

86

6150223

PD-ABA-980
60-839
ME
lell
FOPS

FAMILY PLANNING PRIVATE SECTOR PROGRAMME
EXTERNAL EVALUATION REPORT

FEBRUARY/MARCH, 1986

CONSULTANTS

J.K.G. Mati MD FRCOG University of Nairobi
J. Saenyonga PHD University of Nairobi
P. Maccannon DRH Center for Disease Control,
Atlanta, Georgia
J.M. Hangu National Council for Population
and Development

TABLE OF CONTENTS

	<u>page</u>
1. Background	3
2. Terms of Reference	7
3. Evaluation Methodology	10
4. Summary of Evaluation Report Findings	14
5. Project Performance and Progress	17
6. Project Expansion	23
7. Service Delivery Capacity	24
8. Training	30
9. Operations Research Activities	41
10. Dissemination of FPPS Activities	51
11. Programme Sustainability	52
12. Programme Continuation and Expansion	56
13. Future Strategy and Organization of FPPS Project	58
14. Acknowledgements	61
15. Appendix 1 Documents Reviewed	62
16. Appendix 2 Site Visits to Subprojects	63
17. Appendix 3 Interview Checklist and Questionnaire	64
18. Appendix 4 Persons and Organizations Interviewed	77

INTRODUCTION

The mid-project external evaluation was undertaken as part of the original Cooperative Agreement between USAID and JSI Research and Training Institute Incorporated.

The Report of findings and recommendations is hereby submitted to:

- The Government of Kenya, National Council for Population and Development.
- The Government of the United States of America, USAID/Kenya, and
- The JSI Research and Training Institute Inc., Family Planning Private Sector Programme.

J.K.G. Muri
J. Ssenyonga
P. Maccannon
J.M. Hunge

Nairobi May, 1986

Alphabetical List of Abbreviations used in the Report

AMREF	African Medical and Research Foundation
BAT	British American Tobacco
CA	Cooperative Agreement
CBD	Community Based Distribution/Distributor
CBHC	Community Based Health Care
CMS	Central Medical Stores
CO	Clinical Officer
COTU	Central Organization of Trade Unions
CSM	Contraceptive Supply and Management
DMS	District Medical Store
EAI	East African Industries
ECN	Enrolled Community Nurse
FFAK	Family Planning Association of Kenya
FF/MCH	Family Planning/Maternal and Child Health
PPPS	Family Planning Private Sector
GOK	Government of Kenya
IEC	Information, Education and Communication
IRH/PPP	Integrated Rural Health and Family Planning Programme
JSC	John Snow Incorporated
KTCGA	Kenya Tea Growers Association
MCH	Ministry of Health
MYW	Maendeleo Ya Wanawake
NCPD	National Council for Population and Development
NGO	Non-Governmental Organization
OR	Operational Research
PCMA	Protestant Churches Medical Association
PES	Project Evaluation Summary
PMS	Provincial Medical Stores
PBO	Private Sector Organization
SEA	Seventh Day Adventist Medical Services
SIP	Service Delivery Point
SIDA	Swedish International Development Authority
TAC	Technical Advisory Committee

BACKGROUND

Establishment of FPPS

The JSI Research and Training Institute Incorporated (JSI), established a business office No. F.17/84 during 1984 and this has been responsible for the implementation of the Family Planning Private Sector Programme - under a Cooperative Agreement with USAID. The purpose of the Agreement was for the recipient to carry out a four year project to "demonstrate and increase the institutional capacity of private sector organizations to carry our sustainable programmes for the delivery of family planning and related maternal and child health services." The FPPS Project is primarily a service project and the major efforts to date have been aimed at design and implementation of the thirty demonstration family planning subprojects through a variety of Kenyan Private Sector Organizations, and at activities which directly support the improved functioning of these subprojects.

To supervise and approve FPPS activities, the National Council for Population and Development (NCPD) early in 1984 established the Technical Advisory Committee (TAC) whose chairman is also the Chairman of NCPD. The membership consists of representatives of NCPD Secretariat, the Ministry of Health, the Ministry of Finance, the University of Nairobi, Family Planning Association of Kenya (FPAK), USAID, other private interests, and FPPS staff. This broad membership ensures that FPPS activities have the understanding and support of all agencies of the Government of Kenya (GOK) and non governmental organizations, and that FPPS results have the potential of being widely disseminated.

The terms of Reference of TAC are:

1. To establish criteria for selecting potential demonstration subprojects.
2. To participate in and approve the selection of organizations to be funded as subprojects and to approve the project's work plans which include proposed demonstration subprojects, research dissemination and information/education.
3. To maintain close coordination between the integrated Rural Health and Family Planning Programme and the Private Sector Family Planning Project.
4. To maximise technical competence and linkage with other family planning programmes in the country.
5. To develop the project's data collection systems.

6. To carry out continuous monitoring and evaluation of projects and research activities from the technical, policy, and coordination perspectives on behalf of the Council and to inform the Council periodically.
7. To actively participate in the formative and external summative evaluation of the project and the research activities scheduled to be carried out.
8. To undertake additional tasks drawn up by the council.

TAC meetings are held on an "as needed" basis, on the average about every two to three months, normally at the request of FFPS staff. In order to expedite urgent business, the TAC has given authority to the Chairman to provisionally approve subprojects or documents on behalf of the TAC, subject to confirmation at the next full TAC meeting.

Establishment of Subprojects

The original Project Paper for the FFPS identified a list of prospective companies which had expressed interest in receiving assistance in adding family planning and maternal/child health services to their health programs. These companies were contacted by letter and personal visit. In addition a brochure describing the FFPS Project's goals and staffing, the types of assistance available, and the criteria for eligibility was prepared, approved by the TAC, and widely distributed, along with a brief questionnaire to establish interest in FFPS. Recipients included all companies and parastatal organizations having a registered health facility, as well as other appropriate organizations such as mission hospitals.

As described in the FFPS brochure, criteria for subproject selection included the following:

- the availability of other health services at the project site;
- the willingness of the organization's officials to include family planning services with their other health services, their commitment to continuing the services when funding ends; and
- the potential for the project to reach a large number of people of childbearing age not currently served, either because the project is a large employer, or because there is no other family planning provider in the area.

In addition, a proposal format was prepared and guidelines were established for the approval of subprojects. Information required by the proposal format includes name, address and telephone of the responsible officers; a description of the organization, its target population, and its existing health services; a description of any existing family planning maternal/child health services along with an assessment of the potential for the service expansion; project long-term and immediate objectives; activities to be undertaken; specific inputs to be provided by the organization and by FPPS; a detailed workplan including activities, responsible individuals, and timing; acceptor targets; and budget figures.

In a series of site visits throughout Kenya, FPPS Project staff interviewed prospective subgrantees, and assisted in preparation of proposals where appropriate, for submission to the TAC for approval. An organization was considered appropriate for FPPS assistance if it was one of the types targetted by the Project (i.e. private, parastatal; NGO, Church-based, women's organization, or private practitioner's practice), if it served at least 500 people, if no other family planning services were readily available in the area, and if the organization's management expressed serious interest in the Project.

Subprojects actually receive their funding through specific subcooperative agreements between FPPS and the subproject organization. Each subcooperative agreement is negotiated, based on the proposal. Once a proposed sub-project receives TAC approval, the subcooperative agreement is developed by FPPS and submitted to USAID/Kenya for approval. The subcooperative agreement includes the subproject proposal, along with appropriate USAID regulations covering both performance and financial procedures. An initial difficulty with this process, the Evaluation Team understood, was the fact that the FPPS Project was the first USAID project worldwide to provide grants to profit-making institutions. In consequence, USAID had no standard provisions governing such contract agreements. FPPS staff and staff of USAID/Kenya worked together to develop such provisions, which required review by USAID legal staff before their approval in mid-1984. These new standard provisions are included with each subcooperative agreement under the Project.

Once USAID/Kenya approval is received for a particular subproject, the subcooperative agreement is forwarded to the potential grantee for formal signature. Most organizations consult their legal staff before signing the agreement. Because of the length of time involved in the review and approval process, and the length of time required for training subproject staff in family planning and maternal/child health activities, the subcooperative agreements contain a retroactive cost clause which allows staff training to begin once approval is obtained from the TAC and USAID, but before the required agreements are signed. Thus costs associated with release of subproject staff for the nine weeks family planning training course which are incurred prior to formal signing of the subcooperative agreement can be reimbursed after the agreement is signed. This mechanism has allowed smooth scheduling of the African Medical and Research Foundation training courses, and also maximized the time for actual service delivery under the subcooperative agreements.

The first subcooperative agreement developed under the FPPS Project included an advance funding mechanism which initially provided the subproject with funding equal to approximately four months of the first year's estimated expenses. The subproject was required to open a separate bank account to ensure proper management of funds advanced, and to submit financial statements and documentation of expenses on a quarterly basis for FPPS review and reimbursement of costs incurred.

While this advance and reimbursement procedure was and is satisfactory, most organizations have opted for a straight cost-reimbursement funding mechanism, due to the difficulty of opening new bank accounts and separately accounting for the relatively small amounts of money provided through FPPS. With this latter mechanism, the organization receives no advance, but is reimbursed for actual expenses incurred. Reimbursement is made on a monthly, quarterly, or annual basis upon presentation of proper expense documentation.

TERMS OF REFERENCE OF EVALUATION TEAM

According to the Cooperative Agreement between USAID/Kenya and JSI Research and Training Institute No.615-0223-A-00-3066-00, a mid-term external evaluation is mandated. The purpose of the evaluation is to show project progress and expose problems which are likely to have impact on project activities and purpose.

This evaluation took place during February/March 1986:

The evaluation team was expected to provide, at minimum, sufficient information to enable the GOK, USAID/Kenya and FPPE to assess overall progress, make recommendations for follow-on and expansion of FPPE activities, and to enable the completion of the standard USAID Project Evaluation Summary (PES) form. The Evaluation Team was thus mandated to complete four essential tasks during the period of the Evaluation. These are:

1. To assess the progress of the FPPE to date within the framework of the six major elements and the five end-of-project achievements specified in the Cooperative Agreement;
2. To examine the feasibility and appropriateness of present plans and ideas for continuation and expansion of Project activities, and to suggest modifications or additions to the six major project elements and the five end-of-project status achievements (see below) if required.
3. To assess the long-range viability of the FPPE approach to "increase the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and maternal child health services", including issues of cost-effectiveness, coverage, and eventual phase-out of external grant assistance; and
4. To produce a written report documenting these findings, which provide all necessary information for completion of the USAID Project Evaluation Summary (PES) Form.

Each of these four tasks is discussed in detail below.

1. Assessment of Progress to Date

1. Thirty demonstration subprojects designed, implemented, and evaluated
2. An efficient contraceptive supply and management system for access by the private sector is field-tested, in place and operating efficiently.

- 3 Two hundred enrolled community nurses, midwives, clinical officers, and others trained in family planning motivation, clinical services, and management.
4. An improved training methodology developed, tested and implemented for training family planning service providers.
5. Four to five operations research activities completed and reported
6. Means for evaluating and disseminating results developed.

The original Cooperative Agreement further states that

"Provided the strategy is successful, the end of project status achievements will be:

- (a) 30,000 new users of family planning services;
- (b) 30 institutions operating new or improved family planning programs;
- (c) expanded capacity within the Ministry of Health to support private voluntary and for-profit organizations with improved training and social service workers in MCH and family planning and with dependable and ready access to adequate contraceptives and other supplies;
- (d) a capability and commitment by participating organizations to maintain or expand the level of family planning service delivery upon termination of external assistance; and
- (e) other private sector organizations not directly assisted by this project will have added family planning to their service."

The Evaluation Team was to assess FPPS Project progress to date in each of these areas.

2. Evaluation Report

The Evaluation Team was mandated to prepare a draft written Evaluation Report before the departure of the expatriate Team Member from the U.S.A. The format and outline of the Evaluation Report was to be developed and agreed upon during the first week of the evaluation. The Report had to answer at least the above questions in detail, and provide all necessary information for completion of the USAID Project Evaluation Summary (PES) Form. The draft report had to be discussed fully with the Government of Kenya (in particular the TAC), with USAID/Kenya, and with the FPPS team before the departure of the expatriate Team Member. The Team Leader was responsible for finalizing the report, based on any comments received from the GOK, USAID and FPPS.

EVALUATION METHODOLOGY

The major tasks required of the Evaluation Team were three.

The first was to assess the programme success and problems encountered so far; demonstrate the cost effectiveness of the service delivery system and make the appropriate recommendations for necessary mid-term adjustment to the programme.

The second task was to appraise the suitability and appropriateness of FPPS current plans for continuation and expansion of project activities and make suggestions of the six major elements and end-of-project status goals.

The third task was to assess the long-term viability of the FPPS approach and to establishing modalities of final phase-out of external grant assistance.

The evaluation team designed a four-component methodology for carrying out the task which consisted of review of documents relevant to the FPPS project, interviews with individuals and organizations either involved in the establishment of FPPS project or its activities, or those whose collaboration with FPPS may enhance the achievement of FPPS goals, and finally actual site visits to a sample of selected subprojects. Appendix I shows the list of the documents reviewed, the individuals interviewed and the subprojects visited.

1. Review of Documents

FPPS kindly provided a comprehensive list and copies of the most relevant documents, these numbered 21 in all. Of these the Status Report provided the most valuable information on all the subprojects, operational research activities, training, and almost every facet of the project

2. Consultations

In-house discussions with FPPS and AID officials

These consultations enabled the Evaluation Team to get first hand information on the activities, experiences, and future plans FPPS staff had on hand. The Evaluation team also visited AMREF, the agency subcontracted through a subagreement with FPPS to train the subproject staff. This visit provided the opportunity to discuss the training programme - the new draft syllabus, the plans for the establishment of service delivery points in Nairobi and related issues. (See Appendix 4)

Consultation with other Agencies

Several other agencies - Maendeleo Ya Wanawake, NCFD, FPAK, COTU, MOH, PCMA, SDA, The National Chamber of Commerce, SIDA - were visited. These agencies either run family planning programmes of their own or carry out tasks essential to family planning services, or have the potential to influence future expansion of FPPS programme activities. Review of documents and consultations took up the first week, 17 - 25 February.

3. Site Visits

Altogether 19 subprojects were visited, (Appendix 2) three by the whole team, the rest on an individual team member basis, accompanied by one or two FPPS staff members. Because of the time constraints it was not possible to pay site visits to all the established subprojects. It was therefore necessary to select a sample that would be as representative as possible. In arriving at the subprojects to be visited the Evaluation Team considered among others:

- the type of organization i.e. private industry, parastatal, church based or private practitioners.
- the type of industry i.e. agro-industry, mining, manufacturing, etc.
- geographic and cultural representation
- representation of large and small organizations, and
- the level of performance: visits were made to the most successful, average performers and the weakest of the subprojects, taking into consideration the stage of subproject development.

At the subproject level information was obtained through interviews with staff aided by a questionnaire (Appendix 3). The Evaluation Team members then made direct observations on the performance of the clinic including a review of clinic records and inventory management. Efforts were made to interview not only the clinic staff but the management as well.

The Evaluation Team took advantage of the varied background of the team members to do an indepth study of the subprojects as follows:

Social Scientist

- assessment of FPPS training prog .nes, supervision, information, education and communication (IEC) and community outreach needs, and operations research activities.

Public Health Physician:

- assessment of the quality and appropriateness of family planning and maternal child health services, and evaluation of the overall performance including the adequacy of FPPS clinical oversight, quality of clinic operations and medical provider interest.

Health Management/Information Specialist

- assessment of subproject record keeping, data collection and analysis systems and procedures, clinic management systems, availability of contraceptives and appropriateness of logistics systems, equipment procurement and cost effectiveness data collected to date.

Evaluation of Information and Data Analysis

The Evaluation Team identified the following as the major variables for study:

(a) Level of performance and progress

- status of establishment of subprojects
- inputs by FPPS into subprojects
- inputs by private organizations
- level of client recruitment as a proportion of the agreed target.

(b) Establishment of Service Delivery Capacity

- status of physical facilities and equipment
- personnel recruitment and training

- system of contraceptive supply and management
 - involvement of subprojects in IEC and community based distribution programmes
 - degree of MCH services offered
 - management information system.
- (c) Training accomplishment
- assessment of AMREF Training Programme
 - number of persons trained and the agreed target, facilities for training.
 - revision of syllabus
- (d) Operational Research Status
- number of proposed and accomplished projects
 - relevance of research results
 - applicability of research results
- (e) Programme Sustainability
- contribution of management in terms of personnel and physical facilities.
 - cost effectiveness of project
 - level of client demand for services
 - ability to procure supplies and sustain staff training

SUMMARY OF EVALUATION REPORT FINDINGS

1. At the time of the Evaluation 21 subprojects were on going out of the 30 that FPPS had proposed, giving an achievement level of 70% of the target. Each subproject has a stated family planning acceptor target against which the clinic performance could be assessed. It was found that 15 of the 21 subprojects (71%) were operating at over 50% of the monthly target, of which 3(33%) had reached the 75% level or beyond. Four of the subprojects (19%) were performing below expectation.

FPPS has set a target continuation rate of 60% for the subprojects, but the Evaluation Team found extreme difficulty in establishing how continuation rates could be calculated utilizing the present data collection instruments. It was therefore not possible to establish the current ratio of continuous service users. The report recommends measures for improvement in this aspect.

2. Through FPPS the established subprojects have been registered by the Ministry of Health as service delivery points (SDP) and as such they are eligible to obtain supplies from the MOH medical stores. Currently however, FPPS obtains the supplies in bulk from the Central Medical Stores (CMS) and distributes to the subprojects on a regular basis. The Evaluation Team ascertained that the majority of the organizations were capable of providing transport to obtain supplies directly from CMS. It was also found that storage facilities in the subprojects were adequate. There was a tendency to overstock (61% of the clinics) certain supplies which was partly due to the MOH kit system, and this increased the chances of some of the drugs expiring before use.
3. The subagreement between FPPS and AMREF required that the latter be responsible for the training of 200 enrolled community nurses and clinical officers in family planning in order to form the backbone of clinical services of the subprojects. At the time of evaluation 120 (60%) of this personnel had been trained. It was also found that although US.\$530,000 had been set aside for training, these 120 individuals had been trained at a cost of US\$105,000 which is 15% of the budgetted amount, indicating that the original estimates were not based on the local costs situation.
4. Evaluation of the effectiveness of the AMREF course was undertaken through interviews with the trainees, their supervisors and the direct observation of the Evaluation Team members. The emphasis was on clinical competence, client counselling, motivation skills, clinic management and

record keeping. Overall the assessment is favourable, particularly in clinical skills and motivation. However there is concern in relation to management skills and particularly in record keeping. It is noted that AMREF has already effected changes in a revised syllabus to rectify some of these deficiencies.

5. The subagreement with AMREF included the need to identify special clinical facilities within Nairobi which provided adequate clinical training. This has not been effected yet and all the clinical experience has been obtained in the MOH and some City Commission clinics. Recognizing the fact that FPPS training needs will exceed the original target of 200 AMREF needs to be encouraged to expand the facilities for clinical training. However it is important to note that the Evaluation Team could not identify any clinical deficiencies in the AMREF trainees that could be attributed to inadequate clinical facilities.
6. FPPS was obligated to carry out four to five operational research activities. To date FPPS has undertaken three of these activities, a fourth proposal is under consideration by the NCPD. The three studies are expected to be completed by the middle of this year, the preliminary results of one of them were out last October (1985). Some of the study recommendations have already been translated into programme activities, namely the Information, Education and Communication (IEC) and the Community Based Distribution (CBD).
7. FPPS has also to design a system of evaluating and disseminating results. Since most of the research work has not yet been completed, it is too early to assess the method of disseminating results but the provisional results and the routinely gathered information at subprojects is addressed in the report, and suggestions for improving the current system made.
8. The issue of long term programme sustainability is one of the essential tasks of this evaluation exercise. In practice this means establishment of institutional capacity of private sector organizations to carry out sustainable programmes for Family Planning and MCH after the expiry of the grant from FPPS. This in turn boils down to five service components, namely the ability to maintain facilities for family planning, to pay costs of FP/MCH personnel, procure contraceptives from MOH stores, meet increased client demands for FP/MCH, and finally to provide for future staff training. The Evaluation Team observed commitment to sustain the service delivery system as outlined above in all except three cases where FPPS may have to continue assistance for a longer period.

9. The Evaluation Team had been asked to comment on the important issue of cost-effectiveness of the FPPS approach. On the other hand the only information available was on direct FPPS support to subprojects which excluded other costs such as travel, consultants, MOH inputs and inputs by the private organizations themselves. If the total budget in the Cooperative Agreement is divided by the number of expected acceptors a figure for cost per acceptor is seen to be US\$150. However, bearing in mind that the initial demonstration element and capital investment inflate the product costs, the evaluation team has not gone into details of this issue. Instead, the Team recommends that in future this element should be given serious thought as the programme sustainability largely depends on this issue.

10. The Evaluation Team fully endorses the FPPS approach and commends it for having been the single most important mechanism of arousing awareness of the need for family planning in the private sector in Kenya. Although not all organizations are won to the idea there is a core of projects that could be used as a stimulus to other private sector organizations. Recommendations are made in the report regarding expansion of the activities and the eventual phase-out of the programme as a JSI project.

PROJECT PERFORMANCE AND PROGRESS

According to the USAID/Kenya Project Paper and the USAID Cooperative Agreement with JSI No. 615-0223-A-00-3066-00 the purpose of the FPPS Project is to:

"demonstrate and increase the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and related maternal child health services"

One of the end of project status achievements listed is the recruitment of 30,000 new users (acceptors) of family planning services through 30 subprojects, each of which will operate a new or improved family planning programme. This section of the report analyses the overall progress made towards attaining that goal, as well as reviewing the individual subproject's performance in relation to the inputs made by both the FPPS Project and those of the subproject management.

ESTABLISHMENT OF SUB-PROJECTS

The criteria for subproject selection as shown in the FPPS project plan include:

- the availability of other health services at the project site;
- the willingness of the organization's management to include family planning services in their health services, their willingness to commit staff and other resources such as clinic space for the service, and their commitment to continuing the services when funding ends, and
- the potential for the project to reach a large number of people of childbearing age not currently served, either because the project is a large employer, or because there is no other family planning provider in the area.

These criteria implied that the organization was already making some inputs in the health care of the workers under its jurisdiction. Obviously there was a wide variation in the extent, size and quality of the services offered: e.g. in companies like EAI and Mumias Sugar Company limited curative facilities were availed to workers only and did not include the employees dependants; organizations like Kenya Ports Authority provided excellent curative facilities, antenatal care and child immunization but did not include family planning in the services offered. The need to establish the management's willingness to include family planning in the health services it offered was important if one of the project goals - that of sustainability of the family planning programme was to be achieved. The third

criterion for subproject selection depended on the potential of the project to recruit a large number of family planning users, either in organizations with a large number of employees, or for the project to provide family planning facilities for a population not already served by another family planning provider. The latter assumes the organization's willingness to extend its services to non-employees - as in the case of the Kenya Flourspar. Such an arrangement can play a very important role in supplementing the services provided by the MOH.

Status of Sub-Projects

The FPPS Status Report of January 1986 lists 30 organizations that had been selected for Cooperative Agreement with FPPS, of which 21 (70%) were operational at the time of evaluation, and these are shown in Table 1. The 9 subprojects that are not operational include two (Associated Sugar Company and East African Portland Cement) that were shelved before the agreement was signed. In the case of Kenya Ports Authority there has been a long delay in signing the agreement which seems to reflect the management's non-commitment to family planning. On the other hand the medical staff in this organization are keen to start family planning and already two staff have trained through FPPS. This parastatal is a very large employer and should be encouraged to start operations. Three other organizations (East African Industries, British American Tobacco Kenya and South Nyanza Sugar Company) have been very slow in implementation of their projects. In all three, FPPS has made inputs in way of training and in the case of EAI equipment has also been provided. Other subprojects that are earmarked to start during 1986 are those of Kenya Tea Growers Association (KTGA) and Naivasha North Lake Farmers Association (Naivasha Farmers) both of which have potential to reach a large population and need to be encouraged. Finally, a proposal (not approved by TAC) is under review for the Nanyuki Cottage Hospital which recently received funding from US Ambassador's Fund for construction of a large family planning clinic expected to be completed by February, 1986. It is expected that at least three of the above projects (EAI, BAT Kenya and South Nyanza Sugar Company) should be operational soon, thus bringing the number of active projects to 24.

It should also be noted that two of the subprojects PCMA and Seventh Day Adventist Medical Services (SDA) have numerous sub units. The PCMA sub-project includes five hospitals: Kikuyu, Kima, Kaimosi, Kendu Bay and Lugulu, while SDA includes 25 sites. All the PCMA hospitals have an active family planning programme, and two of the SDA sites namely, Nyanhwa and Ranen have been ongoing since December, 1985. Twenty three other SDA clinics will become operational soon. Each of the PCMA and SDA sites can be compared in size to most of the single sites subprojects operated by private organizations. It is recommended that PCMA sites, although covered under combined projects, should be reported separately in order to permit ease of monitoring of the progress as well as allowing selective inputs, as may be necessary.

TABLE 1

Status of Sub-Project Progress and Performance and the level of Direct Financial Inputs

	No. of Months in Programme	No of Acceptors to date	Monthly Acceptor	Expected Monthly Target	Acceptors % of Monthly Target	Direct Input per Target Acceptor	Construction	Renovation
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Kenya Cannery	18	818	45.4	50	90.8	719/-	N	Y
Kenya Cashewnuts	16	118	7.4	10.4	71.1	629/-	Y	N
Kenya Flourmills	16	197	12.3	10.4	118.4	1478/-	Y	N
Miwani Sugar Co.	19	466	24.5	29.2	83.9	271/-	N	N
Nzoia Sugar Co.	20	1110	55.5	35.4	156.8	403/-	Y	N
Panafrican Paper Mills	20	238	11.9	16.7	71.2	732/-	Y	Y
Protestant Churches Medical Association	14	2640	188.9	150	125.7	415/-	N	N
Kangaru Clinic	14	155	11.9	10.8	57.2	664/-	N	N
Chemelil Sugar Co.	13	197	3.2	33.3	24.6	853/-	N	Y
Kenya Breweries Ltd.	7	184	26.3	50	52.6	641/-	Y	Y
Brocke Bond Mabroukies	12	132	11.0	18.7	58.5	1152/-	N	N
Brocke Bond Kericho	11	142	12.9	70.8	18.2	990/-	N	N
Brocke Bond Sulmac Naivasha	12	278	23.2	50	46.4	900/-	N	N
Mumias Sugar Co.	2	25	12.5	62.5	20.0	614/-	N	N
African Highlands	6	307	51.2	50	102.4	744/-	Y	Y
Elgeyo Saw Mills	8	26	3.2	14.6	22.0	370/-	N	N
Oserian Flowers	4	31	7.7	9.6	83.7	1486/-	N	N
Sulmac Sisal	6	86	14.3	14.6	92.0	1053/-	N	N
Voi Sisal Estates	8	462	57.8	45.8	126.2	377/-	N	Y
Canaan Medical Services	9	160	17.8	25	71.2	743/-	N	Y
Seventh Day Adventist	3	82	27.3	500	5.5	304/-	N	Y

Number of active Projects - 21

N = No
Y = Yes

Input by FPPS and Private Sector Organizations

FPPS Inputs

Article II of the Cooperative Agreement shows that US\$2,000,000 was obligated to support the FPPS project through August 31, 1985. Additional funds in the amount of \$2,500,000 was to be made available, subject to availability of funds, thus a sum of \$4,500,000 was earmarked for a project that was aimed at recruitment of 30,000 new acceptors. This can be expressed as an expenditure of KShs.2,400 of \$150 per family planning acceptor recruited. The inputs by FPPS to subprojects include project and subproject development, technical support, personnel, training, equipment, transport and education materials for IDO activities. The information available does not include the cost value of technical support to individual subprojects the only discussion of cost-effectiveness of the subprojects the only information available relates to direct financial inputs. In Table 1 an estimate of direct input per target acceptor has been calculated and it shows that this ranges from KShs.271/- to K.Shs.1,478/- (US\$17 - 94).

Inputs by Private Sector Organizations

The costs incurred by subprojects management include provision of physical facilities, personnel supplies and overheads such as water and electricity. The relative contribution of the management versus that of FPPS varies from one subproject to another, but on the whole the contribution of the management in most cases exceeds that of FPPS. For instance 7 out of 18 (39%) projects visited by the Evaluation Team had constructed buildings with the intention of starting or expanding family planning services, and 6 (33%) had performed renovations of existing buildings to accommodate family planning services. The willingness by these organizations to incur large expenses can by itself reflect the degree of success of the FPPS Project in motivating them to accept family planning as an important part of the health care they provide to their employees. It is also an indication of the sustainability of the project.

Assessment of Subproject Progress and Performance

Data on the 21 subprojects that are ongoing shows that 5 (23.8%) have been operating for up to 6 months, 7 (33%) for 7 - 12 months, 6 (28.6%) for 13 - 18 months and 3 (14.3%) have operated for more than 18 months. Table 1 shows the actual length of each subproject (a); the total number of acceptors recruited (b); (the acceptor count is as of December 1985 in those that were included in the visit sample, and the monthly recruitment rate (c); the latter is expressed as a percentage of what was the expected monthly recruitment (d) according to the original target set at the beginning of the subproject. Column (e) provides a measure of the achievement of the subprojects at the time of evaluation. It shows that there is a wide variation in the performance of the subprojects ranging from 5.5% of monthly target reached to 157% of target achievement. Five subprojects have exceeded the target before the end of the project period. (Kenya Flourspar, Nzola Sugar, PCMA, African Highlands and Voi Sisal Estates).

Table 2 shows the level of subprojects performance by its duration in the FPPB programme. It can be seen that of the five subprojects which had not exceeded 25% of the monthly target, 2 of them had been in the programme for less than six months, two for 7 - 12 months and one for 13 months. On the basis of this, Chemellil (13 months), Brooke Bond Kericho (11 months) and Elgeyo Saw Mills (8 months) can be classified as poor performers. It is recommended that Chemellil should be visited and a discussion held with Senior Management to see if their interest can be stimulated sufficiently to continue this project. In the case of Brooke Bond both at Kericho and Naivassa, involvement at all levels has resulted in renewed vigour and visit by Evaluation Team showed recent improvement in acceptor rates.

Panafrican Paper Mills has reached 71.2% of the target but has only 4 months to the end of the project. Overall, 15 of the 21 projects (71.4%) are operating at over 50% of monthly target, 8 (38%) have exceeded the 75% level.

An attempt to establish the criteria used in arriving at the acceptor target level revealed that these figures were in most cases arbitrary depending on what the subprojects thought they could recruit, and not based on a contraceptive needs assessment to determine the proportion to be served. It is recommended that targets for future projects be based on the expected coverage of the eligible population.

Table 2

Level of Sub-Project Performance By duration in
The FPPS Programme

Length in Programme	% Target Reached				Total
	25%	26-49%	50-74%	75%	
Up to 6 months	2			3	5
7 - 12 months	2	1	3	1	7
13 - 18 months	1		3	2	6
More than 18 months			1	2	3
	5	1	7	8	21

Sub-Projects that have reached 25% target or below (5)

up to 6 months in programme: SDA, Mumias

7 - 12 months : Elgeyo, Brooke Bond Kericho

13 - 18 months : 'Chemelil

FPPS Direct Input, Management Input and Subproject Performance

Analysis of data shown in column (f) of Table 1 was made in order to establish if financial inputs by FPPS could be related to Subproject performance in terms of acceptor rates. Columns (f) and (h) refer to management inputs in terms of construction and/or renovation respectively.

There is no obvious relationship between the amount of direct financial input by FPPS and the level of performance. For instance of the 9 subprojects that had exceeded the level of 75% of monthly target. 4 of them had received less than KShs.500/= per client in direct input, and only 3 had received more than K.shs.1,000/=.

On the other hand analysis of the major management inputs i.e. construction and renovation, shows that where construction was undertaken (Kenya Flourspar, Nzoiia Sugar, Panafrican Paper, African Highlands, Voi Sisal Estates) all the subprojects, except one Panafrican Paper had exceeded their target level at the time of evaluation, indicating that management commitment is crucial to the success of the FPPS project.

In commending the good work FPPS has initiated the following three points need noting: First, the government has issued a new policy whereby it will play a less prominent role in direct investment and management of business. This policy accords a greater role for the private sector. Second, a corollary of the above proposition is that the private sector is going to expand and it is fair to expect that the number and size of health facilities provided by the private sector will also grow. Third, if the government's effort to promote family planning use gains momentum, as it is most likely to be the case, this will place an enormous burden on the limited Government resources, and hence the need to involve non-government organizations in the sharing of this burden. Hence FPPS has played a pioneering role in galvanizing the private sector into this national effort.

As mentioned in the summary of report findings, FPPS has done a commendable job in generating interest among private sector organizations and assisting them to implement or improve family planning/MCH service. A number of the subprojects have expanded the scope of their MCH services and opened their family planning services to the communities in which their organizations are located. During the site visits, management staff were asked if they would recommend the project to their colleagues. The response was unanimous - yes. Some even suggested other organizations and others said they had discussed the project with other industry managers. FPPS now has 18 additional potential candidate organizations which have expressed an interest in starting or expanding family planning/MCH services. Discussions with representatives from the business community (Kenya National Chamber of Commerce and Trade Unions (COU)) revealed additional untapped potential for expansion of the project among the large private sector employers, which FPPS has concentrated on, as well as recruitment of smaller private sector organizations.

It is additionally encouraging that governmental agencies and NGOs involved with family planning and population issues recognize the FPPS as having a legitimate role in contributing to family planning services. The results in terms of new family planning clients thus far give additional credence to this concept.

The Terms of Reference under which the Evaluation Team operated specifically requested that the issue of continuation/expansion be addressed. In addition to the recommendations dealing with future strategy:

IT IS RECOMMENDED THAT:

- the project be expanded to all major employers in Kenya which meet the criteria established by FPPS and TAC for subprojects
- the demonstration elements of the original project be focused on other underserved populations
- the FPPS Technical Assistance Team develop project plans addressing both the operational programme expansion and the future demonstration plans
- USAID should be requested to provide additional funding to support continuation and expansion during the last two years of the project and beyond.

SERVICE DELIVERY CAPACITY

Physical Facilities and Equipment

The physical facility housing family planning services is provided by each private sector organization as a condition of the grant. Each facility was assessed for the following:

- overall space;
- waiting area privacy;
- examination area privacy;
- clinic cleanliness; and
- visual educational materials.

In addition, the reviewers requested clinic staff assessment of client waiting time. Nine of 13 (47%) clinics were determined to be excellent, that is, all criteria were fully met. Most of these facilities were either built or renovated especially to accommodate family planning services. Eight (42%) of the clinics were determined to be adequate. Each had minor inadequacies such as small waiting area or lack of educational materials but, deficiencies were not considered as a deterrent to clinic services. One site was considered minimally adequate because of the small and congested waiting areas and examination facilities. One clinic was considered inadequate due to its small size, however this clinic is scheduled for expansion.

Personnel and Training

An assessment was made at each site visit to determine if appropriate staff had been hired, trained and functioning in appropriate roles at their respective clinics. Each site except one (Sulmac - Naivasha) was found to have staff trained in family planning clinical services (Nurse and/or Clinical Officer). In some sites the need was to train additional staff in clinical services, however this was for expansion of services or as backup. Most of the sites had not provided the field educators with formal training in educational and motivational techniques.

Most field educators are given only on-the-job training for their work. The lack of training was seen by the evaluators as an important issue. An assessment of IEC/CBD training is discussed further in the training section of this report.

Contraceptive Supply and Management

In addition to the site visits, discussions were held with FPPS staff and Dr. John Kigonda, Director, Division of Family Health, Ministry of Health. Currently supply of contraceptives is available from the Ministry of Health to all designated Services Delivery Points (SDPs) in Kenya. In theory designated SDPs are eligible to obtain supplies from District, Provincial or Central Stores. However, in practice, only the Central and three provincial stores can be reliably used to maintain needed supplies. The MCH has authorized FPPS subprojects eligibility for these supplies and will continue to make contraceptives available.

Because of the unique start-up needs by subprojects for both equipment and supplies, FPPS has provided direct assistance in procuring basic equipment and contraceptive supplies. Almost without exception, FPPS has continued to stock and transport contraceptives to subprojects on request. As the number and size of projects increased this functions has required increasing FPPS staff time to meet routine and emergency requests. Subprojects report satisfaction with the FPPS role of commodity supplier, however, this reliance on FPPS staff is burdensome and problematic for managing inventory at both levels.

A review of each site was made to assess the following:

- Range of methods available/used - Eighteen (95%) of the clinics had the full range of contraceptives available for client use. Only one site excluded a method (depo-provera) because of provider preference;
- Storage facilities - supplies were handled properly in all clinics (e.g. out of sun, off floors, away from the wall and in a ventilated room). Most sites have proper storage rooms for drugs and supplies, however, because of the small stocks on hand, contraceptives were frequently kept in cabinets or desks in the examination rooms;
- Adequacy of stocks - supplies are provided from FPPS to meet an estimated three months need and subprojects are supplied when their supplies run low. None of the sites were observed to use the min/max system recommended by the MOH. This system requires that inventory balance be maintained so that minimum stocks of any item do not fall below the level needed for three months use, with short supply items ordered for an estimated period of 12 months. An assessment during site visits revealed that 8 (42%) of all the sites had one or more items below minimum use requirements. Six others (32%) had only minimally adequate supplies on hand.
- Stocks Imbalances - Eleven of 18 (61%) of the sites reviewed had over-stocked items. In one instance large quantities of expired oral contraceptives were found in the stores. Some of the same sites also had shortages (see above). Most of the over stocking consisted of foaming tablets which are routinely supplied in the MOH contraceptive kits. Unfortunately, the condom plus foam or foam only method is not popular enough to warrant the quantities supplied.
- Inventory control - only four of the 18 sites assessed had a documented system for inventory control. The remaining sites relied on a variety of systems (periodic inventory, observation) to trigger reorder of supplies.

Information, Education and Communication (IEC)
Community Based Distribution Programs (CBD)

The current development and need to expand IEC/CBD components in the subprojects was assessed during the site visit. This assessment and recommendations are discussed in the section of the report on Continuation/Expansion and Training.

MCH Services

According to the Cooperative Agreement related MCH activities should form a part of the MCH/FP programme. All subproject sites visited provide basic MCH services at their facilities. The FPPS programme is viewed by most subprojects as a key part of overall MCH/FP services. Services are integrated or held in conjunction with immunization or other MCH services so that client referral and family planning services delivery is enhanced. This is reportedly seen by clients as attractive in two respects. Accessibility to service is very convenient for potential clients and integrated services reduce any real or perceived stigma attached to attendance at a categorical family planning clinic. FPPS has provided minimal equipment to support basic MCH services and has assisted new subprojects in establishing immunization services supported by the Kenyan Expanded Programme for Immunization (KEPI). All except two sites have active vaccination programmes. The evaluation team views this basic support of other related MCH services as integral to programme success.

Management Information Systems

The design of the FPPS project included a user records management system comprised of client log/tickler file system. This is simple and straightforward.

The one-write service statistics and tickler file system is constructed with carbon copies so arranged that all data are recorded only once. The main log sheet allows space for entering twenty-five visits, and includes client number, name, patient type (new or continuing, male or female), next appointment date, diagnosis, off-duty (sick leave), amounts of contraceptives provided, referrals for voluntary sterilization or natural family planning and comments. One line of this form is completed for each visit. The date, client number, whether new or continuing client, and next appointment date are automatically reproduced on two identical small slips of paper, one of which is given to the client as a reminder of the next appointment, and one of which becomes the tickler file. The tickler file slip is filed in a card box in order by the date of next appointment. When clients return for subsequent visits, their slips are pulled and destroyed. Any remaining slips at the end of each week represent clients who have not returned as scheduled, these clients are then followed up by clinic staff. This system is used in containing demographic information, medical history, initial examination and method accepted.

The system is used to generate a monthly report (FFPS) to track acceptors/contraceptive user data for the project. Its design allows for maximum flexibility by the subprojects to track continuing users, contraceptive supply use and referrals.

During the site visits, the use of this system was assessed. All sites use the one-write systems for recording basic client information and provide clients with the return visit tear off. Each site also use the "expected in" box to file the companion tear-off slip and review the file for clients who were expected to return. Only two sites used the expected in-file system to record the disposition of the defaulter clients if follow up was required. The remaining clinics used the file to initiate follow up, but no information was collected by these sites for either voluntary or voluntary plus follow up continuation rates. Both sites that document client follow up and voluntary continuing users reported short term continuation rates (4 months in excess of 90%).

The reviewers also found that only six clinics used the log sheet to calculate contraceptive use data against inventory. Clinic staff reported use of the system to generate the FFPS monthly report and service statistics for their organization, but no data analysis is performed at the subproject level.

Project Data Collection and Evaluation

A summation of the comments on data collection evaluation made in the various sections of this report include:

- Agreement with the basic subproject data collection instruments (one write client log and tickler system);
- Acceptance of the system by subproject users;
- A sample verification of the quality of monthly reports shows that although the system allows for simple tabulations to control contraceptive inventories, there was little evidence that subproject staff used the system in this manner;
- Although the system is designed to identify clients expected in for continuing service, only two sites used the expected in-file properly. Only one site generated continuing users rate information. A few sites required documented follow up of defaulter clients, but none tabulated the number or reasons for defaulters.
- Each site visit included an attempt to ascertain accurate user continuation rates, however the use of the tickler files precluded an accurate assessment.

The FPPS Status Report (January, 1986) includes a prototype monthly report to combine the current monthly report with inventory control data. This report was reviewed and should provide the subproject with useful service statistics and provide FPPS with sufficient data to monitor progress of the project.

A. IS RECOMMENDED THAT

1. The prototype subproject status report be modified as indicated below, field tested, and prepared for implementation. This modification will permit easy calculation of continuation rates.

The items to be included are as follows:

- a. Number of continuing users expected this month _____
 - b. " " " " who voluntarily returned _____
 - c. " " " " requiring motivation return _____
 - d. " " transfers to other providers _____
 - e. " " users lost to programme _____
- Inservice training for subproject staff should accompany introduction of this replacement form.
2. FPPS should ensure that managerial skills and, in particular, record keeping and inventory control, are emphasized during the AMREF course. It is also recommended that a programme of remedial update courses lasting not more than a week be started to cater for those subproject staff that have already undergone the family planning course.
 3. FPPS should establish a plan for weaning subprojects from dependence on FPPS for their supplies, and encourage them to assume this responsibility as early as possible in order to make it easy to phase out FPPS support at the end of the two year agreement period.
 4. FPPS should apply the min/max system as recommended by the MOH, throughout all subprojects, and establish a monitoring system whereby excess stocks are either re-distributed or returned to the MOH in order to avoid wastage through commodity expiry.
 5. In recognition of the importance of IEC and CBD, these activities should be recognised as integral components of the FPPS Project, and adequate funds should be obtained to expand the training activities in this area.

TRAINING

This section analyses training at both project and subproject levels. At the former, training issues are addressed from the stand point of AMREF, the training institution, and FPPS. Analysis at the subproject level focuses on the evaluation of training by AMREF, trained staff at the subprojects, their current supervisors as well as the on-site assessment of clinics management skills by the evaluation team.

Training at AMREF

AMREF was appointed through the Cooperative Agreement to conduct the formal training activities of FPPS. In order to formalize this arrangement FPPS signed a three year subcooperative agreement with AMREF effective from December, 1983. Specific training requirements were stipulated, the most relevant sections read as follows:

The purpose of this subcooperative agreement is to provide three years of professional and technical services to improve family planning training methodology and to train personnel of the approximately 30 demonstration subprojects in family planning motivation, clinical services, and management. The training will be designed to facilitate the overall project objective of increasing the capacity of private sector Kenyan organizations to deliver family planning and related services."

AMREF was to use its experience in the development of these individual training plans to develop a model or prototype training plan, parts of which may be adopted for use by the Ministry of Health.

The training designs were to be influenced by four factors:

1. the need to meet Ministry of Health standards for certification;
2. the need to address identified shortcomings in existing health workers' training (e.g. programme management, target setting, operating procedures);
3. the need to extend the family planning programme beyond the delivery of clinical services to an integrated approach which responds to community and cultural needs; and
4. the need to improve methods for family planning training suitable to and appropriate for Kenya.

In order to achieve these goals the subagreement further stipulated that a total of 200 enrolled community nurses, midwives, clinical officers and others should be trained.

The subagreement further enjoined that:

1. The training design must take the needs of individual working conditions and institutions and the socio-cultural characteristics of the recipient population into account while still providing cost effective course for a reasonable number of people.
2. Clinical facilities for practice of techniques are essential. The training will therefore require access to facilities with sufficient numbers of clients to provide an acceptable level of practice for all trainees.
3. Training should be accomplished in-country, by locally-based institutions whose training staff is approved by the Ministry of Health. A grant in the amount of US\$580,382 was allocated to AMREF to finance the training programme. Based on the number of trainees this training programme was to cost roughly US\$3402 per trainee.

The AMREF initially adopted the MOH syllabus with an added section on communication skills. Training emphasized clinical skills in the delivery of maternal/child health and family planning services, community education as well as management and record keeping. The nine week course is divided between theory for the three weeks at the AMREF headquarters and six weeks practical training at MOH training institutions and facilities.

Each course enrolls approximately 25 students selected by the sub-projects; as of 31 December 1985, a total of 120 trainees, of whom 40 were from non-FPPS institutions, had been trained at a total cost of US\$108,000 or US\$975 per student; this is just over a quarter (25.7%) of the subgrant allowance of \$402. A consultancy study by Mrs. K. Jonal was commissioned in 1984 to evaluate and recommend changes in the existing syllabus. This was followed by a Curriculum Review Workshop in September 1985 to discuss the recommendations and the parallel study by G. Mule, commissioned by the National Family Welfare Centre.

Topics which were either inadequately covered or altogether left out of the old model curriculum included information, communication and counselling, teenage pregnancies, management of service delivery points and courses for trained staff wishing to update their skills.

After this review work, AMREF started drafting the new course, a provisional draft of which is currently being tested.

According to its authors, the new syllabus puts emphasis on new technologies and addresses new problem areas such as premarital or teenage pregnancies, adolescent sex, scarcity of service delivery points, and the need for refresher courses.

Among the new topics introduced are: Adolescent Fertility, Family Life Education, Community Based Health Care and Evaluation Activities, greater emphasis is put on Information/Communication and Counselling Techniques and Management of Service Delivery Points. (see Table I). The course lasts nine weeks: three spent on didactic teaching and six weeks on practicum.

TABLE 3: COURSES COVERED AND TIME ALLOCATION

Course Covered	Hours	Percentage
1. Introduction	4	3.0
2. Population and National Development	8	6.0
3. Communication	12	9.0
4. Contraceptive Technology	46	34.6
5. Client Management	16	12.0
6. Management of Service Delivery Points	14	10.5
7. Programme Evaluation	5	3.8
8. Problem Solving Activities	28	21.1
Total	133 =====	100.0 =====

Source: Adapted from AMREF Curriculum on Family Planning Training for Nurses and Clinical Officers Draft No.III, January 1986
 - Table I
 P.14

The new subjects present the twin problems of training of teachers and finding suitable teaching material. AMREF has undertaken to train trainers both at overseas and national centres but the scarcity of suitable teaching material is still a largely unresolved problem. It may also be observed here that the curriculum does not include topics which treat the socio-cultural characteristics of the recipient population as required in the agreement.

The lack of clinical facilities at the AMREF premises presents additional constraints such as logistical problems of travel and sharing training facilities at overcrowded MOH institutions. The alternative solution of taking students to subproject clinics is undesirable because of the small number of clients and the attendant lack of diversity in contraceptive methods there. AMREF has tried to solve this problem by looking for a suitable site for constructing new clinical facilities but efforts have so far proved fruitless.

Another area of ground-breaking is the proposed two week refresher course for staff now employed at subprojects. This will enable trained staff to update their theoretical and practical skills.

FPPS Evaluation of AMREF Training

FPPS evaluation of AMREF training services has until recently been rather mixed in three key areas. FPPS feels that the development of a new curriculum has taken far too long. FPPS also contends that AMREF was to find five existing clinics in Nairobi, buy family planning equipment, set up Service Delivery Points (SDP's) which would also serve as training sites (TS'). These SDP's/TS' would, besides taking pressure away from MOH sites, also be added facilities to the BCK. According to FPPS then, the current transport bottlenecks are entirely due to AMREF's failure to meet the terms of the agreement which also provides funds for these services.

The evaluation team recognises that although the subcooperative agreement does not specifically mention five SDP's, the budget allocates funds for "training facilities - 5 clinics" to the tune of US\$12,500 to be spent during the first year of the contract period. Whether or not, and if so to what extent the lack of SDP's/TS' has detracted from the quality of training is a matter the evaluation team could not establish in such a short time.

During separate interviews both parties admitted that the differences in interpreting the subcooperative agreement were compounded by the failure by both parties to open channels for communication.

Training from Subproject Perspectives
Training Activities within FPPS

In the passage of time it has become obvious at FPPS that staff at subprojects would be able to reach a very limited number of clients if they restricted their operations to the clinic settings alone. Two activities were therefore launched to remedy this weakness.

One of these activities is the Information, Education and Communication (IEC) component. A media specialist, D. Nturibi, was recruited in October 1985 to establish and coordinate this activity. Since no provision had been made for IEC in the original FPPS programme, no budget allocation was made for it either. Funds were solicited and obtained from a consortium of donors - the Ford Foundation, the Danish International Development Agency - for supporting IEC activities on ad-hoc basis. Later the USAID provided an additional grant in the amount of US\$181,000 for the IEC programme.

The activities so far undertaken include the production of calendars based on FP themes, family planning posters, promotional material, establishment and support of IEC committees at subprojects, hiring field educators, staging of family planning drama events at subprojects, mounting art exhibitions depicting FP themes and messages.

Another activity not included in the cooperative agreement is community based distribution (CBD). The need to incorporate it in the programme activities arose out of subproject level activities, for example some clients could not travel to the clinics, others felt insecure if they were to be identified as FP clients. A Clinical Management Specialist Mrs. N. Theuri was therefore hired in September, 1985 to establish this component. As of 31 January, 1986, CBD's have been established at three sub-projects and a training course for subproject coordinators who will in turn train local CBD's was organized at Kericho. FPPS has expressed fear that the funds for this activity can train only 200 CBD's or half the target number. FPPS feels that the addition of IEC and CBD activities has boosted the acceptor rate at sub projects where they have been established; this is more so where local committees have also been formed and introduced to IEC and CBD activities. The evaluation team was informed by several FPPS subproject staff members that one reason for requesting for subproject subagreement extension is the spiralling demand for the service in response to these recent activities.

TABLE 4: DISTRIBUTION OF IEC ACTIVITIES BY SUBPROJECTS

Activity	Present		Present/Inadequate		Absent		Total	
	Number	%	Number	%	Number	%		%
IEC	16	84.2	1	5.3	2	10.5	19	100

With increased training activities the impact of IEC and later CBD is going to create an upward spiral which will in turn generate a greater demand for FP services.

Training from Subproject Perspectives

The evaluation team surveyed subproject supervisors and AMREF trained staff to evaluate the quality of AMREF training. Each respondent was asked to assess this training in three areas: clinical nursing, client counselling and motivation; and management of client flow, staff supervision, supplies and data records.

Assessment By AMREF Trained Staff

Out of 19 subprojects visited, information was not collected from six (6) sites either because the staff were not AMREF trained or were absent. As can be noted from the figures in Table 3, the staff were satisfied with their training particularly in clinical and motivation skills for which training was in all cases rated satisfactory to very good. The only deficiency reported was at three subprojects in the management of records.

TABLE 5: ASSESSMENT OF QUALITY OF TRAINING BY AMREF GRADUATES WORKING AT SUBPROJECTS

Type of Training	Adequate		Inadequate		No Information		Total	
	Number	%	Number	%	Number	%	Number	%
Clinical	13	68.4	0	0	6	31.6	19	100
Motivation	13	68.4	0	0	6	31.6	19	100
Management of records	10	52.6	3	15.8	6	31.6	19	100

Assessment By Supervisors

As the figures in Table 6 show, supervisors were also satisfied with the AMREF training in clinical and motivation performance. But in the area of management (particularly records) supervisors were less satisfied. Four supervisors indicated that the poor performance observed was not necessarily indicative of inadequate training. Some knew that there was a reluctance to bother about record keeping.

In some areas too there was no single staff member responsible for either record keeping or report compilation. At some other sites responsibilities were shared. In other instances the supervisors were either wholly or partially responsible for this task. Under such circumstances records can hardly be expected to be well managed.

TABLE 6: ASSESSMENT OF QUALITY OF TRAINING AT AMREF BY SUPERVISORS AT SUBPROJECTS

Type of Training	Adequate		Inadequate		No Information		Total	
	Number	%	Number	%	Number	%	Number	%
Clinical								
Nursing	10	52.6	1	5.3	8	42.1	19	100
Motivation and Counselling	11	57.9	0	0.0	8	42.1	19	100
Management of Records	7	36.8	4	21.1	8	42.1	19	100

Assessment By Evaluation Team

Due to time constraint it was not possible for the evaluation team to have direct observation of staff performing clinical, motivational and management functions. Instead the team inspected the records and interviewed staff on how they kept daily logs compiled monthly reports and handled field visit notes on identified defaulters, and their assessment of continuing users.

The figures in Table 7 show that the evaluation team judged performance or record management to be inadequate in 16 out of 18 subprojects. From the point of view of project success, continuation rate is a crucial measure - 80 percent is deemed the target. Inability to compile information in manner that will facilitate the calculation of this index is a serious deficiency in the management of information.

Although the FPPS has introduced an efficient method for collecting the necessary information, very few staff members were able to readily tell the number of defaulters or expected revisits during any span of time. This defect hinders evaluation of subprojects, improvement of follow up activities, and field educators strategy.

Similarly the fact that most field educators do not keep their field notes at the clinic makes it difficult for other staff members to get the necessary feedback. Furthermore, hardly any of the field educators 'notes' contain records of reasons why defaulters turn away from the service or what problems they encounter. This lack of analytical information is largely a result of inconsistent data collection and lack of adequate training for the job.

TABLE 7: ASSESSMENT OF QUALITY OF MANAGEMENT SKILLS BY EVALUATION TEAM

Type of Training	Adequate		Inadequate		No Information		Total	
	Number	%	Number	%	Number	%	Number	%
Management of Records	2	10.5	16	84.2	1	5.3	19	100

TRAINING RECOMMENDATIONS

It is recommended that:

1. In recognition of the importance of IEC and CBD, these activities be recognized as integral components of the FPPS programme.
2. FPPS and AMREF modify the existing subagreement contract so that AMREF takes on additional responsibilities for IEC and CBD training especially the training of field educators.
3. AMREF explores means of expanding clinic facilities for additional training needs
4. The training curriculum for nurses and clinical officers should strengthen the components of management particularly record keeping, inventory control and reporting systems
5. FPPS training resources be geared towards the need of private sector subprojects and be extended to only those private sector institutions which have shown a demonstrable interest in family planning activities.
6. In addition to the US\$181,000 already provided to FPPS for IEC and CBD activities more funds will be needed for expansion of this service.
7. Selection criteria for training include evidence on the part of the trainee of a commitment to family planning work after training. Similarly supervisors and employers should give the opportunity to trained staff to perform the functions for which they are trained.
8. Field educators be given training appropriate to their job which requires analytical skills and the ability to establish factors, including cultural ones, which determine use and non-use of family planning services.

OPERATIONS RESEARCH ACTIVITIES

Introductory Remarks

The Cooperative Agreement (CA) enjoins that FPPS will, during its project life, carry out, report and disseminate findings from four to five operations research studies which should aim at clarifying specifications of vital importance to project objectives. Although the responsibility to identify research activities is vested in USAID and the Technical Assistance Team (TAT) in collaboration with the Technical Advisory Committee (TAC), the Cooperative Agreement suggested six problems areas, these are: Perceptions of management, methods preference, records adequacy, management input, client flow analysis, and contraceptive logistics/management.

To date FPPS has undertaken three operational research activities, namely the Baseline Survey on Fertility - Related Factors and Family Planning Practices; the Impact of Income on Family Size and Family Planning Practice; and the Cost Impact of Family Planning Programmes in Private and Non-governmental Organizations. A related research activity was the study commissioned in 1984 to evaluate the training course and curriculum used at the AMREF.

There is also a project proposal on Alternative Approaches to Family Planning Services Delivery now under consideration by the TAC. FPPS has therefore met the cooperative Agreement requirements in three respects, the number of research projects undertaken, the procedures for identifying research topics, and the time framework - three of the four studies will, judging by progress made so far, most likely be completed by the middle of this year, leaving ample time for FPPS to translate some of the findings and recommendations into programme activities.

The evaluation team has noted the rigorous procedures for screening research projects and the meticulous way in which methodological issues are addressed. Another commendable aspect of the research projects is the work plan, on average it takes about a year to complete the research programme - from fieldwork to the production of the final report. This will facilitate the incorporation of research findings into the programme activities.

Specific Remarks on Individual Studies

Each study is examined on the basis of its scope and objectives, problem definition and operationalization, methodology, work plan, findings and their relevance to FPPS programme.

Study I: Baseline Survey on Fertility-Related Factors and Family Planning Practices.

Objectives and Scope This study set out:-

1. To determine family planning attitudes, knowledge and practice of project beneficiaries, particularly the males.
2. To establish the willingness of the Union, Management and Employees/beneficiaries to participate in the FPPS Project and to determine how their contribution could be maximized.
3. To increase the opportunity for potential clients to participate in project planning and implementation to ensure that the project is client oriented.
4. To provide information enabling all parties involved in the FPPS project to better understand their roles and issues vital to the programme design, operations, evaluation and performance.

The study was to serve as baseline against which to measure progress of the project and a means of identifying the priority IEC needs which FPPS should address.

Methodology

Altogether 15 subprojects representative of regional and cultural factors were selected for study. A total of 2459 respondents were interviewed, of these 1054 or 42.9 and 1405 or 57.1 were females and males respectively. This distribution is consistent with the stated objective of emphasising male attitudes, knowledge and practices. Questionnaires were used to elicit personal data such as education, age, religion, literacy, marital status, and specific behaviour in terms of knowledge and use of family planning methods and other aspects of the study.

The work plan envisaged research to start in July 1984 and final report to be put in March 1986, preliminary analysis of field material collected between July and September 1984 from eight subprojects was completed in October 1985. A highlight of these results follows.

Preliminary Results.

Literacy Levels of potential clients are high, the percentages of men and women who can read are 83 and 77 respectively. The range in subproject levels of literacy is wide, 83 per cent for Kenya Cannery and 51 percent for Cashewnuts.

The immediate implication for programme activity is that the use of written material for IEC activities is appropriate.

Cash Incomes are relatively low, men and women earn K.Shs.14,672 or US\$917 and K.Shs.2055 or US\$123 per year in that order. At this income level large families can only be supported at unacceptably low living standards.

Ideal Family Size is, for women 4.6 and for men 4.97 children as compared to the national figure of 5.6 children. Although the mean number of living children is relatively low, 3.34 per woman, if they were to attain the additional number of desired children family size would exceed the desired level by 50 per cent. Furthermore at current rates, by age 34 the women will have attained 4.63 children, again a number in excess of desired size.

These findings have two practical implications. First, clients should be influenced to accept a smaller number of additional children. Second, women and their husbands must be persuaded to reduce the number of additional children. These will be key tests of programme success.

Knowledge of modern contraceptives is very high, over 80 percent of the women had heard of at least one method; 73% had heard of the pill but only 19.6 were currently using any of the modern contraceptives.

These findings make it clear that there is little if any, need to expend effort in promoting knowledge of contraceptives, in particular, the pill. The real challenge is to lift the proportion of current users to a much higher level.

It may be appropriate to note that the study was selective in its choice of methods of family planning for investigation; for example no mention is made of abortion, abstinence, the withdrawal and rhythm methods, all of which are, to varying degrees, applied in the study areas. This is unfortunate because the study set out to investigate the current status prior to programme inauguration.

Admittedly the Cooperative Agreement is forthright in its prohibition of the use of project funds to finance or support the following activities: procurement or distribution of equipment for use in abortion as a means of family planning, offer fees or incentives to women to procure abortion; make payments to persons to perform abortion, gather information, provide education or communication programmes promoting abortion as a method of family planning.

These restrictions do not in any way prohibit research intended to throw light on current abortion practices. As a matter of fact studies of the reasons why people procure abortion show the culturally defined notion of unwanted children. This information is vital for FPFS programmes.

Study 2: The Impact of Income on Family Size and Family Planning Practice.

This study has three major objectives, these are:

- (a) Find out the impact of regular income and other benefits on fertility levels
- (b) Identify policy instruments which can be used to enhance favourable attitudes by employees towards family planning and help them create values which encourage them to view their benefits in a manner that is likely to facilitate improvement on their standard of living.
- (c) Identify non-pecuniary factors which can be manipulated to increase the number of family planning users through private sector delivery points.

For each of these objectives a matching hypothesis has been developed as follows:

1. Higher levels of money income will tend to increase people's knowledge about family planning and lead towards more favourable attitudes about the use of contraceptive methods.
2. Higher levels of non-pecuniary benefits (hidden income) will lead to unfavourable attitudes towards family planning.
3. People with large families (would be less willing to get additional children and hence they) will tend to have favourable attitudes towards family planning.

The proposal categorises the variables for investigation into dependent and independent variables. The former include knowledge of and attitudes towards family planning. Respondents will be asked which methods of family planning they know of - the pill, IUD, withdrawal, safe period, injection, abortion, sterilization, diaphragm, foams, other.

This approach includes methods left out of the Baseline Survey checklist, these are, abortion, safe period and withdrawal.

The independent variables are: money income earned as a wage or salary, hidden income or non-pecuniary benefits such as medical care, housing, subsidized food, nursery school, water and electricity, transport, other.

Multistage sampling procedures will be used to select 1700 workers receiving regular cash income from seven subprojects representing three agricultural, industrial and service companies in the ratio of 4:2:1 in that order. A sample of 100 couples living in the same settings but who do not receive the same benefits will be used as a control group.

Workplan

Field data collection started in November 1985 and was expected to be completed by the end of January, 1986. The final results are expected to be out in June 1986.

There is a field experience worth noting. The researchers experienced difficulties in collecting material from the companies where management did not have a strong commitment to family planning activities. This tallies with the evaluation team's finding that where management showed commitment to the FP programme, results were good.

Research Problem

The design and problem conception are both sound and impressive, the research problem is clearly isolated and operationalized. However there also appears to be an internal contradiction in the sequence of hypotheses to be tested. Incomes are expected to be positively related to the ability for greater awareness of family planning and favourable attitudes to contraceptive use. But non-pecuniary benefits are assumed to be negatively related to family planning awareness and favourable attitudes. Yet it would appear to be the case that the higher the income the greater the non-monetary benefits.

There is therefore need to explain the cut-off point at which non-pecuniary benefits become a hindrance to favourable family planning behaviour. It is therefore suggested here that a new variable be intrapolated. This is the ratio of non-pecuniary benefits to incomes, for low medium, and high income groups. It may well be the case that the ratio of non-monetary benefits to income falls as incomes rise, if this is the case the study should show the cut-off point at which the value of non-monetary benefits becomes negligible relative to income. Most probably for low income groups the ratio is high, for medium income levels it is also medium but insignificant for high income groups. In this case the case postulated in the study about non-monetary benefits should be assumed to hold for low income groups.

The study may also strengthen its case by disaggregating the relative impact of education and income. This is because there is emphasis on knowledge and attitudes which are largely shaped by education.

All in all this study is bound to yield practical results of great importance if the suggested refinements are incorporated.

Study 3: The Cost Impact of Family Planning Programmes in Private and Non-Governmental Organizations.

Objectives

The study seeks to achieve two major goals, the first is to establish the economic rationale and incentives for companies to add family planning services to their operations. The second goal is to work out the cost impact of reducing births to employees.

Methodology

After a preliminary review of seven company records including expenditure in mid 1984, four companies were selected for in-depth case studies using questionnaires to collect information on dispensary records, absenteeism, salary and wage schedules, and size of female workforce.

Health care costs for the different categories of workers such as males, females, dependants and children of employees will be calculated.

Work Plan

End of February 1986, with the final report in April 1986.

Provisional Results

Preliminary results from two of the four case study sites show, among other things, that K.Shs.4,296 or US\$269 will, on average, be saved per birth averted; however the range in savings per birth varies between K.Shs.1955 and 7,732.

Relevance to FPPS Programme

The study addresses an issue companies are bound to grapple with precisely because they are there first and foremost to make money. The proposition that benefits to private sector enterprises from family planning services could outweigh their costs, if demonstrated to be valid, is of paramount importance to the FPPS strategy of selling the programme.

Although economic demographers have become wary of the original cost/benefit approach which assigns money values to births, the present study may well serve its purpose of programme salesmanship particularly to company economists for whom this approach may be appealing. Nevertheless the study may be more persuasive if it emphasises broad issues of showing the benefits of a labour force with smaller family size because of reduced costs of maternity leave benefits, sick leave, dispensary running expenditure, school costs, overemployment and absenteeism. The attempt to calculate savings per averted birth is likely to lead to little or no useful information.

The evaluation team also found out that some firms appear to be contented with reaping non-monetary rewards by projecting their motives for providing family planning services as a noble answer to a call from the Government to non-governmental organizations to join hands and complement its effort to reduce the phenomenal birth rates. Some companies derive a measure of moral satisfaction (an intangible or social benefit) from their investment in FP programmes.

The case of small private clinics such as Kangaru and Canaan needs special attention. These may regard the present input by FPPS as a necessary tie-over investment during the early transition period. Their strategy is one of providing comprehensive health services. FPPS-supported services attract customers some of whom will also go for curative services. Eventually, with an enlarged clientele, the clinic will reap benefits for the entire health care system. For this category of subprojects a different approach is necessary.

Study 4: Alternative Approaches to Family Planning Service Delivery

Objectives

This study seeks to evaluate four family planning service delivery systems (SDS) in the country in terms of relative cost per acceptor, couple-years of protection, the relative advantages and disadvantages as perceived by both the target service users and the programme promoters. The four systems to be studied are: static clinics, mobile/outreach units, community based distribution (CBD), and commercial outlets.

A related practical objective is to determine the closeness of the fit between the types and extent of family planning services required to realise set or implicit national population growth size targets on the one hand, and on the other, the degree to which such services are actually provided and utilized in time and space.

Work Plan

The study is programmed to commence in March 1987. A second experimental design is envisaged to start a year later but no proposal for it has been drafted.

Methodology

A total of 32 service delivery points representing the four types and subtypes within these, will be selected by purposive and cluster sampling techniques to ensure representativeness. Details of the sample are given in Table 1 below

Table 1:

Type of SDS	Number	Number of Respondents
Static Clinic	3	600
Mobile/Outreach	3	600
CBD	2	900
Commercial Outreach	24	356
Other	0	50
Total	32	3016

Relevance to FPPS Programme

This proposal is going to be a tripartite venture by the FPPS, FPAK and Maendeleo Ya Wanawake. It is also intended to be a learning experience for the parties involved in it.

The results are bound to be of vital importance to all those involved in health care services. The issue of cost efficiency in service delivery is critical, more so for family planning services. As the evaluation team has remarked elsewhere in this report, this is an aspect the FPPS programme will have to look into more closely. Finally there are interfaces between this proposal and the study on Cost Impact of Family Planning discussed above. Of special interest is the issue of cost per couple year of protection.

Overall, the operations research programme has been both imaginative and problem-solving oriented. It may be worthwhile to look into the machinery for dissemination of results particularly to subprojects. Whereas FPPS assured the evaluation team that the results which have come out so far have been circulated to the subprojects, some of them appear not to be aware of this. In one instance the subproject implementers still expect their site to be included in the Baseline Survey, at yet another subproject the evaluation team noted complaints that the FPPS team had taken far too long to send the results of the insurance reimbursement study. As it turned out, the proposal for this research project has not even been written up. In order to strengthen this aspect of information flow on research activities, a recommendation has been drawn up.

RECOMMENDATIONS

1. Realizing the importance FPPS attaches to continuation rates as a measure of programme performance on the one hand, and on the other the evaluation team's finding that the current information management system does not permit the establishment of this vital index.

It is recommended that FPPS should undertake a short term project to retrieve this information from the daily logs, monthly reports and other records at both FPPS and subprojects. This information should be available for evaluation at completion of the current FPPS programme.

2. Given the growing contribution of IEC and CBD to programme performance, and aware that the interactions involving community nurses, field educators, community based distributors and clients are unrecorded and are therefore inaccessible to programme managers and supporting agencies, It is recommended that a research project be designed to establish the salient aspects of these interactions. For example the nature of the information flow from field educator and community nurse to client and the reactions of the latter are critical elements of IEC but they are largely unknown.

3. Seeing that operational research is intended to enhance performance at both project and subproject levels.

It is recommended that a research brochure or bulletin highlighting the major components of each study - research problem, methodology, workplan, main results and their relevance to FPPS programme activities - be launched on a regular basis and be made available to all interested parties including subprojects, and some of the research institutions which can take up some of the issues for further research. This would save time and money for FPPS as well as enrich its stock of research material and data source bank.

IT IS FURTHER RECOMMENDED THAT:

Two additional types of operational research projects should be undertaken related to the FPPS Project:

4. FPPS Client Education - a research project to establish the basic level of knowledge of family planning acceptors after physician, nurse or clinical officer, motivation and education, delineating determinants affecting clients use and choice of contraception.
5. Cost effectiveness of family planning services in the private sector -- a series of cost-effectiveness studies to determine cost per new client served and cost per couple year protection separately for subprojects at one, two, three and four years after project start, including all capital investment, and other costs, incidental to service delivery.

DISSEMINATION OF FPPS ACTIVITIES

The FPPS Project has demonstrated that there is potential for expansion of family planning in the private sector. In order to expand private sector family planning activities there is need to increase the contact with private organizations beyond the 30 sub-projects, and to establish channels of communication through which sustained motivation, particularly that of the management, can be ensured.

One mechanism of ensuring continued interest in family planning after the termination of FPPS Project, is to involve worker and employer organizations in discussions on the need for family planning services for employees and their dependants. During discussions with the Central Organization of Trade Unions (COTU) it became evident that this body was already considering inclusion of population education in the courses offered at the Tom Mboya Labour College in Kisumu. At this point in time the College lacks persons qualified to teach family planning and it is recommended that FPPS provides the needed expertise to teach FP to all cadres of trade union leaders at the College. It is envisaged that the demand by workers for FP services will remain an important tool in the perpetuation of FP programmes in the private sector.

Several employer organizations also exist whose support for FP activities may be elicited. Some of them such as the Kenya National Chamber of Commerce provide a forum through which FPPS can address FP issues to a vast network of business organizations. All current FPPS subprojects except the church organizations, Canaan and Kangaru Clinics, are members of the KNCC. The Chamber holds monthly meetings and publishes the magazine "Business" which can provide an important medium of dissemination of FP activities across the country. Other employer representative organizations include the Federation of Kenya Employers and Kenya Association of Manufacturers.

The cooperative movement in Kenya extends to the grass-root level and provides a mechanism of expansion of FP services particularly in the rural areas. However the dividing line between establishment of a cooperative health facility and "Harambee" projects is very narrow, and FPPS involvement in cooperatives may duplicate MOH functions in some places.

RECOMMENDATION:

FPPS should as a matter of urgency establish contact with COTU and the KNCC FKE KAM as a means of expansion for FP activities in the private sector. Specifically

- a. FPPS should assist in the teaching of FP at the Tom Mboya Labour College, either through secondment of a FP teacher, or through training their staff in FP
- b. FPPS should endeavour to publish articles in the magazine "Business" particularly to describe some of the successful subprojects and in that way stimulate interest in the business community to join in the FP activities.
- c. FPPS should also seek to address the KNCC at some of its monthly meetings.-

PROGRAMME SUSTAINABILITY

One of the essential tasks outlined in the Terms of Reference for the evaluation team was "to assess the long range viability of the FPPS approach to increasing the institutional capacity of private sector organizations to carry out sustainable programmes for the delivery of family planning and maternal child health services, including issues of cost effectiveness, coverage and eventual phase out of external grant assistance".

In part, the charge to the evaluation team has been addressed in the sections on Performance and Progress of the subprojects and Services Delivery Capacity. Both of these sections document the progress to date relative to capacity building in the private sector. In addition, the section on subproject Continuation and Expansion outline the need and potential for expansion within the established subprojects.

The constraints of the evaluation outlined in the beginning of this report apply specifically to the issue of cost effectiveness. The complexity of this issue is such that the team could only review information and compiled data which show direct support by the project per target client. These figures represent only those funds available for provision of client services through FPPS and exclude support for project personnel, travel, consultants and training. It also excludes support from the MOH (contraceptive supply and training), and support by the private sector organizations. As with any project which starts as a demonstration, one time equipment, development and training costs inflate costs per unit of production (in this instance - acceptors). Likewise, the cost for project design and implementation involve purchase of scarce expertise and adds to the cost per unit. The evaluation team addressed the issue of program sustainability directly with subproject management staff. An assessment was made by the evaluators related to management's commitment to:

- Maintaining facilities for family planning
- Absorbing personnel costs for family planning
- Meeting increased client demands for family planning services
- Providing for the requisition and transport of contraceptive supplies from the MOH; and
- Providing for future staff training needs

Facilities

All subprojects will have adequate facilities after grant assistance is phased out after two years. In two instances, new construction is planned to upgrade family planning clinic facilities during the final year of the project.

Personnel

Fifteen (88%) of the 17 subprojects organizations surveyed intend to absorb personnel costs after the 2 year project support is phased out. However, four of these seventeen subprojects expressed concern that a third year could be needed to ensure their ability to have smooth transition to self support. Various reasons were given to support an extension including slow start delayed by equipment delivery; staff training needs; and addition of field education mid project. These are very important considerations if additional IEC and CBD components are added to existing programmes. Two subprojects (SDA and PCMA) will continue to require outside funding sources to continue family planning/MCH services after the two years period.

Client Demand

Sixteen of 17 subprojects have generated sufficient client demand to support continuation of service by the subprojects beyond two years. Most subprojects are expected to expand the original targets so that demand for service will be an important factor in continuation of service delivered to employees and dependants of private sector organizations.

Contraceptive Supplies

There is considerable scepticism by both management and staff of subprojects regarding their ability to obtain sufficient contraceptives supplies from MCH stores. All subprojects would be willing to establish a supply pick-up system with the Central or Provincial MCH Stores if arrangements can be made with the MCH ensuring the uninterrupted supply of contraceptives.

Staff Training

Once the basic subproject clinical staff is trained, most subprojects will be able to provide support for future clinical training needs. Support for future training needs of IEC/CBD workers was not assessed. However, it is reasonable to assume that most financial support for training field educators and CBD workers will have to be absorbed by the FPS project.

RECOMMENDATION

1. FPPS should continue providing the link between the new subprojects and the MOH. Specifically it should ensure they are allocated a SDP number and authorised by MOH to obtain supplies directly from the MOH stores.
2. FPPS should explore and enhance the capability of organizations such as PCMA and SDA to obtain supplies directly from the MCH for their sub-units.
3. There is evidence of increasing demand for VSC among most of the subprojects. FPPS should arrange for a needs assessment and solicit the involvement of AVSC in creating suitable facilities in deserving subprojects.
4. Recognizing the synergism between MCH and family planning it is recommended that FPPS should provide subprojects with basic MCH facilities and link them to the KEPI supply system.

PROGRAMME CONTINUATION AND EXPANSION

As elsewhere in this report continuation and expansion are discussed in a dual context, namely project and subproject levels. The presentation below begins with the lower analysis.

The Prospects for Subproject Continuation and Expansion

The current contracts between FPPS and subprojects stipulate that at the end of the two year subproject period the various companies, churches or private clinics will be required to provide the family planning services without further assistance from FPPS. In view of this understanding the evaluation team asked each subproject to outline the arrangements for supporting the service delivery at the end of two year contract period. Information was specifically sought on how personnel and training and supply costs are to be financed. Table 9 gives the breakdown of additional inputs subprojects envisage as necessary for the continuation or expansion of current capacity.

Transportation is the single most recurrent need expressed by seven subprojects, three of these requested for vehicles - motor vehicles and bicycles while two wanted transport without specifying, at one site the request is for financial arrangements to pay the bus fare for some local committee members who have to travel long distances to attend meetings or transport the performers discussed elsewhere in this report. This is related to the IEC and CED activities also cited by several subprojects. Five mention IEC materials such audio visual aids, films and education materials. Other IEC components relate to personnel - field educators and CBD. This is no doubt a direct outcome of the recently introduced training which is beginning to create a momentum in the demand for grassroots activities and functionaries.

TABLE 9: ADDITIONAL INPUTS FOR CONTINUATION AND EXPANSION OF SUBPROJECTS

<u>Type of Inputs</u>	<u>Cases</u>
Transport	7
CBD Components	2
IEC Personnel	4
IEC Materials	5
Nurses	4
Training Needs	2
Others	4
None required	2
Unable to assess needs	1

The mention of nurses at four sites comes as no surprise since these play a focal role in service delivery. This request has multiplier effects as it implies training since there is at the moment no surplus of nurses. It also implies an increase in the pay bill. Surprisingly despite the apparent lack of training for IEC personnel only two subprojects expressed training needs.

Failure to perceive subproject needs is no doubt most serious for the subproject where performance has been indeed below standard. This is also the site where management appears to be in need of motivation.

One of the key messages from the data collected on this issue would appear to be that all subprojects may require some form of assistance either to sustain or expand their current capacity for service delivery. The assistance may be given either by way of further extension of current contracts with FPPS or by an alternative agency.

Recognising the need for continued contract between FPPS and subprojects that have run a 2 year subagreement period, and noting the expressed needs of some of the subprojects to continue receiving assistance from FPPS after the two years period;

IT IS RECOMMENDED

- (a) that FPPS be availed the flexibility to maintain links with subprojects and to be able to commit resources to ensure the efficient continuation of family planning activities in the private sector.
- (b) that FPPS in conjunction with TAC establish the criteria to be used in the selection of those subprojects requiring further and continued support. These criteria should specify continued support for expansion, or continuation, and discontinuation of these projects not showing evidence of progress.
- (c) FPPS should be enabled to provide consultative assistance to subprojects even after two years. This is particularly important in order to maintain the reporting system which will permit assessment of the progress of continued family planning activities in the private sector.

FUTURE STRATEGY AND ORGANIZATION OF FPPS PROJECT

Assessment of FPPS Progress and Strategy

The Cooperative Agreement (Article I) charged JSI with the responsibility of carrying out a four year project "which will demonstrate and increase the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and related maternal child health services". This goal was to be attained through establishment of thirty demonstration subprojects, establishment of an efficient contraceptive supply and management system, and training personnel to undertake family planning activities in the private sector.

Review of the progress to date shows that the FPPS project has succeeded in initiating 21 subprojects that are offering family planning services and this number is expected to reach 24 in the next few months. This will mean that 80% of the targetted subprojects will have been established. FPPS has already established the machinery whereby these projects have joined the national network of service delivery points (SDP), and thus able to obtain supplies from the MOH medical stores. Currently most of these subprojects are receiving vaccines through KEPI and most of them have expressed the view that they are in a position to pick supplies from the CMS. The Director of the Division of Family Health, MOH has authorised this, and there are plans to upgrade the medical stores in Kisumu, Nyeri and Mombasa which will make it easier for subprojects to obtain their supplies nearer their site.

The training component has been effected through AMREF and already, 120 individuals have received training out of the 200 targetted (60%). Through a review initiated by FPPS a revised curriculum has been developed jointly with AMREF and MOH and is currently being pretested.

Our overall assessment of the progress made by FPPS towards attainment of the goals set in the agreement, is that the project has been very successful. FPPS has been the single most important mechanism of arousing awareness of the need for family planning into the private sector in Kenya, and although not all organizations are won to the idea, there is a core of projects that could be used as a stimulus to other private sector organizations to get involved in family planning. An important measure of the commitment of private sector management to family planning is their willingness to spend money to provide family planning facilities. This has been the case in seven of the 18 sites visited by the Evaluation Team.

Our assessment is that FPPS successfully fulfilled the demonstration element of subproject design and implementation and no longer needs to set up other "demonstration" projects. FPPS activities henceforth need to change from demonstration to operational mode. It still remains to be shown that family planning can be provided in the private sector in a cost-effective manner. For example the cost per acceptor based on the total provisions of the cooperative agreement has been US\$150. Similarly the cost per family planning trainee has been \$3400 based on the target figure of 200 trainees. Obviously a programme as costly as this is not sustainable. On the other hand such high costs could be justified in a demonstration project, which requires hiring of expertise and other expenses involved in the promotion of a new idea. Analysis of the cooperative agreement budget shows that just over 50% of the costs fall under the category of demonstration, while the direct inputs in the subprojects amounted to 43% of the budget. This suggested that it is feasible that family planning in the private sector could be provided at a much lower cost than what has been the case in a demonstration project. The Evaluation Team recommends that in future this element should be given further thought as the programme sustainability largely depends on its being cost-effective.

Future Coordination of Family Planning in Private Sector

The success of the FPPS project can be attributed to a number of factors. The organizational experience of JSI and the dedication of their Technical Assistance Team in Kenya have been major force in the implementation of the project. FPPS has been able to deal with and to respond to the needs of the private sector in a flexible manner, which has taken into consideration the special needs of each organization. In so doing it has been seen by these organizations as itself belonging to the private sector. The work of FPPS has of course been assisted by the prevailing political climate towards family planning especially by the increasing consciousness in many walks of life of the danger of the rapidly growing population to the economy and wellbeing of the people of Kenya. FPPS has helped materialise the contribution of the private organizations through provision of the link between the private sector and what is basically a social and health service. The views expressed by the management of the subprojects to the Evaluation Team makes it clear that a non-governmental organization would be more acceptable to the private sector than direct control or coordination by a government agency.

A NGO can provide the flexibility that is so vital in the private sector, and it will also avoid fears by the private sector of government coercion to provide family planning. Up to now the TAC of NCPD has played a monitoring role in the activities of

FPPS. This has been necessary and essential during the demonstration period. In an operational programme the NGO charged with the responsibility of private sector family planning programme should receive co-ordination from NCPD just like other agencies involved in family planning in the country.

In recommending the future strategy of FPPS the Evaluation Team has considered a number of facts that arose from the evaluation:

- at the time of evaluation 12 of the 21 subprojects established had been operating for less than 12 months and their level of performance was very varied;
- IEC and CBD activities have been going on for less than 6 months, since FPPS included them in the programme late;
- no studies have been undertaken specifically to consider the question of cost effectiveness, which is vital for sustainability of the programme, also not all the operations research projects had been completed.
- FPPS still has to document the assistance needed to maintain subprojects after the initial 2 years period.

In view of the above the Evaluation Team recommends that the FPPS project should be permitted to run a full four years as provided in the Cooperative Agreement. During this time the project will address the above issues and place the subprojects in a firm footing.

It is also recommended that the necessary amendments be made to permit an extension of the FPPS project for another two years. This will permit easy transition from a JSI programme to a Kenyan Project. The main activities of the FPPS project during the 5th and 6th year of operation should include:

- development of strategic plan for FPPS in terms of what additional services need to be provided, the rate of expansion, and how to interact with other family planning organizations;
- development of procedures for support of continuing subprojects including training and technical assistance;
- development of the operational structure for continuing FPPS as a Kenyan programme, with JSI serving as consultants if need be. It is suggested that this change of responsibility from JSI to Kenyan FPPS should be effected during the sixth year of the programme.

ACKNOWLEDGEMENTS

The work of the Evaluation Team was greatly facilitated by the help and support provided by the JSI Technical Assistance Team which literally opened all their doors to us. FPPS made available to us all the literature relevant to the evaluation, assisted in making appointments for consultation and interviews, and organized our site visits to the subprojects. However the Evaluation Team assumes the responsibility for the selection of the persons interviewed and sites visited.

We are also grateful to Dr. Gary Merritt and Ms. Laura Slobey of USAID/Kenya for their advice and encouragement throughout the exercise. Prof. Philip M. Mbithi Chairman of National Council for Population and Development (NCPD) gave valuable advice and comments which have assisted us in compiling this report.

We acknowledge the support, hospitality and kindness of the organizations and individuals that we visited during the evaluation. Last but not least we thank Mrs. Prisca Okoth and Ms. Esther Kibe whose arduous task it was to type the manuscript.

J.K.G. Mati
J. Ssenyonga
P.Maccannon
J.M. hungu

April, 1986

DOCUMENTS REVIEWED

- USAID/Government of Kenya Memorandum of Understanding,
September, 1983.
- USAID/Kenya Project Paper, No.615-0223-A-00-3066-00,
September 13, 1983
- USAID Quarterly Progress Reports
- FPPS Project Workplan
- FPPS Project Quarterly Progress Reports
- FPPS Annual Report, 1985
- FPPS/AMREF Subcooperative Agreement
- Evaluation of African Medical and Research Foundation
(AMREF) Family Planning Clinical Training
Programme, December, 1984
- AMREF Curriculum on Family Planning Training for Nurses
and Clinical Officers, Draft 3, December, 1985
- Sample of FPPS Subproject Cooperative Agreements
- FPPS Subproject Monthly Reports
- FPPS Project File: Baseline Survey on Fertility-
Related Factors and Family Planning Practices
- FPPS Project File: Cost Impact of Family Planning
Programs in Private and Non-Governmental
Organizations
- FPPS Project File: Impact of Income and Family Size and
Family Planning Practice
- FPPS Project File: Operations Research on Alternative
Approaches to Family Planning Service Delivery
(Proposed)
- Minutes of the National Council for Population and
Development (NCPD) Technical Advisory Committee
(TAC) meetings
- NCPD Population Policy Guidelines, Sessional Paper
No.4, 1984

APPENDIX 2

SITE VISITS TO SUBPROJECTS

<u>SUBPROJECTS</u>	<u>CATEGORY</u>
1. Kenya Cannery - Thika	Agro-industry
2. Nzola Sugar Co. - Bungoma	"
3. Miwani Sugar Co. - Kisumu	"
4. Chemelil Sugar Co. - Mumukoni	"
5. Voi Sisal Estate - Voi	"
6. Kenya Cashewnuts - Kilifi	"
7. African Highlands Produce - Kericho	"
8. Brooke Bond - Kericho	"
9. Brooke Bond Mabroukile - Limuru	"
10. Brooke Bond Sulmac - Naivasha	"
11. Canaan Medical Services - Nairobi	Private Practitioners
12. Kangaru Clinic - Embu	" "
13. Kenya Flourspar - Kerio Valley	Mining
14. Kima Mission Hospital - Kisumu	NGO - PCMA
15. Kikuyu PCEA Hospital - Kikuyu	" "
16. Seventh Day Adventist - Nyanchwa	NGO - SDA
17. Seventh Day Adventist - Ranen	" "
18. Panafrikan Paper Mills - Webuye	Manufacturing
19. Kenya Breweries Ltd. - Nairobi	

SUBPROJECT: _____

INTERVIEW CHECKLIST

AND

QUESTIONNAIRE

I. REVIEW BRIEFING MATERIALS

- A. Months in Program _____
- B. New Acceptors per Month _____
- C. Total New Acceptors _____
- D. Target Population _____
- E. Proportion Target Population Achieved _____
- F. Total Budget (Two Years) _____
- G. Number Staff Paid by Project _____

Type of Staff:

Nurses _____

H. Does this Sub-Project have IEC or CBD Components?

* CBD Workers _____

* IEC Workers _____

I. Does this Sub-Project have MCH Services?

Y/N Full _____ Partial _____

II. MANAGEMENT SECTION

A. Name(s) of Key Management Contact

B. Give Original Reason for joining FPPS Project (e.g. FPPS Recruiting, other Private Sector referred, etc.)

Initial attitudes of Company towards establishing Family Planning Service

Do you recommend to other private sector Organizations? If Yes, Give Example. If No, Why?

Y/N

C. What are your observations of the role and support by the Principle Agencies Involved.

- FPPS _____

- USAID _____

- NCPD _____

- MCH _____

D. Have you Calculated or Evaluated the Project's Value to Your Organization? (e.g. Cost Benefit, other tangible or intangible values, other)

How many pregnant workers do you have off on an average month?

How Long is Paid Maternity Leave? _____

Do you provide any other costs Associated with Employees or Dependent Childbearing?

- Ante Natal Care Y/N
- Delivery Y/N
- Postnatal Care Y/N
- Child Health Care Y/N
- Schooling Y/N
- Other _____

E. Other than Management's time, are there any other costs absorbed by your Organization for this Project? Estimated Costs

- Clinic Construction Y/N _____
- Clinic Renovation Y/N _____
- Furniture Y/N _____
- Equipment Y/N _____
- Supplies Y/N _____
- Other Y/N _____

F. What Arrangements has your Organization made for supporting the Project at the End of two years?

General Response _____

Personnel Costs? _____

Training Costs? _____

Supply Costs? _____

Other Costs? _____

Will your Organization be able to arrange pickup of Contraceptive Supplies if Adequate Arrangements are made at MCH District, Provincial or Central Stores?

C. How did you arrive at your target figure _____?

Given the new Acceptor response to your Family Planning Programme, was the original estimate high or low

If the Programme could expand, what do you think the new target population would be?

Would the new target include area residents other than employees and dependents?

What Resources would be needed?

H. If Project does not have IEC or CED Components, would they consider adding? _____

What Focus and Results would they expect in terms of New Acceptors? _____% increase in new acceptors

I. If Project does not have MCH Services, would they like to expand to include them?

J. Do you get Feedback from FPPS and/or your staff on the Project? _____

Is it sufficient? Explain _____

K. Do you know of other Private Sector Organizations in Kenya that would be good candidates for an FPPS Project if FPPS could expand Y/N List:

L. How Do you assess the AMREF training received by Your Nurses in the Area of:

Clinical Nursing _____

Patient Counselling/Motivation

Management

M. How would you rate your Head Family Planning Nurse in:

Clinic Patient Flow Management _____

Staff supervision _____

Data Collection/Analysis and Reporting

N. What lessons have you learned from the project the FPPS or we would benefit from knowing?

Are there remaining unresolved problems?

III. CLINICAL SECTION

A. Name(s) of key Medical Staff contacts

_____ Lead Nurse

B. Record Clinic Hours _____

Assess:

Clinic Cleanliness _____

Overall Space _____

Privacy (Exam) _____

Privacy (Waiting) _____

Visual IEC _____

Average waiting time/Patient _____

C. Service Offered

- FP Check:

Condom _____
F. Tap _____
Pill _____
IUD _____
Injection _____
Vasectomy _____
Vas. Referrals _____
Tubal Lig. _____
Natural FP _____

MCH Check:

Growth Monitoring _____
Immuniz. _____
Oral Rehydration _____
Vitamin A Supp. _____
Mult-vit. _____
Antenatal _____
Postnatal _____

D. Determine who is in charge of:

Recordkeeping _____
Data Compilation _____

E. Check the following if used as part of Record System:

- Monthly FPPS Report Y/N
- Daily Log (FPPS) Y/N
- Other Daily Log Y/N
- MCH/FP Client Record Y/N
- Defaulters File (FPPS) Y/N
- Other Defaulters File Y/N
- Log of Field Work Follow up Y/N
- Other (specify) Y/N
- Y/N
- Y/N
- Y/N

F. Does any staff member do routine or periodic analysis of data (e.g. new acceptor trends, defaulter trends etc.) obtain copy if available or describe.

G. Review the above use of records and their use by staff. Comment and assess the level of the thoroughness and usefulness of documentation.

H. Review record system used for followup of clients who do not return as continuing users. Record observations.

I. Obtain the following data for continuing users expected during November, December, and January.

* Expected to Return _____

* Returned _____

Of those who returned, give the number requiring field visit _____

K. Do contraceptive use patterns indicate

Client Preference _____

Nurse " _____

Doctor " _____

Comment if needed _____

L. Has staff referred anyone in last 6 months for sterilization Y/N # _____

M. Was AMREF training appropriate to your job function? (probe)

Clinical Care? _____

Motivation? _____

Management? _____

N. What did AMREF training prepare you for:

Best? _____

Least? _____

O. Would you like more training in any of these areas?

P. What involvement has the IEC committee village had in support project? Be Specific.

Q. If applicable, what involvement and support has been provided by Trade Union in this Project?

R. Do you think the original target of _____ was about right? Yes

How many new acceptors will be reach at 2 years? _____

S. If you had more resources (e.g. CBD workers, IE&C, Clinic Nurses), How many more new acceptors could you enroll in Program?

T. What resources would be needed to begin (explain) MCH services?

IV. COMMODITY SUPPLY AND MANAGEMENT

A. Take inventory of Main Stores:

- Codons (boxes of 144) _____

- Pills (Specify cycles)

Microgynon _____

Eugynon _____

Other _____

IUC (Types) units _____

- Foaming Tabs. (tubes) _____

- Depo. Provera (Vials) _____

- Noristerat (Vials) _____

- Other (Specify) _____

B. Are supplies:

In ventilated room _____

Off floor _____

Out of sunlight _____

C. Is FIFO practiced (Are supplies set up with oldest in front and newest in back) _____

APPENDIX 4

ORGANIZATIONS AND INDIVIDUALS VISITED

FPPS

- | | | |
|----|----------------------|---|
| 1. | Dr. Eric Krystall | Director |
| 2. | Mrs. Millicent Odera | Deputy Director/Research
and Evaluation Specialist |
| 3. | Ms. Joan Robertson | Management and Procurement
Specialist |
| 4. | Mr. Daudi Nturibi | Communication Management
Specialist |
| 5. | Mrs. Nester Theuri | Clinical Management
Specialist |

AID

- | | |
|------------------|--|
| Ms. Laura Slobey | Project Officer |
| Dr. Gary Merritt | Head of Population,
Health and Nutrition. |

MINISTRY OF HEALTH

- | | |
|------------------|--|
| Dr. John Kigendu | Director, Division of
Family Health |
|------------------|--|

NCPS

- | | |
|-----------------|----------|
| Prof. P. Mbithi | Chairman |
| Mr. J.M. Hungu | Director |

FPAK

- Executive Director

MAENDELO YA WANAWAKA ORGANIZATION

Chief Executive

SIDA

Mr. Inger Lagerman

Population Officer SIDA

AMREF

Dr. Chris Wood

Director

Dr. Hakan Sandbladh

Head of MCH/FP and

Mrs. Margaret Mwiti

General Nutrition
Chief Trainer

COTU

Mr. Justus Mulei

Secretary General

Mr. Philip Mwangi

Chairman

CHAMBER OF COMMERS

Mr. F. Kanya

Chief Executive