

| | | |
|---|---|---------------------------|
| 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 |
| 2. COUNTRY/ENTITY KENYA | 3. PROJECT NUMBER 615-0232 | |
| 4. BUREAU/OFFICE Africa | 5. PROJECT TITLE (maximum 40 characters) Family Planning Services & Support | |
| 6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 09 3 0 9 2 | 7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4) A. Initial FY <u>85</u> B. Quarter <u>4</u> C. Final FY <u>89</u> | |

| 8. COSTS (\$000 OR EQUIVALENT \$1 =) | | | | | | |
|---------------------------------------|---------------------------------|---------------|---------------|-----------------|----------------|----------------|
| A. FUNDING SOURCE | FIRST FY <u>85</u> | | | LIFE OF PROJECT | | |
| | B. FX | C. L/C | D. Total | E. FX | F. L/C | G. Total |
| AID Appropriated Total | 4,000 | 5,100 | 9,100 | 18,920 | 24,080 | 43,000 |
| (Grant) | (4,000) | (5,100) | (9,100) | (18,920) | (24,080) | (43,000) |
| (Loan) | () | () | () | () | () | () |
| Other U.S. | 1. AID/W Central Projects 1,331 | | | 9,035 | | |
| | 2. _____ | | | - | | |
| Host Country | - 0 - | 2,504 | 2,504 | - 0 - | 54,578 | 54,578 |
| Other Donor(s) | 278 | 4,963 | 5,241 | 3,057 | 54,701 | 57,758 |
| TOTALS | 5,609 | 12,567 | 18,176 | 31,012 | 133,359 | 164,371 |

| 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) PN | 444 | 440 | | - 0 - | - 0 - | 38,877 | - 0 - | 38,877 | - 0 - |
| (2) HE | 483 | 530 | | - 0 - | - 0 - | 4,123 | - 0 - | 4,123 | - 0 - |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | | | 43,000 | | 43,000 | |

| | | | | | | | |
|---|--------|--------|-------|-------|--------|-----------------------------------|--|
| 10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 410 420 430 450 520 | | | | | | 11. SECONDARY PURPOSE CODE | |
| 12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each) | | | | | | | |
| A. Code | BR | BWV | TNG | PVOU | EQTY | PVON | |
| B. Amount | 30,000 | 38,000 | 7,450 | 9,000 | 15,000 | 8,500 | |

13. PROJECT PURPOSE (maximum 180 characters)

to increase user rates of quality family planning methods

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 14. SCHEDULED EVALUATIONS Interim MM YY MM YY Final MM YY 06 88 06 91 | | | | 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 (This is page 1 of a _____ page PP Amendment.)

| | | |
|------------------------|--------------------------------|--|
| 17. APPROVED BY | Signature: | 18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION |
| | Title: Acting Mission Director | |

FAMILY PLANNING SERVICES AND SUPPORT

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ACRONYMS

| | |
|---------|--|
| AVSC | Associations for Voluntary Surgical Contraception (AVS) |
| CA | Cooperating Agency |
| CBPHC | Community Based Primary Health Care |
| CBS | Central Bureau of Statistics |
| CBS | Community Based Services |
| CDSS | Country Development Strategy Statement |
| CIIS | Contraceptive Inventory Information System |
| C&L | Coopers and Lybrand Associates Kenya |
| CPS | Contraceptive Prevalence Survey |
| CYP | Couple Year Protection |
| DANIDA | Danish International Development Agency |
| DFH | Division of Family Health (MOH) |
| DHS | Demographic and Health Survey |
| ECN | Enrolled Community Nurses |
| ESAMI | East and Southern Africa Management Institute |
| FLCAK | Family Life Counselling Association of Kenya |
| FP | Family Planning |
| FPAK | Family Planning Association of Kenya |
| FPPS | Family Planning Private Sector (also PSFP) |
| FPSS | Family Planning Services and Support |
| FRLC | Federal Reserve Letter of Credit |
| GPRD | Government Property Resource Division (of AID) |
| GSA | General Services Administration |
| HPIP | Health Planning and Information Project |
| IBRD | International Bank for Reconstruction and Development |
| IDI | International Development Intern |
| IEC | Information, Education and Communication (IE&C) |
| IFFLP | International Federation for Family Life Promotion |
| INPLAN | Integrated Population and Development Planning |
| INTRAH | Program for International Training in Health |
| IPA | Independent Public Accountant |
| IPS | Information and Planning System |
| IRH | Integrated Rural Health |
| IUCD | Intra-Uterine Contraceptive Device (IUD) |
| JHPIEGO | John Hopkins Program for International Education in Gynecology and Obstetrics |
| JHU | John Hopkins University |
| JSI | John Snow Inc. |
| KANU | Kenya African National Union |
| KCS | Kenya Catholic Secretariat |
| KNH | Kenyatta National Hospital |
| MCH | Maternal Child Health |
| MOH | Ministry of Health |
| MOHA | Ministry of Home Affairs |
| MWRA | Married Women of Reproductive Age |
| MYWO | Maendeleo ya Wanawake Organization |
| NCPD | National Council for Population and Development |
| NFP | Natural Family Planning |
| NGO | Non-Governmental Organization |
| OA | Ovulation Awareness |
| OC | Oral Contraceptive |
| ODA | Overseas Development Administration |
| PCMA | Protestant Churches Medical Association |
| PCS | Population Communication Services |
| PH | Population and Health Office |
| PHC | Primary Health Care |
| PID | Project Implementation Document |
| PIL | Project Implementation Letter |
| PP | Project Paper |
| PSFP | Private Sector Family Planning (also FPPS, PP # 615-0223) |
| PVO | Private Voluntary Organization |
| REDSO | Regional Economic Development Services Organization |
| RFMC | Regional Financial Management Center |
| SCM | Subsidized Commercial Marketing |
| SIDA | Swedish International Development Agency |
| SOMARC | Social Marketing for Change (The Futures Group) |
| TA | Technical Assistance |
| TFCS | USG Treasury Financial Communications System |
| TFR | Total Fertility Rate |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations International Children's Emergency Fund |

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-1-

FAMILY PLANNING SERVICES AND SUPPORT: PROJECT PAPER 615-0232

I. SUMMARY

A major effort by the Government of Kenya (GOK) is taking shape to reduce very high fertility and population growth. The GOK has invited donors to assist Kenya in improving public access to family planning information and quality services. This effort will improve equity of access for lower income groups and improve the status of women; it will lower maternal and infant mortality and morbidity; and it will lessen the growing dependency burden that forces low savings and diminishing investment in social and economic development.

The Family Planning Services and Support Project (FPSS) represents the United States Government's effort to afford maximal support to important elements of Kenya's overall program. If successful, by 1992 the program, of which this project is a substantial part, will make it possible for the vast majority of rural and urban Kenyan couples to make informed choices from among an accessible variety of safe and effective fertility regulation techniques and services. This can be achieved without any inducement or special incentives. Kenya's abortion regulations are more restrictive than those in the USA; there are no efforts underway to change these restrictions. Illegal abortion rates are increasing yearly. Access to and use of effective contraception is crucial.

Couples of all reproductive ages will have more accurate knowledge about the benefits to them of family planning. They will enjoy better access to full cost commercial and private practitioner services and to high quality subsidized and no-cost services, according to income and preferences. Private and public sector hospitals, clinics, dispensaries, trained pharmacists and selected retailers, and respected resident community volunteers will extend essential services throughout the more densely settled rural and urban areas of Kenya where 75% of the population live. More than one in ten fertile aged women today report that they use some method to avoid unwanted pregnancy; within the next eight years that ratio will increase to more than three in ten. It is likely that the birth rate will decline correspondingly from about 50 to about 40 per thousand.

The project has two basic thrusts--to expand family planning service delivery and to improve national family planning support activities. The service delivery element consists of clinical and non-clinical components. The clinical element will provide clinical training for personnel from the public and private sectors, under the direction and coordination of the Ministry of Health (MOH). The non-clinical element will support the expansion of community based services by engaging systems of community leaders and volunteers, coordinated by the Ministry of Health under the guidance and approval of the National Council for Population and Development (NCPD). The strong commercial retail structure in Kenya will also be engaged at the community level through a program coordinated by the NCPD. Support activities will concentrate on improved policy, planning, communications, evaluation and

reporting efforts, coordinated by the NCPD with strengthened authority. It will also promote better information about and more effective local, regional and central planning and budgeting for primary health and family planning activities by the public and NGO sectors.

The proposed AID grant under FPSS will total \$42.9 million over the seven years, 1986 through 1992. The Government of Kenya contribution is estimated to total \$55 million over the period for family planning and requisite associated primary and outpatient care infrastructure. Anticipated contributions by other donors total approximately \$58 million. Assistance from U.S. based Cooperating Agencies, supported with separate funding authorizations from AID Washington's Bureau of Science and Technology, will total approximately \$9 million.

TABLE II

Costing of Project Elements
(\$000)

| Project Elements | FPSS | CA's | GOK | Other Donors | Totals |
|-----------------------------|--------------|--------------|---------------|--------------|---------------|
| 1. Clinical Training (CESS) | 8,716 | 375 | 13,317 | 40,167 | 62,575 |
| 2. Vol. Surg. Contr (VSC) | 6,566 | 1,866 | 1,500 | 1,590 | 11,522 |
| 3. Comm. Based Ser. (CBS) | 7,271 | 440 | 15,826 | 1,833 | 25,370 |
| 4. Sub. Com. Markt. (SCM) | 2,915 | 3,833 | | | 6,748 |
| 5. Ovul. Aware. (OA) | 828 | | | 1,867 | 2,695 |
| 6. NCPD Administration | 747 | | 1,783 | 247 | 2,777 |
| 7. NCPD Pol., Plan., Eval. | 2,484 | 850 | | | 3,333 |
| 8. NCPD Communications | 3,613 | 250 | | 2,973 | 6,836 |
| 9. MOH Info., Plan., Report | <u>3,967</u> | | <u>13,569</u> | | <u>17,535</u> |
| Sub-Totals | 37,107 | 7,614 | 45,995 | 48,675 | 139,391 |
| Inflation | <u>5,792</u> | <u>1,421</u> | <u>8,583</u> | <u>9,083</u> | <u>24,879</u> |
| TOTALS | 42,899 | 9,035 | 54,578 | 57,758 | 164,270 |

Background assessments and technical analyses over the past eighteen months have concluded that the selected FPSS elements are socially, politically, economically, technically, financially and administratively sound. The project directly benefits women as recipients and providers of health care, and improves their rights in reproduction.

As a condition precedent to initial disbursement the GOK will publish a notice in the Kenya Gazette affirming that all project commodities will enter Kenya free of duties and taxes. Prior to disbursement for the Subsidized Commercial Marketing element, an organization will be legally established to sell the commodities, and the GOK must endorse a system for licensing retail outlets to sell contraceptive commodities based on a certification procedure. Prior to

disbursement for procurement of oral contraceptives, the GOK will issue a directive containing specific guidelines governing the distribution of oral contraceptives. By August 1, 1986 the GOK will take various actions to strengthen the administrative and policy coordinating role of NCPD, and to provide sufficient funding in the 1986/87 Development Budget to properly support the project.

The GOK will covenant that during the first year of the Project it will expand and further strengthen the authority of the NCPD to increase inter-ministerial planning and program development and assume a greater leadership role in national family planning activities. The GOK will also covenant that Population and Development Sub Committees will be formed in those districts participating in community based service systems. The GOK will covenant to budget sufficient funds annually throughout the life of the project to assure complete funding of GOK supported elements of the Project and to seek to obtain sufficient other donor funding to meet all expected requirements.

A non competitive assistance award to John Snow, Inc. will be required to allow amendment of the Cooperative Agreement for the Private Sector Family Planning Project. This amendment will permit the Family Planning Services and Support Project to finance of expanded information and communication and voluntary surgical contraception activities now being conducted under the existing PSFP Project. See Annex I for the justification.

Given the highly specialized nature of the technical assistance requirements and the strong collaborative relationships which exist between the proposed implementing Cooperating Agencies and family planning service and support institutions in Kenya, implementation by U.S. based, small, disadvantaged businesses is not feasible. Further, USAID knows of no minority PVO organizations that provide the types of specialized technical assistance required by this project.

USAID project design team members were:

| | |
|------------------------------|---------------------------------------|
| USAID/Kenya: | |
| Gary Merritt | Population/Health Officer |
| Laura Slobey | Population Officer |
| Linda Lankenau | Health and Population Officer |
| Stephen Klaus | Projects and Procurement Officer |
| Gordon Bertolin | Projects Officer |
| Barbara Kennedy | Population and Health Officer (REDSO) |
| Grace Mule | Health and Family Planning Officer |
| Jim Goggin | IDI, Projects Office |
| Imelda Wasike, Anne Macharia | Secretaries, PH and PRJ |

U.S. consultants: Joe Dwyer, Reggie Gipson, Alan Johnston, Claude Lanctot, Mark Lediard, Gene McCoy, Susan Saunders, Carl Stevens, Jim Williams (42 weeks cumulative time)

Coopers & Lybrand, Nairobi Admin. & Fin. Analyses

Many Kenyans contributed guidance, planning, fact finding, and writing for this Paper. The process has gone on steadily over the past eighteen months of assessments, evaluations, analyses and writing. USAID teams without exception enjoyed close cooperation with Kenyan colleagues throughout this period. Officers of the Ministry of Health and Ministry of Home Affairs contributed the bulk of the Kenyan time and effort; they have keen interest in the subject matter, and genuine commitment to meeting the challenge put forth by Kenya's top leaders.

II. BACKGROUND, PROBLEMS AND RATIONALE

A. Background

Kenya's estimated 1984 population of 20 million people is growing annually at the rate of about four percent, with a doubling time of less than 18 years and an average completed family size of eight children. This historically unprecedented growth rate stems in part from the successful achievements of the health system in lowering mortality. These declines in turn have been based on rising standards of living and expanded educational levels. Further declines in the death rate are almost certain. Fertility also increased during recent decades due to improved health and to changing norms of behavior regarding marriage and coitus. These processes underlying rapid growth are still underway in Kenya.

The extraordinary compound growth rate has produced the highest child-to-adult dependency ratio in the world and the greatest underlying momentum for further population growth in the next century. More than half the population is under the age of fifteen. Requirements for land, food and water, schools, jobs, housing, energy and health services are now accelerating beyond the capacity of the economic and social systems to keep pace. Kenya's prospects for further improvements in standards of living for its people are effectively stymied by this growth. A profound crisis is possible within the lifetime of today's young people.

The President, the Vice President, other GOK officials and community leaders now speak regularly with insistence about the urgency of reducing population growth. They publicly promote the use of all safe and proven modern methods of family planning. In 1984 the GOK adopted a goal of 3.5 percent growth in 1988 and has under active review a goal of between 2.8 and 2.0 percent in the year 2000. With fair assumptions about mortality rates, the foregoing overall growth goals will require rapid declines in birth rates and average completed family size.

There is evidence that the GOK's new emphasis should meet with success if there is strong and sustained commitment of resources. Census data show that fertility among older women declined by 50 percent during the 1970s, although the fertility of the larger group of younger women increased. Surveys and pilot service projects in recent years document a growing demand for and use of fertility regulation methods, probably up from less than seven percent in 1977 to over 13 percent of women who reported use of some method in 1984.

4-11

FIGURE 1

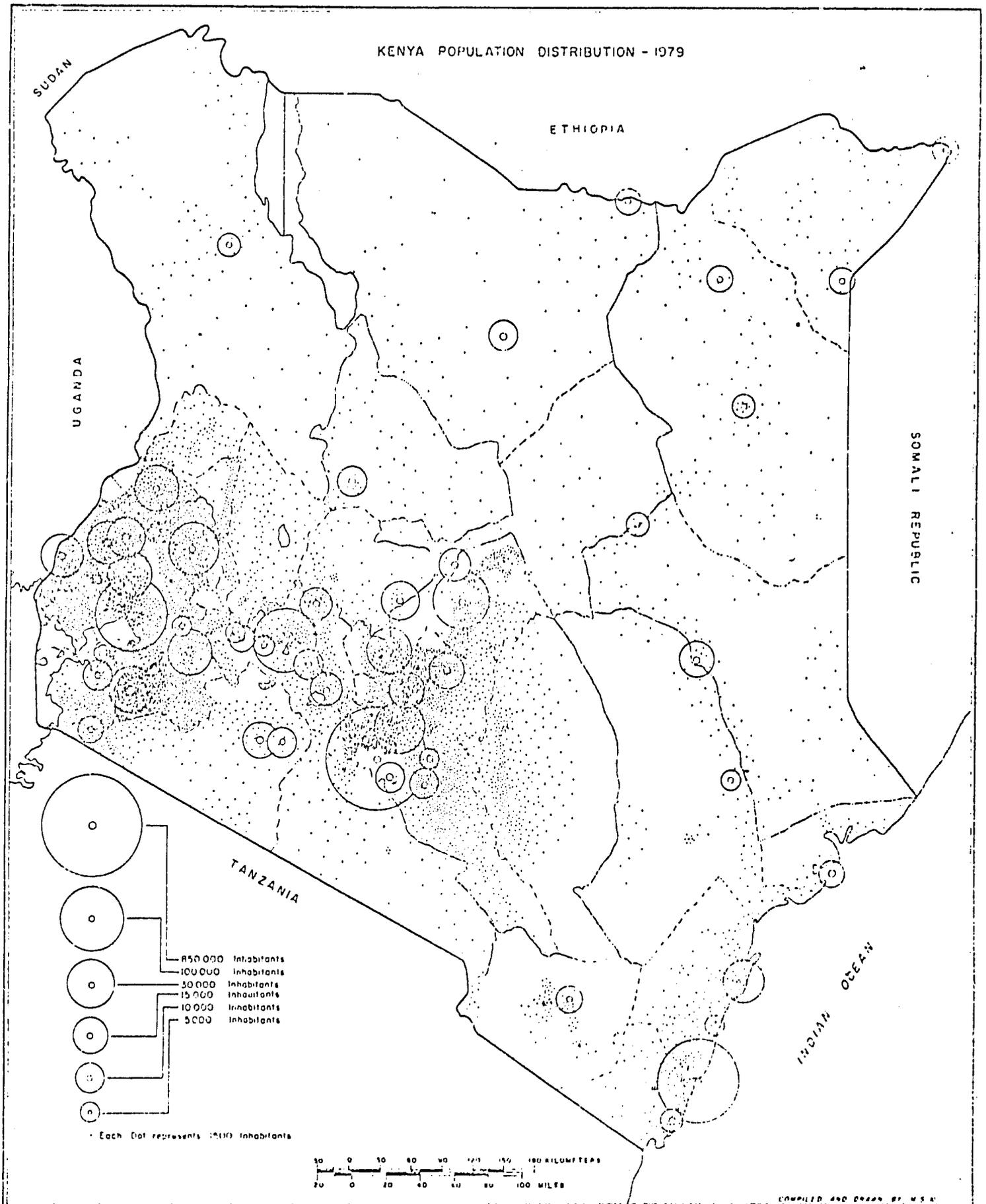


FIGURE 2: KENYA
Momentum of Population Growth

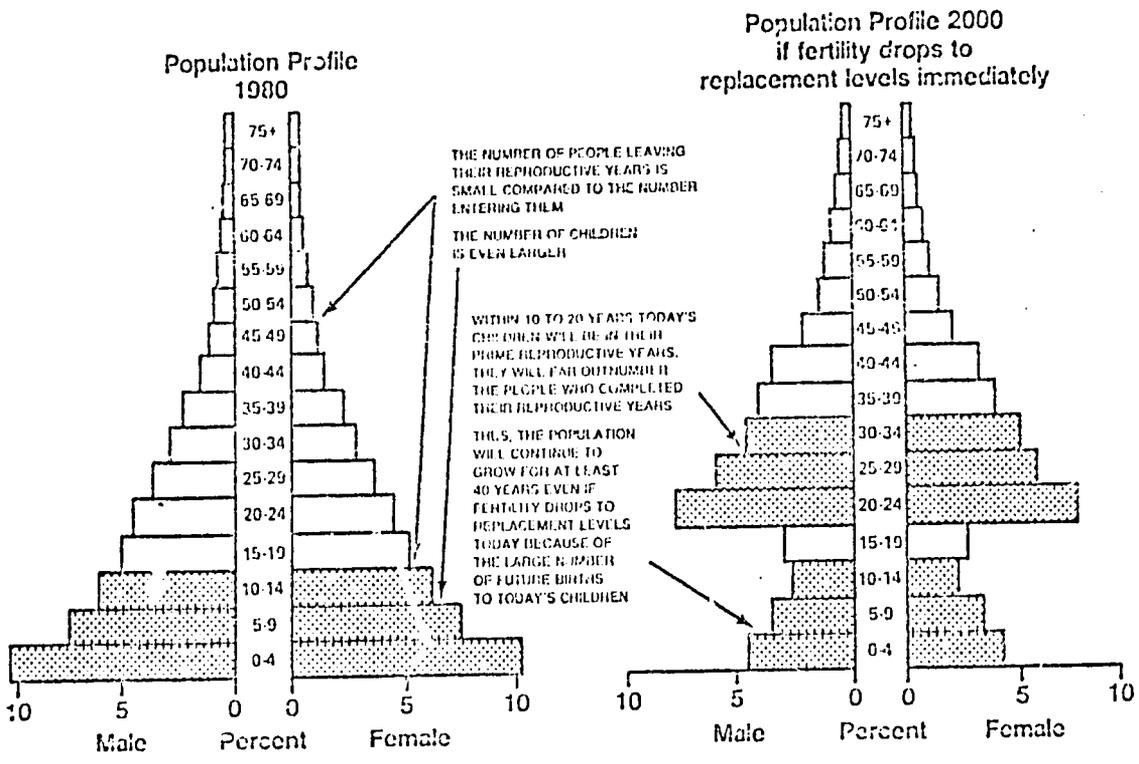
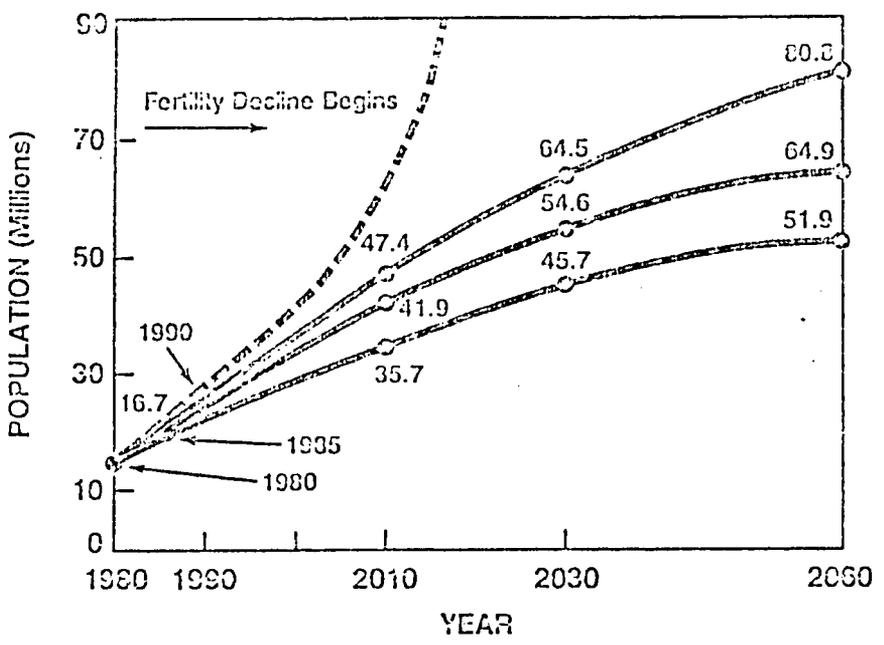


FIGURE 3: KENYA
Effects of a Delay in Reducing Fertility
(Fertility Decline to Slightly Over a 2-Child Per Woman Average in 30 Years)



FIGURES 2 and 3 are adapted from RAPID/The Futures Group presentation on Kenya, 1980.

After almost 15 years of USAID population and family planning assistance in Kenya -- first for improved demographic information, more recently for population policy and planning and extensive field pilot projects -- the time has come for expanded bilateral assistance for family planning service delivery.

B. Problems and Constraints

Limited access to quality family planning services for a majority of the rural population constitutes a major barrier to greater use. (See USAID's Family Planning Strategy, Supplementary Annex A). Demand for services appears to exceed availability of services. For example, preliminary results of the 1984 National Contraceptive Prevalence Survey suggest that 40 percent of women who already have at least one child want no more pregnancies, and that of these women about 40 percent actually reported that they had not wanted to become pregnant the last time. Meeting existing public demand for services should be the highest priority for USAID assistance.

Some potentially major delivery systems have not been utilized much or at all so far in making contraception services available and accessible in the rural areas. Background studies suggest that greater commercial marketing and greater use of community voluntary development groups are possible to extend access to temporary methods of family planning. Existing clinical facilities and personnel are not yet adequate to provide the full range of clinical methods like tubal ligation and intra-uterine contraceptive devices (IUCDs).

Providing access to high quality services may meet existing demand and probably by itself will generate further demand over an extended time period. However, the GOK is convinced that special additional efforts are required to expand and improve the dissemination of information on the benefits of family planning and about specific methods, and to heighten motivation for planning families. Many ad hoc media efforts are already underway on radio, TV and in the press but sustained efforts have not yet been made. Pronatalist and anti-contraception attitudes, especially among males, remain a major constraint, as the GOK clearly recognizes in its NCPD mandate (See Annex F).

At this time, planning and budgeting for family planning are loosely divided between the Ministries of Finance and Planning, Health and Home Affairs; monitoring and implementation are roughly divided between Home Affairs and Health, respectively. The Ministry of Health administers a small budget for primary health care (through which most of its family planning activities are funded) within its large annual recurrent budget. In recent years there have been efforts to achieve a better balance within the MOH budget allocation system between preventive/promotive and curative health investments. It has been politically tough. However, if better balance is not achieved, the prospects for finding adequate budget within MOH for family planning are small given current and expected GOK funding constraints.

USAID believes that long-term success in fertility reduction depends upon the GOK having a strong central agency for policy, planning, budgeting, and evaluation. The Office of the Vice President is the central agency within the GOK for coordinating these essential activities and for setting service delivery objectives and guidelines for family planning. The NCPD in that Office has become established and increasingly productive in its coordinative role during the past two years. However, to date the NCPD has quite limited staff and authority for influencing inter-ministerial budgeting of family planning activities or for monitoring program progress and failure.

Through its experience with four population and family planning projects over the last 15 years, USAID acknowledges a formidably long list of constraints to increased family planning acceptance in Kenya (see Annex F: Social and Behavioral Analysis). Foremost among these, opportunities for demand creation are limited by the comparatively low status of women, their limited role in reproduction decision-making and limited access to wage labor force participation. Even though education has expanded steadily over the years, current levels still impose constraints on family planning acceptance. Many males remain ambivalent at best about use of contraception. This project takes these into account by forecasting only steady, but not rapid progress in socio-economic conditions. The Mission projects, therefore, that only 40-55% of couples will be practicing family planning in the year 2000 and that, only if the GOK's long-term program obtains stronger support.

Other constraints include these: many health facilities and paramedical personnel do not yet provide contraception services; many outlets that do provide family planning have limited hours of service per week; shortages of contraceptives occur; and many prospective clients are turned away because they do not meet GOK guidelines on method suitability (e.g., age and/or parity requirements). This project will endeavor to assist GOK and Kenyan Non-Governmental Organizations (NGOs) to ameliorate these constraints by the year 1992.

C. Rationale and Strategy

Continuation of current rates of natural increase for the next 15 years, even with rapid declines thereafter, would eventually result in a population of more than 100 million people before the middle of the next century -- only three or four generations from now. Even if fertility reduction as now implied by GOK goals has already begun, and fertility were to decline to replacement levels over the next two generations (i.e., in about thirty years), eventual population size will still reach 60 million by 2050. In either scenario the development investments foregone in order to meet the immediate, survival demands imposed by this rapid growth are very large, but are very much greater in the case of the continued high fertility scenario.

USAID's aim is to assist GOK to lower population growth rates so that more resources will be available to be invested in economic growth, long-term employment generation, better education or improved quality of life at the household level. Improved child bearing patterns will also dramatically

improve the health and survival of mothers and children. Reduction of population growth and dependency rates have become the sine qua non for progress in almost every sector and is one of the the cornerstones of USAID's overall development strategy in Kenya.

D. Conformity with Kenya's Priorities

During the past several years, the GOK's resolve to deal with population growth trends has become more pronounced. The current "Fifth Development Plan" states that the GOK's strategy is to "intensify its programme of informing and educating actual and potential parents...and to increase the number of health facilities offering family planning services and also the number of trained personnel to provide these services."

The 1983 ruling KANU Party Manifesto contained a brief but strong statement regarding the need for family planning. In 1984 the GOK Cabinet reviewed and approved a Population Guidelines Policy Paper which will be reviewed by Parliament during 1985. The paper calls for a reduction in population growth from the GOK's estimate of 3.8% in 1984 to 3.5% in 1988. At a Parliamentarians' and District Commissioners' conference in March, 1985 President Moi said, "There is no doubt that the most important factor which has an immediate and profound effect on rural development is the rate of growth of our population. (Satisfying the needs of the majority) will be all the harder to achieve unless purposeful measures are instituted to moderate the growth of our population".

The position of Kenyan leadership is that the GOK firmly supports public access to quality methods and affirms the principles of voluntarism and informed choice. Abortion remains illegal in Kenya for all but extreme medical cases, and there seems to be no move to change the laws.

E. Conformity with USAID CDSS

Woven throughout the FY 1986 Country Development Strategy Statement (CDSS) are USAID's analyses of current and future population trends and their negative impact on every development sector. The CDSS provides a comprehensive analysis of the population issue and gives highest priority to family planning and promotion of economic growth as the means to individual prosperity. The priorities outlined in the CDSS for dealing with this sector were expanded in the Project Identification Document (PID) for this project.

In March, 1985 the U.S. Government Mission to Kenya and AID/Washington approved a paper entitled "USAID Analyses and Strategy for Assistance in Family Planning and Fertility Reduction in Kenya" (ref. Supplementary Annex A). This new strategy stresses equitable access to quality services for all sexually active couples by the year 1992, in strict concordance with GOK policy and program priorities. The strategy exercise identified selected major program components in the public and private sectors as priority areas identified by the GOK and in which USAID has acquired assistance experience. Several critical areas are not deemed feasible for USAID assistance due to lack of experience, resources or USG policy.

F. Other Donor Activity

Donors have in the past carried significant costs for developing the infrastructure for health services in Kenya. Further expansion in that infrastructure is essential to the success of family planning. Since 1982, the World Bank, UNFPA, SIDA, DANIDA, UK/ODA, UNICEF and USAID have participated jointly in a \$61 million Integrated Rural Health and Family Planning Project (IRH/FP). Overall coordination is provided by the World Bank, which has also been the major donor. Phase I contributions for most of these donors are ending during 1985. All present donors plan to continue to support elements of health infrastructure expansion within the IRH/FP framework in forward years, more or less at current levels. Each, of course, is shifting somewhat its support for specific elements in accord with its experiences to date, its individual priorities and the proposals submitted by GOK. The PP design team has thoroughly assessed other donors' plans and their relationship to this project. Their plans are entirely consistent with and supportive of the FPSS. They are described in the technical analyses that were prepared for each project component.

Intensive donor coordination will be called for throughout the life of this project. USAID's commitment to strong informal and formal coordination will continue so that a maximum commitment of GOK resources can be sought while assuring that each donor concentrates its resources on what it can most effectively accomplish.

G. Previous Experience with Other Projects

1. USAID Projects: USAID began assistance in population and family planning during the late 1960s with small grant activities, mostly for building demographic expertise and improving knowledge about population growth and characteristics. These few activities expanded into bilateral grants to the University of Nairobi to institutionalize demographic expertise and to the GOK/MOH for training and information activities in the mid-1970s. Beginning in about 1980 GOK and USAID priorities shifted to: (1) issues concerning strengthening institutional capacities for sustained population policy and planning within the GOK; (2) GOK support for NGO family planning information and communication activity; and (3) continued support for training of paramedical cadres within the GOK. This led to the bilateral project, Family Planning II (FP-II) which is the USAID portion of the IRH/FP Project (see above). FP-II began in 1982 and is scheduled to end in September, 1985.

Family Planning II has two parts. Part A (\$3.0M) with the Ministry of Home Affairs' NCPD supports policy development and information, education and communications (IEC) and provides funds through NCPD to four NGOs for family planning communication activity. Part B (\$1.0M) provides support to the Ministry of Health's National Family Welfare Center, which in 1985 was renamed and upgraded to become the Division of Family Health (DFH). DFH supports in-service training of Enrolled Community Nurses (ECNs) and Clinical Officers (COs). Following two project evaluations it seems clear that new demand for family planning services has outpaced the service delivery elements of the program, and that it is most important to reinforce the NCPD to play a heightened role in coordinating policies and budgeting for family planning.

Private Sector Family Planning (\$4.5M), a four year project ending September, 1987 is being implemented by John Snow, Inc. under the direct guidance of NCPD. This project will recruit and serve a minimum of 30,000 clients in 35 sub-projects with large employers. Although the project only began one and a half years ago and has not been the subject of an evaluation, progress to date and GOK support have been excellent. This project is demonstrating that access to quality services can be expanded through private sector establishments with close GOK overview and guidance.

The Population Studies and Research Institute (University of Nairobi, \$2.7M), an eight year project which was successfully completed in September, 1984, trained ten Ph.D. and 35 M.A. students. It provided an institutional capacity for population research and analysis to support improved awareness, planning and program evaluation. USAID's acquired experience with this project reinforces the view that greater knowledge of demographic realities, based on indigenous institutions, can be a powerful factor in supporting population policies favoring family planning.

The experiences resulting from these projects have been fully taken into account in FPSS project design. In particular, the primary FPSS emphasis on service delivery, the wide and direct utilization of private profit and non-profit organizations, and the continuing efforts to build a permanent institutional capacity at NCPD are direct outgrowths of USAID's experience in these projects.

2. Centrally funded projects: USAID/Kenya's large portfolio of centrally funded activities is comprised of 18 Cooperating Agencies (CA) with about 35 sub-projects providing funding and technical assistance in the areas of policy, information, clinical training, biomedical and operations research, services and training. One of the major elements of USAID strategy in the FPSS will be to provide funding for the larger CAs whose work focuses on planning and service delivery. The CAs have introduced innovation, flexibility and technology transfer, and have strengthened the private sector. These lessons have been taken into account in current project design, as CAs have major roles in all project components, especially in the NGO sector.

III. PROJECT DESCRIPTION

In light of the constraints and experience previously gained in Kenya and elsewhere, USAID has identified the following key project strategy features: (1) USAID assistance will be implemented by GOK or under its thorough review and approval; (2) project efforts will be national in scope; (3) resources will concentrate on equitable access for couples of all ages to quality fertility regulation services, with strong support also for policy, planning and promotional efforts; (4) implementation will be undertaken through a balanced mix of private and public sector institutions; and (5) project components will reflect the most technically effective and cost effective methods of contraception and delivery systems for achieving equitable access for all couples. Costs for services will be low or free for those with limited incomes, but all FPSS supported program elements will strive for cost recovery from consumers.

A. Goal, Purpose and End of Project Status

The goal of this project is to lower population growth rates by enhancing the freedom and opportunity for individuals and couples to choose the number and spacing of children to levels more consistent with their probable ability to provide improved standards of living. The purpose of FPSS is to increase user rates of high quality family planning methods. Project interventions are focused on these objectives: (1) deferring first births by young adults; (2) spacing births among those in the middle of their reproductive years; and (3) completing fertility at earlier ages with a smaller family size.

The project will assist the GOK in reaching its goals of a population growth rate of 3.5% in 1988, a tentative goal of 2.8% in 2000 and an intermediate goal of about 3.2% in 1992. These goals are most consistent with Crude Birth Rates (CBR) of 46 (in 1988), 40 (in 1992) and 35 (in 2000). In turn these CBRs are consistent with prevalence rates of contraception use of 20%, 32% and 40%, respectively. The major intervening accomplishment will be a condition wherein more than 80% of Kenyan couples will both know about and have relatively equitable access to two or more effective, modern methods of fertility regulation, to be achieved through a variety of clinical and non-clinical methods and delivery systems, with trained personnel for education, counseling, referral and service provision in most towns and villages throughout the country. USAID illustrative projections suggest that this can be achieved by providing a total of about 7.3 million couple years of protection (CYP) comprised of: 5.2 million CYPs through an expanded clinic system, 1.5 million CYPs through community based systems, and at least 0.6 million CYPs through subsidized marketing.

B. Project Elements

Project activities fall into two major areas of emphasis-- improved family planning service delivery and increased Kenyan public and private capacity to support and promote family planning. Primary project emphasis is placed on service delivery. Planning, management and demand creation activities nevertheless remain essential elements of a comprehensive family planning program and are an integral part of the proposed project. The magnitude and duration of the project reflect USAID's commitment to a long-term strategy and reflect recognition of the size and complexity of the tasks. Each of these components is described briefly below, more fully in the Annex E: Technical Analyses, and in detail in a compilation of technical reports available at USAID/PII and in AFR/TR/P and AFR/PD/EAP as Supplementary Annex C.

SERVICE DELIVERY

Project service delivery activities will improve and expand family planning throughout Kenya in two broad areas: (1) clinical services, including training of medical and paramedical cadres in the public and private sectors, and a special component of Voluntary Surgical Contraception (VSC), and (2) non-clinical services, including community based volunteer systems, subsidized commercial retail sales, and natural family planning (ovulation detection and

periodic abstinence). Support to private, for-profit institutions providing family planning services continues to be an element of USAID's family planning strategy, but is funded separately through the ongoing Private Sector Family Planning Project. Specific project interventions directly reflect social segmentation by age and parity. For example, tubal ligation is most effective, most cost effective and popular among women of high parity (number of children); commercial sales create access for men and young people; and community based, volunteer services are ideal for couples in remote areas of all ages. By the end of the project there will be 30,000 new or improved family planning service delivery points as compared with perhaps 6,000 today. The contraceptive requirements and targets to meet these objectives, the analytical basis for the estimates, and the corresponding logistic support requirements are described in Annex E.1, "Contraceptive Requirements".

FPSS will provide assistance to the Ministry of Home Affairs, to the Ministry of Health, and to NGOs. Training is the biggest item in the consolidated budget, followed by family planning commodities, equipment and supplies; salary support is a significant feature in early years; local and U.S.-based technical assistance are small funding items; there are few FPSS supported vehicles and no construction (See Financial Plan and Project Costs).

1. Clinical Training and Support Services (CTSS)

The clinical services component will expand and improve the delivery of family planning services through both government and non-government hospitals and clinics. Currently half of the rural health facilities in Kenya do not offer family planning services. Expansion of family planning services is constrained by a lack of appropriate family planning commodities, GOK policy concerning types of contraception offered to various client groups, and a lack of skilled MOH personnel to deliver family planning services. The FPSS response to the first two constraints is discussed in the policy planning and contraceptive requirements sections of this paper. The project's training activities will focus on in-service training for existing staff and improvements in the pre-service training courses. The project does not intend to increase MOH staffing. Rather, it will increase the effectiveness of current staff in the provision of family planning services. Activities include providing support to the Ministry of Health's Division of Family Health to update and print MCH/FP curriculum and training materials, to conduct MCH/FP in-service courses for medical and paramedical employees, hold yearly refresher and training of trainer courses for training staff and provide training scholarships for short term regional and out of country training. Assistance will also be provided to the Ministry of Health's Nursing Division to develop and conduct short in-service training programs for health workers providing and supervising integrated MCH/FP services covering various topics such as management, advances in contraceptive technology and counseling for family planning. All project assisted training programs will be open to up to 25% participation by NOD service delivery staff. It is expected that by the end of the project over 6,000 medical or para-medical staff will have received basic or refresher family planning training.

Project assistance will consist of operating cost support for training programs, training materials and contraceptives. The GOK will provide training facilities, faculty and basic salaries. The AID centrally funded project, Program for International Training in Health (INTRAH), will provide technical assistance and additional funding support for training.

2. Voluntary Surgical Contraception (VSC)

The purpose of the VSC component is to expand the availability of voluntary surgical contraception (VSC) services in Kenya in order to enhance the well being of Kenyan families by reducing the rates of maternal and infant mortality and morbidity. A secondary purpose is to allow all Kenyan families the opportunity to adopt a safe and effective permanent method of family planning if they so desire.

USAID studies suggest that probably 2000 women died in Kenya in 1984 in childbirth or due to childbirth. Most of these are older women with six or more children. Many of these deaths and tragedies to these large families could have been avoided if safe and affordable tubal ligation services had been more readily available. Further, most of the 90,000 infants who die in Kenya each year are born to older women of higher parity. The principal constraints to expansion of VSC services are inadequately or inappropriately trained medical and para-medical staff and a lack of the necessary VSC equipment.

This component will upgrade the facilities and staff capabilities of up to 100 VSC service delivery points. By the end of the project Kenya will have the capacity to provide VSC services to 50,000 people annually (presently the demonstrated capacity is about 7,000).

The components of the effort to expand services include training for physicians, nurses, midwives, community workers and counselors; equipment and supplies to up-grade facilities; program and medical management, technical assistance, and financial support to offset some of the costs in providing quality services for individuals who cannot afford the full cost of surgical contraception. FPSS will provide training, equipment, supplies and partial institutional operating cost support, the GOK and NGOs provide will facilities, staff and other operating support and AVSC will assist USAID and MOH in managing the FPSS support and will provide technical assistance and teaching materials.

3. Community Based Services (CBS)

The Community-Based Service (CBS) component will increase awareness of the benefits of modern methods of preventive health, encourage use of modern family planning methods, and make supplies and other services conveniently accessible to couples by drawing upon Kenya's extensive network of community development leaders and organizations. At present probably no more than 20% of rural women have access to modern family planning methods since provision of modern family planning services is largely confined to the formal health

system and to urban areas. However, there do exist successful community-based service programs with almost one thousand trained and experienced CBS volunteers, trainers, supervisors and administrators working in seven rural districts. Local residents are the key to CBS programs, usually mature women who volunteer to lead and serve their neighbors, friends and kinfolk. Limited objectives, stress on basic skills, a supportive supervisory network and a reliable supply system are the essential elements of CBS.

By 1992 FPSS aims to engage at least 15,000 volunteers and 2,000 supervisors and administrators to be providing non-clinical fertility regulation and other primary health services to as much as 75% of Kenya's rural population (over 3,000,000 couples), especially to those younger couples whom the private sector and Government clinical systems do not reach easily. Based on recent extensive experience with prototype systems that are already providing services to about 7% of all Kenyan couples, by 1992 more than 500,000 couples could be utilizing oral contraceptives, condoms, and spermicides to delay or space births through free or low cost community level services.

USAID and other donor assistance will be administered under the guidance and approval of the National Council for Population and Development (NCPD) and the Ministry of Health. Standards and quality will continue to be monitored by the Committee on Community Based Primary Health Care (CBPHC), chaired by the Ministry of Health, Division of Family Health (consisting of public health representatives of MOH and those NGOs active in delivery systems).

Annex E.4. (CBS) provides illustrative estimates of the number of political sub-divisions in Kenya that could be expected to have established CBPHC planning, services, support, supervision and monitoring groups during project years. Current experience suggests that the key salaried staff management unit will be at the District level where four (4) persons and one vehicle will be needed. These units will directly support CBS planning and budget preparation for local community initiatives at the District level, and will supervise and support the Divisional units.

Most Districts have four or five Divisions each; most Divisions have four to five Locations; most Locations have three to five Sub-Locations. Experience to date suggests that each Division will require a small core staff of three to attend to the many details of organizing logistics, providing personnel support, arranging training and re-training, reporting performance through the District Medical Officer of Health, liaison with the Chiefs and Assistant Chiefs of each Location, ensuring that Locational Budget Planning Committees prepare community proposals for the annual District and GOK budget planning process, and other essential tasks involved in keeping the volunteer system working smoothly. A full-time NGO staff of three persons can adequately supervise the activities of about 14 FE/Supervisors and two ECN/Supervisors. District foci for planning, budgeting and management of personnel and supplies are also required. These ratios, personnel categories, costs and expected accomplishments are summarized in Annex E.4.

The proposed USAID project assistance will provide partial funding and technical assistance for training, supervision, commodities, equipment, supplies, and certain other operating costs. Total costs for a successful national program will be on the order of U.S. \$28 million (KSh. 450 million) over the next seven to eight years, of which the USAID project will contribute \$8 million. Most of the budgetary support for the local recurrent costs of a national CBS program must come from the GOK, through the District focus planning and development budgeting. SIDA, ODA and UNFPA are likely to provide some support, for contraception and local management, District planning and commodities, and communications. USAID will actively encourage other potential donors to participate (as with Japan, recently). CBS programs have strong political and technical/professional support from the GOK leadership, the MOH and major NGOs. If Kenya's rural fertility rate is to decline rapidly this element must play a crucial role in the national program. The CBS program in Kenya could deliver over 800,000 CYPs over the next seven years.

4. Subsidized Commercial Marketing (SCM)

Subsidized commercial marketing (SCM) will increase the knowledge and use of non-clinical contraceptives by making them accessible in the community through selected, local retail outlets at affordable prices. At present Kenya's well developed commercial retail infrastructure in rural areas is under-utilized from the point of view of marketing contraceptives. Couples who would like to use modern contraceptive methods often must travel great distances to obtain supplies. In addition, the cost of modern contraceptives is a major disincentive for rural Kenyans. This component will increase the availability, knowledge and use of contraception among eligible couples by utilizing commercial marketing, promotional and distribution techniques to inform potential users about these contraceptive products, their correct use and where to purchase them. The SCM component complements and supplements the existing and planned family planning activities by the GOK and NGOs as well as those of the private sector.

This component will benefit couples who have limited access to clinical sources of supply, those who cannot afford commercially priced products and those who have a strong preference to avoid clinic situations and/or prefer being able to purchase at convenient locations and times. This effort will use market incentives to encourage private sector participation by regional distributors and retailers. Increased efficiency and effectiveness are major objectives of social marketing.

An organization will be established to issue tenders for the marketing of services to be provided: research, advertising, promotion, distribution packaging and warehousing. Products will be provided under FPSS and other international donor organizations, such as ODA (especially for condoms). It is estimated that by 1992 more than 100,000 couple years of protection will be provided through this system each year.

5. Ovulation Awareness for Periodic Abstinence (OA)

Ovulation Awareness (also referred to as natural family planning--NFP) will promote periodic abstinence for persons for whom other methods of family planning are incompatible with their beliefs or religion. Ovulation awareness techniques of family planning are becoming more known in Kenya. Pilot activities carried out by the Kenya Catholic Secretariat (KCS) and Family Life Counseling Association of Kenya (FLCAK) with assistance from AID/W Cooperating Agencies are already underway. In the view of these organizations, the major barriers to increased use of these techniques is the lack of staff and trained teachers, and the need for operational support.

This component will assist in expanding OA services during the first three years of the project by providing funding to the International Federation for Family Life Promotion (IFFLP), which will in turn provide funding to the KCS/Family Life Program for the expansion of OA services in the two dioceses of Meru and Kakamega; and to FLCAK for a second sub-agreement with IFFLP for expansion of OA services in Nairobi and Central provinces. The FPSS support will assist these organizations to test the feasibility, effectiveness and cost-effectiveness of intensive, optimally designed OA programs, as prototypes for potential expansion.

Based on prior experience, it is assumed that a full-time OA teacher is expected to teach one hundred new OA users per year and that 5% of the new users will be trained as volunteer OA teachers, each then anticipated to teach ten new users. The two IFFLP sub-agreements with KCS and FLCAK are expected to achieve the training of 3,600 full-time teachers and up to 7,200 volunteers, and over 10,000 couples actively using the method. It is not known how to project the eventual couple years protection conferred by learning this technique.

After the first three years of the FPSS project KCS, FLCAK and other interested agencies in Kenya will obtain assistance from GOK, other donors or from AID centrally funded projects.

SUPPORT ACTIVITIES

Family planning support activities will concentrate on assistance to the National Council for Population and Development and the Ministry of Health. Within the NCPD assistance will be provided for administrative strengthening; GOK population policy and planning formulation; coordination of GOK and NGO information campaigns; and continuous monitoring and evaluation of the national population program. Within the MOH the project will support the continuation of planning and information activities begun under the Health Planning and Information Project (615-0187). The project will also assist the MOH in its efforts to strengthen its contraceptive procurement and distribution program.

6. NCPD Administrative Strengthening

The National Council for Population and Development is a most crucial feature of the GOK's national family planning program to which FPSS will make a substantial contribution. The NCPD was created in 1982 and is as yet a young institution. As described in the Administrative Analysis (Supplementary Annex B), the NCPD Secretariat, by virtue of its status and level of personnel, is less effective than its potential given the status of the members of the NCPD itself. The project will strengthen the effectiveness of the NCPD through working towards implementation of the main recommendations of the Administrative Analysis. The most pertinent of these include modifying the legal status of the Secretariat to a more independent Permanent Commission; internal reorganization; increased staff levels and characteristics; and strategy planning. The project includes conditions and covenants concerning needed changes and provides the operational support and technical assistance to help bring them about.

7. NCPD Policy, Planning and Evaluation

The project will assist GOK to further develop the technical and analytical capacities of the NCPD by modifying and strengthening its Secretariat. This component will provide practical technical assistance and budgetary support required by the NCPD in order for it to fulfill expanded mandates within the GOK to set national population policy and supervise the implementation and reporting on the national family planning program.

This component will support NCPD with financial and technical assistance for: formulation of national policies and strategies; coordinating and commissioning the demographic analysis and program evaluation and analysis that provide the basis for policy and strategy formulation; and the provision of support and guidance for district-level population activities;

Continuous monitoring and evaluation of the national family planning program is an essential element of a dynamic policy formulation and planning program and will be supported vigorously by FPSS. A description of the expected monitoring and evaluation activities to be undertaken and of the assistance to be provided is presented in Section V.D. "Evaluation and Monitoring".

8. NCPD Information and Communication

The communication component will increase the demand for family planning services by using a blend of mass media and interpersonal channels to reach selected target audiences with service-related messages. Although demand for family planning services now exceeds supply, achievement of Kenya's family planning objectives will require that demand be increased even further.

The NCPD will receive technical and financial assistance to strengthen its capacity to plan, manage, coordinate and evaluate an intensified national communication program. Substantial support is provided for planning workshops to design a national communication strategy and for production of a variety of

materials, including print, radio, television and film. Actual materials production will be undertaken by specialized private and public sector organizations whose work will be guided by the IEC division of the NCPD.

Coordinated planning, field-testing and evaluating of media products and the overall IEC strategy is a key element in this component. USAID support to NCPD's national communication program is substantial in the first two years of the project in response to GOK's requests to help sustain the current momentum in the population program by supporting a range of mass media activities. Thereafter USAID support will be in the form of ongoing technical assistance in communications planning and evaluation, and support to the management of media production. USAID will also provide financial assistance over the life of the project for communication support to the various service delivery components such as VSC and CBD described elsewhere in the project paper. It is expected that multi-lateral donors will become the main supporters in this area in the third year, thus FPSS support is concentrated in the first two years.

9. MOH Information, Planning and Reporting Systems

The Information and Planning Systems for Health and Family Planning (IPS) component will strengthen the capacity of the Ministry of Health to plan, implement and evaluate the Primary Health Care (PHC) network at the national, provincial and district levels. This component will further strengthen collection, analysis and rapid feedback of information required by communities and decision-makers for evaluating, planning and implementing the delivery of health and family planning services in the public and private sectors. Strengthened planning and management capabilities of up to over 20 officers within the Ministry of Health will lead to the provision of more effective and efficient health and family planning services.

Based on past experience in this field, Kenyans have not yet attained sufficient breadth and depth of experience or are not available to provide the required technical assistance to this component of the project in the area of senior level planning, management/training and information systems, therefore the budget includes three long term specialists (a Senior Planner, an Information Specialist, and a Management Training and Organizational Development Specialist). These specialists will provide training and set up the infrastructure so that local MOH staff will be able to eventually work without assistance.

FPSS will support training of up to 200 health personnel at the district level in the analysis and use of information for better budget planning for local programs and services. Members of the District Development Committees require information about health and family planning services to monitor progress and problems. This information is forwarded to provincial and national level MOH offices and is used for budget and personnel decisions. This component will assist MOH to have the most timely and best quality data feasible.

IV. FINANCIAL ANALYSIS AND PLAN

A. Funding Obligation Mechanism

A single project obligation with the Government of Kenya covering all major anticipated elements of assistance is considered optimal. This approach will strengthen NCPD's ability to coordinate and supervise both private and public population activities. A single obligating document will also enable USAID to provide Kenya greater budgetary flexibility and rapid response to changing circumstances, permitting the shift of funds from one component to another depending on the rapidity and success with which elements of the program are implemented and on shifts in GOK priorities and needs. A single obligation will thus permit more effective management of overall Project resources than numerous separate grants. The single obligation (sectoral) approach will also simplify implementation of AID's internal procedural requirements.

USAID has concluded that the best project implementation arrangement involves multiple management units under this single obligation. This approach is mandated by the diverse technical requirements of the Project. The multiple component approach permits each project intervention and technical assistance input to be specifically tailored to sub-sector constraints.

B. Funding Arrangements

Because of the sectoral nature of the project the funding arrangements are varied. However, each of the ten major elements that make up the project are discrete, self contained, activities which lend themselves to particular types of financing. In Flow Chart IV.1 and Table IV.1 the implementation documentation for each element is summarized and the method of financing each of these documents is shown.

TABLE IV.1

| <u>PROJECT ELEMENT</u> | | <u>APPROXIMATE AMOUNT</u> |
|--|---|---------------------------|
| <u>Contracting Method</u> | <u>Payment Method</u> | (U.S. \$000) |
| -- <u>CONTRACEPTIVE PROCUREMENT</u> (for elements 1,3 and 4) | | |
| a. Purchase by GSA under PIO/Cs | Payment by AID/W | \$10,097 |
| | Element Sub Total | <u>\$10,097</u> |
| 1. <u>CLINICAL TRAINING SERVICES & SUPPORT</u> | | |
| a. Cooperative Agreement with INTRAH | Letter of Credit (TFCS) | 1,003 |
| b. H.C. procurements for training and support to MOH | H.C. Reimbursement with periodic advances | 3,490 |
| c. Participant training AID/W under PIO/Ps | Direct Payment | 78 |
| | Element Sub Total | <u>\$4,571</u> |

| | | | |
|----|---|-----------------------|--|
| 2. | <u>VOLUNTARY SURGICAL CONTRACEPTION</u> | | |
| a. | AID Cooperative Agreements with: | | |
| | John Snow | TFCS/Letter of Credit | 853 |
| | AVSC | TFCS/Letter of Credit | 4,101 |
| | JHPIEGO (optional) | TFCS/Letter of Credit | |
| b. | H.C. procurement for commodities and services and/or PIO/Cs to GSA or GPRD | | H.C. Reimbursement with advances and/or payment by AID/W |
| | | | 1,612 |
| | Element Sub Total | | \$ <u>6,566</u> |
| 3. | <u>COMMUNITY BASED SERVICES</u> | | |
| a. | AID Cooperative Agreement with Pathfinder (Alternative Options are Direct Grant to NGO or H.C. Grant to NGO by MOH) | | H.C. Reimbursement with advances (TFCS/Letter of Credit) |
| | | | 2,306 |
| | Element Sub Total | | \$ <u>2,306</u> |
| 4. | <u>SUBSIDIZED COMMERCIAL MARKETING</u> | | |
| | AID Cooperative Agreement with SOMARC | | TFCS/Letter of Credit |
| | | | <u>1,926</u> |
| | Element Sub Total | | \$ <u>1,928</u> |
| 5. | <u>OVULATION AWARENESS (NFP)</u> | | |
| | Cooperative Agreement with IFFLP and subgrants to FLCAR and KCS | | TFCS/Letter of Credit |
| | | | <u>828</u> |
| | Element Sub Total | | \$ <u>828</u> |
| 6. | <u>NCPD ADMINISTRATIVE SUPPORT</u> | | |
| a. | AID Cooperative Agreement with INPLAN | | TFCS/Letter of Credit |
| | | | 99 |
| b. | H.C. procurement | | H.C. Reimbursement |
| | | | <u>648</u> |
| | Element Sub Total | | \$ <u>747</u> |
| 7. | <u>NCPD POLICY, PLANNING AND EVALUATION</u> | | |
| a. | AID Cooperative Agreement with INPLAN | | TFCS/Letter of Credit |
| | | | 262 |
| b. | T/A contracts issued under PIO/Ps Direct with USAID | | Direct Payment |
| | | | 1,482 |
| c. | H.C. Contracts for T/A | | H.C. Reimbursement or direct L/Com |
| | | | 112 |
| d. | Training and support costs; H.C. procurement | | H.C. Reimbursement |
| | | | 196 |
| e. | Participant training by AID/W under PIO/Ps | | Direct Payment |
| | | | <u>432</u> |
| | Element Sub Total | | \$ <u>2,484</u> |

8. NCPD INFORMATION AND COMMUNICATIONS

| | | | |
|---|-----------------------|----|--------------|
| a. AID Cooperative Agreements with: | | | |
| John Snow | TFCS/Letter of Credit | \$ | 180 |
| PCS | TFCS/Letter of Credit | \$ | 285 |
| | | | |
| b. H.C. Grants to NGOs | H.C. Reimbursement | \$ | 1,730 |
| | | | |
| c. Staff and operating costs; H.C. procurement | H.C. Reimbursement | \$ | 402 |
| | | | |
| d. H.C. TA Contracts | H.C. Reimbursement | | 851 |
| | | | |
| e. Participant training by AID/W under PIO/Ps | Direct Payment | | 165 |
| | Element Sub Total | \$ | <u>3,613</u> |

9. MOH INFORMATION, PLANNING AND REPORTING SYSTEMS

| | | | |
|--------------------------|-------------------|----|--------------|
| a. H.C. Contract for T/A | Direct L/Com | | 3,967 |
| | Element Sub Total | \$ | <u>3,967</u> |
| ----- | | | |
| | Total Project | \$ | 37,107 |
| | Inflation | \$ | <u>5,791</u> |
| | | | |
| | GRAND TOTAL | \$ | 42,898 |
| ----- | | | |

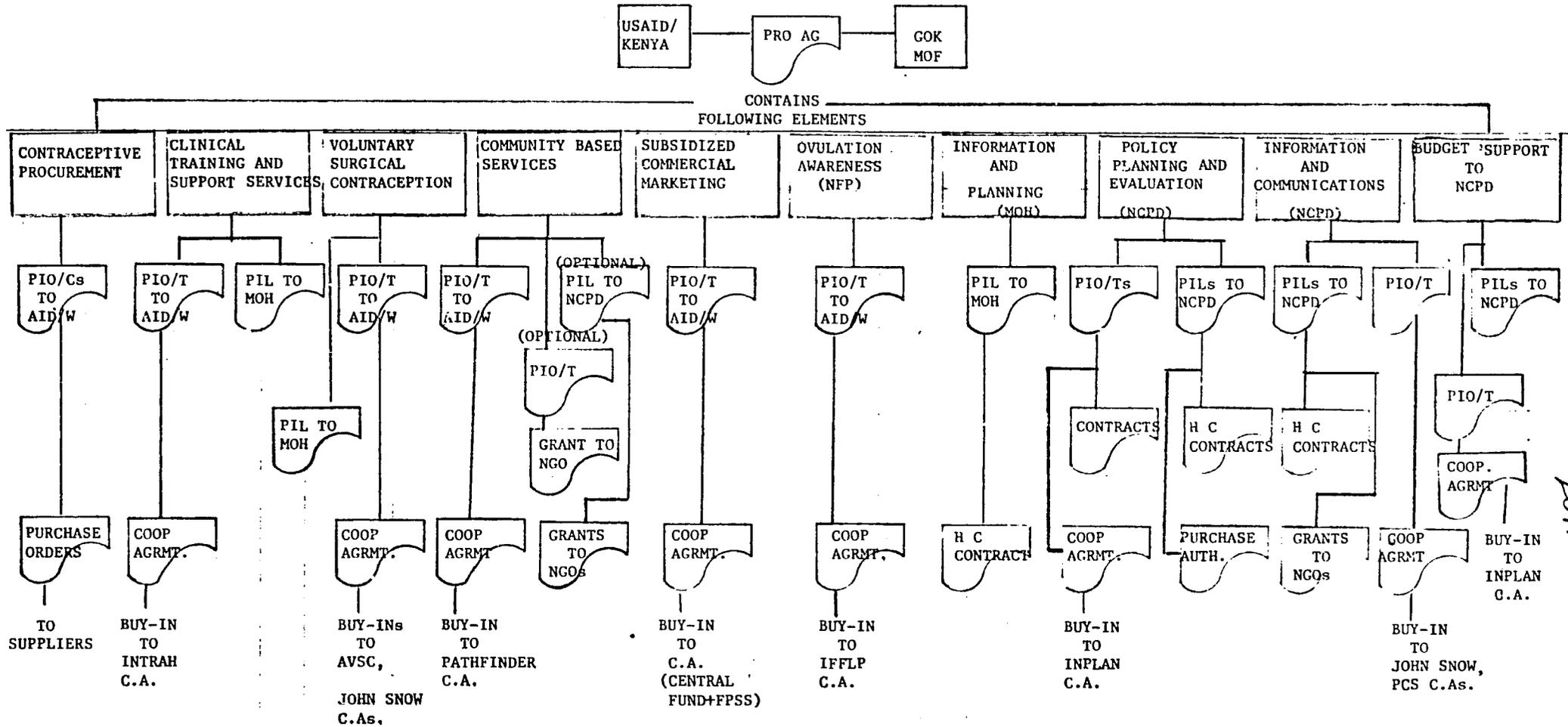
TOTAL FPSS PROJECT BY METHOD OF FINANCIAL

| | | |
|---------------------------|-------------|-----------------|
| a. TFCS/Letters of Credit | \$ | 11,007 |
| b. Direct L/Com | \$ | 3,967 |
| c. H.C. Reimbursement | \$ | 9,879 |
| d. Direct Payment | \$ | <u>12,254</u> |
| | | |
| | TOTAL | \$ 37,107 |
| | INFLATION | \$ <u>5,791</u> |
| | GRAND TOTAL | \$ 42,898 |

FPSS will support NCPD and MOH activities at the level of about \$12 million on a cost reimbursement basis, with advances to the GOK Paymaster General, as requested and appropriate. All advances will be made in conformity with customary AID financial management practices. Senior most GOK officials have repeatedly urged that the FPSS Project provide for advances on the grounds that funds from Treasury will not otherwise be advanced to the line ministries in a timely manner, as proven by the experience of the past two years in MOHA and MOH. The GOK will be expected to account for funds advanced before additional funds are advanced. This will be a management challenge within FPSS.

USAID/KENYA
 FAMILY PLANNING SERVICES AND SUPPORT PROJECT
 IMPLEMENTATION DOCUMENTATION
 FLOWCHART

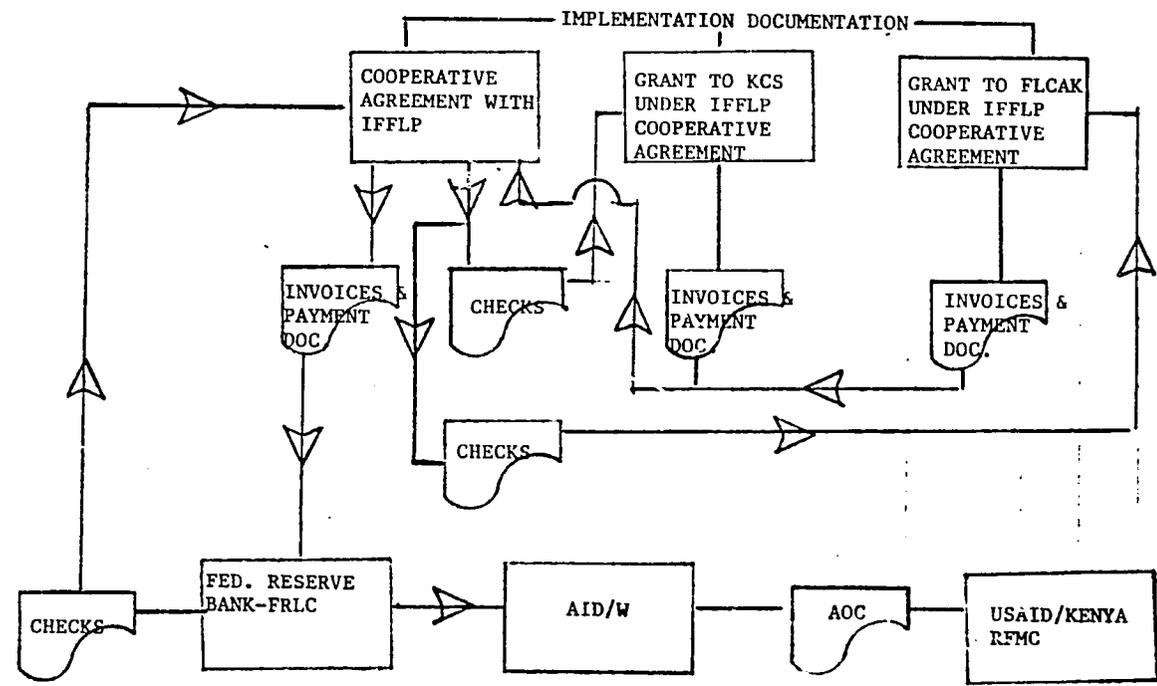
FLOW CHART 1



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USAID/KENYA
 FPSS PROJECT
 OVULATION AWARENESS (NFP)
 FLOW CHART
 PAYMENT DOCUMENTATION

FLOW CHART 6



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After the first year of the project it is expected that funds to support NCPD and its activities will be advanced to an account established in a commercial bank for the Commission of the NCPD. As required by circumstances and when requested by GOK, USAID will directly disburse to suppliers under host country contracts. Those NGO projects presently supported by USAID under Family Planning II through GOK Treasury and NCPD will be continued for another two to three years under FPSS.

To the maximum extent possible Treasury Financial Communication System Letters of Credit (TFCS) will be utilized to finance Cooperative Agreements with non-profit organizations. Where a Direct L/Com is the financing vehicle (the MOH/IPS), this is because past experience has shown that the MOH disbursement procedures are cumbersome and slow or more expensive. A realistic assessment of the needs of the project and the expected demands of contractors dictate that in this case a Direct L/Com will be necessary and in the interest of prompt implementation.

A major thrust of the project is to enhance and improve the administrative capability of the NCPD, and to the extent possible we have utilized the NCPD, as the disbursing agent. However in some cases it will be in the interest of AID and the project to have direct disbursing arrangements with certain NGOs and contractors.

C. Summary Project Budgets

TABLE IV.2 Projected Expenditures by Fiscal Year
(\$000)

| | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | Total |
|--------------|--------|--------|--------|--------|--------|--------|--------|---------|
| USAID FPSS | 7,050 | 6,827 | 4,292 | 3,745 | 5,147 | 5,106 | 4,940 | 37,107 |
| AID/W (CA's) | 1,331 | 1,330 | 1,723 | 1,490 | 527 | 679 | 534 | 7,614 |
| GOK | 2,504 | 3,756 | 8,531 | 6,724 | 7,458 | 8,329 | 8,693 | 45,995 |
| Other Donors | 5,241 | 4,666 | 5,093 | 8,201 | 8,329 | 8,381 | 8,764 | 48,675 |
| Sub-Total | 16,126 | 16,579 | 19,639 | 20,160 | 21,461 | 22,495 | 22,931 | 139,391 |
| Inflation | -- | 829 | 2,234 | 3,178 | 4,625 | 6,215 | 7,798 | 24,879 |
| Total | 16,126 | 17,408 | 21,873 | 23,338 | 26,086 | 28,710 | 30,729 | 164,270 |

TABLE IV.3.

SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(US \$000)

| | AID (FPSS) | | AID(CAs) | | GOK | | Other Donors | | Total | |
|----------------------|--------------|---------------|--------------|----------|----------|---------------|--------------|---------------|--------------|---------------|
| | FX | LC | FX | LC | FX | LC | FX | LC | FX | LC |
| Technical Assistance | 3,205 | 4,948 | 2,657 | - | - | 412 | 1,210 | 1,762 | 7,072 | 7,122 |
| Training | 1,412 | 4,850 | 1,841 | - | - | 1,772 | 18 | 64 | 3,271 | 6,686 |
| Commodities | 11,562 | 932 | 956 | - | - | 12 | 1,216 | 99 | 13,734 | 1,043 |
| Local Operat. Costs | <u>26</u> | <u>10,172</u> | <u>2,160</u> | <u>-</u> | <u>-</u> | <u>43,799</u> | <u>132</u> | <u>44,174</u> | <u>2,318</u> | <u>98,145</u> |
| Sub-total | 16,205 | 20,902 | 7,614 | - | - | 45,995 | 2,576 | 46,099 | 26,395 | 112,996 |
| Inf./Cont. | <u>2,659</u> | <u>3,133</u> | <u>1,421</u> | <u>-</u> | <u>-</u> | <u>8,583</u> | <u>481</u> | <u>8,602</u> | <u>4,561</u> | <u>20,318</u> |
| Total | 18,864 | 24,035 | 9,035 | - | - | 54,578 | 3,057 | 54,701 | 30,956 | 133,314 |

D. GOK Contribution:

The Government of Kenya contribution to FPSS, valued at \$55 million or 33% of the total, supports five project components -- clinical training and services support; voluntary surgical contraception, community-based services, NCPD administration, and Health Planning. To the maximum extent practical the project has been structured to make greater use of existing GOK resources for family planning activities so that the GOK contribution consists primarily of retargeting such resources, thus minimizing budget dislocation and unsustainable recurrent costs. Successful project implementation will nevertheless require the GOK to make some hard budget choices. The GOK has demonstrated commitment to provide increased support for family planning activities (for example by tripling the budget for the NCPD in the recently released 1985/86 Development Budget). A firm USAID negotiating stance and conditions precedent and covenants to the project agreement will help ensure that that commitment does not waver. The magnitude of the GOK contribution to each of the five components identified above is as follows:

Table IV.4 GOK Contributions
((\$000))

| | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | Total |
|---|-------|-------|-------|-------|-------|-------|-------|--------|
| <u>Clinical Services</u> | | | | | | | | |
| In-service training | 138 | 144 | 144 | 144 | 144 | 144 | 144 | 1,005 |
| Book preparation | - | 2 | 2 | 2 | 2 | 2 | 2 | 12 |
| Clinical services support system | 767 | 1,443 | 4,321 | 1,443 | 1,443 | 1,443 | 1,443 | 12,301 |
| sub-total | 905 | 1,589 | 4,467 | 1,589 | 1,589 | 1,589 | 1,589 | 13,317 |
| <u>VSC</u> | | | | | | | | |
| Operating costs | 109 | 125 | 156 | 234 | 281 | 281 | 313 | 1,500 |
| <u>CBS</u> | | | | | | | | |
| Local operating costs - | 184 | 280 | 1,855 | 2,494 | 3,134 | 3,956 | 4,289 | 15,825 |
| <u>NCPD Administration</u> | | | | | | | | |
| Salaries and admin. | 81 | 170 | 218 | 267 | 316 | 370 | 370 | 1,783 |
| <u>MOH Information and Planning Systems</u> | | | | | | | | |
| Technical assistance | | | 67 | 88 | 86 | 86 | 86 | 412 |
| Training | | | | 192 | 192 | 192 | 192 | 768 |
| Local operating costs | | | 175 | 269 | 269 | 269 | 269 | 1,248 |
| GOK HQ operat. costs | 1,592 | 1,592 | 1,592 | 1,592 | 1,592 | 1,592 | 1,592 | 11,141 |
| sub-total | 1,592 | 1,592 | 1,833 | 2,140 | 2,138 | 2,138 | 2,138 | 13,569 |
| Project Total | 2,504 | 3,756 | 8,531 | 6,721 | 7,458 | 8,334 | 8,699 | 45,995 |
| Inflation | | | | | | | | 8,583 |
| Grand Total | | | | | | | | 54,578 |

The nature of the GOK contribution to even or these five components is described briefly below.

1. Clinical Training and Support Services:

The GOK contribution for this component consists primarily of dedicating a greater proportion of medical and para-medical staff, a greater proportion of their time, and greater utilization of medical facilities to family planning activities. No additional staff will be required. Rather, through training, provision of family planning equipment and supplies and central MOH direction, existing staff will devote more time and energy to family planning services delivery within the context of existing clinical service programs. Family Planning clinical service audits will help ensure that additional staff resources are devoted to family planning service delivery. The GOK will also contribute to the training programs at a level of approximately \$1 million over the life of the project. This training has been budgeted at \$250,000 for 1985/86, up from \$125,000 in 1984/85, adequate provision for this activity.

2. Voluntary Surgical Contraception:

As in the case of clinical training and support services, the GOK contribution consists mainly of the facilities, staff, and some of the operating costs of clinical facilities which will now, with project assistance, be utilized a greater portion of time for VSC purposes. There are small budget implications regarding equipment maintenance costs. GOK is currently negotiating with IBRD for construction of a minimum of 22 new VSC units at district hospitals, for which FPSS will provide equipment (through AVSC), but for which GOK must make substantial investment.

3. Community-Based Services:

The GOK contribution will consist of technical support for volunteer co-ordinators by existing MOH clinical personnel (at no significant budget cost) and training supervision and coordination of community volunteers by either NGO, MOH or Ministry of Culture and Social Services (MOCSS) personnel, depending on the district involved. GOK budgeting for CBS activities will be through allocation of portions of district development budgets to CBS activities. The choice of implementing organizations will be a function of the capabilities and interests of district personnel. The average annual cost to GOK of the CBS program will be on the order of 10% of the combined development budgets for MOH, MOHA/VP, and the MOCSS, and less than 2% of their recurrent budgets. Since this element represents the main additional recurrent cost requirement for the GOK it is important to note that FPSS was designed to support two closely related budget planning efforts each aimed at ensuring District allocation of GOK budget resources for community based services. These are the NCPD Policy, Planning and Evaluation, and the MOH Information and Planning components described elsewhere in this Paper.

4. NCPD Administration:

The projected GOK support for NCPD administration is \$1.8 million over the life of the project. The budget for NCPD has been a frequent point of discussion between USAID and the GOK over the past two years. Increased GOK support for population activities is demonstrated in the 1984/85 NCPD budget which is \$2,250,000, up from \$780,000 in 1984/85. This figure compares favorably with the \$ 2,520,000 required for the NCPD in the first year of the project as projected by the C&L Financial Analysis.

5. Ministry of Health Information and Planning:

As with clinical services, the GOK contribution to this component is largely utilization of existing personnel in the service of family planning activities. The MOH planning and information system, substantially expanded under the Health Planning and Information Project, is now in place and regularly provided for in the Development and Recurrent Budgets.

A related but potentially more troublesome issue will be the GOK budgeting for activities to be financed by AID and other donors. Implementation of the Family Planning II project was constrained by inadequate budgeting for these expenditures (even for activities for which the GOK would ultimately be reimbursed). USAID is now working closely with GOK to ensure adequate budget provision for A.I.D. financed programs, with some success as in the new NCPD budget. The project has also included alternative commitment and disbursement options to ensure project implementation even if there is a budget crisis.

In the larger framework, the truly incremental costs of this project, as differentiated from the incremental GOK effort manifested by re-deployment and upgrading of existing resources, appears reasonable in the context of the MOH and MOHA/VP development and recurrent budgets.

As described above, the anticipated total GOK contribution to the program, of which FPSS is a part, is about \$55 million. Of this, the annual development budget requirement will begin at about \$2.5 million in 1986/87, the first full year of project activity, and grow to almost \$10 million by 1992/93.

TABLE IV. 5 GOK DEVELOPMENT AND RECURRENT BUDGETS (L000)

| | <u>1984/85</u> | <u>1985/86</u> |
|--------------------------|----------------------------|-----------------------------|
| <u>Development:</u> | | |
| Total | 201,276 | 287,392 |
| MOHA/VP | 2,770 | 3,831 |
| MOH | 12,350 | 16,814 |
| <u>Recurrent:</u> | | |
| Total | 1,066,960 | 1,148,218 |
| MOH | 70,682 | 75,009 |
| <u>FPSS^{1/}</u> | <u>Average Annual Cost</u> | <u>% of 1985/86 Budgets</u> |
| <u>Development:</u> | | |
| MOHA/VP | 204 | 5.3% |
| MOH | 251 | 1.5% |
| CBS (multi-ministry) | 1808 | 9.9%* |
| <u>Recurrent:</u> | | |
| MOH | 2822 | 3.7% |

^{1/} Calculated at the rate of one Kenyan pound (20Ksh) = \$1.25

* % of combined MOHA/MOH/Social Services budgets of L285,333

As can be seen from the above the required GOK development budget allocations are not an unreasonable portion of the GOK recurrent and development budgets especially when considering that much of the GOK contribution consists of redeployment of existing personnel and facilities. Inclusion of such an increase in the development budget for 1986/87 will be a condition precedent to disbursement after August 1, 1986. GOK will covenant to provide adequate budget coverage for all future years of the project.

USAID/Kenya is prepared to approve all requests for allocations of necessary local currency generations from USG program assistance (e.g., GOK counterpart funds from commodity imports) to finance GOK's family planning program requirements.

In terms of the long-term sustainability of this level of GOK budget contribution, it is estimated that the total budget increment will represent less than 2% of the total Development Budget Estimates over the period. This level of support for family planning activities is clearly feasible. USAID seeks to promote inclusion of appropriate budget allocations during the life of the project. Since most budget allocations are based on a percentage increase from the previous year, increasing the base during the life of FPSS presents the best opportunity for ensuring appropriate future year budgets.

Thirty seven million dollars of currently unidentified other donor contributions to this program will also be required during the life of the project. Most or all of this assistance can reasonably be expected from donors already active in the population and family planning fields in Kenya though they may not yet be prepared to formally commit themselves to future year funding for more than a few years. To the extent that such funding is not forthcoming, an additional GOK financial contribution will be required.

V. IMPLEMENTATION AND PROCUREMENT ARRANGEMENTS

A. USAID Project Administration

USAID/Kenya gives this project the highest priority in its development assistance portfolio and will fulfill its responsibilities of providing responsive and reliable assistance. USAID's Population and Health (PH) Office will manage FPSS. USAID/PH currently has three US Direct Hire and two Kenyan professionals; one Kenyan physician and one Kenyan financial management officer on Personal Services Contracts will join this staff. The latter will assure fulfillment of USAID's internal financial monitoring and project documentation responsibilities. This officer will work directly with the Financial Management Coordinator in NCPD, Budget Supply Officers in the MOH, the Treasury Officer for MOHA and MOH, the External AID (USA) Officer in Ministry of Finance and Planning (MOFP), and with AID's Regional Financial Management Center (RFMC/Nairobi). The entire PH staff will be involved in FPSS implementation. This staff configuration has been developed specifically to discharge USAID's responsibilities for timely and effective sectoral assistance to Kenya's family planning program. USAID/Projects Office has assigned a senior officer to support project implementation. Other offices of USAID, RFMC, and REDSO will fully assist.

B. Proposed Grantee and Implementing Agencies

Family planning program policy guidance and budget direction will be the responsibility of NCPD which is within the Office of the Vice-President, Ministry of Home Affairs. Project assistance will be provided to strengthen substantially the capabilities of NCPD to carry out these functions. Technical implementation of family planning services and oversight of NGOs is the responsibility of the Division of Family Health (DFH) in the MOH. USAID proposes to support eight or more U.S.-based Cooperating Agencies (CA) for technical assistance and sub-project funding as well as ten or more Kenyan NGO groups, to include Family Planning Association of Kenya, Maendeleo ya Wanawake, other voluntary community development groups, and commercial and other private sector groups.

C. Implementation and Procurement Procedures

FPSS background studies and financial analyses indicate that about \$14 million will be required to purchase and transport contraceptives. FPSS will provide about \$10 million, for which USAID will issue PIO/Cs to Government Supplies Agency (GSA). Eight "buy ins" to AID/W funded Cooperating Agency Agreements are planned at a total of \$12 million for in-country service costs, commodities and supplies, and technical assistance for which USAID with assistance from AID/ST/POP project managers will issue PIO/Ps to AID/W for amendments to the CAs. \$1,200,000 additional USAID funding for IEC and VSC activity are proposed under an existing USAID CA arrangement (with John Snow, Inc.) for which USAID will issue a PIO/T to REDSO for CA amendment (See Annex I for justification). Needed vehicle waivers will be covered in a separate forthcoming USAID blanket vehicle waiver request.

An implementation schedule is provided in Annex H, providing the dates for key project events and activities. The following implementation procedures will be used to fund the AID inputs in each component:

1. Clinical Training and Support Services

Implementation of training activities will take place via three mechanisms. The majority of the training will take place through the DFH/MOH. Under the Project Agreement, a cost reimbursement mechanism will be established as with Family Planning II project. The GOK will conduct the training activities and send invoices to USAID for reimbursement at quarterly intervals. At the beginning of each GOK Fiscal year (July 1) a training plan will be reviewed for USAID concurrence and be followed by a Project Implementation Letter (PIL) to commit the funds for that year. A semi-annual review meeting will take place between the USAID project manager, the Director DFH, the Director IRH/FP, the MOH training coordinator and INTRAH's representative to review project status and any modifications of the training plan will be noted. At the end of the training year the MOH will present an annual training status report. This report will form the basis of the next year's training plan.

For the first two years USAID will buy into the centrally funded INTRAH project (total \$230,000) to undertake training of trainer activities. INTRAH will match those monies from AID/W CA resources. In FY88 the existing INTRAH project ends. If there is a continuation of AID/W's grant to INTRAH, USAID will continue the buy-in mechanism for \$100,000 per year for the remaining life of project. If a centrally funded technical assistance project similar to INTRAH is not continued, USAID will fund a host country contract between the MOH and a competitively selected Kenyan-based or U.S. institution for continuation of these activities. The MOH will contract with a printing firm for the publication of curriculum and review manuals and invoices will be sent directly to USAID. Implementation activities will follow the training course outline described in Annex E.2.

2. Voluntary Surgical Contraception

The expansion of services will be implemented as a cooperative effort by the Ministry of Health (MOH) of Kenya, the Family Planning Association of Kenya (FPAK), member hospitals of the Protestant Churches Medical Association (PCMA), Medical College of Nairobi and Kenyatta National Hospital (KNH), private physicians and medical centers. Assistance under FPSS will be funded through the Association for Voluntary Surgical Contraception (AVSC), Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), the International Training in Health (INTRAH), and the Private Sector Family Planning (PSFP) Project (See Annex I).

AVSC will use AID central funds to provide technical assistance in the form of program development, management, medical safety, information education, counseling and quality assurance. AVSC will also utilize AID central funds to implement training in mini-laparotomy information, education and counseling. Training will be coordinated by FPAK, PCMA and the University of Nairobi.

JHPIEGO will utilize central funds to train physicians and surgical nurses in reproductive health through the University of Nairobi and through the provincial hospitals currently working with the University and Kenyatta National Hospital.

AVSC will use FPSS funds to provide equipment for 8 additional NGO sites and 22 government hospitals (MOH is preparing a proposal for IBRD to renovate and up-grade facilities of 22 District hospitals; this proposal is not a part of FPSS except in provision of equipment for the surgical contraception units of the outpatient facilities). Equipment will also be provided for five additional missionar hospitals. FPSS will fund basic minilaparotomy, and emergency back up kits will be provided to about 85 private practice physicians.

Under review and approval of the MOH, AVSC will program and manage FPSS funds for VSC service delivery in the NGO sector and for the mission hospitals. The mechanisms for program management and implementation are currently being developed by AVSC in the NGO sector and in the missionary hospitals. These systems are expected to be fully in place by mid 1986.

USAID will program and manage FPSS funds for VSC service delivery equipment in the government hospitals under PILs to the MOH, only if necessary following negotiations with GOK. Discussions are underway with John Snow, Inc. concerning FPSS funding for VSC services within the private sector projects supported by the Private Sector Family Planning project. The latter would be arranged by amendment of the existing CA (See Annex I).

3. Community Based Services (CBS)

Kenya's rich texture of local community development groups, based on a wide variety of religious and other affiliation structures (both governmental and non-governmental) present unusual opportunities for successful implementation of CBS at the local level. The wide variety of organizations also present a complex challenge from the point of view of planning. To work well, the CBS program must depend upon the pre-existing organizations, and avoid trying to create new organizations, either locally or nationally. For example, in some communities one or more local churches are well-organized, already committed to preventive health initiatives and have good leadership. The best local organization in another area may be the Family Planning Association of Kenya (FPAK), while in another it is a Mandeleo ya Wanawake (MYWO) income generating group, and so on. This is - in effect - exactly how the current 14 pilot projects have successfully evolved and will be expanding during the next year, under already financed local agreements with AID/W centrally-funded Cooperating Agencies.

The project will support MOH/DFH provision of Community Based Services through the GOK Development Budget mostly for training, supervision and logistics management of contraceptives and supplies, and by technical assistance and training of trainer projects through INTRAM. These interventions are described in the Clinical Services/Training and Voluntary Surgical Contraception Technical Analyses (See Annex E).

The method of assisting NGO, CBS programs remains a matter of negotiation with GOK and potential NGOs and CAs. USAID's preferred approach, in light of the administrative analysis' recommendation that NCPD concentrate its efforts on policy planning and program oversight functions, would be to support NGOs through a single Cooperating Agency Agreement, with Pathfinder Fund. USAID's experience with funding NGOs through the Development Budget and NCPD supports the conclusion of the Administrative Analysis. Alternatively, if the option described above proves infeasible, the project could support NGOs through the NCPD either with reimbursable disbursement to NCPD or direct disbursements to NGOs. The final option entails direct USAID/NGO grants with NCPD concurrence.

Depending on the outcome of negotiations, incremental commitment of USAID funds will be done by PILs to GOK or PIO/Ts for CA services, scheduled at approximately two year intervals. Funding levels and implementation plans will depend on the outcome of joint NCPD/USAID Quarterly and Bi-Annual Reviews (See, D. Evaluation and Monitoring Plan, below).

4. Subsidized Commercial Marketing

The new SCM company, created to implement this project component, will operate under an AID/W funded contract with SOMARC for the first four years of FPSS (at about \$2.5 million). The bilateral FPSS Project will support the component starting in year five, and/or assist the SCM organization to identify other resources. USAID/Kenya will purchase contraceptives for all years of the project. ODA is also expected to contribute contraceptives (specifically, condoms) throughout the next seven years, and perhaps other funding. SOMARC will provide technical assistance to the NCPD and the new organization, including: management, registration of contraceptives, forecasting, procurement and shipping, as well as support for developing internal control procedures and marketing strategy.

The estimated total cost of this program is about \$6.0 million (including contraceptives) during the seven years (FY86-92). Small revenues may be generated from the sale of contraceptives over the life of this project component which will be applied to cover local operating/marketing costs, salary incentives, and/or special activities in the later years of the project.

5. Ovulation Awareness/NFP

IFFLP will administer (disburse and monitor) the financial aspects of the KCS and FLCAK sub-contracts; facilitate a gradual, structured and functional national OA service, respecting specific sub-contractor agency orientations and programs yet encouraging the development and use of national OA service standards and close coordination with NCPD and the MOH. The IFFLP will also monitor and offer consultation on the development and implementation plans of each recipient institution; and seek to identify and coordinate priority research on OA.

6. NCPD Administration Strengthening

Funds will be provided on a reimbursable basis as has been done under Family Planning II to NCPD to cover operating costs for the NCPD Council and Secretariat, e.g. sitting fees to non-GOK members of the NCPD, costs for program evaluations, and other program activities as mutually agreed upon. Costs for salaries and other personal emoluments will be fully covered for the first two years of the project, with GOK gradually taking over these recurrent staffing costs from year three on the schedule proposed in the financial analysis (100%, 100%, 80%, 60%, 40%, 20%, 0%; by project year).

7. NCPD Population Policy, Planning and Evaluation

Technical assistance in the area of population policy and planning will be provided to the NCPD through three primary channels. The first will be through the use of project funds to "buy into" centrally funded A.I.D. population projects. The second channel will be through a "consultancy fund" to be administered by the NCPD to contract for local consultants as required

for policy and planning activities. In addition, funds will be programmed for direct USAID contracting of U.S. or Third country consultants where specific technical consultants may be required who are not associated with the above centrally funded projects, as may be requested by NCPD. A buy-in will be used to obtain the services of the Demographic and Health Survey Project (DHS) to work with the Central Bureau of Statistics on sample surveys to independently assess the impact of the program and to support information analyses and dissemination to be carried out in collaboration with the Population Studies and Research Institute of the University of Nairobi. Likewise, buy-ins would be used to obtain the services of the INPLAN for support to the NCPD in policy, and with Family Health International for support in bio-medical studies of the safety and acceptability of contraceptive methods in collaboration with the Nairobi Center for Research in Reproduction.

Training in population policy formulation and population planning will be provided through two primary administrative channels. Long-term academic or technical training and short term overseas courses and observation/study tours to third countries (for NCPD staff and appropriate personnel from NGOs and other ministries) will be programmed by NCPD and funded using the USAID PIO/P funding mechanism for approximately five people. Local training for both the NCPD staff and training for personnel of NGOs or other ministries which is organized by NCPD will be funded through the NCPD.

8. NCPD Information and Communications

All of the information and communication activities occur within the organizational framework of the NCPD. One of the objectives of the overall project is to enable NCPD to strengthen its planning and coordinating role. Though few of the activities are actually to be implemented by NCPD staff directly, it is crucial that the NCPD, and in particular the IEC division, select and supervise the implementing agencies. The choice of messages, approaches and media mix is entirely the responsibility of the NCPD. Most country contracts will be negotiated with one or more Kenya firms to undertake public relations and media campaigns under the review and guidance of the NCPD. NCPD will continue to make IEC grants to NGOs, as in Family Planning II, but possibly with direct USAID disbursements. The following is a review of implementation arrangements by activities described above.

Technical assistance from Johns Hopkins University/Population Communication Services (PCS) through a "buy-in" to AID/W's Cooperative Agreement, will be provided at the outset of the project to assemble previous communication research studies and other available information about the target audiences' family planning knowledge, attitudes and practice. Assistance for specialized tasks will also be provided throughout the project by PCS, as requested by NCPD's IEC Division.

Four local consultants will be contracted by NCPD to work for a two-year period. NCPD/IEC will determine the type and duration of in-service training required and request the technical assistance needed to provide the necessary training. PCS will be responsible for contracting the training consultants.

Procurement and production of media products will be through the issuance of a single tender for a consortium of Kenyan media professionals. This mechanism is viewed as the most efficient means to ensure coherence in the range of products and simplicity in the procurement. PCS will provide technical assistance in the preparation of the tender documents and in reviewing responses. USAID will have the right to approve the RFP and the selection criteria. In the case of the FPSS project, funds will be added to the JSI cooperative agreement to undertake IEC activities as agreed upon by NCPD and the FPSS project personnel (Annex I). The actual materials to be produced must be approved by the IEC division of NCPD to assure that there is no duplication and that messages are sufficiently consistent.

Support to NGOs for information and education programs will be as per the existing arrangement (under Family Planning II) whereby USAID commits funds to the NCPD, through a PIL for allocation to the NGO's against workplans and budgets submitted annually. In light of disbursement difficulties encountered in the first two years of programming funds, improvement in the flow of funds will be needed. (See Administrative Analysis of NCPD, Supplementary Annex B.)

9. MOH Information, Planning and Reporting System

The MOH will implement this component through Host Country Contracts with a university, private assistance organization and consultants for provision of required services.

The Ministry of Health has had previous experience in the implementation of an A.I.D.-financed Host Country Contract. Over the past four and half years, the Ministry has successfully directed the implementation of the Health Planning and Information Project, which has received two favorable mid-term evaluations. This experience demonstrates that the GOK/MOH is qualified to manage another Host Country Contract.

D. Implementation Schedule

Annex G., Main Implementation Schedule, provides a brief schedule of the main events under FPSS. Key events are detailed by Quarter of USG Fiscal Year in Schedule 1 (Year 1), and by larger time segments in Schedule 2, appropriate to USAID's ability to forecast. Essential early events include: through logistics system review, forecasting and purchase orders for contraceptives; completing PILs for the Ministry of Health training and information activities, and a PIL for the NCPD activities; and preparing PIO/Ps for amending the CAs; also, NCPD and MOH will have completed certain internal activities like reviewing administrative procedures and staffing plans, completing training and evaluation plans, and selecting host country contractors.

E. Evaluation and Monitoring

1. Evaluation: This PP's proposed evaluation plan includes: surveys to estimate current levels of fertility and use of contraception; research on the proximate determinants of fertility; focused operations research or community case studies; an information system for regular reporting on new and current contraceptive users and flow of contraceptive commodities; and studies on the safety and acceptability of contraception. General progress toward attainment of project purposes will be gauged by the national household decennial census in 1989, and by the National Demographic and Contraceptive Surveys in 1987/88 and 1991/92 expected to be conducted by the GOK Central Bureau of Statistics (CBS). In addition two overall evaluations of the FPSS will be conducted, one in 1988 and another towards the end of the project, in 1991.

This project does not propose to assist in expanding and strengthening the vital registration system in Kenya (marriages, birth and death), though this clearly needs to occur. To date, only a few sample registration areas (e.g., in Nyeri District) have been established where vital events are being captured with increasing thoroughness and where it is now possible to examine annual birth and death rate trends with some confidence. GOK has worked with the UNFPA in implementing this cost-effective approach to vital registration. USAID has urged UNFPA to continue to provide resources for this purpose and - if possible - to expand the areas included. It is not known what the GOK intentions are. This project, and the overall GOK program, will not be able to rely on vital events trends for assessment of impact.

The chief tool for measuring program impact on fertility and contraceptive usage will be fertility and contraceptive surveys. It must be noted that these surveys generally measure the overall impact of population activities and contraception use. Although USAID will provide a significant share of donor resources, it will generally not be possible to distinguish the impact for example, of World Bank, UNFPA, or SIDA funded activities from AID funded activities. The ability to distinguish AID funded project activities from other population activities will be possible through regular monitoring, site visits, and through specially designed sample surveys.

The Central Bureau of Statistics (CBS) under the guidance of the National Council for Population and Development (NCPD) will conduct two fertility and family health surveys. The surveys will provide information on contraception knowledge, availability, use and family planning attitudes; fertility and fertility intentions. To ensure continuity and comparative longitudinal data, the upcoming survey will use the same sampling frame, and the same basic questionnaire and general procedures of the 1984 Contraceptive Prevalence Survey (CPS). Refinements will of course be made. The sampling plan will be formulated in such a manner that the surveys will provide estimates of fertility and use of contraception. The 1991/92 survey will be able to take advantage of an updated sampling frame from the 1989 census.

Special studies of the acceptability and safety of contraceptive methods will be undertaken by the Nairobi Center for Research in Reproduction (led by the Department of Obstetrics and Gynecology). These will focus on ways to improve the acceptability of methods and will provide a substantial basis for supporting the overall family planning program in the event of public (or parliamentary) debate over methods. This work will be conducted in collaboration with the Family Health, International (FHI).

The Westinghouse Demographic and Family Health Survey Project (DHS) will provide technical assistance to the CBS for the conduct of the two surveys. Further analyses of data from the 1983 National Demographic Survey and the 1984 CPS survey will be undertaken as well as further analyses of the proposed DHS surveys. Topics for further analyses may include the following: fertility impact of contraception prevalence, the application of fertility and contraception use survey data in family planning program target setting; proximate determinants of fertility trends; the prevalence and demographic impact of voluntary surgical contraception; accessibility to contraception as a determinant of contraceptive use; estimation of contraception use-effectiveness; continuation and "drop-out" associated with specific main methods of contraception; and analysis of infertility.

Large scale quantitative surveys do not clarify the reasons or specific program inputs which generate differences in contraceptive behavior. It is proposed therefore to undertake in-depth operations research studies in selected project areas. Operations research (OR) techniques will be used to provide GOK program administrators of family planning and community based distribution programs with the information necessary for improving the delivery of FP/MCH services. Such studies will assist the GOK and private implementing agencies to identify which programmatic aspects of the USAID assisted activities require greater attention in the family planning/development package.

The FPSS project evaluation schedule includes two in-depth project evaluations, one mid-term evaluation at the end of year three (1988) and a final project evaluation to begin in year seven (1991). The purpose of these evaluations will be to review overall progress, to determine the accomplishments or actions taken toward the attainment of project outputs and to identify and make recommendations for elimination of constraints to the achievement of established targets.

All available survey data, survey reports and community studies will be compiled and analyzed. Concurrently each of the project's components will be evaluated: the community based services projects, the information, education and communication activities, the subsidized commercial marketing program and training and policy activities. The interrelationships, constraints and any redundancies among the components will be analyzed. An attempt will be made to document the role of the project and its various components on fertility, contraceptive use and family planning activities. If a particular component is identified as failing to attain objectives, project funds may be shifted to another component that is achieving better results.

The USAID evaluations will be coordinated by the Population and Evaluation officers, with input from AID/W Population Officers. Outside experts may be hired to assist with the tasks outlined above: a public health physician, an information, education and communication specialist and a demographer and social science analyst. Funds for the evaluation and outside consultants will be made available through the FPSS.

AID/W will also conduct routine evaluations of its centrally funded project activities.

2. Monitoring: All project activities, including those funded by AID/W grantees-contractors, will be monitored by USDH and Kenyan staff of USAID. Direct monitoring will be the responsibility of the Project Managers of FPSS elements within the USAID Population and Health Division. These three individuals will be supported by the Projects Office, Program Office, RFMC, the Contracts Officer, and Legal Advisor, in matters pertinent to these latter offices' areas of responsibility.

Monitoring systems within each project element will reveal progress toward attainment of project outputs and identify problems and areas for improvement on a quarterly basis. For example, aggregated commodity distribution records kept by marketing agencies permit estimation of the impact of the social marketing project. Since each link in the network of a retail sales system, including the consumer, pays for the contraceptives used, it can be safely assumed that nearly all will ultimately be used (rather than wasted). A build-up of inventory by pharmacists, and on householders's shelves usually occurs at the time the product is introduced, but sales flows quickly approximate actual consumption levels. Sales data may be converted into the common denominator of couple years of protection (CYP) in order to estimate program impact.

During the life of the project extensive use of independent public accountants (IPA) will be made to determine that NGOs and other implementing organizations outside the scope of regular AID/GOK audit cognizance possess the administrative capability to implement the project. IPAs will also be engaged to conduct annual financial and compliance examinations of the institutions. Funds will be provided in each sub agreement for engaging IPAs.

The central collation and computerized reporting of service records for primary health care and family planning is an ongoing activity of the Health Planning and Information Project (HPIP). Currently, data on family planning users from MOH and some of the major NGO programs are collated, but not analyzed beyond simple tallies by method, new-or-returning client, reporting center (service delivery point), and date. Under the proposed FPSS project an improved reporting system for central and local managers should provide continuous up-to-date statistics on family planning users current contraceptive use prevalence rates. Program field staff will learn to translate demographic targets and measure program performance in terms of use of contraception among couples of reproductive age.

A system of rapid information aggregation and feedback to local service delivery points and to managerial personnel will be in operation during the life of this project. Someone in each statistical unit will be trained to calculate contraceptive prevalence rates and complete prevalence worksheets for specific geographic population catchment areas. Supervisors will be instructed to inform health units of their target and how well they are doing compared to other units and compared to their own previous performance in terms of both prevalence and improved method.

USAID with technical assistance from the Centers for Disease Control and the Kenyan contractor ESAMI will assist the MOH with development of a Contraceptive Inventory Information System (CIIS) to track the movement and usage of contraceptives. The intent is to estimate user consumption of contraceptives by measuring their flow along the distribution chain. Program evaluation will be made possible by analysing changes in contraceptive use over time and geographic area (J.S.A.I.D. project areas may be singled out).

Selected components of the projects which through the daily monitoring process are identified as having problems will be singled out for special evaluations. Such evaluations would be in addition to the two already scheduled.

VI. SUMMARY OF PROJECT ANALYSES

A. Technical Feasibility

The technical feasibility of project components selected to achieve the project purpose are discussed below. Project components were selected based upon consideration of GOK interest, the comparative cost-effectiveness of various delivery systems for meeting project purposes, and conformity with AID population assistance guidelines.

Clinical Training and Support Services: The MOH service delivery system has many strengths including well trained nursing personnel, an increasing focus on community outreach and a recent policy of decentralization. Although some of the MOH's integrated MCH/FP facilities serve as few as one FP client for every 20 or 30 pregnant women, others including at least one entire district, serve approximately one new FP client for every three pregnant patients. The fact that some MCH/FP facilities can provide this level of FP service shows that the MOH has the potential to meet the FP needs of a significant proportion of Kenyan couples.

INTRAH will provide the technical assistance for the MOH training activities proposed under this project. INTRAH has been active in Kenya for five years and has a resident office and local staff who plan, administer and manage local and international technical assistance and training. The coordination with MOH personnel and various training institutions both public and private is good.

Voluntary Surgical Contraception (VSC)/Reproductive Health Services: Based on waiting lists in district and provincial hospitals where VSC services are currently provided we conclude a substantial latent demand for surgical contraception services. The growing popularity of fertility termination services is also illustrated by the great interest shown recently by public and private sector surgeons and clinics. The aim of this component of the project is to expand VSC services to 250,000 couples by 1992. This will be achieved by the permanent installation of surgical contraceptive and related health services in the ob/gyn departments of all MOH provincial and district hospitals, through Family Planning Association of Kenya clinics, member hospitals of the Protestant Churches Medical Association and through private hospitals and physicians.

The approach is straightforward: The AID grantee organization AVSC will follow VSC "graduates" back to their provincial hospitals; and assist these hospitals to identify the specific commodity, space and financial requirements necessary to institutionalize VSC/health services.

USAID accepts the technical premise of this component of the project -- that acceptance of VSC services in Kenya will increase markedly as these services are emplaced around the country. USAID is also confident of AVSC's managerial competence to undertake primary responsibility for this component of the project, based on that organization's record with similar activities worldwide over the past 15 years. An effort is now underway to register an AVSC regional office in Kenya to facilitate better AVSC local management.

Community Based Services: This component aims to expand the access of rural poor to family planning services. During the past two years, pilot programs in a variety of rural areas have shown that interest in and demand for fertility regulation information and supplies is considerable. From almost none four years ago, by 1985 about 1.1 million rural people (about 170,000 families or 7% of Kenya's total rural population) are now provided with access to information and services about preventive health and family planning by members of their own community.

All indications are that CBS is a cost effective and efficient modality for family planning in Kenya. It enjoys political and technical/professional support from the GOK leadership and the MOH. The main challenge is to convert the lessons from many successful but disparate pilot projects into well designed programs for quality nationwide service delivery using present structures. The management of this component will likely be the main implementation challenge of FPSS.

Ovulation Awareness for Periodic Abstinence NFP: The natural family planning activity proposed under FPSS is carefully designed and modest in its overall targets. It proposes to expand NFP services through three channels: the Kenya Catholic Secretariat (KCS), Family Life Counselling Association of Kenya (FLCAK), with coordination and technical assistance via the International Federation for Family Life Promotion (IFFLP) of Washington and its field office in Nairobi. The IFFLP is a growing PVO. Its capacity to coordinate projects like this component of FPSS will be strengthened during implementation of this project.

The specific family methods to be presented by this component of the project (the Billings or Cervical Mucus and the Sympto-Thermal Method) have limitations as have been documented in the FP literature. However, these technical (e.g., low method-reliability) factors must be put in the context of compelling ethical and moral reasons for making NFP available to couples who prefer to use such methods. Technical considerations are deferred in the interest of ensuring a full range of FP services for all persons, consistent with their personal beliefs and preferences.

Subsidized Commercial Marketing: The SCM component is designed to complement and supplement the existing and proposed family planning activities provided by the GOK and NGOs, as well as those of the private sector. It will benefit couples who have limited access to sources of supply and who cannot afford commercially priced products. The innovative feature of commercial distribution projects is that they utilize existing commercial infrastructure. Consultant reports of 1982 and 1984 found the prospects for developing a social marketing program good. The marketing infrastructure is strong, the commercial sector is interested in the program, and there appear to be no restrictions on the sale of contraceptives which would prevent a CSM program from being developed. All of the well known brands of orals, condoms and spermicides are presently sold in the commercial setting, although the price tends to be high relative to disposable income.

B. Social Analysis

Kenya has a range of public, voluntary, and private sector infrastructures which can be utilized to attain the goals and objectives, of this project, including a clinic network that already reaches about 40% of the population annually; the most extensive network of women's voluntary groups in Africa (more than 15,000 community groups); and one of the best private sector mass marketing and private physician systems in Sub-Saharan Africa.

This project has been designed with reference to a number of data sources and background studies. The "USAID Analyses and Strategy for Assistance in Family Planning and Fertility Reduction in Kenya," prepared by the USAID Office of Population and Health, January, 1985, provides the basis for the proposed project approach. The socio-cultural context which supports the low, but rising level of aspiration regarding fertility control is summarized in Annex F.

Preliminary results of the 1984 National Contraceptive Prevalence Survey show that 13% of all women of reproductive age (or their mates) are now practicing some method (8% modern and 5% traditional or new periodic abstinence techniques). All methods appear to have increased. If there have been no major declines in breastfeeding then these findings suggest that the CBR could have declined by as much as three points since 1977, to around 51/1000. About 40% of women in the reproductive years reported desired no more children, and of these about 40% reported that they had not wanted to be pregnant the last time. USAID and the GOK are convinced that a significant portion of the peri-urban and rural middle income and poor Kenyan couples perceive the benefits of family planning and are willing to adopt contraception if it is widely available and of high quality.

Additional data support the conclusion that fertility decline is now more probable than before. Table 2 in Annex F shows the age distribution of fertility as the number of births during the year to women of each five-year age group. Although the Total Fertility Rate (TFR), increased during the period, 1969 to 1979, that increase was clearly attributable to increased fertility among the younger women, ages 15 through 34, due to closer birth intervals. Fertility among older women, however, shows a steady decline over the years. This pattern of declining fertility among older women is recognized as the earliest and most sure sign of fertility transition, as shown repeatedly in demographic history around the world.

There is wide agreement in the public health field that high fertility rates do not decline very much unless infant and child mortality first decline. It appears, however, that infant/child (I/C) mortality in large areas of Kenya may already have reached levels that are below those that would exercise significant inhibition on parents' adoption of child spacing or fertility termination methods. In Nyeri District of Central province it appears that the I/C death rate is one in twenty or lower. In areas akin to Nyeri's recent experience, USAID believes that further reductions in I/C mortality will depend directly and mainly upon improved fertility regulation more than continued improvement in obstetrics and child care.

The commitment of health professionals to strengthen delivery of family planning services can be enhanced by more widespread recognition that the foremost health risks in Kenya for women and infants relate to reproduction and high fertility. About 200 mothers die for each 100,000 live births in Kenya. These deaths in childbirth make up about forty percent of all deaths among young women aged 15-35. These maternal deaths are especially tragic since they usually occur to women with large numbers of children. Childbearing risks remain high because many births are not attended by skilled physicians or midwives, the time between pregnancies is short, women average 8 births and usually complete their childbearing after age 35. Risk of dying in childbirth and infancy increases markedly to mothers over age 35, after the fourth child is born and when birth intervals are less than two years apart, all of which are typical features of reproductive experience in Kenya.

If Kenyan women used family planning and had 4 or fewer children about half the approximately 2000 lives lost in childbirth each year would be saved and the infant mortality rate would decline by about 25%. If the objectives of this project were achieved (TFR = 4 in 2000) we estimate that over 6,000 maternal deaths and more than 80,000 infant deaths could be averted over the next 15 years.

By dramatic contrast, the risk of dying from a side effect of modern contraceptives is quite low, generally about 5% of the risk of dying in childbirth in Kenya. In fact the major risk of death among contraceptive users relates to risk of childbirth when contraceptives are not used effectively or somehow fail. IUCDs, injectables and especially voluntary surgical contraception offer the most striking health benefits for Kenyan women and children.

The immediate beneficiaries will be an estimated 2.5 million couples nationwide provided with access to family planning services. Immediate beneficiaries also include a large, undetermined number of infants and children who will enjoy a greater concentration of household and affective family resources. Long-term beneficiaries include the major portion of Kenyan society in so far as diminished population growth improves multi-sectoral development.

C. Administrative Analysis

NCPD and the DFH are the two GOK entities which will plan, administer, implement, and monitor FPSS. An administrative analysis of these two entities was conducted by Coopers & Lybrand Associates, Kenya (C&L) during May and early June, 1985 upon which this PP section is based. The DFH, originally the National Family Welfare Center, was established in 1975 with responsibility for implementing the first MCH/FP project; and integrating family planning services with the health delivery system. NCPD was formed in 1982 with overall responsibility for the promotion and coordination of family planning activities.

NCPD was mandated to provide policies and plans for population development within the national economic framework. It was also empowered by the Office of the President to establish a specialized technical agency, the Secretariat, within the Ministry of Home Affairs (V.P. Mwai Kibaki, Minister). The Secretariat was to formulate strategies and supervise and co-ordinate various inter-sectoral and inter-agency activities designed to promote planned population development in Kenya, including support to NGOs in communications activity. Outstanding political leadership and cabinet liaison for the Council has been provided by the Vice-President. NCPD has 26 appointed members including 10 permanent secretaries of major GOK ministries and an excellent range of NGOs, medical societies, churches and public leaders. NCPD is independent of the control of any ministry and has little authority.

The Secretary to the Council is the Director of the Secretariat and has the rank of Deputy Secretary in the MOHA. There are four divisions under the Director. They are the Information, Education and Communications Division; Youth and Community Services Division; Research and Evaluation Division; and the Finance and Administration Division. The division of labor and scope of responsibilities for these divisions is still under clarification. The key functions of the Secretariat's administrative procedures are: staff development and personnel services; planning, budgeting and funding; and procurement and supplies. For all these functions the Secretariat follows standard civil service procedures and regulations.

Liaison with the six NGOs funded under the MCH/FP project is primarily effected through bi-monthly meetings between the Secretariat and NGO representatives. Co-ordination of IE&C activities is to be provided by a recently formed sub-committee of the Executive Committee of the Secretariat.

The primary function of DFH is to strengthen and co-ordinate all aspects of maternal and child health, and family planning services in Kenya. The DFH is headed by a Director who reports to the Director of Medical Services. A position of Deputy Director has for a long time been vacant. The Division has four sections: Training; Information and Education; Evaluation and Research; and Administration.

The effective operation of the DFH depends heavily on the administrative and technical support of other Divisions within the MOH, specifically: Administration and Planning; Curative Services; Preventive and Promotion Health Services; Nursing; and Information and Education. In order to strengthen co-ordination between NCPD and the DFH, the Director of DFH has been appointed as a member of NCPD's Executive Committee.

C&L concludes that institutional responsibility for the implementation of family planning programs should remain with DFH (and the NGOs). However, NCPD should be responsible for policy formulation, planning and evaluation for family planning activities; and DFH should retain its Information and Education Section in order to co-ordinate demand creation and service provision at the local level within the MOH system to maximize the impact of its FP programs.

C&L concluded that the weaknesses in NCPD organizational and administrative arrangements include: (a) inertia of the Council; (b) absence of a long-term strategy perspective; (c) constraint of the Secretariat by Civil Service procedures and regulations; (d) limited functional capacity; and (e) inadequate external co-ordinating mechanisms. Weaknesses in DFH organizational and administrative arrangements include: (a) fragmented allocation of functions; (b) scarce management resources; (c) weak administrative support; and (d) a weak FP services component.

In order to strengthen the institutional framework for implementing the FPSS project, C&L proposes that: (1) an Executive Chairman of the Council of the NCPD be appointed on a full-time basis; (2) the Secretariat of the NCPD be removed from its departmental status within the MOHA; (3) the Vice-President be appointed the National Chairman of NCPD; (4) the DFH work more closely with the NCPD Secretariat for the purpose of strengthening IE&C and service delivery activities; and (5) the functional capacity of the NCPD Secretariat be expanded to add responsibilities for policy formulation, strategic and project planning, and the monitoring and evaluation of FP programs.

C&L recommends that the NCPD Secretariat be strengthened through: (1) restructuring NCPD into four new divisions: Information, Education and Communications Division; Programs Division; Planning, Research and Evaluation Division; and a Finance and Administration Division; (2) recruiting and training additional qualified staff, especially for the Programmes Division and the Planning, Research and Evaluation Division; (3) making the NCPD Secretariat independent of the civil service machinery by Cabinet decision and Presidential Directive which will establish the NCPD and its Secretariat as a Permanent Commission; (4) strengthening of financial and accounting procedures to permit direct funding of FP projects; and (5) strengthening external co-ordinating mechanisms through the establishment of two technical committees: National FP Programmes and Services Committee, and a National IE&C Committee.

USAID supports these recommendations and will be taking the following steps to ensure their implementation. FPSS will provide technical and financial support to strengthen NCPD's policy and planning capabilities and to upgrade staff skills. Specifically INPLAN will provide technical assistance for population planning, PCS will assist with communication and media planning. The project will provide core support for hiring additional staff and will arrange for long and short-term training opportunities.

The GOK will undertake the establishment of the NCPD Secretariat as a Permanent Commission with a full-time Executive Director who sits as Executive Chairman of the full Council. This action will be included in the Project Agreement as a Condition Precedent to disbursement for NCPD after August 1, 1986. USAID believes that upgrading the NCPD to a Commission will enhance its authority and ability to influence and involve other Ministries in the national population effort. A Commission will also have the authority to accept direct funding for FP projects. USAID will provide assistance to develop improved and streamlined administrative and accounting procedures so that GOK may have confidence in its capacity to fulfill public goals.

The entire donor community associated with family planning efforts agrees on the need to strengthen the NCPD. The World Bank will lead a coordinated effort to assist NCPD with the development of a comprehensive national strategy for information, education and communication and a work plan for population/family planning activities. This effort will formally begin in August with the World Bank's pre-project assessment, which will include all donors.

C&L proposes to strengthen the capability of DFH to implement FP programs through: (1) recruitment of additional staff, including a Deputy Director and an Assistant Director of Medical Services; (2) specific changes in the budgeting and funding arrangements which would permit more of the GOK development estimates for FPSS project components to be directly controlled by the DFH; and (3) establishment of District FP committees to coordinate all District FP strategies, activities and budgeting (See Clinical Training and Services Support element, Section III. B).

FPSS will provide support for MOH/DFH staff development through in-country and long and short-term U.S. based training opportunities. USAID will not, however, provide support for the recruitment of additional staff as we do not feel it is crucial to successful project implementation. Through the Information, Planning and Reporting component of this project, FPSS will support MOH's efforts to simplify and streamline budget procedures and establish district-level coordinating committees. The MOH has already begun planning for development of these committees, following a directive by the Vice-President.

The C&L report concluded that FPSS is administratively feasible provided that the project encompasses actions, such as those noted above, which are designed to institutionally strengthen both the NCPD and DFH.

D. Economic Analysis

Introduction

As will be seen from the discussion to follow, findings from recent studies leave little doubt that significantly lowering population growth rates in Kenya by the end of the century can make a vital contribution to social and economic development. Indeed, according to IBRD 1983 (p.73)^{1/} "... if population growth does not slow down dramatically by the end of the century there is no solution to Kenya's development dilemma." It is hard to imagine a statement which could convey more urgency with respect to the need for prompt and major fertility reduction in Kenya. If this assessment is correct (and there is no reason to assume that it is not), then a successfully implemented FPSS project and the larger effort of which it is an integral part must be regarded as making a crucial contribution to Kenyan development.

Thus there can be no doubt that a project with the prospective achievements and accomplishments of Family Planning Services and Support (FPSS) must be regarded as clearly cost beneficial. For these reasons, this analysis will not undertake a full-fledged cost-benefit analysis.

Within the context of an overall program of family planning in Kenya that is cost-beneficial, the Family Planning Services and Support Project will place management emphasis on achieving project outputs utilizing project inputs in the most cost-effective manner consistent with evolving family planning demand. The project Monitoring and Evaluation components will include collection and analysis of unit cost data, and of family planning utilization rates, which will be utilized by the project manager to make informed judgments regarding adjustments required to ensure cost-effective use of available resources. Flexibility in project design, and close monitoring, will permit the project manager to take advantage of increased demand within specific approaches (delivery components), and to make appropriate cuts in less successful approaches, particularly where fixed overhead costs may be significant. The cost beneficial nature of the interventions to be supported under the FPSS is virtually guaranteed given reasonable technical execution of individual projects components, and reasonable utilization rates of available services. Given the flexibility of project design, management attention will be directed toward maintaining a reasonable balance between supply and demand for family planning services, and to cost-effective use of inputs based on monitoring and evaluation results.

^{1/} See Kenya - Population and Development, A World Bank Country Study, Development Economics Department, East Africa Country Programs Department, The World Bank, Washington D.C. 1980 (henceforth IBRD 1980). See also Kenya - Growth and Structural Change, A World Bank Country Study, The World Bank, Washington, D.C. 1983 (hence IBRD 1983).

Population Growth and Economic Development in Kenya

In recent words of the World Bank, "... rapid population growth is, above all, a development problem."^{2/} IBRD 1980 analyzes at some length the major consequences of Kenya's rapid population growth for the economy, identifying principal ways in which rapid growth acts as a drag upon efforts to increase income per capita and estimates some of the major benefits from reductions in population growth rates. Although there are some differences, all in all, the IBRD scenario and that contemplated by USAID are similar enough to make it reasonable to take the IBRD findings as a rough estimate of the benefits to be expected from implementing FPSS and the larger fertility-control program of which it is to be a part. Our conclusion from these findings is that implementation of this project will yield major benefits to the population of Kenya in the form of per capita incomes higher in the years ahead than they would otherwise be and an income distribution more equal than in otherwise would be.

Reducing the Strain on GOK Fiscal Capacity

Of particular interest from this point of view are IBRD 1980 estimates of what would be the saving in government resources needed to meet basic needs (education, health, housing, water) over the period 1985 - 2000 if the TFR in Kenya declines to 4.0 by 2000 (a USAID project target) rather than remaining constant at present levels (see p. 115, Table 4.25). These estimates are extremely conservative. Nevertheless, the total saving over this period is substantial, amounting to about 472.4 million Kenyan pounds in 1970 prices or about 1.4 billion Kenyan pounds in current prices.

Equitable access for all citizens to services which meet basic needs is important for service to the GOK's (real income) distribution objectives. With present population growth rates, the GOK has to run very fast indeed on fiscal-effort account just to maintain the current, extremely modest level of basic services per capita. It seems clear that without the sharp decline in fertility rates which will be a consequence of implementing FPSS and the larger fertility-control effort of which it is a part, the prospects for significant improvement in the level of basic services per capita in Kenya are remote.

^{2/} See Population Change and Economic Development, reprinted from World Development Report 1984, The World Bank, Oxford University Press 1984, p. 40, Box 3.1 (henceforth IBRD 1984).

Costworthiness of Expenditure to Implement FPSS and the Larger Fertility Control Program of Which It Is a Part

USAID has estimated the 15-year total expenditure for the larger fertility-control effort at about the equivalent of 400 million Kenyan pounds (1985 prices, exchange rates), or about 27.0 Kenyan pounds million a year on average over the period. The contemplated project will be largely donor financed. However, one way to get some sense of the modest rate of resource commitment contemplated for these fertility-control activities is to compare it with the overall fiscal capacity of the GOK. Currently, GOK current revenue is about 1.0 billion Kenyan pounds. And, since the Kenyan economy will be growing during the 1985 - 2000 period, the real burden of the fertility-control program will be decreasing. Assuming a 4.0% growth rate, it turns out that spending at the average rate per year for this fertility reduction effort would amount on average over the whole period of about 2.2% of GOK current revenue.

From the point of view of USAID and the GOK, this must surely be regarded as a very modest commitment of resources on the margin of the total fiscal effort. Where the objective is to promote the social and economic development of Kenya, surely no alternative project to which these resources might be committed could plausibly be regarded as more beneficial.

Cost Effectiveness/Least Cost Analysis of FPSS

There are major problems in adapting analysis of this kind to fertility-control programs such as FPSS and the larger fertility-control effort of which it is a part. For this analysis, the investigator requires production-function information. That is, functions showing technical or "engineering" relationships between inputs and outputs, showing what combinations of inputs will produce what outputs. However, for fertility-control-program outputs defined in ways of interest for evaluation of project performance -- ways that speak to the actual impact of the project on fertility rates, such as couple years of protection (CYPs) -- the production functions can be known only in a very general way. This is so in part because project output in these utilization-of-services terms depends not only on supply events but also upon demand events -- demand for one or another of the various fertility-reduction services.

An initial, informed judgment has been made regarding the proposed mix of project components. The mix has been chosen with an eye to accomplishing what properly has been identified as "the major intervening accomplishment" of FPSS -- namely, trying to insure that the great majority of Kenyan couples know about and have equitable access to modern methods of fertility control. Because of uncertainties on the demand side, much of the service to least-cost objectives for a project of this kind must derive from an optimizing strategy of on-going project management once it has been launched. Thus, the FPSS budget features flexibility to move resources on the margin from one component activity to another depending upon demand for the services supplied by the various components, i.e., moving resources on the margin in the least-cost directions for which there is still unsatisfied demand for the product.

As one studies the list of project components, it is clear that, in a category-of-program sense, each component is a necessary part of the package -- such that the total project package could be faulted if it failed to include any of the components thereby failing to exploit a potentially promising fertility control strategy. In this sense, the cost effectiveness of the project as a whole depends upon the inclusiveness of the package of components.

The different project components will each deliver CYPs at different unit costs. Included in the package, however, are component activities representing all of the least-cost strategies in this domain -- that is, subsidized marketing through commercial channels, integration of family planning services with general public and private health-services delivery systems, and surgical contraception. If demand proves to stress the capacity of the least-cost project activities, resources can be diverted to these activities from other project components. Cost effectiveness of contraception by methods and types of delivery systems are shown in Table VI.D.1.

TABLE VI.D.1

Illustrative Couple Year Protection and Costs of
contraception by Method and Type of Delivery System

| Delivery System | <u>CYPs</u> | | | | | | | CYP Total | Cost Total | Cost/CYP/ System |
|-------------------------------------|----------------|---------------|---------------|---------------|---------------|----------------|-------------|-----------|------------|---------------------|
| | O.C. | Condoms | VSs | IUCDs | Inj. | VSC | O.A. | | | |
| Clinical Services (cost \$000) | 680 \$1398 | 116 \$720 | 119 \$1344 | 1562 \$855 | 371 \$1943 | 2757 \$7000 | - | 5604 | \$13,261 | \$2.37 |
| Community Services (Cost \$000) | 1066 \$2394 | 303 \$2056 | 151 \$1863 | - | - | - | ?? \$830 | 1530 | \$7,192 | \$4.70 |
| Subs. Com. Sales (Cost \$000) | 415 \$840 | 89 \$586 | 59 \$711 | ? | - | - | - | 563 | \$2,137 | \$3.80 |
| Sub-totals (Cost \$000) | 2161 \$4632 | 508 \$3362 | 329 \$3918 | 1562 \$855 | 371 \$1943 | 2757 \$7000 | ?? \$830 | 7698 | \$22,590 | |
| Cost/CYP/Method(\$) | \$2.14 | \$6.62 | \$11.90 | | \$0.55 | \$5.24 | \$2.54 | ?? | | |
| Cost/CYP (Kshs.) (\$1 = Kshs.16) | 34.30 | 105.93 | 190.36 | | 8.76 | 83.78 | 40.62 | ?? | | |

Inflation (5% compounded annually) included in costs

E. Environmental Analysis

A request for categorical exclusion from further review was included in the PID, and the Mission was notified by 85 STATE 136411 of the approval of this request.

VII. CONDITIONS, COVENANTS, AND NEGOTIATING STATUS

In addition to the standard conditions and covenants, the following special conditions and covenants will be included in the Project Agreement:

A. Conditions Precedent:

1. Prior to the first disbursement of funds, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will provide in form and substance satisfactory to A.I.D., evidence that the Government of Kenya (GOK) has published a notice in the GOK Gazette specifying that all project funded commodities, including those imported into Kenya by organizations under contract with or financed by A.I.D. or the GOK to perform work in Kenya in connection with the Project and those imported by the employees of such organizations for their personal use, will enter Kenya free of all duties and taxes.

2. Prior to disbursement for subsidized commercial marketing activities, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. Evidence that an organization has been established and registered under the laws of Kenya to distribute for sale at subsidized retail prices family planning contraceptives; and

b. Evidence that GOK has gazetted a reclassification of retail outlets that includes a clear and simplified system for licensing retail outlets to sell GOK authorized oral contraceptives. The licensing system will include a requirement for certified retailer training to assure that prospective clients are screened for contraindications and referred to medical personnel within a specified time period, if appropriate.

3. Prior to disbursement of funds to purchase oral contraceptives, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that GOK has published specific guidelines governing the distribution of oral contraceptives so that trained and certified community leaders may dispense this method of contraception.

4. Prior to disbursement to meet the costs of clinical training support to be furnished or contracted for by GOK, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D. in satisfactory form and substance, a clinical training plan which covers the period for which disbursement is requested.

5. Prior to disbursement subsequent to August 1, 1986 for any activities under the project (except for disbursements to third parties pursuant to commitments made to them prior to August 1, 1986), or to the issuance of commitment documents with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the GOK has budgeted funds in the 1986/87 Development Budget in amounts required to assure prompt and complete funding of all local costs of GOK supported elements of all project activities (as described in the amplified project description).

6. Prior to disbursement subsequent to August 1, 1986, for any National Council for Population and Development (NCPD) Administration; NCPD Policy, Planning, and Evaluation; or NCPD Information and Communication activities under the project (except for disbursements to third parties pursuant to commitments made to them prior to August 1, 1986), or to the issuance of commitment documents with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. Evidence that the Cooperating Country, by Presidential Order or by legislative action, has established the Secretariat of the National Council for Population and Development as a Permanent Commission which shall be empowered to discharge the duties of the current Secretariat.

b. Evidence that a full-time person has been appointed to be Executive Director of the Commission and Secretariat of the NCPD.

B. Covenants

The Cooperating Country will be required to covenant and agree as follows:

1. The Cooperating Country will, within the first year of the Project, expand and strengthen the authorities of the National Council for Population and Development (NCPD) in such a manner that NCPD can direct overall GOK inter-ministerial planning and program development; plan and obtain the necessary resource allocations (personnel and financial); monitor and evaluate the progress of the different elements of the national family planning program; and report directly to GOK top leadership.

2. In those districts undertaking organized community-based service delivery, the Cooperating Country will form Population and Development (or Family Planning) Sub-Committees of the District Development Committees, which will consist of appropriate officials and community leaders, such sub-committees to annually prepare work plans and budgets for GOK funding of local costs for family planning activities.

3. The Cooperating Country will operate, maintain and repair project equipment in conformity with sound operational, financial and administrative practices and in such a manner as to ensure the continuing and successful achievement of the purposes of the project. Inventory and distribution records for all project financed contraceptives and other expendible supplies will be maintained in accordance with generally accepted practices and procedures consistently applied.

4. The Cooperating Country will throughout the project budget funds in amounts required to assure prompt and full funding for all GOK financed elements of the project.

5. The Cooperating Country agrees to gradually assume responsibility for payment of the recurrent costs of salaries and personal emoluments of NCPD administration beginning in year three of the project. Unless otherwise agreed by A.I.D., the amount of costs assumed will be equal to 20 percent of the costs in year three and will increase by 20 percent each year thereafter until year seven of the project.

C. Negotiating Status

The Ministry of Home Affairs (through the Director of the Secretariat of the National Council for Population and Development), the Ministry of Health (through the Director of the Division of Family Health), and those Kenyan NGOs and U.S. based Cooperating Agencies envisioned to have major roles in project implementation have expressed agreement with the purposes of the project and its general design as described in the P.I.D. Design features and implementation plans for specific components were generated in collaboration with Kenyan officials and drafts of technical analyses have been provided both key GOK ministries.

FROM SECSTATE WASHDC
TO AMEMBASSY NAIROBI, PRIORITY 3546

SUBJECT: Kenya Family Planning Services and Support Project (615-0232): ECFR Results

REF: (A) STATE 120369 (B) STATE 074759 (C) STATE 074760

1. The Family Planning Project was approved for PP Development at an ECFR on April 18 (See Reftel A Decision Cable.) The PID cleared both the issues review and ECFR Without difficulty. The Bureau compliments the Mission on a well-written, concise PID and looks forward to review of the project paper. AID/W was encouraged to see another Kenya Project with a significant Non-Government component. Although the PID faced no major issues during review, several concerns were discussed. They are summarized below:

2. ECFR Concerns and Guidance:

A. Buy-Ins: The Bureau endorses the PID's proposed use of Buy-In on existing cooperative agreements, grants, and contracts. The only concern at the ECFR was that they have sufficiently high funding levels to cover the Buy-Ins this project will require. The PP should summarize all Buy-Ins contemplated and indicate that the funding in the agreement will be high enough in each case. Also, the PP should indicate that the terms of reference for the agreements are compatible with the scopes of work under the Buy-Ins. AID/W can assist with this task if necessary. Where an assistance instrument (grant or cooperative agreement) instead of a contract is selected this should be justified. To the extent that competition for an assistance instrument will be limited (where competition has not already been held under a Buy-In), the PP should provide the basis for AA/AFR approval under Handbook 13, CH 1B2E. Early consultation with the RLA concerning this point and the obligation mechanism is suggested.

B. Obligor Mechanism: The standard concerns with piecemeal obligations were raised (i.e., the difficulty of meeting obligation schedules and the management concern with many obligating agreements). The Bureau would obviously prefer one primary obligation with the GOK each year but we recognize that the Mission must compare the advantages of single annual obligations with the Government with the disadvantages of running Non-Government activities through the GOK. The ECFR decided that the Mission is in the best position to make the final choices on how the obligations should be handled. The ECFR did request that the Mission explain the reasons for obligations which must be handled outside of single annual agreements with the GOK.

C. AID policy on Family Planning Grants to NGOs: AID/W is developing guidance and draft clauses for Family Planning Grants and cooperative agreements with both U.S. and Foreign Non-Governmental Organizations. (See Refs. B and C.) AID/W will keep the Mission advised on this policy and how it will affect project implementation (e.g., obligation choices).

D. Project Management: The usual concern about the management of complex activities was raised. This project will be particularly difficult because multiple management units (Government and Non-Government) will be involved in project implementation. The Mission has organized and staffed the Population and Health Office to provide strong management on the project but the PP will have to provide more detailed information on the management units involved and how the Mission will handle the heavy workload.

E. Donor Coordination: A number of Donors are providing significant funding for Health and FP activities in Kenya. The role of various Donors and how their efforts will be coordinated should, be thoroughly described in the PP.

F. The National Council for Population and Development (NCPD) and the Division of Family Health (DFH): This project will be carried out primarily through two Kenyan agencies: The NCPD (overall policy Guidance and Direction) and the DFH in the MOH (Technical Implementation of FP services and NGO oversight). An institutional analysis of each organization should be presented in the PP defining the roles of these agencies, the strengths and weaknesses they bring to the project, and how their weaknesses will be addressed during the project.

G. Economic and Financial Analyses: Both the Economic and Financial Analyses will be important in the PP. In particular, the Economic Analysis should present the alternatives considered and the economic rationale for selecting specific approaches in the project's components. The Financial Analysis must also be thorough because it will address, in hard financial terms, the Government's commitment to the project. This is the most important concern about the long-term viability of the project. The recurrent cost issue, OOK Financial Commitment, and Budget forecasts must receive serious and detailed attention in the PP.

H. Obligation Plan: The PID factsheet, Block 19, shows obligations in FY 85, 86, 87. With Dols. 2 million planned for this year and Dols. 7.8 million for 86, Dols 26.2 million would be required in 87. Since this is unrealistic, the obligation plan should be spread over more years.

I. The IEE's recommendation for categorical exclusion has been approved.

3. Please advise when the PP is nearing completion so we can prepare for an expeditious review and minimize the time required for Mission representatives in Washington. DAM

A.2

Doc. 3566G

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Annex B
Page B.1

Project Title and Number: Family Planning Services and Support (615-0232)
Total US Funding: \$4M

Life of Project: From FY85 to FY92
Date prepared: June 14, 1985

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATIONS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|--|
| <p><u>Goal:</u> To lower population growth rates to levels more consistent with Kenya's ability to provide improved standard of living by enhancing the freedom and opportunity of individuals and couples to choose the number and spacing of their children</p> | <p><u>Measures of Goal Achievement:</u> Population growth rate goal of 3.5% in 1988 and a goal of 3.2% in 1992. Crude Birth Rate goals of 46 and 40/1000 respectively</p> | <p><u>Goal:</u> 1989 Census, 1988 and 1991 National Fertility and Contraceptive Prevalence Surveys, Analysis of 1984 Contraceptive Prevalence Survey, MOH computerized Statistics on Health and FP Services, and Contraceptive Inventory and Info. System</p> | <p><u>Goal Assumptions:</u> There is a growing current demand for FP services and by increasing accessibility of FP services, clients will avail themselves of the services</p> |
| <p><u>Purpose:</u> To increase user rates of quality fertility regulation methods</p> | <p><u>End of Project Status:</u> By 1992 32% of all eligible couples will practice an effective method of family planning (up from 13% in 1984)</p> | <p>As above</p> | <p><u>Purpose Assumptions:</u> MOH and NGOs are willing to expand their service delivery systems and NCPD will relax its age and parity guidelines, and further, gradual improvement will be made in social economic status, particularly regarding women's rights</p> |
| <p><u>Outputs:(Service Delivery)</u> <u>Clinical Training and Support Services</u> Increased access to quality clinical services</p> | <p>-MOH and NGO functioning facilities staffed with fully trained personnel in all Districts and Divisions of Kenya, with paramedical screening and referrals at 1424 MOH Service Delivery Points (of which 700 are new), providing over 5 Million Couple Years of Protection</p> | <p>MOH and NGO records, staffing and salary records, inventory records, MOH and NGO reports</p> | <p>MOH and NGO make suitable personnel available for training; MOH and NGOs will establish additional facilities and positions</p> |
| <p><u>Voluntary Surgical Contraception</u></p> <p>Increased access to quality VSC and counselling to provide fully informed consent</p> | <p>250,000 procedures providing over 2 Million Couple Years of Protection -170 sites offer VSC</p> | <p>MOH and NGO training records, CA reports</p> | <p>-Continued high quality VSC -An increasing number of Kenyan couples become interested in VSC</p> |

3

Community Based Services

House to house or community depot distribution of non-clinical contraception

15% of couples of reproductive age reached for 1,520,000 Couple Years of Protection

MCH and NGO reports

-Support of local leaders
-MCH guidelines on OCs are relaxed

Subsidized Commercial Marketing of Contraceptives

Utilization of commercial outlets to increase availability at subsidized prices

6,000 retail and pharmaceutical outlets selling three kinds of contraceptives at subsidized prices

Reports from the Kenyan marketing organization, and CA reports; analysis of contraceptive prevalence surveys

-A new independent marketing organization will be established which will pay salary levels commensurate with the private sector
-The ethical contraceptive products will be registered by COK, advertising will be allowed and OCs will be allowed to be distributed beyond the pharmacies to other retail outlets

Ovulation Awareness(NFP)

Increased understanding and use of OA to promote periodic abstinence for those persons for whom other methods of FP are not acceptable

KCS and FLCAK to train 3,600 teachers and 7,200 volunteers; total 10,860 estimated, cumulative users; Couple Years of Protection are not known

CA reports

-NFP project organization will adhere to AID Population Policy regarding referral of clients and informed choice among methods.
-FPSS support is contingent on these organizations eschewing unscientific criticism of other FPSS project components

Outputs:(Support)
NCPD Administration

Improved capacity of NCPD to handle increased program monitoring, supervision, management, and policy formulation

-Job descriptions, developed and staff hired
-Staff Training Plan completed
-Secretariat upgraded to Permanent Commission
-Commercial Bank account established
-Significant yearly increases in GOK budget allocations to NCPD

-NCPD reports
-COK budget
-Commission established
FPSS evaluations

-Permanent Commission personnel will not be subject to Civil Regulations Service

NCPD Policy Planning and Evaluation

Improved capacity for policy, program and budget planning and evaluation activities; progress reporting to top leadership

NCPD staff unit for policy, planning, and evaluation (at least 4 people), two major program evaluations the first project year; and two national demographic and health surveys completed by 1992

NCPD, CBS and consultant reports; FPSS evaluations

-Close cooperation and availability of data from CBS, and close cooperation of MOFP and Office of the President.
-Development Committees establish Sub-Committees on Population and Development and/or Health and Family Planning

NCPD Information and Communication

Increase public awareness of FP thru mass media and interpersonal (NGO) communications programs

-80 episodes of TV social drama
-160 episodes of radio social drama
-8 films produced
-print material produced
-strategy for national IE&C plan developed through workshops
-NGOs increase outreach
-Print material produced, and promotional activities take place in the private sector

NCPD reports, Surveys, and Broadcasts

GOK policy environment will continue to strongly encourage information and demand creation activities

MCH Information, Planning, and Reporting

Strengthened health and FP, management, budgeting evaluation & information capacity of the MCH at the National, Provincial, and District Levels

-Health Planning Management and Evaluation curricula developed in 4 Health Training institutions.
-District Health Plans incorporated into National Plan with budget allocations
-Information System working at District Provincial & National levels in Health statistics, personnel, management
-District Community Based Health Care Coordinating Committees established
-8-12 Operations Research/Health Projects

Training records

Annual MCH work plans

Quarterly MCH reports

41 Committees formed

Research completed

District Health Care Committees include FP as major items for budgeting

| | | | |
|---|--|---|---|
| <u>Inputs:(Service Delivery)</u> <u>Clinical Training and Support Services</u> -In-service training of MOH and NGO medical clinical and paramedical personnel -Revising Nurse Training curriculum to include FP -Supplying Clinical Equipment | -4800 MOH and NGO personnel of various types trained -5 Pre-Service curriculums developed, and -78 clinics equipped | -Training records -Revised curriculums published and adopted -Site visits | -COK will provide full recurrent cost support for salaries and operating expenses -Other donors will support further expansion of infrastructure -COK will relax restrictions on client access to clinical methods |
| <u>Voluntary Surgical Contraception</u> Training of physicians and surgical nurses in VSC, infertility and sexually transmitted disease Supplying surgical and other equipment and supplies to MOH and NGOs | -412 Physicians, 140 theatre assistants, -869 community workers, and 670 nurse/midwives, trained -VSC equipment provided to 120 sites | -Training records, CA reports -Bills of lading, receipt inspections, -CA reports | -COK will continue to strongly support a policy of access to VSC and will continue to relax restrictive guidelines on client characteristics -COK will expand facilities characteristics -COK will expand facilities |
| <u>Community Based Services</u> Supplying Contraceptives for MOH and NGOs | -15,000 CBS workers recruited and trained, and 2,000 supervisors hired and trained -14,924,000 OC's, 38,000,000 condoms 19,000,000 Vaginal Suppositories on site | Bills of lading, receipt inspections, USAID/PH field visits | -COK will relax restrictions on providers of oral contraception |
| <u>Subsidized Commercial Marketing</u> -Contraceptives -Operating Support to SCM organization | -5,397,000 OC's 11,118,000 condoms, and 7,415 Vaginal suppositories on site -Finance overhead for 1989-1992 costs of SCM organization | -As above -KCS, FLCAK, and CA reports -Organization reports and evaluation, USAID records | |
| <u>Ovulation Awareness(NFP)</u> Grant support for KCS, FLCAK and IFFLP | -subcontracts with IFFLP executed by KCS and FLCAK | -Training records ESAMI/CDC reports -Receipts, vouchers, accurate inventories | OA is a feasible method in the Kenyan context |

| | | | |
|--|---|--|--|
| <p>Inputs:(Support) <u>NCPD Administration</u> Staff salaries, and staff training costs</p> | <p>9 person years of long term training (U.S.) 39 person months of short term training (U.S.)</p> | <p>NCPD reports, USAID records</p> | <p>-GOK will provide salary (and overhead) support at increasing rate, reaching 100% by 1992</p> |
| <p><u>NCPD Policy Planning and Evaluation</u> Technical assistance in population policy, planning and evaluation</p> | <p>TA for planning and assisting in implementation of District level awareness conferences and technical planning services -Support to District Sub. Committees on Population and Development</p> | <p>NCPD records and reports, USAID records</p> | <p>Continued high level GOK support for NCPD</p> |
| <p><u>NCPD Information and Communication</u> -TA, and funds for NGO Communication initiatives -TA for planning, evaluation, and mass media production</p> | <p>-FP Private Sector Project supplies funds for IESC activities to private sector sites -Contracts with 2 or more Kenya-based agencies to undertake public relations and media campaigns -TA, funds for NGO communications initiatives</p> | <p>JSI Contract Amended Signed contracts Signed grants</p> | |
| <p><u>MCH Information, Planning and Reporting</u> -TA to MCH in planning management, curriculum development and information systems -Long-Short term training provided in MS level in planning, public health, health information management, and BS level in computer science -In country, in service training -Commodity support to the Health Information System & District Health Management teams -Grant funds for operations research and community development</p> | <p>360 person months long-term 64 person months short-term 8 Masters level 6 Bachelors level 1,025 people trained in 400 workshops National, 8 Provincial, and 41 Districts level system working 4-6 Operations research grants 4-6 Community Development pilot activities</p> | <p>MCH and USAID records, Contractor reports, Evaluations</p> | <p>GOK will meet its substantial funding and field implementation responsibilities in this component</p> |

A. GENERAL CRITERIA FOR PROJECT

1. FY 1985 Continuing Resolution Sec. 525; FAA Sec. 634A; Sec.653(b).

(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)?

(a) This project was included in the FY 86 Congressional Presentation, page 216, and a Congressional Notification will be forwarded in June 1985. (b) Yes
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) 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?

No further legislation is required.
4. FAA Sec. 611(b); FY 1985 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, or the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)

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?

This is not capital assistance project.
6. FAA S-c. 209. Is project susceptible to executions part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No. It is a country specific activity.
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.

This project will encourage and support Kenya's private sector by assisting in the formation and funding for a private company to handle subsidized social marketing of contraceptives thru existing private commercial retailers.

8. FAA Sec.-601(b). Information and conclusions 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).
- Approximately 20% of project funds will be used to purchase contraceptives and other supplies from private U.S. manufacturers and to introduce these commodities into Kenya. A further 7% of project funds will finance U.S. technical assistance, primarily from private non-profit organizations.
9. FAA Sec. 612(b), 636(h); FY 1985 Continuing Resolution Sec. 507. 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 will provide approximately 33% of the total local currency project costs, with Kenyan NGOs contributing a further 4%.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?
- No, the U.S. does not own excess Kenyan currency.
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?
- Yes
12. FY 1985 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?
- This project is not for the production of any specific commodity for export.
13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16? Does the project or program take into consideration the problem of the destruction of tropical forests?
- Yes. The PID requested a categorical exclusion from further review, and 85 STATE 136411 notified mission of approval of categorical exclusion. By reducing population growth this project will ease the problem of tropical forest destruction.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)? N/A

15. FY 1985 Continuing Resolution, Sec. 536. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(1). 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, 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?

(a) The project will ensure access to family planning services by the poor increasing service delivery points and by providing these services at no cost to those who cannot afford to pay, and at a subsidized cost to those who cannot afford to fully pay; (b) the project will not assist cooperatives, but will assist Maendeleo ya Wanawake, a grassroots women's participatory organization, in training and to provide family planning services; (c) it will not support self-help activities; (d) it will promote the participation of women in the economy by allowing them to decide how many, and when, children will be borne; and (e) it will not encourage regional cooperation.

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? Yes

c. FAA Sec. 107. Is emphasis 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)? N/A

d. FAA 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 assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes. The estimated Kenyan government contribution is above 25%.

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"? (M.O. 1232.1 defined a capital project as "the construction, expansion equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.")

No, this is not a capital assistance project.

f. 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, the project focuses on reducing the birthrate which is Kenya's major constraint to economic development.

g. 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 government processes essential to self-government.

This project will fulfill a largely unmet need and desire for family planning services; encourage the institutional development of NCPD and various NGOs; and support training in management as it relates to family planning activities.

STANDARD ITEM CHECKLIST

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?
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?
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision

Competitive selection procedures will be used as warranted.

Yes

Yes

N/A

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. 604(g). Will construction or engineering services be procured from firms of countries otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? No construction or engineering services will be financed.
6. 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? No
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? 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. Technical assistance will be furnished by private enterprises on a contract basis to the fullest extent practicable; most will be furnished on a contract basis by U.S. private non-profit enterprises. Facilities of other federal agencies will not be used to procure technical assistance.
8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U. S. carriers be used to the extent such service is available? Yes
9. FY 1985 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, will the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes, such provision will be included in all such contracts.

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services to be used? 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 (except for productive enterprises in Egypt that were described in the CP)? 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? N/A
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. Will arrangements preclude use of financing:
 - a. FAA Sec. 104(f); FY 1985 Continuing Resolution Sec. 527: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion? (1) Yes
(2) Yes
(3) Yes
(4) Yes
 - b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes
 - 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? Yes
 - d. FAA Sec. 662. For CIA activities? Yes
 - 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? Yes
 - f. FY 1985 Continuing Resolution, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? Yes
 - g. FY 1985 Continuing Resolution, Sec. 505. To pay U.N. assessments, arrearages for dues? Yes
 - h. FY 1985 Continuing Resolution, Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)? Yes
 - i. FY 1985 Continuing Resolution, Sec. 510. To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields? Yes
 - j. FY 1985 Continuing Resolution, Sec. 511. 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? No
 - k. FY 1985 Continuing Resolution, Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

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NATIONAL FAMILY WELFARE CENTRE
(M.C.H./F.P.)
MBAGATHI ROAD (OLD)
P.O. Box 43319, NAIROBI

Telegrams: "NAFAWA", Nairobi
Telephone: Nairobi 34421
please address all correspondence to
the Director
When replying please quote

..24th April..... 1985

Ref. No. MCH/FP-201. Vol I
and date

Dr. Gary Merrit,
USAID,
NAIROBI.

RE: PROJECT IDENTIFICATION DOCUMENT
FAMILY PLANNING SERVICES AND SUPPORT

Congratulations on well prepared and informative document. You must have done quite a lot of searching to come out with such a document. The candid manner in which it is written is also commendable.

The document was received yesterday at a meeting chaired by Mr. David Mwiraria, Permanent Secretary in the office of the Vice President and Ministry of Home Affairs, and attended by Mr. D. Kaniaru, NCPD and myself.

There are a few issues for which clarification is necessary but as they do not change the document substantially this can be done verbally.

As regards Government of Kenya's commitment of funds in support of the proposed project discussions will be held with the Treasury to ensure this is done.

You may go ahead and prepare the Project Paper.

Once again thank you for such a well done job.


Dr. J.C. Kigundu
DIRECTOR

cc

Dr. W. Koinange,
Director of Medical Services,
AFYA HOUSE.

Dr. S. Kanani,
SDDMS
AFYA HOUSE.

Dr. J. Maneno
ADMS
AFYA HOUSE.

Mrs. E.M. Kiereine,
Chief Nursing Officer,
AFYA HOUSE.

ANNEX D

ANNEX E.1.: CONTRACEPTION USE LEVELS, COMMODITIES AND COSTS
TO MEET GOK GOALS

PURPOSE AND SUMMARY DESCRIPTION: The GOK is currently considering adoption of explicit population growth rate goals for the year 2000. Discussion has centered on a range of rates between 2.0% and 2.8%. The USAID Family Planning Strategy Paper (1985) examined available data in order to translate these growth rate goals into implied Crude Birth Rates (CBR). These, in turn, were converted into estimated levels of use of contraception and abstinence that would likely be required. The results show that in Kenya in 2000 somewhere between 40% and 55% of all fertile aged couples will have to be using one or another of the six major, currently available fertility regulation techniques, or practicing abstinence. This analysis provides estimates of the levels of contraception use and probable costs required to achieve GOK goals. The analysis provides an illustration of long term contributions of different delivery systems. It summarizes what little is now understood about the likely sources by donor.

As described in the Social and Behavioral Analysis, preliminary results of the 1984 National Contraceptive Prevalence (CP) Survey suggest that about 13% of all married couples of reproductive age are now practicing some method (8% modern and 5% traditional or new periodic abstinence techniques). This represents a significant increase in use of fertility regulation methods in six and one half years. All methods appear to have increased.

A. ILLUSTRATIVE OBJECTIVES FOR A SUCCESSFUL PROGRAM:
40% TO 55% IN THE YEAR 2000

Over the next sixteen years, the current estimated total fertility rate of almost 8.0 children per woman could decline to fewer than 4.0 children per woman by the year 2000. Declines greater than this already have been demonstrated in other countries with socio-economic settings in some ways comparable (though usually in cultures that have higher rates of fetal loss). At current levels of use effectiveness of methods and at current marriage and pregnancy ages, this would require that slightly fewer than three of every five couples be practicing fertility regulation. This level of contraception prevalence probably would be consistent with a CBR of 35, a CDR of 7, and an overall annual growth rate of about 2.8%; the latter being the goal for the year 2000 sometimes mentioned in Government planning documents.

The key strategy questions now facing Government and Kenya's international donors concern: (1) how rapidly decline can and should occur and, (2) how to make the most efficient investments in contraception methods, and in the numerous infrastructures available for promoting and delivering services.

Fertile-aged females in Kenya number almost 3 million in 1985. This figure will rise to almost 4 million in 1992 and to over 5 million in the year 2000. Nearly all of these additional women have already been born or conceived. Most of them in fact are currently or will soon be enrolled in school, which

further suggests why family planning educational strategies for youth are so important. In 1984 about 13% of couples (350,000) are using some method of fertility regulation. If average completed childbearing were at or below 4 in 2000, about 40% of couples (2.1 million) at that time would be using some modern method of contraception (or abstaining from coitus) during most of the potentially reproductive phase of their lives.

TABLE E.1. ILLUSTRATIVE COUPLE YEAR PROTECTION AND COSTS
BY METHODS OF CONTRACEPTION AND TYPES OF DELIVERY SYSTEM

| Delivery System | O.C. | Condoms | VSS | IUCDs | Inj. | VSC | O.A. | CYP Total | Cost Total | Cost/CYP/ System |
|-------------------------------------|----------------|---------------|---------------|---------------|---------------|----------------|-------------|-----------|------------|---------------------|
| Clinical Services (cost \$000) | 680 \$1398 | 116 \$720 | 119 \$1344 | 1562 \$855 | 371 \$1943 | 2757 \$7000 | - | 5604 | \$13,261 | \$2.37 |
| Community Services (Cost \$000) | 1066 \$2394 | 303 \$2056 | 151 \$1863 | - | - | - | ?? \$830 | 1530 | \$7,192 | \$4.70 |
| Subs. Com. Sales (Cost \$000) | 415 \$840 | 89 \$586 | 59 \$711 | ? | - | - | - | 563 | \$2,137 | \$3.80 |
| Sub-totals (Cost \$000) | 2161 \$4632 | 508 \$3362 | 329 \$3918 | 1562 \$855 | 371 \$1943 | 2757 \$7000 | ?? \$830 | 7698 | \$22,590 | |
| Cost/CYP/Method(\$) | \$2.14 | \$6.62 | \$11.90 | | \$0.55 | \$5.24 | \$2.54 | ?? | | |
| Cost/CYP (Kshs.) (\$1 = Kshs.16) | 34.30 | 105.93 | 190.36 | | 8.76 | 83.78 | 40.62 | ?? | | |

Inflation (5% compounded annually) included in costs

Table 2: Illustrative Estimates of Couples Protected by Effective Traditional and Modern Methods

| Methods | Percentages | | | | | Numbers (000) | | | |
|-----------------------------------|-------------|------|--------|-----------|-----------|---------------|--------|-------------|-------------|
| | 1978 | 1984 | 1992 | 2000** | 2000** | 1984 | 1992 | 2000** | 2000** |
| No. fertile females at risk (000) | | | | | | 3400 | 5000 | 6500 | 6500 |
| No method | 93.3 | 88 | 69.8 | 60 | 45 | 2992 | 2964 | 3900 | 2925 |
| Breastfeeding† | (35) | (30) | (25.7) | (25) | (20) | (1020) | (1139) | (1625) | (1300) |
| Abstinence | 2.4 | 4.7 | 5.1 | 5.5 | 7.5 | 159.8 | 255 | 357.5 | 487.5 |
| Withdrawal | - | 0.3 | 0.4 | 0.5 | 0.5 | 10.2 | 20 | 32.5 | 32.5 |
| Condoms | - | 0.3 | 2.6 | 2 | 5 | 10.2 | 130 | 130 | 325 |
| Vaginal Supp. | 2.7 | 0.5 | 1.5 | 1 | 2 | 17 | 75 | 65 | 130 |
| Oral contraceptive | - | 4 | 9 | 12 | 15 | 136 | 450 | 780 | 975 |
| IUCDs | - | 2 | 6.3 | 6 | 7 | 68 | 315 | 390 | 455 |
| Injectables | 1.6 | 0.5 | 1.6 | 3 | 4 | 17 | 80 | 195 | 260 |
| Vol. surgical cont | - | 1.2 | 5 | 10 | 14 | 40.8 | 250 | 650 | 910 |
| Prevalence of use | 6.7 | 13.5 | 31.5 | 40 (1) | 55 (2) | 459 | 1575 | 2600 (1) | 3575 (2) |

†Declines in breastfeeding percentages reflect declines in fertility. This model assumes no decline in the percentage of mothers who breastfeed. If breastfeeding rates decline, then contraceptive use must be correspondingly greater in order to meet the goal.

**Scenario 1 applies 60% probable goal of 2.8% growth rate and implicit CBR=35 in 2000, requiring a prevalence of use of 40% of married couples. Scenario 2 is based on more optimistic projections of potential achievements by methods as described in Section F, following.

The challenge in this scenario, then, is to achieve a 7.5 fold increase in absolute numbers of users over the next 15 years. This means an increase in the rate of use of effective traditional and modern methods by an average of about 13% per year in simple compound terms. To put this into perspective, consider that the estimated number of users appears to have increased two-fold during the six and one half years between the 1978 and 1984 national surveys -- an average annual increase in number of users of about 13% per year.

F. PAST, CURRENT AND ILLUSTRATIVE PREDICTED LEVELS BY METHOD

The ease (or difficulty) with which the illustrative national objective could be reached may be examined by looking at the scale of potential changes for each major method of fertility regulation already available and used in Kenya. When looked at by individual methods of fertility regulation, and considering the variety of existing infrastructures for delivering services, the overall task appears attainable. Table 2 provides figures on past, current and illustrative projected use levels of contraception in Kenya on a national level. USAID has utilized two sets of illustrative projections to the year 2000. The first (1) directly reflects the implicit objectives of the GOK's expected goal of 2.6% growth rate in 2000 (CBR=35). The second (2) reflects more optimistic scenario which we think could be achieved if all impediments and constraints (see Part I, Section E) were lifted. Planning to achieve the method specific levels that would cumulatively reach 55% in 2000 will certainly enhance the likelihood of reaching the lower figure of 40%.

Projections are based on the assumption that the backlog of existing demand and the rapid achievement of accessible quality services makes a prevalence rate of 32% in 1992 easily attainable. Achieving additional increments beyond that level may be more slow unless there are parallel improvements in socio-economic levels, whether the national target is 40% or 55% in 2000. Experience in other countries demonstrate that programs with several methods of contraception and reasonably accessible delivery systems can reach 30% rather quickly. Therefore, FPSS assumes identical scenarios through the 1992 PACD.

SURGICAL CONTRACEPTION

The growing popularity of voluntary surgical contraception (VSC) is evidenced by increased demand at provincial hospitals and by the great interest shown recently by public and private sector surgeons and clinics. The 1984 CP Survey supports this observation; CPS figures suggest that the number of Kenyan women electing tubal ligation (TL) rose from negligible in 1978 to probably more than 40,000 in 1984.

The picture in 2000 could easily show that sterilization accounts for 15% of fertile-aged, sexually active couples. Experience in all countries where good male and female sterilization services have been readily available for some time shows a typical 20% or more of couples selecting this inexpensive and most effective method. It is a powerful preventive health service for older women with high parity and those for whom further pregnancies represent a

serious threat to their health. It is most notable that not only political leadership, but family planning professionals greatly underestimated the rapid expansion of sterilization in Latin America all during the 1970s. There were no public promotions and yet the level for the region has shown steady increases. It likely will be similar in Kenya, especially since the GOK leadership has strongly supported the expansion of VSC services. AID supported the development of modern surgical contraception methods and their introduction into Kenya during the past five years. Key issues concern safety, good pre- and post-procedure counselling for clients, and adequate funding systems to compensate institutions and surgeons so that the poor may share in the access to VSC.

INJECTABLES

Kenya like most countries in the world has authorized the availability of injectables to their publics for family planning. The injectable contraceptives have a unique appeal for women in the middle-to-late reproductive years. Perhaps as many as 4% would choose it if easily available. Clinical service providers frequently prefer to offer the injectable to women who are considering or waiting for tubal ligation.

USAID does not provide injectables. The only donor doing so is Danish DANIDA. DANIDA supplied sixty thousand (60,000) vials of 3 month formulations in 1984 -- enough for about 15,000 person-years of protection, or about 0.5% of couples, a figure identical to the estimate of 0.5% prevalence from the 1984 CP Survey. GOK has requested 70,000 vials for 1985, 45,000 of which are already on order. (NOTE: FINIDA [Finland] may be willing to provide all required NORPLANT implants if trials now being designed prove this method to be acceptable as firmly expected by senior MOH officials.) DANIDA has informally agreed to provide as much of the injectable contraceptives as are needed for the indefinite future. Both DMPA and NET formulations are purchased, in roughly equal quantities. See Table 8 for further details of projections to 1992.

INTRA-UTERINE CONTRACEPTIVE DEVICE

The intra-uterine contraceptive devices could easily be found acceptable to as many as 7% or more of women, if their safety and accessibility were improved. Under these conditions the IUCD always appeals to a significant proportion of women in the middle of their reproductive history. Informal canvassing of clinic service providers of FP suggest that the new Copper "T" is becoming popular but severely constrained by supply problems. USAID can meet all IUCD requirements in Kenya over the next few years through central AID/II procurement. MOH has decided to shift entirely to copper bearing IUCDs. See Table 7 for details of quantities and costs through 1992.

The foregoing sums to 25% of 5.2 million couples (or about 1.3 million) who would be using methods that involve clinics and well trained personnel. The remaining 30% (1.6 million) would be relying on non-clinical methods that can be provided by non-clinical people, as below.

ORAL CONTRACEPTIVES

Oral contraception will probably remain a most popular method in Kenya, reaching a level of at least 15% by 2000. Orals have a consistent appeal to youthful couples wherever they have been made accessible. Youth will certainly form the vast majority of sexually active people in 2000 and for those who want to delay their first pregnancy the oral contraceptive is an ideal choice in most cases. The oral contraceptive has proven worldwide to be an extraordinarily safe and effective biochemical formulary, and has been the subject of the most extensive pharmacologic and epidemiologic research in history. A tripling of today's rate of use of the oral contraceptives could confidently be expected over the next few years if steps are taken to make it accessible through community-based programs and subsidized commercial sales. Absolute risk levels -- especially with the ultra-low doses that have evolved during the past decade -- are so low in younger women, and their risks in comparison to the complications of unwanted pregnancies are so very favorable, that these should be regarded ethically as over the counter formulations in Kenya and in the rest of the world.

Sweden has been by far the major donor to Kenya's public sector contraception supply program (all methods) for many years. However, USAID understands that Swedish SIDA intends to gradually reduce its support for contraceptives, having diminished its funding contribution from about \$645,000 in 1984 to about \$440,000 in 1985 (at which level it may remain). SIDA feels it has provided contraceptives for too many years and seems to welcome USAID contributions. MOH has expressed a strong preference for continuing SIDA's support concentrated only on the OC so that there will be no necessity to shift to a different brand. The MOH has become accustomed to the Schering AG products. FPSS proposes to share OC contributions equally between SIDA and USAID. The current Wyeth formulation is identical to that provided by Schering AG.

BARRIER METHODS

There are numerous temporary and semi-effective barrier methods that depend mainly upon the woman, mostly spermicides. They suit a small number of people, usually only for limited periods of time when making transition to other, more secure methods. There seems to always be some small market for them in all countries; 2% in the year 2000 is a fair guess.

It is widely said that Kenyan men have not been willing to help out in the matter of birth control. It is highly unlikely that this situation will persist as economic factors in childbearing become clearer to males. In fact, Kenyan males have never really had easy access to methods or information about them. Males participate in fertility regulation by: total or periodic abstinence; coitus interruptus/withdrawal; by using the condom; or by having a vasectomy. Over the next 16 years as many as 13% of couples could be relying on methods that depend mainly on the direct collaboration of male partners. Attaining 13% could be a worthy challenge; many women might think it an outrageously low estimate. Periodic abstinence training is already in high

demand in areas where it has been introduced. Condoms are selling well recently in the commercial market. Male participation in fertility regulation happens also to be a regular feature of successful preventive health programs; condom use is associated with improved sexual hygiene and reduction of sexually transmitted diseases, a very relevant consideration in Kenya. AID can provide condoms to the GOK's program at whatever level required. Expected requirements are shown in Tables 5 and 6.

SUMMARY ON METHODS

The rate of adoption of family planning methods projected here is less than or roughly equal to the diffusion rates for numerous other successful innovations in recent Kenyan history. These include the acceptance of new vaccines, the adoption of new agricultural practices (e.g., hybrid and Katumani maize, and fertilizers), the spread of radio receivers and other commercial products, and the administratively induced land consolidation movement during the late 1950's and early 1960's. The assertion is often heard in Kenya that family planning will take a long time, that all change in deep-seated customs takes a long time among traditional peoples. International evidence nevertheless shows that rapid change does occur when political and public willpower is exerted. USAID will be able to fully assist Government in meeting rapidly growing requirements for contraception in Kenya.

The estimated contraception commodity requirements and costs for the foregoing level of effort and consumption is shown in Table 9. The anticipated distribution of these commodities among specific project components is given in Tables 10 A, B, and C. Table 11 estimates the contribution of contraceptives by several donors.

Tables 3 through 11 represent projections of the rough implications of a seven year trajectory from 13% in 1984 to 32% in 1992. Taken into account are: types of method, types of delivery system (clinical, CBPHC, and marketing), quantities, costs and couple years protection (CYP), and donor contributions. The tables are linked (Lotus 1-2-3) in such a way that assumptions from Table 2 may be varied and the results quickly calculated. This model should prove useful throughout the FPSS period. Comparisons among delivery systems, shown in Tables 10 A - C show that the introduction of non-clinical delivery systems have the effect of reducing the demand for these services at the clinics, thereby creating a significant efficiency in overall program design.

To be effective, CBS programs need well developed and very reliable logistics support. Contraceptive supplies come from the Central Medical Stores on order from the Ministry of Health through the Division of Family Health (DFH, formerly NFHC). They are imported duty free upon certification by the DFH Director. MOH will remain directly responsible for forecasting requirements, participating for GOK in product selection (e.g., approving USAID PIO/Cs), in-country import arrangements, and consignments to field distribution points. To date most of the local CBS and family planning programs report that the MOH and the Central Medical Stores have made it possible for them to operate a smooth pipeline of official encouragement, training, organization and supplies, and have felt good about GOK local assistance.

The Ministry of Health and SIDA are both seeking a review of the logistics system with a view to improving it still further. The Ministry of Health has enlisted a thorough effort from the Eastern and Southern Africa Management Institute (in collaboration with the Centers for Disease Control) in June through August, 1965. This preliminary exercise will refine national estimates of contraception requirements for the next two or three years (an important benefit to all concerned) and will review efficiencies within the system. This exercise must be gone through thoroughly by Kenyans as early in the FPSS process as possible. ESAMI's effort will include interviews and impressions concerning the entire public sector pathways of SIDA allocations and tendering, import, consignment, storage, dispatch, logging, and so on. USAID's Commodity and Projects Officer will remain closely apprised.

Regulations regarding the prescription of oral contraceptives have been realistically modified in recent months to permit CBS volunteers to provide one or more cycles of OCs to first time clients, based on a thorough check-list and referral to a clinical for confirmation of the client's eligibility to receive supplies directly from community agents. This lifts a major constraint on contraceptive delivery in Kenya.

| CY | PROJECT USERS (000) | QUANTITY (000) | COST/UNIT (\$) | COST (000) |
|------|---------------------|----------------|----------------|------------|
| 1986 | 200 | 2794 | 0.13 | \$363 |
| 1987 | 236 | 3306 | 0.13 | \$430 |
| 1988 | 273 | 3617 | 0.13 | \$496 |
| 1989 | 309 | 4329 | 0.13 | \$563 |
| 1990 | 338 | 4737 | 0.13 | \$616 |
| 1991 | 370 | 5180 | 0.13 | \$673 |
| 1992 | 405 | 5675 | 0.13 | \$738 |
| | 2131 | 29838 | | \$3,879 |

Users from Table 3.A
 Quantity assumes 14 cycles of OC per user equals one couple year protection (CYP)
 Costs assume procurement through AID/W

| CY | PROJECT USERS (000) | QUANTITY (000) | COST/UNIT (\$) | COST (000) |
|------|---------------------|----------------|----------------|------------|
| 1986 | 36 | 4523 | 0.044 | \$199 |
| 1987 | 50 | 6210 | 0.044 | \$273 |
| 1988 | 60 | 7459 | 0.044 | \$328 |
| 1989 | 72 | 9053 | 0.044 | \$398 |
| 1990 | 85 | 10646 | 0.044 | \$468 |
| 1991 | 98 | 12240 | 0.044 | \$539 |
| 1992 | 107 | 13346 | 0.044 | \$587 |
| | 508 | 63476 | | \$2,793 |

Users from Table 3.B
 Quantity assumes 125 units per year = 1 CYP
 Costs assume procurement through AID/W
 (GDA costs may be higher)

| CY | PROJECT USERS (000) | QUANTITY (000) | COST/UNIT (\$) | COST (000) |
|------|---------------------|----------------|----------------|------------|
| 1986 | 29 | 3623 | 0.08 | \$290 |
| 1987 | 36 | 4456 | 0.08 | \$357 |
| 1988 | 41 | 5175 | 0.08 | \$414 |
| 1989 | 48 | 5991 | 0.08 | \$479 |
| 1990 | 53 | 6579 | 0.08 | \$526 |
| 1991 | 59 | 7368 | 0.08 | \$589 |
| 1992 | 64 | 7969 | 0.08 | \$638 |
| | 329 | 41160 | | \$3,293 |

Users from Table 3.C
 Quantity assumes 125 units per year = one CYP
 Costs assume procurement through AID/W

| CY | USERS (000) | AVERAGE #/YR. | QUANTITY (000) | COST/UNIT (\$) | COST (000) |
|------|-------------|---------------|----------------|----------------|------------|
| 1986 | 123 | 0.70 | 86 | 0.84 | \$72 |
| 1987 | 152 | 0.68 | 103 | 0.84 | \$86 |
| 1988 | 182 | 0.65 | 118 | 0.84 | \$99 |
| 1989 | 211 | 0.63 | 132 | 0.84 | \$111 |
| 1990 | 240 | 0.60 | 144 | 0.84 | \$121 |
| 1991 | 269 | 0.57 | 154 | 0.84 | \$129 |
| 1992 | 299 | 0.55 | 164 | 0.84 | \$138 |
| | 1476 | | 901 | | \$757 |

From TABLE 3.D
 Assumes that in 1986, 0.7 IUCD insertions = 1 CYP (improving efficiency over time)
 Number of insertions = Number procured (no loss)
 Unit cost assumes AID/Washington bulk procurement

| Project CY | Users | Quantity (000) | Cost/Unit (\$) | COST (\$000) |
|------------|-------|----------------|----------------|--------------|
| 1986 | 32 | 126 | 1.10 | \$139 |
| 1987 | 39 | 155 | 1.10 | \$171 |
| 1988 | 46 | 183 | 1.10 | \$201 |
| 1989 | 53 | 213 | 1.10 | \$234 |
| 1990 | 61 | 242 | 1.10 | \$267 |
| 1991 | 67 | 269 | 1.10 | \$296 |
| 1992 | 74 | 295 | 1.10 | \$325 |
| | 371 | 1455 | | \$1,633 |

Users from Table 3.E
 Quantity assumes 4 vials/unit = 1 CYP
 Costs assume DANIDA procurement

| CY | A: OC | B: Condoms | C: VEs | D: IUCDs | E: Inject. | Sub-total | Inflation | TOTAL |
|--------|---------|------------|---------|----------|------------|-----------|-----------|----------|
| 1986 | \$363 | \$199 | \$290 | \$72 | \$139 | \$1,064 | \$0 | \$1,064 |
| 1987 | \$430 | \$273 | \$357 | \$86 | \$171 | \$1,317 | \$65 | \$1,382 |
| 1988 | \$496 | \$328 | \$414 | \$99 | \$201 | \$1,539 | \$158 | \$1,697 |
| 1989 | \$563 | \$398 | \$479 | \$111 | \$234 | \$1,785 | \$261 | \$2,046 |
| 1990 | \$616 | \$468 | \$526 | \$121 | \$267 | \$1,998 | \$431 | \$2,429 |
| 1991 | \$673 | \$539 | \$589 | \$129 | \$296 | \$2,227 | \$615 | \$2,842 |
| 1992 | \$738 | \$587 | \$638 | \$138 | \$325 | \$2,425 | \$325 | \$2,750 |
| TOTALS | \$3,879 | \$2,793 | \$3,293 | \$757 | \$1,633 | \$12,354 | \$2,376 | \$14,730 |

from Tables 4A through 6E
 Inflation 5% compounded annually

Table 10-A: Commercial Retail Sales Component
(Est. Number of Units, CYPs, and Cost by Method of Contraception (000s))

| CY | A:ORALS | | | B:CONDOMS | | | C:VSS | | | TOTALS | | | |
|-------|----------|------|-------|-----------|------|-------|----------|------|-------|--------|---------|-----------|---------|
| | Quantity | CYPs | Cost | Quantity | CYPs | Cost | Quantity | CYPs | Cost | CYPs | Cost | Inflation | Total |
| 1986 | 346 | 27 | \$45 | 712 | 5 | \$31 | 475 | 4 | \$38 | 36 | \$114 | \$0 | \$114 |
| 1987 | 537 | 41 | \$70 | 1166 | 7 | \$49 | 739 | 6 | \$59 | 56 | \$178 | \$9 | \$136 |
| 1988 | 719 | 55 | \$93 | 1431 | 12 | \$65 | 988 | 8 | \$79 | 75 | \$235 | \$24 | \$262 |
| 1989 | 810 | 62 | \$105 | 1569 | 13 | \$73 | 1113 | 9 | \$89 | 65 | \$268 | \$42 | \$310 |
| 1990 | 901 | 69 | \$117 | 1956 | 15 | \$82 | 1238 | 10 | \$99 | 94 | \$298 | \$64 | \$362 |
| 1991 | 992 | 76 | \$129 | 2044 | 16 | \$90 | 1363 | 11 | \$109 | 107 | \$328 | \$91 | \$419 |
| 1992 | 1092 | 84 | \$142 | 2250 | 19 | \$99 | 1500 | 12 | \$120 | 114 | \$361 | \$123 | \$484 |
| TOTAL | 5397 | 415 | \$702 | 11118 | 89 | \$489 | 7415 | 59 | \$593 | 563 | \$1,784 | \$353 | \$2,137 |

Table 10-B: Community Based Programs
(Est. Number of Units, CYPs, and Cost by Method of Contraception (000s))

| CY | ORALS | | | CONDOMS | | | VSS | | | TOTALS | | | |
|-------|----------|------|---------|----------|------|---------|----------|------|---------|--------|---------|-----------|---------|
| | Quantity | CYPs | Cost | Quantity | CYPs | Cost | Quantity | CYPs | Cost | CYPs | Cost | Inflation | Total |
| 1986 | 490 | 35 | \$64 | 1250 | 10 | \$55 | 625 | 5 | \$50 | 50 | \$169 | \$0 | \$169 |
| 1987 | 756 | 54 | \$98 | 1875 | 15 | \$83 | 1000 | 8 | \$80 | 77 | \$261 | \$13 | \$274 |
| 1989 | 1288 | 92 | \$167 | 3250 | 26 | \$143 | 1623 | 13 | \$130 | 131 | \$440 | \$45 | \$486 |
| 1989 | 1849 | 132 | \$240 | 4750 | 38 | \$209 | 2250 | 18 | \$180 | 168 | \$629 | \$99 | \$728 |
| 1990 | 2646 | 169 | \$311 | 6750 | 54 | \$297 | 3375 | 27 | \$270 | 270 | \$911 | \$196 | \$1,107 |
| 1991 | 3542 | 253 | \$460 | 9000 | 72 | \$396 | 4500 | 36 | \$360 | 361 | \$1,216 | \$336 | \$1,553 |
| 1992 | 4354 | 311 | \$566 | 11000 | 88 | \$484 | 5500 | 44 | \$440 | 443 | \$1,490 | \$507 | \$1,997 |
| TOTAL | 14924 | 1066 | \$1,940 | 37875 | 303 | \$1,667 | 19875 | 151 | \$1,510 | 1520 | \$5,117 | \$1,196 | \$6,313 |

Table 10-C: Clinical Services
(Est. Number of Units, CYPs, and Cost by Method of Contraception (000s))

| CY | ORALS | | | CONDOMS | | | VSS | | | IUCDs | | | TOTALS | | | |
|-------|----------|------|---------|----------|------|-------|----------|------|---------|----------|------|-------|--------|---------|-----------|---------|
| | Quantity | CYPs | Cost | Quantity | CYPs | Cost | Quantity | CYPs | Cost | Quantity | CYPs | Cost | CYPs | Cost | Inflation | Total |
| 1986 | 1958 | 140 | \$255 | 2561 | 20 | \$113 | 2523 | 20 | \$202 | 86 | 123 | \$72 | 304 | \$641 | \$0 | \$641 |
| 1987 | 2013 | 144 | \$262 | 3229 | 26 | \$142 | 2718 | 22 | \$217 | 103 | 156 | \$86 | 347 | \$708 | \$35 | \$743 |
| 1989 | 1010 | 129 | \$235 | 2728 | 22 | \$120 | 2562 | 20 | \$205 | 118 | 187 | \$99 | 359 | \$560 | \$68 | \$727 |
| 1989 | 1671 | 119 | \$217 | 2634 | 21 | \$116 | 2628 | 21 | \$210 | 132 | 220 | \$111 | 381 | \$654 | \$103 | \$757 |
| 1990 | 1190 | 85 | \$155 | 2040 | 16 | \$90 | 1956 | 16 | \$157 | 144 | 257 | \$121 | 374 | \$523 | \$113 | \$635 |
| 1991 | 646 | 46 | \$64 | 1196 | 10 | \$53 | 1505 | 12 | \$120 | 154 | 290 | \$129 | 357 | \$386 | \$107 | \$493 |
| 1992 | 229 | 16 | \$30 | 96 | 1 | \$4 | 969 | 8 | \$78 | 164 | 329 | \$138 | 353 | \$249 | \$85 | \$334 |
| TOTAL | 9517 | 680 | \$1,237 | 14483 | 116 | \$637 | 14870 | 119 | \$1,190 | 901 | 1562 | \$757 | 2476 | \$3,821 | \$510 | \$4,331 |

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ANNEX E.2. CLINICAL TRAINING AND SUPPORT SERVICES

I. PURPOSE AND SUMMARY DESCRIPTION: The purpose of the clinical services sub-component is to expand and improve the delivery of family planning services through both government and non-government hospitals and clinics. Clinical services will be improved by increasing the supply of contraceptives available on a regular and timely basis, providing limited family planning (FP) supplies and equipment to district and sub-district Maternal and Child Health (MCH)/FP facilities and by training of Ministry of Health (MOH) staff in various aspects of family planning and family planning management.

II. BACKGROUND: Currently half of the Rural Health Facilities (RHF) do not offer family planning services. The current total represents a 47% increase in five years, and the MOH is proposing to add an additional 300 in 1985 and project an additional 400 over the next three year period from 1986 - 1988. The health system does reach a large and growing proportion of the population with other MCH services with at least 65 percent of pregnant women receiving prenatal care and 49 percent of children being immunized.

All MOH facilities seem to be utilized to and beyond capacity. This is especially true in rural areas, where most of the people but relatively few health professionals live. Thus rural health facilities often are crowded and MCH/FP out-patients frequently undergo long waits. Shortages of trained personnel constrains expansion of services. Although the number of Enrolled Community Nurses (ECNs) being graduated each year has increased due to MOH efforts to overcome shortages of this cadre, the increasing supply of ECNs seems to only keep up with the increasing need associated with the opening of more and more rural health facilities. The MOH estimates that there are now approximately 8,000 ECNs. They plan to increase this cadre to 12,000 by 1988. The numbers of COs and nurses other than ECNs being trained annually is relatively stable.

Until April 1983, the DFH in Nairobi was the only center offering these in-service courses. However in 1983, an additional six decentralized centers were opened and began training ECNs which greatly expanded the training capacity of the MOH. The MOH expects to expand this output of health personnel in the next 5 years with the addition of 7 more health training facilities.

Calculating the number of health personnel currently working in the country only 4 percent of COs (86), 12 percent RRN/Es (387), and 22 percent of the ECN (1,924) work force have received the specialized nine week in-service family planning training courses. It is anticipated that currently 6000 ECNs are working in areas that should be offering family planning services. Judging from the number of ECNs trained to date and presumably working in family planning, this leaves an additional 7166 ECNs in need of family planning training. In addition, there are numerous mission run nursing training schools. Most of these graduates will work in Mission run hospitals/clinicals which though serving 30% of the total Kenyan population, serve 70% of the population living in remote areas.

III. DESCRIPTION:

CONSTRAINTS:

Three major constraints were identified during the Family Planning II project which inhibit the delivery of family planning services in MOH facilities.

- (1) Lack of appropriate and continuous family planning commodities;
- (2) GOK policy concerning types of contraception offered to various client groups;
- (3) Lack of skilled MOH personnel to deliver family planning services.

The area of skilled personnel encompasses several areas. First the existing personnel have not been adequately trained in family planning methods and other technical areas - motivation of acceptors, timing of motivation, identification of risk factors, new and on-going development of family planning methods. In addition, in-service training in family planning for CO and nurses must be further defined giving the different job responsibilities each has.

Secondly, there is a lack of sufficient trainers of trainees (TOT) to support the in-service training program envisioned by the MOH. The MOH plans to increase this TOT cadre within the project life. These new TOTs must be first trained and their curriculum strengthened in technical and managerial areas.

Thirdly, the ECNs to be trained are responsible for the delivery of MCH/FP services in their respective communities. They organize MCH/FP clinics; supervise midwives and attendants at the clinic; are responsible for maintenance of family planning records; recruitment and follow-up of clients; community education on family planning; advising the clinical officer on commodity supplies needs; training of TBAS; and, liaison with other community health workers for client referral and follow-up. However, these ECNs have not received management skills training. The nurses providing MCH/FP services especially in rural areas must receive management/administration/supervision training in accordance with current GOK district planning and implementation focus.

Fourthly, the pre-service training curriculum in family planning technical and managerial areas (points 1 and 3 above) is very weak. In order to be able to change the focus of in-service training in family planning to updating skills the basic family planning technical and managerial skill areas must be strengthened in pre-service training.

Fifthly, medical personnel especially in isolated rural areas with no near-by higher level (KRN or HD) medical personnel available need relevant up-to-date procedural and technical manuals in order to prescribe and follow-up patients in an appropriate manner.

Sixthly, there needs to be specialized family planning training to key TOTs in order to incorporate the newest family planning methodologies and practices into MOH treatment/counseling procedures.

And finally, more appropriate family planning motivational and educational materials need to be available in MOH clinics. The IEC component of this project addresses this issue.

OBJECTIVES

The major objective of the family planning project component is to provide skills to medical and paramedical personnel to provide effective Family Planning Services to the target groups. In order to achieve this objective, the following training activities will be supported.

(1) Through MCH/FP in-service training programs offered in Nairobi and the 11 decentralized training centers throughout the country, 3,435 ECNS, 420 KRN/M's, COs and PHNs will be trained in 267 nine-week courses in family planning technical skills; (2) A 4-week curriculum development workshop will be held for 25 DFH training staff to revise the KRN/M, and CO training curriculum in family planning technical skills; (3) 1,000 copies each of the revised MCH/FP curriculum for KRN/Ms/COs and 3,000 copies of the revised family planning Procedure Manual will be printed and distributed; (4) Two training of trainers workshops and six one-week refresher courses will be held for trainers of the in-service components of 1. and 2. above, training a total of 200 participants over the life of project; (5) 21 scholarships or three scholarships per year will be provided for short term regional or out of country training courses in MCH/FP technical skills; (6) 600 ECNS will be trained in MCH/FP management skills, 24 district trainers will be trained as trainers and a core training team of four nurses and a coordinator at the central MOH will be trained to organize and implement management training for personnel delivering MCH/FP services in years 1 and 2 of the project. MCH/FP management skill training sessions will continue in years 3-7 of the project at lower levels as management skills are incorporated into pre-service training; (7) The project will provide technical assistance of two (2) FP Specialists for 3 months each, a total of 6 person months, to modify and improve the pre service ECN, KRN/M, PH, CO courses.

The direct project focus is to assist the MOH personnel to upgrade their skills both technical and managerial for better family planning service for clients. In order to achieve this two levels of training as described above will be provided -first to direct service deliverers and secondly to trainers. As stated before private and mission groups provide approximately 30% of health care. The project will impact them in three ways: First, physicians and operating room assistants will obtain skills in voluntary surgical contraception (see VSC technical report); second, the changes in the pre-service curriculum will be approved by the Kenya Nursing Council. The pre-service training changes are even more important when one analyses the distribution of ECNs within the system. Over 70% of ECNs trained in mission institutions will work in MOH facilities. Furthermore, these mission trained personnel will then be included in the MOH in-service training schedule. Once approved, these curricula must be followed by all health training institutions; thus, private and mission training schools will be using the upgraded family planning methods, skills and procedures. Third, the various

Mission groups hold periodic in-service training of their field personnel. These NGO trainers (approximately 30% per class in years 2 - 7) will be included in the updates from the Ministry of Health training centers and will then incorporate these new skills areas into their ongoing in-service training program. Finally, we must note that the Mission groups will have direct contact with other project inputs for skill development.

The Community Based Distribution program aspect (CBD) will entail support and training for all groups in rural areas and especially for the catholic groups, Natural Family Planning (NFP) elements will be incorporated (see CBD and NFP technical annexes for details).

V. ADMINISTRATIVE ANALYSIS

In November 1984, AID conducted an evaluation of the Division Family Health (DFH) in-service clinical family planning training program supported through AID's Family Planning II Project (Part B). The evaluation assessed the appropriateness, effectiveness and impact of the DFH's in-service training for enrolled community nurses (ECNs) and clinical officers (CO). This included a detailed review of course training content materials, trainers skills, selection and assignment of trainees, trainees own course evaluations, NFWC management of training and budget and adherence to planned schedules. It was found that the training was appropriate and that the output of trained ECNs was close to the 300 per year which was scheduled in the original project plan, however, only 60 of the projected 270 CO's had been trained through the project. The evaluators recommended that AID continue to support the training of health providers in MCH/FP in-service program with change of training emphasis for COs as described in Section III. Recommendations were also made to conduct yearly refresher training for tutors and update some of the training materials. These recommendations have been accepted and are involved in the project design. In 1983 the DFH also conducted a survey which showed that 20% percent of the ECNs trained in family planning clinical skills were deployed in MCH/FP service areas. Another recommendation pointed out the weakness of the quantity and quality of library reference materials and teaching aids (models). Under Family Planning II these materials will be procured; therefore, this project will not address the reference materials issue except as noted.

VI. ACTIVITY BUDGET

Table I breaks out the various project components and USAID contributions. USAID will provide a total of \$3,196,000 (FY86 dollars) to support the MCH/OFH In-service Training Component. COK contribution is estimated at \$943,000. USAID will also contribute \$77,700 (FY85 dollars) for the 21 scholarships for out of country specialized training.

\$20,000 will be made available for the printing of curricula and procedures manual in year one of the project. COK will distribute these manuals and maintain the reprint and updated versions during the life of the project estimated at \$2,000/yr. total of \$12,000 (FY86 dollars).

The 1986-1987 budget for the management training program is \$460,000. The project will pick up half the training costs, or \$230,000, and INTRAH/Kenya will support the remaining costs through their core budget. After the completion of this two year training effort, the project will make available \$100,000 a year for the remaining five years of the project to support future in-service training needs of clinical family planning personnel. While it is not possible to specifically identify training course content or types of trainees to be trained beyond 1987, these monies will support an additional 40 health personnel with in-service training opportunities.

The project will provide TA to modify the pre-service family planning curricula for various health personnel in year two of the project with resources from MOH and World Bank. It is calculated that \$15,000 per person month will be required. The total will be US\$15,000 x 6 = \$90,000. This amount will be shared between USAID and INTRA/Washington account; each meeting US\$45,000. Other inputs will be from MOH and World Bank.

And finally the TOF courses will be jointly supported by USAID/MOH/INTRAH. Two four week curricula development/TOF courses will be held in Year I and six two-week refresher staff development workshops will be supported from years 2-7. An average of 25 participant will be trained per course. In Year I INTRAH/Kenya will support consultant and book costs estimated at \$10,000 MOH will support costs of accommodation and transport \$18,400 and USAID will support materials and supplies at \$10,000. In the following years MOH and participating NGOs at 30% will support \$7,300/yr (FY86 dollars) total 43,800 in transportation and accommodation, USAID will support \$4,700 (\$28,200 total) for supplies and central funds will support 4 p/w TA and books \$15,00/yr. (\$90,000 total).

ANNEX E.3. FPSS: VOLUNTARY SURGICAL CONTRACEPTION

I. PURPOSE AND SUMMARY DESCRIPTION: The purpose of expanding the availability of voluntary surgical contraceptive services in Kenya is to enhance the well being of Kenyan families by reducing the rates of maternal and infant mortality and morbidity. A secondary purpose is to allow all Kenyan families the opportunity to choose a safe and effective permanent method of family planning if they so desire.

USAID studies suggest that probably 2000 women died in Kenya in 1984 in childbirth or due to childbirth. Most of these are older women with six or more children. Many of these deaths and tragedies to these large families could have been avoided if safe and affordable tubal ligation services had been more readily available. Further, most of the 90,000 infants who die in Kenya each year are born to older women of higher parity.

This component of this Kenya family planning project describes a plan to make voluntary surgical contraception services available to 250,000 couples by the year 1992.

The components of the effort to expand services include training for physicians, nurses, midwives, community workers and counselors; equipment and supplies to up-grade facilities; program and medical management, technical assistance and financial support to offset some of the costs in providing quality services for individuals who cannot afford the full cost of surgical contraception.

II. BACKGROUND: The 1984 Contraceptive Prevalence Survey suggests that the number of women in Kenya who have elected tubal ligation (TL) has risen from negligible in 1977 to almost 30,000 by 1984. This very large increase is quite plausible based on interviews with surgeons and leading Ob/Gyn specialists. At least 125 physicians are estimated to have completed some training in this simple surgical skill in Kenya over the past few years. An informal reckoning of the number of procedures being provided during 1984 at the main clinic facilities in the country totals to over 5000, including the private sector; thus the total number of procedures could be as many as 9000 this year.

Over the past five years AID has assisted the University of Nairobi, the Family Planning Association of Kenya and numerous reproductive health specialists. The assistance has included: training in modern surgical procedures, client counselling, clinic management, information networking and program safety surveillance, and provision of some equipment. AID has also assisted in training and information for the diagnosis and treatment of infertility.

The growing popularity of fertility termination services is also illustrated by the great interest shown recently by public and private sector surgeons and clinics. During a one-month visit by officers of the Associations for Voluntary Surgical Contraception in July, 1984, many institutions exhibited

commitment and developed proposals for: setting aside or establishing operating theaters for VSC; committing surgeon/nurse teams to regular time/sessions for VSC clients; completing training in modern mini-laparotomy and laparoscopy techniques; and producing plans to establish low cost services. The AVSC was unable to respond to all of the requests for assistance. USAID expects that bilateral assistance to Kenya in all of the above VSC activities will increase during the next few years.

Kenya's first national conference on reproductive health and surgical contraception in August, 1984 was heavily attended by Kenyan surgeons and family planning professionals and constituted the first time that sterilization as a term was used openly in professional discourse (according to the conveners).

AVSC has provided support to increase VSC service sites from six in 1984 to 20 in 1985. AVSC is supporting a training program in mini-laparotomy with local anesthesia and workshops for training rural midwives in information, education and communication and VSC counseling. JHPTEGO supports a Training Program for physicians and nurses in endoscopy and mini-laparotomy coordinated by the Medical School at the University of Nairobi.

The primary implementing agencies are the Family Planning Association of Kenya, the Ministry of Health and the Protestant Churches Medical Association in Kenya.

NGO SECTOR: The Family Planning Association of Kenya (FPAK) provided over 1,000 clients with VSC services in 1984 and will serve over 2,000 in 1985. They trained 20 physicians in minilap with local anesthesia in 1984 and, in 1985 will train 30 physicians. Twenty nurse/midwives will be trained in information, education and VSC counseling and 50 field educators are oriented to VSC outreach and information and education each year.

FPAK will operate 5 service delivery sites in 1985 and 7 sites in 1986. The current administrative team is well organized and they have demonstrated the ability to develop and implement quality service delivery and training programs.

The Mkomani Harambee Clinic in Mombasa will serve about 500 VSC clients in 1985.

PUBLIC SECTOR: Ministry of Health hospitals have been providing VSC services over the past few years. Kenyatta National Hospital provided over 100 clients with VSC services in 1983 in its JHPTEGO training program and the KNH maternity theater. The provincial hospital in Nyeri will serve over 400 clients in 1985 and Pumwani hospital Nairobi will serve over 800 clients this year. The Nyeri Provincial General Hospital and Pumwani

Hospital projects are supported by AVSC. A number of additional MOH hospitals are providing VSC services and have requested assistance to expand their facilities to meet the waiting lists of 6 months to one year.

Over the past five years KHH, with JHP/IEGO assistance has trained 30 gynecologists in endoscopy, 78 physicians and 90 nurses have attended update courses in reproductive health and 32 nurses and physicians attended equipment workshop.

The primary barriers to expansion of VSC services is the fact that the personnel and facilities of many EGH hospitals are already over extended in providing curative services. Minor surgical theaters need to be established or up-graded in all EGH hospitals that have waiting lists for VSC services. The proposed World Bank project should alleviate the problem of inadequate facilities. The equipment needs can be met by AVSC with bilateral funds, USAID/Nairobi can utilize bilateral funds to maintain needed supplies, support for quality information, education and counseling services as well as financial management of the resources.

MISSIONARY HOSPITALS: Many of the member hospitals of the Protestant Churches Medical Association (PCMA) are also providing VSC services. Tumu Tumu Hospital provided services for about 500 clients in 1984 with support from Family Planning International as assistance. Four other hospitals serve between 200 and 250 clients per year and all could provide more services with support. The main barrier to expanded services has been inadequate facilities and the need, in most cases, to charge client fees that have prohibited clients from coming for VSC.

The AVSC project beginning May 1, 1985 should alleviate the barriers. Equipment and minor renovations are provided where needed and 9 hospitals will receive subsidies to offset costs in serving clients who cannot afford the full fee.

The PCMA is developing a central management team. Initial indications are that the central management will have the capability to handle expanded programs.

PRIVATE SECTOR: Expanded services in the private sector is the least developed part of this project. The main barrier to services has been fees averaging from KSh. 1,000 to 4,000 per client (US \$60 to 240). The FPPS project, assisted by John Snow and AVSC are holding discussions to develop a plan for up date orientation to minilap with local anesthesia, and a mechanism to certify the competence and facilities of participating clinics is being developed.

FPPS has demonstrated its ability to administer a multi-site family planning program and its administrative capacity could be expanded to incorporate private sector physicians in providing low cost VSC services. AVSC would provide technical assistance medical consultation and equipment.

ANNEX E.4. Rural Community Based Service Programs

I. PURPOSE AND SUMMARY DESCRIPTION: The purpose of Community-Based Primary Health Care (CBPHC) is to increase awareness of the benefits of modern methods of preventive health, to encourage use of modern family planning methods, and to make supplies and other services conveniently accessible to all couples. This component of the Family Planning Services and Support (FPSS) Project aims to expand the access of rural and urban poor to family planning and other simple preventive health services by drawing upon Kenya's extensive network of community development organizations. Local residents are the key to CBPHC programs, usually mature women who volunteer to lead and serve their neighbors, friends and kinfolk. Limited objectives, stress on basic skills, a supportive supervisory network and a reliable supply system are the essential elements of CBPHC.

By 1992 at least 15,000 volunteers and 2,000 supervisors and administrators could be providing non-clinical fertility regulation and other primary health services to as much as 75% of Kenya's rural population (over 3,000,000 couples), especially to those younger couples whom the private sector and Government clinical systems do not reach easily. Based on recent extensive experience with prototype systems, by 1992 more than 500,000 couples could be utilizing oral contraceptives, condoms, and spermicides to delay or space births through free or low cost community level services.

II. BACKGROUND: For those who could afford the costs, family planning services in Kenya have been available for over 20 years in Nairobi and Mombasa -- more recently in other large towns. For the 80% of Kenya's population who live in rural dispersed homesteads, access to accurate information and quality CBPHC services currently is limited by under-utilization of existing local community development groups and their leadership. False information about side effects to modern contraception and other health measures is common in the traditional cultures of rural Kenya and constitutes a serious constraint to wider adoption of better preventive practices. Probably 50% of the population live in households with very little disposable income, unable to afford private sector preventive health services (even if they were available).

Studies of survey and program data suggest that while use of modern methods of family planning has increased significantly in urban areas, knowledge and use of FP methods is only beginning to reach rural areas. In 1978, the Kenya Fertility Survey showed that rural women on the average could expect about 10 pregnancies, while urban women could expect about 7 pregnancies.

During the past two years, however, pilot programs in a variety of rural areas have shown that interest in and demand for fertility regulation information and supplies is considerable. Table 1 summarizes information on these pilot projects. From almost none four years ago, by 1985 probably 1.1 million rural population (about 170,000 families or 7% of Kenya's total rural population) are now afforded access to information and services about preventive health, including family planning, by members of their own communities.

In a relatively short time and with good efforts by only a few medical doctors, nurses, administrators, and about 850 volunteer community health agents (mostly part-time) in approximately 28 rural locations provided the equivalent of an estimated 48,000 couple-years protection in 1985. This translates overall into about 20% of all the fertile aged couples in project areas. In the Chogoria area, about 30% of all couples in a population of at least 250,000 people are currently practicing some form of birth planning, four years after this (the first) CBPHC project began. It seems warrantable to infer that over the long term under average program circumstances at least 20% of rural couples would use CBPHC fertility regulation services if they were accessible.

USAID records on the eight programs shown in Table 1 suggest that over \$600,000 were spent in 1985, including some of the foreign technical assistance on these projects. These data suggest that average costs for a standard couple-year protection (CYP) were on the order of \$12 - \$13, compared to an estimated \$20 or more per CYP in the larger GOK program (See FP Strategy Paper).

TABLE E.4.1. 1984/85 CBD PROGRAMS

| | <u>No. of Loc't</u> | <u>No. of Div.</u> | <u>Est. Pop. Size(000)</u> | <u>No. of Agents</u> | <u>Est. CYP (000)</u> | <u>Est.(\$) Costs</u> |
|---------------|-------------------------|------------------------|--------------------------------|--------------------------|---------------------------|---------------------------|
| 1. FPAK | 2 | 2 | 80 | 30 | 3 | 100 |
| 2. MYWO | 2 | 2 | 75 | 75 | 3 | 80 |
| 3. PCMA | 5 | 2 | 250 | 250 | 15 | 75 |
| 4. CORAT | 10 | 8 | 350 | 350 | 15 | 250 |
| 5. SARADIDI | 2 | 1 | 20 | 15 | 1 | 25 |
| 6. KARACHUNYO | 2 | 1 | 130 | 100 | 4 | 20 |
| 7. KAWAKWARE | 1 | 1 | 30 | 10 | 1 | 10 |
| 8. MACHAKOS | 4 | 2 | 150 | 20 | 6 | 50 |
| | <u>28</u> | <u>19</u> | <u>1,100</u> | <u>850</u> | <u>48</u> | <u>610</u> |
| | ===== | ===== | ===== | ===== | ===== | ===== |

Average of about 160 families per volunteer

Several types of organization now have demonstrated capacity to organize and deliver CBPHC services: (1) both the Kenya (Roman) Catholic Secretariat (KCS) and the Protestant Churches Medical Association (PCMA), each with direct access to literally thousands of local community groups; (2) MYWO women's organization with over 12,000 active local groups registered; (3) FPAK with its provincial and district officers throughout most of the populous parts of the country; and, (4) the MOH with its extensive network of over 1100 clinics, sub-clinics and

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dispensaries spread over rural Kenya. Recently GOK social worker leaders have participated in orientation and planning workshops, part of a long-term GOK strategy to place these people (several thousand nation-wide) at the service of local CBPHC programs.

President Moi and Vice President Kibaki on several public occasions during the past year requested that national organizations of local community groups (specifically citing MYWO) take up family planning as a core responsibility. MYWO leadership has accepted the challenge, as have the other groups above; all are currently expanding their CBPHC activities at a rapid rate, constrained mostly at this time by limited funding availability and the limited number of skilled persons available for District-level training of volunteers and management personnel. As Minister for Home Affairs and leader of the MCPD, the V.P. has invited USAID's assistance in this area.

In Kenya a struggle is taking shape over further extension of women's legal rights, perhaps especially related to "rights in reproduction," polygamy and marriage laws. The issues are very tough ones in the context of customary laws and the mixed legal system that governs adjudication of rights. CBPHC programs directly benefit women and enhance their personal choice and reproduction rights. This is no doubt one reason the programs have proven to be quite popular at the local level.

Given current and anticipated rural household income levels among a large portion of the population to whom this component is addressed, cost recovery from service consumers will be limited, consisting mainly of informal reciprocities between the volunteer agents and their clients. GOK budgets will have to support most local level recurrent costs. However, indications are that CBPHC is a cost-effective and effective modality for family planning delivery in Kenya.

ANNEX E.5. SUBSIDIZED COMMERCIAL MARKETING OF CONTRACEPTIVES

I. BACKGROUND: In the early 1970s, Population Services International established a local organization in Kenya to conduct a pilot contraceptive social marketing program in Kenya with support from AID. The Kinga project, located in Meru district, distributed and promoted condoms through the retail distribution system. The program was closed down after the first year of sales due to adverse reaction from local leaders and the press. The demise of the Kinga program was instructive and has provided guidance in planning this new effort. USAID and the COK leaders agreed on two principals: the program would be purely Kenyan, and would not encourage strong advertising during the early stages of the program. Today a broad consensus exists that the time has come for a renewal of efforts to engage the commercial marketing systems in Kenya on behalf of the overall family planning effort.

In 1982 and 1984, consultants sponsored by the International Contraceptive Social Marketing Project (ICSMP), a USAID centrally funded cooperative agreement, explored the feasibility of developing a CSM program in Kenya. The consultants found the prospects for developing a commercial marketing program in Kenya were good. The marketing infrastructure is strong, the commercial sector is interested in the program, and there appear to be no restrictions on the sale of contraceptives which would prevent a SCMC program from being developed. All of the well known brands of orals, condoms and spermicides are presently sold in the commercial setting, although the price tends to be high relative to disposable income.

On 9 May 1985, NCPD held a one day meeting with the commercial marketing sector to informally gather their thoughts about how a CSM program in Kenya should be organized and structured. The recommendations from the meeting were to establish a private organization under the companies act with the approval of the government. Representatives from twenty-two companies attended. This included British American Tobacco; The Boots Company; East Africa Industries Limited; Phillips, Harrisons & Crossfield Limited, Johnson's Wax East Africa Limited, Johnson and Johnson, etc. A high degree of interest and support was expressed by the participants at the meeting.

II. DESCRIPTION: The subsidized commercial marketing (SCM) component will increase the availability and accessibility of modern temporary contraceptive methods by marketing them at an affordable price to the consumer through retail outlets nationwide. Demand for contraceptives will increase with low key specially designed promotion and advertising efforts.

Although there may be a limited amount of product substitution in the initial stages of the SCM project sell in, it is anticipated that the overall market for modern contraceptives will expand during the life of the SCM component. This is due to the fact that brand specific advertising will be designed to reach a select target audience yet it will have an overall impact on stimulating an increase in demand for modern temporary contraceptive methods.

There are a number of constraints which will impact on the component's ability to achieve its goals and objectives. First and most important is the establishment of a new organization in the private sector which operates independently but with the approval of the government. It is expected that NCPD will formally endorse this arrangement within the next two months. Agreement on product procurement, registration and pricing by the GOK will have a direct impact on timely implementation and product launch. An attorney will be hired to collect information on laws and regulations pertaining to these factors and the issues will be addressed in the marketing strategy.

Particularly important is authorization to extend ethical products beyond the pharmacy. Without this authorization, there will be a delay in supplying contraceptives to the consumer. The result of demand creation effort without adequate product supply is a frustrated consumer who has a negative impact on the program. Special programs to train and license retailers in a responsible program can be designed to refer consumers back to the medical community for services as necessary. USAID will make every effort to overcome these obstacle which frustrate the consumer.

An agreement between the donor, the NCPD and the implementing organization must be completed which specifies how the revenue generated from the sale of products can be used. The amount of revenue to be generated from the sale of contraceptives will be limited. Products will be priced at a level that the target audience (C and D classes) can afford. Nevertheless, the revenue will be maintained in a separate account and used in the later years of the project in accordance with the terms set forth in the revenue agreement. All of these constraints are common among CSM programs and are taken into account as the program develops its marketing plan, advertising strategy research protocols, and distribution methodology.

The component will provide 594,000 cumulative couple years of protection (CYP) over the life of the project. It is anticipated that this project component will provide approximately five percent of the overall CYP under the FPSS and will reach 10% of the target SCM market (as shown in Table 1). The target market is estimated to be 955,000. In year one of project sales, it is estimated that 4 percent of the market, a total of 38,000 users can be reached. By the sixth year of product sales, it is estimated that 10 percent of the target market or 100,000 users, will be reached by the program. The number of outlets selling contraceptive will increase to approximately 5,000 and the type of outlets (e.g. bars, kiosks, dukas, etc.) carrying products will expand. Thus, the number of hours that contraceptives are made available on a daily basis will be substantially increased. These results will be verified through the component internal, automated management information system and through marketing research efforts.

The component inputs include funding for the local operating and marketing costs total about \$8 million over the project period. Funding and technical assistance will be provided by SOMARC, Social Marketing for Change, a centrally funded contract with the AID Washington's Bureau of Science and Technology. Technical assistance will support project start up, marketing

management, communication, and research and commodity logistics. Technical assistance will consist of 31 person months for a total of \$372,000.

Contraceptive commodities totaling \$1.8 million, consisting of 4,305,000 total cycles of oral contraceptives, 8,868,000 condoms, and 5,925,000 vaginal foam tablets are projected (See Annex E.1., Contraception Requirements). These will be purchased under FPSS (with purchases from other donors also expected, especially ODA) and consigned to the SCM organization. Although the program is not expected to be self sufficient, revenue from the sale of contraceptives is estimated at \$2,500,000 by the end of the project. This revenue will be used for SCM operating and marketing costs, salaries, and/or special initiatives. Funding from other donors and or Kenyan philanthropic organizations may provide the support necessary to carry the component forward. It is not expected that the GOK will be expected to pick up the costs of this component at the end of the bilateral.

III. IMPLEMENTATION ARRANGEMENTS: A new private organization will be created to implement the SCEC program. This organization will be Kenyan owned and managed. The organization will issue tenders and contract with commercial marketing resources in Kenya to carry out the research, advertising, promotion, distribution packaging and warehousing activities. Staff will be recruited to manage and supervise the primary marketing and management functions. Salary levels and benefit packages will be compatible with the commercial sector so that qualified and experienced professionals will be attracted to the program and new organization.

It is envisioned that the organization will have a Managing Director, Marketing Manager, Sales/Product Manager, and a Financial Manager. This organization will be located on its own premises outside of the government or NGO facilities.

A Board of Directors will be selected to provide overall guidance and oversight for the project. USAID will strongly recommend that the composition of the board be senior executives in the private sector, with representatives from NCPD, FPAK and possibly the MOH. The new organization will be approved by the GOK/NCPD and operate with their support and concurrence, coordinating its activities with the NCPD as appropriate.

Initially the component will market three contraceptives: orals, condoms, and vaginal foam tablets which will be donated by USAID and possibly by ODA. The products will be of high quality and be packaged differently than those provided to government and NGO programs. The products will be registered with the GOK by the manufacturer with the assistance of the new organization. Contraceptive and health related commercial products can be added to the product line (e.g. Norplant, IUD, Oral Rehydration Therapy) if their target market is other than an existing private sector market and if their revenues support the original program objective of increasing contraceptive use.

Each of the elements of the marketing mix will be organized and coordinated through the development of a marketing plan. This plan, to be developed by the managing director and the staff, will guide the decision making process and activities to be undertaken during project start up, pre-launch and launch phases. Products will be overpackaged and branded. Package designs and name brands will be selected through marketing research. Package designs and name brands will be registered in accordance with the GOK regulations. Packaging activities will be contracted out to a qualified supplier.

Product price levels will be established at a level that the target audience can afford and at a level to attract wholesalers and retailers to stock the products. The price structure will be compatible with commercially accepted margins for consumer and ethical products. The sales/product manager will develop incentives to complement the product price which will attract the wholesale and retail market.

The marketing manager will work with the selected advertising agency to develop an advertising and promotion strategy for the program and the products. Advertising and promotion efforts will combine mass media (print and broadcast) and interpersonal communications. The media strategy, media mix and placement will be based on listenership patterns of the target audience. Development of advertising concepts and messages will be based upon findings from qualitative and quantitative research efforts with the target audience. Pretesting (although it is not typically done in Kenya) and post testing efforts will be carried out to ensure that the message is culturally acceptable, comprehensible, and effective in responding to information needs of the target audience. Brand and method specific information will be provided through the media. Point of purchase materials will be designed to stimulate sales and product awareness.

Special promotion and public relations efforts will be devised to reach select segments of the target market, including opinion leaders, influentials, providers, retailers and current and potential contraceptive users. This will include the development of an uplifting program which is designed to move the products from the wholesaler to the retailer with a heavy emphasis on product promotion, shelf placement, and point of purchase materials.

The sales/product manager will work with the selected distribution firm(s). Condoms and vaginal foam tablets will be distributed through the wholesale level to consumer retail outlets (e.g. bars, kiosks, dukas). Oral contraceptives will be distributed through pharmacies and licensed outlets.

A special program will be designed to train retailers in selected retail outlets to effectively screen, counsel potential consumers for oral contraceptives and refer individuals to the medical community when necessary. Local consultants supported by outside technical assistance will design and conduct this program. The results of the program will be monitored for effectiveness.

A marketing research protocol will be developed to identify the marketing decisions which must be made. The marketing manager will work with the research supplier to design and conduct the quantitative and qualitative research on the consumer, potential consumer and retailers. Marketing research findings will be used to making decisions on product positioning, image, benefits, package design, name brand selection, promotion and advertising messages.

The new CSM company, created to implement this project component, will operate under a contract with SOMARC for the first four years of the bilateral. USAID/Kenya will pick up the component under the bilateral in year five. USAID/Kenya will purchase the contraceptives for all years of the project. ODA will contribute contraceptives and funding for its product line. SOMARC will provide technical assistance to the NCPD and the new organization. Technical assistance will be to manage the funding from AID/Washington; contraceptive registration, ordering, procurement, and shipping; as well as support for developing the internal procedures, and marketing strategy.

IV. ADMINISTRATIVE ANALYSIS: Kenya has a strong private sector marketing infrastructure. There are many multinational and local organizations distributing consumer and ethical products, as well as supplying advertising, promotion, research and packaging services.

International experience has shown that the most efficient, cost effective CSM programs are located outside of the government, but operate with their concurrence and support. Government organizations burdened with bureaucracy, are not able to respond quickly to changes or opportunities in the market place, nor are staff with the requisite skills and experience working in the government.

Private local organizations, e.g. FPAK, do not have institutional objectives that are compatible with those of a social marketing program. These existing organizations generally have not worked with the commercial marketing infrastructure, as a result, tend to be suspicious of the commercial marketing organizations. It is essential that the SCM organization have the ability to recruit experienced marketing professionals and that the organization be allowed to operate effectively in the market place.

TABLE E.5.1. CALCULATION OF CSM TARGET MARKET

| | | |
|--------------------------|---|------------------|
| TARGET AUDIENCE | | 3,500,000 |
| "E" Class (50%) | - | <u>1,750,000</u> |
| | | 1,750,000 |
| 9% current users | - | <u>157,500</u> |
| | | 1,592,500 |
| 40% want to get pregnant | | <u>637,000</u> |
| TARGET MARKET | | 955,500 |

TABLE E.5.2. MARKET PENETRATION

| | | <u>Base</u> | <u>Escalated @ 4%</u> |
|--------|-------|-------------|-----------------------|
| Year 1 | - 4% | 38,000 | 38,000 |
| Year 2 | - 6% | 57,000 | 59,000 |
| Year 3 | - 8% | 76,000 | 79,000 |
| Year 4 | - 9% | 86,000 | 89,000 |
| Year 5 | - 10% | 96,000 | 100,000 |
| Year 6 | - 11% | 105,000 | 109,000 |
| Year 7 | - 12% | 115,000 | 120,000 |

* Product use assumptions: 70% ORAL
 15% CONDOM
 10% VAGINAL FOAM TABLETS

TABLE E.5.3. CSM PROJECTED PRODUCT SALES

| YEAR* | <u>ORALS</u> | | <u>CONDOMS</u> | | <u>VAGINAL FOAM TABLETS</u> | |
|--------|---------------|-----------|----------------|-----------|-----------------------------|-----------|
| | TARGET MARKET | NO. UNITS | TARGET MARKET | NO. UNITS | TARGET MARKET | NO. UNITS |
| YEAR 1 | 26,600 | 346,000 | 5,700 | 712,000 | 3,800 | 475,000 |
| YEAR 2 | 41,300 | 537,000 | 8,850 | 1,106,000 | 5,900 | 738,000 |
| YEAR 3 | 55,300 | 719,000 | 12,000 | 1,481,000 | 7,900 | 988,000 |
| YEAR 4 | 62,300 | 810,000 | 13,350 | 1,669,000 | 8,900 | 1,113,000 |
| YEAR 5 | 69,300 | 901,000 | 14,850 | 1,856,000 | 9,900 | 1,238,000 |
| YEAR 6 | 76,300 | 992,000 | 16,350 | 2,044,000 | 10,900 | 1,363,000 |
| YEAR 7 | 84,000 | 1,092,000 | 18,000 | 2,250,000 | 12,000 | 1,500,000 |

CALCULATIONS: PILL 13 cycles/year
 CONDOMS 125 units/year
 VAGINAL FOAM TABLETS 125 units/year

* YEAR in left column refers to sales year, not year of project funding.
 Sales are anticipated to begin 12 - 18 months after project start up.

ANNEX E.6. OVULATION AWARENESS FOR PERIODIC ABSTINENCE

I. PURPOSE AND SUMMARY DESCRIPTION: The purpose of this project component will be to increase the understanding and use of Ovulation Awareness (OA) to promote periodic abstinence for those persons who find that other methods of family planning are incompatible with their beliefs. The FPSS support is to assist IFFLP, KCS and FLCAK to test the feasibility, effectiveness and cost-effectiveness of intensive, optimally designed OA programs, as prototypes for potential expansion.

II. BACKGROUND: Following several years of OA pilot efforts by KCS and FLCAK, both agencies submitted separate OA services proposals to IFFLP who then refined the proposals and prepared draft sub-contracts. In May 1984 a consultant team from Family Health International (FHI) visited Kenya to: assess the current status of OA services in Kenya; assess the potential for training, research and expansion of OA services; and to submit recommendations. A report of their visit was prepared in June 1984. In response to this report, KCS submitted to USAID in November 1984 a five year proposal aimed at expanding OA services over all of Kenya, and FLCAK submitted to USAID in December 1984 a proposal for opening twelve regional centers and expanding their Tutors Training Program in four provinces of Kenya over a three year period.

In December, 1984 IFFLP was asked if they would be willing to be considered as an intermediary to fund these two proposals and to provide technical assistance to a coordinated effort to expand and develop a national OA program for Kenya. In response to this inquiry the Executive Director of IFFLP visited Kenya in late January for preliminary discussions with KCS, FLCAK and USAID. Following PID approval, the Executive Director returned to Kenya in April 1984 to refine the two proposals in light of the proposed project purpose and level of funding.

All AID previous experience with OA services have all been centrally funded with the exception of some IFC support provided to KCS in the Family Planning II Project (615-0193).

III. DESCRIPTION: The overall OA component is divided into three complementary parts as follows:

(a) Coordination, monitoring and consultation will be supplied by IFFLP as the OA component CA. Its function will be closely coordinated between a small field office in Kenya and the International IFFLP Secretariat's office in Washington, D.C.

(b) FLCAK will develop a high quality training program for ensuring competency-based OA tutor training services for both new OA and existing OA tutors in Nairobi and Central Province of Kenya. The tutors' tasks will include, but are not restricted to: (1) Training new OA teachers recruited from any agency within the districts in the two provinces and maintain quality control of new teachers with six to eight month supervisions of OA teaching services; (2) Evaluating and providing continuing education for existing OA teachers in each of the two provinces, and (3) Supervising existing OA teaching services to evaluate (with local agencies) the service centers most appropriate for placement and supervision of new OA teachers.

FLCAK will establish two provincial OA tutors/supervisors centers and provide them with educational resources used for continuing education, materials for teaching clients, e.g. the WHO learning package, thermometers, sympto-thermal and ovulation method charts, record keeping forms and classroom(s) for both client teaching and group conferences for practicing teachers.

will also establish an OA medical consultation service in the two provincial for backup of problem follow up; coordinate and develop core education and standards with IFFLP; train tutors for GOK and other NGOs interested in developing their own OA programs (on a contractual basis); expand the six week OA teacher training with opportunities for supervised practicum for nurses and health professionals at Mater Misericordiae Hospital, with trainees being recruited from both GOK and other NGOs interested in OA; and, compare the efficiency of a tutor center with transport subsidies, and one with that of a vehicle.

(c) KCS will expand the educational, service and coordinating capabilities in OA and family life education of its ongoing program throughout the Catholic diocese of Meru and Kakamega of Health and Education agencies including the parishes as the most immediately available community organized structures for OA services.

KCS will expand their existing OA services in Meru and Kakamega diocese to improve their OA reporting systems. Also, KCS will strengthen its administrative, coordinating, training and consultation capabilities both at the national and diocesan levels to identify priority needs requiring planning and implementation assistance to improve their efficiency in both outreach and services to better meet increasing needs. Further KCS will develop their own applied research capabilities to various facets of OA and its training and service delivery to safeguard a certain degree of autonomy and flexibility in services both at the national and diocesan levels.

USAID/Kenya will issue a PIO/T to buy into the existing IFFLP AID contract and then IFFLP will enter into sub-agreements with both KCS and FLCAK. IFFLP will then formally assign a Kenyan officer (already identified). The following actions will be required:

- | | |
|---|---------------|
| 1. PIO/T to obtain IFFLP services prepared | August 1985 |
| 2. IFFLP signs sub-agreements with KCS and FLCAK | October 1985 |
| 3. IFFLP engages Nairobi representative | November 1985 |
| 4. National OA Advisory Council formed | January 1986 |
| 5. Kenya delegates attend IFFLP 4th International Conference | June 1986 |

IV. ADMINISTRATIVE ANALYSIS: IFFLP is a small non-profit private organization established in U.S.A. in 1978 as an international association of mostly Roman Catholic laity organizations collaborating in the promotion of modern methods of "natural family planning (NFP)". The IFFLP now has over 130 members in over 75 countries. It conducts workshops and provides technical assistance for establishing NFP demonstration projects. IFFLP in 1983 received funding from 15 organizations, including AID (largest supporter) WHO, CIDA, FPIA and FHI. Its office consists of a

full-time Executive Director, and a few support staff. It administers sub-grants under its Cooperating Agency agreement with AID/W. The IFFLP will engage an accountant in 1986 to expand its administrative capacity which is deemed necessary in order to fulfill growing responsibilities including those envisioned under the proposed "buy-in" by the USAID/Kenya FPSS.

GOK and USAID/Kenya lack technical expertise to adequately assist and monitor FPSS support for expanded teaching of methods of OA, but are committed to expanding access to these methods. For this reason a qualified intermediary is required. USAID knows of no other organization than IFFLP with a proven capability to provide assistance who -- at the same time -- is not committed to criticism and undermining other elements of a secularly-oriented family planning program.

KCS is the largest non-governmental agency administering hospitals and clinics in Kenya. By some estimates, KCS has for years provided about 30% of total health services through its 30 mission hospitals and 250 medical centers in all areas of the country. The background assessments suggest that KCS has excellent, demonstrated capacities to implement the proposed FPSS project activities.

FLCAK was established in 1977, and is mainly a loose association of Catholic lay medical doctors and nurses who promote NFP. FLCAK administrative capacities are quite limited but will be strengthened under FPSS. Historically, FLCAK has taken extremely restrictive positions on issues regarding informed choice about family planning methods, -- a quasi-administrative (and legal) issue which could prove difficult under AID support. USAID and IFFLP will monitor FLCAK teaching and training to assure compliance with USG regulations for use of AID family planning resources.

ANNEX E. 7 INFORMATION AND COMMUNICATION

The demand for family planning services will be increased through the following activities:

1. NCPD Staff development, planning and evaluation:

The project will strengthen the IEC division of the NCPD by providing financial support for the contracting of 4 production consultants to assist the IEC division to manage contracts for media and materials production. NCPD core staff and consultants will then receive in-service training in communication planning, leading to the joint development of a detailed Kenyan master plan for the Interagency Information and Education Program. The modality for developing a comprehensive plan is a series of workshops at the national, provincial and district level. All of the agencies whose efforts the NCPD is charged with coordinating will participate in the workshops in order to develop a strategy and management plan with maximum coverage of the entire population. The output of the workshops will be a detailed national IEC strategy and workplan for the outreach activities of the various participating agencies as well as a plan for the production and utilization of the media products described below. The plan will also provide a basis for evaluation of the national IEC program after two years.

2. Media product development:

The majority of the assistance in IEC is for the development of media products.. To date, despite the existence of a clear population policy for nearly twenty years, there has been little use of the mass media in support of population objectives. To mobilize all channels of the mass media in support of population programming this project will support -over a two-year period- the planning, producing, and evaluating of a full range of media products. Such a major program of mass media promotion of family planning would have been impossible in Kenya before the recent past. Now the political leadership is not only willing but is actively pursuing mass media coverage of family planning. The media products to be developed include:

(a) Television. A "social drama," patterned after the successful Mexican experience of the mid-1970's. Support is provided for a total of 80 episodes to be produced and broadcast over two years. Though television's audience is primarily urban and presumed to be no more than 25% of the total population, the audience is made up of influentials who in turn reach other segments of the rural population. Technical assistance will be provided for the planning and production of the television dramas

(b) Radio Social Drama. Like the television social drama, this activity would provide support for 160 episodes of a radio drama in Kiswahili. Both the television and radio dramas are to be preceded by a field research, the primary purpose of which is to collect information which can be used to establish the themes and objectives of the series.

(c) Regional radio series: Focus on men. A two-year series of programs to be broadcast in regional languages focusing on the need for men to participate in and support family planning. The plan to develop a regional radio series targeted at men was specifically requested by the Vice President, who opened the workshop on using radio for population communications.

(d) Film production (approximately 6) Kenya currently has no locally produced films in Kiswahili which can support family planning motivation efforts. There is need to produce specially scripted films for use by fieldworkers, at barazas, for distribution by mobile vans of the MOH, MOIB, and for broadcast by VOK where appropriate. Although suggested messages and technical specifications were developed for these films in December, 1984, the IEC Division of NCPD should make the final determination of the messages in the context of the new master plan.

(e) FPFS Project IEC support. NCPD recently requested support by USAID of a subproject for IEC materials development to be managed by the JSI/FPFS project. Its major output would be the provision of printed materials for the service network reached by the FPFS project and made freely available throughout the organized formal private sector of factories and plantations. Much of the promotional material produced under this subproject will be of general application in the GOK's communication program.

(f) Print materials. At present, there are very few print materials on family planning methods, benefits, and side effects. An annual allocation of \$40,000 for each year of the project is required for print materials. These will focus on pretested, national and regional language pamphlets, posters and flipcharts depicting methods, benefits, and side effects. A production and distribution plan will be developed by NCPD, MOH and selected NGO's to ensure that appropriate materials are developed for the target audiences. The principal target audience for these materials will be rural couples of reproductive age, and youth. Portions of this allocation may also be used for NCPD brochures and newsletters as well as for materials for specialized target groups such as pharmacists.

3. Continuing Support to NGO's

This is the major focus of interpersonal communications financed through the project. \$1.7 million is budgeted for support of IEC activities of the four NGO's supported by USAID through the NCPD in FP II. They are: The National Council of Churches of Kenya, the Protestant Churches Medical Association, the Family Planning Association of Kenya, Mwendeleo ya Wanawake, the Kenya Catholic Secretariat, and the Salvation Army.

The NGO's with a collective extension network of staff and volunteers are a vital part of the national family planning program. A major contribution of the NGO's is the delivery of the family planning message to rural areas from a variety of credible sources. Working through local leadership and church leadership, the NGO's add considerable credibility to a message which must come from other sources than government or health practitioners alone.

ANNEX E.8. MOH: INFORMATION, PLANNING AND REPORTING SYSTEMS

I. PURPOSE AND SUMMARY DESCRIPTION: The Information and Planning Systems for Health and Family Planning (IPS) component of the Family Planning Services and Support (FPSS) Project will strengthen the capacity of the Ministry of Health to plan, implement and evaluate the Primary Health Care (PHC) network at the national, provincial and district levels. This component will strengthen collection, analysis and rapid feedback of information required by communities and decision-makers for evaluating, planning and implementing the delivery of health and family planning services in the public and private sectors. Strengthened planning and management capabilities of up to 750 officers within the Ministry of Health and District Development committees will lead to more effective and efficient health services. FPSS will support training of up to 200 health personnel at the district level in the analysis and use of information for better budget planning for local programs and services. Members of the District Development Committees require information about health and family planning services to monitor progress and problems. This information is forwarded to provincial and national level MOH offices and is used for budget, management and administrative decisions. IPS will assist MOH to have the most timely and best quality data feasible. In addition, a system of targeted family planning data will be developed allowing family planning data to pass in a timely manner to the National Council on Population and Development and hence to the cabinet and Office of the Vice President.

The IPS component of MOH plans is estimated to total \$8.7 million over the three years, January, 1986 to December 1989. FPSS will finance \$3.9 million over the period.

II. BACKGROUND: In 1978-79 the GOK requested assistance from USAID to strengthen its institutional capacity to plan and implement Health Sector Programs and Policies intended to facilitate better programming, more efficient use and more equitable distribution of health sector resources. The purpose was to expand health services delivery to rural populations. USAID and the Government signed a Grant Agreement in 1979, initiating the Health Planning and Information Project (HPIP; 615-0187).

The original project design was based on what then appeared to be the appropriate timing and phasing of USAID inputs, taking into account the GOK's absorptive capacity. The project has focused on headquarters, provincial and district institutional structures. However, the design also envisioned possible expansion of the project.

Given the successes thus far achieved in the HPIP Project, the timing is appropriate to enlarge the project to provide expanded delivery of Primary Health Care and Family Planning Services in the rural areas using both public and private delivery mechanisms. The Government's policies programs and resources have improved considerably over the past four years, such that expansion of the scope of the original project is warranted at this time.

In 1982, the Presidential directive made districts the Focus for Rural Development in all sectors. This directive provided official sanction and support for broad based local level participation in the planning and delivery of preventive and promotive rural health services. The GOK five-year Development Plan (1984-88) and the Development Budget, and Government Policy clearly focus on preventive approaches which emphasize primary, community-based health care, and on alternative mechanisms for cost sharing in the delivery of health services.

In the past the Health Information System has been providing vital health statistics. With the recent addition of six computers (one mini-computer donated by USAID and five microcomputers donated by IBM, the Health Information System will provide management information as well as health statistics. The family planning statistics for 1983 and the first three quarters of 1984 have been processed as part of the HPIP and forwarded to the National Council for Population and Development. This activity will be strengthened and broadened to provide timely information in reference to family planning services. With the arrival of computers, the information system has the challenge of providing management information as well as health statistics. If proper computer systems are developed, the MOH will have a better capability of managing its financial, personnel, transport, supply and institutional resources. The new focus on decentralization can provide for quicker, more accurate and better controlled data collection. Thus, the potential of H.I.S. to supply management reports and data on health statistics is great.

There is a need for the GOK/MOH to continue to strengthen its capacity to translate policies for decentralized rural health services into action. Because of the momentum established, the GOK/MOH should elaborate, without delay, well defined goals and develop and implement plans of action to ensure that Primary Health Care and Family Planning Services is made accessible to the entire population. The highest priorities should be given to underserved areas and groups.

The IPS component of the FPSS will build upon the groundwork and infrastructure developed by the HPIP. At present, a core national planning/management structure now exists in the MOH. A policy level steering committee was established in 1982, and a functioning Health Planning Working Group is now in place. Seven (7) Provincial and forty-one (41) District Health Management Teams have now been formed. Intensification of efforts to strengthen the planning and managerial skill/performance of this planning management network, has been facilitated and now needs to be further expanded.

A. PERCEIVED PROBLEM: Although significant progress has been made to date, planning and management of MOH resources represent a major constraint on the ability of Kenya's health sector to improve and expand health care delivery to rural populations.

MAJOR BARRIERS INCLUDE:

(1) The Government does not now fully utilize the personnel, facilities and other capabilities of non-governmental organizations as a means of reducing public sector burden.

(2) The efficiency of planning and management structures at the sub-district/primary care levels require considerable improvement.

(3) The Government does not yet fully utilize the potentials of community participation to encourage better expression of felt needs or to more fully share the responsibility for their own health care.

(4) The MOH has used an antiquated manual system of data collection which has not been tabulated for the past four years. In addition, information that traditionally was gathered was limited to gross vital statistics - not information useful for planning and evaluating health projects and programs. Information vital to the project includes measures of health statistics (e.g. population growth, birth rates, maternal/infant mortality, rates of contraception and methods used), and measures of resources management such as numbers of trained personnel, clinical facilities, community based resources supplies and cost - effective methods and delivery.

C. OBJECTIVES: The main objective is to further strengthen health/population planning, management, implementation, evaluation and information capacities of the MOH especially at the sub-district/community levels in support of Primary Health Care/Family Planning System development.

1. PLANNING AND MANAGEMENT:

Activities in this area will include the following:

(a) Strengthening the Health Planning Working Group (HPWG) coordinative linkages (including linkages with Integrated Rural Health/Family Planning (IRH/FP) core project team, MOH and MOFP programming/budgeting functions; expanded capacity in technical areas such as management problem solving, program/project design and development manpower and personnel planning).

(b) Strengthening of district management teams (including workshops or annual implementation planning consistent with MOH/MOFP budgeting cycles and to develop a supervisory infrastructure to support primary health care).

(c) Assistance to the MOH in developing national guidelines and training district/sub-district staff in the more efficient management of key administrative components of the delivery system, i.e. financial controls, personnel, supplies, equipment maintenance, transport and health facilities.

(d) Strengthening of district medical officers capacity to provide effective input to District Development Committees and health/population sub-committee (including preparation of written guidelines and organizing orientation workshops).

(e) Institutionalize MOH Health Planning Management and Evaluation curricula in the syllabuses of health training institutions (including University of Nairobi Department of Community Health, Medical Training Centre, Rural Health Training Centres and Kenya Institute of Administration).

(f) Coordinate the administration and dissemination of findings research grants geared toward improving methods of primary care/family planning service delivery.

2. INFORMATION:

In order to achieve the objective of the H.I.S. in the area of health statistic to provide timely, accurate, and complete reports of morbidity, mortality, family planning and nutrition and in the area of management to assist the Ministry of Health to better manage resources by providing computer assistance in the areas of finance, personnel, supplies, equipment, transport and health facilities the following activities will take place.

(a) Strengthen the MOH headquarter's capability to design, plan, and implement various health information systems by providing technical assistance, training of staff and commodities

(b) Develop district level ability to collect analyze and use health information statistics within a systems approach by training manpower at the district level,

Developing H.I.S. offices in all districts including data processing ability;

(c) In order to strengthen the management of Health Services, systems will have to be developed in the areas of finance, personnel, supplies, equipment, transport and health facilities. These systems should operate at both district and national levels. This effort requires technical assistance, training and commodities at both headquarters and district level;

(d) Establish a library facility for H.I.S.;

(e) Develop relevant research in H.I.S. providing maintenance facilities to the districts for the H.I.S. equipment;

(f) Provide timely printing and dissemination of reports of H.I.S. section.

3. PRIMARY HEALTH CARE:

Activities in this area will include the following:

- (a) Strengthening the MOH community based health care unit, CBHCU.
- (b) Strengthen the GOK/NGO community based health care coordinating committee, established and functioning as part of the CBHCU.
- (c) Assess Kenya's Primary Health Care especially family planning activities experience to date and identify requirements to strengthen and consolidate Primary Health Care capabilities in the MOH and NGO's.

- (d) Provide technical assistance to NGO's in cooperation with NGO associations, in response to needs as identified (i.e. training of trainers Community Health Workers (CHW), training of CHW provision of family planning services, strengthening of management and supervisory skills, etc.).
- (e) Strengthening, promotion and expansion of community based health care projects (including operations research to support CHB project development, a development fund (seed money) for innovative, self-sustaining schemes to assist communities and organizations in initiating CBHC projects i.e. community based distribution of contraceptives.

D. EXPECTED OUTCOMES:

- Increased coordination between the GOK and NGO's;
- Increased utilization by the GOK of NGO experience and resources;
- Improved community participation in health policy decision-making;
- Improved community participation in preventive and promotive health care;
- Increased community contributions to the financing of health services;
- Improved GOK and NGO training management capabilities services;
- Improved capability of the HPWG to develop methods to coordinate budget forecasting, personnel forecasting, establishing priorities allocating resources for design, implementation and delivery of health programs;
- Improved management and supervision capacity of district health management teams;
- Introduction and widespread use of a comprehensive district level training series on MOH planning, management and evaluation audits incorporated into the training programs of relevant Kenyan health training institutions;
- Implementation of an Information System that provides minimal data needed for decision-making at all levels of the system;
- Completed research activities that facilitate the design and funding of projects in primary and community based health care.

ANNEX F. SOCIAL AND BEHAVIORAL ANALYSES

The use of contraception is only one factor that determines fertility levels. The same level of fertility occurs today internationally in different societies based on different mixes of contraception use levels and the other determinants of fertility. Kenya's fertility is extremely high because of a combination of factors described briefly below:

1. EARLY AGE AT FIRST COITUS; BRIEF BIRTH INTERVALS: The age pattern of fertility plays a major role in growth rates, more or less independent of the above direct determinants of fertility. Kenya's overall population growth is attributable in significant measure to the fact that fertility begins early and is highest among the young, irrespective of the total number of children being born per woman. Time trends in this regard have been most unfavorable in recent years due to either earlier ages of first sexual intercourse or to declining average age at menarchy. Table 2 provides the hard evidence. Though most of the rise in fertility is directly attributable to ever shorter intervals between births of young women, the data suggest that sexual activity levels at youngest ages probably has been increasing.

The total fertility rate (TFR) between 1969 and 1979 showed an increase of almost 4%, but the underlying shift in the age patterns of fertility during those short ten (10) years was great. Table 1 summarizes many changes in Kenya very succinctly. The rapid rise in teenage fertility, and the substantial rises among those in the twenties are most unfavorable trends for reducing growth rates in the near future.

2. PROPORTION MARRIED OR IN ACTIVE SEXUAL UNION: Prevailing sexual patterns involve nearly universal female participation; as in North America today, celibacy is rare in Kenya. In Kenya women's sexual activity tends to begin only a few years or even months after ovulation is established and tends to continue throughout most of the reproductive years. Divorce and widowhood are frequent by any worldwide standards (about one-third of first marriages are terminated by divorce and/or widowhood within 29 years of marriage); however, high rates of remarriage or subsequent unions (supported by high levels of polygamy) ensure that most women of reproductive age are in union at any point in time.

3. FREQUENCY AND PATTERN OF COITUS; LOSS OF ABSTINENCE: Sexual frequencies and marriage patterns also favor high and increasing levels of fertility in Kenya. This subject has several aspects. Strong evidence from demography and anthropology indicates that the coital frequency of females is lower in polygamous arrangements than in monogamous ones. Polygamy lowers fertility because male time and energy are shared, because wives beyond the first tend to have older husbands (greater age differentials), and because polygamous women tend more often to have separate households sometimes at a great distance from each other and from the husband.

Table F.1. Age-Specific Fertility Rates in Kenya, 1969-79

| Age Groups | Census 1969 | Surveys* 1977 | Census 1979 | Rates of Increase (69-79) |
|------------|----------------|------------------|----------------|---------------------------------|
| 10-14 | - | 6 | 3 | - |
| 15-19 | 132 | 172 | 179 | 36% |
| 20-24 | 331 | 360 | 368 | 11% |
| 25-29 | 337 | 373 | 372 | 10% |
| 30-34 | 294 | 308 | 311 | 6% |
| 35-39 | 223 | 236 | 226 | 1% |
| 40-44 | 135 | 128 | 105 | -22% |
| 45-49 | <u>68</u> | <u>35</u> | <u>14</u> | <u>-80%</u> |
| TFR | <u>7.6</u> | <u>8.0</u> | <u>7.9</u> | |

These data made available by Population Studies and Research Institute; Kenin, personal correspondence, 1983. Raw data are available from a large 1983 National Demographic Survey but have not yet been analyzed by GOK/MOFP, Central Bureau of Statistics. Their tabulation will be a critical test for confirming or denying the conclusions advanced in this paper.

Weighted Averages of 1977 National Demographic Survey and 1977/78 Kenya World Fertility Survey - USAID.

It is not well documented, but the prevailing wisdom in Kenya seems to be that monogamy has become increasingly common in recent decades. The spread of Christian teaching is cited as the main reason; a gradual increase in the relative power of women has also occurred. Monogamy entails continuous cohabitation and proximity of partners, making abstinence supremely difficult and, in effect, significantly increasing the frequency of intercourse and exposure for females.

Many cultures in Kenya used to practice post-partum abstinence for as much as three years while the mother was breastfeeding. The result was an average interval between births of three to four years. Abstinence was probably the single most powerful fertility regulation "method" in traditional households. The practice was supported by beliefs conveyed ritually; for example, that breastmilk was contaminating to men and semen was contaminating to the breastfeeding. These beliefs and practices have virtually disappeared in recent years with the effect that most women now return to coitus after intervals of only a few weeks or months, akin to patterns throughout most of the world today. USAID believes that even though these trends increase

fertility, it is probably inappropriate for donors to encourage prolonged sexual abstinence of couples since it is not consistent with any of our prevailing domestic behavior patterns and it is not possible to anticipate what other effects such programs (if successful) would have on marriage, sexual practices and women's status.

4. STERILITY, NATURAL AND PATHOLOGICAL: STEADY DECLINES: As shown in Table 1 evidence might suggest that infertility among women approaching menopause has been increasing. Increasing use of contraception, however, is certainly the main reason for the decline. For example, the growing popularity of female tubal ligation indicates that women are now choosing to become infertile at earlier ages than would be imposed by natural processes. (Probably more than 40,000 procedures were performed in the past seven years.) Studies across sub-Saharan Africa indicate that infertility due mainly to infections and subsequent occlusion of the fallopian tubes account for more variation in fertility rates than any other factor. If about 3% of women are "naturally" infertile during their twenties, and another 15% are infertile due to pathologies, this translates into an average two children fewer in the overall maximum total fertility rate (TFR). Improvements in the prevention and early detection and treatment of sexually transmitted diseases are responsible in a significant way for the rise in fertility in Kenya in recent years, perhaps by almost as much as one child in the TFR. Improved hygiene and treatment have resulted in a pathological sterility level of perhaps 7% today and the level will undoubtedly decline further in coming years, continuing to be a force for increasing fertility, especially as rates of female circumcision continue to decline. The latter trend can only be encouraged and in no way seen as an acceptable "passive" restraint on fertility to be tolerated or ignored. JHPIEGO, under AID/W funding will continue to assist GOK and NGOs in improving the early detection and treatment of sexually transmitted diseases and other infertility factors.

5. FETAL LOSS: LOW AND DECLINING: Rates of spontaneous abortion and stillbirth seem to be quite similar across cultures and peoples -- around 20 percent of conceptions. Data are scarce in Kenya but informal evidence suggests that induced abortion is increasing. Hospital admissions records for treatment of incomplete abortions certainly seem to have increased over the past five years, based on informal interviews with gynecologists and casual perusal of hospital records.

USAID will in no way support the promotion or provision of abortion services, in strict accord with the clear language of USG legislation. The Government of Kenya likewise does not in any way support access to information or services.

6. LACTATIONAL AMENORRHEA/BREASTFEEDING: Modern nutrition education and promotion favor supplemental feeding of infants only a few months after birth because it improves weight gain and survivability. It has the unintended effect of diminishing breastfeeding. Trends towards wage earning among women also encourages more rigid scheduling and longer intervals between breastfeeding as well as earlier weaning. The effect of all these is to

diminish the intensity and the duration of nipple stimulation in breastfeeding women and shortens the interval between parturition and the return of ovulation. Women enter risk of pregnancy much sooner than in past generations because today they ovulate sooner, and because they are more likely to be in active sexual union at that time due to the declines in post-partum abstinence.

The results of these changes in sexual behavior and breastfeeding combine as shown clearly in Table 1: high and increasing fertility of young women during the 1970s. Today the level of breastfeeding in rural areas is quite high but probably because it is not intensive (timing and supplementary feeding), it does not seem to confer very much protection from pregnancy. USAID consultants estimate that breastfeeding in recent years probably confers an average of about four to five months of effective protection per live birth. Fertility will almost certainly rise even more if lactational amenorrhea declines further. If the average conferred protection could be increased by even a month or two health and fertility regulation benefits would be measurably improved.

FPSS and AID/W funded training and communications assistance will support all reasonable efforts to encourage widespread retention of traditional intensive breastfeeding practices.

7. PROPORTION USING CONTRACEPTION: Figure 1 illustrates the power of contraception in determining fertility. It shows the distribution for thirty-two countries in 1980 of crude birth rates (CBR) and percent of married women of reproductive age using contraception. Kenya clearly shows a highest fertility pattern, lowest use levels and poor effectiveness in use of contraception. Overall, in this linear relationship, every percentage point increase in prevalence of use of contraception on the average lowers CBR by about 0.4 births; or, each point reduction in CBR correlates with an average increase of 2.5% in the prevalence of use of methods.

The types of methods used, the age distribution of use and the average effectiveness of couples in applying the methods are all crucial to the actual fertility effects in particular settings. Kenya's outlying position in 1979 with respect to the regression line suggests three possibilities: (1) an unusual convergence of high fertility factors other than contraception (as argued earlier and especially because of low abortion rates), (2) unusually poor or ineffective use of methods, and/or (3) reliance on comparatively ineffective methods. Probably all three factors apply. Kenya's worst possible position in international comparisons indicates that special efforts should be made to improve the use-effectiveness of contraception in Kenya, a point that has been stressed by the Ministry of Health in its persistent concern about "continuation rates" on methods which are definitely low by international comparisons.

Great effort will need to be devoted to community outreach to find and counsel those who "drop out" of programs. This issue is critical in the case of CC users. Community-based programs should be the key to bringing Kenya's overall

program performance closer to international standards (see Fig. 3). The discontinuation rate problem appears to be so great in Kenya that approaches to follow-up must form a core part of the strategy for CBD from the inception of the new and expanded programs.

8. IMPEDIMENTS AND CONSTRAINTS ARE MAJOR AND NUMEROUS: Until very recently most observers -- Kenyans and outsiders alike -- have said that rapid fertility decline simply will not be possible for many years to come in Kenya. They cite persuasive reasons, including:

1. traditionally high fertility values based on strong beliefs regarding under-population, and on sometimes competitive clan and ethnic loyalties;
2. indifference and even hostility to "imported" family planning concepts and methods, especially on the part of males;
3. unfulfilled economic, educational and health aspirations;
4. "low" status and power of women in society;
5. need for children's labor in rural economies;
6. lack of assured security in old age combined with a deep seated traditional experience of high loss of infants and children;
7. rural, dispersed living conditions that make information and service delivery difficult;
8. an attitude that all efforts have so far "failed," and the "situation is hopeless"; the futility syndrome;
9. pervasive rumors and misinformation among both women and men about the dangers and side effects of modern contraceptive methods;
10. apprehension that easy accessibility to fertility regulation methods will be abused by the youth, undermine their morality, reduce discipline, and favor sexual promiscuity and prostitution.
11. administrative and managerial constraints and the comparative lack of GOK tangible commitment of finances and management.

A study by the Family Planning Association of Kenya in 1979 and several background studies prepared for USAID in 1984 indicate that: (1) most health outreach facilities and paramedic personnel do not yet provide contraception services; (2) most outlets with family planning have limited hours of service per week; (3) shortages of contraceptives occur; and (4) most common and problematic, clients frequently face long waiting at delivery points for family planning services. Almost all field studies have remarked on the fact that many women who come to clinics and hospitals for family planning services actually leave without obtaining help.

The list of impediments and constraints is long indeed, the foregoing including only major ones. Even some of the most ardent supporters of family planning understandably feel pessimistic.

C. CONCLUSION: Despite the foregoing facts and prevailing opinions USAID has concluded, based on a year of thorough assessments backgrounds studies, and evaluations that conditions now favor realization of long-established Government goals of reduced population growth. Studies show that awareness of family planning has been high in Kenya since the mid 1970s. Recent trends suggest that more and more couples are using effective regulation methods and that fertility declines already are underway at least among older women (Ref. 4).

Between 1977 and 1984 the percent of fertile-aged married couples who reported practicing some method of fertility regulation increased from 6.7% to about 10%, based on preliminary findings from a major national sample survey. Overall use rates for methods seem to be increasing at about 10% percent each year despite the constraints listed above, apparently "demand" driven.

During 1983 several baseline surveys were undertaken in poor rural areas prior to the introduction of community-based services delivery studies. These studies showed that awareness levels were high and that use levels were higher than those previously estimated in rural areas. These pilot projects have also shown that the levels of use of contraception increase with accessibility, and that there are no serious political issues at the local level; to the contrary, most project personnel have encountered supportive communities.

There are long waiting lists for free tubal ligation services at many of the provincial and district hospitals where the service is offered. Between 1969 and 1979 fertility among women aged 40 and above declined about 50%, a phenomenon almost always occurring in societies as they begin sustained fertility decline. We take all of the foregoing to constitute evidence of substantial and growing demand for services. These observations provide a main basis for deciding upon an assistance strategy and a major project that stresses making high quality modern contraception services more equitably accessible.

USAID and the Government of Kenya agree on priorities in family planning and its overall significance to development. Virtually everyone representing major bilateral and multi-lateral donors is in full agreement with current GOK emphasis on reducing population growth by increasing family planning and fertility regulation services. USAID believes that the only effective option in Kenya is also the one that characterizes the U.S.A, as well as all of the many documented international cases of successful fertility reduction in both industrial and developing societies: access to and use of safe and effective contraception. Further social analyses and rationals for the FPSS may be found in the USAID Strategy Paper on family planning and fertility reduction.

ANNEX G. ECONOMIC ANALYSIS

1. INTRODUCTION: As will be seen from the discussion to follow, findings from recent studies (e.g., IBRD 1980, 1983) leave little doubt that significantly lowering population growth rates in Kenya by the end of the century can make a vital contribution to social and economic development. Indeed, according to IBRD 1983 (p. 73), "... if population growth does not slow down dramatically by the end of the century there is no solution to Kenya's development dilemma." It is hard to imagine a statement which could convey more urgency with respect to the need for prompt and major fertility reduction in Kenya. If this assessment is probably correct (and there is no reason to assume that it is not), then a successfully implemented FPSS project and the larger effort of which it is an integral part must be regarded as making a crucial contribution to solution to the Kenyan development problem.

2. POPULATION GROWTH AND ECONOMIC DEVELOPMENT: In recent words of the World Bank (IBRD 1984, p.40) "... rapid population growth is, above all, a development problem." The individuals who comprise a nation's population are at once the producers and consumers of that nation's output of goods and services. Consequently, the relationship between population growth rates and economic development (measured, say, as increases in per capital GNP) is not a simple or straightforward one.

Indeed, an attempt fully to explore these relationships would entail an attempt to construct and estimate an elaborate econometric model. Fortunately, resort to such an analysis is not necessary to reach the conclusion that, with Kenya's rapid rates of population growth, positive effects of labor force growth on aggregate output are not enough to offset the drag of population growth on growth of per capita income. (IBRD 1980, pp. 42-43). Thus, reductions in fertility rates by FPSS activities can be expected to yield benefits to the population of Kenya in the form of per capita incomes higher than they otherwise would have been. And, it is important to recognize that there will be additional benefits from slowing the rate of growth of Kenya's population -- notably, better service to the GOK's distributional objectives and favorable consequences for the health status of mothers and children (see discussion to follow).

CONSEQUENCES OF KENYA'S POPULATION GROWTH FOR THE ECONOMY AND SOME BENEFITS OF FPSS

IBRD 1980 thoroughly analyzes the impact of Kenya's population growth on the economy under several population growth-rate projections. Usually, the economic-impact comparisons are of the outcomes that would obtain with constant fertility at present levels (TFR assumed to be 8.0) until 2000 compared with the outcomes that would obtain under greatly reduced fertility rates (Projections 3 and 4). To achieve the reductions in fertility rates assumed by Projections 3 and 4 will require, in the view of the study, vigorous implementation of a comprehensive fertility control program which as described in the study is very similar to the large, multi-donor program to reduce fertility rates in Kenya proposed by USAID and of which FPSS is to be an integral part (See USAID 1985).

All in all, the IBRD scenario and that contemplated by USAID are similar enough to make it reasonable to take the IBRD findings as an estimate of the benefits to be expected from implementing FPSS and the larger fertility regulation program of which it is an integral part as compared with what would otherwise obtain.

IBRD 1980 identifies a number of important effects of rapid population growth on the economy of Kenya viz:

1. The effect of diminishing returns in agriculture associated population-growth pressure on the land and other natural resources, with tends to lower agricultural output per head.

A good summary evaluation of the importance of the agriculture sector to economic development in Kenya and of the implications of rapid population growth for this sector is provided by IBRD 1983 (pp.64,73):

"There can be no doubt that for the foreseeable future the evolution of Kenyan agriculture will be the key to the country's development

There are no technical problems to expanding output and employment sufficiently to accommodate population growth through the rest of the century. It will, however, require major investment to expand land areas, difficult political decision to redistribute land, and improvements in policy and development supporting institutions to encourage intensification of land use. However, if population growth does not slow down dramatically by the end of the century there is no solution to Kenya's development dilemma." (emphasis supplied)

As we remarked at the outset, it is hard to imagine a statement which could convey more urgency with respect to the need for prompt and major fertility reduction in Kenya. It would seem obvious that even if the probability that this assessment is correct is considerably less than 1.0 the expected value of benefits to fertility reduction in Kenya must far outweigh the modest resource commitment proposed for FPSS and the larger fertility control effort of which it is an integral part.

2. The effect of labor force growth on the aggregate employment situation.

IBRD 1980 presents findings (p. 68, Table 3.3) from which one may estimate that successful implementation of FPSS and the larger fertility control efforts of which it is an integral part will mean a Kenya labor force smaller by 1,840,000 in the year 2000 and smaller by 5,629,000 in the year 2010 than it otherwise would be (i.e., were current fertility rates to remain constant at present levels).

As IBRD 1980 points out (p.iv), the Kenya economy could not provide gainful employment for all its workers during the past decade when GDP growth was on the order of 6.5%/year. It is a reasonable assumption that constant-fertility acceleration in labor-force growth rates would further complicate the

employment problem over the 1985 - 2000 interval. A potentially substantial benefit to successful implementation of FPSS will be represented by what IBRD 1980 characterizes as the self-evident attractiveness of the low fertility scenario from the employment standpoint, viz:

"A larger proportion of workers can expect to be in the high wage modern sector. The absolute number trying to earn a livelihood in the rest of the economy will be smaller, thereby diminishing somewhat the severity of the competition for jobs which generate income above the poverty level."

In sum, successful implementation of FPSS and the larger fertility control effort of which it is a part can be expected to yield substantial benefits of a peculiarly important kind for the quality of social and economic development in Kenya in the form of income inequalities less than they otherwise would have been and "invisible underemployment" less than it otherwise would have been.

3. The effect of population growth on the pattern of public expenditures, especially with regard to basic human needs objectives.

TABLE G.1. */ SAVING IN GOVERNMENT RESOURCES NEEDED TO MEET BASIC NEEDS IF THE TFR DECLINES TO 4.0 IN 2000 RATHER THAN REMAINING CONSTANT AT PRESENT LEVELS - 1985-2000

| | (KL million, 1970 prices) | | | | Total |
|-----------|---------------------------|--------|---------------|-------------|--------|
| | Education | Health | Urban Housing | Rural Water | |
| 1085-90 | 7.43 | 9.23 | 20.15 | 7.45 | |
| 1990-95 | 55.05 | 18.46 | 50.06 | 10.28 | |
| 1995-2000 | 138.38 | 35.64 | 107.82 | 12.44 | |
| Total | 200.87 | 63.33 | 178.03 | 30.17 | 472.40 |

*/ Source: Adapted from IBRD 1980, p. 115, Table 4.25

As IBRD 1980 emphasizes, these order of magnitude estimates should be regarded as minima.

Even so, the total saving is substantial, amounting to KL 472.40 million in 1970 prices or about KL 1,400m in current prices. USAID has put the 1985 - 2000 total cost of a fertility control program which can meet these fertility reduction targets at about US\$500 million or about KL 400 million (1985 prices, current exchange rates). Clearly, even if the GOK picked up the total cost of the fertility-control program from its own resources, it would come out well ahead in terms of its own resources recouped -- by about KL 1.0 billion over the period. Operating-budget savings of this kind are of course important, but the major benefit of the fertility-control program from the GOK's point of view is to be measured in terms of the impetus it can give to the social and economic development of Kenya.

Also it seems clear that without a sharp decline in population growth rates, the prospects for significant improvement in the level of basic services per capita in Kenya are remote. This is particularly important in the case of education services where rapid labor force growth combined with diminishing education opportunities is likely to exacerbate income inequalities.

4. The effect of population growth as a bar to capital deepening.

IBRD 1984 (pp. 43 et seq.) directs attention to this important relationship between rapid population growth and economic development. For per capita incomes to rise, investment in physical and human capital needs to grow faster than the labor force such that capital per person and per member of the labor force increases, i.e., such that so-called "capital deepening" takes place.

Rapid population growth works against capital deepening in various ways and therefore works against increases in income per capita. Where, as in Kenya, the labor force is growing rapidly, the stock of capital must increase rapidly just to maintain capital per worker and current productivity. Similarly, rapid increases in the school age population call for rapid increases in resources committed to education even to maintain resources per student at existing levels. IBRD 1984 (p. 44) sets out the "awkward choices" entailed, viz:

"Countries such as Kenya face a doubling or tripling of their school age population by the end of the century. The main implication is clear. More school-age children require more spending on education, even if the objective is just to maintain current enrollment rates and standards. As most developing countries want to improve their schools quantitatively and qualitatively, they will have to generate more national savings or curtail other investments in, for example, power and transport. If a country is unwilling or unable to make these sacrifices, spending must be spread over a larger group of school children (to the detriment of the quality of education); otherwise a growing number of children have to be excluded."

Summary of Benefits to Fertility Reduction in Kenya and of the Costworthiness of Expenditure to Achieve them by Implementation of FPSS and the Larger Fertility Control Program of which it is a Part

We have elucidated these propositions: That rapid population growth is above all a development problem. That in Kenya rapid population growth is exerting a major drag on economic and social development. That, therefore, significant reductions in fertility rates in Kenya will yield important benefits in the form of more rapid and higher quality economic and social development. And that, therefore, it is in these terms that the benefits to implementation of the FPSS project and the larger fertility control effort of which it is a part are to be conceptualized and measured.

To obtain these benefits, resource commitment at the modest rates contemplated for FPSS and the larger fertility control effort of which it is a part must be regarded as costworthy. As noted, USAID has reckoned the 15-year total expenditure for the larger fertility control effort at about the equivalent of KL 400 million (at current exchange rates, 1985 prices) or about KL 27.0 million a year on average over the period. The contemplated project will be largely donor financed. However, one way to get some sense of the modest rate of resource commitment contemplated for these fertility-control activities is to compare it with the overall fiscal capacity of the GOK. Currently, GOK current revenue is about KL 1.0 billion. Thus, in the early years of the fertility reduction program, spending at the average rate per year would amount to about only 2.7% of GOK current revenue. Since the Kenyan economy will be growing during this period, the real burden of the fertility-control program will be decreasing during this period. If we assume that the economy grows at, say 4.0% per year on average during this period and that GOK current revenue grows at this same rate, by 2000 spending at the average rate per year for the fertility reduction program would amount to only about 1.6% of current GOK revenue -- the average over the whole period is 2.2%.

COST-EFFECTIVENESS AND LEAST-COST ANALYSIS OF PROGRAMS TO REDUCE POPULATION GROWTH RATES

It is much easier to sketch the general logic and general nature of C/E, least-cost analysis than it is to apply such analysis in any meaningful (non-trivial) way to projects such as fertility control projects. It will greatly inform our analysis in this domain to consider some of the problems.

One major problem is that for fertility-control-program outputs defined in ways of primary interest for evaluation of project performance (ways that speak to the actual impact of the project on fertility rates) -- such as couple years of protection (CYPs) -- the production functions are known only in a very general way. This is so in part because project output in these utilization-of-services terms depends not only on supply events but also demand events -- demand for fertility reduction in general, and, given that kind of demand, demand for one or another of the various fertility-reduction goods and services.

Responding to these circumstances, the project will feature activities to create demand for fertility reduction (experts are in agreement that in the case of Kenya major reductions in fertility rates are unlikely without major changes in preferences, attitudes and behavior on the demand side of the market). And the project will feature a large menu of fertility-reduction goods and services to be produced by the various project components. In the initial design of FPSS, an informed judgment has been made that the proposed mix of project components in this sense is probably optimal. But, of course, in the nature of this program, what combination of program activities and components will actually maximize output in terms of CYPs cannot be known with anything like certainty at this point.

Service to least-cost objectives is no simple matter for a project of this kind. Because of uncertainties on the demand side of the market, much of this service must be derived from an optimizing strategy of on-going project management once it has been launched.

The different project components will each deliver a CYP at rather different unit costs. However, in the instant case, a CYP secured with even the highest cost component activity is regarded as worth it in terms of benefits realized if there is no less costly way to secure that CYP. With this proviso, we can take as the objective of the project maximizing project output measured in terms of CYPs.

Pursuant to this objective, FPSS features, as it should, a quite wide array of contraceptive goods and services to be provided through a number of different delivery systems -- thus seeking to cater to the preferences and locations of the potential customers. This is necessary to get the kind of exposure and provide the kind of access necessary to maximize project output. That is, although as noted, some of the project activities in the array will deliver a CYP at less cost than others, it would make no sense at all in the initial design of the project to put all our eggs in the least-cost of these baskets, so to speak. After all, the customers may prefer the eggs in other baskets and its utilization of these services that we're after, not just the capacity to provide lowest cost services if anybody happens to want them. Once the project is launched, the project will require some budget flexibility. That is, within the bounds allowed by those initial commitments necessary to implement the various program components, the total FPSS budget should feature flexibility to move resources from one project component activity to another depending upon demand for the product of each component and depending upon the least-cost way of serving that demand.

It would be ideal if once the project is launched it turns out that demand at high levels is stressing capacity on the supply side -- the project could reallocate resources on the margin to the least cost of those component activities where demand calls for additional resources. However, we must be prepared for the contingency that things may not work out this way, particularly in the early years of project life.

In the relevant future the demand picture may feature (1) continued low level demand or (2) a substantial and rather sudden increase in demand. As FPSS project documentation has stressed, it takes long time to get a high quality supply system in place. FPSS could adopt either of two strategies: (1) build a comprehensive coverage supply system, even though this may entail building excess capacity as we go along or (2) limit supply system capacity more or less to current demand as we go along. Which strategy should FPSS elect? This is a domain in which, it may be urged, rationality calls for electing the one of these strategies with the best of the worst outcomes (i.e., appeal to the maximin decision criterion). If we go with FPSS strategy (1) and the demand picture turns out to feature Demand (1) this would be a disappointment. It would surely be a far better worst outcome, however, than it we went with FPSS strategy (2) and the demand picture turns out to feature

Demand (2) -- for in this case we would confront perhaps substantial excess demand for fertility-control services which the project could not respond adequately to for perhaps several years. As previously remarked, this kind of delay in the initiation of any given fertility-control regimen can have a large impact upon the ultimate stable size of the population, in this sense, FPSS strategy (2) would have entailed missing a golden opportunity.

We have been at some length to make this point as a hedge against what could well be an unfortunate misunderstanding from the point of view of cost-effectiveness evaluation of FPSS. Thus, the possibility of excess capacity issue, while of great interest from the point of view of prognosticating future population events in Kenya, cannot be considered decisive for project approval.

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ANNEX H. IMPLEMENTATION SCHEDULE

ANNEX TABLE H.1: MAIN FPSS IMPLEMENTATION SCHEDULE (YEAR 1, YEARS 2-3, YEARS 4-7)EVENTS BY USG FY 86 QUARTER

| ELEMENT | 1ST QUARTER | 2ND QUARTER | 3RD QUARTER | 4TH QUARTER |
|--------------------------------------|---|--|---|---|
| Procurement of Contraceptives | Complete logistics review Complete PIO/C for 1986 and 1987 | Purchase orders | Import | Import |
| 1. Clinical Training/ Support | Complete PIL to MOH | Completed PIO/T and Amendment to IMIRAH Cooperating Agency | Participant training (PIO/Ps) | Training PIO/Ps |
| 2. Voluntary Surgical Contraceptives | Complete CA with AVSC | Complete registration Regional Office; Complete CA with John Snow | PIL to MOH New sub-agreements NGOs and Missions | Establish AVSC Regional Office New Subagreements under John Snow order equipment for all sectors |
| 3. Community Services | | Complete CA with Pathfinder | Complete PIL with MOH; MOH new guidelines on methods | |
| 4. Subsidized Marketing | | GOK registers new organization | GOK amends OC guidelines on retailers | Product launch |

| ELEMENT | 1ST QUARTER | 2ND QUARTER | 3RD QUARTER | 4TH QUARTER |
|--------------------------------|---|---|--------------------------|---|
| 5. Ovulation Awareness/NFP | Complete PIO/T, to IFFLP | Sub-agreements completed | | Complete |
| 6. NCPD Administration | Complete PIL to NCPD | Complete NCPD staffing plan | Complete PIO/T to INPLAN | GOK decides NCPD status re MOHA vrs. Permanent Commission |
| 7. NCPD Policy/Plan/Evaluation | Complete PIL to NCPD | Complete CA with INPLAN PIO/T for policy TA Training begins | Select H.C. contractor | Select H.C. contractor PIO/T for Evaluation TA Training |
| 8. NCPD IE & C | Complete PIO/T to John Snow, Inc. | Complete PIO/T to NCPD | Complete PIO/T to PCS | Select H.C. contractor Prepare forward year donor budgets |
| 9. MOH Information/Plan | Complete PIL for H.C. contractor to MCH and issue RFP | Complete new H.C. contractor | | |

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ANNEX TABLE H. 2: MAIN FPSS IMPLEMENTATION SCHEDULE (YEARS 2 -7)

EVENTS BY PROJECT YEARS (2 -7)

| <u>PROJECT ELEMENT</u> | <u>YEAR 2 (1987)</u> | <u>YEARS 3-4 (1988-1989)</u> | <u>YEARS 5-7 (1990-1992)</u> |
|-------------------------------------|---|---|--|
| Procurement of Contraceptives | Complete PIO/C and purchase orders for 1988. Monitor logistics evaluations | Complete PIO/Cs and purchase orders for 1989. Monitor logistics: FPSS Monitor logistics | Complete PIO/Cs and purchase orders for 1991 and 1992. |
| 1. Clinical Training/Support | Revisions to nursing curriculum implemented. PIO/Ps for training. ECN and KRN training expanded to 5 new sites. | PIO/Ps for training. FPSS evaluations | PIO/Ps for training |
| 2. Voluntary Surgical Contraception | VSC sub agreements with NGOs and Missions all completed; JSI sub agreements completed. MOH national program completed | Hospital facilities completed, equipped; training completed FPSS evaluation. | VSC program implementation |
| 3. Community Services | Expansion of CBS to 15 district level. organization with DDC sub-committees and GOK budget through MOH. | 2nd PIL to GOK for CBS. CBS project detailed evaluation. FPSS evaluation. | 3rd PIL to GOK for CBS activities |
| 4. Subsidized Marketing | Program implementation (SOMARC resident TA withdrawn) | SCM detailed evaluation. SCM support from SOMARC shifts to FPSS. FPSS evaluation. | FPSS funding begins, local contract. |

| <u>PROJECT ELEMENT</u> | <u>YEAR 2 (1987)</u> | <u>YEARS 3-4 (1988-1989)</u> | <u>YEARS 5-7 (1990-1992)</u> |
|--|---|--|---|
| 5. Ovulation Awareness/NFP | Program implementation | OA/NFP final evaluation/ FPSS termination. FPSS evaluation. | - |
| 6. NCPD Administration | New NCPD administration begins | FPSS contribution to salary/support declines. FPSS evaluation | FPSS contribution to NCPD ends in 1991. GOK assumes greater budgeting support. |
| 7. NCPD Policy/Planning/ Evaluation | 1984 National Demographic Survey analyses completed National FP strategy completed. FPSS evaluation design completed | Contraceptive Prevalence Survey. Overall evaluation coordination. FPSS evaluation. | Final FPSS evaluation |
| 8. NCPD IE & C | TA contracts implemented, audience impact evaluation. UNFPA and IBRD support arranged | FPSS supports ends. FPSS evaluation. | - |
| 9. MOH Information/Planning | Seminars, workshops and training are implemented | All training completed. Final evaluation of this component. FPSS evaluation. | - |

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ANNEX I. REQUEST FOR APPROVAL OF NON-COMPETITIVE ASSISTANCE AWARD

PROBLEM: Approval is needed to authorize an amendment of John snow International's Cooperative Grant Agreement to increase the scope of activities and funding authorized.

DISCUSSION: After a competitive selection was held, John Snow International (JSI) received a Cooperative Grant Agreement under A.I.D.'s Private Sector Family Planning Project (PSFP) (615-0223) in an amount of four and half million dollars to establish family planning service delivery within major private sector factory and plantation clinics operated by employers. JSI is responsible for initiating and supporting family planning service delivery at forty to fifty sites or clinics servicing 30,000 clients by the end of project in August 1987. JSI is well ahead of the project's schedule in introducing and supporting family planning services to clinics. However, the Cooperative Agreement did not provide any funds for Information, Education and Communication (IE&C) activities; or for Voluntary Surgical Contraception (VSC) activities.

Under the Family Planning Services and Support Project (615-0223) it is proposed to increase JSI's Cooperative Agreement by \$1,202,000. This would allow \$192,000 for IE&C activities, such as the printing of posters and pamphlets relating to family planning services to encourage clients of the private sector clinics to utilize the family planning services being offered by the FPPS project. It would also allow for \$1,010,000 to support the addition of VSC service activities in the clinics currently supported by JSI for other family planning services under the PSFP project, and partially or fully compensate other private sector clinics and physicians for their costs to deliver VSC services.

It is not reasonable to engage the services of an organization other than JSI to deliver these IE&C and VSC services to the same clinics where JSI is already working. JSI has already established family planning service delivery at most of the same clinics that will require IE&C and VSC activities under this project. These new activities are an extension of the activities already being undertaken by JSI, in which JSI has a demonstrated competence. JSI already has a good working relationship with the clinic's management and personnel. JSI has demonstrated its competence to obtain IE&C services, because after JSI discovered that their Cooperative Agreement included no funds to inform potential clients of the family planning services offered, JSI, using other donors funds, arranged for artists workshops which produced a series of highly acclaimed posters. Thus, JSI, already liaises with most of the Kenyan artists who would prepare the IE&C materials. Likewise, for the VSC services, it would be unreasonable to engage the services of any organization other than JSI to provide these services because of the excellent working relationship that JSI has engendered with the clinics where it works.

RECOMMENDATIONS: That, as part of the FPSS project approval, authority be given to the USAID/Kenya Mission to amend the JSI Cooperative Agreement by an amount not to exceed \$1,202,000 to provide both IE&C and VSC services without competition.

PROJECT AUTHORIZATION

Name of Country: Kenya
Name of Project: Family Planning Services & Support
Number of Project: 615-0232

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning Services and Support Project involving planned obligations of not to exceed \$43.0 million in grant funds over a seven-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. The planned life of project will be seven years from the date of initial obligation.

2. The Project consists of various activities to improve and expand family planning service delivery throughout Kenya and to increase Kenya public and private capacity to support and promote family planning. A.I.D. will finance technical assistance, training, commodities and equipment, logistical support, operating expenses and other costs of the project.

3. The Project Agreement, which may be negotiated and executed by the officer(s) to whom such authority has been 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.

a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Cooperating Country of the United States as their place of nationality, 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

1. Prior to the first disbursement of funds, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will provide in form and substance satisfactory to A.I.D., evidence that the Government of Kenya (GOK) has published a notice in the GOK Gazette specifying that all project funded commodities, including those imported into Kenya by organizations under contract with or financed by A.I.D. or the GOK to perform work in Kenya in connection with the Project and those imported by the employees of such organizations for their personal use, will enter Kenya free of all duties and taxes.

2. Prior to disbursement for subsidized commercial marketing activities, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. Evidence that an organization has been established and registered under the laws of Kenya to distribute for sale at subsidized retail prices family planning contraceptives; and

b. Evidence that GOK has gazetted a reclassification of retail outlets that includes a clear and simplified system for licensing retail outlets to sell GOK authorized oral contraceptives. The licensing system will include a requirement for certified retailer training to assure that prospective clients are screened for contraindications and referred to medical personnel within a specified time period, if appropriate.

3. Prior to disbursement of funds to purchase oral contraceptives, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that GOK has published specific guidelines governing the distribution of oral contraceptives so that trained and certified community leaders may dispense this method of contraception.

4. Prior to disbursement to meet the costs of clinical training support to be furnished or contracted for by GOK, or to the issuance of commitment documentation with respect thereto, the Cooperating Country will furnish to A.I.D. in satisfactory form and substance, a clinical training plan which covers the period for which disbursement is requested.

5. Prior to disbursement subsequent to August 1, 1986 for any activities under the project (except for disbursements to third parties pursuant to commitments made to them prior to August 1, 1986), or to the issuance of commitment documents with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the GOK has budgeted funds in the 1986/87 Development Budget in amounts required to assure prompt and complete funding of all local costs of GOK supported elements of all project activities (as described in the amplified project description).

6. Prior to disbursement subsequent to August 1, 1986, for any National Council for Population and Development (NCPD) Administration; NCPD Policy, Planning, and Evaluation; or NCPD Information and Communication activities under the project (except for disbursements to third parties pursuant to commitments made to them prior to August 1, 1986), or to the issuance of commitment documents with respect thereto, the Cooperating Country will furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. Evidence that the Cooperating Country, by Presidential Order or by legislative action, has established the Secretariat of the National Council for Population and Development as a Permanent Commission which shall be empowered to discharge the duties of the current Secretariat.

b. Evidence that a full-time person has been appointed to be Executive Director of the Commission and Secretariat of the NCPD.

c. Covenants

The Cooperating Country will be required to covenant and agree as follows:

1. The Cooperating Country will, within the first year of the Project, expand and strengthen the authorities of the National Council for Population and Development (NCPD) in such a manner that NCPD can direct overall GOK inter-ministerial planning and program development; plan and obtain the necessary resource allocations (personnel and financial); monitor and evaluate the progress of the different elements of the national family planning program; and report directly to GOK top leadership.

2. In those districts undertaking organized community-based service delivery, the Cooperating Country will form Population and Development (or Family Planning) Sub-Committees of the District Development Committees, which will consist of appropriate officials and community leaders, such sub-committees to annually prepare work plans and budgets for GOK funding of local costs for family planning activities.

3. The Cooperating Country will operate, maintain and repair project equipment in conformity with sound operational, financial and administrative practices and in such a manner as to ensure the continuing and successful achievement of the purposes of the project. Inventory and distribution records for all project financed contraceptives and other expendable supplies will be maintained in accordance with generally accepted practices and procedures consistently applied.

4. The Cooperating Country will throughout the project budget funds in amounts required to assure prompt and full funding for all GOK financed elements of the project.

5. The Cooperating Country agrees to gradually assume responsibility for payment of the recurrent costs of salaries and personal emoluments of NCPD administration beginning in year three of the project. Unless otherwise agreed by A.I.D., the amount of costs assumed will be equal to 20 percent of the costs in year three and will increase by 20 percent each year thereafter until year seven of the project.

d. Waivers

As justified in Annex I of the Project Paper, the following action is hereby approved:

- a non-competitive assistance award to John Snow, Inc. in the amount of \$1,202,000 to amend the Cooperative Grant Agreement No. 615-0223-A-00-3066-02.

Date _____

M. Peter MacPherson
Administrator

Drafted:PRJ:JGoggin:am - 06/14/85
Clearance:RLA:PScott (Draft)
RFMC:GEidet (Draft)
PROG:Schernenkoff (Draft)
PH:GMerritt
D/DIR:BRiley

