

USAID KENYA  
PROJECT ASSISTANCE COMPLETION REPORT  
FAMILY PLANNING PROJECT (615-0161)

A. Project Status

The project consisted of the following elements: technical assistance, participant training, commodity procurement and salary supplements. Each project element has been completed.

B. Summary of Contributions

1) AID Financial Inputs

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	194,000	194,000
Participant Training	802,000	791,961
Commodities	729,000	560,357
Salary Supplements	572,000	571,784
Total	<u>2,297,000</u>	<u>2,118,102</u>

2) Other Donor Inputs-Parallel Financing

World Bank	\$12.0 million
Denmark	.6 million
Federal Republic of Germany	.9 million
Norway	1.8 million
Sweden	5.4 million
United Nations	<u>1.2 million</u>
Total	\$21.9 million

3) Government of Kenya Inputs

Ministry of Health - \$14.3 million, of which \$2,744,000 attributable to AID Project 615-0161.

C. Project Accomplishments

The Project Paper specified the following project outputs:

	<u>Projected</u>
Community Nurses (CN) on the job	117
Family Health Field Educators (FHFE) on the job	817
Supervisory/Professionals employed	92
NPWC Administrative Unit (NPWC/AU) employed	19
Health Education Unit (HEU) employed	99
Health Education Unit FP (HEU/FP) activities as percentage of total effort	50%

950 enrolled/community nurses received in-service FP training, but many of those trained were deployed where their training could not be utilized. On the average only one out of every 2.5 nurses trained in FP was posted to a MCH/FP Service Delivery Point (SDP). There were 364 SDPs established by the MOH and staffed by an enrolled/community nurse. Though Family Health Field Educators were trained in sufficient numbers, 750 vs. a target of 817, they were inadequately supervised and supported. During 1978 each FHFES managed to recruit less than 18 new FP acceptors on average during the year. The output of 92 supervisory professionals was not accomplished because the MOH decided to abolish the cadres of Family Health Field Officers and Nurse Trainers/Supervisors (NT/S). Clinical Officers, who are incharge of rural health centers, never received training in FP. Supervision was left in the hands of 46 provincial and district matrons who were overburdened with other duties. More than 19 employees were employed at the National Family Welfare Center's Administrative and Planning Unit, but the unit gave only limited support because the key posts of Administrative Officer, Executive Officer and Accountant were vacant through much of the project period. Although the Health Education Unit expanded its staff substantially, the HEU was not able to retain skilled audio-visual production personnel. Delays in utilization of a new HEU building and in provision of audio-visual equipment also adversely affected materials production. Finally, the HEU FP activities never approached 50% of the HEU's total effort because of other needs believed to be of higher priority by the Ministry of Health.

D. Progress Towards Achievement of Project Purpose

The original purpose of this project was to create a national framework capable of recruiting 640,000 new family planning acceptors over the five-year period ending June 30, 1979, and significantly additional acceptors in succeeding years. The 640,000 new acceptor target was reduced to 450,000 as a result of the Mid-Term Review. However, only 310,000 acceptors were actually recruited. Progress Toward End of Project Status (EOPS) Conditions has been uneven.

1. Family Planning services were to be available on a full-time basis at 400 SDPs which would each recruit 300 new FP acceptors yearly. Although 364 SDPs were operating, most SDPs fell far short of recruiting 300 new FP acceptors during the final year of the project. Although two FHFES were generally assigned to SDP, they did not provide FP community outreach as envisioned by the project designers. Additional recruitment for this cadre has been frozen pending revision of FHFES duties.

2. 17 Mobile Units were to provide FP services on a part-time basis to 190 additional service points and recruit 150 new acceptors yearly. The 17 were operating but were ineffective in recruiting new FP acceptors largely because vehicles and staff were often diverted to other health activities. The MOH has decided to phase out the mobile units.

3. An effective system of community nurse and PHFE supervision was never established at the district and provincial levels because the NT/S and FHFO cadres of supervisors were abolished by the MOH. Lack of effective field supervision continues to be a major constraint.

4. Although a National Family Welfare Center (NFWC) has been operational within MOH, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out its mandate, the spearheading of the National Family Planning Program. There was not a full-time, relatively independent Director, and the principal responsibility for directing NFWC activities fell to the Deputy Directors, who were changed three times during the life of the project and themselves received little support. Key professional staff resigned or transferred as donor salary support was phased out according to project design. At the end of the project, the NFWC had little institutional capacity to carry out its mandate.

5. Although the Health Education Unit of the MOH received substantial inputs (new building, audio-visual production materials and increased staff), it never attempted to mount a comprehensive FP Information and Education (I&E) Program and has utilized those inputs for other forms of health education.

6. The number of FP acceptors increased to 310,000 instead of 640,000.

The Project Paper's assumption for achieving the project purpose was that sufficient demand for FP services already exists or would be generated by educational activities under the project to attain the 640,000 new acceptors. In light of widespread popular attitudes favoring high fertility as revealed by the Kenya Fertility Survey and the meager FP I&E activities implemented under the project, the assumption appears highly unrealistic in retrospect. It is difficult however, to attribute the lack of project success solely to

lack of demand for FP services. The MOH's management deficiencies and lack of commitment to FP resulted in inadequate quality and quantity of FP information and services. Both supply and demand constraints probably caused low acceptance of FP by the Kenyan public.

The goal of this multi-donor assisted Government of Kenya five-year family planning program was a reduction in the annual rate of natural increase from an estimated 3.3 percent in 1974 to 3.0 percent in 1979, leading to continued reductions over the succeeding 20 years, which would bring the growth rate down to 2.8 percent by 1999. Although it is still possible to achieve the goal of 2.8 percent growth rate by 1999, the project did not materially contribute to the reduction of the growth rate from 3.3 percent to 3.0 percent during the project period. Evidence from the National Demographic Survey, the Kenya Fertility Survey and the 1979 Population Census indicates that the growth rate has risen to 3.8-4.0 percent rather than declining. The number of births averted through project activities was too low to have any appreciable demographic effect at the goal level. The assumption that the birth rate would be reduced faster than the death rate provided to be unrealistic.

If the project had attained its purpose, it would have contributed to substantial progress toward the goal. Because the project progress has been so unsatisfactory in terms of increasing FP acceptance, there has been no progress toward the goal. Other projects and external factors have likewise failed to contribute to goal attainment. In our view, the purpose goal linkage remains valid. The project designers erred in thinking that donor inputs would ultimately lead to achievement of the project purpose. The input-output and output-purpose linkages were unrealistic because they failed to adequately recognize and deal with the significant external constraints. These constraints include: lack of political support for FP, inadequate commitment to FP within the MOH, fundamental organizational weaknesses within the MOH and socio-economic/cultural support for large families.

#### E. Recommended Adjustments in Project Design

The project has been completed and there are no remaining Grantee reporting requirements. All projects funds have been disbursed and expended. There are no remaining conditions or covenants for the Grantee to fulfill.

**P. Continuing Monitoring Responsibilities**

A multi-donor follow-on project, the Integrated Rural Health and Family Planning Project, was initiated in 1982. The Governments of the United States and Kenya signed the Family Planning II Project Agreement on August 30, 1982. USAID/Kenya will continue to monitor family planning activities initiated under the Family Planning Project and continuing under the Family Planning II Project. Resources required are described in the Family Planning II Project Paper (615-0193).

**G. Data Collection and Remaining Evaluation**

The 310,000 Kenyans who accepted FP services together with their families were the primary beneficiaries of this AID project. The Project Paper estimated that there would be 640,000 new FP acceptors. The Project Paper provided no detailed analysis of the intended beneficiary group, but indicated that reduced rates of population growth resulting from FP acceptance would have a beneficial socio-economic impact on Kenya in terms of employment, social services and per capita income. It is difficult to estimate the births averted by the recruitment of 310,000 FP acceptors as continuation rates are not precisely known. Moreover, there is evidence to suggest that adoption of modern methods of contraception often served as a substitute for traditional methods of child spacing such as abstinence and prolonged lactation. The demographic impact of the project was relatively negligible.

Several factors may have contributed to the increased fertility observed during the project period: improved health, reduced lactational amenorrhea and declines in the practice of polygamy. Death rates were not expected to decline appreciably during the period, but improved health services and socio-economic development led to a reduction in the death rate from about 17 in 1974 to about 14 in 1978.

Although project activities did not have their anticipated impact on fertility, the impact on maternal and child health was encouraging. During 1977 there was a 30% increase over 1976 in the number of clients requesting MCH services at clinics. About 440,000 first visits and 850,000 revisits for antenatal services, and 465,000 first visits and 1,050,000 revisits for child welfare services were carried out in 1977. A majority of pregnant women (about 65%) and a smaller but growing portion of children utilized MCH services. Although it is difficult to prove causality, there were substantial declines in infant mortality during the project period. Analysis of the 1969 Census and 1977/78 Kenya Fertility Survey indicates that infant mortality declined from 119 in 1969 to 87 in 1977.

The final evaluation for Project 615-0161 has already been performed. Project Evaluation Summary (PES) 615-82-05 was submitted to AID/W on March 2, 1982.

#### H. Lessons Learned

The multi-donor 1974-79 MCH/FP Program was quite successful in the following areas: a) construction of health facilities and training schools, b) training of paramedicals and c) expansion of MCH services in rural Kenya. The impact on the health of Kenyan women and children was positive.

The project was not successful in terms of recruiting FP acceptors or reducing the rate of population growth. In retrospect, one can conclude that the conditions necessary for a successful FP program were not present and that donor assumptions about FP in Kenya were unrealistic.

A number of important lessons were learned that will influence the design of follow-on activities funded by USAID. Firstly, the GOK 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. Thus a greater emphasis on activities designed to change family size norms and attitudes about FP is clearly indicated.

Secondly, it is clear that donor agencies supporting the GOK MCH/FP Program overestimated the level of GOK commitment to reduction of the rate of population growth and provision of FP information and services. Lack of GOK commitment seriously affected the establishment and operation of the National Family Welfare Center. It is important that designers of future FP projects in Kenya realistically appraise Kenyan commitment to project objectives and build realistic assumptions into the project design. A greater emphasis on activities designed to foster clearer understanding of POP/FP issues on the part of leadership groups is clearly indicated.

Thirdly, the GOK MCH/FP Program relied excessively on the MOH as the sole vehicle to achieve its objectives. 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's objectives. Such a broad, multi-sectoral involvement is important for the achievement of fertility reduction objectives which require wide community cooperation and political support. Follow-on activities should involve the establishment and institutionalization of mechanism to encourage and coordinate the implementation of POP/FP activities by Government and private sector agencies.