban areas, with the exception of the sale of condoms. The present government policy looks unfavorably on community-based distribution of the pill and IUD, although there have been 14 closely-supervised initiatives undertaken by non-government organizations. A pilot marketing scheme to provide the sale of condoms for family planning was undertaken in Meru district in the mid-seventies, but despite positive evaluations (see for example Rogers 1973), this program is seen as having generated harmful controversy and is generally characterized as a failure. The concept, however, remains attractive. There is considerable potential for well-designed social marketing effort.

It appears that private and voluntary organizations offer promise in helping to promote effective family planning, although considerable resources and time will be required to realize such promise. Christian church-related institutions are one example. Although at present they account for a very small fraction (3%) of contraception service delivery, they provide over 30 percent of health services in rural areas. Although certain Christian beliefs severely restrict the acceptability of contraceptive practices, most Christian teachings promote family life styles (eg. husband-wife communication and shared decision-making, responsibility for the development of children, participation in community and group activities) which are favorable to the spread of family planning. These teachings are especially effective in changing male attitudes towards the family in rural areas. Many church organizations have a long history of development-related activities in the communities they serve, and retain the kind of creditability and local leadership which can create and sustain a favorable environment for family size limitation and contraceptive use. While examples of the potential are few, the cases analyzed within Kenya are encouraging (Kabwegere and Mbula 1979, Greeley in Ndeti and Ndeti:1980: 139-140).

A third area of promise in rural places lies with women's groups. Women participating in groups can be exposed to family planning messages relatively efficiently, leaders of these groups are often those most likely to adopt family planning and hence may serve as role models, and the benefits of women's groups, such as increased education and understanding of the modern world, and greater income in some cases can be supportive of family planning practices. A preliminary study of 10

income-generating women's groups in Nyeri district, for example, found family planning use among group members increased from 25% to 75% over a two year period (Odera, personal communication). A fourth area of promise lies with initiatives undertaken by groups promoting breast-feeding, and a fifth area would include family planning promotion and service delivery among co-operative members, labor and teachers' union members and other worker organizations.

H. Conclusion

A basic conclusion of the analysis is that fertility trends do not support and even threaten Kenya's development. When coupled with the steady decline in mortality and an increase in the proportion of Kenyans in the lower age brackets, the situation assumes alarming dimensions. The most effective practice limiting the present high rate of fertility is prolonged breast-feeding, but the effect on family fertility is unintended and is declining with modernization. Similarly the practice of polygamy, which is a non-intentional but nevertheless significant constraint on fertility, will probably decline over time. Modernization is promoting the conditions which support voluntary use of contraceptives, but by and large families whose life styles include preference for smaller family size are those with a considerable degree of educational attainment, higher levels of income, better status of women, and, in many cases, urban exposure and professional level occupation. Current family planning use among married couples in Kenya is less than 5 percent, average desired family size among rural couples has increased in the last decade and the National Family Planning Program has remained essentially stagnant since 1978. In brief, current conditions suggest that for many rural smallholders in Kenya, limiting fertility is simply not yet a desirable or attainable option.

The Government extended official sanction to the promotion of family planning in 1966, and since that period, a continuing series of reports and papers have been published which characterize the population situation as alarming and threatening to development. Most reports, moreover, have been misleading in that, after noting alarming trends, they have tended to conclude on an optimistic note. Documents from the 1974-79 National MCH/FP program, for example, claimed that despite a growing fertility rate in the early 1970's, Kenya would achieve a decline in birth rate from 50 to 47 per thousand and a decline in the population growth rate from 3.3 percent in 1974 to 3.0 percent in 1979 (World Bank 1982:17). The actual population growth rate in 1979 was 3.9; it is now estimated to be 4.0 percent despite the nationwide program and related efforts.

Thus a significant change in fertility trends is unlikely in the short term. Given such a situation, development efforts should be broad-ranging and realistic in purpose, and targeted towards influencing changes in values, attitudes and practice as well as improving family planning service delivery. The proposed project therefore is efficiently and sensibly tailored to address the key constraints to a reduction in the Kenya population growth rate.

The results of the national effort, however, will be slow in coming and will be realized as a reduction in the increase of the population growth rate well before an actual population decline in the growth rate is achieved.

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Economic Analysis1. Assessing Costs and Benefits of Fertility Control

Kenya's rate of population growth has increased in recent years and the rate of growth of its per capita output has fallen. It would be incorrect, however, to infer that past or future rates of GDP and population growth are entirely independent of one another, capable simply of being combined to determine growth rates of per capita output. Complex causal relationships exist between population and output growth extending in both directions. Nonetheless, it can be demonstrated that the positive effects on output resulting from increases in the Kenyan labor force are likely to be insufficient to offset the negative effects of rapid population growth on per capita income.

Cost/benefit analysis of family planning programs has been criticized, even by its supporters, for the uniformity with which it predicts large economic benefits from expenditure on fertility control.¹ The major cost of any family planning program is represented by the output foregone by reducing the potential labor force. The actual cost of the family planning program by comparison is only a secondary expense. The major benefit, of course, is the reduced level of expenditure on consumption due to reduced population. To quote one expert, "The value of the consumption stream...is always far larger than the discounted productive contribution of an individual plus the costs of preventing a birth, which will be seen to be small. This holds true for two reasons. The first is that the consumption and productivity streams are discounted. Since consumption starts immediately after birth, and production is delayed for at least ten to fifteen years, even moderate discounting leads to large differences between the present values of the two streams...The second reason is that average consumption is being compared with marginal product. In the long run, average consumption and average production are identical. However, whereas an unborn child would have consumed as much as the average person through its lifetime, his marginal output falls short of the average. Insofar as the difference between the average and marginal output is a measure of the extent of the pressure of population on limited resources, this source of bias is legitimate."²

1. See Zaidan, George, The Costs and Benefits of Family Planning Programs. Baltimore: John Hopkins Press for IBRD, 1971, pp. 14-15. Zaidan's analysis for the UAR (Egypt) shows cost benefit ratios of 270%-870% depending on assumptions.

2. *ibid.*

Although an elaborate econometric model would be required to fully elucidate all of the above considerations for the Kenyan case, such a model is not necessary to arrive at a judgment that the benefits of proposed expenditures on rural health and family planning will far outweigh the costs involved. Moreover, the logic of discounting makes a positive outcome of any pro-forma cost/benefit exercise almost inevitable. Nonetheless, the logical structure of the cost/benefit approach is adopted in the analysis below as a framework for discussion.

2. Economic Cost of Reductions in Potential Labor Supply

Labor is the most abundant of Kenya's available resources, and its efficient utilization the most problematical. Kenya's estimated 1981 population of 17.5 million is growing at an annual rate of more than 4 percent. If fertility remains at current levels and mortality continues to decline along its historic trend, Kenya's population will double in 16 years, and there will be 38.6 million Kenyans by the year 2000. Under this "medium" projection proposed by Henin¹, Kenya's labor force is expected to rise from 6.1 million persons in 1978 to 15.7 million by the end of the century. Under any reasonable assumptions only a small proportion of this increase in the labor force can expect to find employment in the modern sector. If the growth rate of modern sector employment rises above its recent trend of 4.7 percent per year to as much as 6 percent, modern sector employment will only rise from 1.1 million persons in 1978 to 3.9 million persons by the year 2000. The remainder of the labor force, totaling some 11.8 million persons, will still be left to find employment outside the modern sector, primarily in rural areas. Unfortunately available supplies of land are not growing as fast as the population.

Kenya has some excellent agricultural land, but the amount of such land is strictly limited. Based on rainfall patterns, 9.3 percent of Kenya's land is officially classified as high potential and a further 9.3 percent as medium potential. Of the total land area of 5.7 million hectares, however, only about 7 percent can be described as good agricultural land defined as having adequate and reliable rainfall and good soils and not steeply sloping.

Thus far Kenya's rural sector has acted as a "sponge" absorbing rapidly increasing population through subdivision of large land holdings and through more labor intensive farming. Cross section data on small farm output during the mid-1970's

1. Henin, R., "The Characteristics and Development Implications of a Fast Growing Population" in Killick, T. Papers on the Kenyan Economy, Nairobi: Heineman Educational Books, 1981, pp.200-201.1981.

indicated no significant diseconomies of scale in Kenya for holdings as small as .5 hectares (the smallest class for which data were collected). Nonetheless, average availability of high and medium potential land per capita will fall from .91 hectares per capita in 1969 to .62 hectares in 1979 and to less than a quarter hectare by the year 2000. Given inequalities in the distribution of land, most holdings would be significantly smaller than that, strongly suggesting that diseconomies of small-scale farming will begin to limit output before the end of the next decade. Moreover, whatever the past absorptive capacity of the land, Integrated Rural Survey data for 1976/77 indicate that some 14 percent of households questioned did not own land within the areas in which they were enumerated. Although some of these families might have had landholdings in other areas, it is likely that the majority were landless. This suggests that landlessness is a much larger problem than had been estimated using available data for 1974/75 and that the problem will become increasingly serious in future years.

Unemployment, landlessness and diminishing returns to scale in agriculture have been described above as likely consequences of rapid population growth in Kenya. Analytically, such outcomes limit the expected increase in output resulting from growth in the labor force, and hence reduce the calculated costs to society resulting from a successful family planning program.

Although it might be possible to assess the extent of such effects directly, it is worth noting that all such effects are normally dwarfed in conventional cost/benefit calculations by effects of the discounting process itself. The higher the discount rate, the smaller is the present value to society of labor foregone in the future. A discount rate of 15 percent may be conservative both in terms of current rates of interest in international markets and especially in terms of expected rates of return on alternative internal investment in Kenya. Even at a discount rate of 15 percent, however, the present value of the work to be performed by a potential worker born today upon entering the labor force at age 15 is less than 9 percent of its future value. By age 25 that present value would be reduced to less than 2 percent. As a result, the calculated costs of labor foregone as the result of successful family planning programs is not normally large compared to calculated benefits if one accepts the standard cost/benefit methodology.

4. Benefits of Reduced Fertility

Benefits arising from a successful family planning project include reduced private and public expenditure on the consumption and investment required to support an additional individual throughout his lifetime. Food, clothing and to a lesser extent housing represent largely private expenditures in

Kenya. Although school fees through the first seven grades have been abolished, the private sector still contributes significantly to education costs as well. Because consumption begins at birth, and many of the private sector "investments" in human needs occur early in life, their present discounted value bulks large in traditional cost/benefit analysis inevitably acting to more than offset the discounted value of labor foregone (as has been discussed above). The question still arises whether investment of public funds is sufficiently offset by public benefits to warrant project expenditure on family planning.

As will be indicated below, calculations of direct public sector benefits demonstrate that the project is economically sound without consideration of additional factors of a secondary nature which might also be taken into account. These include labor productivity effects and indirect effects on the rate of savings and investment. It can normally be expected that the direct effect of increased per capita income resulting from a family planning program will be followed by increased per capita expenditure on food, which acts indirectly to increase labor productivity. In labor surplus economies, such as Kenya, the productivity effect is at first of lesser economic value, increasing in importance as full employment is approached and the value of labor increases.

Similarly increases in current per capita income may result not only in increased consumption, but in increased savings as well. In countries such as Kenya, the savings effect in the private sector is expected initially to be very low. Available Kenyan household budget data do not establish a direct link between high dependency rates in the family and low savings rates. There is evidence, however, that at given income levels, the nuclear family tends to save more than the near-nuclear or extended family so that some small indirect effects on private savings may result from increased family planning.

Evidence on increased public sector savings and investment resulting from reductions in current consumption demands are more certain. The average propensity to invest budget resources, as measured over five GOK budget cycles (1977-1981), is 31.7 percent. Of all the secondary effects to be expected from a successful family planning program, the effect on increased government saving is likely to be the most significant. While all such effects can be expected to be relatively small, particularly in the early stages of Kenya's expanded family planning program, they add to the direct positive effects estimated below.

Public sector expenditures to meet basic needs in Kenya during the years 1980-2000 have been estimated by the World Bank in an elaborate study which serves as the basic reference document for this economic analysis.¹ Projections were made for three possible population growth scenarios and four categories of public expenditure: education, housing, health, and rural water supply. Assumptions underlying alternative population projections are indicated in Tables 1 and 2 below.

Projection I corresponds to a conservative estimate of population growth assuming no increase in family planning interventions. Projection II is based on an average reduction in the birth rate of 1 per 1000 during the current decade (measurements of birth rates to be based on the average for the base period 1975-80 compared to that for 1985-90). Projection II is consistent with the objectives of the current project which is to reduce the birth rate from 53 to 47 per thousand over a six-year period in two phases of three years each. Projection III is based on a more rapid rate of decline in the birth rate than is likely to be achieved at levels of investment in family planning currently under consideration.

TABLE 1 FERTILITY AND MORTALITY ASSUMPTIONS IN NATIONAL POPULATION PROJECTIONS

YEAR	<u>Projection Series</u>		
	I	II	III
	<u>Total Fertility Rate</u>		
1969	7.6	7.6	7.6
1975	8.0	8.0	8.0
1980	7.9	7.4	7.1
2000	6.0	5.5	4.0
	<u>Expectation of Life at Birth</u>		
1969	49.0	49.0	49.0
1975	52.5	52.8	53.4
1980	53.6	54.3	54.6
2000	58.2	60.5	62.4

Source: IBRD, op.cit. pp. 39.

1. Population and Development in Kenya, Report No. 2775-KE. Washington, D.C.: IBRD, Development Economics Department, East Africa Country Programs Department, March 1980.

TABLE 2 PROJECTED TOTAL POPULATION AND IMPLIED VITAL RATES, 1975-2000

Demographic Indicators	Projection		
	I	II	III
Total Population (Millions)			
1975	13.5	13.5	13.5
1980	16.4	16.4	16.4
1985	19.6	19.5	19.4
1990	23.4	22.8	22.4
1995	27.6	26.6	25.6
Birth Rate			
1975-80	53.0	53.0	52.9
1985-90	47.4	43.5	39.9
1995-2000	42.9	38.7	29.9
Death Rate			
1975-80	14.8	14.7	14.3
1985-90	12.7	11.7	10.9
1995-2000	10.4	9.1	7.8
Growth Rate			
1975-80	38.1	38.3	38.7
1985-90	34.7	31.9	29.0
1995-2000	32.5	29.7	25.2

Source: IBRD, op.cit, pp. 40.

Estimates of public-sector expenditure prepared by the World Bank are conservative in every case. Moreover, expenditures on education, housing, health and rural water are clearly not the only ones which are related to population growth although they are the main ones that are population sensitive. The Bank's education estimates cover only primary and secondary schooling with enrollment ratios increasing along their historic trend. Under such assumptions by the year 2000 primary school enrollment ratios would be at 112 percent of the eligible age cohort (which is quite possible given the historic repeater rate in Kenyan primary schools). High school enrollment ratios will have risen to 17 percent of the total eligible population. With regard to health expenditures the major assumptions made are that current ratios will be maintained regarding hospital beds, rural health units, and clinical officers per 1000 of population. Urban housing requirements are based on the need to provide for the 70 percent of new household additions in urban areas which will not be financed by the private sector (and on a standard house with two

rooms, kitchen and bathroom). Expenditures on rural housing have not been included due to the lack of cost data and of available statistics regarding overall needs, and due to the lack of a clear understanding of the likely role of the GOK in responding to rural housing demand. Finally, estimated expenditures for rural water supplies were developed to permit achievement of the GOK objective to provide water within a walking distance of one to five kilometers depending on variations in ecological conditions. GOK expenditures on urban water supplies were not estimated due to wide variations in cost estimates and lack of a clear perception of the role of municipalities in meeting needs in future years.

Table 3, reproduced from the World Bank study, summarizes the results of the estimation process outlined above. While these estimates are somewhat crude, they do represent orders of magnitude of public resources required to meet basic human needs. The "without project" estimates are provided in the columns headed Projection I. Projection II estimates are based on reductions in fertility levels consistent with project outputs and assume that reductions at such rates will be continued through the year 2000.¹ Despite the limited coverage included in the estimates and the conservative approach utilized in determining costs, the total difference in public costs between Projection I and Projection II are quite large.

In terms of constant 1970 prices, total costs averted for the 20 year period 1980-2000 amount to some 324 million Kenyan Pounds. This is equivalent to some 855 million Kenyan Pounds at 1981 prices (i.e. some U.S. \$1.7 billion at the approximate exchange rate of 10 shillings per U.S. dollar). Total costs for the entire Integrated Rural Health and Family Planning Project during its first three year phase amount to U.S. \$49.2 million at 1981 prices. Total costs for the six year program lasting from 1982/83 through 1987/88 amount to U.S. \$116 million at 1981 prices.

Costs of continued expansion of a successful program for an additional twelve years through the year 2000 cannot be realistically estimated before the results of the current program can be evaluated. Nonetheless, it is clear that total costs of any reasonably successful program must be a fraction of the public sector cost saving from family planning of \$1.7 billion. It should be noted, moreover, that health benefits of the combined

1. Throughout the description in this section, time periods designated in the World Bank study have been retained. Realistically all of the analysis should now be assigned to the period 1982-2002 with some increase in overall net budget savings.

health and family planning project have not been included in the estimate of benefits described above, although they may be substantial. On the basis of the cost/benefit considerations reviewed above, the combined rural health and family planning project is economically sound and economically feasible predicated on achievement of targets with respect to a fall in the birth rate over time as projected on the basis of currently available technical information.

USAID DISTR(7/27/82)JM

ANNEX E

OFFICIAL FILE

ACTION: HNP

(DUE:8/4)

INFO:O/DIR; PROG; PRJ;

RFMC; CHRON; RF

REPUBLIC OF KENYA

MINISTRY OF FINANCE

Project 615-0193

Telegraphic Address:

FINANCE-NAIROBI

Telephone: 338111

When replying please quote

Ref. No. EA/FA 9/03

and date



THE TREASURY
P.O. Box 30007
NAIROBI

KENYA

26th July, 1982

ACTION COPY

Mr. Charles E. Costello,
Acting Director,
USAID Mission to Kenya,
P.O. Box 30261,
Nairobi, Kenya.

Action taken: _____

No action necessary: _____

(Initials)

(Date)

INTEGRATED RURAL HEALTH/FAMILY PLANNING
PROGRAMME - USAID CONTRIBUTION, FAMILY
PLANNING II PROJECT NO. 615-0193

The Office of the Vice-President and Ministry of Home Affairs, and the Ministry of Health have addressed letters to this Ministry regarding the above subject.

The proposed USAID contribution to the Integrated Rural Health/Family Planning (IRH/FP) Program provides an integral and essential set of components for implementation of this very important national program. The Government appreciates this timely support for Family Planning activities within this integrated program.

It has been agreed that the total cost of USAID's contribution to the IRH/FP Program is \$ 4.0 million. This includes \$ 1.0 million for the Part B Project for support to the Ministry of Health, and \$ 3.0 million for support of the National Council on Population and Development in the Office of the Vice-President and Ministry of Home Affairs. The Government will be contributing \$ 10.5 million to the IRH/FP Program and other donors, including the World Bank (IDA) will contribute the remainder, \$46.8 million, to complete the proposed Financing Plan of \$61.3 million.

The purpose of this letter is to request USAID for financial assistance in the light of the understanding reached between the Government of Kenya and USAID on implementation of the USAID Family Planning II Project No. 615-0193.

W.P. Mayaka

W.P. Mayaka

PERMANENT SECRETARY

for:

C.C.

**The Permanent Secretary,
Office of the Vice-President and
Ministry of Home Affairs,
P.O. Box 30478,
NAIROBI. (Att: Mr. P.M. Wambugi)**

**The Permanent Secretary,
Ministry of Health,
P.O. Box 30016,
NAIROBI. (Att: Dr. J. Maneno)**

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DONORS AS WELL AS BY US INPUTS. EXPERIENCE WITH INTER-MINISTERIAL BODIES SUCH AS THE PROPOSED MCPD SHOULD BE THOROUGHLY EXAMINED AND MEASURES BUILT INTO PROJECT TO LIMIT OPPORTUNITIES FOR COUNCIL BREAKDOWN OR INACTIVITY.

IF, FOR WHATEVER REASON, MCPD IS NOT ESTABLISHED OR FAILS TO FUNCTION AS PLANNED, WHAT CONTINGENCY PLANS WILL AID PROJECT HAVE FOR ITS PROPOSED \$4.5 MILLION CONTRIBUTION TO THE IEC PROGRAM? WE UNDERSTAND SIDA HAS RAISED IDEA OF MANAGEMENT STUDY AS PRE-CONDITION TO INITIATING PROGRAM. WE BELIEVE THIS WOULD RESULT IN UNREASONABLE DELAY BUT THINK AID AND OTHER DONORS MUST GIVE INSTITUTIONAL AND MANAGEMENT PROBLEMS HIGH PRIORITY IN THEIR PLANNING AND THAT AID'S PROJECT SHOULD BE DESIGNED IN FULL RECOGNITION OF LIMITATIONS THAT EXIST AND WILL LIKELY CONTINUE TO EXIST DURING THE FIVE YEARS OF IMPLEMENTATION.

4. FAMILY PLANNING COMPONENT OF IRH/FP PID IS AMBIGUOUS IN DESCRIBING WHICH ELEMENTS OF IRH/FP PROGRAM AID PROPOSES TO FUND UNDER FAMILY PLANNING II. HOW WILL DESIGN ATTEMPT TO ASSURE THAT PROJECT (A) FINANCES ONLY THOSE COSTS DIRECTLY RELATED TO FAMILY PLANNING SERVICES AND INFORMATION; (B) OBTAINS THE PERSONNEL, LOGISTICAL AND OTHER NEEDED SUPPORT AND PRIORITY REQUIRED FOR THE FAMILY PLANNING COMPONENT IN THE FACE OF COMPETING DEMANDS ON THESE SAME RESOURCES BY THE PURAL HEALTH COMPONENT OF THE FAR LARGER BANK-DOMINATED IRH PROGRAM; AND (C) PROVIDES THAT THE FAMILY PLANNING INTERVENTIONS SPONSORED BY FP II ARE INDEED INNOVATIVE AND FLEXIBLE,

AND DESIGNED TO HAVE HIGH IMPACT ON KENYA ACCEPTOR AND CONTINUATION RATES? IN THIS CONNECTION, PROJECT MIGHT CONSIDER UTILIZING FULL-TIME FAMILY PLANNING MOTIVATORS AND MIDWIVES TO PROVIDE FAMILY PLANNING COUNSELLING.

5. PRIVATE SECTOR ROLE: REVIEWERS FELT THERE IS A POTENTIAL FOR THE PRIVATE SECTOR TO PLAY A SIGNIFICANT ROLE IN FERTILITY REDUCTION PROGRAMS, BOTH FROM A DEMAND AND SUPPLY SIDE - E.G., SEX EDUCATION SEMINARS SPONSORED BY INDIGENOUS PRIVATE GROUPS, COMMERCIAL RETAIL SALES PROJECT AND COMMUNITY-BASED DISTRIBUTION, ETC. PROJECT DESIGN PROCESS SHOULD EXPLORE ALL AVENUES OF POSSIBLE PRIVATE SECTOR INVOLVEMENT. PRIVATE SECTOR SOURCES COULD ALSO BE INSTRUMENTAL, IF ADEQUATELY PREPARED AND FUNDED, TO MEET ANTICIPATED INCREASE IN DEMAND FOR SERVICES (AS A RESULT OF IEC PROGRAM) ASSUMING THAT (A) THE MOH MAY BE UNABLE TO MEET ALL NEEDS AND (B) NOT ALL CLIENTS CAN OR WANT TO UTILIZE GOVERNMENT-SPONSORED SERVICES. IT WILL BE PARTICULARLY IMPORTANT FOR THE PROJECT TO ASSESS AT CERTAIN POINTS IN ITS LIFE THE RATIO OF DEMAND TO SERVICES AID TO BE PREPARED TO RESPOND, IF NECESSARY, WITH ADDITIONAL SERVICES THROUGH BOTH PUBLIC AND PRIVATE

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SECTOR CHANNELS.

6. TARGET GROUP: WHILE PID IDENTIFIES A BROAD TARGET GROUP (ENTIRE POPULATION SIX YEARS OF AGE AND ABOVE), BENEFICIARIES ARE NOT IDENTIFIED WITH SUFFICIENT PRECISION, PARTICULARLY FOR THE SERVICES DELIVERY COMPONENT. PP SHOULD CLEARLY INDICATE WHICH POPULATION GROUPS WILL BE FOCUS OF PROJECT AND NUMBER OF EXPECTED BENEFICIARIES IN EACH SUCH GROUP. THE SOCIAL ANALYSIS SHOULD ADDRESS THE ATTITUDES AND BEHAVIOR PATTERNS OF THE VARIOUS REGIONAL/TRIBAL/INCOME GROUPS TOWARDS FAMILY PLANNING, THE FAMILY DECISION-MAKING PROCESS WITH REGARD TO FAMILY SIZE, IMPLICATIONS OF THE TARGET GROUP'S PERCEPTION OF HOUSEHOLD LABOR NEEDS ON FAMILY SIZE, AND THE ACCEPTABILITY OF PROPOSED OUTREACH (IEC) CAMPAIGN AND SERVICE DELIVERY SYSTEM. PP SHOULD DISCUSS THE ATTITUDE OF MEN TOWARD CONTROLLING FAMILY SIZE, WHAT ROLES MEN WILL PLAY IN THE EXPANSION OF FAMILY PLANNING COVERAGE AND PROJECT ACTIVITIES WHICH WILL BE UNDERTAKEN TO ENCOURAGE THEIR PARTICIPATION.

7. AID/W HAS BEEN ADVISED BY FUGO DIAZ AT THE IBRD THAT THE APPRAISAL REPORT HAS BEEN CLEARED AND FORWARDED TO THE GOK. THE IBRD HAS RECOMMENDED TO THE KENYANS THAT MEETING WITH DONORS BE SCHEDULED FOR EITHER THE WEEK OF MAY 11-14 OR THE LAST WEEK OF MAY AT WHICH THE REPORT AND TENTATIVE

DONOR FUNDING LEVELS WOULD BE DISCUSSED. THE IBRD WILL NOT BE ABLE TO APPROVE ITS PROJECT CONTRIBUTION UNTIL SEPTEMBER 1981 BUT IS PREPARED TO REIMBURSE THE GOK RETROACTIVELY FOR EXPENSES INCURRED BEGINNING JULY 1981. APPROVAL BY THE BANK WILL BE TIED TO FIRM COMMITMENTS FROM THE GOK ON STAFFING AND FUNDING, AND ASSURANCES ON ASSUMING RECURRENT COSTS AT COMPLETION OF PROJECT. CLARK

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VI. F. Response to PID Approval

1. Paragraph 1:

Funding plans have been changed, with FY 82 obligation budgeted for \$4.0 million.

2. Paragraph 2:

Donor coordination is a potential problem which will require attention throughout life of project. The splitting of the project into two phases will make coordination easier during this first three year phase. Similarly, the identification of responsibility for discrete activities and a parallel funding mechanism with the World Bank committed to taking responsibility for activities not funded by other donors should also reduce potential problems of coordination. Frequent periodic checks have been instituted for both Part A and Part B. There will be joint donor supervision missions approximately every six months. The annual work plans and requirements for progress reports will facilitate monitoring of Part A. A strong Core Project Unit for monitoring and supervision, plus the establishment of a steering committee, will assist donor coordination in Part B.

3. Paragraph 3:

The institutional arrangements for Part A are in process of being implemented; but are not expected to be completed until well into the first year of this project. The administrative analysis explains in detail the necessary steps that have been taken, and must still be taken, to ensure adequate functioning of the National Council on Population and Development, the Secretariat within the Council, and, for Part B, effective implementation and utilization of the training program for Enrolled Community Nurses and Clinical Officers. The Council has been established by Presidential Decree and given a home in the Office of the Vice-President and Ministry of Home Affairs. Institutional weaknesses of the National Family Welfare Center are being addressed, and resolved, partly in response to strong concern being expressed and shared by the donors.

USAID will continue to give high priority to addressing the potential institutional and management problems which may well accompany establishment of the new institutions, and institutional arrangements envisioned under this project.

4. Paragraph 4:

USAID is supporting clearly defined activities under Part B of the project; these include training of the main cadres of MOH personnel responsible for delivery of family planning services nationwide. Although innovative activities are being supported by USAID under Part A, they have not been included within USAID's purview in Part B. Using other sources of support the Mission has been involved in promoting innovative and flexible family planning service delivery programs. Success with such programs should increase the likelihood of MOH adoption of improved, innovative approaches in the future.

5. Paragraph 5:

The Mission similarly sees a significant role in Kenya for so-called private (non-government) sector activities both for demand creation for fertility limitation and provision of family planning supplies. Several activities are planned or underway, some directly supportive of the GOK IRH/FP Project and some not.

The Mission has explored the potential for private sector (including church-based) activity under the IRH/FP Project, and has determined that separate efforts to assist this sector are more appropriate at this time.

6. Paragraph 6:

The beneficiary subsection in the project description and the Social Analysis and Social Soundness Annex discuss the characteristics of project beneficiaries for both Part A and Part B and estimate numbers of persons likely to participate in project activities. The roles played by men, as well as women, regarding family planning are considered in the analysis.

Interagency MCH/FP Program - Information and education guidelines and format for project preparation for participating agencies

A. Outline of Format

Any project proposal should enhance easy budgeting and justification of expenditure. It should, therefore, contain at least the following:

0. Name of Organization/Agency
1. Agency Project Number and title
Officer and Section Responsible for Implementation
2. Duration of Project (e.g. From..... To)
3. Project Justification
4. Objectives of the Project (a) General
(b) Operational or Specific
5. Target Groups, Characteristics and Numbers
6. Geographic Coverage and/or Specific Location(s)
7. Project Activities
8. Resource Estimates - Staffing
- Equipment and Supplies
- Supportive Services, e.g. technical assistance in terms of design, planning, production, etc.
- Others (to be specified, if possible)
9. Project Costs
 - Itemized as in point 8 above, and
 - approximately costed for each of the Project's budget years.
10. Evaluation and Monitoring Components
11. Collaborating Agencies

B. Detailed Comments

0. Name of the Agency/Organization/Ministry is required.

1. (a) Agency Project Number and Title: Since agencies are going to request funds for at least more than one project, it would be appropriate if each agency could serially number all its projects that are submitted for consideration. Similarly, all projects should have a title.

(b) Officer and Section Responsible for Implementation: Department of Section should be indicated together with officer responsible for implementation (not necessarily name of officer but rather indication of office).

2. Duration of Project: The starting date (Month and year) of the Project should be indicated, as well as the ending date (month and year).

3. Project Justification: In justifying a project proposal, the question of why this particular project or approach or what need is the project responding to must be answered. The justification of the project should include an explanation of how the proposed specific activities or objectives represent the best way of promoting or implementing the proposed Interagency MCH/FP Information and Education Programme.

4. Objectives of the Project: The definition of project objectives corresponds to the "what do I want to do?" phase of developing a project proposal. Objectives of a project provide the basis for the activities to be conducted, the resources to be utilized, and the results to be expected of the project. The definition is also essential for evaluation purposes. Therefore, a project can be seen as any set of closely related activities, which are aimed at the realization of one easily quantifiable or identifiable objective.

Objectives can be either general or specific. A project may have one or more of each type.

(a) General Objectives: can be defined as the final result of the project or the "effect" of the project. For example, the general objective of a family planning information programme could be "to motivate people to adopt family planning".

(b) Operational or specific objectives: are generally means to the general objective. They are the immediate results that can be expected from the project. Specific objectives should be expressed in easily quantifiable, measurable (identifiable) and realistic terms (achievement indicators), that take into consideration the needs of the target population. Examples of such objectives may include:

- (i) increasing the number of family planning acceptors in a community from 20 to 40 percent;
- (ii) changing attitude "A" among community leaders to attitude "B" among, at least, 30 percent of the leaders;
- (iii) training lay educators in x number more communities to increase from 80 to 250 by the end of the year y, etc;

To conclude, an operational or specific objective should endeavor to include the following:

- the target population that the project will benefit, e.g. rural women of fertile age;
- magnitude or size of the objective, e.g. to provide family planning services to 1,080 women;
- length of time it will take to achieve the objective (s), e.g. one year.

5. Target Group(s), Characteristics and Numbers: refer to the target population you are aiming at through the proposed project. It is desirable that the characteristics and the approximate numbers of the target group are included.
6. Geographic Coverage and/or Specific Locations(s): Where will project activities be carried out? You should attempt to be specific in responding and avoid statements like "nationwide". For instance, if you project is "Introduction of Community-Based Distribution (CBD) of Contraceptives", you cannot possibly cover the whole country within a period of one or two years. You may wish to cover certain districts during the first year, and maybe different districts during the second year, and so on. This information should be given. Should a project cover an even smaller area than a district, this should also be indicated.

7. Project Activities: An outline of project activities makes it possible to assess resources required. Solely indicating that training is going to be carried out, is not enough. Those activities involved in training ought to be specified, e.g.:

- recruiting and equipping of 8 trainers;
- training strategy - 40 seminars during 5 months in 5 market centres in Meru District, involving
 - (a) preparation of seminar materials, i.e. 300 booklets
 - (b) preparation of Lay-Educator's Guide; 4000 Guides of 15 pages each
 - (c) evaluation of field educators - field practice, travelling, etc.

Similar specifications indicate the budgetary items clearly.

8. Resource Estimates: should indicate quantities and quality in stating, for example, how many, what level of training and what possible remuneration. Resources may be human and/or material:

- Human resources refer to the personnel that will be involved in the project - project staff as well, technical assistance required for designing, planning, and production, etc. purposes.

NOTE: You should also indicate the resources that you have at present in order to carry out the project, and those resources that you may want to acquire.

9. Project Costs: On the basis of your project activities and resource estimates, it should be possible to indicate your cost estimates. Please itemize as in point 8 above, and cost for each of the Project's Budget Years.

Example: Training of New Family Planning Motivators

<u>Item:</u>	<u>Estimated Cost in K.Shs.</u> <u>(in 1980 prices)</u>		
	1980/81	1981/82	1982/83
<u>Staffing:</u> Per diem for 4 Supervisors @ 300/-per day for 10 days	12,000	12,000	---
<u>Equipment and Supplies</u> Literature and Stationery	4,000	---	---
<u>Supportive Services</u> Others: Accommodation and Meals for 40 people for 42 days @ 150/-per person per day	252,000	252,000	---
Transport for 40 participants at 120/- (return per person)	<u>4,800</u>	<u>4,800</u>	<u>---</u>
TOTAL	<u>272,800</u>	<u>268,800</u>	<u>---</u>

NOTE: (a) 1980/81 Budget Year starts 1st July, 1980, and ends 30th June, 1981.

(b) The above project is scheduled to be completed by the end of 1981/82.

10. Evaluation and Monitoring Component: Monitoring is the continuous process of assessment, which is a part of an implementation strategy. Have the resources arrived in time? Are they of the right specification? What human problems must be overcome? And so on. Evaluation is implied by the achievement indicators and programming chart, but it must be planned to take place at the end of the project. Specification as to who and how it will be done should be made.
11. Collaborating Agencies: Most areas of activity of the MCH/FP I & E Programme for different agencies are logically overlapping. In addition, different agencies might carry out the same activities but in different geographic zones or communities.

Indication should be made as to the:

-- awareness of such agencies

-- specific collaborative activities, e.g. Agency "F" may find it rewarding to liaise with Agency "A", when implementing certain activities in which both have common interests.

PROFILES OF PARTICIPATING AGENCIES
PROVISIONALLY SELECTED FOR AID FUNDING

Family Planning Association of Kenya (FPAK)

Voluntary associations began to promote family planning during the mid-1950s. In 1961, these associations formed the FPAK. In 1962, the FPAK became the first family planning association in sub-Saharan Africa to affiliate with the International Planned Parenthood Federation (IPPF). President Daniel arap Moi is the FPAK's patron. Overall supervision is provided by a Management Committee and eight area committees.

The FPAK concentrates on POP/FP information and education activities. It has been particularly effective in its activities to sensitize leadership groups. FPAK has youth programs, lay educator activities and family planning extension workers to inform and educate the general public.

The FPAK was for many years the most important provider of family planning services, but has phased out most clinical activities as the Ministry of Health expanded its network of family planning services. The FPAK maintains eight model urban clinics. The FPAK plans to initiate, with Pathfinder Fund assistance, pilot community-based MCH/FP services. The International Project is assisting the FPAK to modify clinical facilities to enable the FPAK to offer voluntary surgical contraception. FPAK receives almost \$1 million annually in budget and commodity support from IPPF.

Kenya Catholic Secretariat (KCS):

The KCS is the coordinating body for health care institutions affiliated with the Catholic Church. KCS health institutions contain 4,850 beds for in-patient care and serve approximately 5.5 million outpatient visits annually. KCS institutions provide 70% of the in-patient beds and handle 90% of the out-patient care of the church-related health institutions in Kenya. KCS institutions do not provide artificial FP methods as a matter of Catholic Church policy, and few KCS institutions are providing natural family planning instruction. The IRH/FP

Program will assist KCS institutions to expand programs for educating married couples in natural family planning methods. It remains to be seen whether natural family planning will find much acceptance in Kenya, but the key role of the KCS institutions in the provision of out-patient health care in rural areas will facilitate the attempt to promote natural family planning methods.

The Protestant Churches Medical Association (PCMA):

The PCMA is the coordinating body for the majority of Protestant health care institutions in Kenya. PCMA institutions include 15 hospitals, 28 health centers/dispensaries and 2 community-based health care programs. PCMA institutions contain 2,084 beds for in-patient care and serve approximately 600,000 outpatient visits annually. Although few of PCMA institutions are currently providing FP services, the IRH/FP Program will assist PCMA institutions to establish additional MCH/FP Service Delivery Points and to initiate mobile MCH/FP services. Two PCMA institutions, Chogoria Hospital and Tumu Tumu Hospital, are already running successful FP programs. The Anglican Dioceses of Maseno South and Mt. Kenya East (with AID/ST/POP funding) are integrating family planning information and services into their ongoing community-based health care programs. Chogoria Hospital, which has received extensive assistance from Family Planning International Assistance, is also implementing one of the few significant adolescent family life education programs in Kenya. PCMA institutions have enormous potential for expanding FP information and services in rural Kenya, but the PCMA management and administrative capacity will require considerable strengthening under the IRH/FP Program.

Salvation Army (SA):

The SA has a national organization with divisions at eight locations throughout Kenya. The SA runs a diversified program of activities including: hostels and training schools for children and youth; schools and rehabilitation centers for crippled persons; farms and an agricultural training center; a community center; and churches. The SA proposal to provide family planning information to leaders of 40 communities, to train lay educators, and provide family planning services to members of the 40 committees is a new type of activity for the SA.

AID PROJECT STATUTORY CHECKLIST

5C(1) Country Checklist

The country checklist was authorised this fiscal year, 1982 under the Kitui Rural Health Project (615-0206).

5C(2) The Project Checklist and 5C(3) Standard Item Checklist are included on the following pages of Annex H.

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? Yes.
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes.

A. GENERAL CRITERIA FOR PROJECT

1. Continuing Resolution

SEC. 505(a).

(a) Describe how authorizing and appropriations Committees of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

Normal CR procedures will be followed.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

The GOK has agreed to take the necessary legislature/administrative actions required for this project and appropriate conditions precedent and covenants will be part of the Project Agreement.
4. FAA Sec. 611(b); Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?

N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

This project is considered part of a larger integrated rural health/family planning program to be undertaken by the GOK with multidonor participation.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(a)-(f) This project will not discourage these activities but as a Government-supported, integrated rural health and family planning project - it is not specifically designed to encourage them.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Kenya-based US private enterprise will be encouraged to participate in the supply of equipment and in implementation of subprojects funded under the National Council on Population and Development Program.

9. FAA Sec. 612(b), 636(h); Continuing Resolution Sec. 508. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The GOK contribution directly attributable to AID support is \$ 1,354,000, or 25% of combined GOK, AID costs. There are no US owned foreign currencies available for this project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and,

N/A

if so, what arrangements have been made for its release?

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? N/A

12. Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

B. FUNDING CRITERIA FOR PROJECT

I. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives,

(a) This project is directed at encouraging and assisting rural families and individuals space births and limit family size in accordance with their own wishes and socio-economic needs. (b) N/A

(c) Institutional and community self-initiated activities supported by the project will serve to increase involvement of individuals, families and groups in improving their well-being.

(d) Women are the prime beneficiaries of both parts of this project.

(e) N/A

especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: N/A
(include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; 103A if for agricultural research, full account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with programs carried out under Sec. 104 to help improve nutrition of the people of developing countries N/A

through encouragement of increased production of crops with greater nutritional value, improvement of planning, research, and education with respect to nutrition; particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration of programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, (i) extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

This Project is designed as part of a national comprehensive multidonor and GOK supported Integrated Rural Health and Family Planning Program. AID resources will aim to promote child spacing and family size limitation practices among all segments of the population, and will provide training necessary to increase coverage of free family planning service delivered by paramedical personnel throughout the country.

(4) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development; and (ii) extent to which assistance provides advanced education and training of people in developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

(5) [106; ISDCA of 1980, Sec. 304] for energy, private voluntary organizations, and selected development activities; if so, extent to which activity is: (i) (a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; (b) facilitative of geological and geophysical survey work to locate potential oil, natural gas, and coal reserves and to encourage exploration for potential oil, natural gas, and coal reserves; and (c) a cooperative program in energy production and conservation through research and development and use of small scale, decentralized,

N/A

renewable energy sources for rural areas;

(ii) technical cooperation and development, especially with U.S. private and voluntary or regional and international development, organizations;

(iii) research into, and evaluation of, economic development process and techniques;

(iv) reconstruction after natural or manmade disaster;

(v) for special development problems, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small laborintensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] is appropriate effort placed on use of appropriate technology? (relatively smaller, cost-saving, labor using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor.)

d. PAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which

The use of small grants to NGOs and other agencies to undertake appropriate family planning promotion activities and the use of a low-cost community based integrated rural health for family planning service delivery system is considered to be an appropriate means to promote efficient nationwide coverage to rural areas.

The GOK is contributing \$1354000 (25.3%) to the costs of various project activities (Part A and B) which can be directly attributed to the project financed by AID.

the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least developed" country)?

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

N/A

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The project is designed to generate participation by supporting activities which will explicitly tap the needs, desires and capacities of the population. Institutional development is major element of project design, as is systematic involvement of community-based and government institutions.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to

N/A

repay the loan, at a reasonable rate of interest.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N/A

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

N/A

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? N/A

2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will commodities be insured in the United States against marine risk with a company or companies authorized to do a marine insurance business in the U.S.? Yes.

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be N/A

financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

5. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates? N/A
7. FAA Sec. 621. If technical assistance is financed, to the fullest extent practicable will such assistance, goods and professional and other services be furnished from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes
8. International Air Transport Fair Competitive Practices Act, 1974. Is air transportation of persons or Yes.

property is financed on grant basis, will provision be made that U.S. carriers will be utilized to the extent such service is available?

9. Continuing Resolution Sec. 505. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) projects, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interests? N/A
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million? N/A

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? Yes
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.
4. Continuing Resolution Sec. 514 N/A
If participants will be trained in the United States with funds obligated in FY 1981, has it been determined either (a) that such participants will be selected otherwise than by their home governments, or (b) that at least 20% of the FY 1981 fiscal year's funds appropriated for participant training will be for participants selected otherwise than by their home governments?
5. Will arrangements preclude use of financing: (a)-(k) Yes.

- a. FAA Sec. 104(f). To pay for performance of abortions as a method of family planning or to, motivate or coerce persons to practice abortions; to pay for performance of involuntary sterilization as a method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization?
- b. FAA Sec. 620(q). To compensate owners for expropriated nationalized property?
- c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?
- d. FAA Sec. 662. For CIA activities?
- e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained.
- f. Continuing Resolution Sec. 504. To pay pensions, annuities retirement pay, or adjusted service compensation for military personnel?
- g. Continuing Resolution Sec. 506. To pay U.S. assessments, arrearages or dues.
- h. Continuing Resolution Sec. 507. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to

multilateral organizations for lending.)

i. Continuing Resolution Sec. 509. To finance the export of nuclear equipment fuel, or technology or to train foreign nationals in nuclear fields?

j. Continuing Resolution Sec. 510. Will assistance be provided for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

k. Continuing Resolution Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

SOURCE/ORIGIN WAIVER
FOR VEHICLES

WAIVER CONTROL NO: 616-82-C.47
WAIVER EFFECTIVE DATE: 13 AUGUST 1982

TO: Mrs. Allison B. Herrick
Director, USAID/Kenya

FROM: Satish P. Shah, Chief, Projects Division

SUBJECT: Family Planning II Project 615-0193

PROBLEMS:

Request your approval of a source/origin procurement waiver from Geographic Code 000 to Geographic Code 935 for vehicles indicated below:

a) Cooperating Country	:	Kenya
b) Authorizing Document	:	Project No. 615-0193
c) Project	:	Family Planning II Project
d) Nature of Funding	:	Grant
e) Description of Commodities	:	Two minibuses
f) Approximate Value	:	U.S. \$24,500
g) Probable Procurement Origin	:	Kenya (component parts from Germany or Japan).
h) Probable Procurement Source	:	Kenya
i) Previous source waivers	:	Nil

approved by Mission Director

DISCUSSION:

Section 636 (1) of the Foreign Assistance Act of 1961, as amended, prohibits AID from financing motor vehicles unless such vehicles are manufactured in the United States. Section 636 (1) does provide, however, that "...where special circumstances exist, the President is authorized to waive the provision of the act in order to carry out the purpose of this Act." Additionally, in accordance with AID Handbook 1, Supplement B, procurement of motor vehicles of other than U.S. manufacture requires a source/origin waiver. The authority to determine that (1) there is adequate justification for a waiver under Handbook 1, Supplement B, and (2) special circumstances exist for purposes of Section 636 (1), has been delegated to the Mission Director under DOA 140, dated June 9, 1982, up to \$50,000 per transaction for vehicles.

AID is providing grant funds (\$4 million) to the Government of Kenya to provide support in the development of the National Council on Population and Development and in providing training in family planning service delivery for Clinical Officers and Enrolled Community Nurses working in the Ministry of Health. The assistance AID is providing is a complementary but distinct part of the Integrated Rural Health and Family Planning Project-- a Government of Kenya multidonor interministerial three year national program.

The two right-hand drive minibuses are required by the Ministry of Health (National Family Welfare Center) for travel between the training sites providing the family planning training to the CO's and ECN's. The training sites, in addition to Nairobi, are Thika, Mombasa, Nyeri, Meru, and Kisumu. The vehicles will be used in the transport of staff and materials between the sites, and will assist staff at the Nairobi-based NFWC to administer the training programs.

Handbook 1B, Section 5B4(a)(2) provides that a waiver may be granted if the commodity is not available from countries or areas included in the authorized Geographic Code. For purposes of safety, it is extremely important that the vehicles financed under this project be right-hand drive, since by law all traffic in Kenya moves on the left side of the road. There are no right-hand drive minibuses manufactured in U.S. There are, however, right-hand drive minibuses manufactured in Kenya from component parts having their source and origin in other Code 935 countries. There are adequate spare parts and maintenance facilities in Kenya.

Pursuant to Handbook 1B, Section 4C2d(1), special circumstances are deemed to exist because of the inability of U.S. manufacturers to provide a particular type of needed vehicle: e.g. right-hand drive vehicles.

RECOMMENDATION

For the above reasons, it is recommended that you:

(1) approve a vehicle procurement source/origin waiver from AID Geographic Code 000 to Code 935;

(2) conclude that special circumstances exist which merit a waiver of the provisions of Section 636(i) of the Foreign Assistance Act, as amended; and

(3) certify that exclusion of procurement from Free World countries other than the cooperating country and countries included in Code 941 would seriously impede the attainment of U.S. foreign policy objectives and the objectives of the foreign assistance program.

Approved ABKernik

Disapproved _____

Date: 13 Aug 82

Drafted: SP Shah / L DeSoto: pao
Clearances: HRP: Kori Tanak NY
HNP: SS Silberstein ms
ALDSU: Alacmerzahl ms