

MANAGEMENT DEVELOPMENT PLAN FOR  
FAMILY PLANNING MANAGEMENT TRAINING PROJECT  
IN KENYA

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## EXECUTIVE SUMMARY

Kenya has a population growth rate which hovers around four percent, a doubling time of approximately 17 years, and a contraceptive prevalence of 10 percent. Concern about the serious economic and social consequences of such rapid population growth has attracted a large and complex array of donors to Kenya, resulting in an environment which is "donor rich" but also a difficult one in which to initiate successful new program activities.

The FPMT team visited Kenya in February 1987 to assess needs and opportunities for the Project with the Ministry of Health and with the multiple organizations in the private sector which provide family planning services. Based on predetermined criteria (organizational commitment to change, magnitude of family planning service delivery, organizational potential to maximize FPMT inputs), three sets of activities were identified as highest priority. First is work with the Family Planning Association of Kenya (FPAK), the only organization in the country providing "monopurpose" family planning services. FPAK will have completed a reorganization and development of a strategic plan by April 1987, at which time they have requested both technical assistance and training by FPMT. FPMT also proposes to provide technical and training assistance to Maendeleo Ya Wanawake, the largest women's organization in the country. Maendeleo, through its nationwide network of community women's groups, is actively involved in a CBD program. The third priority is to work with the Ministry of Health, Division of Technical Support. The Assistant Director of Medical Services has asked FPMT to carry out a detailed analysis of the management of FP/MCH services in one of three pilot districts which will serve as models for national implementation.

### DESCRIPTION OF THE ASSESSMENT

FPMT consultants Jean Baker and Joyce Lyons conducted a country visit to Kenya from February 6-22, 1987. Support and assistance in-country was provided by the Nairobi office of the Pathfinder Fund, especially by the Regional Representative, Dr. Ayo Ajayi and the Assistant Regional Representative, Mr. Nelson Keyonzo. The FPMT team met with both government and nongovernment providers of family planning services, USAID-funded cooperating agencies working in Kenya, USAID/Kenya, the AID/REDSO office, multilateral donors, and local consulting and training organizations. The team also visited the Center for African Family Studies (CAFS), a potential regional training site. The team travelled to Nyeri to view surgical contraception service providers and assess their potential as a site for FPMT study/observation tours. A complete schedule of the team's activities is provided in Appendix A.

## I. INTRODUCTION

Any assessment of population and family planning activities in Kenya must be prefaced with recognition of two facts of overriding importance.

First, Kenya faces a population crisis of profound proportions in the very near future as a result of a growth rate which hovers around 4 percent per year, a population doubling time of less than 20 years, and contraceptive prevalence of approximately 10 percent. This despite the fact that Kenya was the first country in East Africa to establish national family planning services and to adopt an official policy in support of family planning. So urgent is population pressure that a recent World Bank report states "...if population growth does not slow down dramatically by the end of the century, there is no solution to Kenya's development dilemma."

Second, as a result of international concern about the demographic, economic and social consequences of explosive population growth in Kenya, the environment is "donor rich", with a complex array of donors and service organizations, attempting to influence all sectors of population and family planning activity. At present, over 150 population projects are being funded in the country. During the decade from 1980 to 1990, the two major donors, the World Bank and AID, have committed almost \$100 million in support of population and family planning. This funding is provided primarily to a government bureaucracy which is fragile and limited in its ability to absorb and efficiently use such resources. The capacity of the NGOs to take on additional responsibilities is already strained.

In sum, Kenya is a country where the need is great, successful implementation and activity are often elusive, and new projects face a crowded field seeking opportunities for meaningful program work.

## II. COUNTRY BACKGROUND REPORT: KENYA

### A. Economic, Social and Demographic Indications of Development

#### 1. Background

Kenya is situated on the Eastern Coast of Sub-Saharan Africa and is bordered by Uganda, Tanzania, Somalia, Ethiopia and Sudan. The capital, Nairobi, is the largest city as well as the chief commercial city. Kenya covers about 583,000 square kilometers, which includes almost 15,000 square kilometers of inland water.

The population of Kenya is estimated at 20.3 million, with an annual growth rate hovering around 4 percent per year, making Kenya one of the fastest growing countries in the world. The population is distributed unevenly. An estimated 90 percent of the population dwells on less than 20 percent of the land. North Kenya is thinly populated with some 21 people per square kilometer, while the population density in Nairobi is 750 per square kilometer.

Kenya is comprised of tribes from over 40 ethnic and subethnic origins, which are often broken down into four groups: the Bantu, Nilotics, Hamites, and Nilo-Hamites. The ethnic Somali, Rendile, Beran, Samburu and the Turkana live in the North, and the Masai raise their cattle south of the highlands near Tanzania.

Swahili is the national language in Kenya, but English is widely used in schools, government, and businesses.

#### 2. Economy

Agriculture sustains both the domestic and export economies of Kenya. More than 80 percent of the population is involved in rural farming. Exports of coffee, tea, and pyrethrum make up 2/3 of the foreign exchange, with tourism playing an increasingly important role. Per capita income is falling in Kenya, down to US \$340 in 1983. The GNP was US \$310 per capita in 1984, with a growth rate of 2.1 percent. Economic problems that plague the country are an annual inflation rate of 10.8 percent, a rising unemployment rate and a national debt that was recorded at \$3,062 million in 1984, then 53 percent of the GNP. A steady rural to urban migration, with its concomitant social problems has added to the problem of rising unemployment in the cities, while overcrowding in the rural areas has forced farmers to cultivate mediocre and less fertile land.

Kenya is one of the few African countries where the private sector prospers with minimal interference from the government. Thus, the Government addresses the economic problems by increasing the rate of investment and growth of Kenya's private sector in order to provide productive employment opportunities for the population.

### 3. Politics and Government

Since 1963, Kenya has been governed as a republic. Despite many changes in the democratic structure of Kenya since then, the Government has maintained political stability. The Government consists of three branches: the executive branch is currently led by President Moi, who acts as chief of state, head of the government, and commander in chief of the armed forces; the legislative branch is comprised of a unicameral parliament; and the judicial branch is the High Court, supported by various lower courts. In addition, there are over 25 ministries, including health, education, finance and planning, social services, and community affairs. Kenya is divided into 40 rural districts which join to form 7 rural provinces. Nairobi is distinguished by a special status. The administration of these provinces is supervised by the central government. The sole and ruling political party is the Kenya African National Union (KANU). Kenyans enjoy universal suffrage for all citizens over 18 years of age.

### 4. Cultural and Religious Characteristics

Major religions in Kenya include Christianity (Catholic and Protestant), Islam, and Traditionalist. Those living in the country's interior are predominantly Christian, while the residents of the Coastal and Northeastern regions tend to be Moslem.

The religious groups have a significant influence on the acceptance and practice of family planning. The National Christian Council of Kenya (NCCCK) and the Christian Organizations Advisory Trust (CORAT), are active in population education and training. Protestant, Catholic and Moslem groups are represented on the National Council for Population and Development (NCPD).

### 5. Social Characteristics

#### a. School enrollment:

Since the mid-1960's the government has placed emphasis on the development of education by allocating to it 30 percent of its national budget. Primary education is free. About 93 percent of eligible school-age boys and girls go to school. The literacy rate is estimated at 60 percent for males and 35 percent for females. The cost of education beyond the primary school level is the parents' responsibility, resulting in lower enrollment rates.

#### b. Age of Marriage:

The official age for marriage in Kenya is 18 for men, while for women it was just recently raised to 18. The actual average marriage age for women is 19. Ethnic groups residing on the Coast generally encourage earlier marriage. Monogamy, a lifestyle that tends to be associated with higher fertility, is quickly becoming the norm, with 80 percent of the women in Nairobi in monogamous situations.

## 6. Health Characteristics

The most common health problems are associated with childbearing, communicable diseases, malnutrition, and poor sanitation. Major causes of death are meningitis, dysentery, and tetanus.

Some health indicators are:

Infant mortality rate.....	92
Child mortality rate.....	16
Maternal mortality rate.....	46
Life expectancy at birth.....	53
Doctor/patient ratio.....	1/7540
Nurse/patient ratio.....	1/99
Hospital beds/100,000 people (1983).....	156
Percentage MDs in urban areas.....	75

## 7. Current Demographic Situation

Demographic indicators:

Population (1985).....	20.2m
Percent of population under 15.....	52
Percent of women in the childbearing ages of 15-49..	42
Crude birth rate.....	53
Mortality rate.....	13
Rate of natural increase.....	4.1
Number of years for population to double (at 4.1 rate).....	17
Total fertility rate.....	7.9
Contraceptive prevalence rate (1983).....	17
Growth rate of urban areas.....	8%/yr

## B. History and Current Status of Family Planning

### 1. Attitudes Toward Family Planning

A survey undertaken in 1981 about perceptions and attitudes toward the family planning program and contraception among rural Kenyan women (Dow and Werner. Studies in Family Planning, Vol.14 #2, Feb 1983) revealed that among the obstacles to the use of (modern) contraceptives were lack of access to service outlets/providers, and to an even larger extent, lack of demand for contraceptives created by a desire for a high number of children (8 among both males and females). According to the latest data available (Kenya CPS 1984) nearly 60 percent of Kenyan women aged 45-49 have eight or more children. Other surveys undertaken in Kenya show a high level of information about contraception, with more than 90 percent of all ever-married women knowing at least one method of contraception. However, even though approval of the practice of family planning is associated with family planning knowledge and use, it is not associated with lower fertility (Dow and Werner in Studies in Family Planning, Vol 12, #6/7 and Vol 13 #1)

It is clear from these and other surveys that, despite aggressive family planning campaigns, the traditional desire for large families has not changed. Children are still valued as a source of labor, a form of old age insurance, a gift from God, and as confirmation of status within the community.

## 2. Origin of the Family Planning Effort

In 1962 several local groups merged to become the Family Planning Association of Kenya, and became an IPPF-affiliate. In 1966, in collaboration with the Population Council, Kenya became the first Sub-Saharan African country with a national family planning program. The policy emphasized child-spacing rather than limitation of family size. The GOK provided free contraception to all married women of childbearing age by 1968, and in 1974 an integrated Maternal and Child Health/ Family Planning Program was announced.

## 3. Current Population Policies and Laws

### a. Policies

The GOK considers the country's current population situation to be an obstacle to social and economic development. The GOK's policy of reducing the rate of population growth primarily through decreasing fertility has as its objective the creation of a better balance between population growth and economic development. The aim of the national family planning program is to make family planning information, education and services available on request through free clinics in all public hospitals and health centers. The program is closely linked with the maternal and child health program and includes provision of assistance to couples with infertility problems. The target is to reduce the population growth rate to 2.8 percent by the year 2000. During the 1978-1983 period special emphasis was placed on "delivering the message" through improved coordination of activities and administrative and organizational improvements.

The 1984-1988 Development Plan seeks to educate potential parents of the benefits of smaller families and to make family planning available with emphasis on rural areas. The country statement at IPPF in Mexico in 1984 declared Kenya's need to make contraception available to all by increasing the number of service points throughout the country through various strategies such as CBD, social marketing and private sector efforts.

Recent speeches by President Moi and other ministers reveal an aggressive approach to increase family planning acceptance. This approach includes an emphasis on male responsibility and the introduction of disincentives to have more than four children through restricted maternity leave for public employees and educational fees.

Problems concerning spatial distribution and internal migration are addressed through the diversion of a large part of available resources for the development of Western Kenya, a region that has a high level of out-migration to Nairobi and Mombasa. International migration is perceived as being satisfactory and not significant.

b. Laws and regulations affecting service delivery:

Since 1978, sterilization has been a legal form of birth control with no restrictions, and available in many state hospitals and clinics. Abortion, however, is legal only in situations where the woman's life is endangered. There are restrictive guidelines (3 children and 30 years old) on client eligibility for injectables or the IUD, and lactating women are denied oral contraceptives.

Restrictions on the distribution of oral contraceptives outside clinics by community distributors were lifted recently.

4. Family Planning/Population Policy Implementation

Two organizations, the Ministry of Health (MOH) and the National Council for Population and Development (NCPD) have major responsibility for implementing the population policy.

a. Structures

The Ministry of Health, which is the central administrator of health services throughout the country, is headed by the Permanent Secretary of the MOH. The professional branch is headed by the Director of Medical Services. The Division of Family Health (formerly the National Family Welfare Centre) is responsible for expanding and improving the quality of MCH/FP services.

At the provincial and district levels, medical officers are in charge of all health services including municipal and private (i.e. church) health services. At the district level, the district hospital management team oversees the district hospital. Supervision of all other rural health facilities is the responsibility of the rural health management team. The management structure extends to sub-district levels through rural health management committees. The role of these committees should become increasingly important as district planning and the family planning subcommittees of the District Development Committees (DDCs) gain momentum.

The nation's 41 districts are divided in 254 rural health units (RHU), subdistricts averaging 54,000 people. The MOH plans to have a rural health centre (RHC) in each RHU, staffed and equipped to offer a full range of MCH/FP services and to serve the remaining facilities (dispensaries) on a mobile basis. The RHC also supervises the satellite dispensaries and provides limited in-patient services (normal obstetrics and minor surgery). They are headed by a clinical officer, paramedicals (who can perform most MD functions) and employ community nurses, family health educators, and sometimes a lab technician and a public health nurse.

b. The National Council for Population and Development

Established in 1982 within the Office of the Vice-President and Ministry of Home Affairs, the NCPD is composed of representatives from the main agencies in the population-family planning sector, religious organizations and the main Ministries. The Council's Secretariat provides financial and technical assistance to organizations involved in R & E and innovative service delivery. The NCPD plays a crucial role in creating awareness of FP and Population problems and generating support for program implementation. The NCPD was instrumental in the creation of standing DDC sub-committees on FP, as called for by the 1985 Circular from the Office of the President.

c. Family Planning Service delivery:

Since the beginning of the 70s, when FP service delivery was entirely clinic-based, dramatic changes have taken place. In order to increase accessibility many heretofore untapped resources have been mobilized: service providers now include non-medical personnel such as TBAs, malaria workers, and education/motivators to educate and distribute contraceptives.

d. Clinical Services

The private sector plays an important role in clinical service delivery, as some 70% of all hospital beds and rural health facilities are in private hands.

Currently clinic services are provided by the MOH, church-sponsored medical facilities, FPAK, some employers in the private sector and some private MDs. Two-thirds of the MOH clinics offer services full-time, the rest on a weekly, fortnightly or even monthly basis (if supplies are available). Supply and staff shortages are major obstacles in improving access and quality of services. Some of the private clinics have a better record as they are engaged exclusively in FP services. In urban areas, such clinics are important as the MOH has no other facilities than the national hospital in Nairobi and provincial and district hospitals in other urban centers.

The private commercial sector has been boosted largely through the Family Planning Private Sector Program (FPPS), a USAID-funded \$ 4.5 million project implemented by John Snow Inc. Its goal is to enhance the institutional capacity of private employers to develop and implement sustainable programs for health and FP service delivery. Since the end of 1984, the project has enabled 30 of Kenya's largest employers to incorporate family planning into their medical services package for employees and their families. Private MDs do not add appreciably to the availability of services as they reach mostly the urban elite. Both Pathfinder and FPAK are trying to involve more MDs in FP through the Kenya Medical Association.

e. Community-based Distribution

A number of organizations, such as Maendeleo Ya Wanawake (the Women's Progress Organization), FPAK, the National Christian Council of Kenya, Aga Khan Foundation, CORAT and the Institute for Cultural Affairs have integrated distribution of contraceptives into their community-based health care programs with the help of foreign donors such as UNFPA, SIDA, the Pathfinder Fund. There is some controversy as to the wisdom of rapid expansion of CBD programs. Advocates have pointed to the advantages of accessibility and better client treatment; dissenters feel that CBD will be imposed on communities without sufficient attention to popular sensibilities and the likelihood of insufficient medical back-up in case of complications and adverse side-effects.

The NCPD is currently involved in developing a national CBD program to provide a framework for development, implementation and policy regarding CBD projects.

f. Social Marketing

This is the least developed service delivery strategy. USAID has included support for social marketing programs in its new agreement with the GOK and is beginning to initiate planning activities.

g. IEC Activities

Due to a great extent to the personal efforts of President Arap Moi himself, education and information activities have evolved over the last decade. Beginning as the effort of an individual service delivery organization limited to information for married women about child-spacing, they have evolved into a major national undertaking aimed at married and unmarried people of both sexes, about the benefits of small families. These efforts are coordinated by the NCPD. All Ministries which reach a significant population subgroup have an I&E unit; population information officers are appointed at provincial level and DDCs have been instructed to establish standing subcommittees on FP.

Now, several strategies are implemented to educate and inform the (adult) public about the benefits of small families ranging from IE&C committees within commercial enterprises, special training sessions for women's group leaders, and through interpersonal networks made possible by the increasing ranks of community distributors and volunteers. IE&C activities aimed at young people are expanding rapidly and are aimed at both the in-school and out-of-school population.

The major criticism of the national I&E program is that it has created high levels of awareness without significantly affecting fertility behavior. A number of factors is thought to be responsible for this, such as insufficient attention to certain target groups (students, males, local officials), insufficient attention to the psychological factors that inhibit change; lack of appropriate material; lack of baseline information; and evaluation and inadequate training of I&E professionals.

Problems facing MOH and NCPD:

The implementation of the Integrated Rural Health Program has faced many problems which have affected the accessibility and quality of MCH/FP services: staffing shortfalls, curative demands, inadequate training, and transport problems. [Supply problems, which plagued the project in the early eighties have been addressed and a significant improvement in the drug- contraceptive distribution system has been achieved.]

The major tasks awaiting the NCPD are in the areas of coordination, guidance (technical assistance) and dissemination of findings, guidelines and other information that is relevant to program implementation. A July 1985 report presented by a special advisor from the World Bank (Dr. K. Kanagaratnam) identified a number of issues that need to be addressed to improve the management and professionalism of the NCPD such as the composition and mandate of the NCPD; leadership; financial management; research and evaluation of activities to improve program performance (including MIS systems), human resource management, I & E strategy and management, and the coordination of planning and budgeting between ministries that are involved in I & E activities.

##### 5. Training for Family Planning Personnel

Many training activities both in I&E and service delivery have taken place, with considerable duplication as the various organizations have developed their own curricula and training courses, without the benefit of lessons learned from others.

a. Clinical Family Planning Training

The MOH Division of Family Health provides clinical training to both CBD and clinical personnel. The University Department of OB/GYN, faculty of Medicine provides in-service training for medical personnel, and the Department of Community Health teaches undergraduate students in demography and MCH/FP. Furthermore, the MOH and Church hospitals operate pre-service training institutions for nurses and midwives. All training includes FP. The organizations involved in CBD activities all train their own people.

b. Demographic Training

The Population Studies and Research Institute (PSRI), established at the University of Nairobi in 1977 with USAID funding and a Population Council executed USAID grant, provides post-graduate training in demography up to the PhD level. Population issues are also taught in the Faculty of Agriculture with the collaboration of FAO.

c. IEC Training

Training is organized by the various ministerial departments involved in spreading "the population message" and are designed to have a snowball effect, where the various levels in the hierarchical order train the next level down. Similarly, some of the NGOs have their own training programs that start at the national level using curricula that can be adapted to local situations.

d. Training Institutions

Three organizations offer population and family planning training and serve as training resources to other programs:

- o African Medical and Research Foundation (AMREF)  
AMREF is involved primarily in clinical and IEC training of respectively, rural health management teams and community health workers, TBAs, shopkeepers. The Private sector FP Program has subcontracted AMREF to train nurses. AMREF also serves as a resource to the College of Health Professionals.
- o INTRAH  
Its regional center trains predominantly paramedics, auxiliary and community health workers (PAC II) in FP and IEC.

- o Centre for African Family Studies (CAFS)  
CAFS was established by IPPF to provide training in FP, Population and Family Life Education. Its programs include awareness seminars for policymakers, workshops for teachers and trainers focused on material preparation, and FP training for trainers and supervisors of clinic staff. CAFS also has considerable experience in developing materials for adolescents.

Some of the problems observed are that many of the training programs focus heavily on content (FP) and little on skills and practice. The tier training system aggravates the problems as this imbalance becomes magnified. Another problem is that of coordination: ministries and organizations duplicate efforts by developing training packages for similar audiences.

#### e. Non-FP-Related Management Training

USAID, in its 1985 CDSS paper, listed among planned projects a management training program to be initiated by the Private Enterprise Bureau to establish or upgrade institutions in Kenya for training in business and financial management. (SV has been trying to get info on this from AID but so far no one knows about this)

## 6. Financing and Donor Support

The national family planning program is financed almost entirely by donor funding. The nongovernment sector is equally dependent on external support. The donor situation is extremely complex as all the major sources of population assistance are represented in Kenya.

The major bilateral donors have joined in financing the large \$61 million World Bank Second Population Project (1979-1985, amended to 1987). (Data are from 1985) They are: IDA (credit of 23 m), SIDA (9.8m), DANIDA (8.5m), USAID (4m), ODA (1.2m), UNICEF (0.7m), UNFPA (0.6m). The GOK contribution to this project in 1985 was 10.5m

Obligations from USAID for FY 1987 are \$2,039,000, down from \$7,800,000 in 1986. AID monies are spent in various ways, i.e. direct bilateral assistance and through other channels such as the World Bank and block grants executed by a multitude of NGOs, the most important of which are AVSC (Sterilization), The Pathfinder Fund (innovate projects in policy, service delivery, support to women's groups), IPPF (through its affiliate, the FPAK), FPIA (through a variety of groups, and mostly service delivery) and John Snow, Inc. (Private Sector Project).

UNFPA's contribution during the period from 1979-1983 amounted to US \$6 million and covered those projects whose major emphases included policy development, information, service delivery, and training.

### III. THE FAMILY PLANNING ORGANIZATIONS

This section will describe the major family planning service delivery organizations in Kenya. These include:

1. The Family Planning Association of Kenya (FPAK)
2. Maendeleo ya Wanawake
3. The Protestant Churches Medical Association (PCMA)
4. National Christian Churches of Kenya (NCCCK)
5. The Ministry of Health (Family Service Division)

#### A. Family Planning Association of Kenya

##### 1. Overview of the Organization

###### a. Background

The Family Planning Association of Kenya was formed in 1962 by volunteers who initiated provision of family planning services in the country, at a time when the government was providing neither service delivery nor motivation for family planning. In 1977 the FPAK became an IPPF affiliate.

###### b. Services Offered

The FPAK provides the only "vertical" family planning services in the country through its model clinic in Nairobi (Phoenix House) and through other FPAK centers (i.e., as in Nyeri, Thika and Mombasa). IEC services are provided by 144 field educators located at the divisional level and another 120 lay educators operating at the sub-locational level. The FPAK also provides family planning motivation through existing women's groups, and through mass media (i.e., radio, television and newspapers).

The Association operates 12 base clinics of which five provide surgical contraception, in urban areas. FPAK is implementing a community based distribution system of contraceptives through 60 outreach clinics. This CBD program, established in 1983 (and initially funded by the Pathfinder Fund) operates in several pilot areas. FPAK plans to expand this project to six new areas based on positive results indicating higher acceptor rates in areas being reached by CBD distributors over areas without CBD services.

Voluntary surgical contraception is another important component of FPAK family planning services. This program offers both male and female surgical contraception as well as training in minilaparotomy procedures for doctors from government and private hospitals as well as private practices.

The 1983 Kenya Contraceptive Prevalence Survey (KCPS) conducted by the Central Bureau of Statistics indicates that FPAK provides 27 percent of all family planning services in Kenya.

### c. Organizational Goals, Policies and Strategies

The FPAK's Three Year Plan 1986-88 outlined the role the organization has defined for itself as follows:

"The Association will continue complementing and supplementing the efforts of the Government and other agencies in stimulating the knowledge and practice of family planning. The Association will contribute to the improvement and expansion of services delivery and continue to pioneer the development of innovative approaches to family life education, population education, family planning motivation as well as service delivery."

FPAK's stated strategies are:

- o Promoting and intensifying the present level of family planning information, education and motivation in collaboration with the government and other agencies.
- o Responding to the FLE/FP needs of youth.
- o Integrating family planning with other development activities.
- o Facilitating the availability of family planning services particularly in disadvantaged areas.
- o Improving the capacity of the Association to meet future needs.
- o Improving collaboration between FPAK and other agencies.

### d. Organizational Structure and Decision Making

FPAK is one of 21 IPPF affiliates in the region. It is an organization composed of staff and volunteers. FPAK is organized through a network of volunteer branches which currently number 104 and are spread all over the country. At the field level, the Association has offices in seven of the eight provinces. These are called Area Offices and are managed by Area Program Officers. One of the provinces, Rift Valley, is so large geographically that FPAK has sub-divided it into two areas, with a Program Officer for each area. Therefore, although FPAK has area offices in only 7 of the 8 provinces, there are a total of 8 Area Program Officers. Altogether the Association has more than 276 staff including professionals trained in family planning and 120 lay educators. At the national level, three bodies preside:

- i. The National Annual Delegates Conference (NADC). This is the policymaking arm, composed of delegates from each local branch.
- ii. The National Executive Committee (NEC), composed of the FPAK National office holders and representatives from each Area Office.
- iii. The Management Committee (MC). Meeting every two months, this body oversees the management of FPAK assisted by the FPAK Executive Director, a Finance and Administration Manager, and a Program Manager. The Executive Director is responsible for the day-to-day supervision of all FPAK activities.

Besides the Management Committee, other Committees, such as Medical Advisory, Law, Finance and IEC oversee other areas of organizational activity.

At the grassroots level are local branches which send representatives to the divisional level, who in turn send representatives to the district level, which then forms an area committee. These area committees relate to the FPAK headquarters in Nairobi.

e. Financial Considerations

The annual budget of FPAK for FY 1987 is 34 million K. shillings (\$2,125,000). This support is broken down as follows: IPPF, 43 percent; NCPD, 29 percent; Ministry of Health, 9 percent; and others, such as Pathfinder, IPAUS and a local fund drive make up the balance.

f. Community Involvement/Public Relations

FPAK takes an active interest in involving communities in the activities of the organization, and has played a leading role in public education and motivation for family planning in Kenya. A community based distribution program is a key aspect of FPAK's service delivery.

2. Program Management

a. Planning

i. Strategic and Operational Planning - FPAK is currently in the process of devising a new strategic plan. As a result of this plan, it is expected that there will be major changes in both the organizational structure and also in organizational priorities.

ii. Program Planning - When the new FPAK Strategic Plan is finalized in March 1987, program planning will begin for both national and local areas.

iii. Planning for Financial Sustainability; Fundraising - FPAK faces serious financial questions at the current time. The funding level for the Association has exhibited a declining trend in recent years, in part because international and local funds are limited and cannot support the Association's expansion indefinitely. The Association's future growth will increasingly depend on its ability to develop its own resources and achieve a greater degree of self reliance.

In 1985, FPAK set up a Resource Development Unit to assist in developing and conserving human, financial and material resources. This Unit will:

- o Continue traditional fundraising activities to raise funds for loan repayment of the new headquarters building;
- o Set up and expand an income generating clinic at Phoenix House;
- o School transport;
- o Marketing of handicrafts and cottage industry through utilization of PPWD groups.

## b. Key Management Support Systems

FPAK is in the process of developing a new strategic plan which will be completed by April 1987. Information about management support systems, which are in flux, will be available at that time.

## 3. Analysis of the Strengths and Weaknesses of the FPO

In the last 4 years, the FPAK has had 5 different Executive Directors. (The newest Director, Mrs. Mworio, had just been appointed in February 1987 when the assessment team visited Nairobi). The recent history of the organization was characterized by financial mismanagement, inadequate administration, and overall poor program performance. However, the major donors continue to support FPAK because of its significance as a major provider of family planning services and also its tremendous potential for expanding services in Kenya. FPAK has been a leader in experimentation with CBD services and provides a significant share of the voluntary surgical contraception services. Lastly, in the tradition of other private Family Planning Associations, FPAK is innovative, testing approaches and service delivery mechanisms without the constraints the government must face in attempting to deliver similar services.

## B. Maendeleo Ya Wanawake (MYWO)

### 1. Overview of the FPO

#### a. Background

Maendeleo ya Wanawake (which literally means Progress for Women) is the largest women's organization in Kenya, formed over 30 years ago. It originated with the Kenyan "Harambe" movement, which began with the country's first President, Jomo Kenyatta. In the beginning of Maendeleo, women's groups were formed at the community level, with the goal of assisting one another, primarily with financial support. Regular community meetings were held at which each member was asked to donate five shillings to the group "money fund". On a rotational basis, each member was allowed to use the group's fund as she chose (usually for a "major" purchase to improve the family domestic or financial situation, such as starting a poultry project). Today, as in Maendeleo's earliest days, the core of Maendeleo's efforts in supporting women is in income generation.

#### b. Services Offered

Maendeleo has worked with the Pathfinder Fund in Kenya since 1979, initially with information, education and motivational activities among women's groups. In 1983, with support from Pathfinder, Maendeleo began a CBD program, using members and volunteers from Maendeleo as community and field workers. These workers, based at the community level, serve as supply centers for contraceptives in their communities, as well as providing information/education to new and continuing users. Maendeleo employs fieldworkers to act as catalysts for forming women's groups in Kenyan communities. Maendeleo maintains staff in half (20) of the country's districts for this purpose.

### c. Organizational Goals, Policies, Strategies

Maendeleo's purpose is to improve the economic, social and political status of women in Kenya by lifting the standard of living of rural member communities to the level where they can help themselves, thus enhancing their integral development as well as the development of Kenya.

The objectives of the organization are to:

- o Promote the qualities of integrity, honesty, truthfulness tolerance, service and friendship as the foundation of all activities of the organization.
- o Develop and improve the status and conditions of life of women and girls of all communities in Kenya.
- o Stimulate discussions among its members on problems affecting women and children in Kenya and take active steps to bring about solutions to those problems.
- o Raise funds through subscriptions, gifts, loans, investments, and other such financial activities which can facilitate achievement of the above aims.
- o Coordinate the women's activities in Kenya through groups in rural and urban areas.

### d. Organizational Structure and Decision Making

Maendeleo is a grass-roots based organization with branches throughout the country starting with Women's Groups at the community level and progressing through Sub-location Committees, Location, Division, 42 Districts and 8 Provincial branches. There is a National Council which is the policy-making body of MYWO. This Council is comprised of representatives from each province. Management of MYWO activities is the responsibility of the National Executive Committee which is elected by the National Council. The Executive Committee meets four times annually. Daily management of the organization is undertaken by the Chief Executive Officer who is assisted by professional heads of the various programs of MYWO.

### e. Financial Considerations

At present Maendeleo receives core support from the World Bank for rent, vehicles and so on. The organization also receives support from a German agency, KONRAD, to maintain district Maendeleo field workers who serve as catalysts for new groups. Maendeleo will receive \$900,000 of AID support via the Pathfinder Fund for the MCH/FP Project, targeted for CBD activities.

### f. Community Involvement/Public Relations

Maendeleo is a uniquely grassroots organization, founded for the purpose of assisting in the development of rural women in Kenya. Community involvement is mandated to carry out the goals of the organization.

## 2. Program Management

### a. Planning

Since May of 1986, a Government-appointed Care-Taker Committee has been managing the affairs of MYWO. The previous National Executive Committee was dissolved due to several mismanagement practices. Elections for new officeholders will commence in February 1987 and will be completed by May 1987.

### b. Key Management Support Systems

Although MYWO has suffered a period of malpractice and disorganization, it has recouped in recent months and now possesses the professional integrity and qualifications to effectively administer its programs. Financial affairs are now overseen by Keah & Co., Certified Public Accountants who are in the process of developing a Financial and Accounting Manual for the MYWO CBD Project, funded by Pathfinder.

## 3. Analysis of the Strengths and Weaknesses of the FPO

Maendeleo's strength as an organization lies in the fact that it is truly a community-based, grass roots organization whose primary concern is the welfare of Kenyan women. It is a national organization, with representation in more than half of the country's 40 districts. MYWO has many years of experience in cooperative efforts with international agencies. It remains one of the most sophisticated and effective organizations in Kenya through which projects can be implemented.

There is concern among some in Kenya that Maendeleo is becoming "politicized". This concern stems from a recent decision to make Maendeleo part of the development arm of the KANU political party. As yet it is unclear what ramifications this will have for Maendeleo's organizational structure, philosophy or activities.

## C. Protestant Churches Medical Association (PCMA)

### 1. Overview of the FPO

PCMA is a loose association of medical, nursing, teaching and evangelistic service deliverers operating almost exclusively in the rural areas of Kenya, unserved by government health services. PCMA is a nonprofit association whose membership includes all major Protestant denominations (i.e, Prebysterian, Seventh Day Adventist, Baptist, African Inland Conference) active in Kenya. Each religious denomination maintains its own facilities in its own manner - there is no uniformity among the units themselves or between the units and the MOH. PCMA's role is purely advisory; the organization has no authority to compel activity by its members. The PCMA office acts as a distribution center for the annual, recurrent and capital grants from the Ministry of Health and for its circulars. PCMA also runs an annual conference.

The Association is made up of 14 hospitals, 20 health centers, and about 140 dispensaries. Not all are currently providing MCH/FP services, although PCMA believes all have the potential to do so. The member churches are in various stages of development in the provision of MCH/FP services. The focus of most service activity is currently hospital-based curative services. PCMA believes there is still a need to convince some members of the necessity of instituting community based preventive activities.

## 2. Program Management

In 1962 PCMA was formed to coordinate all health and medical services of Christian churches in Kenya and to present a "united front" to facilitate liaison with others. At that time, it was agreed that the objectives of the Association would be:

- o To coordinate the medical and health work carried out by its members;
- o To provide such services as are deemed necessary for the Association or its members;
- o To present the views and wishes of the Association and/or its members to the Government Ministry of Health on any matter which affects the medical and health work of its members;
- o To assist members in connection with staffing and supplies where requested to do so by the members concerned; and,
- o To encourage and promote high standards of Christian medical practice amongst its members by all possible means.

Membership may be applied for by any recognised Christian body which is legally responsible for medical and health services in Kenya. The Association will hold an Annual General Meeting on or before the 28th of February of each year.

## 3. Analysis of the Strengths and Weaknesses of the FPO

PCMA serves as a coordinator for the numerous Protestant run mission health services (primarily hospital based). As such it serves as a central focus for training, technical assistance, etc. It has potential as a base for instituting improvements in service delivery, such as standardized reporting and quality control.

The future of PCMA as a viable organization is currently in doubt and the Secretary General of PCMA described its situation as that of "being slowly starved to death". He was referring to the steady decrease in recent years in the amount of the government grant to PCMA which forms its core support. The Secretary General attributes this to a general "hardening" on the part of the government toward all NGOs. Unlike its members, PCMA has no project money from AID or other donors and so must rely on the annual assessment from the government grant to support the two fulltime professional staff in the headquarters office in Nairobi.

## D. National Council of Churches of Kenya (NCCCK)

### 1. Overview of the FPO

The NCCCK is a made up of representation from the Christian Churches working in Kenya. It is governed by a General Assembly which meets annually. The national headquarters of NCCCK is administered by a Secretary General, who oversees volunteers and a staff of about 200. The NCCCK Program which provides family planning and health services is called the Urban Community Improvement Program (UCIP). This program is based on the philosophy of "helping people to help themselves". Community outreach is the core of UCIP. By providing training and technical assistance to churches and other community groups, UCIP's goal is to assist poor communities to organize themselves to become aware of their situation, and to develop the leadership and skills to make desired changes in their lives. The main components of the program are:

- o Community Health - Using a holistic approach to community health, UCIP operates its Nutrition Education Project, Family Planning Education and Services, and Mother/Child Health Care.
- o Small Business Enterprise - Through low interest loans and business training, groups and individuals are able to begin small enterprises.
- o Village Improvement - UCIP demonstrates methods of upgrading traditional shelter for the poor through innovative use of materials and traditional skills.
- o Youth Development - Children's homes provide shelter to orphaned children in the northern nomadic areas. UCIP is also exploring ways of assisting churches to develop creative programs for youth training and development.

### 2. Program Management

There are approximately 30 program staff in NCCCK who are responsible for the administration of NCCCK programs like the UCIP described above. Each program has a director and a deputy director.

### 3. Analysis of the Strengths and Weaknesses of the FPO

NCCCK's potential lies in the nature of the organization: its members include churches all over Kenya, and its philosophy is an orientation to community development and self help.

The director of the UCIP program felt that NCCCK as a national organization would benefit from management training in numerous areas (i.e., bookkeeping, fundraising, proposal development); and also the UCIP program would benefit from specialized training for the CBD project staff.

## E. Government Family Planning Services

### 1. Background

The Government of Kenya was the first sub-Saharan African country to develop a national family planning program. Since 1966 when the Government first expressed concern about the impact of population growth on economic development and the standard of living, the government has included family planning as part of the national development policy. From 1969 to the present every development plan has devoted attention to reducing population growth. The Ministry of Health has integrated family planning with other health services, expanded the family planning service delivery points and trained personnel to provide family planning services and repeatedly set targets for acceptors. Despite these efforts the population growth rate continued to rise and the Kenya population census set the growth rate at 3.8 percent per annum. Faced with the reality of a mean desired family size of 8 and a contraceptive prevalence rate of 6 percent for modern methods, the government developed an information-education strategy in the 1979-83 plan. This strategy provided the following direction: the need for a comprehensive interagency MCH/FP I & E program to refocus I & E efforts towards population and development issues instead of family planning and improved health; a shift from creating new cadres to utilizing all available field staff as providers of FP services and the creation of a new body, the National Council for Population and Development (NCPD) outside the Ministry of Health with responsibility for population policy, planning, and coordination.

Now with the population growth rate reported at 4.0 percent, the government is more actively supporting population initiatives. The Government is attempting to shape popular opinion, encouraging reduced fertility rather than appealing to the family's concern for reduced infant mortality. Further, the target audience for population programs is being expanded to include motivation and education programs for both men and young people. Two additional initiatives are expected to have a dramatic effect on family planning services. First, the government through NCPD is providing financial support for nongovernment medical facilities to integrate family planning into their existing services. Second, the government is facilitating community based distribution efforts of NGOs. Although community based delivery systems are currently provided mainly by NGOs, the government is linked to these programs through supervision and supply networks. Also, the government has recently decided to allow volunteers to distribute low-dosage pills in addition to the non-clinic methods, such as condoms and foaming tablets. The government commitment to reduction in the growth rate is creating a supportive environment for innovative family planning programs and the NCPD and Ministry of Health are beginning to translate that commitment into program activities that will improve and expand family planning services.

## 2. Services Offered

Throughout the 1970s delivery of family planning services was clinic based but during the last decade both the means of service delivery and the range of services has changed significantly. Then the providers included the government, the Family Planning Association of Kenya (FPAK), mission facilities and a few practitioners. Since the beginning of this decade, and in response to the rising fertility rate, the delivery system has changed. Now services are provided through a greatly expanded MOH system, (742 service delivery points as of October 1984, an increase of 47 percent in approximately 5 years), mission services are significantly increased and the commercial sector is emerging as a source of family planning services. In addition, community based service delivery is growing in importance. Government educators and motivators are now distributing contraceptives in addition to their more traditional activities and community health workers as well as traditional birth attendants are distributing contraceptives. The range of available contraceptive services has also broadened with the acceptance of female sterilization and the removal of restrictions on distribution of oral contraceptives outside the clinic.

Although the ministry has been successful in expanding the number of service delivery points, at present only half of the rural health facilities offer comprehensive health services. The disparity between the availability of clinic facilities and the availability of family planning services is said to be caused by the shortage of Enrolled Community Nurses with family planning training. In 1984 USAID estimated that in-service FP training would require a ninefold expansion to reach the levels required for adequate coverage of the population.

Community based health care has been established in Kenya since the 1970s. Since 1982, community based distribution of contraceptives has been added to the community health workers' traditional responsibility for sharing information and education about family planning. The government supports CBD through the Integrated Rural Health and Family Planning project as well as through funding for NGO efforts. To date the development of CBD activities has benefited from the leadership of NGOs such as Maendeleo ya Wanawake (through Pathfinder funding), Family Planning Association of Kenya, National Christian Council of Kenya (Pathfinder), the Aga Khan Health Services, Maua Methodist Hospital, (UNFPA funding), Chogoria Hospital (FPIA and SIDA), Tenwick Mission Hospital and others.

Surgical contraception is now available in government and some protestant church hospitals, FPAK clinics and through private practitioners. USAID estimates place the total number of women in Kenya who have elected tubal ligation at around 300,000. Evidence of considerable unmet demand comes from the long waiting lists at government services and from the many requests received by the Association for Voluntary Surgical Contraception.

The use of IUDs by clients in MOH clinics increased steadily from 10 percent in 1974 and 75 to 23 percent in 1982. Data from patient logs gathered by an ISTI team\* indicate that the proportion of clients choosing IUDs has continued to grow, so that IUDs now represent at least a quarter of total contraceptive use. The nurse at the Family Planning Association of Kenya Phoenix House clinic in Nairobi reported that the IUD is growing in popularity as a method of child spacing among urban women with 3 to 4 children.

\* "Evaluation of Kenya's National Family Welfare Center program of Inservice FP training for Enrolled Community Nurses and Clinical Officers", International Science and Technology Institute, Inc.

### 3. Organizational Goals, Policies and Strategies

The policies of the government of Kenya are guided by three principles: (1) freedom of fertility decision making, (2) maintaining a balance between efforts to reduce mortality and fertility, and (3) the unacceptability of abortion. Use of coercion or incentive is not allowed.

The government has developed the following strategies to guide the implementation of these principles; (1) stress on the desirability of a smaller family norm, (2) responsibility for FP information and education to include all ministries and NGOs in the social and economic sectors and (3) responsibility for services broadened to include the voluntary and private sectors and community organizations and members.

The overall goal of the MOH is to increase the accessibility and quality of health and family planning services to rural areas. The MOH has used two main strategies to attain this goal: (1) provide medical facilities with reasonable access for the rural population, and (2) consolidate preventive and curative services. The main objectives of the government's plans for family planning services are:

- o to increase the number of, and hence access to, full service delivery points;
- o to increase the availability of practitioners trained in family planning service delivery;

- o to improve supporting services: distribution of contraceptives and maintenance of vehicles, equipment and buildings;
- o to increase motivation through the work of the Health Education Unit in the MOH and the Family health field educators attached to the service delivery points;
- o to increase the capability of the Division of Family Health to undertake in-service training, research and evaluation, and central planning.

#### 4. Organizational Structure and Decision Making

Two organizations, the National Council for Population and Development (NCPD) and the Ministry of Health (MOH) have responsibility for achieving the goal of lowered fertility. The NCPD formulates policy; plans, supervises and coordinates the national information and education program; supports innovations in service delivery; promotes contraceptive technology and population-development research. The MOH provides family planning services and assists the nongovernment service providers.

NCPD, founded in 1982 is expected to support, financially and technically, both the information and education program and the innovative service delivery activities of other organizations. As such, the NCPD can exert a powerful influence on the direction of both government and NGO program activities. To date much of the effort of the secretariat staff has been directed toward fulfilling the role of intermediary, participating in proposal development, consolidating proposals into annual budgets, securing approval and funding, and disbursing and monitoring. In the role of intermediary, the NCPD perceives external intermediaries as redundant and has attempted to block the involvement of Pathfinder and other intermediaries in the new \$43 million USAID/Kenya, Family Planning Services and Support Project.

The structure of the MOH was presented in Section II B. 4.

#### 5. Financial Considerations

See Section III B. 6.

#### 6. Community Involvement

The emphasis on and need for an active family planning program has been promoted by President Daniel Arap Moi who speaks strongly and frequently on population issues. His commitment gives legitimacy to family planning and to initiatives within and outside of government. Still, opinions change slowly and popular beliefs include fears that the government is secretly instilling contraceptives into food and drinks.

The community based programs seem to be well received and although some critics suggest that the original philosophy of community decision making is being ignored by current programs, increasing numbers of women are participating in the CBD programs.

## B. Program Management

### 1. Planning

Traditionally, population issues are covered in the government five year development plan. NCPD, since its inception in 1982, has played a key role in shaping the national family planning strategy. Over the years, development plans have responded to the ever increasing population growth rate by shifting the population strategy from child spacing to fertility limitation. Family planning strategies include broadening the cadre of service providers, initiating a comprehensive information and education program, supporting NGO providers, emphasis on community distribution and support for sterilization as a contraceptive method.

In 1984, the NCPD organized a National Leaders Seminar for some 2,000 participants to begin the process of implementing the President's mandate. The meeting served the dual purpose of influencing participants and initiating a planning-strategy formulation process for spreading concern and activities outward to all organizations and leaders and downward to district, sub district and ultimately community levels. (Abigail Kristall 1985)

NCPD has not yet fulfilled expectations for leadership and direction of family planning programs in the country. As a technical resource for planning, NCPD is limited by lack of basic information with which to map programs, projects and activities, or to analyze the common needs of organizations with similar types of programs.

Mr. K Kanagaratnam, Special Advisor at the World Bank, made the following recommendations for strengthening NCPD planning capacity.

- o Research and evaluation to improve program performance, including the establishment of feedback mechanisms and information systems(especially on service delivery);
- o Staff development, including identification of the skills, qualifications and experience needed for NCPD positions and of opportunities for technical, administrative and managerial training;
- o Formulation of a comprehensive I&E strategy, including central themes, production of materials, media programs, feedback, coordination and quality;
- o Coordinated planning and budgeting between ministries that undertake I&E activities.

## 2. Key Management Support Systems

**Logistics:** The Ministry of Health rural health services have been negatively affected by irregular supply of contraceptive supplies. The current Integrated Rural Health and Family Planning project has as a focus, improvement of the contraceptive supplies distribution system. The project is reported to have significantly improved the contraceptive supply system which has a history of closed rural health facilities due to lack of drugs.

### a. Human Resource Development and Management

In 1981, severe shortfalls in clinical officers and enrolled community nurses were reported for both government and NGO health facilities. It is reported that staff lack the skills implied by their qualifications. Since then, major training efforts supported by the IRHP/FP project have succeeded in narrowing the gap in clinical family planning clinics although targets were not achieved between 1982-1985. INTRAH, AMREF and the MOH have developed a standard curriculum for pre-service training of enrolled community nurses for their family planning tasks. This is a big step toward improving the competency-based orientation of training programs. The Division of Family Health training department and the district training teams conduct a nine week in-service training course for enrolled community nurses that includes contraceptive technology updates as well as clinic management and supervision.

The MOH lacks functional job descriptions, performance standards, a performance appraisal system, and supervisory guidelines and procedures for family planning service providers.

### b. Management Information Systems

The MOH Health Information Unit aggregates information provided by government and nongovernment health facilities on family planning service utilization. The government capacity for collecting and evaluating health information for management decision making has been greatly expanded through the USAID funded Health Planning and Information Project. In addition, the project assisted the government to develop systems for budget and personnel management and conducted management training for MOH staff. This project, funded at 2.45 million from August 1979 thru December 1985, was implemented through a government contract with Drew University. New computerization and MOH personnel commitments suggest that management of the information system will continue to improve.

### c. Evaluation Systems

Operations Research: Krystall in her review of the population sector for the Ford Foundation, made the following observations about the evaluation and operations research efforts in Kenya: "Largely through donor initiative, evaluation has come to be an accepted and even valued, component of programmes and projects. However, evaluations can go only so far towards improved practice. They need to be informed by operations research which tries to establish the principles of improved practice. Currently the CORAT programme is the only operations research on non-clinic service delivery in Kenya. The NCCR study which is comparing the impact of experimental (ideal) family planning with the impact of MOH clinics is the only operations research activity on clinic services. The lack of operations research is a serious gap in view of the proliferation of evaluation and evaluators. It is even more serious in view of the fact that the MOH will at some point in the future begin to regularize non-clinic service delivery. Without the input of information from operations research activities, MOH guidelines will necessarily be based on popular opinion rather than evidence."

The lack of operations research is due to factors that include: lack of researchers skilled in operations research, lack of request from the Research and Evaluation Unit in the Division of Family Health and the presence of medical research institutes familiar with the experimental-control model, often a lengthy and costly research procedure. (Krystall)

#### IV. TRAINING INSTITUTIONS

##### A. Institutional Profile: Center for African Family Studies

###### 1. Institutional Context

CAFS was established in 1979 as an institution of the International Planned Parenthood Federation to meet the need of family planning personnel for special programs in family planning. At that time IPPF anticipated the need for a core group of professionals with relevant skills to motivate leaders and others to practice family planning, to assist in the development of population policies and to design and manage programs to promote the objectives of the family planning movement. Further, CAFS was to develop expertise for integrating family planning into other social development programs.

CAFS is unique in Sub-Saharan Africa since no other training institution has taken on the task of providing training for family planning personnel. The university programs that address population issues emphasize research, demographics and policy issues for undergraduate and graduate students. CAFS' programs concentrate on the practical issues of family planning, motivation, program development and service delivery for senior and intermediate personnel.

###### 2. Training and Consultation

Since 1979, CAFS training programs have been regional. The participants are drawn largely from English speaking countries, but since 1980, francophone programs have been offered.

CAFS programs so far have been of three types:

- a. Training courses on a specific theme or on a combination of related themes for family planning staff, and for development practitioners.
- b. Seminars/consultations designed to disseminate up-to-date information or ideas among policy makers, decision makers, and opinion leaders, and to encourage policies and programs in family planning and population activities.
- c. Workshops to produce teaching or training materials.

###### 3. Structure and Management

Since 1983, CAFS has become a separate non-profit institution. It has its own Board of Directors and has status analogous to that of a family planning association. The Director, Professor De Graft Johnson, has been with the institution since its founding.

###### 4. Facilities

CAFS occupies space in Mlima House, an office building in Nairobi. The facilities include offices, conference room, and a training room. There are no residential facilities, and participants are housed at a nearby hotel. In 1987, four of the eleven scheduled courses are to be conducted at CAFS facilities, the others will be taught in a variety of countries in Africa.

## 5. Human Resources

The CAFS core staff of six professionals is supplemented by resource persons drawn from Universities, government, IPPF Africa Field Office staff and other agencies.

The currently filled professional staff positions include  
Director: Dr. DeGraft Johnson  
Deputy Director: Dr. Ahade  
Senior Program Officer: Ezekiel Kalaule  
Program Officer: Jane Kwawu  
Program Officer Communications (Francophone): P.M. Guy Moutia  
Assistant Program Officer/ Nurse Midwife Tutor

Professor De Graft Johnson is expecting two additional staff members to be funded by IPPF within the next year. These new staff, social scientists, will be expected to assist with training. The IPPF evaluation team was particularly interested in directing the new staff members toward support of IPPF affiliates. IPPF requested that emphasis be given to trainee selection and training follow-up activities to strengthen the impact of training (areas in which CAFS has not been particularly aggressive).

The two program officers, Ezekiel B. Kalaule and Jane A. Kwawu, both social scientists, worked with FPMT consultant, Bellamine, and have developed management training skills. However, there is no strong technical management expertise in areas such as HRM, MIS, Evaluation, and Finance among the staff at CAFS. Dr. De Graft Johnson feels that the resident skills can be developed through continuing education and on-the-job training by consultants.

Given the training program for 1987 and the existing staffing patterns, CAFS participation with FPMT this year will be limited. The Professor would like FPMT to sponsor two of his staff members for training in the U.S: Ezekiel to MSH's Skills for Managing Effective Training Organizations and Jane to CEDPA's Supervision course.

## 6. Financial Stability

CAFS receives support for core staff from IPPF which accounts for approximately 35-40 percent of the annual budget. In addition USAID/ REDSO is providing CAFS with funds to assist in the development and presentation of new courses. UNFPA funds CAFS to conduct a course and other donor agencies have already requested or anticipate requesting CAFS to develop and conduct courses for project staff.

The CAFS courses are well subscribed and are offered for fees that are substantial enough to suggest that the Center could become self financed. In fact, most of the participants receive scholarships sponsored by the agency that has contracted CAFS to develop and conduct the course. Dr. De Graft Johnson is not optimistic about the prospect for client organizations to support staff training.

Although there is adequate support for the Center, all financing, except for the core funding from IPPF, is tied to projects and to very discrete outcomes. To date major shifts in program emphasis and expansion of program offerings have been supported by REDSO, including the development francophone courses and the shift to management training. Donor support has been critical to the growth and development of CAFS but within the next 12-18 months before major funding ends, CAFS will need to consider long term sustainability of training activities.

## 7. Training Materials

CAFS has developed a set of training modules for each of their major courses. These modules are well structured and address the major topics of concern in each area. Modules have been developed for Training of Trainers in Contraceptive Technology, Contraceptive Technology Update, Management of Family Planning Projects and Family Planning and Population Communication Training. Use of the modules ensures that specific minimal objectives are addressed during training. CAFS staff also shape the training program in response to audience requirements.

## 8. Mechanisms for Evaluation and Feedback

The CAFS training staff implement a fairly rigorous trainee evaluation process that includes grading of a written paper as well as classroom participation. Participants who do not attain expected standards of performance do not receive a certificate of completion; instead they are given a certificate of attendance.

The students are asked to provide feedback about the performance of trainers as well as the program content. The CAFS staff are unable to follow up trainees with visits, and there is no routine communication between the Center and past participants to obtain feedback about the effects of training on current performance.

### B. Analysis of CAFS' Management Training Resources

During 1987, CAFS schedule of activities is full and staff time is totally committed. During calendar year 1987, FPMT can provide some support for CAFS, including management training for staff, support for the french language management training and presentation of a management library. Because of staff commitments it is not possible for CAFS to participate in any other project activities.

Future involvement of CAFS as a collaborating regional training institute for FPMT project activities should be reassessed in the fall. At that time, the criteria for project involvement should include: the presence of a staff member with management expertise; willingness to commit 3-4 person months of a management expert's time to FPMT activities; and interest in developing skills in organizational analysis and development.

CAFS is an important and unique regional resource that should be nurtured to maximize its potential. As part of its current mandate, CAFS could develop into a critical management development resource for family planning associations in the region. Before CAFS can realize its role as a management training and development resource, the staff should be supplemented with a management professional who can plan and direct the management development activities.

The FPMT strategy for collaboration with regional training institutes is to select an organization which expresses interest and has basic expertise, and then to develop that organization's expertise through experience in joint management development, training activities and management assistance for family planning organizations. CAFS is an excellent candidate to participate as a collaborating regional training institute in FPMT activities in the future, but just now CAFS does not have the time to commit to FPMT nor the staff resources to participate in regional activities.

## V. COOPERATING AGENCIES

FPMT has identified three AID funded cooperating agencies in Kenya through which it will work. These are Family Planning International Assistance, the Family Planning Private Sector Project (John Snow, Inc.) and the Information and Planning Systems Project (Thunder and Associates).

A brief description of each of these projects and an outline for FPMT's involvement with each is given in the following section.

### A. Family Planning International Assistance (FPIA)

Family Planning International Assistance is the International Division of the Planned Parenthood Federation of America. Its mandate is to respond to the family planning assistance needs of nongovernmental organizations and government institutions in developing countries. FPIA has supported 14 different projects in Kenya; in 1985 FPIA assistance to Kenya totalled almost \$300,000. At present, FPIA supports activities in the Institute of Cultural Affairs, Chogoria Hospital, the University College of Eastern Africa (in Western Kenya), the University of Nairboi and the Kenyan Association of Social Workers.

Most of these are in support of family planning service delivery and training.

### B. The Family Planning Private Sector Program

The Family Planning Private Sector Program began operations in Kenya at the beginning of 1984. This program, the first of its kind in Kenya, has demonstrated that nongovernment agencies, such as private sector companies, parastatals and mission hospitals who provide health services to their employees and their communities, can successfully and effectively deliver family planning services. FPPS is now supporting almost 40 projects throughout the country. The FPPS supported network of clinics is the largest provider of family planning services after the Ministry of Health; the program now reaches over one million people and has recruited over 8,000 new acceptors. The program has built an infrastructure for effective delivery of services in the private sector.

### C. Information and Planning Systems Project

The Information and Planning Systems for Health and Family Planning (IPS) component of the FPSS project will strengthen the capacity of the Ministry of Health to plan, implement and evaluate the Primary Health Care network at the national, provincial and district levels. The IPS project 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 both the private and public sectors. 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. In addition, a system of targeted family planning data will be developed, allowing family planning data to pass in a timely manner to the NCPD and hence to the Cabinet and the Office of the Vice President.

### D. INTRAH

The INTRAH work in Kenya is supported through a buy-in from the AID Kenya bilateral project. The goal is to improve rural MCH/FP services within the MOH through in-service training of approximately 350 nursing personnel in rural Kenya over a two year period. The objectives of the project are:

- o To improve the utilization of available resources at the health center and other service delivery points.
- o To increase the number and strengthen the training capability of MCH/FP management trainers within the nursing division.
- o To develop six district training teams.
- o To develop a management in-service training system.
- o To establish a training evaluation system.

At present, INTRAH is undertaking two large projects with the Kenyan Ministry of Health. The first is with the Division of Nursing to train the managers of family planning clinics. This is a three-tiered project to train national trainers, who will train 24 provincial/district management trainers in management training skills, and who will in turn conduct training in the provinces for about 300 nurses from MCH/FP clinics in six provinces in family planning clinic management skills. (Twenty-five percent of the nurses trained will be from NGOs). The second major project is with the Ministry of Health, Division of Family Health. These training activities include training of trainers for provincial centers and an annual refresher course.

#### E. Association for Voluntary Surgical Contraception (AVSC)

The expansion of voluntary surgical contraception services is an objective of the new AID bilateral project. Assistance through the FPSS will be funded through AVSC and several other centrally funded contracts (i.e., JHPIEGO). 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 minilaparotomy information and education and counseling. Training will be coordinated by FPAK, PCMA and the University of Nairobi. AVSC will use FPSS funds to provide equipment for eight additional NGO sites and 22 government hospitals, as well as equipment for five additional missionary hospitals. FPSS will fund basic minilaparotomy and emergency back up kits for about 85 private practice physicians. Under the review and approval of the MOH, AVSC will program and manage FPSS funds for VSC services in NGOs and the private sector.

#### F. Pathfinder Fund

The Pathfinder Fund has been an important participant in family planning activities in Kenya for more than a decade. At present, Pathfinder is involved in support of numerous innovative policy and service delivery projects through the private sector. For example, Pathfinder works with both FPAK and Maendeleo Ya Wanawake in promotion and expansion of CBD activities.

Because of Pathfinder's sound reputation, its access to other local family planning organizations, and its collaboration in the FPMT Project, we believe FPMT activities in Kenya should be orchestrated through the Nairobi Pathfinder office.

## V. PROPOSED FPMT ACTIVITIES

### A. Introduction

All FPMT assistance and training provided to Kenya will support the three components of AID's new family planning project, (1987-92). The three focuses are; enhanced service delivery, Community Based Distribution (CBD), and support to the private sector and NGOs. FPMT has identified opportunities for assistance to service divisions within the Ministry of Health as well as nongovernment service providers and organizations implementing CBD activities.

In all cases we have attempted to pair technical assistance to strengthen management systems with training in order to enhance the effects of FPMT inputs. We have selected organizations which had clear need, were receptive, and which showed potential for change. We have identified opportunities for technical assistance and/or training interventions which are discrete, focused, and lend themselves to discernable measurement of impact.

At the outset of our needs assessment visit it became obvious that FPMT would be entering a complex and donor rich environment, but one that is also characterized by organizational inefficiencies and a desire to improve service delivery. There is a clear recognition of the inadequacies of current management structures and procedures within both the government program and the NGOs providing services. Given the magnitude and diversity of family planning program activities in Kenya (150 donor supported population projects currently exist), the management development plan was largely limited to providing focus and direction for potential FPMT activities in Kenya, and to identifying opportunities for more in-depth assessment and program planning. Because the donor environment is diverse, FPMT's link to Pathfinder is all the more important. As a result of its longevity and solid reputation in Kenya, Pathfinder provides FPMT with an entre into most organizations and a great deal of associational credibility.

We are recommending that FPMT provide assistance to organizations representing the nongovernment health services community and intermediaries (AID supported cooperating agencies), as well as selected components within the government's integrated FP health delivery system. In each case we have recommended or have been asked to conduct a detailed management development plan as the first step in program implementation. The management development plans, which represent an essential first step in comprehensive program design and planning, will also provide invaluable baseline information to be used at a later date for impact evaluation.

After reviewing the many potential opportunities for FPMT to work in Kenya, we have established priorities based on the following criteria: organizational commitment to management change; magnitude of family planning service delivery; and organizational potential to maximize FPMT inputs. In keeping with FPMT's commitment to provide substantive assistance, we have ranked indiscriminate requests for ad hoc training as a low priority. Application of these criteria resulted in selection of three interventions in the private sector and one in government. The programs for these organizations are described in detail in the following section.

## B. Assistance to Nongovernment Organizations

### 1. Family Planning Association of Kenya

FPAK is one of the two major providers of family planning services in Kenya. At the current time FPAK is undergoing reorganization with a new executive director, the fifth in five years, who has recently been appointed. With the assistance of an IPPF consultant, FPAK is developing a new strategic plan which will guide the anticipated reorganization. The strategic plan will be completed by April 1, 1987 at which time FPAK will be in a position to receive technical assistance and training inputs. FPAK has requested the FPMT return in May, after the strategic plan is completed and agreed, to initiate a more detailed assessment and develop the plan for technical assistance and training.

#### a. Technical assistance

Probable areas which will require technical assistance:

- o Staff Management Structure:  
Clarifying job descriptions,  
Grading staff,  
Defining functional areas,  
Revision of performance appraisal guidelines and procedures.
- o Staff Development Planning:  
Salary scales,  
Performance standards,  
Motivation,  
Training needs analysis,  
Career ladder.
- o Program Planning:  
Project design,  
Project conceptualization,  
Implementation planning,  
Budgeting,  
Operations research.

- o Development of a Training Department:  
In-service training program,  
Tuition paid courses for external participants.
- o Management Information System (expected to be managed by  
Thunder and Associates):  
Information system improvement emphasizing; acquisition,  
storage, retrieval and record keeping for service  
delivery statistics for decision making.
- o Logistics:  
Storage and distribution,  
Requisition and supply procedures,  
Inventory management.
- o Financial Management:  
Budget planning and management and expenditure control  
for headquarters and district staff.

b. Training Assistance

FPAK anticipates the need for extensive training of headquarters and district level staff, but any definitive training plan will have to await finalization of the FPAK strategic plan.

At this time FPAK anticipates the need for headquarters staff to be trained in the following areas:

- o Management information system and computer use for the  
CBD program officer. (Thunder is expected to conduct this  
training and may seek assistance from FPMT).
- o Management of training (i.e. MSH course "Skills for  
Managing Effective Training Organizations") for the newly  
appointed Training Officer.
- o Logistics management training for the supply officer.

2. Maendeleo Ya-Wanawake

MYA, which has organized the largest network of women's cooperative organizations in the country, provides family planning services through a community based distribution program. The CBD activities supplement income generating activities which are the core of the Maendeleo program. They carry out this activity with AID support provided through the Pathfinder Fund.

a. Technical Assistance

The current funding for Maendeleo's CBD program ends in June. The money to extend the program activities is included in the current bilateral awaiting release of funds. Prior to the implementation of the extension, Pathfinder Fund plans to provide support to MYW to undertake a management audit. It is this audit that will identify the technical assistance and training needs of MYW. Pathfinder has requested FPMT to provide two consultants to take part in the management audit currently planned for May 1987. Following the audit, it is expected that the FPMT project will provide technical assistance as necessary.

b. Training Assistance

Jennifer Mwakolwe, the Program Manager MCH/FP Project, identified the following training needs which she expects to be confirmed by the management audit. Jennifer supports the need for a thorough training needs assessment before any additional staff training is initiated. Also, roles and responsibilities of staff members should be clarified before staff training begins. Training activities are anticipated for both headquarters and field staff. At headquarters the project is managed by five (5) staff; at the field level the project has three (3) district supervisors, five (5) community health nurses, and volunteer supervisors oversee the work of 381 local distributors.

Jennifer suggested the following training for MYW staff but the scheduled management audit will assist to more precisely define training needs.

Headquarters Staff Training Needs:

Nurse Trainer

- o planning of training
- o implementation of training
- o evaluation of training

Research Evaluation Officer

- o Time management
- o Work planning (MBOR)
- o Evaluation Planning

Program Manager

- o Strategic Planning
- o Staff supervision
- o Staff development
- o Performance Evaluation
- o Fundraising
- o Coordination

## Field Staff Training Needs:

### Managerial skills including:

- o Decision making
- o Supervision
- o Work planning including: objectives, target setting, program planning
- o Community development
- o Record keeping, reporting procedures and the use of information for program planning
- o Contraceptive supply management

## Religious NGOs

There are a variety of religious organizations which provide a significant percentage of family planning services in Kenya. Some of these organizations are receiving support from the AID funded Family Planning Private Sector project to add family planning to their range of health services. Among the organizations with which FPPS are the following: The Protestant Churches Medical Association (PCMA), Crescent Medical Aid (an Islamic non-profit organization) and the Adventist Development and Relief Agency (ADRA).

The FPPS project has identified the need for improved management skills among the managers of these service delivery organizations but is unable to provide such assistance through its own project. FPPS has suggested the Voluntary Association for Development Assistance (VADA) as the most appropriate training organization to assist in conducting this training. FPMT will further explore the possibility of assisting VADA to conduct both the needs assessment and the appropriate training for project staff.

VADA is a private non profit Kenyan organization that provides a wide range of support services to NGOs involved in community development work throughout Kenya. VADA's objective is to maximize the impact of these NGOs by strengthening and enhancing NGO institutional capabilities, creating and improving linkages between NGOs and the donor community, and by promoting collaboration among the NGOs. VADA was founded in 1984 and was the result of research discussions and analysis of the management needs and problems of NGOs and their existing and potential contribution to national development. VADA was founded with initial funds from Ford Foundation and has since received a seven year grant from USAID Kenya. This will make it possible for VADA to support various NGO activities in the areas of training, consultancy services, communications, project funding and evaluation.

The organizations that FPPS has identified as needing management training include: the Protestant Churches Medical Association, Crescent Medical Aid (an Islamic non-profit organization) and the Adventist Development and Relief Agency (ADRA).

### 3. Protestant Churches Medical Association

PCMA is a coordinating organization for all major protestant denominations which provide family planning services in mission hospitals, health centers and dispensaries throughout the country. The association consists of 14 hospitals, 20 health centers and about 140 dispensaries which form part of the private sector health services constituting approximately 40 percent of all health care services in the country. PCMA's role is advisory and as such is actively promoting family planning services among the missions. A full range of family planning services are provided in integrated PCMA facilities.

#### a. Technical Assistance

No technical assistance needs were identified during our interview with the secretary general of PCMA.

#### b. Training Assistance

PCMA director identified training needs among the managers of service facilities. The PCMA secretary recognizes various management training needs among the service facilities coordinated by PCMA. To date, some management training activities for facility staff have been implemented by VADA and MAP and the Secretary General suggested that FPMT support the work of these groups. He divided the managerial responsibilities among a local management committee composed mostly of lay volunteers and the administrative committee made up of the medical officer, matron and finance officer. As described by the secretary general, the management training needs of these two very different committees are described below:

##### Management Committee

- o Strategy planning
- o Managerial ethics

##### Administrative Committee

- o Personnel salary schedules
- o Program planning
- o Personnel management

#### 4. Crescent Medical Aid

Crescent Medical Aid is an Islamic nonprofit organization. CMA provides health services to the populations which surround several mosques in Nairobi. Support for these services is provided by the mosques themselves. At present there are six clinics in Nairobi which provide health services to poor urban populations. Each clinic offers family planning services one day per week. CMA has asked assistance from FPPS to develop a full time MCH/FP service in each clinic site. FPPS has expressed interest in FPMT providing management training for CMA clinic managers and to assist in strengthening management systems and with special emphasis on financial management as well as recording and reporting procedures.

#### 5. Seventh Day Adventist

The SDA church, through its development and relief branch, the Adventist Development and Relief Agency (ADRA), manages a network of hospitals and health facilities in Kenya. ADRA operates, supervises, or is associated with 35 health centers and dispensaries throughout Kenya and is developing more. These clinics currently provide a range of services, some of which include family planning. ADRA is currently involved in several development projects to improve dispensaries and upgrade health centers so they can provide full MCH/FP services. As in the case of CMA, FPPS is interested in improving the management of the family planning services and has asked FPMT to assist in supporting this training. Management training and system supports needs specified to date include:

- o General management skills for clinic supervisors
- o Financial management systems for clinics
- o Record keeping systems for clinics
- o Commodity inventory systems
- o Monitoring and evaluation of recording and financial systems

#### Implementation

At this time we have not specified the timing of the management development plan for these religious health service providers. Any FPMT work with these service providers should be coordinated through VADA, the designated technical assistance agency for NGOs. During this visit there was insufficient time to assess VADA's capacity to support this work, although the Deputy Director has expressed interest in working with FPMT. During a follow-up visit to Kenya FPMT should plan to conduct a more detailed assessment of VADA and through VADA, the service provider agencies.

## C. Assistance to Government Family Planning Organizations

### 1. Ministry of Health Family Planning Service Programs

Kenya's health service and health management system is headed by the Permanent Secretary of the Ministry of Health. The technical branch is headed by the Director of Medical Services. The Division of Family Health is responsible for improving the quality of Family Health/FP services. At provincial and district levels the respective medical officers are in charge of all health services whether government or nongovernment (mainly church related). At the district level the district hospital management team oversees the district hospital. The rural health management team supervises all other rural health activities. This management structure extends to sub district levels through rural health management committees.

#### a. Division of Family Health

Dr. J. Kigundu, the Director of the Family Health Division, made the following suggestions for the FPMT project activities:

i. Staff scholarships for overseas training: In the funding for FPSS, Dr. Kigundu has requested that the project provide overseas training for a priority list of trainees originally identified for training through the Family Planning Services Support Project (FPSS).

ii. Training for district public health nurses responsible for in-service training programs: The Public Health Nurses at the district level supervise all MCH/FP activities in the forty (40) districts. In addition these PHNs monitor staff performance and design appropriate training activities. Dr. Kigundu proposes that groups of 20 PHNs receive three weeks training in order to improve their skills.

#### b. Health Services Administration and Planning

Discussions with Dr. Kanani, who has recently been appointed to the Division of Curative Services and Institutional Management, yielded a request to train the managers of ten major hospitals in the following management areas: logistics and supply, human resource development, and budget and financial control. Dr. Kanani has suggested that a needs assessment could be accomplished by bringing a senior manager from each hospital to Nairobi for a two day seminar, during which time they would present and discuss the management problems in their service delivery facilities.

### c. Division of Technical Support

Dr. Maneno, Assistant Director of Medical Services and project manager for the donor supported Integrated Rural Health and Family Planning Project, expressed the need to identify more explicitly the actual management training needs at various management levels of the Ministry. To do this he believes a situation analysis is necessary. He prefers to focus on the district level as the Ministry is in the process of decentralizing health service management to the district level. Further, Dr. Maneno has suggested that there is a need to document the activities of the MCH/Family Planning Clinics in order to plan appropriate modifications in services.

To date training of district health management personnel has been relatively general and at this time Dr. Maneno would like to improve managerial skills in more specific management areas such as management information systems, evaluation and monitoring, personnel and logistics management.

Dr. Maneno identified three districts (Embu, South Nyanzya, Baringo) which the MOH has targeted as models for implementation of national staffing norms. He asked FPMT to undertake a management needs assessment in at least one of those three districts and to provide the required technical assistance and training.

Five steps for implementing this activity were outlined during the meeting:

- o Review of documents and reports on district activities i.e. WHO/MOH Resource Allocation Study, district reports etc.
- o AID Washington and Kenya Mission approval
- o Consultant to design needs assessment plan with Dr. Maneno
- o Consultant to undertake needs assessment in chosen district
- o Planning session with Maneno to develop implementation plan for technical assistance and training
- o Technical assistance and training

## 2. National Council on Population and Development (NCPD)

NCPD shares major responsibility with the Ministry of Health for achieving the goal of lower fertility in Kenya. The main functions of NCPD are:

- o To formulate policy;
- o To plan, supervise and coordinate the national information and education program;
- o To set standards and guidelines for service delivery;
- o To support innovations in service delivery;
- o To assist NGO health services to provide family planning;
- o To promote contraceptive technology and population-development research.

The role of the MOH is to ensure the availability and quality of family planning services (which include information and counseling on fertility and infertility in government hospitals and rural health facilities), and to encourage and assist the efforts of nongovernment providers.

Mr. Hungu, the Director of NCPD, described the proposed evaluation of both the NCPD itself, and the NGOs for which it has coordinating responsibilities. This evaluation, funded by AID/K and UNFPA, will take place in the Spring of 1987 and will assess management of these organizations. After discussions of the potential input of the FPMT project (including participation in the evaluation), Mr. Hungu suggested that the evaluation results would be available to the project by June 1, 1987, and that he would look to the project for assistance in improving management particularly among the NGOs. Mr. Hungu supports the FPMT proposal to collaborate with local management organizations in the implementation of project activities.

### C. Training and Technical Assistance with Cooperating Agencies

#### 1. Family Planning International Assistance (FPIA)

FPIA'S mandate in Kenya is to respond to the family planning assistance needs of governmental and non-governmental family planning organizations. FPIA is attempting to expand and extend family planning programs by innovations in service delivery and a focus on service to the hard to reach. FPIA places special emphasis on involvement of groups and organizations not traditionally associated with family planning efforts. In Kenya, FPIA works with, among others, the Institute of Cultural Affairs, the University College of Eastern Africa, the Kenya Association of Social Workers.

FPIA Deputy Director, Mr. Ruben Johnson, and the Kenya program officer, discussed their concerns about the management capabilities of country project managers. FPIA is interested in improving the skills of these managers and would like FPMT to conduct a management development plan of 4-6 country projects with the objective of designing a specific program of management training. FPIA suggested a June or July management development plan and October or November as the date for the first training activity.

## 2. Thunder

Thunder is a for profit management consulting firm with expertise in computer based health system management. Thunder has a regional office in Nairobi and will implement the AID/K funded Information and Planning Systems Project (IPS). The IPS project will assist the government of Kenya, particularly the Ministry of Health, to improve its information systems for management. Thunder will also implement the information components of Pathfinder CBD project with Maendeleo Ya Wanawake and Family Planning Association of Kenya (FPAK).

Tom Caruso, the program manager for Thunder is interested in the FPMT project providing assistance with various aspects of training associated with these Pathfinder CBD projects.

## D. Regional Training Institutions

### 1. Centre for African Family Studies

CAFS was originally established as an institution of the International Planned Parenthood Federation IPPF, in 1975. The rationale for establishing CAFS was derived from the special problems encountered in family planning in Africa: absence of a core of persons knowledgeable in population and family planning issues, with relevant skills to motivate different categories of people to practice family planning, with the confidence to develop appropriate population policies, and the ability to design and manage programs or projects for promotion of family planning. An institution was deemed necessary as a reference point to coordinate training and promote a consistent program for improving the competence of family planning and related personnel throughout Africa.

Since 1979 CAFS training programs have been regional. So far CAFS programs have been of three types:

- a. training courses on a specific theme or on a combination of related themes for family planning staff and for development practitioners;
- b. seminars/consultations designed to disseminate up-to-date information or ideas among policy makers, decision makers, and opinion leaders, and to encourage policies and programs in family planning and population activities;
- c. workshops to produce teaching or training materials.

CAFS offers an annual schedule of courses for managers and service providers of family planning programs, including;

- o Population and Social Development,
- o Family Life Education and Family Health,
- o Family Planning Technology,
- o Communication, Motivation and Counselling in Family Planning and,
- o Project Development, Management, Supervision and Evaluation

During the visit in February, the FPMT project conducted discussions with CAFS director, Professor De Graft Johnson, and staff to determine CAFS interest in the project as well as its capacity to participate in project activities.

## 2. Observation and Study Tour Sites

During this assignment, the Voluntary Surgical Contraceptive program at Nyeri was identified as a possible study tour site. AVSC supports three service sites in the area including a provincial hospital, a Family Planning Association of Kenya Clinic and a mission hospital. The AVSC programs are well managed and very effective, providing surgical contraception services for large numbers of women in the immediate community and the surrounding district.

Innovative approaches to providing family planning services including clinic and community based services are currently being tested in Chogoria. This pilot project funded through FPIA and SIDA is titled the Health for The Family and provides integrated services at 25 static service delivery points and six mobile clinics as well as through CBD activities. The project is well known as one of the most effective family planning service providers in Kenya. Although we were unable to visit Chogoria, the AID mission and many professionals in the family planning community have recommended the program as a model of effective clinic based and CBD activities.

### 3. US Based Training

This brief management development visit did not allow us to identify specific candidates for short or long term US training. In principle, candidates should be selected from the organizations with which FPMT works in Kenya. This strategy will maximize the effect of FPMT assistance.

### E. Family Planning Private Sector Project (FPPS)

The FPPS, which began implementation with AID/K funding in 1984, works with nongovernment agencies such as private sector companies, parastatals and mission hospitals who provide health services to their employees and to communities. The project assists these organizations to add and effectively deliver family planning services. Approximately 50 percent of the organizations receiving support from the FPPS are church supported and nongovernment organizations.

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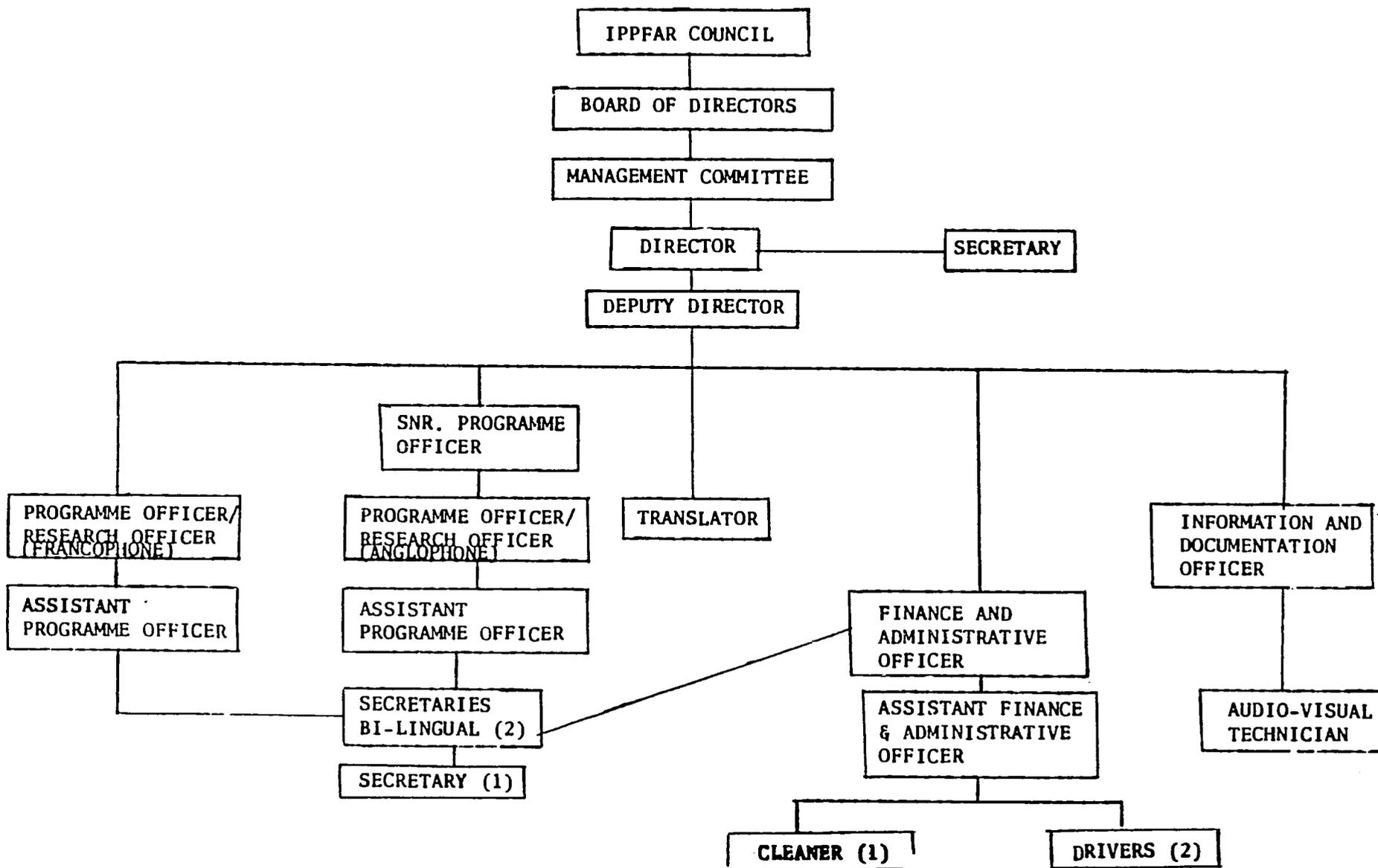
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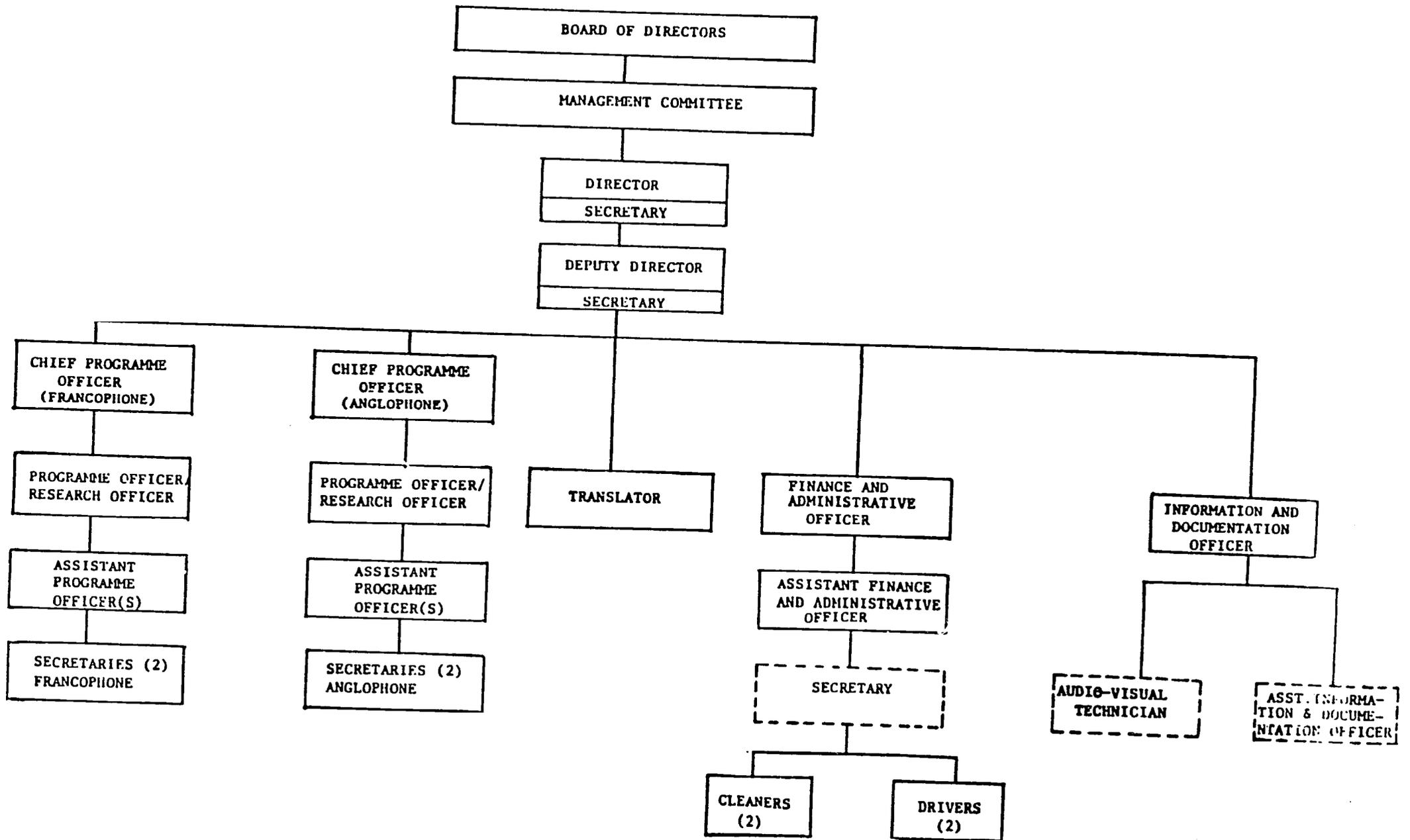
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PROPOSED ORGANIGRAM



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