

PRIVATE SECTOR FAMILY PLANNING II

615-0254

PROJECT PAPER

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EXECUTIVE SUMMARY

Although Kenya has experienced a significant decline in the total fertility rate over the past ten years (from 8 to 6.7), the annual population growth rate still remains one of the highest in the world, at about 3.6%. Contraceptive prevalence has increased to 27% among married women of reproductive age¹ and for the first time, the 1989 Kenya Demographic and Health Survey (KDHS) showed a marked decrease in desired family size, from 5.8 to 4.4.

Both the Government of Kenya (GOK) and USAID are seeking to meet this growing demand to space births and reduce family size in a number of ways. Specifically, USAID will continue to support delivery of family planning services through the public and private sectors, as part of its three-pronged strategy to expand and strengthen clinic-based services, community-based family planning (CBFP), and contraceptive retail sales (CRS). Since 1984, at the request of the GOK, USAID has supported the expansion of family planning services in the private sector through the Private Sector Family Planning Project (PSFP). This project was developed to increase access to family planning (FP) by adding or enhancing FP services at the medical facilities of selected private sector organizations which employ significant numbers of men and women. PSFP I was evaluated twice, in 1986 and 1990. Both evaluations found that: private sector firms can and will contribute to the national FP program; there was substantial room for expansion; and that most services continued to be sustained by the private firms, clinics and parastatals after the subgrants ended.

A subsequent survey² of private organizations in Kenya found evidence of significant potential unmet demand for assistance for family planning services provision. A large number of firms, private health facilities, non-governmental organization (NGO) networks, and teacher training colleges were identified as being potentially in need of and eligible for assistance to offer family planning within their existing health services.

The purpose of PSFP II therefore will be to increase the availability, use and sustainability of FP services in the private sector. By the end of the project, it is anticipated that 150,000 couple years of protection (CYPs) annually will be generated by 60 continuing and 50 new private sector organizations supported by PSFP. It will achieve this through the following means:

- (1) add or expand FP services through subprojects with 50 organizations not covered by PSFP I;

¹Kenya Demographic and Health Survey, 1989.

²See Annex F, Demand for Family Planning by Anne Inserra.

- (2) maintain the network of 60 entities assisted by PSFP I (small-scale technical assistance, training and IEC support);
- (3) identify and finance alternative models for expanding private sector delivery, and increasing cost effectiveness;
- (4) disseminate information on project successes and lessons learned.

The project is a U.S. \$10 million, seven year activity to be financed under the Development Fund for Africa (DFA). A seven year Cooperative Agreement will be competitively awarded to a Kenyan non-profit, NGO, private organization or combination of organization(s), including a U.S. NGO in a joint venture with a Kenyan NGO which bid on the project. This implementing organization (IO) will be responsible for liaising with USAID and the GOK; providing long- and short- term technical assistance; procuring equipment and ensuring contraceptive supply; project monitoring and financial and progress reporting; conducting special diagnostic studies or operations research studies; providing training and IEC assistance to subproject staff; and disseminating information about the project.

The project will be administered by USAID under a Memorandum of Understanding signed by the Ministry of Finance (MOF) and countersigned by the Ministries of Health (MOH) and Home Affairs and National Heritage. Under the Cooperative Agreement, USAID/Kenya anticipates maintaining substantial involvement with the IO during the performance of this activity.

Coordination will be through convening of a Technical Advisory Committee (TAC) which will meet semi-annually to review project progress, review and approve annual implementation plans, and confirm identification of potential subprojects. The GOK will be represented on the TAC by the National Council for Population and Development (NCPD) and the MOH. The MOH will play a significant role in assuring overall quality standards for clinics and personnel; providing contraceptives and certifying the training of clinical personnel.

It is estimated that about \$9.5 million of the total A.I.D.-financed project budget will be available for the Cooperative Agreement. The balance of project funding, i.e., \$500,000, will finance costs for special studies, financial management, evaluations, audits, and contingency/inflation.

Project progress will be measured by numbers of subprojects developed and maintained, numbers of CYPs generated by year and cumulatively over the life of the project, and other outputs related to the elements cited above. Two project evaluations

will be conducted over the life of the project. Regular semi-annual progress reports will be required.

I. PROJECT BACKGROUND

A. Population Trends

Population growth continues to be one of Kenya's major long term development constraints. In spite of recent declines in the total fertility rate, from a high of 7.9 in 1984 to a current estimate of 6.7³, the population growth rate at 3.6% remains one of the highest in the world. While this recent downward trend is encouraging, continued growth at this rate will cause the population of Kenya to double in only 19 years. Furthermore, because 50% of Kenyans are under 15 years of age, at best, only modest declines in Kenya's population growth rate can be expected during the next two decades. Increasing numbers of young people entering childbearing ages will cause the number of births in Kenya to remain high, even if the average number of children borne by each Kenyan woman declines. As a result, the population of Kenya will more than double to about 50 million before stabilizing late in the 21st century, even under the most optimistic assumptions about future declines in the population growth rate.

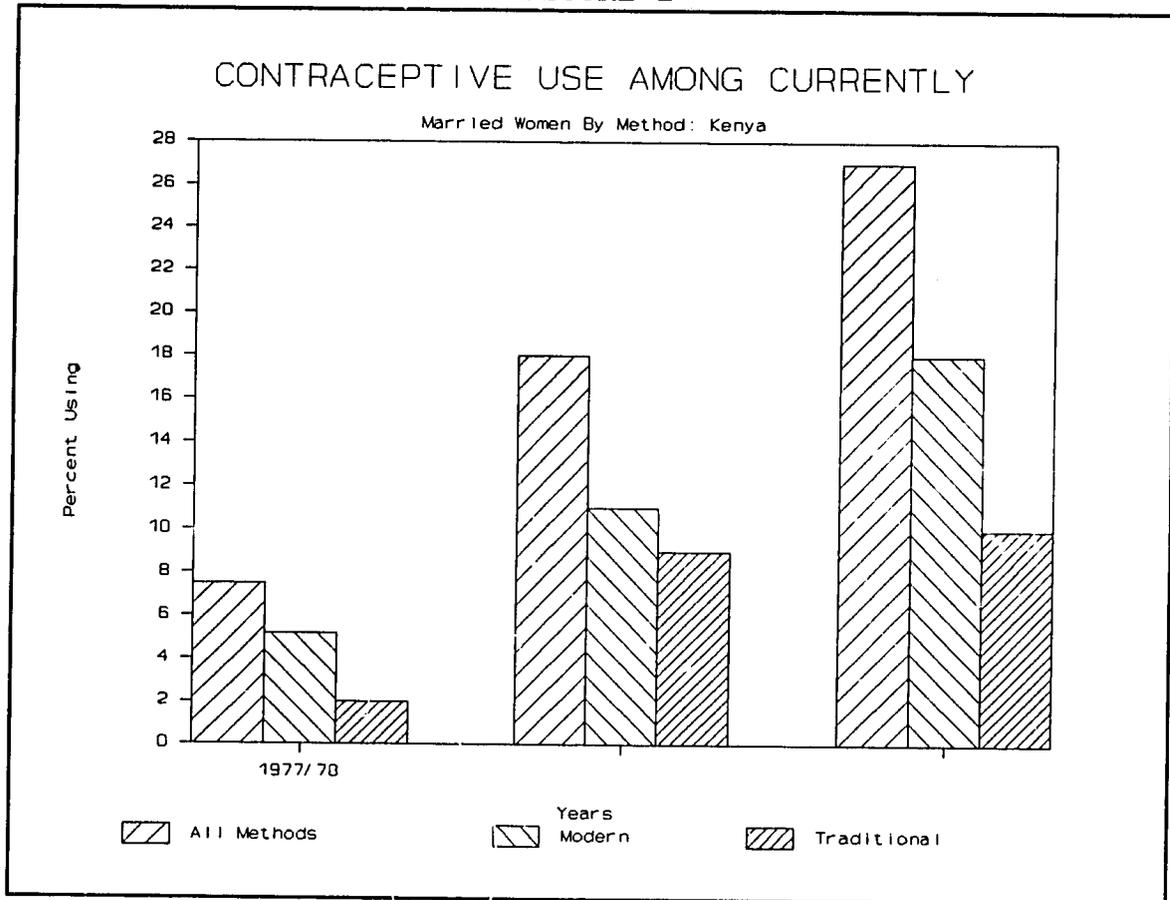
This rate of population growth already places enormous strains on Kenya's education system, health services, labor and housing markets, and natural environment, making reductions of rapid population growth one of the highest priorities of the Kenyan government today.

Although fertility has started to decline in Kenya the rate is still high. The national total fertility rate, which was close to 8 in 1980, had fallen to 6.7 in 1989. The 1989 Kenya Demographic and Health Survey (KDHS) estimates that the total fertility rate declined by over 15% between 1978 and 1989.

Contraceptive use is correspondingly increasing in Kenya. Overall contraceptive use among married women of reproductive age increased from 7% in 1977/78 to 27% in 1989. Modern contraceptive prevalence has increased from 5% to 18% during the same period. See Figure 1.

3 Source: Country Program Strategic Plan FY 1990-1995, Agency for International Development, March 1990

FIGURE 1



There are important differentials in overall contraceptive prevalence, according to the KDHS. For example, modern methods are used by 26% of urban women, compared to only 16% of rural women. Modern method prevalence also varies widely by province, ranging from 31% in Central Province to only 10% in Western and Nyanza province.

Perhaps the most remarkable findings of the 1989 KDHS are the marked decrease in desired family size (from 5.8 in 1984 to 4.4), and the equally impressive increase in the proportion of women who say they want to limit or space future births. Since 1977/78 the proportion of married women wanting no more children has nearly tripled, from 17% to 49 % currently (see Table 1). This is the highest level of demand for family limitation in sub-Saharan Africa. Overall, about 75% of married women in 1989 said they wanted to either limit or space future births. Even more striking is the fact that 11% of married women said they did not want their last child; an additional 42% said they had not wanted it so soon.

TABLE 1

% Who Want No More Children, % Who Want to Space Next Birth, and Ideal Family Size, By Age:

Age	Percent Who Want No More			Percent Who Want To Space			Mean Ideal Family Size		
	1977/78 KFS	1984 KCPS	1989 KDHS	1977/78 KFS	1984 KCPS	1989 KDHS	1977/78 KFS	1984 KCPS	1989 KDHS
15-19	2	4	9	NA	NA	54	6.5	5.7	3.7
20-24	4	11	18	NA	NA	55	6.3	5.6	3.9
25-29	12	23	39	NA	NA	36	6.6	5.9	4.4
30-34	19	45	56	NA	NA	18	7.2	6.6	4.8
35-39	25	54	67	NA	NA	12	8.0	6.9	4.9
40-45	40	67	78	NA	NA	2	8.1	7.2	5.5
45-49	42	76	81	NA	NA	1	8.6	7.4	5.3
All	17	32	49		45	26	7.2	6.3	4.4

NA = Not Available

* For the Kenya Contraceptive Prevalence Survey (KCPS), those who want to wait at least one year; for KDHS, two years or more.

** For KFS, ever-married women; for KCPS, currently married fecund women; for KDHS, all women.

Source: A.I.D Impact Evaluation Report: A.I.D. Assistance to Kenya's Family Planning Program, Nov. 1990.

Women interviewed were also asked about their ideal family size, specifically the number of children they would like to have if they could start over again. Their answers show a reduction in mean ideal family size of almost three children between 1977-78 and 1989, from 7.2 to 4.4. (see Table 1). In all age groups over 30, mean ideal family size is actually lower than mean children ever born. This means that for the first time, women with many children would choose to have fewer children if they could do it all over again.

The draft 1990 Center for Development Information and Evaluation (CDIE) Impact Evaluation of A.I.D. Assistance to Kenya's Family Planning concludes, "This rapid decline in ideal family size gives ample evidence of a strong demand for family planning, and highlights the need to increase the availability of family planning services to allow women to achieve their stated preference for smaller families."

Further evidence of demand for family planning is provided in 1990 report by Charles Knobbe and Allen Kelly, entitled, "Kenya at The Turning Point? Hypotheses and Proposed Research Agenda." In their discussion of the factors contributing to the recent fertility decline in Kenya, the authors conclude that a reduction in the demand for children has been a major factor contributing to the increased use of family planning and decline in fertility. They point out that the reduction in demand for children between 1984 and 1989 (24%) exceeds the reduction in the TFR (15%), and conclude that there is presently considerable unmet demand for family planning which is widespread geographically. They recommend that the priority short-run strategy should be to meet existing demand for family planning as rapidly as is feasible.

USAID's focus on expanding family planning services through both public and private sector channels is based on the premise that a considerable unmet demand for family planning exists in Kenya, and that providing quality family planning services is the best way to respond to this demand. Data from the 1989 KDHS strongly supports the assertion of unmet demand. Confirmatory findings from the 1989 KDHS are the marked decrease in desired family size, compared to earlier studies, and the equally impressive increase in the proportion of women who say they want to limit or space future births.

B. Government of Kenya Policy

The GOK was the first in sub-Saharan Africa to articulate concern about the effects of population growth on its social and economic development and to create an official national family planning program. During the early 1960s, the Family Planning Association of Kenya (FPAK) was established and in 1967, the national family planning program was launched under the Maternal Child Health Division of the Ministry of Health (MOH). However, in spite of early expressed GOK support for family planning, the effective provision of family planning information and services on a wide scale began only in the 1980s.

In 1982, GOK concern and resolve for dealing with the problem of rapid population growth resulted in creation of the National Council for Population and Development (NCPD) in the Office of

the Vice President and Ministry of Home Affairs. The NCPD was created to establish official population policy and to guide and coordinate the population activities of the numerous agencies involved in Kenya's family planning program.

An official population policy to reduce the rate of population growth was articulated in the 1984 GOK Parliamentary Sessional Paper Number Four. At that time, both the President and the Vice President began to speak frequently and forcefully on the subject of rapid population growth and to openly support efforts to reduce rapid population growth through voluntary family planning. The latest statement of official policy and strategy was set forth at the Second National Leader's Population Conference in 1989. Currently, the GOK's stated goal is to reduce the rate of population growth to 2.5% by the year 2000. To achieve this goal it plans to reduce the number of births from 51 to 35 per 1,000, the number of deaths from 13 to 11 per 1,000, and the level of family planning practice from 28% to 40% by the year 2000. Strategies to achieve this goal are to expand and intensify the current service delivery approaches, increase involvement of men, upgrade the status of women, and improve related MCH measures. Since 1979, USAID has been supporting GOK programs to increase information and expand accessibility to quality family planning services.

C. USAID Strategy and Relationship to the Country Program Strategic Plan (CPSP)

One of the main factors which constrains Kenya's effort to maintain and accelerate economic growth and improve the life of its people is rapid population growth. Thus one of the three major long-term goals, identified in USAID/Kenya's approved CPSP for 1990-1995, is to assist in reducing Kenya's very high rate of population growth. USAID's strategic objective is to increase the contraceptive prevalence rate among married couples of reproductive age from the 1989 level of 27% to 35% by the end of 1995. Use of modern methods of contraception by that group is expected to increase from 18% to 24% during the same period. As shown in Figure 1, contraceptive use increased dramatically, from only 7% in 1977/78 to 27% in 1989, with an increase from 9% to 18% in modern method use since 1984. It is USAID's belief that improvement in the availability and quality of services will help respond to the considerable unfilled demand for contraceptive services which exists in Kenya.

USAID'S approach is centered on three major strategies which taken together cover the spectrum of family planning assistance channels; expanding and strengthening clinic-based services, community based family planning, and contraceptive retail sales.

Improving clinic-based services continues to be an important means of attaining the target of increased contraceptive use. Despite recent gains, many public and private health facilities still do not routinely offer family planning services.

Under its eight year \$46.2 million bilateral Family Planning Services and Support (FPSS) Project (615-0232), USAID provides public sector support to train key service providers in maternal/child health and family planning, to strengthen logistics management, and for contraceptive supplies. One special subset of clinic-based services is the voluntary surgical contraception (VSC) program, which supports the establishment of VSC sites in both the public and private sector.

Complementing this public sector effort have been programs to introduce and/or strengthen family planning services in private clinical facilities. The major project has been the Private Sector Family Planning (PSFP) Project (615-0232) from 1984-1991, which introduced family planning into health facilities of private commercial firms, parastatals, training institutions, private maternity homes, and NGO hospitals and health centers. In addition, both bilateral and central funds are being used to introduce family planning into the clinics of private medical practitioners.

The bilateral FPSS Project also supports family planning service delivery through community-based approaches, primarily implemented by NGOs. The portion of the country served by community-based family planning workers has increased dramatically since 1985. At that time, it was estimated that less than 15% of the population was served by such programs. Since 1988, there has been a major expansion in the community-based family planning programs implemented by among others Family Planning Association of Kenya (FPAK), the Maendeleo ya Wanawake Organization (MYWO), and the Christian Health Association of Kenya (CHAK) which represents a network of Family Planning Associations, women's groups and Christian hospitals, clinics and dispensaries.

The Contraceptive Social Marketing (CSM) Project (615-0251) is the newest intervention in USAID's strategic approach and supports efforts to enhance the availability of reasonably priced condoms and oral contraceptives sold through commercial retail outlets. USAID is financing the marketing and distribution of four products to be obtained through a commercial arrangement between a local marketing firm and commercial suppliers.

D. Other Donors

Although the World Bank, UNFPA, the United Kingdom and Sweden devote a large share of their aid to activities designed to decrease population growth rates, USAID is still the major donor supporting service delivery with the largest dollar amount and broadest scope of assistance. Support for private sector family planning activities are almost entirely funded by USAID. United Nations support for population and family planning is channeled through UNFPA, and provides funding for the 1989 census, population education, family life education, and research and training. Its largest support area is for population education channeled through the Ministry of Labor, the Kenya Federation of Employers, the formal school system and through a mass media effort to enhance awareness of family planning. The World Bank, through the International Development Association, provides concessional loan financing to Kenya for population and family planning activities. Like USAID, assistance is channeled both through the NCPD and the MOH. Assistance includes strengthening NCPD's management capacity and its monitoring of information and service programs being implemented by NGOs, and support to the MOH for the construction and renovation of VSC facilities and health centers.

All contraceptives for PSFP and other USAID projects are provided by external donors and distributed through MOH channels. Since the early 1970s, the Swedish International Development Agency (SIDA) has been the sole supplier of oral contraceptives. Recently, the World Bank agreed to finance injectable and vaginal foaming tablets (VFTs) as well as the contraceptive implant (Norplant) with FINIDA funding provided through the Population II Project. ODA has agreed to help finance injectables. USAID continues to provide condoms, IUDs, and until CY 1992, VFTs.

In addition to USAID support, PSFP has received a total of \$625,000 from other donors. The Ford Foundation and SIDA provided \$480,000 for IEC materials and folk media activities. The Jesse Smith Noyes Foundation has been supporting the PSFP-sponsored internship training program. Small grants have been received from UNICEF for child survival activities, from the Association for Voluntary Surgical Contraception (AVSC) for VSC services and from the ILO, DANIDA and NORAD for IEC activities.

E. Previous Experience

PSFP I was developed in 1982/1983 in order to increase access to family planning by adding or enhancing these services at the medical facilities of selected private sector organizations which employ significant numbers of men and women. The specific objective was to establish thirty (30) subprojects of

approximately two years duration each, after which time the firms would continue family planning service delivery without external support to 30,000 new family planning users. Based on competitive selection, the John Snow Research and Training Institute (JSI), a U.S. non-profit entity, won a four year \$4.5 million cooperative agreement and began work in Kenya in January 1984.

PSFP I operates in Kenya under a Memorandum of Understanding with the GOK, endorsed by the Ministries of Finance, Health and Home Affairs. The latter Ministry provides secretariat support to the NCPD which is comprised of senior persons from several ministries and major health-related NGOs. The NCPD appointed a Technical Advisory Council (TAC) to establish PSFP policy guidance, handle case-by-case subproject reviews and approvals, and provide evaluation support.

A USAID financed mid-term evaluation of the PSFP I project was conducted in 1986. It concluded that the project was successful in delivering family planning services through existing private sector medical facilities, thus demonstrating that private sector firms can and will contribute to the national family planning program. A major recommendation of the evaluation was that the project be extended and service targets increased. Thus the project was amended upwards to include 50 subprojects and 50,000 users. It was extended for two years and LOP funding was increased to \$6.5 million.

The project was amended once again in August 1988, bringing total LOP funding to \$8.4 million through the September 30, 1991 PACD. Revised outcomes of the project were 85,000 new users of family planning services and 60 private institutions operating new and/or improved family planning programs, as well as the commitment of private organizations to maintain family planning services upon termination of PSFP project assistance.

Thus from its original design and initiation to the present, the project has expanded significantly (almost doubling) in terms of outputs, timeframe and expected achievements. This history reflects the private sector's willingness to seriously consider the provision of family planning services, and the GOK's endorsement of a complementary approach to the delivery of family planning services nationwide.

In May 1990, an end-of-project evaluation of PSFP was conducted. The purposes of the evaluation were to evaluate overall project impact, assess progress to date, assess the sustainability of subprojects and verify the extent of unmet need for family planning in the private sector. The evaluation found that the project has performed well, meeting or exceeding most of its

targets. Specifically, at the time of the evaluation 54 institutions were providing family planning services through 156 service delivery points. 88,300 Kenyans have been served through PSFP subproject contraceptives, and 75,040 couple years of protection were being provided annually. Of the 54 approved subprojects, 44 had passed the two year point and were continuing to provide family planning services, 28 of these with no additional financial support from the project.

PSFP I has largely succeeded in achieving sustainability. All subprojects continue to provide clinic-based family planning services upon termination of grant funds. Most of the subprojects still rely on PSFP for assistance in obtaining contraceptive supplies. Increasingly, however, subprojects obtain these supplies directly from MOH sources, either at the central, regional or district level. Some of the subprojects, particularly NGOs and Mission hospitals, and some private clinics continue to request PSFP financing and technical assistance for IEC and outreach services and sometimes salary support because of their own limited funding. Commercial organizations and parastatals can more easily draw upon their own resources to continue services for their workers. Activities which tend to phase down as PSFP support diminishes are IEC, outreach, community based services and training.

F. Project Rationale

The evaluation noted considerable unmet need/demand for family planning services in the private sector, a finding borne out in a subsequent needs assessment carried out by USAID/Kenya in October/November 1990 (See Annex F). This survey-based assessment identified significant potential unmet demand for assistance in providing family planning services by those entities that met the basic eligibility criteria. The survey had an excellent response rate, with 122 of the 178 organizations contacted responding. Of these, 90 companies and private health facilities were found to be potentially in need of and eligible for family planning assistance of the type offered under PSFP I.

In addition, the study found that three major NGOs, (the Christian Health Association of Kenya, Crescent Medical Aid, and the Seventh Day Adventists Rural Health Services), that received assistance under PSFP I for some of their health facilities, support an additional 80 facilities that were not previously assisted and do not currently offer family planning services. There are also approximately 20 teacher training colleges in Kenya with a demonstrated need for assistance to provide family planning services to students. Other potential sources of demand for assistance to provide family planning include additional large branches of firms assisted under PSFP I, and approximately

35 organizations that have requested assistance but have not yet been helped, due to funding and time constraints. Thus, the total number of facilities potentially in need of family planning assistance of the type offered by PSFP I total over 200. Clearly, an important need has been demonstrated for continued investment in private sector family planning in Kenya.

In addition to unmet demand for new subprojects, there is a need for continued technical assistance to ongoing subprojects. As noted above, although project sustainability is impressive, most subprojects still rely on PSFP for contraceptive supply, management support, clinical training, IEC and outreach activities. There is need to further analyze the potential long-term sustainability of family planning programs offered by the various types of assisted organizations. In addition, continuing assistance needs will have to be identified and potential mechanisms for addressing those needs defined.

Under PSFP I, USAID has had considerable success in getting family planning accepted as an important and valued service in the private sector. Significant numbers of family planning users have been recruited through this approach. The 1990 evaluation concluded that PSFP I currently serves between 10% and 13% of all family planning users in Kenya.

Given the continued high rate of population growth, substantial unmet need for family planning which still exists in Kenya, the demonstrated demand by private sector organizations and clear evidence for sustained private sector service delivery, a compelling rationale exists for continued AID support of the private sector in FP services over the next seven years.

II. PROJECT DESCRIPTION

A. PROJECT GOAL AND PURPOSE

The project goal is to reduce fertility and the population growth rate, major constraints to sustained and broad-based economic growth in Kenya. The indicator of progress towards goal achievement will be a continuing decrease in the Total Fertility Rate (TFR) from its current level of 6.7 to 5.5. This reduction will be achieved in large part through an increase in the national Contraceptive Prevalence Rate (CPR) from the current level of 27% of married women of reproductive age (MWRA) to 40% by the end of the project. Raising the CPR continues to be the most effective and direct strategy for reducing fertility. The feasibility of positive private sector participation in the national family planning program has been clearly demonstrated in the PSFP I Project.

The purpose of this project is to increase the availability, use and sustainability of family planning services in the private sector. An important assumption made at the purpose level is that the GOK will continue its partnership with and support for the private sector in implementing the national FP program. With the long history of GOK receptivity to private sector participation by the Family Planning Association of Kenya (FPAK) and other NGOs in the national FP program, its endorsement and request for continuation of project activities similar to those of the eight-year PSFP I Project, and the recent initiation of a contraceptive social marketing project, there is every indication that this is a valid assumption. Similarly, there is a high confidence level in the assumption that a sufficient number of private sector organizations will be willing to participate in subprojects funded by this project. This belief is based upon the backlog of requests for assistance for future follow-up, and the recent needs assessment which identified 44 companies, 46 private health facilities, 80 health facilities of three NGOs and 20 teacher training colleges potentially in need of the type of assistance offered by this project.

If these assumptions are correct, the project is expected to achieve the following EOPS by the PACD:

- o 50 additional private sector firms and organizations will be providing FP services as part of their routine health services to clients, employees, dependents of employees, and, sometimes, people of surrounding communities;
- o a cumulative increase will be realized in couple years of protection (CYP) from approximately 350,000 in 1991 to 800,000 attributable to private sector organizations (including those from the predecessor project which continue to report, See Chart 1); and,
- o the CYP attributed to these organizations during the last year of the project will have increased from the current 80,000 to 150,000 CYP per annum. (See Chart 2).

Data from the Logistics Management Information System (LMIS) and the 1993 and 1998 DHS will be used both to monitor project implementation and to assess impact. Additional means of verification will be information from contractor reports, site-visit reports, and clinic records.

PROJECT ELEMENTS AND OUTPUTS

ELEMENT 1. The addition or expansion of family planning services through subprojects with fifty (50) organizations not covered by PSFP I.

As in PSFP I, the private sector as defined herein encompasses firms and organizations which maintain health/medical delivery systems without being largely dependent upon government subsidy. This includes clinical facilities managed by commercial firms, parastatals, individuals, communities and NGOs. Certain training institutions are included because, like the parastatals, they maintain their own medical facilities and are not totally dependent on government for financing. The number of subprojects, by type of private sector organization, will be determined, as project implementation proceeds. The PSFP I project financed subprojects with 23 private companies, 9 parastatals, 3 NGOs (five subprojects with 58 sites), 13 private clinics, 4 training institutions and 3 community-owned facilities. It is likely, however, that the subproject mix of this project will differ, depending upon the degree of receptivity and interest within the various categories and the universe of such organizations which meet the criteria for selection as subprojects (see below).

Criteria to be met and the process for subproject selection are derived from experience under PSFP I. The criteria for selection of organizations to receive project assistance are as follows:

1. The organization has an acceptable accounting system and procedures to reasonably assure that it has the management capacity to meet standards for funds control and accountability.
2. The organization has clinical staff and facilities and already offers curative medical services to its clients (for an exception, see Element 3 of this section).
3. The organization's top management is willing to include FP services within its medical delivery system, commit staff and other resources, and agrees to continue offering FP services after subproject assistance ends.
4. The organization's medical service has the potential to reach a large number of people of childbearing age not currently served due to lack of available FP services or constraints to their use (such as being too costly, too remote, or not convenient because of the hours when services are offered). In the case of commercial firms and parastatals, subgrantees will normally employ a minimum of

CHART 1

ACHIEVED AND EXPECTED CYP, 1985-2000

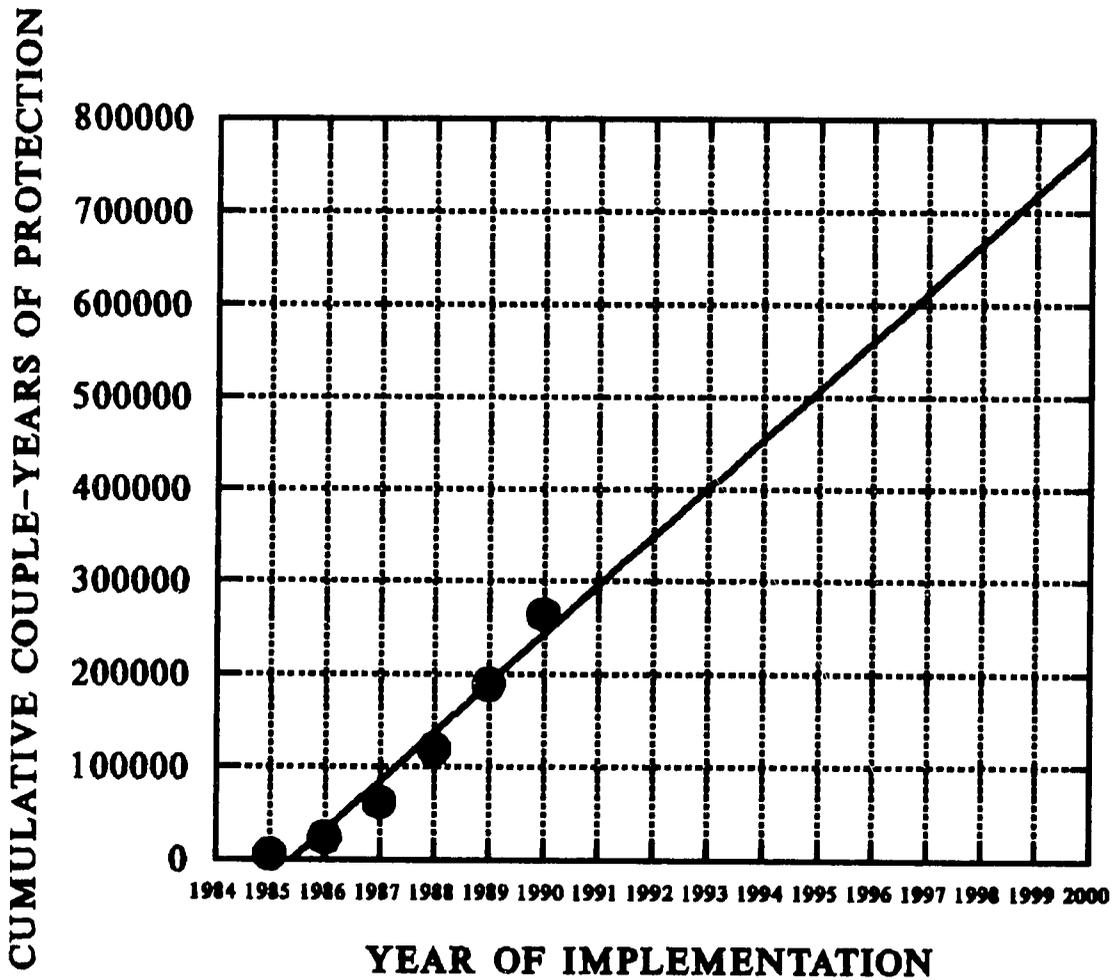
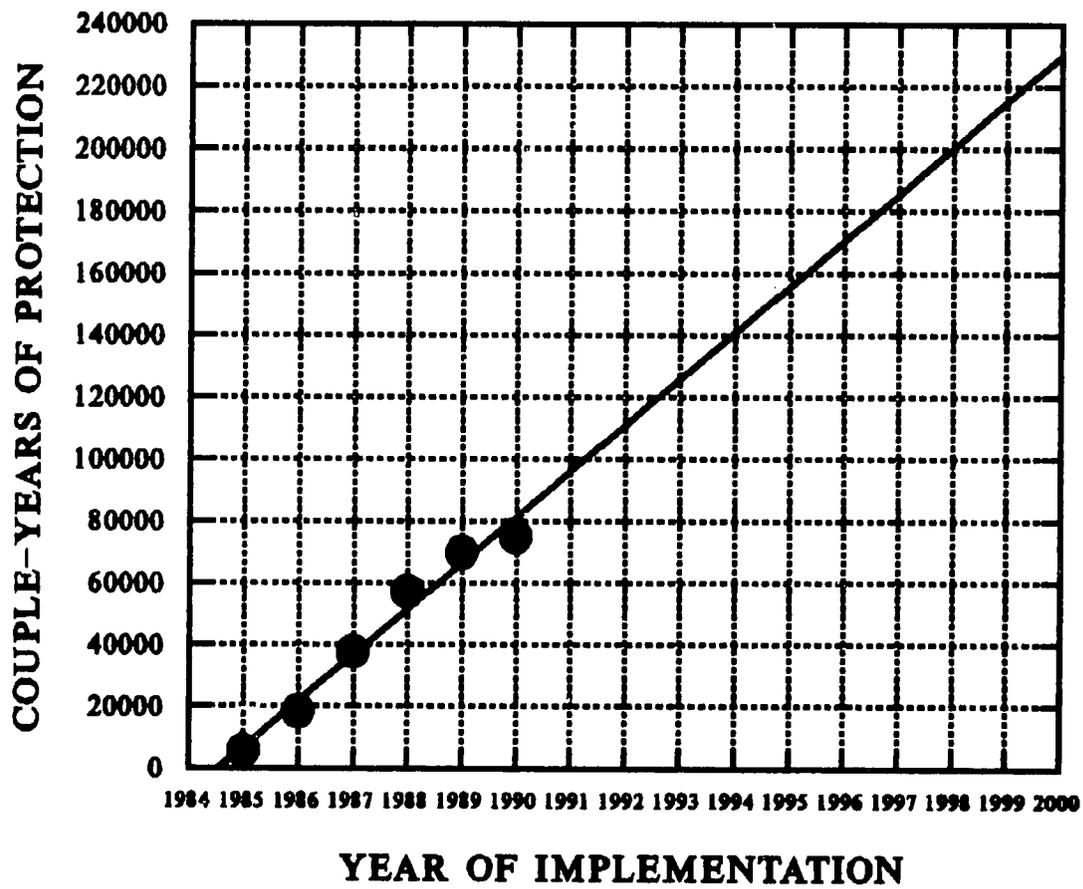


CHART 2

ACHIEVED AND EXPECTED CYP, 1985-2000



500 employees, but selection for PSFP assistance will depend on the gender mix of the employees, whether or not dependents are eligible for services, availability of FP services from other nearby locations, and the willingness of the firm to serve persons from the surrounding community. Selection of subprojects with private clinics, NGOs, training institutions and community-owned facilities will be done on a case-by-case basis, and depend on actual and potential case load, in addition to the criteria stated above.

5. Priority will be given to qualified organizations operating in low contraceptive prevalence areas.

The types of organizations expected to satisfy the criteria listed above and become subprojects are described below. These categories of organizations have been identified based on the experience in PSFP I.

Private Firms - Private commercial firms are expected to be a prime target for assistance in this project. Industrial, service-oriented, and agribusiness companies, including factories and plantations, that employ significant numbers of men and women and provide health services to employees (and sometimes dependents), have proved to be very successful in providing and sustaining family planning services. All of the private sector firms assisted in PSFP I have been willing to assume the recurrent costs of maintaining family planning services, presumably because of the perceived economic benefits attributable to providing these services. Although 23 private firms received support under PSFP I, the recent needs assessment (Inserra, 1990) identified 28 additional private companies that had at least one branch with 250 or more employees, offered health services to employees and could potentially be in need of assistance to add or expand family planning services.

Parastatals - Large parastatals often employ thousands of workers and usually maintain multiple clinic sites, making them important potential family planning providers. The needs assessment identified eight parastatals, including industrial firms, development corporations, research and educational institutions, and a transportation company that have at least one branch with 250 or more employees, provide health services and could potentially need family planning assistance.

An additional eight firms that qualify on the basis of size and provision of health services were identified by a 1988 survey of demand as potentially needing assistance with family planning. Potential recipients of subproject assistance also include additional large branches of firms, (both firms already assisted by PSFP I and new targets).

Private Health Facilities - Private nursing homes, maternity homes, hospitals and clinics have been very successful in providing family planning services. There exist numerous such privately-owned institutions run by doctors and nurses that could introduce or expand family planning services with PSFP support. 46 private health facilities were identified by the needs assessment as being potentially in need of family planning assistance.

Educational Institutions/Teacher Training Colleges - These institutions provide health services to large populations of students, faculty, staff, and their families. Two teacher training colleges were assisted during PSFP I to provide family planning services at their health facilities. A study carried out in 1988 by Alan Ferguson, Jane Gitonga and Daniel Kabira, entitled, "Family Planning Needs in Colleges of Education" recommended that steps be taken to try to introduce family planning services in all of the colleges. This conclusion was based on the evidence of a high pregnancy drop-out rate, and the finding that the majority of female students and clinic staff expressed support for the introduction of such services. This study suggests that there is need to target the approximately 20 teacher training colleges for assistance in PSFP II.

Non-Governmental Organizations - The unrealized potential for provision of family planning services through the health facilities of NGOs and church-related institutions in Kenya is considerable. For example, the Christian Health Association of Kenya (CHAK) supports approximately 200 health facilities throughout the country. Only 15 of these received assistance under PSFP I. Crescent Medical Aid and the Kenya Seventh Day Adventist Rural Health Services are two other NGOs that participated in PSFP I and support networks of health facilities that have not yet been targeted but that require assistance in order to introduce delivery of family planning services to clients.

Each subproject will be tailored to meet the resources and needs of the individual grantee. A "basic" or typical assistance package for subproject requirements normally will cover funding requirements for two years and will include:

- Salary support for temporary replacement of clinical personnel while they are being trained.
- Salary support, normally for a two year period, for additional personnel needed for effective FP service delivery, with the understanding that the organizations will assume these costs at the end of the subproject period. Examples in the latter category include clinical officers, nurses and IEC Field Educators.
- Basic clinical MCH/FP training of personnel from the organization's medical service. The basic training must follow the Ministry of Health (MOH) curriculum and be approved by the MOH. The duration and content of the MOH curriculum are currently under review. If revised, basic clinical training provided by this project will conform to the changes. The Technical Annex provides a description of the training curriculum currently in use.
- Training of IEC field educators. Under PSFP I most subprojects found that acceptance was enhanced by the use of Field Educators who formed a liaison between the clinics and the community, coordinated field IEC activities and acted as FP motivators. These personnel were recruited by the firms, trained by the IO, and supervised by subproject clinical personnel. The basic and refresher training of IEC Field Educators in this project will be developed by the IO. The training curriculum and format used in PSFP I is described in the Technical Annex.
- Periodic one-two day seminars/workshops with appropriate management levels, volunteer IEC Committees and community leaders associated with the subprojects to ensure their understanding and support.
- Provision of FP and FP-related equipment such as examining tables, IUD insertion kits, sterilizers, scales, examining lights, etc. Contraceptives will not be provided by the project, but will be obtained through regular Ministry of Health (MOH) channels. Evaluations of PSFP I found that because of problems existent in the MOH contraceptive supply system, the subproject grantees became overly dependent upon the IO to intervene with the MOH to insure continuing contraceptive supply during and after completion of the subproject. The MOH supply system has improved

significantly in recent years and further improvement under the MOH's Logistics Management program is expected. Under PSFP II, the IO will present a plan acceptable to USAID within the first project year describing a time-phased plan for linking the subprojects and the MOH contraceptive logistics system so that, in most cases, contraceptive resupply will occur without PSFP assistance once the subproject has been completed. (See Technical Annex for further discussion).

- Technical assistance in subproject administration and record keeping, clinical management, supervision, IEC, contraceptive logistics management, quality control and reporting.

- Time-limited provision of FP-related operating expenses such as transportation costs, office supplies, telephone, IEC activities, etc.

Depending on the size and state of development of the subproject grantee's medical delivery system, its financing, and the demand for FP services, the "basic" assistance package for a subproject may be modified or enhanced on a case-by-case basis in several ways:

- Technical assistance and training for community-based family planning (CBFP) schemes. This may be considered for subprojects serving widely scattered populations such as plantations, logging areas, etc. FPAK, MYWO, CHAK and several other NGOs currently offer CBFP in many locations, though often not in areas expected to be assisted under PSFP II. This project will ensure, however, that CBFP activities are not financed in areas currently served by other organizations.

- Technical assistance, training, and support for additional IEC activities. This might include support to mobilize volunteer IEC committees comprised of local leaders of women, youth, school, and church groups to implement information and motivation activities. In PSFP I, these committees were particularly useful in subprojects with commercial companies and plantations. Another example is development of Folk Media Groups for community FP information, education and motivation through socially acceptable popular performances of drama, music, dance, poetry and story telling. Performers are community volunteers identified by the IEC Committees. The project will provide technical assistance to subprojects to ensure that FP messages are technically correct and communication methodologies appropriate for the situation.

Most client education and other IEC materials to support this project are expected to be provided through the Client-Provider Education project supported by the FPSS Project and implemented by FPAK with assistance from Johns Hopkins University/Population Communication Services (PCS). PSFP I staff is on the IEC working group of this IEC project. There may be a need, however, to develop targeted, specialized materials under PSFP II. When approved by USAID, IEC materials developed and distributed by the IO for subprojects may include posters, pamphlets, calendars and other educational materials not available from FPAK or other sources.

- Assistance with voluntary surgical contraception (VSC). The Association for Voluntary Surgical Contraception (AVSC), financed under the bilateral FPSS Project, is assisting the national FP program under the direction of the Division of Family Health to expand the availability of quality VSC in Kenya. For interested subproject sites with adequate surgical capability and appropriate staff, it provides technical assistance, training of surgical teams, equipment, supplies, quality control and financing for VSC-related operating expenses. From established subprojects, PSFP I staff identified and recommended 16 sites to AVSC which were interested in, and had a demonstrated client demand for adding high-quality VSC to their FP portfolio. The sites had suitable clinical facilities available. They agreed to provide physician-nurse teams for VSC training, were willing to implement quality control, made assurances of voluntarism and met all other VSC project criteria. PSFP I staff provided managerial and administrative supervision, medical oversight for quality control and assurances of proper recording and reporting. PSFP I was able to draw upon the well-established mechanism of AVSC, an A.I.D. cooperating agency, to add VSC services to those subprojects that met the relevant criteria. It is expected that AVSC will continue to provide assistance to selected subprojects under PSFP II.

- Technical assistance and training for selected MCH interventions such as oral rehydration therapy (ORS) and immunizations might be supported in areas with high infant and child mortality rates and limited availability of other MCH services. Subprojects eligible for these interventions will be selected on the basis of the following criteria:

- o IO and USAID agreement that FP objectives are likely to be enhanced through provision of additional MCH services;

- o Identification of significant (higher than the national average) child survival threats in the subproject catchment area which are amenable to specific MCH interventions and are not being supported through existing MOH programs;
- o Evidence that the organization already provides curative MCH-related services;
- o Evidence of strong interest and support of top management of the assisted entity for including and maintaining these services at the end of subproject assistance; and
- o Presentation of a plan to link these interventions to MCH services of the MOH such as the Kenyan Expanded Program on Immunization (KEPI).

As well as being priority A.I.D. child survival measures, interventions such as ORS and immunization are justified demographically on the assumption that FP services often are more acceptable when offered as part of MCH services. It is also assumed that over the long term, improvements in child survival will translate into increased receptivity to family planning.

In the case of subprojects with church-supported NGOs, the duration of the subproject may be longer than the two years of the "basic" assistance package. Under PSFP I, private commercial firms, parastatals, training institutions and private clinics were more successful than were the not-for-profit NGOs in supporting the costs of maintaining FP services in their facilities after completion of two years of subproject funding. However, evaluation findings showed that church-related NGOs generated the largest number of CYPs. In recognition of this, on a case-by-case basis, subprojects with NGOs in this project might be designed for a longer duration to enable the NGOs to develop the financial and managerial resources necessary to maintain FP services without continued project financial support.

FIRST OUTPUT:

Private sector subprojects which add or expand availability of FP services designed, implemented and evaluated.

The magnitudes of the output are:

50 additional private sector entities representing

approximately 120 service delivery points will routinely provide FP services to users of these facilities.

SECOND OUTPUT:

Selected subprojects provide enhanced MCH family planning services.

The magnitudes of the output are:

Based on past experience and current expectations, the family planning services of 15 subprojects will be enhanced by VSC services; 15 by CBFP; 15 by additional IEC; and, 10 by selected MCH interventions.

THIRD OUTPUT:

Additional trained FP providers deployed in the private sector.

The magnitudes of the output are:

Approximately 450 qualified clinical officers and nurses from the new subprojects and PSFP I subprojects will receive the MOH-approved basic FP/MCH course and return to their clinic sites. This estimate is based on the experience in PSFP I which provided training for about 430 personnel for a similar number of service sites and from estimates of requirements for replacement training.

Approximately 450 clinical personnel from both PSFP I and PSFP II will receive refresher clinical training of one or two weeks duration. Selection criteria will include the length of the interval since basic training occurred (normally after five years) and observation of need for updating noted during subproject monitoring.

Approximately 150 field educators will attend three-day regional workshops annually. These workshops will update their IEC and outreach skills and provide a forum for refresher training and updating on new techniques to improve outreach.

Approximately 90 Field Educators (65 from this project and 25 replacement personnel from PSFP I) will receive basic training in the form of two-week workshops.

Approximately 210 CBFP volunteer field workers will be trained in two-week workshops and deployed. This number assumes training of 15-20 per project site with CBFP interventions; exact numbers will depend on the design of each specific subproject assisted.

FOURTH OUTPUT:

Private sector entities routinely receive sufficient and appropriate contraceptives.

The magnitudes of the output are:

All the subprojects supported under the PSFP I and II projects will be assisted to gradually establish direct linkages to the MOH contraceptive supply and management system and routine access the national supply system. Important assumptions at this level are that the MOH contraceptive logistics system will continue to improve and that the MOH will maintain sufficient stocks of contraceptives needed to supply the private sector. Under PSFP II, a plan will be developed and implemented to enable most subprojects to be supplied directly by the MOH.

ELEMENT 2. **Liaison, networking and maintenance of entities assisted in PSFP I subprojects.**

Upon completion of subproject grant assistance, in most cases PSFP I staff continued to provide modest amounts of technical and administrative assistance. PSFP I staff kept these former subprojects informed of overall project activities, provided IEC materials and technical assistance, invited providers and IEC field educators to regional and national seminars for FP training for the private sector, and continued to provide periodic refresher IEC and clinical training. The project also responded to requests for basic clinical training for replacement personnel when originally trained personnel retired, moved, or terminated their employment for any reason. This continued support was critical in maintaining the interest of the companies, with the result that all have continued to provide FP services and reports, some as long as five years after the end of formal subproject assistance. Similar support is planned under PSFP II.

FIFTH OUTPUT:

Liaison, networking and maintenance of entities assisted in PSFP I subprojects.

The magnitudes of the output are:

All active subprojects periodically will be provided with IEC materials distributed by the project.

Up to 80 percent of graduated PSFP I organizations will receive three days of technical assistance in IEC, clinic management, contraceptive logistics and/or record keeping.

Up to 15 PSFP I graduates will receive supplementary grants to finance additional services, such as CBFP or MCH. These supplementary grants are not expected to exceed 25% of the original subproject grant.

ELEMENT 3. Innovative Activities/Operations Research

Illustrative examples include:

a. New models identified and financed for private-sector service delivery.

This will include development of subprojects to link small-to medium-sized private firms without medical services on their premises to private clinics which can provide FP services to the firm's employees. Under PSFP I, a subproject was developed with the private Machakos Medical Clinic which provided FP services to employees and dependents of 26 firms representing a total of more than 2,500 employees. The Machakos Clinic provided the services either in its clinic or in regularly scheduled visits to temporary satellite clinics on the premises of the firms. Under PSFP II, opportunities will be identified and subgrant financing provided to replicate the Machakos model or other models in several other sites.

b. The feasibility and cost effectiveness of adding FP services to existing health insurance schemes assessed. If found feasible, interested firms assisted to add this benefit to their existing programs.

Management staff, employees and dependents of some private firms in Kenya are provided with reimbursable health benefits through

private insurance schemes which do not presently include FP services. Similarly, family planning is not covered under the National Hospital Insurance Fund (NHIF), which provides hospitalization coverage to nearly 7.0 million people. The project will finance an assessment of the feasibility of including family planning services within existing insurance schemes. It is unlikely that insurance companies will, on their own, add these benefits. Thus, collaboration with GOK health and insurance regulatory bodies will be needed to fully explore the feasibility of this approach, identify needed changes and define the steps necessary to introduce these changes.

c. Research undertaken to identify solutions to constraints that subproject grantees face in maintaining achieved levels of FP services when subproject assistance ends, and to identify and study factors that improve the performance or quality of private sector FP services.

As noted above, active PSFP I subgrantees will continue to receive support for IEC, contraceptive logistics, and training under the new project. While the project recognizes and supports the need for this continuing assistance, more emphasis must be placed on identifying the issues affecting family planning service delivery and long-term sustainability.

Examples of operations research and diagnostic studies which this project will undertake to enable private organizations to increase sustainability of services include: development of cost-recovery mechanisms to defray costs of additional personnel and operating costs associated with FP services, (a significant problem for the NGOs); cost-benefit analyses for individual firms to assess the economic feasibility of employer provision of FP; development and testing of strategies to enable continuation of outreach and other IEC activities subsequent to termination of subproject assistance; and, in conjunction with other USAID support to improve contraceptive logistics management, establishing backup or "fail-safe" mechanisms to assure adequate continuing supplies of contraceptives.

The studies on costs and benefits, cost effectiveness and cost recovery are particularly important. The cost-benefit analyses will assess the initial and recurrent costs of adding family planning services to existing health services. Favorable results from these studies can be used to encourage management to commit financial resources to continue family planning services and/or to interest new firms in adding family planning to their clinic services.

Operations research will be used to help improve the quality of family planning services. Examples include evaluation of the impact and effectiveness of interventions such as CBFP, MCH, VSC and specific IEC activities (e.g., use of folk media); assessment of factors influencing subproject contraceptive method-mix, and development of strategies for enhancing access and acceptability of services (e.g., reducing waiting times). (See discussion in Technical Annex).

These operations research activities will be conducted by the IO or sub-contracted to organizations specializing in such activities.

SIXTH OUTPUT:

Alternative models for expanding private sector participation in FP developed and implemented and operations research and diagnostic studies carried out.

The magnitudes of the output are:

The Machakos Medical Clinic model and/or other models for service delivery will be introduced and tested in up to six sites.

A study to determine the feasibility of adding family planning services to health insurance schemes will be conducted. If indicated by the study, project activity will be designed, implemented and evaluated to test the feasibility.

Up to six operation research projects focussed on sustainability issues will be designed and conducted, and results disseminated.

ELEMENT 4. Information dissemination

PSFP I broke new ground in increasing the participation of the private sector in family planning. This follow-on project will build upon this experience. PSFP I experience has potential for wider replication, but to date this experience has not been widely disseminated within Kenya or elsewhere. A focussed effort is needed to document and disseminate the lessons learned through conferences and publications that reach researchers, technicians and service providers both in Kenya and abroad. A.I.D./Washington support will be sought to share the costs for international dissemination.

Further dissemination of project results will be through papers prepared for professional journals and international fora; coverage in local and international media (newspapers, television and radio); and the preparation of video-tapes, slide-sets and cassettes. IO staff and consultants will prepare these materials and papers on an ad hoc basis.

SEVENTH OUTPUT:

Project experience documented and widely disseminated.

The magnitudes of the output are:

Two national workshops will be conducted for subproject personnel from PSFP I and PSFP II, and others as appropriate.

Project personnel will make presentations to at least two international conferences heavily attended by family planning professionals.

At least three articles or case studies of high professional quality will be prepared to publicize the approach, methodology, lessons learned or impact of the project.

Selected results of mid-term and final evaluations will be disseminated.

III. PROJECT MANAGEMENT AND IMPLEMENTATION PLAN

A. Project Coordination and Administration

1. Roles and Responsibilities

The project is designed to ensure that clear lines of authority and communication between the IO and other relevant project parties are established, thereby assuring cooperative and productive relations and contributing to the success of the project. Specifically, the five main groups involved in project implementation and oversight are: the sponsoring organizations, i.e., the Government of Kenya, NCPD and the MOH; the funding agency, USAID; the Technical Advisory Committee, TAC; the IO, i.e., the recipient of the cooperative agreement; and the subgrantees.

The project will be administered by USAID under a Memorandum of Understanding (MOU) signed by the Ministry of Finance and

countersigned by the MOH and the Ministry of Home Affairs and National Heritage. The MOU will describe the project and roles and responsibilities of the various parties.

a. The Technical Advisory Committee (TAC)

The TAC, comprised of public and private individuals, will provide overall policy guidance to the project. TAC membership will include the following:

NCPD Council Chairman,
NCPD Secretariat Director,
MOH, Director/Division of Family Health,
PSFP Project Director (IO),
USAID/Kenya Population and Health Officer,
Family planning NGO representative,
Commercial firm/parastatal representative, and
Private medical practitioner

Consistent with PSFP I, the TAC will be composed of prominent, socially-motivated individuals who are strong supporters of family planning. The Chairman of the NCPD (or his designee) will serve as the Chairman of the TAC. Ex-officio attendance of staff from the IO, NCPD staff or invited consultants will be allowed at the TAC.

The TAC will convene at least semi-annually, or more often, if requested by the Chairman. The TAC's main task is to ensure effective implementation of the PSFP project. The TAC will also be expected to assist in maintaining an enabling environment to facilitate project implementation.

On the basis of the IO's annual workplans and written semi-annual reports, the TAC's specific functions are to:

- o review and approve annual project implementation plans, including identification of potential subprojects;
- o review progress, accomplishments, and constraints and recommend future actions;
- o review and resolve any policy, legal, organizational, and technical issues that may arise;
- o help generate awareness of and support for the project, both in public and private spheres; and
- o ensure effective collaboration between the various GOK ministries, private sector institutions, USAID and the IO in project implementation.

b. The Government of Kenya

The GOK is represented on the TAC by the NCPD and the MOH. NCPD is the GOK's official body for setting population policy and coordinating the implementation of the national family planning program. It will assist in generating continuous national support for the project. As a TAC member, NCPD will provide policy guidance, review semi-annual reports presented to the TAC, and participate in the mid-term and final project evaluations.

The MOH is also represented on the TAC, and is responsible for assuring the overall quality of national family planning by setting standards for personnel. It will certify training courses and sites and ensure that an adequate supply of all contraceptive commodities is made available for the project. The MOH will provide guidance regarding provision of clinical services, the adequacy of the clinical training curricula and venues or any medical questions concerning the contraceptive methods and commodities needed for the project. Through the LMIS, the MOH will monitor the ordering and distribution of contraceptives to the project to ensure timely procurement. This will assure that adequate stocks of all contraceptive methods will be available at Central Medical Stores (or at the provincial and district stores) and made accessible to the project as needed. The contraceptives will be obtained utilizing the guidelines set forth in the MOH's contraceptive management and procurement system.

c. USAID

USAID/Kenya's Population and Health Office (O/PH) will assume primary responsibility for A.I.D.'s management and monitoring of the project, which will be financed through an A.I.D. Handbook 13, Cooperative Agreement with a nonprofit organization. A U.S. direct hire Population and Health Development Officer will be designated Project Officer for the project. This individual will work closely with the IO and maintain frequent contact with the IO Project Director. He/she will liaise with the NCPD and the DFH/MOH and serve as a member of the TAC. In addition, under the supervision of this officer, a Kenyan financial analyst hired as a Personal Services Contractor will spend approximately 25% of his/her time in backstopping financial monitoring requirements. USAID's substantial involvement in the project management is explained in Annex E, Administrative/Institutional Analysis.

d. Implementing Organization (IO)

Operating under the terms of the Cooperative Agreement, the IO will have the overall responsibility for project administration, management and implementation. Responsibilities include liaising with USAID and GOK entities to obtain agreement on annual workplans; providing long- and short-term technical assistance to subgrantees; procuring commodities and equipment; overall project monitoring, including financial and progress reporting; conducting special diagnostic or operations research studies that contribute to evaluation; providing training and IEC assistance to subprojects; and disseminating information about the project.

B. Project Management and Implementation

The project will be financed and implemented under a direct AID Handbook 13 Cooperative Agreement (CA) with a qualified nonprofit organization(s) selected on the basis of open competition. The Request for Applications (RFA) for the CA will state that special consideration and priority in selection of the IO will be given to Kenyan non-profit organizations and/or joint ventures between Kenyan and U.S. non-profit organizations.

In Kenya, there are a number of local family planning-related NGOs that have demonstrated technical capabilities to implement the project. Several of these organizations have directly benefitted from AID assistance in enhancing their managerial and institutional capacities to carry-out nationwide family planning and MCH efforts. A number of these NGOs have well-established track records in administering AID-financed grants. It is USAID/Kenya's and the GOK's view that every effort should be made to maximize consideration for NGOs that can demonstrate a well-established, legal presence in Kenya, including the existence of a legally established Board of Directors, with a majority representation of Kenyan citizens, that will assume responsibility in-country for management, administration and oversight of the project.

This approach to project management will help to ensure project success and credibility within the GOK and private sector environment. It is also recognized that some Kenyan NGOs may wish to either establish or maintain a linkage to a U.S. NGO in order to augment their capacity in such areas as procurement, financial or administrative management. In this regard, the RTP for the CA will invite submissions from Kenyan and U.S. NGOs who wish to be considered as a joint venture application.

A Cooperative Agreement has been selected as the assistance instrument for this activity as opposed to a grant or contract because financing will be used to support the accomplishment of an A.I.D.-designed project and because substantial involvement is anticipated by USAID with the recipient during performance of the activity.

It is estimated that \$9.5 million in funding will be required over the seven year project period to finance the CA. The scope of work for the technical assistance CA will include financing for long-term staff, short-term technical consultants, training, subgrants, commodities and equipment. It is anticipated that the CA will include as much local Kenyan technical assistance as possible. Breakdowns of the activities to be funded under the CA are as follows:

1. Long-term project staff:

Long-term project staff budgeted for in the project will form a project management team. The long-term project staff will consist of a project director; a deputy director (focusing on finance and administration); and six specialists, i.e., medical oversight, training, IEC, commodities/logistics/management information systems (MIS), research and evaluation, and finance. Thus, approximately eight full-time professional equivalents will be required. In addition, eight support personnel, (secretaries (3), drivers (4) and one messenger/cleaner), will be hired. See Section IV for budget details.

2. Short-term technical consultants

The long-term project staff will be expected to have considerable expertise in a variety of technical areas. However, it is anticipated that it will be necessary to augment their skills under certain circumstances. Thus, the IO will be responsible for contracting with short-term consultants (both Kenyan and U.S.), for special diagnostic or operations research studies scheduled over the life of project (LOP). The specific short-term TA needs for the project will be identified annually in the IO's workplans. Specifics may change over time to meet the evolving needs of the Project. Illustrative areas for short-term consultant expertise include community-based FP, health care financing and insurance schemes, and development of fee-for-service systems. Approximately three person-months of short-term technical assistance per year are anticipated.

3. Commodities and equipment

It is not planned that the project will directly finance the purchase and procurement of contraceptive commodities. However, since contraceptive commodities are an essential part of any service delivery program, the IO will be responsible for linking subprojects with the national contraceptive logistics system, i.e., by reporting to the national LMIS and, where possible, helping subprojects to directly obtain contraceptives themselves from district medical stores (DMS). Where necessary, the IO may itself obtain contraceptives from the MOH and deliver them to both continuing and new subprojects. However, over the LOP, direct supply of subprojects by DMS's will be encouraged. The RFA requirements will request applicants to draft a preliminary plan to be finalized in Year One which gradually establishes direct linkages between subprojects and GOK suppliers over the LOP, while the IO continues to monitor the supply situation and "trouble shoot," as necessary. The IO will have to ensure that each subgrantee reports promptly to the LMIS to assure that supplies will be adequate.

The CA will include financing for the purchase of vehicles, clinic equipment, IEC materials and training materials. The IO will also be responsible for procuring equipment (see list Annex K).

4. Subproject selection and management.

The CA will include financing for direct subproject assistance for 50 subprojects. The Financial Plan in Section IV. shows the estimated funding ranges among different types of organizations. The following areas will be the responsibility of the IO.

a. New subgrantee selection

On the basis of the USAID report on potential demand (Annex F), and further IO assessments, the IO will identify potential subgrantees (up to 50 with 120 sites) for project support. The IO will develop a plan for approaching firms or other entities, (NGOs, parastatals, nursing homes, community clinics and educational institutions), of significant size and with interest in family planning as potential subgrantees under the project.

As part of the requirements for submission of a technical response under the RFA for the CA, applicants will be requested to describe a systematic and proactive methodology that would generate written

applications for assistance from priority organizations and to respond to applications generated as a result of contacts with project staff, promotional materials or word-of-mouth. The first five subgrantees will be identified in the annual workplan submitted by the selected IO within 90 days of project initiation for approval by the TAC. The workplan will include a brief description of how each applicant meets the criteria for selection.

To the extent that there are ad hoc requests for support, these would be submitted, as appropriate, to the TAC Chairman for consideration. Applications from interested organizations will include a description of the organization, its expression of interest, an inventory of medical staff and services offered, and numbers of employees, dependents and others eligible for medical services. If the foregoing criteria are met, personnel from the IO will visit the site, confirm that the criteria are met, and prepare and negotiate a formal agreement document outlining the objectives, expectations, responsibilities and contributions (inputs) of the implementing and assisted organizations. The agreement must be approved by USAID prior to implementation. The IO will keep the TAC informed of subproject progress, accomplishments and problems associated with implementation as part of status reports provided for semi-annual TAC meetings.

b. Liaison with continuing PSFP I subprojects

Within the first 90 days of the CA signing, the IO will be expected to review the status of PSFP I projects in order to (1) confirm whether FP services are still ongoing; (2) assess the need for basic and refresher training for staff and include participants in the training plan as appropriate; (3) determine the amount of technical assistance to be provided (estimated at about 3 days per year); (4) verify access to GOK contraceptive supplies and provide such as necessary; (5) provide required IEC materials; and (6) evaluate desire or need by these subprojects to receive supplementary grants for the addition of discrete services (e.g., MCH). This assessment will provide important information for the IO's annual workplan.

In addition, it is estimated that up to 15 PSFP I graduates may receive supplementary grants over the LOP to implement CBFP, MCH or other types of services to complement their ongoing FP programs. The project will also be expected to

provide support on an ad hoc basis to PSFP I graduates who may need funding to correct deficiencies in FP service delivery or maintain FP services.

Because CYPs generated from continuing PSFP I subprojects are included in the project's overall outputs, the IO will be responsible for encouraging and assisting PSFP I subprojects to continue reporting to the project on a regular basis.

c. Subproject Monitoring

The IO will monitor each subproject and ensure that appropriate technical personnel make regular visits (e.g., the IEC specialist to assess IEC needs and activities, or the accountant to set up financial controls and reporting systems). The MIS specialist will assure that subgrantees understand how to calculate service statistics and other reporting requirements.

The IO will also assure that financial assistance is disbursed to each subgrantee on time, and that each subgrantee receives adequate supplies of contraceptives, either directly from the MOH or with assistance from the IO project office.

The planned schedule of subgrantee awards are:

Year 1 - five subgrants
Year 2 - ten "
Year 3 - fifteen "
Year 4 - fifteen "
Year 5 - five "

d. Training

A major financing element of CA budget for this project is training for several different categories of personnel as described in Section III. C.2 (training schedule). The IO will identify potential trainees within subprojects, schedule them for training at an outside training course or from within the recipient MO, and monitor and follow-up on trainees.

It is expected that the IO will have to identify, modify or develop curricula for all types of personnel to be trained under the Project; and develop a training schedule so that both basic and refresher training takes place in a timely manner. The Technical Analysis (Annex B) contains further details on these training requirements.

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e. Develop, test and disseminate alternative FP strategies within the private sector

Building on the experience of PSFP I, this project will seek to introduce new models or innovations in selected subprojects. This would include expanding the Machakos Medical Clinic or developing other models in up to six sites; studying and testing the feasibility of adding FP to health insurance schemes; and designing up to six diagnostic or operations research projects focused on sustainability issues. Operations research and diagnostic studies will contribute to the evaluation plan for the project, and will identify which types of interventions should be emphasized over the LOP. Both PSFP I and II subprojects could be eligible to participate in implementing these initiatives with additional subgrant financing possible.

f. IEC and Information Dissemination

The CA budget will include limited financing for the design, production, distribution and evaluation of IEC activities and materials. In general, the IO will provide training in motivation, counselling and outreach to subproject staff, especially field educators and CBFP personnel. Most materials will be produced by FPAK's Client-Provider Education Project. PSFP II will help subprojects to utilize these materials in the most optimal way. Where necessary, specific IEC materials may be reproduced or adapted, e.g., flip charts/informational cards for CBFP workers; or booklets on specific FP methods. The project may also organize film shows or community talks. PSFP I subprojects will continue to be eligible to receive IEC support (e.g., technical assistance and materials). The IO will be responsible for ensuring that all IEC materials production is closely coordinated with FPAK and approved by FPAK's IEC committee on which the IO will be represented.

In the population sector worldwide, the nature of this project is perceived to be highly innovative and appears to offer the potential for replication in other countries. Thus the IO will be expected to disseminate project experience in the following ways: through two national

seminars; through presentations at two international conferences; and by preparing at least three articles for publication, e.g., case studies, "lessons learned," etc.

C. IMPLEMENTATION PLAN

1. General

The illustrative first year implementation plan provided below is based on the assumption that the PP will be authorized by USAID/Kenya's Mission Director in May 1991. It assumes that the RFA will be issued in May 1991, with proposal review scheduled to occur in July 1991. Final selection of the grantee(s) is scheduled for August 1991. Signature or award of the CA to obligate funds is anticipated to occur in September 1991.

Annually, the IO will be required to submit a workplan to USAID and the TAC for review and approval. The plan will define activities to be undertaken by the IO, including subgrantee selection, training, procurement, special studies and dissemination activities. The first year workplan will be submitted within 90 days after CA signing, and thereafter, 90 days after the end of the A.I.D. fiscal year.

Prior to the preparation of the Year One workplan, a team planning meeting will be held in Nairobi with IO staff, the USAID technical officers and TAC members to review and refine SOW tasks and agree on reporting formats.

It should be noted that the Year One illustrative workplan represents a number of important start-up events and selected activities that will be repeated at an increased rate annually over the LOP. For example, training activities will increase in number after Year One subproject selection. Other more discrete activities, such as operations research or special studies, and information dissemination efforts, will be reflected increasingly in the IO's workplans for Years 2-7.

2. Training Schedule

Extensive training will be supported under this project, which may be provided through a subcontract with an outside training organization and/or be provided directly by the IO. The IO will be responsible for making sure that training is of the highest quality and is delivered through the most efficient mechanism possible. Proposed training programs will have to be approved by the TAC and USAID/Kenya, as well as by the MOH in some cases. The RFA will request applicants to define how training needs will be met and to fully describe support arrangements for ensuring the optimal combination of external and internal training resources. In the event that the IO proposes to offer some training

itself, it will have to demonstrate that the training meets MOH criteria, (if applicable), and compares favorably with alternative sources of training available in Kenya in terms of cost-effectiveness and quality.

a. Level of training effort required

(1) Basic 7 weeks training course for up to 450 Clinical Officers (COs) and Nurses:

Years 1 & 2: 50 participants per year
Years 3 & 4: 100 participants per year
Years 5, 6 & 7: 50 participants per year
(2) Refresher training (one week) for up to 450 COs and nurses:

Years 1 and 2: 50 participants per year
Years 3 and 4: 100 participants per year
Years 5, 6 and 7: 50 participants per year

(3) Three day regional workshops annually for 980 Field Educators:

Years 1 - 7: 140 participants per year

(4) Basic (two weeks) training for 90 Field Educators:

Years 1, 5 and 6: 10 participants per year
Years 2 - 4: 20 participants per year

(5) CBFP volunteers workshops (2 weeks):

Years 1 - 7: 30 participants per year

During Year One, it is not anticipated that any participants will be trained before the second quarter (January - March 1992). From Year 2 onwards, the full training schedule will be similar to that described above.

3. Illustrative Year One Implementation Schedule

M O N T H

Task Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep

A. Project start-up and administration

1. TAC selected X

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Task	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2. TA team recruited & in place.		X										
3. Office space rented.		X										
4. PSFP I equipment/commodities turned over.		X										
5. Vehicles/equipment ordered.		X										
6. PSFP I sub-projects reviewed for TA/other needs.			X									
7. Workplan for Yr 1 submitted to USAID and the TAC (includes names of first 5 new subs & PSFP I needs assessment).				X								
8. Semi-annual reports submitted to USAID and TAC 30 days after end of 2nd and 4th quarters.								X				

B. Subgrantee selection and approval

1. TAC meets to approve workplan and subproject selection.				X								
2. USAID approves subgrant proposals.				X								
3. Subproject commodities ordered.				X								
4. Contraceptive orders provided to MOH.				X								
5. Subproject grants signed.				X								
6. PSFP I assessment completed.		X										

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Task	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
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C. Training

1. Trainees identified from PSFP I projects and 1st five PSFP II project groups.

X

2. Curricula developed/approved.

X-----0

3. Training:

a. Basic trng/COs &Ns (7 weeks).

X-----0

X-----0

b. Refresher trng/COs&Ns (1-2wks).

X

X

X

c. Field educators regional workshops (3 days/yr).

X

X

d. Field educators basic (2wks).

X

X

e. CBFP basic trng (2 wks).

X

X

D. Information Dissemination

a. National conference presentation.

X

b. Articles submitted.

X

E. Evaluation

Planning begins in Year 2.

4. DFA Procurement Plan - Goods and Services

Under the proposed project, U.S. \$10 million in goods and service support is planned. Under DFA procurement policies, A.I.D. Geographic Code 935 is generally authorized. It remains A.I.D. policy, however, to maximize U.S. procurement wherever practicable. The following represents USAID/Kenya's analysis of the planned source and origin of goods and services. It is expected that the scope of work for the CA, estimated at \$9.5 million, will include financing for long-term staff, technical assistance, subgrants, training, selected operations research and studies, commodity/equipment procurement, related overhead, and contingency/inflation.

For procurement of the IO under the CA, USAID/Kenya plans to limit procurement to eligible Kenyan and/or U.S. nonprofit institutions. Priority consideration in selection criteria will be placed on joint ventures between Kenyan and U.S. nonprofit organizations. It is anticipated that a number of qualified U.S. and Kenyan nonprofit organizations will bid on the RFA. Over the past decade, a number of Kenyan family planning organizations have developed expertise in administration and management of AID-financed family planning programs over the past decade. USAID/Kenya will encourage the participation to the maximum extent possible of those firms eligible for preferential consideration under Gray Amendment provisions in project implementation activities in accordance with the requirements of the Federal Acquisition Regulations.

The IO will have responsibility for procurement of all office, household and subproject site equipment and short-term technical assistance for the project. Procurement of these goods and services will be carried out in accordance with the grantee's established procedures which must comply with U.S.G. regulations. The source for procurement of non-federal audits, the mid-term and final evaluation(s), and selected operation research/other studies will be U.S. or A.I.D. Geographic Code 000. USAID/Kenya will also require that any travel to and from the U.S. be on U.S. carriers. USAID/Kenya also will require conformance with the 50/50 requirements of the Cargo Preference Act for ocean shipments from the United States.

It is anticipated that source and origin of the commodities including vehicles, office equipment, IEC equipment and family planning commodities to be financed under the overall technical assistance CA will total approximately \$556,500 and will come from countries included in A.I.D. Geographic Code 935.

USAID/Kenya believes the above adequately conforms to the intent and requirements of the DFA with regard to procurement planning and implementation. USAID/Kenya will report to A.I.D./W annually on the status of procurement in conformance with A.I.D./W's requirements.

IV. FINANCIAL ANALYSIS AND PLAN

A. Summary Cost Estimates

Over the seven year LOP the total estimated cost is \$13.9 million. USAID will provide \$10 million (72%) in grant financing and the Private Sector and the GOK will contribute the local currency equivalent (Kenya Shillings) of \$1.3 million and \$2.6 million respectively.

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B. A.I.D. Contribution

(See Annex G(i) for a detailed breakdown.)

The CA to be financed under this project will cover a seven year period and will include A.I.D. financing as shown in the table below.

Table 1
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(U.S. \$000)

<u>Source</u> <u>Project Element</u>	<u>A.I.D.</u>		<u>Private Sector</u>		<u>Government of Kenya</u>		<u>Total</u>
	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	<u>FX</u>	<u>LC</u>	
Technical Assistance	1,013	2,757	0	59	0	11	3,840
Training	0	1,314	0	0	0	0	1,314
Equipment & Supplies	163	393	0	0	0	2,383	2,939
Subprojects	402	1,717	0	1,056	0	0	3,175
Other Direct Costs	28	273	0	34	0	0	335
Eval. & Audit	340	81	0	0	0	0	421
Overhead	156	454					610
Inflation/Contingency	210	699	0	115	0	239	1,263
Grand Total	2,312	7,688	0	1,264	0	2,633	13,897

A.I.D. support for foreign exchange and local costs includes an inflation/contingency factor of 10% per annum. The GOK and private sector contributions are also assumed to increase by 10% per annum.

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- 1) Technical Assistance (TA) and Management Support: Total TA is estimated to cost \$3.8 million over the LOP and will cover:
 - a) Salaries and Benefits: These costs are calculated on the assumption that the Project will require a team consisting of eight professional staff. These staff include: Project Director, Deputy Director, IEC, Training, Research and Evaluation, Medical oversight, Commodities/Logistics/MIS, and Financial Management). It is anticipated that there will also be eight support staff. Salaries have been assumed to increase by 10% per year to cater for mandatory salary increases and inflation. Staff benefits have been assumed to be 20% of basic salaries which are estimated at current market labor rates. Provision for the salary of one expatriate team member has been made in the budget.
 - b) Consultants: Three person-months of external technical assistance per year for two specialists are budgeted for such areas as Management Information Systems, Logistics and Operations Research. It is anticipated that the project will utilize locally available, qualified Kenyan consultants in areas such as training and IEC. Costs for consultants will include consultancy fees, travel and per diem, consistent with U.S.G. regulations.
- 2) Training: The IO will provide training to sub-projects' personnel directly or through a sub-contract with a Kenyan-based firm eligible for A.I.D. financing. The training will include seven weeks of the basic family planning course approved by the MOH; one week for family planning refresher courses; two week basic courses for the Field Educators and Community-Based Family Planning Volunteers; and annual regional workshops (3 days) for 140 Field Educators. The costs for the seven week family planning training have been estimated at \$2,500 per student per course.
- 3) Subprojects: It is anticipated that the IO will provide support to 50 additional private sector firms and organizations with approximately 120 service delivery points that routinely provide family planning services to employees, the dependents of employees, or clients. A "basic" package which will normally cover funding requirements (including equipment but excluding training) for two years has been estimated using actual costs from the

PSFP I project, adjusted for inflation and contingency at 10% as follows:

<u>Subproject Type</u>	<u>Actual PSFP I Costs for 2 years</u> ($\$$)	<u>Estimated PSFP II Costs</u> ($\$$)
Private Company	25,979	28,577
NGOs*	115,608	127,168
Parastatals	26,890	29,579
Training		
Institutions	19,210	21,131
Nursing Homes	20,509	22,560
Community Projects	13,591	14,950

(See Annex G(ii) for a detailed breakdown.)

In addition, subgrants include the cost of enhancing family planning services in some subprojects as follows:

- Up to 15 subprojects will introduce VSC services; up to 15 will include CBD;
- Up to 15 will add IEC; and,
- Up to 10 may add selected MCH interventions.

Also included in the subproject estimates are costs for additional support to the PSFP I subprojects, including up to three days per year of TA in IEC, clinic management, contraceptive logistics or record keeping for 80 percent of graduated PSFP I organizations. In addition, up to 15 percent of PSFP I graduates will receive supplementary grants averaging US \$15,000 per year for the addition of discrete projects such as IEC and CBFP.

- 4) Other Direct Costs (ODC): Approximately \$0.3 million will be used to finance ODC, such as general office expenditures and costs associated with various workshops and seminars to be held during the LOP.
- 5) Equipment and Supplies: Various equipment and supplies will be purchased to support project administration, implementation, and monitoring. Costing estimates are based on the purchase of four motor vehicles, four computers, printers and relevant software, one photocopier and a fax

* NGO support is for nationwide organizations such as SDA, CHAK and Crescent Medical Aid. These costs are higher because support to NGOs is usually for more than 2 years and for multiple sites.

machine and related installation costs. A comprehensive list of commodity purchases is provided in Annex K. In addition, all CBD workers will be supplied with basic equipment to carry their contraceptives. To support IEC activities, limited equipment will be purchased, e.g., projectors, overheads, and a VCR, and print and video materials developed and/or reproduced.

- 6) Evaluation and Audit: The overall project budget allocates \$130,000 for a mid-term (\$60,000) and a final (\$70,000) evaluation. In addition, site audits will be conducted by the IO every other year. The project budget also allocates \$110,000 for non-federal audits to be conducted by A.I.D. in the fourth and the seventh years of the project. The costs budgeted for audits are determined to be reasonable because potential risks appear to be minimal, since the project will be carried out by a well-established IO that will be required to have a demonstrated track record in administration and management of A.I.D.-financed projects. In addition, the project budget allocates 25% of an O/PH Financial Analyst's time to assist in financial management and monitoring. Approximately \$100,000 has been budgeted in the CA for special operations research studies in cost effectiveness and sustainability.
- 7) Overhead: The project budget allocates 15% of technical assistance and other direct costs as overhead costs for the IO.

C. Private Sector Contribution

The private sector contribution of U.S \$1.3 million which represents 9% of the total project budget includes: personnel and operating costs for health facilities, clinic space utilization for FP, and office and MCH equipment. (See Annex G(iii) for a detailed breakdown of private sector cost estimates).

D. GOK Contribution

The GOK contribution to the project is valued at U.S. \$2.6 million (19% of total cost) which mainly consists of the cost of contraceptives supplied by the MOH and costs attributed to the time spent by GOK personnel in project monitoring and administration. (For a detailed breakdown of the GOK contribution, see Annex G(iv)).

E. Expenditure Projections

The USAID grant of U.S. \$10 million will be expended as noted in Table II assuming the project is authorized and obligated in late FY 1991.

Table II
PROJECTION OF EXPENDITURES BY FISCAL YEAR
(U.S. \$000)

Fiscal Year	A.I.D.	Private Sector	GOK	Total
1992	1,129	84	342	1,555
1993	1,394	313	342	2,049
1994	1,586	356	342	2,284
1995	1,672	304	342	2,318
1996	1,065	66	342	1,473
1997	1,052	13	342	1,407
1998	1,193	13	342	1,548
Inflation/ Contingency	909	115	239	1,263
Total	10,000	1,264	2,633	13,897

F. A.I.D Obligation Schedule

A.I.D. financing will be incrementally obligated during the first six years (i.e., FY 1991 - FY 1996) of the project to ensure that adequate resources are available for start-up costs and project completion as indicated in Table III below. The initial obligation will be for \$750,000 in FY 1991.

Table III
AID Obligation Schedule by Fiscal Year
((\$000s)

<u>FY 91</u>	<u>FY 92</u>	<u>FY 93</u>	<u>FY 94</u>	<u>FY 95</u>	<u>FY 96</u>	<u>Total</u>
750	1,000	2,000	2,000	2,000	2,250	10,000

The detailed Illustrative Budget in Annex G(i) shows Year One funding requirements of approximately U.S. \$1.2 million (including inflation/contingency). However, the availability of USAID FY 1991 resources for this project is only U.S. \$750,000.

It will therefore be important that the FY 1992 - FY 1996 obligations be significantly increased to make-up for this initial shortfall. This will also require the IO to initiate activities at a somewhat more modest pace than planned. It is expected, however, that the pace of implementation will reach an ideal level by FY 1993.

G. Financial Analysis

1. A.I.D. Contribution

The financial analysis shows the cost estimates developed for this project to be reasonable and in line with actual costs of the PSFP I project. The costs for local technical assistance, equipment and supplies are based upon actual costs incurred by on-going A.I.D. projects in Kenya. The cost estimates for the PSC contractors are based on salary levels of U.S. PSC contractors who provide similar services under local contract to A.I.D.

Technical assistance costs will, however, vary depending on the staff composition (local versus expatriate) and the type of IO which is awarded the CA. The seven week family planning training costs are estimated on the basis of the range between FPAK's \$2,000 per student cost and AMREF's \$3,600 per student charge. Other training costs are based on actual costs charged by training institutions/facilities in Kenya. Subproject costs are based on actual costs supplied by the PSFP I project, adjusted for inflation and contingency.

Although A.I.D.'s contribution to this project has been tightly budgeted with only small allowances for inflation and contingencies (10%), the total project budget is deemed to be adequate because most of the costs are local currency based. This allows for savings as the dollar appreciates against the local currency (Kenya Shilling). Additionally, the salaries have been increased by 10% per annum to cater for mandatory salary increases and inflation. However if major cost over-runs arise these will have to be met either by a reduction in the level of activity or by increasing the level of funding from either the private sector or the GOK.

2. Private Sector Contributions

As noted earlier, the private sector contribution includes the space made available in subproject health facilities for FP service delivery, MCH and office equipment and personnel. After a two-year subgrant, the private sector contribution will continue to include the above and all or most of the family planning-related personnel costs.

3. GOK Contributions

Over 90% of the GOK contribution includes the costs of contraceptives supplied to the subprojects by the MOH. Since these contraceptives are contributed to the GOK by various donors, it has been assumed that this situation will continue and that the GOK through the Contraceptive Logistics System will avail the contraceptives to the subprojects.

With these concerns noted, the technical design and cost estimates reflected in the budget tables are determined to be reasonable and adequately planned, thereby satisfying the requirements of Section 611(a) of the Foreign Assistance Act, as amended.

H. Methods of Implementation and Financing

The following is an illustration of the methods of implementation and A.I.D. financing required by this project.

<u>Type of Assistance</u>	<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Amount (\$000)</u>
Cooperative Agreement -Technical Assistance, -Equipment & Supplies, -Other Direct Costs and Overhead	HDBK 13 Cooperative Agreement	*Direct Payment Letter of Credit	5,237
-Training	Sub-contract	Direct Payment	1,314
-Site Audits	Sub-contract	Direct Payment	35
-Sub-Projects & Studies	Subgrants, subcontracts	Direct Payment	2,120
Studies, Evaluations, PSC & NFAS	Direct Contract	Direct Payment	385
Contingency/Inflation	—	—	909
Total			<u>10,000</u> =====

* Method of financing may vary depending on whether grantee is U.S. or Kenyan organization.

V. SUMMARIES OF PROJECT ANALYSES

A summary of the significant technical, economic, social and administrative aspects derived from the full analyses for the project is presented below. Details are available in Annexes B through E of this PP. The analyses take into account evaluations conducted of the predecessor project, PSFP I; a study on demand for family planning by Anne Inserra; and issues raised during the review of the Project Identification Document (see Annex H, PID Approval Message). The analyses form the basis for the overall project design and the conclusions reached in this PP.

A. Technical Analysis Summary

See Annex B for the complete Technical Analysis.

1. Sustainability

The Technical Analysis explored the degree to which the project design addressed the sustainability issue. Three elements of sustainability were identified and analyzed. The first element, of retainability, was defined as the extent to which PSFP I projects continued to provide FP services. It was found that of 47 grantees, 44 were still providing FP services and reporting regularly to the project. This supported the assumption that once a service was added to a grantee's delivery system and perceived to be a benefit by clients and management, it would continue to be offered. Therefore, it is assumed that most grantees of PSFP II will continue to provide FP services at the end of subproject assistance.

Maintainability is herein defined as the maintenance or increase of achieved levels of FP services. An analysis was done of CYP data from 28 projects which had received at least two years of subproject assistance and had continued to provide FP services for at least two additional years. There was a wide variation in the degree to which individual grantees succeeded in maintaining services. However, aggregate results from PSFP I showed that with relatively minimal, continuing inputs after formal assistance ended, subprojects maintained or even increased levels of FP service delivery reached during subproject assistance.

Finally, to address the element of financial sustainability, PSFP I conducted a study to determine the financial capability of a sample of 18 PSFP I subprojects to continue FP services beyond the period of direct PSFP I assistance.

Overall self-sufficiency was defined as the percentage of all program costs which were met by non-PSFP I grant funds, including direct supporting costs (excluding development and administrative costs) incurred by the central project office and allocated to each subproject. The median level of self sufficiency for the 18 sites was 66%, with visit volume as the most influential factor in variations between subprojects in cost effectiveness and self sufficiency. CBD and IEC expenditures and the number of field educators had a positive correlation to visit volume. Clinics which had integrated FP/MCH services with primary curative services showed the greatest cost-recovery performance.

2. Constraints to Sustainability

The Technical Analysis also recognized the need for "graduated" PSFP I subprojects to continue to call upon the project for technical assistance in contraceptive logistics, IEC and training. Sustainability issues will receive increased attention under PSFP II.

The project will provide assistance to several types of private sector organizations that differ considerably in their organizational structures, modes of operation, needs for assistance, and potential for maintaining services. For example, companies, both private and parastatal, are profit-making organizations. The project's assumption, which is supported by preliminary evidence from PSFP I, is that employers can realize savings from providing family planning (e.g., reduced expenditures for maternity, health care, and other dependent benefits such as education, and less absenteeism), that more than offset the cost of adding family planning to existing medical facilities. Similarly, privately-run health facilities have the potential to achieve financially sustainable family planning programs by charging fees for services in areas where demand is sufficiently high. The potential for employers to maintain financially sustainable family planning programs will be carefully monitored and evaluated during PSFP II. Data will be collected and cost-benefit analyses undertaken to document the experience of participating companies.

Not-for-profit, NGO-supported health facilities, however, may have less potential for running financially self-sustaining family planning programs. NGOs experienced more difficulty than companies in maintaining family planning services after subproject grant assistance ended in PSFP I. The church-related NGOs are service organizations devoted to assisting disadvantaged people, often in poor rural areas. Opportunities for full cost recovery through charging

service fees are often constrained by the low socio-economic status of clients. Some degree of subsidy, especially for preventive services, may be necessary indefinitely. In PSFP II, monitoring and evaluation systems and special studies will document the costs and financial feasibility of adding family planning services to existing medical facilities for these organizations. Studies will include analysis of the potential for cost recovery; cost-benefit analysis in terms of the cost of enhancement activities such as IEC and outreach in relationship to CYPs generated; and the relative cost effectiveness of assisting NGO clinics as opposed to other subproject types within PSFP, which will depend on the number of family planning clients served and the costs per client.

Monitoring and evaluation systems and special operations research studies will be used to analyze the sustainability issue in PSFP II. The results of these analyses are important to establish the institutional sustainability and replicability of the PSFP approach to providing family planning assistance in the private sector both in Kenya and elsewhere. Findings will be disseminated to subproject management in Kenya and to the population sector worldwide through conferences and publications.

The results of these analyses on sustainability of family planning services in the PSFP subprojects will serve to determine whether or not there is a continuing need for a support institution after project assistance ends. It is expected that most subprojects will have trained staff in place, clinics fully equipped, and access to contraceptives through the MOH logistics system. If this is the case, the need for a project intermediary may be minimal. This issue will be fully assessed during the course of PSFP II implementation.

At the same time, the PP design team also recognized that requests for specific types of assistance may be the consequence of external factors. For example, support in contraceptive logistics will remain an area of critical importance to both PSFP I and II subprojects. While the IO will assure that subprojects are supplied either directly from MOH service delivery points (SDPs) or directly from the project which will obtain them from the MOH, it is expected that all subprojects will gradually be linked up with local SDPs and be able to obtain contraceptives on their own. Improvements in the MOH's commodities system have been taking place, and the provision of USAID logistics technical assistance in this regard has made significant improvements.

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IEC outreach was recognized as an important factor in increasing client volume, and hence cost recovery, for clinics. However, the support for such outreach was financed through PSFP I core funds and when this funding ceased, so did the IEC efforts. The Technical Analysis suggests that specific supplemental grants be made available to selected subprojects so that they can continue IEC efforts. The new project contains support for training, technical assistance, and packages of enhanced assistance for subprojects in this regard. At the same time, establishing the position of an IEC Specialist within the PSFP II project will enhance efforts to demonstrate to both management and clinical personnel the need to continue IEC support directly from subproject resources, if necessary. Operations research on the impact of specific interventions, including IEC, and on developing alternative cost-effective mechanisms to continue outreach and other IEC activities will also be conducted.

Clinical training for subproject personnel has, to date, been provided through a subcontract with AMREF, which is currently the only source approved by the MOH for clinical training of the private sector in Kenya. AMREF provided both basic and refresher training for PSFP I subproject personnel. The MOH is open to approval of alternative training. In fact, the MOH is in the process of approving the training program designed by FPAK. Both trained personnel from PSFP I, as well as new clinical personnel from PSFP I and II projects, will continue to require both basic and refresher training in order to maintain their clinical proficiency. The project has emphasized the importance of this area by establishing two clinical positions, one for a clinical specialist (MD or nurse) who will provide medical/quality oversight (in-service); and a training specialist who will be a nurse or nurse-midwife with extensive training experience to monitor the implementation of training courses and follow up with trainees.

IEC training for Field Educators (FEs) was also seen as an area for increased support. The FE is a key link between the clinic and the community served. The FE informs potential clients of available services, provides promotional and educational information on methods, dispels rumors, etc. The FE is an important part of community-based family planning (CBFP) efforts. Training of FEs will continue under PSFP II. Workshops will be of both the basic and refresher varieties.

3. Other Technical Comments

Development of new technologies will not be a primary emphasis of this project. However, use of new contraceptive methods, such as contraceptive implants, may be appropriately incorporated into FP service delivery programs of the project. Greater emphasis on MCH services and expanding VSC will be explored. The contraceptive method mix, which at present is heavily pill based, may change over the life of the project as VSC becomes more widely available. Over time, the method mix of project clients should conform more to the national method mix which has greater proportions of tubal ligation and IUD clients and lower condom use. The principle of "informed choice" will be well served by better trained personnel who can safely provide a wider variety of contraceptive methods.

B. Administrative/Institutional Analysis Summary

The complete Administrative/Institutional Analysis is contained in Annex E.

1. Implementation Mode

PSFP II will continue to support FP services delivered through the private sector. Implementation will be through a cooperative agreement to be competitively awarded to a Kenyan or U.S. non-profit organization, or joint venture of both. USAID/Kenya and the TAC have concluded that in order to ensure the success of the project, address selected sustainability issues, provide on-the-ground management and oversight of project activities, and operate effectively in the Kenyan environment, ideally the lead implementing organization should be a Kenyan non-profit institution. The technical skills and capabilities necessary to implement this project can be found in Kenya. There are a number of Kenyan NGOs who have demonstrated technical competence, who have effectively administered direct A.I.D. financing for nation-wide family planning-related project efforts, and who have established productive links with local communities and the GOK. However, it is also recognized that certain Kenyan organizations may wish to link up with a U.S. institution to augment their administrative and financial management capacities. This approach to implementation has been accommodated in the project design by encouraging joint ventures between Kenyan and U.S. nonprofit institutions. Direct GOK administration of this project while considered was not seen as the optimum mode of implementation given past experience which confirmed the importance of maintaining a "private sector" orientation in the project

and which demonstrated that a private sector organization is best suited to effectively addressing the needs of businesses or non-governmental institutions.

2. USAID and GOK Management

The CA with the IO will include provisions for substantial involvement by USAID's O/PH in the management and monitoring of the Project. The GOK will participate in project oversight and monitoring through the TAC and NCPD. The MOH will continue to supply contraceptives to the subprojects, either directly or through the IO. Eventually, it is envisaged that subprojects will be directly supplied by MOH SDPs. However, because commodity supply is so critical to successful project implementation, the IO will focus on developing a smooth transition for subprojects to be directly supplied by the GOK.

3. Role of the Implementing Organization (IO)

The IO will be required to demonstrate its abilities in the following areas: ability to provide technical assistance/personnel; understanding of U.S. Government regulations; previous A.I.D.-financed project experience (especially in Africa); ability to establish administrative and other systems relating to subgrant management; and training support capability. Furthermore, the IO will have to demonstrate that it has a legally-established presence in Kenya, with a Board of Directors (the majority of whom are Kenyan), capable of providing effective oversight, management and administration to the project. The detailed technical selection criteria for the IO are shown in Annex J.

The IO will have to show that it can hire and deploy various types of long- and short-term personnel required to meet project needs. The 50 new subprojects with 120 clinical sites, as well as the continuing PSFP I subprojects, will need substantial amounts of technical assistance. This will range from design, implementation, monitoring and evaluation of new subprojects, to maintenance of existing ones through technical assistance in special areas such as IEC, CBFP or MCH. Given the emphasis on procurement of a Kenyan non-profit institution for project implementation, it is anticipated that most of the long-term technical assistance team, including the Project Director, will be Kenyan nationals. However, because joint ventures between Kenyan and U.S. institutions will be encouraged in selection criteria for the CA, one long-term expatriate position has been budgeted.

Specific skills needed for project implementation include overall project management and administration (including procurement); personnel management; financial management and accounting; subproject design, monitoring and evaluation; FP training; FP related IEC; data management/contraceptive and supply logistics; operations research; and clinical management and medical oversight.

Therefore, the staffing pattern proposed includes eight professionals including a director and deputy director; and specialists in training, communications, supply and contraceptive logistics/management information systems, clinical oversight, operations research, and financial management. Short-term technical assistance may be provided in specialized areas such as health insurance, cost recovery, preparation of publications, etc.

Previous A.I.D.-financed project management experience with African development programs, governmental and non-governmental organizations will be important. The potential IO's experience in managing specific private sector project activities and dealing with a variety of non-governmental and private firms will be an important criteria for selection.

The IO will be required to demonstrate that it is familiar with USG regulations related to cooperative agreement and grant administration (HB 13), procurement requirements (HB 11), and training policies (HB 10). As part of the Cooperative Agreement, USAID/Kenya, through the REDSO Contracting Officer, will ensure that the applicable Standard Provisions are included in the document. In addition, USAID/Kenya's Controller's Office will review and approve the recipient's financial management, personnel, property management and procurement systems to ensure compliance with the applicable requirements of OMB Circular A-110 and other A.I.D. regulations.

The IO will be required to set up a variety of computerized management information systems dealing with all aspects of the project inputs and outputs that will be evaluated, e.g., service statistics (CYPs generated), project monitoring, training, finance, etc. The IO will be responsible for accounting for funds at the subproject level. Thus, special attention will be paid to the IO's ability to assess or install proper financial reporting systems.

Since the numbers of personnel to be trained are very large and cover a variety of personnel types, the IO will have to establish a system for: identifying candidates for basic

and refresher training; scheduling training either in-house or through its training subcontractor; and developing or revising curricula, as necessary. Follow-up of trainees will be essential.

4. Subgrantee selection

A critical responsibility of the IO will be subgrantee selection. Criteria for selection have been described in Section II of the PP. The IO will have to ensure that the subgrantees have the institutional capability to carry out and maintain project functions. For example, the existence of already established medical services and staff within an existing facility and the desire and commitment of the organization to deliver FP services will be important.

C. Social Soundness Analysis Summary

See Annex D for the complete Social Soundness Analysis.

1. Socio-cultural context and background

The 1989 Kenya Demographic and Health Survey (KDHS) showed conclusively that the transition to lower fertility levels in Kenya had definitely begun. The total fertility rate (TFR) dropped sharply during the past five years, from 7.7 in 1984 to 6.7 in 1989. Correspondingly, the contraceptive prevalence rate (CPR) in Kenya increased from 17% to 27% over this same period. The 1989 KDHS also showed a change in fertility preferences and attitudes toward childbearing. Half of the married women interviewed in the survey reported that they did not want any more children. This represents the highest level of demand for family limitation in sub-Saharan Africa. Overall, about 75% of married women said they wanted to either limit or space future births. 11% of married women said their last birth was unwanted, and an additional 42% said they wanted their last birth later. The reduction in mean ideal family size from 5.8 in 1984 to 4.4 in 1989 gives ample evidence of a strong demand for FP and suggests the need to increase the availability of FP services to allow women to bring actual fertility in line with their stated family size preference.

Factors contributing to the increased demand for FP include the increased cost of living, changing perceptions regarding the value of children, increased pressure on land, improvement in the status of women, and increased confidence that more children will survive.

The cost of child raising is an almost universal response among parents asked to explain why they do not want additional children. The high cost of education and the fact that most Kenyans desire to educate their children make the real cost of raising children readily apparent. The role of women is also gradually changing. Social changes, such as increased access to public education and a breakdown in traditional family roles, with women taking on a large share of household support and economic activity, mean that women are more active in making fertility decisions and demanding contraceptive services. It also appears that men, thought to be negative in their attitudes toward FP, may be changing their attitudes. Data from the DHS show that 95% of men know of a FP method and 42% of those not currently using a method say they would do so in the future.

2. Socio-Cultural Feasibility and Unmet Need

Despite the increased use of FP in Kenya, there is still a large unmet need for services. KDHS estimates imply that over one-third (36%) of married women are in need of FP; 22% for spacing purposes and 14% percent for limiting. It is estimated that 30%-40% of the population still does not have ready access to FP services. In the public sector, services are routinely available at approximately 50% of the facilities.

The rapid decline in ideal/desired family size and evidence of strong demand for FP supports USAID's emphasis on the expansion of FP services through both public and private sector channels. Although access through the private sector has increased over the past five years, substantial need and opportunity exists to further expand the availability of FP services within private institutions.

The best indicator of acceptability of the PSFP approach is its past accomplishments. PSFP I had considerable success in recruiting significant numbers of FP users. With nearly 90,000 FP users, the May/June 1990 evaluation concluded that PSFP I currently serves between 10 to 13 percent of all FP users in Kenya.

PSFP I also demonstrated the receptivity of private sector firms to adding FP to their services. In fact, PSFP I has a number of outstanding requests from private organizations which it was unable to respond to because of funding and project limitations. At the time of the evaluation, six large commercial firms, four parastatals, thirteen private maternity homes and five NGOs had applied for support to start FP services.

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In addition, in December 1990 USAID undertook a survey of private sector organizations to determine the potential for expansion of the PSFP project. This survey identified 90 private sector organizations which were potentially in need of assistance for FP service provision.

Impressions of social benefits by firms (and individuals) are mostly anecdotal. Firms observed greater involvement of dependents in health and FP promotion (dramas, song, dance). Company viability/respect is apparently elevated in the eyes of employees and communities. Community participation is viewed favorably as are perceived reductions in absenteeism. A reduced number of maternity cases and of septic abortions in the general employee population has been reported. These and other examples contribute to the belief that family planning service is a desired and respected service at the community level and has benefits which transcend birth spacing and reduced fertility. The Sulmac Flower Co. Naivasha, is a good example of corporate commitment to family planning. Over the project's LOP, Sulmac has provided FP services. Figure 5 (Annex C) presents a clear inverse relationship between new clients and deliveries between 1984 and 1990. Sulmac has continued to provide services beyond PSFP support under the premise that FP services are beneficial in terms of worker productivity, absenteeism and general health status.

3. Project Beneficiaries

Among those groups that can be expected to benefit from the project are private firms, parastatals, private health facilities, training institutions, NGOs, and men and women among the eligible couples. The GOK will also be a beneficiary of a successful private sector service program. A 1990 evaluation of PSFP I found that the managers of various private firms involved in the project reported reduced absenteeism, savings in maternity benefits, increased employee satisfaction, increased technical skills for staff trained by PSFP and generally better employer/employee relationships. NGOs have been strengthened by training received in service delivery, IEC and management. Their ability to provide a wider variety of high quality FP services has enhanced their standing in the communities they serve, and enabled them to institutionalize services within their overall programs. (See discussion of "retainability" and "maintainability" in the Technical Analysis). The GOK has benefitted from the increased

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availability and efficiency of services that have neither added to an already overloaded management structure nor used scarce resources, and that have promoted self-sufficient, non-subsidized family planning.

The project will provide many tangible benefits to women. Women are expected to benefit from gaining access to contraceptive services and from receiving training under the project. (In order to document the impact of the project on women and comply with USAID guidance, the project monitoring and evaluation systems will be designed to provide information on gender-related issues.)

For eligible couples, every year of CYP generated by PSFP results in decreased maternal and infant mortality and morbidity, increased economic opportunity, and reduced health risks to the family.

Over 1,200 clinicians and field educators, mostly women, were trained under PSFP I. The new project will train an even larger number of workers, approximately 2,200 project staff. This training will provide a substantial number of women with the opportunity to participate in productive employment.

D. Economic Analysis Summary

1. Overview

As with any development project, analyzing costs, comparing costs (cost effectiveness) and estimating benefits are difficult tasks. Annex C provides a review of the economic indicators of the PSFP project. The total costs of couple years of protection are calculated as are the births averted attributable to project activities. The costs and savings for births averted are subsequently estimated. The analysis briefly compares project costs to other family planning projects in Africa and other parts of the world. From a cost-effectiveness viewpoint, the PSFP project compares favorably with other projects in Africa and elsewhere. Savings are calculated for corporate institutions as an index of benefit-cost for the private sector. Total benefit is also calculated at the national level to estimate total savings attributable to project activities and discern future benefits from PSFP II. The analysis also discusses sustainability in economic terms by a cohort analysis of services delivered.

2. Cost-Effectiveness (Comparative Costs of CYP)

During PSFP I, CYP costs declined (as expected) as PSFP activities became established and startup costs decreased. Average total CYP costs by project year declined from \$23.23/CYP/yr in 1985 to \$1.75/CYP/yr in 1990. The mean CYP cost by institution over the five-year LOP ranged from \$5.21 to \$10.59 (Table 2, Annex C). The average total project cost per couple year of protection was \$26.80 (inclusive of all operating costs and external TA but exclusive of contraceptives). This figure is comparable with an average annual CYP cost estimate of \$44.20 from other parts of Africa. As with all cost-effectiveness estimates for FP programs, data should be taken with caution, especially when comparing cost between and among programs. If both demand and availability continue to increase, costs per CYP in PSFP II can be expected to remain comparable over the medium term.

3. Benefit-Cost

The analysis defines benefit-cost as the ratio between the value of outcome and total costs. The outcome of family planning efforts is directly linked to births averted, and thus the estimate of averted births is an essential component of benefit-cost analyses. Two scenarios for births averted are presented. The first implies a satisfactory impact of family planning and the second, a poorer impact. Table 4 (Annex C) estimates total births averted to be 83,286 and 33,107 respectively. Total project cost per averted birth respectively ranged from \$80.46 to \$214.59. It is noteworthy that even with an estimated "total project" cost, the PSFP I project cost per averted birth is comparable to other programs within Kenya and other countries.

Assigning a dollar value per birth averted is comparable to an estimate of savings. The analysis utilized calculations by Savosnick (1986) to estimate corporate savings due to reduced expenditures for pregnancy and child care (pre-partum care, delivery, post-partum care, immunizations, childhood curative care, education, etc.). It is estimated that company savings range from \$200 - \$670 per birth averted per employee over a 10 year period. The difference is based on calculations for unskilled and skilled employees and wives of unskilled employees (Table 5 Annex C). Total PSFP I project-related corporate savings ranged from \$3.44 million to \$1.29 million per year for satisfactory and poor project performance respectively.

At the national level, it was estimated that the discounted present value (DPV) of consumption for an individual (over a 20 year period) averaged \$1378 for private sector (total consumption minus public consumption). Using this figure as an index of

savings for one birth averted, PSFP I estimates of total savings are \$121.7 million and 45.6 million for good and poor project performance respectively. This translates into respective mean benefit-cost ratios of 17.12 and 6.42 over the project period (Table 9 Annex C). The impressive benefit/cost ratio achieved over the LOP indicates that the PSFP I promoted technically and economically sound family planning services to the private sector in Kenya.

Prospectively, it is estimated that given present demographic trends in Kenya (Table 11, Annex C), over the next eight years, even with continued family planning practice (i.e. a national population growth rate reduced to 3.04% and a reduction in the birth rate from 44/1000 to 38.4/1000), 9,358,000 births will occur. Annual births will increase steadily from 1,082,000 in 1990 to 1,230,000 in 1998 due to the increased number of women of reproductive age. Without family planning (i.e. a constant growth rate of 3.6% and a birth rate of 44/1000), 10,134,600 births will occur. Thus, it is estimated that family planning in Kenya will avert an estimated 776,410 births between 1991 and 1998. Of these, approximately 13% (100,930) could be averted by PSFP II activities. If the births averted-consumption value attributed to PSFP I for individuals (Table 9, Annex C) is applied to the projected estimate of births averted at the national scale (i.e. \$1378/birth averted), it is estimated that the potential savings realized by PSFP II would be \$139,067,760 (Table 12, Annex C). This would present a benefit/cost ratio of 13.9 (\$139,067,760/\$10,000,000). Thus, if PSFP II performs as well as PSFP I in generating acceptance and use of family planning services, there is little doubt that the effort will be cost beneficial in terms of the private sector and the general economic health of Kenya.

4. Sustainability

Table 13 and Figure 6 (Annex C) present an estimate of sustainability based on levels of reported CYP. The levels correspond to the inception, conduct and cessation of PSFP I support. Twenty organizations were identified which had at least four years of CYP reporting. It is assumed that Year I represents the inception of FP activities and Year IV is the first year totally without PSFP support. The data indicate a clear pattern of activity. For each organization, a modest level in CYP increase is observed in Year I. This is followed by an impressive increase in Year II. In Year III, with PSFP support on the wane, family planning services appear to be maintained. In Year IV, an expected decline is observed concomitant with the complete withdrawal of PSFP support. However, most importantly, CYP levels in Year IV remain significantly greater than Year I estimates. It is interesting to note that CYPs in Year V for

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private sector and parastatal organizations increase on average but, appear to decline to levels below Year IV in Year VI (Table 13). Whether this represents a real trend or is an annual fluctuation remains to be seen.

If the impact of PSFP I is gauged in terms of "before and after" (Year I and Year IV), all types of private sector organizations reported increased levels of CYPs (a three-fold increase being the lowest). This is viewed as a positive index of sustainability. However, given the small sample sizes, proportionate increases should be viewed with caution.

Although potentially ephemeral, and perhaps complicated by other sources of external support, the data contained in Table 13 and Figure 6 (annex C) demonstrate that the potential for truly sustainable interventions exists in the Kenyan private sector. If the elements of management, cost recovery, logistics and supply are improved in a FP service delivery system, it is believed that a greater opportunity for prolonged sustainability will be realized. Thus, in addition to the aim of broadened private sector service delivery, PSFP II will emphasize the above-mentioned components of sustainability in an effort to encourage corporate commitment; maintain the supply of a good method mix; assure reasonable compliance; and increase indigenous cost recovery.

VI. MONITORING, EVALUATION AND AUDIT PLAN

A. Monitoring

Mechanisms for monitoring project results are: the IO semi-annual reports, which include routine data from the project's MIS; reports from the MOH LMIS; specific subproject data collection and reports; USAID semi-annual monitoring meetings; regular semi-annual TAC meetings; site visits; and national and regional conferences held specifically for purposes of information sharing and dissemination.

In addition to attending the TAC meetings, USAID will convene semi-annual monitoring meetings to review progress and any constraints toward achievement of project objectives. Data from the MIS will be reviewed and efforts will be made to resolve any implementation problems at an early stage. Semi-annual progress reports will provide information on progress toward attainment of project objectives and outputs and identify problems and areas for improvement. Direct monitoring will be the responsibility of the USAID Project Manager with assistance from the O/PH Office Chief and other Mission staff, e.g., the Projects Office, the Contracts Office and the Controller's Office.

The IO's progress in attaining purpose-level project objectives will be measured primarily by the numbers of CYPs generated. Measurement of CYPs will also serve to assess the project's contribution to the overall national program. Therefore, the IO must have established a management information system (MIS) that subgrantees (from both PSFP I and PSFP II) can easily report to in an accurate and timely fashion. The MIS must also generate accurate statistical information for USAID and GOK purposes.

Thus, as part of its MIS and semi-annual reporting responsibilities to USAID and the TAC, the IO will be required to provide data on contraceptives distributed, procedures performed (IUD, sterilization, etc.), cumulative CYPs, current CYP, CYP by method, CYP by subproject and by subproject types, and cost per CYP. CYP calculations should use standard international conversion factors. If operations research or other data allow the use of more refined or local conversion factors, the IO should report them separately and clearly label them as project-specific CYPs. The reporting will need to assess CYP trends in subprojects which no longer receive PSFP funding by providing information on the extent to which CYP levels are maintained in these subprojects. The reports will also be required to track the impact of the enhanced packages of service interventions, (i.e., IEC, VSC, CBFP, MCH), by reporting separately on CYP levels when these interventions are introduced and periodically thereafter.

In addition, the following FP service provision information for each subproject will be required in the semi-annual reports in order to measure whether the client load at each site is growing, declining or staying level. The data needed to perform these measurements are: new acceptors at each SDP; revisits at each SDP; and effective VSC referrals. The IO may wish to continue with the PSFP I service statistics system in providing these data, as well as the "tickler file" system used to track clients for follow up.

In order to document the impact of the project on women and comply with USAID guidance, the monitoring and evaluation systems will be designed to provide information on gender-related issues. Output status targets for persons trained and employed by the project will be disaggregated by gender. Data on couple years of protection by contraceptive method generated by the project will provide further documentation of the benefits to women of protection from an unwanted pregnancy.

Qualitative information on the subprojects and the extent to which they are successfully delivering family planning services should be included in semi-annual reports. This will include a description of the extent to which special interventions or

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enhanced packages of MCH, VSC, IEC, and/or CBFP are being successfully implemented; and specific output data, such as number of personnel trained by category. Any problems encountered in project implementation or financing issues should be detailed in the semi-annual reports, together with possible proposed solutions to problems that have arisen.

The semi-annual reports should also include adequate financial information to enable AID to ascertain the costs of supporting FP programs for different types of private sector entities, such as church-related NGOs, parastatals, etc. The reports should include a financial plan format which permits USAID/Kenya to track expenditures against each approved budget line item in the CA as shown below in Table 1.

Table 1

Approved Budget Line	Total Amount	Cum Prior Period	Expenditure this Period	Cum Exp. to date
1. Technical assistance				
2. Training				
3. Equipment & Supplies				
4. Subprojects				
5. Other Direct Costs				
6. Evaluation & Audit				
7. Inflation/Contingency				
Totals				

The above information will be directly linked into O/PH's monitoring and evaluation plan for assessment of program impact (API). Under the LMIS, contraceptive supply and distribution data is collected on a quarterly basis from all MOH service delivery points. The LMIS has also been installed in PSFP I sites and is expected to eventually be utilized by all NGO service providers. This improved system will provide the

MOH and donors with quarterly reports of the quantities of each product issued to clients, contraceptive stocks on hand at each level of the distribution system, and the quantity of contraceptives needed at each level to maintain desired stock levels.

In order to keep the DFH informed about contraceptive supply requirements and to ensure that PSFP service statistics are included the national Family Planning Information System (FPIS), the project will submit quarterly reports to the MOH LMIS. The IO will be responsible for collecting contraceptive supply data from all SDPs, including both PSFP I and II subprojects, compiling these data and submitting these reports to the MOH's Division of Family Health and the HIS Unit.

At the clinic level, the quantities of contraceptives required will be calculated using data on:

- stock on hand at each facility (by product) both at the beginning and the end of the reporting period; and
- consumption/distribution from each facility (by product).

This information is used to determine the quantity of the product needed to restore stock levels to the desired minimum/maximum range, (between 2 and 5 months supply for SDPs).

The MOH/LMIS uses three forms at the SDP level for contraceptive commodity management and reporting-- a Bin Card, the new Daily Activity Register (Family Planning), and the Quarterly Report and Request for Contraceptives.

Each SDP is required to fill out the Daily Activity Register (Family Planning) form. The Register is designed to replace a multitude of forms previously required by the MOH. It is very complete and easy to use. It records only a single line for each client, noting the client's number, whether she/he is a new client, the actual amounts of contraceptive dispensed (by brand), and other services which were provided at the visit. As each page is filled, totals for each column are recorded at the bottom of the page. Monthly totals are obtained simply by adding the totals from all the pages used that month. The IO's staff will be expected to review the register during site visits and instruct on its use if necessary.

Individual quarterly reports from each SDP will be prepared and submitted to the IO. These reports will indicate the quantity of contraceptives, (by product), issued during the quarter, the beginning and ending balance, and the quantity needed. These data will be aggregated and submitted to the Division of Family

Health, using the standard MOH/LMIS Quarterly Reporting Form. The Division's LMIS unit will incorporate these data into their quarterly logistics reports and export the data needed to calculate CYP by method to the MOH's HIS Unit for inclusion in the FPIS. The quarterly logistics report will also be used as the basis for requisitioning additional supplies from the MSCU.

In addition to routine reporting, project implementation monitoring will include the semi-annual TAC meetings, site visits, and national and regional conferences at which progress will be reviewed and information shared.

A number of regional seminars will be held to share findings of operations research or special studies and to disseminate project results among the subprojects and other key players. During the LOP, the IO will conduct annual regional monitoring meetings to share experience among subprojects and disseminate results of innovative approaches to service delivery. Starting in Year Two of the project, the first of two national-level dissemination seminars will be held to present project experience. Participation will include national population policy makers, organization managers and health and IEC staff of the PSFP subprojects, as well as other representatives of family planning organizations.

The IO will produce and present a final project report to USAID and the TAC that includes details on project design, project activities, research findings, evaluation results and lessons learned regarding approaches and strategies for private sector family planning.

B. Audit

The project has made provision for site audits by IO-approved external auditors (CPAs) once every two years. In addition, the project budget provides for two non-federal audits in the fourth and seven years of the LOP which will be arranged by AID. The IO will be required to have a well-established track record in administration and management of A.I.D.-financed projects and subgrant monitoring. In this regard, the IO will be expected to ensure that the subprojects possess adequate administrative and financial systems to meet A.I.D.'s accountability requirements.

In addition, the IO will be expected to comply with Standard Provisions for Grants to NGOs which include requirements for submission of annual independent CPA-audited financial statements to A.I.D.

C. Evaluation

Two project evaluations will be conducted over the LOP. A mid-term evaluation will be conducted in the middle of 1994 and a final evaluation in early 1998. The purposes of the mid-term evaluation will be to assess program impact and progress toward achievement of major project outputs and to identify any problems likely to affect successful project completion.

Data from the second 1993 KDHS, expected to be available prior to the mid-term evaluation, will provide estimates of contraceptive use among married women of reproductive age and will contribute to the assessment of program impact. The survey will collect information on contraceptive use, knowledge, attitudes, desired family size, etc. KDHS II will also collect more detailed and accurate information on source of supply in order to estimate the portion of contraceptive users attributable to the PSFP II project. (NOTE: DHS surveys are financed under USAID/Kenya's bilateral family planning project.)

It is estimated that the mid-term evaluation will require three outside consultants for a minimum of three weeks each. The team should include a public health physician, a social scientist and a management specialist. The USAID Project Manager, Evaluation Officer, and TAC and NCPD members will also participate.

The IO will be responsible for pre-evaluation activities including the compilation and review of all available data from the PSFP project's MIS system and CYP data from the LMIS. Findings from the operations research and diagnostic studies will be finalized, summarized and made available to the team by the IO.

The mid-term evaluation will also include findings from the studies on sustainability, cost/benefit analysis, cost effectiveness and cost recovery. Positive results from calculating the marginal costs of adding family planning to existing health care services can be used to intensify the resolve of management to commit financial resources to continue family planning services and/or to interest firms in adding family planning to their service delivery packages. The studies will assess the commitment and financial ability of the various types of subprojects to sustain project activities and to continue to provide family planning services after completion of project assistance. Where financial self-sufficiency is problematic, the feasibility of alternative financing or cost recovery schemes will be tested. If continued external resources are required to maintain services, these cases need to be identified early on and alternative funding mechanisms found.

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Specific areas to be assessed in the mid-term evaluation include: (a) the extent to which the subprojects have been able to establish linkages to the MOH contraceptive management and supply system and can routinely obtain adequate contraceptive supplies, with recommendations on appropriate action to be taken if problems are noted with this transition to the MOH system; (b) a comparative assessment of the impact, ease of development, acceptability and cost effectiveness of the alternate service delivery structures (e.g., NGOs, educational institutions, parastatals, private firms and private health facilities), with recommendations for future approaches; (c) the impact and cost effectiveness of the various enhanced packages of service delivery, i.e., MCH, VSC, IEC and CBFP, with recommendations on the extent to which these interventions should be continued or expanded; (d) the extent and quality of the training being provided under the project; (e) the extent to which PFSF I subprojects are still reporting and still providing FP services and the extent of project technical assistance they are receiving to maintain services; (f) the success/replicability of alternate approaches to expanding family planning service delivery in the private sector, such as the Machakos Model, with recommendations on the extent to which these innovative strategies should be continued or expanded; and, (g) the feasibility of adding FP to health insurance schemes, and if found feasible, proposals for testing this approach.

The final evaluation is scheduled for 1998, after the third KDHS. It will assess overall program impact, progress toward achievement of project objectives (EOPs), and sustainability of subprojects. It will assess and recommend what follow-on assistance, if any, is required. The composition of the final evaluation team and the duration of the effort will be similar to that of the mid-term evaluation team.

Planning for this evaluation will begin at least one year in advance of the PACD. Prior to the conduct of this evaluation, the IO will be responsible for ensuring that the following are completed and made available to USAID: (a) documented findings from innovative strategies undertaken for expanding private sector family planning services; (b) operations research/diagnostic studies completed with findings analyzed; (c) all available data from the MIS systems compiled; and (d) comprehensive up-to-date status reports prepared and shared with USAID and TAC. Detailed terms of reference for the final evaluation SOW will be prepared by USAID, and reviewed by TAC at least six months prior to the final evaluation.

VII. LEGISLATIVE REQUIREMENTS AND NEGOTIATING STATUS

The legislative requirements of key relevance to this project are those concerning abortion, involuntary sterilization, and informed choice. The provisions of the 1991 Foreign Assistance Act contain restrictions regarding population funds. Population funds may not be used to perform, motivate or coerce persons to practice abortions or undergo involuntary sterilization, or to finance biomedical research relating to these procedures used as methods of family planning. The regulations also stipulate that funds should be made available only for voluntary family planning projects that offer information and services pertaining to a broad range of methods. Discriminating against grant applicants for natural family planning on the grounds that they offer only natural FP because of religious or conscientious commitment is also prohibited. (See Statutory Checklist, FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535).

USAID/Kenya does not anticipate any difficulty in complying with these regulations. The Cooperative Agreement will include standard provisions that the grantee will have to sign in order to assure compliance.

Regarding the status of negotiations with the GOK, a draft Memorandum of Understanding (MOU) has been prepared, (see Annex I), which describes the responsibilities of the GOK. The draft MOU has been shared with the GOK and agreement in principle has been secured. It is anticipated that the GOK will sign the document and that it will be finalized by May 1991.

WP5:PSFPPP

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORKProject Title and Number: Family Planning Private
Sector (615-0254)Life of Project: \$10,000,000
Total US funding: \$10,000,000
Date Prepared: May 16, 1991

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Goal:</u> Reduce fertility and population growth rate	<u>Measures of Goal Achievement:</u> Decrease total fertility rate from current level of 6.7 to 5.5.	- Analysis of national population data	- Increased contraceptive use is the most effective and rapid approach to reducing fertility.
<u>Sub-Goal:</u> To increase prevalence of contraceptive use	Increase contraceptive prevalence rate from current 27% to 40% of MIRA.	- Demographic and Health Survey (DHS)	
<u>Purpose:</u> To increase availability, use and sustainability of family planning services in the private sector.	<u>End of Project Status</u> - Cumulative increase in CYP from 1991 level of 350,000 to 800,000, attributable to private sector organizations (including PSFP I subprojects). - CYP during last year of project will have increased from the current level of 80,000 to 150,000 per annum. - 110 (60 continuing and 50 new) private sector organizations routinely provide family planning services to their clients, employees, dependents and/or the surrounding community.	- 1993 and 1998 DHS - Logistics Management Information Systems (LMIS) - Clinic records - Site visits - Contractor reports	- Increased availability of contraceptives through static clinics will increase contraceptive use. - GOK remains committed to the expansion of family planning in the private sector. - Sufficient number of organizations willing to participate in the follow-on project. - Expanding family planning service through the private sector will increase overall contraceptive prevalence, not merely replace services available elsewhere.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title and Number: Family Planning Private
Sector (615-0245)

Life of Project: \$10,000,000
Total US funding: \$10,000,000
Date Prepared: May 16, 1991

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Outputs:</u>	<u>Magnitude:</u>	- Mid and final evaluation	- All subprojects, new and continuing (PSFP II and PSFP I) continue to report.
1. Discrete private sector sub-projects provide and/or expand availability of family planning services.	1. 50 new subprojects representing an estimated 120 service delivery points routinely offer family planning services.	- LMIS	- Institutions have interest and are willing to commit resources to service programs.
2. Enhanced service delivery packages provided to selected new subprojects	2. VSC services added to 15 sub-projects; CBFP and/or IEC to 30 subprojects; MCH interventions to 10.	- Site visits, contractor reports, evaluation	
3. Liaison, networking and maintenance of entities assisted in FPPS I subprojects.	3. 80% of graduated PSFP I projects receive 3 days TA/yr as well as promotional/IEC materials. Up to 15 receive supplementary grants for addition of discrete services (e.g., CBFP, MCH) up to 25% of original grant amount.	- Site visits, contractor reports, evaluation	
4. Additional trained family planning providers deployed in the private sector.	<ul style="list-style-type: none"> - 450 clinical officers, nurses and midwives from PSFP I and PSFP II receive clinical family planning training. - 450 clinical personnel from PSFP I and PSFP II receive refresher training. - 90 field educators receive basic training. 	- Site visits, contractor reports, evaluation	- MOH approves the institutional arrangements and curriculum for clinical training provided under this project.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title and Number: Family Planning Private
Sector (615-0245)

Life of Project: \$10,000,000
Total US funding: \$10,000,000
Date Prepared: May 16, 1991

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
5. Private sector entities routinely receive sufficient and appropriate contraceptives.	<ul style="list-style-type: none"> - 150 field educators/year attend workshops. - 210 CBFP volunteer field workers trained and deployed. 5. Adequate supply of all program methods available at all sub-project sites.	- LMIS	<ul style="list-style-type: none"> - MOH has adequate stocks of contraceptive supplies available for private sector use. - MOH contraceptive logistics system continues to improve with assistance provided outside this project.
6. Innovative strategies to increase family planning service delivery in the private sector developed and tested.	- The Machakos Medical Clinic and/or newly developed model introduced at 6 sites.	- Site visits, contractor reports, research reports, evaluation	- Institutions are able to charge for services.
a. New models for private sector family planning service delivery identified and financed.	- A study carried out to assess feasibility of expanding health insurance benefits to include family planning.		
b. The feasibility of adding family planning to health insurance schemes assessed.	- Up to six diagnostic studies and/or operations research projects completed.		
c. Operations research and diagnostic studies to assess constraints to effective subproject implementation and sustainability.			

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title and Number: Family Planning Private
Sector (615-0245)

Life of Project: \$10,000,000
Total US funding: \$10,000,000
Date Prepared: May 16, 1991

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
7. Information dissemination	<ul style="list-style-type: none"> - Two national seminars held. - Presentations made at two international conferences. - Three articles prepared for publication. - Results of evaluations disseminated. 	<ul style="list-style-type: none"> - Site visits, contractor reports published reports. 	
<u>Inputs:</u>			
1. <u>USAID</u>			
<ul style="list-style-type: none"> - Technical assistance. - Training. - FP-related equipment and commodities. - IEC related materials. - Evaluation/research studies/ audits. 	<ul style="list-style-type: none"> - Cooperative Agreement for \$9.5 million. - Individual USAID direct contracts \$500,000 (evaluation, audit, special studies). 	<ul style="list-style-type: none"> - Contractor reports. - Evaluations and audit reports. - Research reports. - Field monitoring visits. 	<ul style="list-style-type: none"> - Grantee is acceptable to GOK.
2. <u>GOK:</u>			
<ul style="list-style-type: none"> - Contraceptives. 			
3. <u>Subproject Grantees:</u>			
<ul style="list-style-type: none"> - Personnel. - Clinic facilities. - Operating costs. 			

TECHNICAL ANALYSIS

A. Sustainability

1. Retainability
2. Maintainability
3. Financial Self-Sufficiency
4. Conclusions Regarding Sustainability

B. Major Constraints to Sustainability and Response of Project Design

1. Contraceptive Logistics
2. IEC Outreach
3. Clinical Training
4. IEC Training

C. Other Technical Comments

1. New Technologies
2. Contraceptive Method Mix

D. Summary Conclusions

Technical Analysis

The purpose of this project is to increase the availability, use and sustainability of FP services in the private sector. Analysis of the 1989 Demographic and Health Survey indicates that a significant unmet need exists for FP services (See also Annexes D and F). While it has long been known that in Kenya non-governmental organizations were willing and able to deliver family planning services, it was only during the predecessor Private Sector Family Planning (PSFP I) Project that the feasibility was demonstrated of inducing other private sector entities to add family planning services to the clinical services offered to their clients. By the end of 1989, an evaluation of the project found that fifty-four private sector organizations were operating with new or improved family planning activities, 88,000 Kenyans were using contraceptives supplied through project outlets, and in 1989 alone, over 70,000 couple years of protection (CYP) had been provided. Accordingly, this analysis at the onset accepts that increasing the number of functioning private sector service delivery points (through subprojects) will respond in part to existing demand for FP services, and will increase use and availability of FP services. The first part of the analysis will focus on the degree to which project design addresses increasing the sustainability of FP services in the private sector. The major identified constraints to sustainability will be examined, and comments made on the degree to which the project is designed to address or reduce those constraints. The analysis will then briefly comment on new technology, contraceptive method-mix and adequacy of technical assistance.

A. SUSTAINABILITY

When PSFP I was designed in 1983, the expectation was that after two years of subproject assistance, the organizations which received assistance would continue delivering family planning services at the same or increased levels achieved during subproject activity, and would assume associated costs except for costs of contraceptives, which would continue to be supplied free from government sources. The same basic expectation underlies the current project. Experience gained from PSFP I should help determine the validity of that expectation.

This analysis will talk of "sustainability" at three levels, based on the extent to which, at the end of subproject assistance, assisted organizations ("grantees"):

- o Continue providing family planning services, termed retainability of services.

- o Maintain or increase the achieved levels of family planning services, termed maintainability.
- o Retain and maintain services without continued external financial project assistance (except for provision of MOH contraceptives), termed financial self-sufficiency. This means that the grantee will assume responsibility for providing the continuing inputs necessary for retainability and maintainability from sources other than the project. Since PSFP II very clearly has the primary objective of increasing contraceptive prevalence rather than stimulating the economy of the private sector, for definitional purposes, the source of the continuing inputs (e.g., whether from company operating expenses, cost recovery, another funding source, etc.) is irrelevant, but possible sources will be looked at.

1. Retainability

By the end of 1990, 47 grantees had received two or more years of subproject assistance, 44 of which were still viable entities. One of the three grantees in receivership, Kenya Cashews, was still providing clinical services and reporting regularly, but is excluded from this analysis. Of the 44 remaining grantees, all continue to provide FP services and report regularly, supporting an assumption of PSFP I that once a service is added to a grantee's delivery system and perceived as a benefit by clients and by management, it would be unlikely (and very difficult) to rescind. Based on PSFP I experience and the similarities of the two projects, it is reasonable to conclude that most, if not all, grantees of PSFP II will continue to provide family planning services at the end of subproject assistance (retainability).

2. Maintainability

Tables TA 1 and TA 2 present CYP data from 28 projects which by June 30, 1990 had received at least two years of subproject assistance and had continued to provide family planning services for at least two additional years. From examination of these tables, it is possible to make some cautious observations about maintainability. Caution is needed because:

- a. Cut-off points for two-years of project assistance are not precise, but represent two years after significant project activity got underway. For

example, the Kenya Tea Growers Association (TGA) Sotik grant was signed in August, 1984, but significant subproject activities did not begin until early 1986. Subproject support years selected for KTGA Sotik are the two years ending June 30, 1988.

b. Subproject assistance often extended longer than two years. For example, Kenya Cashews required a non-funded extension of 20 months to expend subgrant funds. Additionally, most subprojects continued to receive some project inputs (discussed later) which were not attributed to the subgrant.

c. The criterion of at least two years of post-grant provision of family planning by subprojects was selected as a result of balancing two considerations the desire to examine the longest possible time period of experience in FP provision by subprojects, and the desire to define the largest possible universe of subprojects for analysis. For example, analysis of subprojects with only one year of post-grant experience would have increased the sample but may have weakened confidence in the findings.

Table TA 1

Couple Years Protection (CYP) by Organization After Two Years of Subproject Support and Two Years Later

Company	Signed	Year Ending June 30				
		1986	1987	1988	1989	1990
Miwani Sugar	5/84	344		226		
Pan Paper	5/84	402		952		
Nzoia Sugar	5/84	837		649		
K. Fluorspar	5/84	163		191		
K. Canners	5/84	1274		1402		
CHAK	8/84	7471		9094		
KTGA Sctik	8/84			352		1113
A.H. Produce	3/85		2728		1601	
Oserian	3/85		356		500	
Elgeyo Sawmil	5/85		95		335	
Kanguru Clini	5/85		2059		1039	
E.A. Indust.	5/85			822		292
Canaan Med.	5/85		256		1034	
B.B. Mabruki	5/85		500		409	
Chemilil	5/85		339		746	
B.B. Kericho	5/85		2120		2098	
B.B. Naivasha	5/85		1006		1313	
B.B. Kibwezi	7/85		517		135	
K. Breweries	7/85		516		1516	
SDA	8/85		6495		9490	
B.A.T. Kenya	10/85			180		135
KTGA Nandi	11/85			2532		1940
So. Nyanza	12/85			416		448
KTGA Kericho	1/86			310		344
Nanyuki Hosp.	6/86			664		602
Voi Changamwe	7/86			628		901

As can be seen in Table TA 1, there is a marked variation in the degree to which individual organizations succeed in maintaining services. Some showed lowered levels (e.g., Miwani Sugar, African Highlands Produce, Brooke Bond Kibwezi); some were at about the same levels (Kenya Fluorspar, Brooke Bond Mabruki, BAT Kenya), and others showed significant increases (Panpaper, Elgeyo Sawmills, Canaan Medical Services, Kenya Breweries).

Table TA 2 presents the same data as Table TA I, but shows subprojects as if they all started at the same time and the CYPs were determined for the second and fourth years following.

Table TA 2

Couple Years Protection (CYP) by Organization After Two Years of Subproject Support and Two Years Later

Company	Signed	After two years of subproject support	Two years later
Miwani Sugar	5/84	344	226
Pan Paper	5/84	402	952
Nzoia Sugar	5/84	837	649
K. Fluorspar	5/84	163	191
K. Canners	5/84	1274	1402
CHAK	8/84	7471	9094
KTGA Sotik	8/84	352	1113
A.H. Produce	3/85	2728	1601
Oserian	3/85	356	500
Elgeyo Sawmil	5/85	95	335
Kanguru Clini	5/85	2059	1039
E.A. Indust.	5/85	822	292
Canaan Med.	5/85	256	1034
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B.B. Kericho	5/85	2120	2098
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B.B. Kibwezi	7/85	517	135
K. Breweries	7/85	516	1516
SDA	8/85	6495	9490
B.A.T. Kenya	10/85	180	135
KTGA Nandi	11/85	2532	1940
So. Nyanza	12/85	416	448
KTGA Kericho	1/86	310	344
Nanyuki Hosp.	6/86	664	602
Voi Changamwe	7/86	628	901
TOTAL		33,382	38,505
Total less CHAK and SDA		19,419	19,916

TA 2 shows that when the CYPs of the subprojects are aggregated, the organizations produced more CYPs two years after subproject assistance ended than they attained during the second year of formal project assistance. It should be pointed out that only 58% of the organizations in this table showed an increase in CYP over a four year time period. However, the aggregate increase persists even after the removal of CYPs contributed by the Christian Health Association of Kenya (CHAK) and the Seventh Day Adventist

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Rural Health Services (SDA), both not-for-profit NGOs which continued to receive financial assistance throughout the four years represented in the data.

In view of the caveats expressed earlier, the foregoing data cannot be interpreted as proof of maintainability. The data from PSFP I experience are highly encouraging and suggest that subgrantees of PSFP II, with relatively minimal continuing inputs after formal assistance ends, can achieve maintainability or even increase levels of FP service delivery reached during subproject assistance.

3. Financial Self-Sufficiency.

In 1989, PSFP I conducted a study (Thomas Kibua, Stewart J., Njiru S. and Gitari A., Sustainability and Cost Effectiveness of FPPS Subprojects.), part of which was to determine the financial capability of a sample of 18 PSFP I subprojects to continue family planning services beyond the period of direct PSFP I assistance. Overall self-sufficiency was defined as the percentage of all program costs which were met by non-PSFP I grant funds, including direct supporting costs (but not development and administration costs) incurred by the central office and allocated to each subproject. The medium level of self-sufficiency for the 18 sites was 66 percent, with a range of 13 to 111 percent. The study noted that visit volume had a positive effect and was the most influential factor explaining variation between subprojects in cost effectiveness and self sufficiency, and CBD, IEC expenditures and the number of field educators had a positive correlation to visit volume. Cost recovery was greater in clinics which integrated family planning and MCH with primary curative services rather than providing non-curative FP/MCH services separately from curative services. According to the study, "Issues of continued sustainability for these subprojects focus on the need for continued support from the central PSFP office and the need for activities promoting education and awareness (note: "awareness" undefined). Specifically, managers and clinic personnel noted the need for ongoing training opportunities as a result of staff turnover, resources for IEC activities, and continued need for a reliable source of contraceptive supply."

4. Conclusions Regarding Sustainability

From the foregoing, it is reasonable to conclude that in PSFP II, organizations will continue FP services after direct subproject assistance ends, but some will require

additional inputs to maintain the levels of service delivery achieved during assistance and will have to generate additional funding to become fully self-sufficient financially, i.e., no longer require PSFP II inputs to retain and maintain levels of FP services. (Seeking other donor sources for the required additional inputs is not discussed here, nor is cost recovery, which is discussed in the referenced study on sustainability and in the Economic Analysis).

B. MAJOR CONSTRAINTS TO SUSTAINABILITY AND RESPONSE OF PROJECT DESIGN

As noted, many "graduated" subprojects continued to call upon PSFP I for assistance with contraceptive logistics, IEC and training. Although management of almost all graduated entities assumed responsibility for the most expensive component of recurrent costs (personnel, estimated to account for 59 percent of these costs), the Project Design team considered the possibility that inadequate initial commitment of management might be responsible for some part of the continuing requests for PSFP I assistance. The Project Paper reflects the project intent to address this possibility by making increased efforts to secure early and continuing management commitment, which it will do through educational efforts on the part of the Implementing Organization, monitored by USAID, and special studies to quantify, document and disseminate the economic costs and benefits of FP. While these efforts may help, it is likely that other more important factors underlie requests for assistance in each of these three areas, and each shall be examined separately.

1. Contraceptive Logistics

Project contraceptives are supplied without charge by the MOH through its contraceptive logistics system. The system was established as a "pull" or indent system under which clinics (public or private) delivering family planning services and designated as Service Delivery Points (SDPs) are authorized to draw required stocks from central and district level warehouses. One of the requirements to qualify for SDP designation is that clinic personnel delivering FP services have received MOH-approved FP/MCH training. This training was provided in PSFP I. However, because of existing deficiencies in the contraceptive logistics system which resulted in frequent shortages of contraceptives at the warehouses, project staff were required to help each assisted facility to process its application for SDP designation. This situation resulted in an intermediary role being established whereby PSFP I represented the SDPs (except for CHAK and a few private

firms), secured MOH contraceptives on their behalf from the central warehouse, and distributed them to the facilities. The subprojects, not PSFP I, reported through the Logistics Management Information System. The system worked quite well, but problems arose as subprojects graduated without being weaned from this parallel supply system, either because district level warehouse shortages continued, administrative mechanisms did not work well, or simply because it was more convenient for the subgrantee to continue depending on PSFP I assistance.

Reportedly, both contraceptive supply and the logistics system have markedly improved in recent years, in large part because of USAID provision of logistics technical assistance provided through a "buy-in" to the central Family Planning Logistics Management Project. Subsequent implementation of a contraceptive logistics management information system (LMIS) has also improved the situation.

Helping to ensure adequate provision of contraceptives to the subprojects through the MOH supply system is key to the project. Therefore, the project design requires the Implementing Organization to develop a plan to gradually enable all subproject entities to obtain contraceptives directly from the MOH without PSFP II assistance. The design also requires the IO's team to include a Commodities and Logistics Specialist whose major task, in conjunction with FPLM and the MOH, will be to help subprojects establish this link with the MOH. It is expected, however, that this transition will occur gradually as the performance of the MOH system improves. In the meantime PSFP will continue to be responsible for ensuring distribution of contraceptive supplies, obtained from the MOH, to their subproject sites.

An alternative approach of the project developing an independent contraceptive supply system was not seriously considered, because of host country sensitivities and because it would build in a non-sustainable, expensive intervention. Depending indefinitely on a parallel distribution system maintained by the IO similarly was deemed unacceptable and duplicative. The conclusion of this analysis is that the issue of contraceptive logistics was given full consideration during project design.

2. Support for IEC Outreach

The previously cited sustainability study positively correlated numbers of field educators and amount of funds spent on IEC to visit volume, the most clear and important predictor of cost effectiveness of subproject activities.

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It also indicated that PSFP I core funding tended to support IEC activities and field education functions and that without this funding, subprojects tended not to do so. It concluded that these areas should receive appropriate emphasis in subproject design. Finally, the study suggested: "It may be appropriate to target subsidies in the form of a supplemental grant program specifically supporting activities which the subprojects would propose within the parameters of IEC and outreach." (A similar suggestion for supplemental IEC grants was made in the final evaluation).

The project design responds to these concerns by including an IEC component, (training, technical assistance and time limited provision of operating expenses for outreach activities), in the "basic" assistance to subprojects. It also has provided for enhanced IEC assistance to 30 subprojects for additional technical assistance and outreach activities. Finally, it provides for supplemental grants to 15 PSFP I grantees wishing to add discrete components, which could be IEC, to their programs.

It is not clear why subproject management is willing, at relatively high cost, to continue to employ Field Educators, which most of them do, yet curtails their effectiveness by not funding continuation of relatively inexpensive field activities. Because of decreased operating funds after grant expiration, the Field Educators tend to constrict activities closer to the clinic. This might be because management is insufficiently aware of the programmatic contributions of the Field Educators, or it may be that clinical personnel, who supervise the FEs, are unaware. The additional IEC support (mentioned above) is a project design response to provide greater opportunity to educate both management and clinical personnel on the need of continuing IEC support. Inclusion of an IEC Specialist on the project assistance team should help focus on the problem. Finally, operations research on the impact of specific interventions, including IEC, and on developing alternative cost-effective mechanisms to continue outreach and other IEC activities should help answer this question.

3. Clinical Training

The medical services of the MOH and the larger private entities are supervised by physicians, but the majority of patient services in these clinics (and in clinics without physicians) are delivered by enrolled community nurses (ECN), Kenyan Registered Nurses (KRN), Clinical Officers (CO) and dressers.

Over the past 20 years, a variety of nursing categories have been developed¹, but will here be described in three categories. The largest category is the Enrolled Community Nurse (ECN) or its equivalent, previously with 10 and moving now towards 12 years of primary and secondary education followed by three years of training at the Medical Training College (MTC). The MTC is a parastatal organization linked to the MOH which trains all health delivery personnel in Kenya except for physicians and some categories of nurses trained in universities. The middle tier is the Kenyan Registered Nurse (KRN), a high school graduate but sometimes with one-two years of university, who also receives three years of training at the MTC, separate from the ECN and with more academic and administrative content. Both categories receive basic nursing training, public health and community nursing. The apex is represented by the university graduate (there are few of these), who holds the Diploma in Advanced Nursing (DAN). She corresponds in many respects to the Nurse Practitioner found elsewhere. She often finds her way into academia and administration, and rarely delivers significant clinical services except in the private sector as an independent practitioner/proprietress of a nursing or maternity home.

Clinical Officers are males, who after 12 years of basic education pursue a three year course at the MTC similar to undergraduate medical school. Upon graduation, COs function as do Physician Assistants elsewhere, and often maintain a private practice. In both public and private sectors, they are used heavily in administrative and supervisory roles.

Although all these categories have had rather intensive training, they are not considered by the MOH to be qualified to deliver family planning and MCH services until they have completed an MOH-approved "in-service" training course. Over the years, the duration has been modified from twelve to nine weeks, and since 1987, to the current seven-week course.

Personnel for the public sector are trained in MCH and FP in 11 Decentralized Training Centres (DTCs). The course currently consists of three weeks of didactic training, and

¹ These include the Kenya Enrolled Midwife (KEM), KEM/Health Visitor, KE Community Nurse, KE Nurse/Midwife, KE Midwife, Kenya Registered Community Health Nurse (KRCHN), and KR Nurse/Midwife.

four weeks of supervised practical experience. Until the PSFP I project was initiated, there was no MOH-approved training program available for private sector personnel. NGOs, private clinics and others wishing to provide FP services hired personnel who had received MOH training. In preparation for PSFP I, the African Medical and Research Foundation (AMREF) established a program which in all regards, (entrance requirements, content, format and curriculum), was considered to replicate that of the MOH. The MOH subsequently has certified graduates of the AMREF program as qualified to deliver FP services. Supported by PSFP I funds, AMREF in 1986 participated in an MOH review which modified the common curriculum and condensed it to the current seven weeks. A resulting document, MCH/FP Curriculum for Nurses and Clinical Officers has been used extensively since then. (Note: rather than a curriculum, the document is a course outline). As the only non-MOH FP/MCH training program accredited by the MOH AMREF provided all clinical training funded by PSFP I.

Currently, due to the large backlog of personnel in both the public and private sector who need such training, the MOH is prepared to authorize other qualified institutions to provide this training. Several local organizations have the requisite staff and ready access to adequate clinical facilities, and have indicated interest.

The three weeks of classroom instruction of both the MOH and AMREF course include:

- Communications in FP/MCH, including adult learning and techniques of interviewing and counseling;
- Population and national development in Kenya;
- Anatomy and physiology of the male and female reproductive systems applied to family planning practice;
- Family life education, human sexuality and adolescent fertility;
- Techniques of interviewing and counseling;
- Patient assessment, including history taking and general physical exam, with emphasis on breast and pelvic exams;
- Contraceptive techniques and practices. Includes effectiveness, indications and contraindications, side effects and their management, and counseling for orals, injectables, the implant, IUDs, diaphragms, condoms,

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jellies, VSC, natural and traditional methods.

-Conditions associated with the male and female reproductive system, including sexually transmitted diseases (e.g., AIDS/HIV) and cancer;

-Infertility and its management;

-Clinic management, including principles and policies of the MOH, application of management principles, planning, implementation and evaluation of activities within the scope of practice, sterilization of FP equipment and record keeping;

-Primary health care and the provision of selected services related to child health; child growth and development, immunization, breastfeeding and oral rehydration therapy.

The four weeks of practical training have the objectives of providing each student with supervised practical experience with:

-Insertion of 10 IUDs; 5 check-up visits; 2 removals;

-Five new clients for oral contraceptives; 10 re-visits of OC clients;

-Three new and 5 revisits for injectables;

-Three clients using foaming tablets;

-Three clients using condoms;

-Twenty-five pelvic and breast exams;

-Two pap smears;

-Two group teaching sessions;

-Forty-two hours in the record keeping section of the facility.

-Immunization (optional).

Following completion of the seven week course, students passing a final exam are certified by the MOH to deliver FP/MCH services.

The MOH training (not AMREF's, which is nearly identical) was evaluated in 1989-1990, and an excellent

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report was prepared (Evaluation of the Maternal, Child Health, and Family Planning In-Service Training Programme, Ministry of Health Division of Family Health. Nairobi, June, 1990). The evaluation notes that generally good quality training and reference documents were being used, but that the curriculum was not supported with adequate instructional materials. A most useful document for students and teachers alike is the "Blue Book," or Family Planning Procedures Manual for Health Workers, Division of Family Health, Nairobi 1988. The evaluation stated that "With the exception of reproductive anatomy and physiology, this manual contains all the basic technical information a student will need to know to provide family planning services." The evaluation report also states that "The 7 week course essentially covers the subjects normally appropriate for MCH/FP providers with an emphasis on the FP content. Additional attention needs to be given to counselling in new contraceptive technologies such as Norplant." It also comments that in the practical training, an inordinate amount of time and effort involves the logistics of matching students with sufficient patients to complete their allotted procedures.

Assessment:

The focused didactic and practical training provided in Kenya by the MOH and AMREF rates most favorably when compared to FP clinical training available to non-physicians in many, if not most, other developing countries. Unquestionably, the course could be improved by making it more competency based, eliminating or reducing course content of those elements which are extraneous to the day-to-day tasks performed by the practitioners and maximizing those which are. This requires rather formalized and continuing task analysis, and presupposes that the practitioners are homogeneous in their tasks, and therefore in their learning needs. Similarly, some flexibility in course content or emphasis might be desirable to accommodate differing consumer demands. The MOH's Training Committee and donors are currently reviewing the training course with the aim of introducing additional training techniques and streamlining it.

While the AMREF course is commonly described as a clone of the MOH course, there are some institutional and practical differences between the courses and the results of training. Selection of candidates is one difference. In the MOH, selection is made in the field, frequently by public health nurses, and the candidate may not necessarily return to a post where he/she will use his training. PSFP I

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candidates have been taken from and will return to private sector posts where FP service delivery will be a major responsibility. These students, therefore, may be more motivated. Another difference is that teaching posts within the MOH are not coveted or adequately rewarded; accordingly, "untrained" trainers are sometimes impressed into service, and turnover is high. AMREF has the resources to attract and retain qualified instructors. Additionally, it has easier access to sufficient quantities and a greater variety of training aids, audiovisual materials, and instructional materials and handouts to provide to students. Logistical arrangements for practical training are difficult for both the MOH and AMREF, but AMREF has access to human and financial assets needed to solve them.

For the private sector, the AMREF program is currently the only training source available for clinical training. There is a high degree of satisfaction with the technical level of the training and the clinical capacities of the graduates. The costs of this training for the predecessor project were high. The MOH training evaluation report estimated that the total direct cost for training one MCH/FP worker (regardless of rank, KRN, CO or ECN) was \$400 for the seven-week residential course, including training staff, materials and transport. The current AMREF charge to PSFP I is \$3,600 per student which is considered to be high.

Related to basic clinical training is refresher training for FP clinical service delivery. The MOH has designed a contraceptive update course, but it is not obligatory for continuing practice. In modified form this refresher course has been given by AMREF for PSFP I on an irregular basis. In project design, allowance has been made for one week refresher training for 500 personnel. About 350 of this number would be made up of personnel from PSFP I who have been in their practice sites for five or more years, and 150 from this project five years after receiving basic training. Some allowance would be made within these numbers to accommodate clinic personnel identified by project or subproject technical personnel who are felt to be technically weak. The IO will design the course, likely concentrating on selected modules from the basic course.

The conclusion of this portion of the analysis is that the basic clinical training proposed in this project not only is technically appropriate, but is required by the MOH. Currently, AMREF is the only officially-sanctioned source available for project-related clinical training, but other organizations, especially those experienced in family planning service delivery, are interested in developing this

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planning service delivery, are interested in developing this capacity. Refresher or update training will be necessary for clinical personnel to maintain clinical proficiency, and provision for that training has been considered in project design.

4. IEC Training

According to the 1989 Kenya Demographic and Health Survey (KDHS), half of all married women want to have no more children, and more than a quarter want to delay having another child for at least two years. Fewer than one in three married women, however, use any form of contraception and fewer than one in five use a modern method. Awareness of at least one method of contraception is high (about 90 percent), but little is known about the accuracy and completeness of that knowledge. There is some indication that knowledge may include incorrect and negative beliefs. For example, the KDHS found that only 22 percent of all women and 33 percent of women who practice natural family planning could correctly identify the fertile period. A conclusion from the foregoing is that there remains a need for motivational and educational activities within family planning service delivery programs, including PSFP II.

Building from experience in PSFP I, project design includes IEC related training at several levels. The Field Educator (FE) is the principal front-line IEC technician to bridge the gap between the clinic and the community served. In addition to informing potential groups of clients of the availability of services, he/she provides FP promotion and education and focuses on dispelling rumors and providing correct information about contraceptive methods to providers and clients. The Field Educator helps to establish volunteer IEC Committees for FP related activities, and in subprojects with enhanced IEC, CBD and MCH programs, participates in related IEC activities. Supervised by clinic personnel, the majority of activities are community based.

If agreed between the IO and the grantee organization, the grantee hires a full time employee for one or more FE positions, and agrees to continue employment after completion of grant activities. All candidates are to be literate in English (the language of training), and will be selected by the firms partly on the basis of interpersonal skills. Ideally, the candidate will be a user of family planning services. Some, but not all, will have had some training or experience related to health or social work.

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Training of these FE has been done successfully in PSFP I through project-developed two-week workshops, and the project design anticipates that the IO in PSFP II will develop a similar approach. The content of the workshop, which would be conducted by core and consultant staff, illustratively would include:

- Delineation of the roles, tasks and characteristics of a Field Educator;
- The population situation in Kenya and the national family planning program;
- Family planning concepts;
- Methods of family planning;
- Effective communication, identification of messages;
- Family welfare: home economics, environmental sanitation, maternal child health, nutrition, and adolescent fertility;
- Interpersonal communication, home visiting, group dynamics;
- Community needs surveys, community clients and community messages;
- Data collection; field work for community analysis;
- Counselling techniques, including role play;
- Community based distribution;
- Folk media concepts and techniques;
- Use of audio-visual materials;
- Practical instruction in media production, with later presentation;
- Record keeping and reporting;
- Cooperation and coordination with co-workers and agencies.

Periodic three-day, regional refresher workshops are planned on topics to be selected depending on need.

In projects with IEC Committees, the Field Educators will assist core IEC personnel in a 4-6 hour orientation of the committees.

The conclusion of this review is that the IEC training proposed in the project design is appropriate and sufficient for project needs, and that experience from PSFP I will provide an informational base for developing and implementing it.

C. OTHER TECHNICAL COMMENTS

1. New Technologies

There are no project inputs or outputs specifically intended to develop or introduce new technologies. As conceived, innovative activities involve variations in service delivery approach and operations research. It is probable that during the project period, contraceptive implant technology will be more widely incorporated into the national family planning program, possibly into some clinical sites assisted by this project. The basic clinical training course includes material on the implants, but this undoubtedly will be given greater emphasis prior to the MOH expanding coverage. Similarly, properly staffed project clinic sites which elect to utilize the technology will be required to follow established national and A.I.D. guidelines, restrictions and other conditions for implementation that evolve. The project and USAID will have a monitoring and reporting role similar to that in VSC.

2. Contraceptive Method Mix

In PSFP I there was no concerted effort to influence method mix in the subproject activities, a possible exception being making VSC more accessible in selected project sites. This approach to the issue of method mix is consistent with the principle of informed client choice in the context of a full range of methods. The MOH training approach similarly educates providers in all approved methods so that they may help clients select the safest, most effective and culturally acceptable method. Presuming PSFP I subproject personnel followed these precepts, each subproject in a large sense was demand driven by its clients concerning method mix. The same conditions of informed free choice also pertain generally throughout the national program, and it would be expected that method mix in PSFP I subprojects would be similar to the method mix nationally. Such is not the case.

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TABLE TA 3

Percentage of Users of Modern Methods of Contraception
by Method, All Married Women (KDHS) and PSFP I Subprojects , 1989

	All Married Women %	PSFP I %
Orals	29.0	19.3
Tubal Ligation	25.3	4.0
IUD	20.7	4.8
Injectables	18.4	18.4
Condoms	2.8	48.9
Foam	2.2 <u>a/</u>	4.3
Total	99.4 percent <u>b/</u>	99.7 percent <u>b/</u>

a/ Includes diaphragms, jellies

b/ Does not equal 100 percent because of rounding

Data sources: 1989 KDHS; PSFP figures derived from Final
PSFP Evaluation

The most striking difference in method mix reflected in Table TA 3 is the 17-fold difference in the percentage of users of condoms in the PSFP I subprojects compared to use of condoms reported by all currently married women in the 1989 KDHS. The comparison between the two groups is not precise because the figures used for PSFP I subprojects was derived from dividing computed Couple Years of Protection attributed to each method by an appropriate factor (100 in the case of condoms) to estimate numbers of users. Nonetheless, there is an apparent significant difference between condom usage in the two groups. Using serial project service statistics, it appears that condom use has increased sharply since 1987 concurrent with greater public concern with the AIDS virus, possibly indicating that IEC efforts have popularized the method. If this were the case, however, a parallel increase of condom off-take in the public sector would be expected, but this has not happened.

There is no way to know whether condoms delivered by PSFP I projects were used for contraception or for STD preventions, but there have been no reports of significant non sexually-related use, nor has it been suggested that there is diversion to outside of Kenya. Even if fully a half of the condoms were misused or diverted, there would still be an apparent eight-fold difference between the two groups.

It is possible that PSFP I subprojects dealing with a male-dominated workforce and the several male-oriented subprojects with universities were unusually successful in gaining male participation in family planning. There is no information on whether multiple sexual partners by condom users of PSFP I might account for part of the difference.

Provider bias is yet another possibility, but it is unlikely that the bias would exist widely enough throughout the subprojects to account for such a marked effect on method selection.

A final factor contributing to the difference is the wide distribution of condom dispensing machines throughout Kenya by the PSFP I project. The machines, manufactured in Kenya, are in great demand by resorts, hotels, universities and other locations, and dispense four free condoms at a time. The idea has been picked up by FPAK and the Marie Stopes clinic. The machines normally are distributed through subprojects, and stockage and resupply is managed by the subproject's Field Educators. Reporting to the LMIS and to PSFP I is through the subproject.

The intent of this discussion of method mix is to draw attention to the fact that PSFP I apparently delivered a significantly different method mix than did the national program, the reasons for which are not completely understood. Since any method of family planning is better than no method, there is nothing inherently wrong with this. If this apparent difference persists in PSFP II, however, operations research to explain the causes of this and other differentials might be a fruitful area for investigation. Only then would it be appropriate to consider programmatic efforts to encourage greater use of less costly and more effective methods.

D. SUMMARY CONCLUSIONS

Based upon review of project design in terms of the project purpose, identification of major constraints, design response to the constraints, and review of proposed technical assistance, the project appears technically feasible. In combination with other project inputs, technical assistance of the type and levels proposed by project design should be sufficient to help produce the project outputs which collectively should make achievement

of the project purpose probable. This assessment is strengthened by the fact that the experiences, evaluative studies and lessons learned from PSFP I were carefully considered and incorporated within the project design.

Annex C

ECONOMIC ANALYSIS

I. Overview

As with any development project, analyzing costs, comparing costs (cost effectiveness) and estimating benefits are difficult tasks. Annex C provides a review of the economic indicators of the PSFP project. The total costs of couple years of protection are calculated as are the births averted attributable to project activities. The costs and savings for births averted are subsequently estimated. The analysis briefly compares project costs to other family planning projects in Africa and other parts of the world. From a cost-effectiveness viewpoint, the PSFP project compares favorably with other projects in Africa and elsewhere. Savings are calculated for corporate institutions as an index of benefit-cost for the private sector. Total benefit is also calculated at the national level to estimate total savings attributable to project activities and discern future benefits from PSFP II. The analysis also discusses sustainability in economic terms by a cohort analysis of services delivered.

II. Cost-Effectiveness (Comparable Costs of CYP)

Estimated CYP costs of project-supported activities have been impressively low. As anticipated, all costs dropped drastically after the first year. Mean CYP costs by institution (between 1985 and 1990) ranged from \$5.21 to \$10.59 (education- and CBD-based PSFP I activities excluded due to lack of data). Average annual CYP costs for all institutions declined from \$23.23 in 1985 to \$1.75 in 1990 (Table 2 and Figure 2). (These costs do not include costs of contraceptives and only include PSFP I costs devoted to service delivery. The cost estimates exclude general project operation and technical assistance costs incurred by PSFP I.) If total cost per CYP (exclusive of contraceptives) is calculated, the average "project CYP cost" (through 9/90) is \$26.80 (\$7,104,300/264,859). This figure is comparable with CYP cost estimates from other parts of Africa (Senegal \$29.00, Niger \$21.90, [Barlow, 1988]; Ivory Coast \$67.00, Gambia \$25.00, Liberia \$25.00, S. Leone, \$157.00, Tanzania \$36.00, Uganda \$32.00, Zambia \$37.00 Zimbabwe \$12.50; [Ajayi/Pathfinder - personal communication]). It is noteworthy that the Pathfinder Fund's total cost/CYP for the Africa region is \$22.50. As with all cost estimates for FP programs, data should be taken with caution, especially when comparing cost between and among programs. However, within the PSFP I activity, it is promising that costs appear to be decreasing over time and general interest in FP is increasing within the public and private sectors.

III. Total Number of Births Averted

Assessments of cost effectiveness and cost-benefit rely on accurate reporting of service delivery, effectiveness of service delivery, and a reasonably accurate estimate of savings per birth averted. The estimate of the number of births averted is essential in assessing either the cost effectiveness or cost-benefit of a family planning program. Table 4 presents two estimates of total births averted for PSFP I (calculated as proportions of couples years of protection [CYP]). The first ratio (CYP/3) indicates good compliance with and use-effectiveness of contraceptives. The denominator of 3 represents the mean birth interval for non-contracepting couples in years. Thus, if a couple is making no deliberate effort to prevent births, then an average birth interval of three years over a whole range of parities would be expected. Therefore, providing three years of contraceptive protection, with reasonably high use-effectiveness, can be used as an estimate for preventing one birth. Total CYPs/3 can be used to estimate total births averted for project activities.

The second estimate is based on CYP/8 which implies very poor compliance and use-effectiveness by clients. This means that contraceptive supplies sufficient for 8 years of protection yield only one birth averted. Use-effectiveness is only one-third of the CYP/3 estimate. This is an extreme estimate and is shown only for contrast of project success. The more favorable CYP/3 ratio is our best judgement of use-effectiveness during the PSFP project and represents actual compliance in our opinion.

If it is assumed that during PSFP I relatively effective contraceptive protection was realized, then the total births averted over the life of project (LOP) of PSFP I is estimated to be 88,286 (264,859/3). If a poor experience was encountered, estimates of total births averted decreases to 33,107 (264,859/8) (Table 4).

IV. Total Project Cost of Births Averted

The total project cost of an averted birth over the LOP ranged from \$80.46 (\$7,104,300/88,296) to \$214.59 (\$7,104,300/33,107). These estimates are based on the total cost of the project over the seven year funding period. The numerator of \$7,104,300 represents disbursements made by USAID/K through October 1, 1990. This figure represents project costs inclusive of overhead and the cost of external technical assistance (but not cost of contraceptives). If one included only the direct costs of service delivery, the cost of a birth averted would be reduced significantly. For the purposes of this analysis the total project costs provide a "comprehensive" and more accurate estimate of the returns on the investments made. With either project performance estimate, the cost per unit of output is comparable to other FP programs within Kenya and in other

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countries (Huber & Harvey, 1989; Robinson, 1981). This is quite remarkable considering the fact that many of the studies of cost effectiveness include only service delivery costs and omit technical assistance, operating costs, and other expenses.

V. Savings Per Birth Averted for Private Sector Corporate Institutions

Table 4 and Figure 4 present estimates of corporate cost savings to companies for the births averted. The estimated savings of \$39 USD per birth averted per year (Table 5) is based on previous calculations by Savosnick (1986). Since the data were accrued in 1986, shilling estimates were prorated at a 15Ksh/1USD conversion rate. The \$39 savings estimate represents an unweighted average and could serve as a general, annual estimate of prospective cost savings to companies for each employee birth averted. Savosnick estimated corporate savings for skilled and unskilled female employees and wives of skilled and unskilled male employees. These calculations were based on company-related costs of a pregnancy. Costs estimates include delivery, maternity leave, infant and child care, absenteeism, and school costs. Discounted over a 10 year period, total savings ranged from \$200.00 (2990 Ksh) for wives of unskilled employees to \$670.00 (10,047 Ksh) for skilled female employees. (A 10 year period was used based on the rationale that the first 10 years of life represent the most burden in economic terms for the employees [parents] and the company. According to a \$39/year savings estimate, total savings for companies generated by PSFP I-assisted activities are estimated at \$3,443,167 (effective CYP) and 1,291,188 (less effective CYP) per year (Table 4).

Of the groups considered, Savosnick concluded that company savings from births averted by skilled female employees were greater than those from unskilled female employees and/or wives of unskilled employees. However, on a per capita basis, the larger labor force of the latter two groups represents a greater proportionate cost of births to unskilled labor. Therefore, if a weighted average of attributable savings was calculated, the mean savings of \$39 USD might be somewhat lower. Although the data presented in Table 5 and the savings estimates presented in Table 4 and Figure 4 should be viewed with caution, they can be used as a general index of individual savings country-wide which might be realized by workers and members of the general population.

VI. Cost-Benefit of PSFP I at the National Level

The cost-benefit of PSFP I can be estimated using the mean per capita consumption and prorating this over 20 years for various cohorts of the general population (Tables 6 and 7). The 1989 total annual consumption for Kenya (the sum of private sector and

public sector consumption) is estimated at 140,565,000,000 Ksh (GOK, 1989). Given a total population estimate for Kenya of 22.4 million persons, the mean per capita consumption is estimated at 6,275 Ksh annually (140,565/22.4). Table 6 presents estimates of per capita consumption in Kenya. At 1989 conversion rates (20Ksh/1USD) it is estimated that the average Kenyan consumes \$314 dollars annually. Private sector and GOK annual consumption estimates are \$241 and \$72 respectively. These estimates represent annual per capita consumptions (the respective outputs of individuals and the GOK less estimates of savings). (Note that this analysis did not attempt to estimate reductions in future production as a result of averted births. Per capita production prorated over a lifetime varies greatly and cannot be accurately estimated. As a result, production estimates, other than the savings estimates inherent in the consumption values, were not incorporated.)

Individual future consumption is the product of years of life and annual per capita consumption (the cohorts 0-14 years and 60-70 years have been assigned 50% consumption values due to their status in the society) (Robinson, 1981). The cohort consumption values are then summed and divided by 70 years of productive life to yield an annual average future consumption rate per capita. Table 6 presents estimates of per capita consumption for Kenya as a whole, with breakdowns of private and public sector future annual consumption estimates. These estimates are \$280, \$215 and \$64 respectively.

Table 7 illustrates the total cumulative consumption per capita, for the private sector (individual), and for the GOK (discounted at 15% over a 20 year period). (Discounting beyond 20 years is not considered to be meaningful because per capita consumption levels become insignificant.) Thus, it is estimated that, on average, a Kenyan citizen, (consuming in both the private and public sectors), will consume a discounted present value (DPV) of \$1,794 over a 20 year period. Respective private sector and public sector DPV consumption is estimated at \$1378 and \$417. These figures can be used as generalized savings estimates per birth averted for Kenya as a nation, for Kenya's private citizens, and for the GOK.

Tables 8-10 provide a compendium of PSFP I project cost/savings estimates and also present estimates of benefit/cost ratios annually. Annual estimates of births averted are derived from data presented in Table 4 (for effective and less effective CYPs). The benefit per birth averted of \$1,764 (Table 8), \$1378 (Table 9), and \$417 (Table 10) represent the calculated benefit stream per birth averted from Table 7. The DPV of project benefit as a whole is the product of the births averted and estimated benefit per birth averted. The benefit-cost ratio is the dividend of the total, annual DPV project benefit and the annual project expenditure (cost) (Tables 8-10). (Annual costs

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were derived from the financial records of the USAID/K Population/Health Office.)

Table 9 should be used as the guide to the benefit/cost ratio of the PSFP I project because it presents a benefit estimate for private sector consumption (excluding the GOK investment). As Table 9 illustrates, if figures for low CYP efficacy are used (1 birth averted = CYP/8), the total benefit from births averted is estimated to be \$45,621,446. The benefit/cost ratio remains positive throughout the project period ranging from 1.77 in 1985 to 9.38 in 1989 with an unweighted mean of 6.42. If a more satisfactory CYP ratio is used (1 birth averted = CYP/3), the total estimated benefit of PSFP I is \$121,658,108. The respective range is 4.73 (1985) to 25.01 (1989) with an unweighted mean of 17.12. Even if births averted were calculated to be half of those estimated in the less favorable compliance/efficacy scenario (i.e. 1 birth averted = CYP/16), the benefit/cost ratios would be above 1.00 for each year of the project with the exception of 1985. It is also impressive to note that throughout the PSFP I project period, even for the total public sector (GOK) benefits attributable to births averted (Table 10), the benefit cost ratio has been above 1.00 (with the exception of 1985), and has increased generally as time progressed.

Based on the assumptions for births averted and per capita consumption, it is clear that the PSFP I project has demonstrated an impressive benefit/cost ratio throughout the LOP. Thus, if use-effectiveness, contraceptive availability, and levels of contraceptive usage continue at comparable levels under PSFP II, it can be stated with confidence that cost-effective and economically sound FP services will continue to be provided to the private sector in Kenya.

VII. Anticipated Impact of PSFP II at the National Level

Table 11 represents a projection of anticipated PSFP II accomplishments under the assumption that PSFP II will perform at least as well as PSFP I. The table presents estimates of growth rate and birth rate declines over the eight year period 1991-1998, with and without family planning in Kenya. In 1990 a birthrate of 44/1000 is presumed with a presumed decline of 0.07% each year, (primarily attributable to nationwide FP activities) (DHS, 1989). Estimated births with and without FP are the product of the present population with and without FP and the birth rate with and without family planning. The estimates of births averted are the differences between the estimates of births with and without family planning. The number of births averted by the PSFP II project is the product of the estimated births averted and 0.13 (the estimated proportionate contribution to CYP [i.e. family planning activities] by PSFP I). Table 11 shows that 9,358,200 births will occur from 1991 to 1998, even

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with continued progress in family planning practices. Although the national population growth rate will decline to 3.04% and the birth rate will decrease from 44/1000 to 38.4/1000, annual births will increase steadily from 1,121,000 in 1991 to 1,230,000 in 1998 due to the increased number of women of reproductive age. Without family planning (i.e., a constant growth rate of 3.6% and a birth rate of 44/1000), 10,134,610 babies will be born. Table 11 indicates that family planning in Kenya will avert an estimated 776,410 births between 1991 and 1998 (10,134,610 - 9,358,200). Of these, it is estimated that 100,930 (776,410 x 0.13) could be averted by PSFP II activities. If averted-consumption values attributed to PSFP I for individuals, (i.e., \$1378/birth averted-see Table 9), are applied to the projected estimate of births averted at the national scale, it is estimated that the potential savings realized by PSFP II would be \$139,067,760 (Table 12). This would present a benefit/cost ratio of 13.9 (\$139,067,760/\$10,000,000). Thus, if PSFP II performs as well as PSFP I in generating use of family planning services, there is little doubt that the effort will be cost beneficial in terms of the private sector and the general economic health of Kenya.

VIII. Social Benefit Perceived by PSFP-Assisted Organizations

Cost-effectiveness and cost-benefit analyses are tools for assessing the benefits of specific development activities. Family planning projects/programs are generally assessed in terms of cost per CYP and benefits related to reduced fertility and births averted. Broad assumptions about costing, savings and estimated achievements (CYP & births averted) limit the tangible evidence specifically derived from a particular investment. The PSFP I project is no exception. However, anecdotal evidence does exist which indicates that FP services are valued by the private sector and are perceived to contribute to productivity and overall corporate savings. Anecdotal evidence accrued from PSFP I-supported organizations is presented below.

- o **Sulmac Flowers** - A reduced number of maternity cases was observed with concomitant reduction in costs (see below).
- o **Kenya Cashews** - A reduction of septic abortions was reported in the large number of unmarried, female shellers. An improvement in treatment of cases was observed. A reduction in drug expenditures and absenteeism was perceived by company officials.
- o **Teacher Training Colleges** - Two TTCs had no expulsions due to pregnancies in the second year of the PSFP assistance.
- o **Delmonte (Kenya Cannery)** - Delmonte officials perceived that a general reduction of illness, absenteeism and

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therapeutic drug use was linked to FP activities provided by PSFP.

o **Kamosi Tea, Nzoia Sugar, Elgeyo Saw Mills, Pan African Paper** - There has been an increased demand for FP services from surrounding communities as PSFP project activities progressed. (Problem: Once PSFP assistance ended, community demands could not be met.)

o **Brooke Bond, Portland Cement** - Workers bring their wives from rural areas for FP services. This serves to improve company-employee relationships.

o **General Impressions** - Some firms observed greater involvement of dependents in promotion of health and FP activities through dramas, song and dance. Company visibility/respect improved in the eyes of workers and residents in environs. Community participation in FP promotion has been observed in Sulmac, Machakos Medical Clinic, Malindi Nursing Home, and BB Mabroukie. This is presumed to have had a significant impact on levels of contraceptive use. CBD has reduced embarrassment of men in asking for condoms, with an implied reduction of STDs and possibly HIV transmission. FP services on site saved time and money for the company in terms of absenteeism and productivity and, reduced congestion at nearby clinics. There has been a perception of improved child health in company clinics since FP services have been offered.

Figure 5 presents annual summaries of monthly data from Sulmac Farm, Naivasha, Kenya. The data indicate a strong inverse relationship between the number of new clients and number of deliveries. PSFP assistance ceased in 1986. However, it appears that delivery levels stabilized at a lower level than 1984 and that the much higher rate of new clients (established in 1986) was maintained. Average births per year declined from 32 in 1984 to 13 in 1990 (a 59% decrease); with a six-fold increase in new users realized between 1984 (10) and 1990 (62). Sulmac Farm supports an estimated 20,000 Kenyans and provides MCH/FP services to its employees and the contiguous community. A standard contraceptive mix is available and those desiring VSC are referred to Naivasha Hospital. An increased number of health care providers have been trained in FP and field educators visit families in the camps to promote and explain FP services. Sulmac Flowers is a demonstrable success story for FP promotion, corporate involvement and sustainability.

IX. Sustainability

Sustainability is an important pillar of A.I.D. development policy. Implicit in sustainable investments is a demonstrated capacity for sound management (administrative, technical,

logistic), a declining dependence on external support, popular demand, user-effectiveness and availability of required commodities. Furthermore, sustainability can only be assessed over a continuum. Often it is difficult to assess "sustainability" because after one donor's support for an investment expires, external support is often generated from another source to fill the gap. Thus, in most LDC FP projects, it is difficult to identify a truly self-supportive institution which functions effectively and demonstrates growth in, and quality of, service delivery.

Table 13 and Figure 6 present an estimate of sustainability based on levels of CYP. The levels correspond to the inception, conduct and cessation of PSFP I support. Twenty organizations were identified which had at least four years of CYP reporting. It is assumed that Year I represents the inception of FP activities. Years II and III represent ongoing PSFP support, (albeit in Year III, a decline in PSFP support can be presumed). Year IV is presumed to be the first year totally without PSFP support. The data indicate a clear pattern of activity. For each organization, a modest level in CYP is observed in Year I. This is followed by an impressive increase in Year II. In fact, the greatest increases in the utilization of FP services appear to occur in Year II of PSFP support. In Year III, with PSFP support on the wane, PSFP services appear to be maintained. Private sector organizations are the exception demonstrating a continued increase in service delivery in Year III. In Year IV, a decline is observed concomitant with the complete withdrawal of PSFP support. It is interesting to note that CYPs in Year V for private sector and parastatal organizations increase on average (10,637 to 11,034 and 1989 to 2341 respectively), but in Year VI appear to decline to levels below Year IV. (Table 13). Whether this represents a real trend or is an annual fluctuation remains to be seen.

If the impact of PSFP I is gauged in terms of "before and after" (Year I and Year IV) almost a six-fold increase in CYP is observed in the private companies. Similarly, approximately three-, eight- and thirty-two-fold increases are observed in parastatals (n=4), private clinics (n=4) and NGOs (n=1) respectively. Given the small sample sizes, proportionate increases should be viewed with caution. However, it appears clear that even when PSFP support is on the wane, and for at least a year after support fully ceases, private sector organizations continue to deliver FP services at a significantly higher rate than that which existed prior to PSFP I support. Clearly this is a positive index of sustainability. Although potentially ephemeral, and perhaps complicated by other sources of external support, the data contained in Table 13 and Figure 6 demonstrate that the potential for truly sustainable interventions exists in the Kenyan private sector.

If the elements of management, cost recovery, logistics and supply are improved in a FP service delivery system, it is believed that a greater opportunity for prolonged sustainability will be realized. Thus, in addition to the aim of broadened private sector service delivery, PSFP II will emphasize the above-mentioned components of sustainability in an effort to encourage corporate commitment; maintain the supply of a good method mix; assure reasonable compliance; and increase indigenous cost recovery.

X. Summary

The economic analysis, coupled with the estimate of potential demand (Inserra, 1990), and the evidence presented above demonstrate that an economic, perceived and quantifiable benefit is associated with FP activities in Kenya. Thus, there is every reason to believe that the PSFP II project will continue to provide a valuable and appreciated service to private sector organizations in Kenya.

SOCIAL SOUNDNESS ANALYSIS

I. DEMOGRAPHIC/FERTILITY SITUATION IN KENYA

A. Trends in the Demographic Situation

Kenya currently has a population of approximately 24.6 million people with a growth rate of 3.6 percent a year. This means that the population of Kenya will double by the year 2008. (Population Reference Bureau, 1990). Kenya is clearly a country with serious demographic problems. A stable government and a good economic environment based on agriculture exports and tourism have to some degree isolated the people of Kenya from the consequences of their high growth rate. However, this situation cannot continue. Shortages of arable land, increases in rural landlessness, urban unemployment, and slow downs in economic growth will all precipitate serious social consequences for Kenya over the next twenty years. However, it is clear that Kenya is undergoing a demographic transition. This transition will have both positive and negative impacts on the social climate of Kenya. Fertility, the major driving force in demographic change in Kenya, will be discussed separately in a later section. However there are a number of other demographic factors which will play an important role in demographic change in Kenya.

Migration has not been a major factor in determining the population size of Kenya. However, as economic and political stability are reached in Uganda and Tanzania, both political and economic refugees can be expected to leave Kenya. On the other hand, the deteriorating political situations in Somalia, Ethiopia and Sudan suggest that Kenyan support of refugees will not come to an end at any time in the immediate future. Internal migration is following the path traditionally set by developing countries of rural to urban migration. The growth of mid size and large cities has been quite substantial and can be expected to increase as educational levels go up and the desire to participate in the formal economy increases.

There is considerable evidence of declines in mortality which, unless compensated for by declines in fertility,

could result in even higher annual growth rates for Kenya. Currently infant mortality is about 60 per 1000 live births, a relatively good rate for an African country. About 80% of mothers are receiving antenatal care and 50% of births are attended by a trained medical person. Recent successes in the national immunization program have resulted in very high levels of immunization, with 73% of children between the ages of 1 and 2 years having received all of the major vaccinations. The result of these successes in reducing infant and child mortality would be a short term effect on the rate of population growth. In the long run parents will realize that is necessary to limit fertility because of the high levels of survivalship their children would experience. (DHS Summary, 1990).

There are other demographic changes which deserve brief mention. The DHS found that the proportion of women who had never married had increased since the Kenya Fertility Survey of 1977/8. Likewise, the age of marriage has shown some increase. For example, the mean age of marriage among women 40-44 was 17.3 years, while for women aged 20-24 the current mean age of marriage was 19.8 years. Likewise the age of marriage is currently higher for urban women than for rural women, suggesting that this trend will continue. Changes in marriage patterns could heavily influence future fertility. (DHS, 1989).

B. Trends in Fertility

The recent DHS survey clearly shows that fertility has experienced its first substantial declines in Kenya. The total fertility rate (TFR) declined from 8 children in the late 70s to about 6.7 in 1989. While fertility is still high in Kenya, the decline of one child in about 5 years represents a major drop in fertility. Reaffirming the declines in fertility, the DHS also reported that the percentage of all women who are currently pregnant declined from 13% in 1977 to 11% in 1984, and was 8.9% during the 1989 survey, (DHS 1989).

Other indicators of changes in fertility practices are the changes in desired family size and desire for additional children. The DHS found that in 1989 the stated ideal number of children was 4.4 as compared to 5.8 only 5 years earlier. Because the actual number of living children influences the ideal family size, couples just starting their families have even lower ideal family size norms than the average suggests, (model response of three children). This would

indicate that the recent fertility declines will continue for the foreseeable future, as younger women attempt to achieve their desired family size. There is some geographic variation in desired family size which could be expected to influence future levels of fertility decline. Both Coast and Western Provinces have considerably higher desired family size and can be expected to show small declines in fertility unless major interventions in these areas are undertaken.

The declines in fertility are further supported by the data from the DHS on unwanted fertility. For women having a baby in the year before the survey, 42% indicated that while they wanted the pregnancy they would not have had it at that time. Another 11% indicated that they did not want the pregnancy at all. The survey also found that 49% of all Kenyan women covered in the survey indicated that they wanted no more children. More than half of all Kenyan women are at risk of unwanted pregnancy. One unwelcome consequence of unwanted pregnancy is the use of abortion. There is a growing body of data to suggest that Kenyan women are using abortion to limit family size even though it is illegal in Kenya, (Harbison 1990).

The declines in the fertility which were previously discussed are generally accepted in Kenya because of concomitant changes in marriage patterns, increased availability of comprehensive health services, dramatically declining infant mortality rates, and substantial increases in the use of contraception. The DHS found that 27% of all currently married women were using contraception. This represents a 50% increase over the rates observed in 1984 (17%) and almost four times the rate observed in 1977/78 (7%). The use of modern methods have doubled since 1984, from 9 to 18% among currently married women. While the pattern of contraceptive use is most reassuring to family planning service providers in Kenya it also strongly indicates that traditional resistance to fertility controls are falling and that there will continue to be a major opportunities to influence the demographic future of Kenya by family planning programs. The use of traditional and less effective methods by 9% of all currently married women represents a significant target for the program. Also the high levels of contraceptive use are still substantially below the reported percent of women who want no additional children (50%), suggesting a considerable amount of unmet need for family planning services.

C. Social Context for Family Planning in Kenya

In considering any large scale family planning program one must take account of the social situation currently prevalent in the country. The social context determines not only the current level of acceptability, (which has already been established for PSFP I), but the likely future demand for services. Described below are some of the current social issues which are likely to have an impact on the demand for PSFP and other family planning services.

Kenya is experiencing a gradual improvement in the status of women. The increased availability of public education has raised educational levels of women. Also the breakdown of traditional familial roles of men and women has resulted in women taking on a larger share of household support and economic activities. A large number of income generating programs set up by the Government of Kenya and other non-governmental organizations have resulted in the entry of women, at fairly low levels, into the cash economy. As a result of these changes women appear to be more active in making fertility decisions and demanding contraceptive services. Frequently these decisions are made without regard for the husband's attitude or approval. (Keyonzo 1989). It is likely that women will continue to claim an increasing role in making household economic and family formation decisions. Inevitably the results of these changes will be continuing declines in fertility and increased demand for services to allow them to achieve their low desired family size.

Kenya is also experiencing changing perceptions of the economic value of children. As Kenyans move from subsistence agriculture to a cash economy, the real cost of child raising becomes readily apparent to the household. The high cost of child raising is further brought home by the fees for mandatory education that parents must pay. The cost of education is almost a universal response when parents are asked why they do not want additional children. In addition, the decline in subsistence agriculture and the need for child labor, linked with the increasing real cost of child bearing, strongly indicate that future families will make childbearing decisions based on economic resources and will demand contraceptive services to help meet their desired family size goals (Dumm 1990).

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The role of men in seeking family planning services or making family size decisions has generally been a negative factor in declining fertility and increased contraceptive use. However, there are some preliminary indications that men may be changing their attitudes towards family planning. DHS found that 95% of all men surveyed knew of at least one method of contraception. Almost 93% knew of a source for a method. When asked if they intended to use a method of contraception in the future, 42% of those not currently using one indicated that they would. A subnational survey carried in 1988 found that 88% of all men approved of family planning. (Inambao 1988). While changes are likely to be slow, it appears that family planning services will begin making gradual inroads into the male population over the next several years. Services geared towards men are likely to encounter increasing demand for a variety of reasons.

The tragic spread of AIDS in Africa can be expected to have a considerable impact on the demand for family planning services, especially those providing condoms. Service providers working in AIDS high risk areas already report substantial demand for condoms (Lewis, 1990). Even though the purpose of commodities consumed might be to prevent sexually transmitted diseases rather than to limit fertility, any use of contraception can be expected to have some impact on fertility and method acceptability, regardless of the intent of the users.

II. SOCIAL CULTURAL FEASIBILITY

A. Acceptance of PSFP Approach

The best indicator of the acceptability of the PSFP approach is past accomplishments. The number of sub-projects PSFP I has implemented and the number of requests for services that have been received clearly indicate that the non-government sectors have relatively few constraints to providing contraceptive services to employees or others. At the time of the final evaluation six large commercial firms, four parastatals, thirteen private maternity homes and five NGOs had applied for support to start family planning services. Additional requests had also been received from a number of organizations too small to justify PSFP technical input. A questionnaire sent out by PSFP on interest in provision of family planning services found 42 private organizations with clinics which were willing to add family planning services. Also, the

assistance offered to NGOs by the existing PSFP project, while substantial, is still small in comparison to the potential given the large number of NGOs available to collaborate with in Kenya. (Obungu, 1990).

In November 1990 USAID undertook a survey of private sector organizations to determine the potential universe of expansion for the PSFP project. This survey, which had a very high response rate due to telephone follow-up, identified 90 companies and private health facilities that met the basic criteria for a PSFP sub-project and could potentially be in need of assistance to add family planning services or upgrade current services. 55 of these 90 organizations expressed an interest in family planning, (although the study noted that the survey was probably not an adequate tool for accurately gauging interest in family planning on the part of management). The high level of potential demand suggest a high level of approval and need for PSFP services. However, even this level of potential demand understates the potential universe of sub-projects. For example, it does not include the 20 teacher training colleges and other educational institutions which might desire services for their student populations, and those clinics attached to various religious and NGO groups not currently providing a full range of family planning services. (Inserra, 1990).

Another issue to be considered in the acceptance of the PSFP approach is the response of the Government of Kenya. While it may be difficult to judge levels of approval based on direct comment from any government officials, there are numerous examples of government support for the provision of family planning services in the private sector. This support has been expressed in statements at meetings and by involvement in the advisory groups used by PSFP I. In addition, the Government's recent clearance of a totally private sector family planning social marketing project and a project for service provision by the private sector is a clear indication of support for the role of the private sector in family planning service provision.

B. Constraints to Use of PSFP Services

In considering potential constraints to utilization of PSFP services one of the most obvious factors would be cultural constraints. In Kenya, most cultural constraints to family planning apply to contraceptive use, and not service delivery approaches. The

attitudes of men, the desire for large families, and the low status of women all hinder family planning use. Where family planning use has been adopted there is no evidence of cultural constraints to specific types of service providers, including private sector sources and job site provision. DHS and other surveys have found that a major issue for couples is easy access to services rather than any cultural constraints. Private sector outlets might be one way of overcoming possible cultural objections to family planning use by making access to services convenient, private, and low cost (both in terms of opportunity and real costs).

It is expected that PSFP II might face some geographic constraints to its family planning service delivery. The major difficulty would probably be assuring service provision in rural areas. The fact that the project will work through private sector organizations and specifically focus on large scale employers suggests that most subprojects will be in or reasonably close to urban centers. Commercial agriculture/plantation subprojects located in rural areas will be an exception to the urban bias in subproject location. The NGO subprojects will be more widely dispersed and will ensure that more remote rural areas are targetted.

Even in urban areas, where family planning services are more available than in rural regions, there is considerable room for expansion of services through PSFP II. Lack of knowledge, overcrowding of facilities, and inadequate counselling all contribute to constraints experienced by urban residents seeking access to family planning services.

In terms of specific areas, it is likely that PSFP II will be very active in the urban and employment centers of the Central and Coastal Provinces, (based on the responses received in the Inserra Study). Central Province, and Nairobi specifically, represents an area of high growth, transient rural population, and considerable marital disequilibrium. Coastal Province represents a region of high fertility and traditional attitudes toward family size. Both of these are areas of substantial unmet need.

In sum, there is no indication that PSFP II will encounter major geographic constraints to its operation. The job site services will be located mainly in urban centers and some rural areas, while NGO-supported subprojects can be expected to be more widely dispersed.

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Religious constraints to private sector service delivery have not been significant to date. Religious objections focus primarily on the use of family planning and not service delivery approaches. The major focus for objections has been on family planning messages in the mass media, and the possibility of service provision to unmarried adolescents. By working with firms and special groups, and by serving in an intermediary role, it is unlikely that PSFP II will encounter any major religious constraints.

A consideration of micro-economic or individual cost constraints to the use of PSFP services could find no empirical or logical reason as to why services would not be used. Most of the services are subsidized, and the greater ease of access generally represents a savings in real cost to the client.

C. Role of IE&C in Future Project Successes

The PSFP II project will also include funding for a component to support information, education and communications (IE&C) activities. There might be some question as to how necessary this function is for the project. The issue is made more complicated by the variety of possible IE&C activities, but if the social soundness of some of the potential activities are examined individually, the overall rationale for inclusion in the project is sound.

The PSFP II project should put some effort into disseminating information on the project. The PSFP I project was criticized for its failure to adequately document the approaches, methodologies, outputs, and lessons learned from the implementation of sub-projects (Obungu, 1990). While this information is available internally, the lack of general access means that Kenyan firms not eligible for PSFP support, firms interested in developing their own projects, donors, and others interested in private sector family planning services outside Kenya have not been able to learn from the experiences of the PSFP I project. Dissemination of information on the process of delivering services in the private sector will be an important output of PSFP II.

Interpersonal communication skills were an important element of training in PSFP I and will continue to be important in PSFP II. The need for counselling skills, especially in a clinical setting, has been recognized by a number of projects in Kenya, because of inadequacies in formal medical training and social

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values which have not placed a high value on information flow and informed decision making. Increasing interpersonal communications skills will be beneficial to the service providers and the clients, and will remain as a viable output long after the project is finished.

PSFP II will also be required to use traditional approaches to providing information to motivate and inform clients and would-be clients. Several surveys have found that overall levels of family planning awareness are quite high in Kenya. However the quality of information, the quantity of misinformation, and the differentials in awareness between sub-populations clearly show a continuing need for IE&C activities. While USAID/Kenya has recently developed a large IE&C project, the materials are directed at the general population. PSFP II should have the ability and resources to coordinate with the IE&C project and develop materials for the specific audiences to be served - working men and women, employers, school populations, religious denominations, and small group members. The ability to use private sector channels of communication, to target information to more select populations, and to use private sector skills and approaches to develop materials will ensure that the IE&C component of PSFP II contributes to raising general levels of awareness of family planning in Kenya.

D. Unmet Needs and Future Demand for Private Sector Family Planning

The issues of future contraceptive demand and non-government service provision have been addressed at various points in this piece and in the Project Paper. However it might be useful to summarize the issues in one place.

The demand for contraceptives can only increase in Kenya.

- Desired family size is declining.
- Men are becoming more supportive of limiting family size and using contraceptives.
- The changing social status of women is giving them more influence on the decisions involved in controlling fertility.
- The improving economic opportunities for women are raising the opportunity costs for having children.

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- The real costs of child raising are increasing.
- There is an increased awareness of the benefits of spacing and an increased use of contraception to space births.
- Awareness of the risk of AIDS is increasing demand for condoms and allied services.
- The worldwide experience is that contraceptive demand increases as educational levels increase. Kenya is expanding the educational sector, illiteracy is declining, and couples are gaining greater access to modern channels of communication.
- The changing social situation in high fertility, rural areas of Kenya (characterized by landlessness, smaller land holdings, surplus labor, etc.) diminish the economic value of large families.
- Delayed age at marriage and other changes in marriage practices suggest that there will be concomitant changes in fertility.

The various social factors described above all suggest that fertility declines in Kenya will continue, the demand for contraceptives to control fertility will expand, and pressure on service providers to provide more and better services will increase.

If demand for contraceptive services increases substantially in Kenya, the Government's ability to meet demand will need to be assessed. The current family planning program is heavily subsidized by external donors. Demands on the Government's social services budget already far exceed current funding. As the budget gets stretched further it is likely that resources will go to more politically sensitive areas like health or education. The Government recognizes its inability to meet all the demands for social services and has taken very positive steps to privatize or reduce subsidies for family planning and health services. In this environment the PSFP project offers a timely and tested approach for non-government family planning service delivery. Increased availability, cost sharing, and the relatively greater efficiency found in the private sector indicate that much of the future expansion in service delivery will take place in the private sector.

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III. PSFP PROJECT BENEFICIARIES

A. Private Firms

In considering the beneficiaries of the project it is often difficult to quantify the benefits generated by any specific subprojects. PSFP I is no exception. However, it may be possible to consider some of the anecdotal and qualitative information which suggest the success of PSFP I in benefiting various elements of society within Kenya.

Among those groups that could be expected to benefit were the private firms providing services. The 1990 evaluation found that the managers of the various private firms involved in the project reported reduced absenteeism, savings in maternity benefits, increased employees' satisfaction, increased technical skills for staff trained by PSFP I and generally better employer - employee relationships. As noted in the economic analysis, it is logical to expect cost savings to the employer who provides maternity benefits to his workers or dependents, although little quantitative data exists. In an industry or organization that employs primarily women this saving could be very substantial.

The private firms will also benefit from the upgrading of staff skills envisioned in the PSFP II. For those firms or sites that already have clinics and staff, the staff will be trained in family planning, counselling, and clinic management. These skills will increase the number of services provided, as well as improve overall service quality. For those sites without a clinician, PSFP II will allow the firms to introduce a wide variety of health services with some confidence that the staff has at least some of the basic skills. The retraining component of PSFP II will allow the project to maintain contact with staff, correct any shortcomings in earlier training and introduce new materials when appropriate.

B. NGOs

The benefit an NGO gets from participating in the PSFP project can best be described as increased institutional viability. The traditional benefits to the private sector such as profit and productivity are not relevant to an NGO whose primary purpose is to do community development. However, NGOs do benefit from the increases public exposure which helps generate financial support and new members. The provision of valued services to the community increases their

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influence in other areas. Perhaps the most important benefit from the PSFP project the development of management systems structures to manage the family planning project, which then are applied to other projects and the management of the NGO.

C. Educational Institutions

The provision of family planning services by educational institution brings significant benefits to the clients who receive the services as well as some advantages for the institution. The institution saves limited resources that would be wasted by having students drop out due to accidental pregnancy. The ready availability of family planning services is a benefit to the entire institutional community.

D. Women

The project will provide many tangible benefits to women. Women will benefit from family planning services, from filling newly created administrative, management and health worker positions at various levels, and from receiving training under the project.

The relationship between the use of contraception and its benefits to women has been well established. For every couple year of protection generated by PSFP it can be assumed that there will be commensurate declines in maternal and infant mortality and morbidity, increases in economic opportunity, reductions in health risks to the family, and improvements in marital stability. These benefits will extend to women regardless of whether they gain access to family planning by visiting a health facility, or indirectly through their partners. The PSFP contributions to women's status become even more important when the women served do not have ready access to alternative sources of contraception.

In addition to improvements in the health and economic benefits to women derived from delaying or limiting pregnancies, the project will create a limited number of employment opportunities for women, specifically at subproject and Implementing Organization levels. Finally, women are expected to continue to be well represented among participants in project-sponsored, in-service family planning training that will enable them to improve their current job status and provide the job-related skills that may enhance their future employment opportunities. In PSFP I, the majority of the 1,200 clinicians and field educators that received

training were women. Evidence has been provided in assessments of community-based family planning projects that women CBDs have achieved enhanced status in the community, as well as increased self-confidence in their ability to share health-family planning information and deliver family planning commodities.

Experience from PSFP I indicates that constraints to women's participation in most aspects of the project are not overly significant and appear to be decreasing. Cultural norms regarding acceptance of family planning as a national priority and gender roles are changing rapidly. Desired family size is decreasing, men are changing their traditionally negative attitudes toward contraception, and women are gaining increased status through education, participation in the cash economy, and more active roles in household decision making, including fertility decisions. The general environment in Kenya today is supportive of increasing women's participation in decision making, as manifested by their greater participation in the political process from the national to the village level. Despite these improvements, the project design recognizes the need to support efforts that continue to inform local leaders, communities and key groups about family planning and motivate their support for the national program.

Consistent with A.I.D. guidance on women in development, PSFP II output status targets for persons trained and employed by the project will be disaggregated by gender. In addition, EOPs for cumulative new family planning acceptance will be disaggregated by gender. Data on couple years of protection by contraceptive method generated by the project will provide further documentation of the benefits to women of protection from unwanted pregnancies.

E. Men

Men can expect to derive the same benefits as their partners from participation in a PSFP project. In addition, taking an active role in the decision to use and the acquisition of contraceptives should result in greater participation of men in family decision making. The increased availability of condoms and the opportunity for education can also be expected to reduce the risk of contracting AIDS, (a benefit that obviously extends to women as well).

G. Government of Kenya

While it is true that any benefits that citizens receive are benefits to the government, PSFP II does offer some real benefits for the Government of Kenya. Desperately needed services will be provided. These services will cost the Government almost nothing. Private sector management of services takes pressure off the already overloaded government management structure. The private sector can generally operate more efficiently than the government. The cost-sharing elements of PSFP II can help break the widely held misconception that free family planning services are a right. This will ultimately make it easier to introduce cost sharing into government programs. Increasing the number of sources of family planning services will reduce the risks of political attacks inherent in government run programs. Decentralization of management and funding decreases the risk of policy, management or personnel changes influencing the availability of services at the national level. Increased use of contraception can limit the use of abortion and reduce the pressure on the health infrastructure.

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ADMINISTRATIVE/INSTITUTIONAL ANALYSIS

A. Introduction

Prior to deciding on the implementation mode for this project, several options regarding the approach to project implementation were carefully reviewed. Because of the focus of the project on the private sector, it was concluded that a private/non-profit organization would be best equipped to serve private firms, companies, private hospitals etc. A private/non-profit organization would also be able to provide the special expertise businesses or profit-making organizations may require, for example, in determining the cost-benefits of delivering FP services, or integrating FP services into an already functioning private clinic.

Therefore, the Mission decided not to incorporate this project into its broad bilateral project (Family Planning Services and Support) which is more focused on support to the public sector and selected NGOs rather than just on the private sector. Continuation of a separate bilateral project will assure the special focus on the private sector. The mode of implementation selected is designed to give the IO maximum flexibility for creativity and routine decision making within the framework of GOK rules and regulations while assuring that the GOK and USAID remains informed and participates in the planning process. Placing the project under direct GOK control might reduce project flexibility, limit project scope and jeopardize successful implementation. Furthermore, NCPD already has a very heavy workload and does not have the administrative capacity to manage an additional program of this magnitude. The Ministry of Health, is also unable to assume this management burden.

Close links with the GOK are important to the success of the project and to the overall national family planning program. Therefore, the project will operate under a Memorandum of Understanding with the GOK, endorsed by the Ministries of Finance, Health and Home Affairs. The Ministry of Home Affairs, National Council for Population and Development (NCPD) has established a Technical Advisory Committee (TAC) for overall guidance, project review and evaluation. The interaction of GOK entities with the project is discussed in C below.

In Kenya, there are a number of local family planning-related NGOs that have demonstrated technical capabilities to implement the project. Several of these organizations have directly benefitted from AID assistance in enhancing their managerial and institutional capacities to carry-out nationwide family planning and MCH efforts. A number of these NGOs have well-established track records in administering AID-financed grants. It is

USAID/Kenya's and the GOK's view that every effort should be made to maximize consideration for NGOs that can demonstrate a well-established, legal presence in Kenya, including the existence of a legally established Board of Directors, with a majority representation of Kenyan citizens, that will assume responsibility in-country for management, administration and oversight of the project.

This approach to project management will help to ensure project success and credibility within the GOK and private sector environment. It is also recognized that some Kenyan NGOs may wish to either establish or maintain a linkage to a U.S. NGO in order to augment their capacity in such areas as procurement, financial or administrative management. In this regard, the RTP for the CA will invite submissions from Kenyan and U.S. NGOs who wish to be considered as a joint venture application.

A Cooperative Agreement has been selected as the assistance instrument for this activity as opposed to a grant or contract because financing will be used to support the accomplishment of an A.I.D.-designed project and because substantial involvement is anticipated by USAID with the recipient during performance of the activity.

Direct management of the project by USAID O/PH was also considered and it was concluded that it would not be feasible for O/PH to manage over 50 new subprojects, plus provide technical assistance to 60 continuing projects. Having a cooperating agency responsible for project implementation significantly reduces the management burden to USAID.

B. USAID Management of the Project

The USAID Population and Health Office (O/PH) will assign one Population and Health Officer (PHO) to manage the project. Based on past experience, it is estimated that this will require 25% of his/her time. O/PH has had almost seven years experience managing the predecessor project PSFP I, and is a fully staffed office with three USDH PHO officers as well as two US PSCs, and four professional FSNs. O/PH is fully capable of providing the appropriate amount of technical backstopping and administrative support required by the project. The project will also require 25% of the time of a Kenyan PSC financial analyst. The USAID Projects Office will provide support for overall project management functions. The USAID Controller's Office will advise on financial matters and process financial documentation. Backstopping support in evaluation will be provided by the Mission's Evaluation Officer.

USAID will exercise substantial involvement in the administration of the cooperative agreement, through approval of subprojects, approval of consultants, review and approval of annual workplans, receipt of semi-annual progress and financial reports, and periodic visits to project sites. A close working relationship between USAID staff and the project team is envisaged.

C. The GOK's Management Role

The specific tasks of the TAC, NCPD and the DFH are described in the Project Management and Implementation Section III. The Technical Advisory Committee (TAC) was established in 1984. It is responsible for ongoing oversight of project activities from the technical, policy and coordination perspectives. It is mainly an advisory body that supervises and monitors PSFP project activities. To date, the TAC concept has worked well, and a close working relationship has been established between PSFP I staff and this body. To enable the TAC to focus its attention on important policy and program issues, TAC review and approach to most subprojects will occur in the context of the annual workplan. The subprojects considered to be innovative, high-risk, and/or requesting more than the basic assistance package will be considered separately. At the same time, the TAC will meet semi-annually or more often if necessary to review progress of the project and resolve any technical or policy issues that might arise. The Chairman of the TAC, who is also the Chairman of the NCPD, will appoint the members of the TAC and convene its semi-annual meetings. The broad membership of TAC, described in Section III, will ensure that the PSFP activities have the understanding and support of all concerned agencies of the GOK and the private sector.

The National Council for Population and Development (NCPD) was established in 1982, placed in the Office of the Vice-President. Its Secretariat was created with the mandate of formulating population policies and strategies and coordinating inter-sectoral and inter-agency population activities, including support to NGOs for communication activities. As an inter-agency coordinating council, the NCPD's role is to foster work of other agencies, rather than to undertake service delivery or assume a directive role. In this capacity, the NCPD will monitor and facilitate project implementation within the government system. Under its bilateral Family Planning Services and Support (PSFP) Project USAID provides assistance to NCPD to strengthen its technical and management capabilities in order to more effectively carry out its mandate. USAID's assistance has been in the areas of administration; policy, planning and evaluation; information, education and communication; and support for NGO CBFP services.

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The MOH is responsible for the quality of FP service delivery activities through certification of personnel and approval of training curricula, as well as maintenance of a constant supply of contraceptives to the national program.

Under its bilateral FPSS project, USAID has helped the MOH to improve its contraceptive logistics management through the establishment of the LMIS. As the MOH is responsible for the planning and procurement of contraceptive commodities for the national FP program, the DFH will provide contraceptives to the project subgrantees, either directly or through the IO. There will be close links between the project and the DFH with subprojects reporting regularly to the project headquarters, which in turn will report to the DFH/LMIS Unit. Ultimately, it is envisaged that most subprojects will draw commodities directly from MOH stores at the regional, provincial or district level.

The MOH will also certify the curriculum used for the training of clinical officers and nurses, to make sure it meets national certification standards.

D. The Implementing Organization

1. Technical Assistance/Personnel

The ability of the IO to manage the PSFP Project is obviously crucial to the ultimate success of the project. The successful applicant for the cooperative agreement will have to show that it can hire and deploy the types of long and short-term personnel required to meet project needs.

The 50 subprojects with 120 clinical sites to be established by this project will be labor-intensive in terms of subproject identification, design, implementation and monitoring requirements. To this management load is added monitoring and maintenance responsibilities for a portion of a similar number of subprojects and clinic sites from PSFP I. Additionally, implementation will require a combination of specific technical skills because of the nature of the project components. Consideration of these factors led to a design team conclusion that members of the IO's technical assistance team must be able to provide both management and technical support to the relevant subprojects, as well as assist in the identification, design and monitoring of subprojects.

Specific skills needed for successful project implementation include overall project management and administration; personnel management; financial management and accounting; subproject design, monitoring and evaluation; FP training;

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FP IEC; data management; contraceptive and supply logistics; operations research design, implementation and evaluation; and clinic management and medical oversight. Incorporated within the team must be awareness of A.I.D. policies, regulations, and mechanisms for audit and financial accountability; a comprehensive knowledge of Kenya and its national family planning program; and, experience working with private sector organizations.

The subprojects will be phased in over the life of the project, but the full IO team should be present from project onset. Monitoring of new subprojects will be relatively minimal initially, increasing as implementation progresses. In the early stages, a variety of technical skills will be needed for orientation and development of team process, and for input into development of procedures for subproject development, monitoring and evaluation; development of operating procedures and monitoring instruments; development of a workplan and training schedule; and other tasks associated with final adjustments to the team's strategy for implementation.

Although the IO will propose its team composition in its proposal to A.I.D., the design team estimated that eight professionals plus nine support staff will be required. Most of the team, including the Project Director, will be Kenyan nationals. However, one long-term expatriate position has been budgeted for. The team members and major responsibilities of each are as follows.

a. Project Director: Responsible for overall project management and implementation. Liaison between project and USAID and the GOK. Member of TAC. Should have at least five years experience managing large population projects with focus on the private sector/NGOs. Academic qualifications include at least a Master's level degree in public health, population or a related social science. It is anticipated that this person will be a Kenyan citizen.

b. Deputy Project Director: Responsible for daily management of the project. Focus on subproject design, and providing progress and financial reports to USAID. Can provide overall management technical assistance to projects. Schedules monitoring/TA visits by other staff. Should have at least five years experience in a position of responsibility on a population/FP project, preferably in Africa. Should have in-depth knowledge of management and financial systems.

c. Training Specialist: This will be a nurse or nurse-midwife with at least ten years experience designing, conducting and evaluating clinical training programs for non-physician personnel. The Training Specialist will review training curricula; monitor the training in all subprojects, monitor basic and refresher clinical training; assist the Communications Specialist with the IEC training; assist subprojects to select candidates; and conduct ongoing assessments of project training needs. Should have experience in direct service provision. Qualifications include Kenya Registered Nurse or registered nurse-midwife certification (or equivalent).

d. Communications Specialist: Develop and oversee implementation of project support for IEC; develop content and arrange/conduct basic and refresher training workshops for Field Educators; provide liaison with FPAK and others involved in IEC. Focus of this job will be on improving outreach, counseling and person-to-person communications rather than developing new types of IEC materials. Should have a Master's level degree in communications, education or a related social science. At least five years experience working on communications training, mass media or population education projects.

e. Management Information System and Logistics Specialist: Develop MIS systems for project and subproject management, including subproject data collection and reporting, and develop and monitor computerized systems for financial management and statistical reporting of service statistics. Keep track of contraceptive commodity inventories and needs, establish linkages with and act as liaison with LMIS, and assure that projects either obtain supplies directly from district medical stores or from PSFP II. Assure procurement and supply of equipment to project sites (including inventorying). Develop and assist with implementation of plan for subprojects independently to access MOH contraceptives. Qualifications include at least five years experience in data management, commodity procurement and computerization of management and/or logistics systems (for FP or health related commodities). Academic degree in social science with computer and statistical skills.

f. Clinical Specialist: Provides technical assistance to project and subproject personnel on contraceptive technology and clinic and client management; provides medical oversight for clinical and nonclinical methods; and assists Training Specialist with management of clinical training activities. This person is a resource on overall FP issues for the project. Qualifications include at least five years

experience providing clinical backstopping to family planning projects; and advanced training in contraceptive technology, including VSC. May be either a physician or registered nurse.

g. Research and Evaluation Specialist: Primarily responsible for setting up project monitoring systems, identifying operations research needs, planning research design, monitoring research and disseminating actionable research findings. Will be responsible for developing papers and convening workshops on issues arising out of project special or OR studies. Will develop appropriate reporting formats for subprojects, interpret and analyze MIS data (with the MIS/Logistics Specialist) and contribute qualitative and quantitative analyses dealing with project progress. Should have at least five years experience designing and implementing program evaluation systems in FP or health areas. At least Master's level degree in public health/evaluation, demography, economics or a related social science.

h. Financial Management Specialist/Accountant: Will establish project and subproject financial management mechanisms; develop tools for audit and subproject management; and provide cost-recovery assistance to subprojects. Will be in charge of overall accounting for the project as well as creating formats for financial reporting by subprojects and monitoring finances and expenditures. Will report on project finances, and submit standard voucher, liquidation and advance documentation to USAID. Qualifications include 3-5 years experience in serving as financial manager or chief accountant for an organization with commensurate funding levels as this project. Academic qualifications include bachelor's degree in business, management, commerce or finance, and chartered accountant or CPA certification.

The project design also allows for provision of additional short-term technical assistance for specialized areas such as health insurance, cost-recovery, preparation of publications, etc.

The IO is responsible for recruiting and backstopping of core personnel and short-term consultants and for assuring that all applicable A.I.D. and GOK rules and regulations are complied with.

2. Organizational capabilities.

a. USG Regulations

The IO will be required to demonstrate that it is familiar with U.S. Government regulations related to cooperative agreement and grant administration (Handbook 13), and procurement requirements (Handbook 11).

b. Previous project experience (Africa)

Previous project management experience with African development programs, governmental and non-governmental organizations, and with A.I.D., will be important criteria for selection. The IO will have to show that it has previous experience relevant to managing this type of private sector project and dealing with private firms, clinics, NGOs, private hospitals, etc. It will need to demonstrate that it is fully staffed and has the ability to administer this project, both technically and managerially.

c. Ability to establish administrative systems

The IO will be required to report extensively on service statistics (e.g. couple years of protection generated) and commodities distributed, according to the MOH Logistics Management Information System (LMIS). They will need to provide further analysis of these data, and develop systems and reporting formats for the financial and technical assistance provided, and numbers and types of personnel trained. Therefore, ability to set up a variety of computerized management information systems will be important. As part of overall project monitoring, the IO will have to establish a framework in order to account for and manage funds disbursed to subgrantees according to A.I.D. financial reporting requirements.

d. Training

Because such a wide variety of personnel require training, the ability to identify training needs, and revise or develop new curricula as well as follow up on trainees is essential.

E. The Subprojects

In selecting recipient subgrant organizations the IO will have to use a set of criteria described in the Project Description (Section II) to ensure that subgrantees have the institutional capability to carry out and maintain project functions. Included

in these criteria are the importance of already established services and staff within an existing facility; and the desire and commitment of the organization to deliver family planning services. The project will work closely with the subgrantees to maximize their ability to deliver FP services while minimizing problems of administration and management. For example, while many subgrantees (notably from PSFP I) do not presently obtain contraceptives from the MOH, the project will help subgrants to increasingly access MOH district medical stores directly. Subgrantees will be required to establish standard audit and book-keeping systems. However, it will be the responsibility of the IO to make sure funds are properly utilized and accounted for.

WP# ANNEXEJ

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POTENTIAL DEMAND FOR FAMILY PLANNING ASSISTANCE
IN THE PRIVATE SECTOR IN KENYA

Anne Inserra
Nairobi
December 8, 1990

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LIST OF ACRONYMS

AMREF	African Medical and Research Foundation
CBS	Central Bureau of Statistics
CHAK	Christian Health Association of Kenya
FPIA	Family Planning International Assistance
FPPS	Family Planning Private Sector
KIRDI	Kenya Industrial Research and Development Institute
MOH	Ministry of Health
NGO	Non-governmental organization
NHIF	National Hospital Insurance Fund
PSFP	Private Sector Family Planning
SDA	Seventh Day Adventists
USAID	United States Agency for International Development

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The author would like to thank the representatives of all of the organizations listed under Sources who offered assistance in the form of advice and information during the preparation of the needs assessment. Special appreciation is extended to staff of the Family Planning Private Sector Programme for their cooperation and assistance.

I. EXECUTIVE SUMMARY

The purpose of the survey was to assess the potential unmet demand for assistance for family planning services provision in the private sector in Kenya. The needs assessment was carried out to try to estimate the potential demand among organizations that have not yet been targeted for the type of assistance that has been offered under the Kenya Private Sector Family Planning (PSFP), or Family Planning Private Sector (FPPS) project. The current FPPS project has been very successful, and the needs assessment was conducted to determine if there is need for a follow-up project. The targets of the survey were the types of organizations that have been assisted under the existing project, and included parastatals and teacher training colleges in addition to private sector firms and health facilities.

Mailed questionnaires were used to survey potential demand among the largest private companies and parastatals, and among private health facilities in Kenya. Demand among colleges of education and clinics administered by several non-governmental organizations was assessed through research and informal interviews. Information from these sources was augmented with the results of a survey of demand among companies that was carried out by FPPS in 1988.

The results of the study indicate that there is substantial potential unmet demand for assistance in providing family planning services among these organizations in Kenya. According to the results of the present questionnaire survey, 36 companies and 46 private health facilities could potentially be in need of assistance of the type offered under the Family Planning Private Sector program. To this total of 82 organizations should be added eight companies that responded to the FPPS 1988 survey. The total number of organizations is thus 90. All of these organizations were judged to be potentially in need of and eligible for family planning assistance of the type offered in the current FPPS program. However, more detailed information would have to be gathered on these institutions in order to determine if they would actually be interested in receiving and would qualify for assistance. (55 of the 90 identified organizations indicated interest in receiving assistance to offer family planning services in their survey responses, but the interest and commitment of their management should be more accurately assessed through further investigation.)

Evidence from additional sources suggests that the list of organizations potentially in need of assistance could be expanded even more. The need of approximately 20 Teacher Training Colleges for family planning service provision for students is clearly documented in a separate study. There are approximately 80 health facilities sponsored by the Christian Health Association of Kenya, Crescent Medical Aid, and the Kenya Seventh Day Adventists Rural Health Services, that have not yet been assisted by FPPS and do not offer family planning. Some of the organizations targeted by the present questionnaire survey that have not responded might need assistance. Finally, there are additional large branches of companies already working with FPPS

that might need assistance, and FPPS has received direct requests for help from many companies and health facilities around the country. All of these organizations could potentially be targeted by assistance in a future family planning program, although the evidence is not clear cut enough to add them to the questionnaire survey information.

The success of the Family Planning Private Sector project as judged by the recent evaluation, and the evidence of significant potential unmet demand for family planning service provision in Kenya revealed by this study, suggest that there is great need to continue the type of assistance offered by the program. Ninety organizations have been identified that demonstrate potential need for assistance to provide family planning services to their employees or clients. Additional potential sources of demand suggest that there are at least as many organizations in need of assistance as have benefitted from the FPPS program to date.

II. INTRODUCTION

A. PURPOSE OF NEEDS ASSESSMENT

The purpose of the survey was to assess the potential unmet demand for assistance for family planning services provision in the private sector in Kenya. The needs assessment was conducted to try to estimate the potential unmet demand for the type of assistance in providing family planning services that has been offered under the Kenya Private Sector Family Planning (PSFP) Project. As the current project is scheduled to end in September 1991, USAID/Kenya determined that it was necessary to assess the need for a follow-on phase of the program. The target of the survey was large commercial firms and parastatals, private clinics, teacher training colleges, and health facilities run by selected non-governmental organizations (NGOs) in Kenya. The needs assessment was carried out from late September to early December 1990. The principal tool used with regard to companies and private clinics was a mailed questionnaire, followed up by telephone. Research and interviews were conducted to gather information on teacher training colleges and NGOs.

B. BACKGROUND

The Private Sector Family Planning Project, or Family Planning Private Sector (FPPS) program, has been operating since January 1984. The goal of the project has been to strengthen the ability of large firms, private clinics and non-governmental organizations in Kenya to provide family planning through existing health programs. The FPPS program has worked with already established health facilities in these institutions to introduce or expand family planning services. The project's success led to two amendments and extensions and greatly increased benchmarks for achievement. Since 1984, financial,

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logistical, and training assistance have been provided to 23 private companies, eight parastatals, 12 private nursing homes, three non-governmental organizations, four educational institutions, and two community based clinics. Through this total of 54 subprojects, 154 clinics have been helped to introduce or expand family planning services offered to employees and clients.

The Family Planning Private Sector Project is currently scheduled to terminate in September 1991. This needs assessment was undertaken in an attempt to determine if there is need for a follow-on program. The success of the project to date and receipt by FPPS of numerous requests for assistance suggest that there is justification for continuing the program. However, it was felt that a formal needs assessment should be conducted to try to estimate the potential demand for assistance in providing family planning services that exists among organizations that have not yet been targeted by the project.

The categories of organizations selected for inclusion in the study were based largely on the history of the Family Planning Private Sector program. (Note that although the FPPS program is directed toward the private sector, parastatals and government-run educational institutions have also been assisted.) The project has worked with private companies and parastatals that provide health services to relatively enclosed populations of employees, and sometimes to dependents and surrounding communities. Two universities and two teacher training colleges have been assisted under the program. These educational institutions also provide health services to relatively closed populations. Teacher training colleges were included in the study of future needs because they were earlier identified as holding special promise for expanding family planning services to students.

Private medical facilities have also been assisted under the FPPS program. They were included in the needs assessment because there is believed to be a great deal of demand for assistance among private clinics that have not yet been reached. Health facilities are likely to be capable of offering family planning, and probably more disposed than companies to offer it. Similarly, FPPS has worked with the Christian Health Association of Kenya (CHAK), Crescent Medical Aid, and the Kenya Seventh Day Adventists (SDA) Rural Health Services, three organizations that administer health clinics throughout the country. The needs assessment included these organizations because it was felt that there was potential to expand assistance to additional clinics managed by these NGOs. Health facilities differ from companies and educational institutions in that they provide services to clients that probably do not form enclosed populations. In any case, private clinics function within the mode of assistance offered by FPPS in basically the same way as companies.

III. METHODOLOGY

A mailed questionnaire was used to survey potential demand for assistance in family planning service provision among private companies, parastatals, and private health facilities. Potential demand for assistance among teacher training colleges and selected non-government organizations was assessed through research and interviews.

A. SURVEY

The survey of companies and private health facilities was based on a purposive sample. Accurate, current and complete lists of all private companies and health facilities in Kenya were not available, so it was not possible to determine the size of the universe of these organizations. The samples used in the survey for large private firms and health facilities might not be representative of the universe of these organizations in the country. For each category of organization, lists from several sources were used to identify target institutions.

1. Lists

a. Private Companies

The study was designed to target the largest companies in Kenya. The Central Bureau of Statistics (CBS), the Kenya National Chamber of Commerce, the Kenya Industrial Research and Development Institute (KIRDI), the Federation of Kenya Employers, the Kenya Association of Manufacturers, and other sources were contacted in an effort to obtain lists of firms. No single list was complete or accurate. In the end the primary source used was a master file of companies in Kenya maintained by the Central Bureau of Statistics. This was supplemented by information from the Kenya National Chamber of Commerce and from the KIRDI Directory of Industries (1987).

A total of 139 firms were identified that were listed in at least one of these three sources as having 500 or more employees. Twenty-three of these were eliminated because they had already worked with FPPS, (firms were eliminated from the sample even if only one branch of the company had been involved with FPPS). An additional ten firms were eliminated because they had responded to an earlier survey of demand conducted by FPPS in November 1988. The final sample included 106 companies with 500 or more employees.

b. Parastatals

The same sources mentioned above were contacted for lists of parastatals in Kenya. Ultimately the same three sources, the CBS master file, Kenya National Chamber of Commerce membership information, and the KIRDI directory, were used to identify a total of 36 parastatals that were listed in at least one source as having 500 or more employees. These firms were checked against a list of State Corporations maintained by the Inspectorate of State Corporations in the Office of the President. Ten of the 36 had already worked with FPPS and were eliminated from the sample. Two additional companies that had responded to the 1988 survey, and one that had made a direct request for assistance to FPPS were also eliminated. The final sample included 23 parastatals with 500 or more employees.

c. Private Health Facilities

Finding reliable lists of privately run health facilities in Kenya proved to be even more difficult than for companies. The Ministry of Health (MOH), National Hospital Insurance Fund (NHIF), Kenya Medical Association, Central Bureau of Statistics, USAID/Kenya, and the African Medical and Research Foundation (AMREF) were all contacted. The main source became the MOH list of registered medical facilities that was published in The Kenya Gazette of 27 January 1989. All facilities listed here as "Non-Government", "Private" or "Company" were identified. Information from the National Hospital Insurance Fund on private, declared NHIF health facilities was used to supplement the MOH list. (The information from NHIF came from an internal computer file and the schedule of declared hospitals under "The National Hospital Insurance Act" as published in The Kenya Gazette of 12 April, 1990.) A few additional facilities were identified from among the membership of the Kenya Medical Association. Information on the status of some of the health facilities, (private or other), differed between lists. Facilities were included in the sample if at least one source identified them as privately run.

After eliminating those that were obviously run by the government, religious organizations, or companies, a total of 125 private health facilities were identified from the three sources to make up the sample. Unfortunately, addresses could not be found for 43 of them. Of the remaining 82, eight had already worked with FPPS, and an additional five had made requests to FPPS for assistance. After eliminating these, the sample of private health facilities totaled only 69. It should be noted that because the source lists were especially outdated and incomplete, the sample might not be representative of the universe of private health facilities in Kenya.

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2. Questionnaires

One questionnaire was designed for private companies and parastatals, and another for health facilities, (see Appendices A and H). The questionnaires were mailed with a cover letter printed on FPPS stationery that explained the purpose of the survey. In an effort to increase the response rate to the questionnaire, an addressed, stamped return envelope was included. In addition, extensive telephone follow-up was undertaken, beginning approximately one week after the mailings. The consultant and a Kenyan university graduate spent approximately two and a half weeks doing telephone follow-up. An attempt was made to contact every organization on the mailing list at least one time, with the exception of those organizations for which it was impossible to obtain accurate telephone numbers. It was necessary to mail duplicate questionnaires to many of the organizations, since it often proved to be impossible to trace the originals. It was also necessary to contact most organizations multiple times, in order to try to locate the questionnaire within the institution. During the later stage of the follow-up, organizations were asked to respond to the questions over the telephone, in an attempt to receive the information in time for analysis.

Several caveats should be stated with regard to the survey methodology. As mentioned above, the absence of accurate lists of organizations made it impossible to determine the universe for private firms and health facilities in Kenya. (This was not as much of a problem for parastatals, since the list from the Inspectorate of State Corporations seems to be accurate.) In addition, there may be some bias in the responses, since it is possible that organizations would be more likely to respond if they had some interest in providing family planning services and/or receiving assistance to do so. The results of the survey may not indicate much about those organizations that did not respond, nor about those that were not included in the samples. Finally, telephone follow-up could only be provided to organizations for which working telephone numbers could be found. Thirteen private companies, one parastatal, and eight health facilities could not be contacted by telephone.

B. TEACHER TRAINING COLLEGES

The assessment of potential demand for assistance in providing family planning services among teacher training colleges in Kenya was based on research and interviews. The findings are taken almost entirely from Family Planning Needs in Colleges of Education: Report of a Study of 20 Colleges in Kenya, a report written by Alan Ferguson, Jane Gitonga and Daniel Kabira in November 1988.

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C. NON-GOVERNMENTAL ORGANIZATIONS

The study also examined the potential demand for assistance among additional health facilities managed by three associations in Kenya that have worked with the Family Planning Private Sector program. Informal interviews were held with staff at the Christian Health Association of Kenya, Crescent Medical Aid, and the Kenya Seventh Day Adventists Rural Health Services to determine the number of clinics not currently offering family planning that could potentially be in need of assistance. In addition, conversations were held with representatives of Pathfinder and Family Planning International Assistance (FPIA) on the subject of additional organizations that sponsor health facilities that might need assistance in order to provide family planning.

IV. FINDINGS

A. SURVEY

1. Private Companies

a. Questionnaire

The questionnaire that was sent to private companies and parastatals consisted of nine questions, (see Appendix A). It was deliberately designed to be brief in order to encourage people to respond. The information requested on the questionnaire included: the total number of employees, (broken down by males and females); whether or not the firm provides health services for staff, dependents and/or others; whether or not family planning services are available; and whether or not firms that do not provide family planning at present would be interested in doing so if resources were available.

b. Results

Appendix B contains an abbreviated version of the chart of the responses to the survey of private companies. The full chart is attached as Appendix C. It should be noted that the responses to the questionnaire revealed that the information gained from some of the questions was ambiguous. Some attempt was made to clarify items that were not clear during telephone follow-up. For these firms additional notes were written on the questionnaires. Unfortunately, it was not possible to provide this sort of detailed follow-up to all respondents. The introduction to Appendix B contains a detailed description of how the responses to the questionnaire should be interpreted.

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Questionnaires were sent to 106 private companies with 500 or more employees in Kenya. Fifteen of the 106 were later eliminated from the sample for various reasons. (Five are going or have gone out of business, three are branches of another company targeted in the survey, six are branches of companies that have already worked with FPPS, and one turned out to be a parastatal targeted in the survey.)

Responses were received by mail or telephone from 56 of the remaining 91 companies in the sample, giving a response rate of 62%. Responses were not received from 35 companies. Ten of the 56 responses had no branch with 250 or more employees, and so could not qualify for FPPS assistance. (See Appendix D for lists of the private companies that do not have any sites with 250 or more employees, those that did not respond, and those that were eliminated from the sample.)

Forty-six companies that responded to the survey could potentially qualify for future project assistance on the basis of size, since they have at least one branch with 250 or more employees. Out of this group, any company that indicated that it provides health services to staff at a company clinic should be considered to be a potential target for the type of assistance that has been offered under the Family Planning Private Sector program. This includes both companies that do not provide family planning services, and those that do, although those currently lacking family planning services might be a priority for assistance. As explained in the introduction to Appendix B, a "Yes" response to the question asking whether or not companies provide family planning does not indicate anything about the extent or quality of the services being offered. Those that already provide some family planning could potentially need assistance to expand or improve services. Further, respondents with a company clinic should be considered to be potentially in need of assistance for family planning regardless of what was indicated for Question #9 on interest in adding family planning if resources were available. Interest and commitment on the part of management in the company is probably one of the most important criteria for ensuring the success of a family planning program. However, as explained in Appendix B, this question is subjective and it is difficult to accurately gauge the interest of management with a brief questionnaire. Because of this, the responses marked on the questionnaire to the interest question are probably not indicative of future demand for family planning assistance. For these reasons all of the companies with company clinics should be considered to be potentially in need of assistance for family planning service provision.

A total of 28 of the 46 respondents have a company clinic, and could potentially be in need of assistance to provide family planning services. (Fifteen of these also provide some health services through an outside clinic, while 13 have only a company

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clinic. However, because of the ambiguity surrounding the responses to the question on outside clinics, this information is not very meaningful. See explanation in Appendix B.) The following chart shows the relevant information for the 28 respondents that have a company clinic.

<u>PRIVATE COMPANIES WITH COMPANY CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Central Glass Industries Ltd.	No	Yes
Cooper Motor Corporation Ltd.	No	Yes
Firestone E.A. (1969) Ltd.	No	Yes
Hughes Ltd.	No	Yes
Kenya Vehicle Manufacturers, Ltd.	No	Yes
Majani Mingi Sisal Estate	No	Yes
Serena Lodges & Hotels	No	Yes
Siret Tea Co. Ltd. - Kaboswa	No	Yes
Sunflag Spinning Mills (EA) Ltd.	No	Yes
Teita Estate Ltd.	No	Yes
Thika Cloth Mills	No	Yes
Put Sarajevo General Engineering	No	Do Not Know
Kenya Glass Works Ltd.	No	No
NAS Airport Services Ltd.	No	No
Unga Ltd.	No	No
Associated Battery Manufacturing	Yes	Yes
Bamburi Portland Cement Co.	Yes	Yes
Hotel Intercontinental	Yes	Yes
Kenya Bus Services Ltd.	Yes	Yes
Kenya Tea Packers Co. Ltd.	Yes	Yes
Metal Box Co. of Kenya Ltd.	Yes	Yes
Socfinaf Company Ltd.	Yes	Yes
Spin Knit Ltd.	Yes	Yes
E.A. Coffee Plantations - Savani	Yes	-----
East Africa Packaging Industries	Yes	-----
Kicomi (1983) Ltd.	Yes	-----
Koisagat Tea Estate Ltd.	Yes	-----
Hilton Hotel	Yes	Do Not Know

Fifteen of the companies with clinics indicated that they do not offer family planning services to employees, while 13 do. As mentioned above, those that do not yet provide family planning might be priority targets for future assistance. Eleven of the 15 that do not offer family planning indicated that they would be interested in adding it for employees and/or dependents if resources were available. One of the 15 indicated that it did not know if it would be interested, while three stated that they would not be interested in adding family planning. All of these

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companies could potentially need assistance to introduce family planning services for staff.

Thirteen other companies with clinics already offer family planning services to employees but could potentially be in need of assistance to expand or improve their programs. Eight of these indicated that they would be interested in adding family planning if resources were available, four left the question on interest blank, and one did not know. (Technically all of these companies should not have answered the question on interest since they already offer family planning. It is possible that a "Yes" response to the interest question for one of these companies suggests that the company is especially interested in expanding family planning services and/or receiving assistance for them.) All of these companies could potentially need family planning assistance.

The remaining 18 companies that responded indicated either that they do not have company clinics but provide some sort of health services through outside clinics, or do not provide health services through either company or outside clinics. As explained above, the information contained in the questionnaire responses regarding provision of health services to employees through an outside clinic (Question #5) is not very meaningful because of the wide range of meanings that could be attributed to "outside clinic". However, if the responses on outside clinics were to be considered relevant, the following seven companies that responded indicating that they do not have company clinics but use outside clinics might merit further study. Five of the seven marked that they would be interested in adding family planning if resources were available, and two others did not know.

<u>PRIVATE COMPANIES WITH NO COMPANY CLINIC BUT WITH OUTSIDE CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Kenya Threads Industry	No	Yes
Nyakinyua Investments Ltd.	No	Yes
Raymond Woollen Mills (K) Ltd.	No	Yes
Securicor (Kenya) Ltd.	No	Yes
Timsales Ltd.	No	Yes
Barclays Bank of Kenya Ltd.	No	Do Not Know
Standard Chartered Bank Ltd.	No	Do Not Know

Future program development might focus on developing innovative ways to target this type of company. Companies that provide some medical benefits to employees at outside health facilities could be assisted to provide family planning to staff through the outside clinics. The current FPPS project has already begun to experiment with this approach in Machakos, where it has begun to provide assistance to a private clinic in the urban center that

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serves the employees of several firms in the area. FPPS is looking into the possibility of providing this type of system in several other towns, including Eldoret, Kisumu, Nyeri, Nakuru, and Thika.

An additional 11 respondents indicated that they do not provide health services through either a company or an outside clinic. Nine of these do not offer family planning. Six of these nine indicated interest in adding family planning, two do not know, and one left the response blank. An additional two companies with neither company nor outside clinics already offer some sort of family planning, and indicated interest in adding it. All of these companies might be more difficult to reach with future family planning assistance since they do not appear to have any health services or links to clinics. However, another approach to providing family planning assistance to companies has been implemented in Kenya and might provide a useful model for assisting those companies that are interested but lack health facilities. The Population Health Services Commodity Distribution Project has assisted many companies by providing contraceptive supplies and some information on family planning to employees. This type of assistance could be useful for reaching companies without health programs.

<u>PRIVATE COMPANIES WITH NO COMPANY CLINIC NOR OUTSIDE CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Akamba Public Road Services Ltd.	No	Yes
E.A. Match Company (Kenya) Ltd.	N/A	Yes
Factory Guards Ltd.	No	Yes
Rai Plywoods (K) Ltd.	No	Yes
TM-AM Construction Group	No	Yes
Wells Fargo Company Ltd.	No	Yes
Bob Morgan Security Services Ltd.	No	Do Not Know
Combined Warehouses Ltd.	N/A	Do Not Know
Kacharoba Estate Ltd.	-----	-----
Orbitsports Ltd.	Yes	Yes
Security Guards Ltd.	Yes	Yes

2. Parastatals

a. Results

The same questionnaire that was sent to private companies was also sent to parastatals. The same caveats that were mentioned with regard to interpreting the responses for private companies apply to parastatals, (see introduction to Appendix B). An abbreviated chart with the information from the questionnaires received from parastatals can be found in Appendix E. Appendix F contains the full chart of responses from parastatals.

Questionnaires were mailed to a total of 23 parastatals. Responses were received by mail or telephone from 20 of them, yielding a response rate of 87%. Responses were not received from three parastatals. Three of the 20 respondents indicated that they have no branch with 250 or more employees and thus could not qualify for project assistance. (Appendix G contains lists of parastatals that responded but have no branch with 250 or more employees, and those that did not respond.)

Seventeen of the 20 parastatals indicated that they have at least one branch with 250 or more employees. On the basis of size, these companies could potentially qualify for assistance in a future family planning program. Out of these 17 parastatals, any firm that indicated that it provides health services to employees at a company clinic should be considered to be a potential target for future family planning assistance, whether it indicated that it does or does not already provide family planning and whether or not it indicated interest in family planning. The same reasoning that was described above to determine which private company respondents would potentially be in need of assistance for family planning applies to the parastatals. Parastatals that do not provide family planning services could be helped to introduce it, while those that do might need assistance to expand or improve services. Those without any family planning at present might be a priority for future assistance. As long as the parastatal has a company clinic, it should be considered to be in possible need of future assistance.

Eight of the 17 parastatals that responded and have large branches have a company clinic. (Four of the eight also indicated that they provide some health services through outside clinics, although this information is probably not meaningful, as explained above.) These eight parastatals should be considered to be potential sources of demand for future family planning assistance of the type offered by the Family Planning Private Sector program. The chart below shows the relevant information for these parastatals.

<u>PARASTATALS WITH COMPANY CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Agricultural Development Corporation	No	Yes
Kenya Medical Research Institute	No	Yes
Kenya Taitex Mills Ltd.	No	Yes
Pyrethrum Board of Kenya	No	Yes
E.A. Fine Spinners Ltd.	No	Do Not Know
Kenya Railways	Yes	Yes
Kenya Utalii College	Yes	Yes
Coffee Research Foundation	Yes	N/A

Five of the eight parastatals with company clinics do not currently provide family planning to employees, while three of them do. Four of the five who do not offer it indicated that they would be interested in adding family planning services if resources were available. One of the five that does not currently provide family planning marked "Do Not Know" to the question on interest. All five of these firms could be assisted to introduce family planning.

Three additional parastatals with company clinics do currently provide family planning. Two of them indicated interest in adding it, while the other marked "Not Applicable". All of these companies could also be targets for assistance in expanding or improving their family planning programs. (As described above, any company that already provides family planning should not have responded to the question on interest. It is possible that a positive answer to this question for these companies suggests special interest in family planning or getting assistance.)

The remaining nine parastatals that responded to the questionnaire and have large branches indicated that they have no company clinic. Eight of the nine provide some health services through outside clinics, while one does not. As explained before, the questionnaire information on outside clinics is probably not meaningful very meaningful. However, if the information on outside clinics were held to be relevant, the following eight parastatals that lack company clinics but use outside facilities might merit further consideration. Six of these eight do not offer family planning, while two do. Three of the six that do not offer family planning indicated interest, two did not know, and one marked "No" for interest. One of the two that currently offers some family planning marked "Yes" for interest in adding it, and the other left the question on interest blank. As for private companies, these parastatals that lack company clinics but use outside clinics could possibly be targeted in a future family planning program through an alternative mechanism that assisted the outside clinics.

<u>PARASTATALS WITH NO COMPANY CLINIC BUT WITH OUTSIDE CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Coffee Board of Kenya	No	Yes
Kenya Commercial Bank Ltd.	No	Yes
Kenya Seed Company Ltd.	No	Yes
Mount Kenya Textile Mills	No	Do Not Know
Pan Vegetable Processors Ltd.	No	Do Not Know
Agricultural Finance Corporation	No	No
Kenya Tea Development Authority	Yes	Yes
Kenya National Assurance Co. Ltd.	Yes	-----

One remaining parastatal that responded to the questionnaire indicated interest in adding family planning, even though it does not offer health services through a company or an outside clinic. This company might prove to be more difficult to assist with family planning under the FPPS model, although it could possibly be targeted through a program along the lines of the Commodity Distribution Project.

<u>PARASTATALS WITH NO COMPANY CLINIC NOR OUTSIDE CLINIC</u>	<u>FAMILY PLANNING OFFERED</u>	<u>INTEREST IN FAMILY PLANNING</u>
National Irrigation Board	Yes	-----

b. Summary for Companies

36 with company clinic

The responses to the survey revealed that 28 private companies and 8 parastatals have company clinics. This makes a total of 36 firms that could potentially be sources of demand for future assistance in the model of the Family Planning Private Sector program. Twenty of these firms, (15 private companies and five parastatals) do not at present offer family planning services to employees, while 16 do, (13 private companies and three parastatals).

(In the event that a "Yes" response to the question regarding interest in adding family planning were considered to be an additional criterion for determining which companies were potential sources of demand, then 25 of the 36 companies with clinics would fall in this category. Nineteen private companies

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and six parastatals indicated interest. Fifteen of these firms do not at present offer family planning, (11 private companies and four parastatals), and ten do, (eight private companies and two parastatals))

It should be noted that a more detailed analysis would have to be carried out before it could be determined that all 36 companies identified as having clinics could actually be assisted under terms similar to those used by the Family Planning Private Sector project. Details on the actual numbers of people eligible to use the company clinic, staff and equipment of the health clinic, and perhaps most importantly, the interest and commitment of management regarding provision of family planning services for employees would all have to be assessed. Nevertheless, all 36 are potentially in need of family planning assistance.

c. Additional Branches for Companies in Survey

Some of the companies with clinics also have additional branches that have 250 or more employees that could be in need of family planning assistance in a future FPPS-type program. Information from the questionnaires revealed that four companies have an additional branch that has its own clinic. These are East Africa Coffee Plantations (Kepchomo Estate returned a separate questionnaire from Savani Estate), E.A. Packaging Industries, Metal Box Company of Kenya Ltd., and the Agricultural Development Corporation, (the Agricultural Development Corporation has 52 branches with 250 or more employees, but only one additional branch has its own dispensary). These four branches should be considered to be additional sites with potential demand for assistance in family planning service provision.

In addition, several other of the private firms and parastatals with company clinics that were identified by the survey indicated that they have other branches with 250 or more employees. However, the information contained in the questionnaires does not identify which or how many of these large branches also have company clinics. Further follow-up is needed for the companies listed below to determine how many of the separate branches have their own clinics and could potentially be in need of assistance.

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<u>Private Companies with Company Clinic</u>	<u>Interest in Family Planning</u>	<u># Branches with 250+ Employees</u>
E. A. Coffee Plantations		
-Savani Estate	-----	2
-Kepchomo Estate	Yes	2
Majani Mingi Sisal Estate	Yes	3
Serena Lodges & Hotels	Yes	2
Siret Tea Co. - Kaboswa	Yes	3
Socfinaf Co. Ltd.	Yes	7
Teita Estate	Yes	3

<u>Parastatals with Company Clinic</u>	<u>Interest in Family Planning</u>	<u># Branches with 250+ Employees</u>
Kenya Railways	Yes	Several

3. Health Facilities

a. Questionnaire

The questionnaire that was sent to private health facilities consisted of eight questions, (see Appendix H). The questionnaire was made to be as brief as possible to encourage people to respond. The questionnaire asked respondents to provide information on the type of health facility, (hospital, nursing home, etc...); the type of organization that administers the facility, (government, private, etc...); the average number of clients served in a week, and of these, the percentage that is female; whether or not family planning, maternal and child health care, delivery and surgical services are offered; and whether or not facilities that do not at present provide family planning services would be interested in introducing them if resources were available.

b. Results

Appendix I contains a condensed version of the chart of responses to the survey of private health facilities, along with a brief guide to interpreting the responses. The full version of the chart can be found in Appendix J. The questionnaire for health facilities proved to be very straightforward, with almost no ambiguities. Very few responses required telephone follow-up for clarification.

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Questionnaires were sent to 69 private health facilities in Kenya. Five were later eliminated from the sample for various reasons. (One clinic turned out to be attached to a hospital already targeted by the survey, one turned out to be a specialist clinic for eyes while another treated only children, one turned out to be a government hospital, and another was run by a religious organization and provided only natural family planning.)

Responses were received by mail or telephone from 46 of the remaining 64 facilities in the sample, giving a response rate of 72%. Responses were not received from 18 health facilities. (See Appendix K for lists of the facilities that did not respond, and those that were eliminated from the sample.)

Basically all 46 respondents should be considered to be potentially in need of future assistance under a family planning program modeled on the Family Planning Private Sector project. Provision of family planning falls within the normal sphere of activity for health facilities, (with the exception of some religious ones, which were eliminated from the sample). Thus the respondents could all be considered to be potentially interested in offering family planning. Most facilities would also be capable of offering family planning services, although some might require different degrees of assistance to do so. In fact, 35 of the 46 respondents indicated that they already provide some family planning. Only 11 health facilities that responded do not presently provide family planning services. These facilities without family planning might be a priority target for future assistance. As was explained earlier for companies, the questionnaire information does not include any details on the type, quality and extent of family planning services offered. Those that indicated that they already provide family planning could be in need of assistance to improve or expand services. For these reasons all 46 respondents should be considered to be potentially in need of assistance, regardless of whether or not they provide family planning, and no matter what response they marked regarding interest in adding family planning. The following chart lists the responses for health facilities.

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<u>HEALTH FACILITY</u>	<u>FAMILY PLANNING PROVIDED</u>	<u>INTEREST IN FAMILY PLANNING</u>
Alpha Maternity Home	No	Yes
Bethany Hospital	No	Yes
City Nursing Home	No	Yes
Guru Nanak Clinic	No	Yes
Huruma Medical Centre	No	Yes
Nakuru War Memorial Hospital	No	Yes
Soc. Serv. League (MP Shah) Hosp.	No	Yes
Uasin Gishu Memorial Hospital	No	Yes
Wangu Maternity Home	No	Yes
Young Muslim Dispensary	No	Yes
Burhani Foundation Clinic	No	Do Not Know
Avenue Nursing Home	Yes	Yes
Boya Rural Nursing Home	Yes	Yes
Bungoma Nursing Home	Yes	Yes
Guru Nanak Ramgarhia Hospital	Yes	Yes
Kibirichia Maternity Home	Yes	Yes
Koru Nursing Home	Yes	Yes
Lake Nursing Home	Yes	Yes
Machakos Nursing Home	Yes	Yes
Oruba Nursing/Maternity Home	Yes	Yes
Park Road Nursing Home	Yes	Yes
Ramgarhia Sikh Dispensary	Yes	Yes
Vibhakar's Maternity/Nursing Home	Yes	Yes
Aga Khan Hospital (Kisumu)	Yes	-----
Central Memorial Hospital (Thika)	Yes	-----
Christa Marianne Nursing Home	Yes	-----
Galana Hospital	Yes	-----
Ideal Nursing Home	Yes	-----
Inder Nursing Home	Yes	-----
Jamaa Maternity Hospital	Yes	-----
Kericho Nursing Home	Yes	-----
Kikuyu Nursing Home	Yes	-----
Kitale Nursing/Maternity Home	Yes	-----
Limuru Nursing Home	Yes	-----
Menengai Nursing/Maternity Home	Yes	-----
Meru Nursing Home	Yes	-----
Milimani Nursing Home	Yes	-----
Mombasa Hospital Association	Yes	-----
Mount Elgon Hospital	Yes	-----
Pandya Memorial Hospital	Yes	-----
Radiant Health Clinic	Yes	-----
Thika Nursing Home	Yes	-----
Webuye Nursing Home	Yes	-----
Aga Khan Hospital (Mombasa)	Yes	N/A
Aga Khan Hospital (Nairobi)	Yes	N/A
Guru Nanak Harambee Dispensary	Yes	N/A

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Of the 11 facilities that do not offer family planning, ten marked "Yes" and one marked "Do Not Know" to the question on interest in adding family planning if resources were available. Of the 35 that do offer family planning, 12 marked "Yes", 20 left it blank, and 3 marked "N/A". As was discussed for companies, the answers to this question are subjective. In addition, the question was not designed to be answered by facilities that already offer family planning. Because of this, it is not clear that significant meaning can be attributed to the survey responses to this question, especially for those that answered "Yes", even though they already offer family planning. Through additional notes attached to the questionnaire, several of these facilities explained that they would like to receive assistance for the family planning they already offer in order to be able to expand or improve services. Some of the facilities already offering family planning that left the interest question blank could possibly be interested in the same type of assistance.

It should be noted, however, that even for clinics that are found to be very interested in introducing or expanding family planning services, more detailed information would be needed to determine whether or not they could receive assistance of the type that has been offered under the Family Planning Private Sector program. Staff from FPPS carry out a detailed analysis of interested clinics. Questions are asked on staffing and equipment, proximity of alternative health facilities, distances traveled by clients, potential to serve the employees of small industries in the area, and other issues. A combination of criteria are used to determine eligibility.

c. Summary

46 health facilities

All 46 of the health facilities that responded to the questionnaire should be considered to be potential sources of demand for assistance in a future family planning program modeled on the FPPS program. Eleven respondents do not yet offer family planning and could be priority targets for assistance designed to introduce such services. Thirty-five other respondents already offer some family planning but could potentially be in need of assistance to expand or improve their services.

(If interest in adding family planning as indicated on the questionnaire were considered to be relevant, then ten of the 11 that do not offer family planning, and 12 of the 35 that do offer it, could be priority targets for assistance. These 22 facilities all marked "Yes" for the interest question.)

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B. TEACHER TRAINING COLLEGES

During the implementation of the Family Planning Private Sector project, teacher training colleges were identified as another potential source of demand for family planning assistance. FPPS has helped two colleges of education, Kagumo and Siriba colleges, to provide family planning services at their health clinics. Through clinics, the colleges provide health services to institutional populations of students. There is substantial evidence suggesting that the female students at the teacher training colleges have a pressing need for family planning services.

A detailed study of these needs was carried out in 1988 by representatives of the GTZ Support Unit of the Division of Family Health of the Ministry of Health, and the Family Planning Association of Kenya. The study, Family Planning Needs in Colleges of Education: Report of a Study of 20 Colleges in Kenya, was prepared by Alan Ferguson, Jane Gitonga and Daniel Kabira and published in November 1988. (The information contained in the rest of this section is taken almost entirely from the Ferguson et al report.)

The study was sanctioned by the Ministries of Education and Health (Division of Family Health). The study covered 20 of the 23 then existing teacher training colleges. The purpose of the study was to examine the problem of female students dropping out of school because of unplanned pregnancies, find out more about the family planning needs of female students, and assess the prospects for introducing family planning services in college health facilities. The major tool used was a survey of Knowledge, Attitudes and Practices among a sample of female students, and informal interviews of academic and health staff at the colleges.

Four of the colleges already had some form of family planning services. Two colleges that were not included in the study were working with FPPS, (Kagumo and Siriba). Two others that were included in the study provided limited family planning services.

The major conclusions of the study were that the great majority of female students and nearly all of the clinic staff at the colleges supported the idea of offering family planning services at the health facilities. Most academic staff seemed to be concerned about the pregnancy drop-out problem. However, a significant proportion of them opposed introducing family planning on the grounds that it would lead to an increase in promiscuity among students. In spite of this, it was concluded that a slight majority of academic staff would probably approve of introducing family planning in the college clinics. The study concluded that action should be taken to provide family planning services in all of the colleges. It argued that the program

should be based on the methods used by FPPS in its work with Kagumo and Siriba colleges, and should include a training program for clinic staff, renovation and equipping of clinic facilities, and provision of contraceptives. (The 1988 study found that most of the colleges in the survey would be able to add family planning services without significant changes to the facilities. However, eight did not have adequate space. Only two of them were believed to require construction of a new space.)

The study also recommended that certain colleges receive priority for assistance, based on such factors as the number of students, the pregnancy drop-out rate, and staff attitude toward family planning services. The total female enrolment at the 20 colleges in the survey was approximately 6,000, (an average of 300 per college).

Despite the strong recommendations, little action appears to have been taken since the report was issued. It seems that FPPS agreed to assist with the training portion of the recommended program, and some attempt was made by FPPS and the GTZ Support Unit of the Division of Family Health to launch the training program. However, no action was apparently taken by the Ministry of Education, and the introduction of family planning services at the teacher training colleges did not begin.

Currently there are 21 teacher training colleges. Fifteen are run by the government and specialize in primary education. Three other government-sponsored colleges provide training for secondary education. Finally, there are three private primary education colleges. The current set of 21 colleges is nearly identical to the group of 23 that existed at the time of the survey in 1988. Moi teacher training college in Eldoret has since become a university, no longer offering teacher training, and is covered by FPPS. The same is true for Siriba college.

Because the set of teacher training colleges is virtually identical, and there is no indication that any change has occurred from the point of view of the Ministry of Education, the situation appears to be basically the same as it was two years ago. The findings of the 1988 study regarding the great need for family planning services at the teacher training colleges should be considered valid. However, it is difficult to determine how easy it would be to offer family planning assistance to the colleges, given the history described above.

C. NON-GOVERNMENTAL ORGANIZATIONS

Informal interviews were held with three different non-governmental organizations that administer health facilities in different parts of Kenya and have worked extensively with Family Planning Private Sector. All three are religious organizations. Numerous health facilities under the Christian Health Association of Kenya, Crescent Medical Aid, and the Kenya Seventh Day Adventists Rural Health Services have had subprojects with FPPS.

1. Christian Health Association of Kenya

The Christian Health Association of Kenya (CHAK) is a membership organization that provides support to more than 200 health facilities managed by 18 different Christian denominations throughout Kenya. Records show that in December 1989 there were 204 active health facilities under the CHAK umbrella. Of these, 17 were hospitals, 29 were health centers, and 158 were dispensaries. (CHAK carries out an annual survey of the health facilities to update records on status.)

Fifteen of the total number of facilities have been assisted by Family Planning Private Sector. An additional 18 sites were covered under a Ministry of Health sponsored Integrated Rural Health program that provided rehabilitation for provision of family planning and maternal and child health care. The funding for those 18 sites will expire in December 1990. CHAK is currently writing a proposal for a family planning program that would cover all of the facilities. They would like family planning to be part of an integrated community health program.

It is difficult to determine exactly which health facilities under CHAK currently provide family planning. A CHAK staff member estimated it at approximately 60%. However, the results of the most recent annual survey indicated that 82% of the hospitals, 68% of the health centers that reported, and 68% of the health centers that reported provided family planning. (This information is based on responses to the latest annual survey as indicated in a computer file of October 1990. In that record 100% of hospitals, 86% of health centers, and 82% of dispensaries had reported, for an overall response rate of 84%).

An estimate of the number of CHAK health facilities that do not provide family planning can be derived from this data on responses to the latest CHAK annual survey of facilities. The above mentioned computer record indicates that 14 of the total number of 17 hospitals reported that they provide family planning. Three hospitals reported that they do not. Seventeen of the 25 health centers that reported indicated that they provide family planning, which means that at least eight do not.

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(Four health centers did not report, and some of them might not provide family planning.) Sixty-six of the 129 reporting dispensaries do provide family planning, which leaves 63 that do not. (Some of the additional 29 dispensaries that did not report as of October 1990 may not provide family planning.)

Thus the total number of CHAK health facilities that do not provide family planning can be estimated as:

Hospitals	3
Health Centers	8
+ <u>Dispensaries</u>	<u>63</u>
Total:	74

There may be additional health centers and dispensaries that do not provide family planning that had not reported in time to be included in the October 1990 list.

All of these facilities could possibly be targets for an expanded assistance program modeled on the Family Planning Private Sector project. CHAK is clearly interested in supporting family planning programs among its member health facilities, and as mentioned above, is hoping to cover all of the members in a comprehensive family planning assistance program. However, a CHAK representative stated that some 40% of the health facilities have not been rehabilitated yet, and so might not be able to introduce family planning. It is difficult to know whether or not all of these facilities could be assisted under the type of system that has been applied in the FPPS program.

A CHAK representative explained that problems related to the existing family planning programs have included difficulty in paying staff. Inadequate salaries have resulted in high turnover after training. The quantity and quality of equipment have been inadequate for some sites. CHAK perceives an ongoing need for community outreach and education. These factors suggest that some of the facilities that have already received FPPS assistance might be in need of additional help in the future.

In conclusion, at least 74 CHAK health facilities do not offer family planning services. Some of these might require physical rehabilitation before they could introduce family planning. Facilities that have been assisted by FPPS may need some additional support.

2. Crescent Medical Aid

Representatives of Crescent Medical Aid informed the consultant that FPPS currently works with eight of ten existing health clinics. The two that do not yet receive FPPS assistance are Mtongwe Clinic in Mombasa, and Muslim Hall in Nakuru. Both have

been functioning for approximately a year, and both see between 70-80 clients per day. Both clinics have apparently already applied to become FPPS subprojects. Crescent Medical Aid also stated that three additional clinics are in the early planning stages and might be functioning one to two years from now, in Kariobangi North, Athi River, and Kitui.

The staff at Crescent Medical Aid explained that some of the current subprojects are in need of replacement equipment. Staff salaries are also a problem, since employees have tended to go elsewhere in search of higher pay, after receiving family planning training. Crescent is also having trouble absorbing the payment of Community Health Workers' salaries since FPPS funds ceased.

Crescent Medical Aid staff explained that they view the Community Based Distribution program as the most valuable service that has arisen from the FPPS assistance. An interesting fact that came to light during the interview is that some of the Crescent health clinics have links to companies. Some clinics have arrangements with companies whose staff use the facilities, at company expense. Crescent views the arrangements as very useful, since they generate income for the clinics. In addition, a staff member visits companies to distribute contraceptives and information on family planning. Currently a fee of 15 Kenya shillings is charged for a family planning visit at most of the clinics.

In conclusion, it seems that two new Crescent Medical Aid clinics could potentially be targets for future family planning assistance modelled on the current FPPS program. In addition, the clinics that have already been assisted by FPPS now seem to need additional funds in order to maintain the family planning services.

3. Kenya Seventh Day Adventists Rural Health Services

The Kenya Seventh Day Adventists (SDA) Rural Health Services was established by the SDA church to coordinate rural dispensaries run by SDA throughout the country. The organization administers 39 health facilities throughout the country. Three of the facilities are classed as health centers, and the rest are dispensaries.

Family Planning Private Sector has assisted approximately 35 of the total number of clinics administered by SDA. The four remaining clinics have recently opened and SDA hopes to secure FPPS assistance for them. In addition, SDA has tentative plans to open two more facilities. The four new health facilities, which would be a likely target for future family planning assistance, are:

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Kebokyek SDA Dispensary (Kericho)
Chepareria SDA Dispensary (Kapenguria)
Bukwalla SDA Dispensary (Yala)
Rapedhi SDA Dispensary (Ndhiwa)

Three of the four see very few clients per week. It is not clear that they would be eligible for assistance of the type that has been offered by FPPS. However, the clinics are new, and the number of clients may increase.

SDA Rural Health Services has instituted a nominal charge of five Kenya shillings for family planning services at 25 of the clinics. Staff believe that this has led to a decline in family planning client visits at some of these clinics. The headquarters representative explained that the intent of the charges is to try to cover some of the costs of running the facilities, and to plan for the future cessation of FPPS funds. This effort to make the family planning program more sustainable is notable, although the resulting decline in client visits for family planning services should be carefully studied.

SDA Rural Health Services feels that the staff of the facilities that have already been assisted by FPPS need more training, both in outreach and clinic based services. The field motivators of the facilities do not receive enough remuneration. Transport is also a problem, both in terms of the vehicle for SDA Rural Health Services, and maintenance of the bicycles belonging to the field workers. SDA Rural Health Services views maternal and child health care as a priority for the future, to be integrated with family planning. Community outreach is also a priority. A problem related to outreach is that field motivators are often asked to work in the clinics, where staff are overworked, instead of out in the communities. SDA Rural Health Services is planning to broaden the community education program for family planning by using church related youth, women's, and evangelist groups. They would like to give training in family planning and health to members of these groups, who could then spread information in the communities.

In conclusion, it seems that there are four additional health facilities administered by the Kenya SDA Rural Health Services that could be targeted by future family planning assistance delivered in a form based on the Family Planning Private Sector program. Some of them might have too small a client base to qualify for assistance. At least some of the facilities that have already been assisted by FPPS also appear to need more support.

4. Conclusion for NGOs

It appears that the information on the additional health facilities administered by the Christian Health Association of Kenya, Crescent Medical Aid, and the Kenya Seventh Day Adventists Rural Health Services is not clear cut enough for them to be added to the results from the questionnaires. The number of facilities administered by these NGOs that do not yet offer family planning can be estimated as:

74	CHAK
2	Crescent
+ 4	<u>SDA</u>
Total: 80 health facilities	

However, it is not clear that all of the facilities would qualify for assistance of the type that has been provided by FPP. Another factor is that some of the facilities run by these organizations that have already been helped by FPPS seem to be in need of additional assistance.

Representatives of Pathfinder and Family Planning International Assistance in Nairobi were also consulted for suggestions of additional organizations that sponsor health facilities that might be in need of assistance for family planning services. No organizations were identified as being clearly in need. However, a staff member from Pathfinder suggested that perhaps the following organizations would merit looking into in order to determine their possible need for assistance for family planning service provision. The organizations mentioned were the Aga Khan Foundation, the Kenya Muslim Welfare Association, the Red Cross Society, the Salvation Army, and World Vision.

V. ADDITIONAL POTENTIAL DEMAND

Some of the organizations that have not responded to the present questionnaire survey might be in need of assistance for family planning service provision. In addition, there are three other sources of potential demand that could augment the results of the present survey. A survey of demand among companies that was carried out in 1988 by FPPS indicated the existence of some additional large companies that would be interested in receiving assistance to offer family planning services to employees. In addition, several of the companies that have worked with Family Planning Private Sector as subprojects have other large branches that could potentially be targeted with future assistance. Finally, many requests from companies and health facilities have been received directly by FPPS. The firms identified by the 1988 survey should be added to the results of this questionnaire survey. Organizations from the other two sources should not be

added, because details are not available for many of the organizations and because the data is old for some of them. However, some of these would also no doubt prove to be potentially in need. The great number of branches of existing subprojects and requests received by FPPS suggests that the number of potential future subprojects is actually far greater than the present study can document.

A. 1988 SURVEY

A survey of potential demand for assistance to provide family planning services to employees was carried out by Family Planning Private Sector in 1988. Questionnaires were sent to approximately 2,500 companies in Kenya. The sample was not limited to large firms. Sixty-nine responses were received to the survey. A number of firms that responded to the survey later became FPPS subprojects. The following eight firms did not become subprojects, but responded indicating that they had 450 or more employees, offered health services to employees, and were interested in receiving assistance to offer family planning services to employees:

<u>Company</u>	<u>Interest in Family Planning</u>
Kaisugu Ltd.	Yes
Kapsumbeiwa Tea Factory	Yes
Karirarana Estates Ltd.	Yes
Ken Knit (K) Ltd.	Yes
Njoro Canning Factory Ltd.	Yes
Nyambene Tea Company Ltd.	Yes
Rift Valley Textiles Ltd.	Yes
Unga Feeds Ltd.	Yes

It is not possible to verify whether or not these companies offered family planning to employees. Nevertheless, this data should be added to the results from the present survey. Thus the total number of companies with clinics is:

36 (firms with company clinics from present survey)
+ 8 (firms with health services from 1988 survey)
Total: 44

(The total number of companies with clinics that expressed interest in family planning is: 25 (from this survey) + 8 (from 1988 survey) = 33.)

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B. BRANCHES OF FPPS-ASSISTED COMPANIES

The Family Planning Private Sector project has worked with several firms that have large branches that have not yet received FPPS assistance for family planning services. It is difficult to determine if these branches could all potentially become subprojects in their own right, since some might be too small or might lack health services. These three companies merit further investigation:

Kenya Breweries Ltd. (FPPS has not worked with the Kisumu or Mombasa branches yet.)

Kenya Posts & Telecommunications (FPPS has only worked within Nairobi.)

East African Industries (FPPS has not worked with the Mombasa branch.)

Added to these should be various tea companies. FPPS has worked with tea estates belonging to the major firms in the country. It is not possible to list all of the additional estates not yet reached by FPPS assistance. (It is possible that some of the tea estates targeted by the present survey are actually subsidiaries of large companies already working with FPPS.) Future planning for program assistance should include study of the additional branches for the following tea companies that have worked with FPPS to date. There is room for expansion to additional estates for some of these companies.

African Highlands

Brooke Bond

Kenya Tea Growers Association - Kericho

- Limuru

- Nandi Hills

C. REQUESTS

Family Planning Private Sector has received numerous requests for assistance in offering family planning services from companies and private health facilities. The following lists include eight firms and 28 private health facilities that have made direct requests to FPPS. However, details are not available on the nature of the facilities available for all of the requests, and some of them are several years old. Because of these factors they should not be added to the results from the present survey, although at least some of the following could certainly still be potential targets for future assistance.

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Companies

EATAC (Eldoret)
Galot Industries
Galsheet Kenya Ltd.
Kenya Airways
Kenya Power & Lighting
Laikipia Ranching Company
Mau Forestry Ltd.
Mohan Meakin

Health Facilities

Africa Health Services (Maai Mahiu- Kijabe)
Aga Khan Hospital, Nairobi (requested assistance for employees)
Apex Nursing Home (Nairobi)
Bakarani Medical Clinic (Mombasa)
Diani Clinic
Happy Health Clinic (East Kitutu, Kisii)
Hatimy, Dr. Alhad Clinic
Home Health Clinic (Kebirigo, Nyanira)
Jamii Medical Center (Karatina)
Jata Medical & Maternity Centre (Rongo, Kamagambo)
J.E.C. Health Services (Nairobi)
Kakamega Highway Nursing Home (Kakamega)
Kirika, Dr. (Thika)
Kisauni Nursing & Maternity (Mombasa)
Magua, Dr. Billy N. (Naivasha)
Mariini Maternity (Nyeri)
Mungungu Clinic (Koyonzo-Mumias, Kakamega)
Nairobi Hospital (requested assistance for employees)
Nyeri Medical Center
Old Mutual Group Practice (Nairobi)
Palani Medical Center (Mariakani)
Rift Valley Nursing Home (Naivasha)
St. Jude's Clinic (Msambweni)
St. Leonard's Maternity (Kericho)
Ugenya Cottage Hospital (Siaya)
Ugeng'a Health & Family Planning Centre (Nairobi, Busia)
Umoja Maternity Home (Nairobi)
Usagi, Dr. (Kitale)

VI. CONCLUSION - RECOMMENDATIONS

The results of the present study indicate that the following organizations could potentially be in need of future family planning assistance in the form offered by the current Family Planning Private Sector program. The totals are based on the results of the present questionnaire survey of private firms, parastatals, and private health facilities, on the results of the 1988 survey carried out by FPPS. (Appendix L contains a more detailed summary of the data.)

36 firms with company clinic from present survey
46 health facilities from present survey
+ 8 firms with health services from 1988 survey

Total: 44 firms
+ 46 health facilities
90 potential organizations

(Alternatively, if only those organizations that specifically indicated interest in providing family planning services on the questionnaires are included, the following numbers would be potential targets for assistance:

25 firms with company clinic from present survey
22 health facilities from present survey
+ 8 firms with health services from 1988 survey

Total: 55 potential organizations)

It should be noted that the characteristics of these organizations would need to be assessed in greater detail before firm conclusions could be drawn about whether or not they could actually be assisted on terms similar to those used in the current FPPS program. For firms, detailed information on the medical facilities, staff, services offered, clients served, and the interest of management would be needed. For private health facilities, more information would be needed on such things as staff and equipment, the proximity of alternative facilities, distances traveled by clients, and potential to serve employees of companies in the area.

The organizations included in the lists above are those which were assessed by the present study and the 1988 survey of demand administered by Family Planning Private Sector, and for which evidence of potential demand for assistance in providing family

planning services within the organizations was found. There are indications that the lists could be greatly expanded, although the evidence is not as clear cut. Some of the organizations that did not respond to the present questionnaire survey might need assistance to provide family planning services. There are also many additional health facilities not yet offering family planning services that are administered by the three NGOs that have been assisted by the current FPPS project. The Christian Health Association of Kenya, Crescent Medical Aid, and the Kenya Seventh Day Adventists Rural Health Services all have additional facilities that are potentially in need of family planning assistance. In addition, it is very likely that the other large branches of companies that have been assisted by FPPS could become subprojects, although the branches would need to be individually assessed. Direct requests for assistance have been received by FPPS from eight more companies, and 28 private health facilities. All of these organizations would need to be examined in greater detail to determine whether or not they would qualify for assistance of the type that has been offered under the program to date.

In addition, there are 20 teacher training colleges that could be assisted to provide family planning services to students. The need for family planning services in the colleges is well documented by the Ferguson et al study. Some administrative or political constraints would have to be overcome before such assistance could be implemented, however.

In conclusion, evidence from the survey and from other sources suggests that the potential demand for assistance in providing family planning services among large firms and private health facilities in Kenya in the form that has been provided by the Family Planning Private Sector is very great. Ninety organizations have been identified that demonstrate potential need for assistance to provide family planning to their employees or clients. Not all of the identified organizations would necessarily end up working within a future project. However, evidence from the additional sources listed above suggests that the number of organizations that need and could benefit from future assistance is at least as great as the number of organizations that has been assisted by the current program to date.

The Family Planning Private Sector program has been evaluated and judged to be a very effective project. The evidence of significant potential unmet demand for assistance for family planning service provision among large companies and private health facilities as revealed by this study suggests that there is great need to continue the type of assistance that has been offered under the program.

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ORGANIZATIONS CONSULTED

Representatives of the following organizations were contacted for advice and information. Their assistance is greatly appreciated.

African Medical and Research Foundation (AMREF)
Center for African Family Studies
Central Bureau of Statistics
Christian Health Association of Kenya
Crescent Medical Aid
Family Planning International Assistance
Family Planning Private Sector Programme
Federation of Kenya Employers
Inspectorate of State Corporations (Office of the President)
Kenya Association of Manufacturers
Kenya Industrial Research and Development Institute
Kenya Medical Association
Kenya National Chamber of Commerce
Kenya Seventh Day Adventists Rural Health Services
Ministry of Education
Ministry of Health, including the Division of Family Health and the
Information and Planning Systems Project
National Hospital Insurance Fund
Pathfinder
Population and Health Services
Population Services International
Research International East Africa
USAID/Kenya
U.S. Department of Commerce
World Bank

APPENDIX A
QUESTIONNAIRE FOR COMPANIES



Family Planning Private Sector Programme

7th Floor, Longonot Place, Kijabe Street, P O Box 46042, Nairobi, Kenya.
Telephone: 24646, 24655, 27614, 29159. Telex: 25342 "JSI GROUP".

October 30, 1990

The Managing Director

Dear Sir or Madam:

The Family Planning Private Sector program (FPPS) was created in 1984 to provide family planning services in the private sector. FPPS operates under the guidance of the National Council for Population and Development (NCPD) of the Ministry of Home Affairs and National Heritage. The NCPD is the government organization that provides policy guidance and coordinates family planning activities in Kenya. Under the FPPS program, financial, logistical and training assistance have been offered to approximately 30 private companies and parastatals to introduce or expand family planning services offered to employees, and in some cases to dependents and surrounding communities. Assistance has also been offered to private health clinics throughout the country. The programme is funded primarily by the United States Agency for International Development (USAID).

As the current project is scheduled to end in September 1991, USAID is now determining if there is need for a follow-on phase of the program. USAID would like to estimate the potential demand for family planning assistance that exists among organizations that have not yet been involved in the project. In order to do this we are sending the attached questionnaire to a sample of the largest companies and parastatals in Kenya. The purpose of the questionnaire is to find out if companies offer health and family planning services to employees and dependents. Your assistance in completing the attached questionnaire would be extremely helpful.

Please be assured that the questionnaire is informal, and is meant to serve as a guide for USAID's planning. Your responses will be kept confidential. We hope that you will take a few minutes to complete the questionnaire and will return it as quickly as possible in the enclosed, stamped envelope. We appreciate your assistance. Thank you.

Sincerely,

Mary Ibutu
Program Administrator

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QUESTIONNAIRE

1. Name of Firm/Organization: _____
Postal Address: _____

Telephone Number: _____
Name of Contact Person: _____
Title of Contact Person: _____

2. Approximately how many people are employed by your organization, (full time and casual)?

Total Employees: _____

3. How many of the total employees are men and how many are women?

Male Employees: _____ Female Employees: _____

4. If the organization has more than one branch, factory, plantation or work site, please list all of the branches that have at least 250 employees. For each branch, please indicate the total number of people that work there, (full time and casual), and the number of male and female employees.

<u>Branch</u>	<u>Total Employees</u>	<u>Male</u>	<u>Female</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please continue on separate sheet of paper if necessary.)

5. Do any of the branches or work sites that have at least 250 employees provide the following for staff?

	<u>YES</u>	<u>NO</u>
- health services at company clinic	_____	_____
- health services at outside clinic	_____	_____

6. If health facilities/services are provided, are the following people eligible to use them?

YES NO

- dependents of employees

- others (surrounding community)

7. If health facilities/services are provided, are family planning services available?

YES _____ NO _____

8. If family planning services are provided, are the following services available?

YES NO

- contraceptives

- counselling

9. (FOR THOSE ORGANIZATIONS THAT DO NOT AT PRESENT PROVIDE FAMILY PLANNING SERVICES):

If resources were available, would the organization be interested in adding family planning services for employees and/or dependents?

YES _____ NO _____ DO NOT KNOW _____

THANK YOU!

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APPENDIX B

PRIVATE COMPANIES - RESPONSES

Some of the items on the questionnaire that was sent to private companies and parastatals resulted in ambiguous responses. Some attempt was made to clarify these responses with telephone follow-up, although this was not possible for all respondents. The following notes should serve as a guide to interpreting the responses in the chart.

For responses received by mail, answers were left as marked on the questionnaire, unless telephone follow-up occurred. If clarification was received by telephone on mailed questionnaires, or if the entire questionnaire was answered by telephone, then responses were adjusted or marked according to the following guidelines. Additional notes were marked directly on the questionnaires.

Question #4

The questionnaire attempted to screen out companies whose employees were so dispersed that no site had 250 or more employees. (The figure of 250 employees as the minimum size was provided by FPPS staff as a rough indicator for determining whether or not companies are large enough to potentially qualify for project assistance.) Results indicated that the wording of this question was somewhat confusing to some companies. The responses for these firms were followed-up by telephone and clarified. In the chart, the column "# of Branches 250+ Employees" indicates the number of branches that have 250 or more employees. If the company has no branches, "N/A" (for "Not Applicable") is marked in this column. Note that for companies with more than one of these large branches it is not possible to know which of the branches the responses to the rest of the questions on the questionnaire refer to.

Question #5

Question #5 asked respondents to indicate whether or not they provide health services for staff at a company clinic or an outside clinic. A "Yes" response for company clinic does not indicate anything about the type of clinic that is provided for staff. (For responses received by telephone, "Yes" was marked to indicate the presence of any health facility, even a simple dispensary.)

A "Yes" response for outside clinic could represent any one of a wide range of situations, from one in which a company provides full medical coverage for staff and has a special arrangement with a particular outside clinic, to one in which a company has no medical scheme and simply refers employees to any number of

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health facilities in the area. (For responses received by telephone, "Yes" was marked if a company provides some degree of medical coverage to at least some employees at an outside facility.) Because the information regarding outside clinics is so ambiguous, it is difficult to draw meaningful conclusions about the responses to this item.

A company's response to Question #5 places it in one of four groups:

a) Yes Company Clinic, Yes Outside Clinic

If a company indicated that it provides health services at both a company clinic and an outside clinic, the responses to the rest of the questions may refer to either clinic.

b) Yes Company Clinic, No Outside Clinic

If a company indicated that it provides health services at a company clinic but not through an outside clinic, it may be assumed that the rest of the responses on the questionnaire refer to the company clinic.

c) No Company Clinic, Yes Outside Clinic

Because of the ambiguity of what is meant by outside clinic, the responses to the rest of the questions are more uncertain. The second part of Question #6, referring to eligibility of others to use health facilities, should be "N/A" for firms in this category, since outside clinics must be open to others.

d) No Company Clinic, No Outside Clinic

If a company indicated that health services are not provided through a company nor an outside clinic, Questions #6-8 should be "N/A".

Question #6

This question asked whether or not dependents and others are eligible to use health facilities, if they are provided. There is some uncertainty regarding the responses for dependents, since many firms only provide health benefits to the dependents of some categories of employees. (For responses received by telephone, a "Yes" was marked for dependents if the dependents of at least some of the staff are eligible.)

Question #7

The question on availability of family planning services was phrased to be dependent on provision of health services at either a company or outside clinic. For a firm that has no company

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clinic but uses an outside clinic, this question is ambiguous. The response could refer to the availability of family planning at the outside clinic, or at the company itself. (For responses received by telephone, this question was answered with reference to availability of family planning at the company itself.) Question #7 should be "N/A" for a company that does not provide health services at either type of clinic. However, it is possible for family planning services to be provided in the absence of a clinic, and the questionnaire would not necessarily account for this.

In addition, a positive response to the question on provision of family planning services does not indicate any details on the types, quality and amounts of family planning offered, although additional notes on some of the questionnaires provide more information. (For responses received by telephone, a "Yes" was marked even if the family planning services offered were minimal.) For this reason even those companies that already provide family planning could be considered to be potentially in need of assistance to improve services.

Question #8

The question on availability of contraceptives and counselling was phrased to be dependent on the provision of family planning services. If the response to Question #7 is "No" or "N/A", then Question #8 should be "N/A".

Question #9

The responses to the final question on interest in adding family planning services are subjective and probably not very meaningful as a guide for planning future targeting strategies. (A similar question was asked in the 1988 survey administered by FPPS. After the survey, six of the firms that had responded to the questionnaire and indicated that they were interested in getting assistance to offer family planning became FPPS subprojects. However, an equal number of firms that had responded indicating that they were not interested also became FPPS subprojects.) Interest and commitment on the part of management in the companies is extremely important to the success of family planning programs, but this is difficult to assess with a mailed questionnaire. In addition, Question #9 was phrased to apply only to firms that do not currently provide family planning. A response to this question from a company that indicated that it already provides family planning should be "N/A". A "Yes" response for such a company might indicate that the company is interested in expanding services or in receiving assistance for them.

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PRIVATE COMPANIES - RESPONSES (CONDENSED VERSION)

COMPANY	TOTAL # EMPLOYEES	MALE	FEMALE	# OF BRANCHES 250+ EMPLOYEES	# OF EMPLOYEES LARGEST BRANCH	MALE	FEMALE	COMPANY CLINIC	FAMILY PLANNING	INTEREST*
AKAMBA PUBLIC ROAD SERVICES LTD.	600	580	20	1	450	435	15	NO	NO	YES
ASSOCIATED BATTERY MANUFACTURING	300	280	20	N/A				YES	YES	YES
BAMBURI PORTLAND CEMENT COMPANY	880	850	30	N/A				YES	YES	YES
BARCLAYS BANK OF KENYA LTD.	3230	1776	1454	1	445	331	114	NO	NO	DO NOT KNOW
BOB MORGAN SECURITY SERVICES LTD.	1100	1084	16	N/A				NO	NO	DO NOT KNOW
CENTRAL GLASS INDUSTRIES LTD.	328	300	28	N/A				YES	NO	YES
COMBINED WAREHOUSES LTD.	322	308	14	N/A				NO	N/A	DO NOT KNOW
COOPER MOTOR CORPORATION LTD.	1100	1075	25	1	800	784	16	YES	NO	YES
E.A. COFFEE PLANTATIONS- SAVANI	834	681	153	2	367	301	66	YES	YES	-----
E.A. MATCH COMPANY (KENYA) LTD.	650	580	70	N/A				NO	N/A	YES
EAST AFRICA PACKAGING INDUSTRIES	700	680	20	2	450	446	14	YES	YES	-----
FACTORY GUARDS LTD.	1598	1596	2	1	1400	1399	1	NO	NO	YES
FIRESTONE EAST AFRICA (1969) LTD.	650	625	25	N/A				YES	NO	YES
HILTON HOTEL	550	388	172	N/A				YES	YES	DO NOT KNOW
HOTEL INTER-CONTINENTAL	583	511	72	N/A				YES	YES	YES
HUGHES LTD.	370	325	45	1	269	231	38	YES	NO	YES
KACHAROBA ESTATE LTD.	390	270	120	N/A				NO	-----	-----
KENYA BUS SERVICES LTD.	2500	2350	150	N/A				YES	YES	YES
KENYA GLASS WORKS LTD.	600	595	5	N/A				YES	NO	NO
KENYA TEA PACKERS COMPANY LTD.	595	517	78	1	478	430	48	YES	YES	YES
KENYA THREADS INDUSTRY LTD.	800	777	23	1	790	771	19	NO	NO	YES
KENYA VEHICLE MANUFACTURERS LTD.	580	569	11	N/A				YES	NO	YES
KICOMI (1983) LTD.	1821	1765	56	N/A				YES	YES	-----
KOISAGAT TEA ESTATE LTD.	750	440	310	1	740	440	300	YES	YES	-----
MAJANI MINGI SISAL ESTATE	2096	1495	601	3	781	549	232	YES	NO	YES
METAL BOX COMPANY OF KENYA LTD.	1000			2	500			YES	YES	YES
NAS AIRPORT SERVICES LTD.	800	700	100	N/A				YES	NO	NO
NYAKINYUA INVESTMENTS LTD.	380	180	200	N/A				NO	NO	YES
ORBITSPORTS LTD.	400	240	60	N/A				NO	YES	YES
PUT SARAJEVO GENERAL ENGINEERING	700	693	7	1	450	448	2	YES	NO	DO NOT KNOW
RAI PLYWOODS (K) LTD.	1500	1400	100	N/A				NO	NO	YES

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PRIVATE COMPANIES - RESPONSES (CONDENSED VERSION)

COMPANY	TOTAL # EMPLOYEES	MALE	FEMALE	# OF BRANCHES 250+ EMPLOYEES	# OF EMPLOYEES LARGEST BRANCH	MALE	FEMALE	COMPANY CLINIC	FAMILY PLANNING	INTEREST*
RAYMOND WOOLLEN MILLS (K) LTD.	2820	2270	550	N/A				NO	NO	YES
SECURICOR (KENYA) LTD.	7000	6970	30	3	2000	1980	20	NO	NO	YES
SECURITY GUARDS LTD.	850	850	0	N/A				NO	YES	YES
SERENA LODGES & HOTELS	1125	975	150	2	403	386	52	YES	NO	YES
SIRET TEA CO. LTD.- KABOSWA	904	753	151	3	308	311	77	YES	NO	YES
SOCFINAF COMPANY LTD.	3168	1723	1445	7	600			YES	YES	YES
SPIN KNIT LTD.	701	654	47	N/A				YES	YES	YES
STANDARD CHARTERED BANK LTD.	2200	1432	768	1	370	273	97	NO	NO	DO NOT KNOW
SUNFLAG SPINNING MILLS (EA) LTD.	1482	1415	67	1	1097	1094	3	YES	NO	YES
TEITA ESTATE LTD.	1674	1185	489	3	600	454	146	YES	NO	YES
THIKA CLOTH MILLS	1112	1097	15	N/A				YES	NO	YES
TIMSALES LTD.	3000	2890	110	1	2000	1900	100	NO	NO	YES
TM-AM CONSTRUCTION GROUP	850	849	2	1	660	660	0	NO	NO	YES
UNGA LTD.	562	466	96	1	245	199	46	YES	NO	NO
WELLS FARGO COMPANY LTD.	700	695	5	1	600	595	5	NO	NO	YES

APPENDIX C

PRIVATE COMPANIES' RESPONSES (EXPANDED VERSION)

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PRIVATE COMPANIES - RESPONSES (EXPANDED VERSION)

COMPANY	P.O. BOX	CITY	TELEPHONE	CONTACT PERSON	TITLE	TOTAL # EMPLOYEES	MALE	FEMALE
AKAMBA PUBLIC ROAD SERVICES LTD.	40322	NAIROBI	555637, 555690	J. OLOO, MR.	TRAFFIC MANAGER	600	580	20
ASSOCIATED BATTERY MANUFACTURING	48917	NAIROBI	558249, 558022	THAGISHU, MR.	MANPOWER MANAGER	300	280	20
BAMBURI PORTLAND CEMENT COMPANY	90202	MOMBASA	(011) 485501	CHARLES MACHOGU	ASST. ADMINISTRATION MGR.	880	850	30
BARCLAYS BANK OF KENYA LTD.	30120	NAIROBI	332230	JOSEPH KIGATHI	PERSONNEL SERVICES MGR	3230	1776	1454
BOB MORGAN SECURITY SERVICES LTD.	21606	NAIROBI	567701, 567211	BOB MORGAN	MANAGING DIRECTOR	1100	1084	16
CENTRAL GLASS INDUSTRIES LTD.	49835	NAIROBI	803681,802880	F. MWANGI, MR.	SENIOR PERSONNEL ASST.	328	300	28
COMBINED WAREHOUSES LTD.	81862	MOMBASA	(011) 433521/2	JAMES MBOTELA	PERSONNEL MANAGER	322	308	14
COOPER MOTOR CORPORATION LTD.	30135	NAIROBI	554211, 554112	J.I. ADAMSON	PERSONNEL MANAGER	1100	1075	25
E.A. COFFEE PLANTATIONS- SAVAMI	94	MANDI HILLS	(0326) 43010	JOSHUA AGORO	AG. GROUP MANAGER	834	681	153
E.A. MATCH COMPANY (KENYA) LTD.	82525	MOMBASA	433206/7	WALTER OLOO DRUKO	CHIEF ENGINEER	650	580	70
EAST AFRICA PACKAGING INDUSTRIES	30146	NAIROBI	556011	P.B. CLIFF	MANAGING DIRECTOR	700	680	20
FACTORY GUARDS LTD.	18670	NAIROBI	557800	HARUN SOROBEA	PERSONNEL & ADMIN. MGR.	1598	1596	2
FIRESTONE EAST AFRICA (1969) LTD.	30429	NAIROBI	559922	JANE N. BARASA	PERSONNEL/ADMIN. MGR.	650	625	25
HILTON HOTEL	30624	NAIROBI	334000	PETER E. FRANK	GENERAL MANAGER	550	388	172
HOTEL INTER-CONTINENTAL	30353	NAIROBI	335550	STANLEY KIRIMI	CLINICAL OFFICER	583	511	72
HUGHES LTD.	30060	NAIROBI	544170	A.I. MUSOTSI, MR.	GROUP CO. SECRETARY	370	325	45
KACHAROBA ESTATE LTD.	115	KIAMBU	(0154) 40076	S.J. WILLIAMS KAMAU	ESTATE MANAGER	390	270	120
KENYA BUS SERVICES LTD.	30563	NAIROBI	764706/9	MASHEDI, MR.	PERSONNEL OFFICER	2500	2350	150
KENYA GLASS WORKS LTD.	80180	MOMBASA	(011) 25204	PETER MMBAYA	PERSONNEL MANAGER	600	595	5
KENYA TEA PACKERS COMPANY LTD.	413	KERICHO	(0361) 20531	JAMES WEKOTO	ADMINISTRATIVE ASST.	595	517	78
KENYA THREADS INDUSTRY LTD.	41973	NAIROBI	340392	P.N. NYAGA	PERSONNEL MANAGER	800	777	23
KENYA VEHICLE MANUFACTURERS LTD.	1436	THIKA	(0151) 21711-5	B.N. WABULE, MR.	DIRECTOR ADMINISTRATION	580	569	11
KICOMI (1983) LTD.	47	KISUMU	41200	SAMSON O. AMAYO	PERSONNEL MANAGER	1821	1765	56
KOISAGAT TEA ESTATE LTD.	53104	NAIROBI	334349	L.K. KARANJA	ADMINISTRATIVE OFFICER	750	440	310
MAJANI MINGI SISAL ESTATE	580	NAKURU	(037) 45276	VAKIS, MR.	MANAGER	2096	1495	601
METAL BOX COMPANY OF KENYA LTD.	30101	NAIROBI	557811	BWIRE, MR.	PERSONNEL OFFICER	1000		
NAS AIRPORT SERVICES LTD.	19010	NAIROBI	822500	W. SHIRAMBA	PERSONNEL ASSISTANT	800	700	100
NYAKINYUA INVESTMENTS LTD.	5	RUIRU	(0151) 21005	P. GITAU, MR.	BOOKKEEPER	380	180	200
ORBITSPTS LTD.	14075	NAIROBI	555636, 555066	E.O. MKAN	PERSONNEL MANAGER	400	240	60
PUT SARAJEVO GENERAL ENGINEERING	48331	NAIROBI	722277	GORAN, MR.	SECRETARY AG.	700	693	7
RAI PLYWOODS (K) LTD.	241	ELDORET	(0321) 33811	CHEGE, MR.	PERSONNEL OFFICER	1500	1400	100

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PRIVATE COMPANIES - RESPONSES (EXPANDED VERSION)

COMPANY	P.O. BOX	CITY	TELEPHONE	CONTACT PERSON	TITLE	TOTAL # EMPLOYEES	MALE	FEMALE
RAYMOND WOOLLEN MILLS (K) LTD.	735	ELDDRET	(0321) 31811-17	K.D. JOSHI, MR.	TRAINING MANAGER	2820	2270	550
SECURICOR (KENYA) LTD.	30242	NAIROBI	559033	NGORU, MR.	PERSONNEL MANAGER	7000	6970	30
SECURITY GUARDS LTD.	46175	NAIROBI	568115	ZIGARRAS, MR.	DIRECTOR	850	850	0
SERENA LODGES & HOTELS	18690	NAIROBI	339800	J.H. KARUNGU	GROUP PERSONNEL MANAGER	1125	975	150
SIRET TEA CO. LTD.- KABOSWA	321	MANDI HILLS	(0326) 43043	A.S.A. SOROBEA	GROUP MANAGER	904	753	151
SOCFINAF COMPANY LTD.	10	RUIRU	(0151) 21020/16	J.M. SAUNDERS, MRS.	EXECUTIVE ASSISTANT	3168	1723	1445
SPIN KNIT LTD.	1478	NAKURU	(037) 41665	EDITH NJOKI NGURE	NURSE	701	654	47
STANDARD CHARTERED BANK LTD.	30003	NAIROBI	330200	F.X. ONDARI	SENIOR MGR. PERSONNEL	2200	1432	768
SUNFLAG SPINNING MILLS (EA) LTD.	41627	NAIROBI	559711	ONDORO, MR.	PERSONNEL OFFICER	1482	1415	67
TEITA ESTATE LTD.	PRIVATE BAG	P.O. MWATATE	(0148) 2502/2506	SAVAS HADJISAVAS	GENERAL MANAGER	1674	1185	489
THIKA CLOTH MILLS	120	THIKA	(0151) 21651-3	PETER K. HEHO	INDUSTRIAL RELATIONS OFF.	1112	1097	15
TIMSALES LTD.	18080	NAIROBI	559584	TORA, MRS.	SECRETARY TO MNG. DIR.	3000	2890	110
TM-AM CONSTRUCTION GROUP	18424	NAIROBI	559088/9	M.L. MATHUR, MR.	COMPANY SECRETARY	850	848	2
UNGA LTD.	30386	NAIROBI	555133	WARUHIU, MRS.	OFFICE MANAGER	562	466	96
WELLS FARGO COMPANY LTD.	43370	NAIROBI	556935	GAI CULLEN, MRS.	GROUP OPERATIONS MGR.	700	695	5

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PRIVATE COMPANIES - RESPONSES (EXPANDED VERSION)

# OF BRANCHES 250+ EMPLOYEES	# OF EMPLOYEES LARGEST BRANCH	MALE	FEMALE	COMPANY CLINIC	OUTSIDE CLINIC	DEPENDENTS	OTHERS	FAMILY PLANNING	CONTRACEPTIVES	COUNSELLING	INTEREST *
N/A	.			NO	YES	YES	NO	NO	NO	NO	YES
3	2000	1980	20	NO	YES	YES	N/A	NO	N/A	N/A	YES
N/A				NO	NO	N/A	N/A	YES	YES	NO	YES
2	438	386	52	YES	YES	YES	NO	NO	N/A	N/A	YES
3	388	311	77	YES	YES	YES	NO	NO	NO	NO	YES
7	400			YES	-----	YES	NO	YES	YES	NO	YES
N/A				YES	YES	YES	NO	YES	YES	NO	YES
1	370	273	97	NO	YES	YES	N/A	NO	N/A	N/A	DO NOT KNOW
1	1097	1094	3	YES	YES	NO	NO	NO	N/A	N/A	YES
3	600	454	146	YES	YES	NO	NO	NO	NO	NO	YES
N/A				YES	NO	NO	NO	NO	NO	NO	YES
1	2000	1900	100	NO	YES	YES	N/A	NO	N/A	N/A	YES
1	660	660	0	NO	NO	NO	NO	NO	N/A	N/A	YES
1	245	199	46	YES	NO	NO	NO	NO	N/A	N/A	NO
1	600	595	5	NO	NO	N/A	N/A	NO	NO	NO	YES

APPENDIX D

PRIVATE COMPANIES (OTHER)

PRIVATE COMPANIES - FEWER THAN 250 EMPLOYEES

BUDGET SHOES LTD.	(160 TOTAL EMPLOYEES - QUESTIONNAIRE ANSWERED BY TELEPHONE)
CAPITAL CONSTRUCTION CO. KENYA LTD.	(25 EMPLOYEES NAIROBI, MANY LARGE CONSTRUCTION SITES OUTSIDE NAIROBI NEED TO BE CONTACTED INDIVIDUALLY)
CORRUGATED SHEETS LTD.	(118 TOTAL EMPLOYEES, LARGEST SITE HAS 74 -RETURNED QUESTIONNAIRE)
KENYA GRAIN GROWERS CO-OP UNION LTD.	(2450 TOTAL EMPLOYEES, NO SITE HAS 250, INTERESTED IN F.P. - RETURNED QUESTIONNAIRE)
KUNDAN SINGH CONSTRUCTION LTD.	(400 TOTAL EMPLOYEES, LARGEST SITE HAS 150 - RETURNED QUESTIONNAIRE)
LALJI BHINJI SANGHANI	(250 TOTAL EMPLOYEES AT PRESENT, LARGEST SITE HAS 190 - QUESTIONNAIRE ANSWERED BY TELEPHONE)
MOBASA COIR INDUSTRIES	(BETWEEN 20-150 TOTAL EMPLOYEES - INFORMATION RECEIVED BY TELEPHONE)
MOUNT KENYA MUSIC STORE	(10 TOTAL EMPLOYEES - INFORMATION RECEIVED BY TELEPHONE)
SHELL DEVELOPMENT (K) LTD.	(71 TOTAL EMPLOYEES, INTERESTED IN F.P. - QUESTIONNAIRE ANSWERED BY TELEPHONE)
WELLCOME KENYA LTD.	(109 TOTAL EMPLOYEES - QUESTIONNAIRE ANSWERED BY TELEPHONE)

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PRIVATE COMPANIES - NO RESPONSE

ACIF LTD.
AFRICAN RETAIL TRADERS KENYA LTD.
BAHARI MILLS (FORMERLY KENYA RAYON MILLS LTD.)
BLOCK HOTELS LTD.
CBM PACKAGING KENYA LTD.
EAST AFRICAN TANNING EXTRACT COMPANY
ELGON HOTEL
EMCO STEEL WORKS KENYA LTD.
HIGHWAY CARRIERS LTD.
H.Z. & COMPANY LTD.
INTERNATIONAL HOTELS CORP. LTD.
JAYDEES KNITTING FACTORY LTD.
KAHIUMWIRI FARMERS COMPANY LTD.
KALUWORKS LTD.
KARURI CIVIL ENGINEERING LTD.
KAVEE QUARRIES LTD.
KAYDEE CONSTRUCTION COMPANY
KENYA CO-OPERATIVE CREAMERIES LTD.
KENYA KAZI LTD.
KENYA TRADE & DEVELOPMENT COMPANY LTD.
KOBIL PETROLEUM LTD.
L.Z. ENGINEERING CONSTRUCTION
MAHALAXMI CONSTRUCTION LTD.
MANJI D CONSTRUCTION
M.D. HINDOCHA
MIGOTIYO PLANTATIONS LTD.
MUGOYA CONSTRUCTION & ENGINEERING LTD.
NAKURU INDUSTRIES LTD.
PRINTING & PACKAGING CORPORATION
SASALA CONSTRUCTION COMPANY
UNITED TEXTILE INDUSTRIES (K) LTD. (MANAGING DIRECTOR NOT INTERESTED)
VIPINGO ESTATE
WAFULA LARENCE WEKESA
WESKINS LTD.
WOOD PRODUCTS (K) LTD.

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PRIVATE COMPANIES - ELIMINATED FROM SURVEY

ARCADIA CONSTRUCTION CO. LTD.	(GOING OUT OF BUSINESS)
ASSOCIATED SUGAR COMPANY LTD.	(NO LONGER EXISTS, TAKEN OVER BY MAKEN HOLDINGS WHICH ALSO OWNS EMCO STEEL)
ATHINAI SISAL ESTATES LTD.	(PART OF MIGOTIYO PLANTATIONS LTD.)
BANITA SISAL ESTATE	(PART OF MAJANI MINGI)
DWA PLANTATIONS	(SAME AS BROOKE BOND SULMAC SISAL, KIBWEZI - ALREADY FPPS)
EAST AFRICA BAG & CORDAGE CO. LTD.	(UNDER RECEIVERSHIP)
EASTERN PRODUCE AFRICA LTD.	(KAKUZI LTD. IS PART OF EPA - FPPS ALREADY WORKS WITH SEVERAL EPA ESTATES)
KENSACK LTD.	(CLOSED DOWN)
KENYA TORAY MILLS LTD.	(NOW KENYA TAITEX MILLS - SEE PARASTATALS)
KERICHO TEA FACTORY	(SAME AS BROOKE BOND KERICHO - ALREADY FPPS)
KERITOR LTD. (ESTATE)	(PART OF KIPKEBE, SOTIK COMPANY - ALREADY FPPS)
KIBABET ESTATE LTD.	(PART OF EASTERN PRODUCE AFRICA LTD. - FPPS ALREADY WORKS WITH SEVERAL EPA ESTATES)
KIPKOINET TEA COMPANY LTD.	(PART OF EASTERN PRODUCE AFRICA LTD. - FPPS ALREADY WORKS WITH SEVERAL EPA ESTATES)
LOMOLO LTD.	(PART OF MIGOTIYO PLANTATIONS LTD.)
UPLANDS BACON FACTORY (K) LTD.	(UNDER RECEIVERSHIP)

APPENDIX E

PARASTATALS' RESPONSES (CONDENSED VERSION)

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PARASTATALS - RESPONSES (CONDENSED VERSION)

PARASTATAL	TOTAL # EMPLOYEES	MALE	FEMALE	# OF BRANCHES 250+ EMPLOYEES	# OF EMPLOYEES LARGEST BRANCH	MALE	FEMALE	COMPANY CLINIC	FAMILY PLANNING	INTEREST
AGRICULTURAL DEVELOPMENT CORPORATION	17500	15000	2500	52	1300	1000	300	YES	NO	YES
AGRICULTURAL FINANCE CORPORATION	1200			1	400	224	176	NO	NO	NO
COFFEE BOARD OF KENYA	2176	1626	550	1	2176	1626	550	NO	NO	YES
COFFEE RESEARCH FOUNDATION	984	800	184	1	834	658	176	YES	YES	N/A.
E.A. FINE SPINNERS LTD.	1107	1041	66	N/A				YES	NO	DO NOT KNOW
KENYA COMMERCIAL BANK LTD.	3386	2434	952	1	1104	747	357	NO	NO	YES
KENYA MEDICAL RESEARCH INSTITUTE	1000+	500	500	1	750	375	375	YES	NO	YES
KENYA NATIONAL ASSURANCE COMPANY, LTD.	2500	1600	900	1	700	400	300	NO	YES	-----
KENYA RAILWAYS CORPORATION	21032	20292	740	SEVERAL				YES	YES	YES
KENYA SEED COMPANY, LTD.	1000	650	350	3	500	180	320	NO	NO	YES
KENYA TAITEX MILLS LTD.	761	636	125	N/A				YES	NO	YES
KENYA TEA DEVELOPMENT AUTHORITY	10813	6210	4603	1	600	400	200	NO	YES	YES
KENYA UTALII COLLEGE	623	448	175	N/A				YES	YES	YES
MOUNT KENYA TEXTILE MILLS	1200	1190	20	N/A				NO	NO	DO NOT KNOW
NATIONAL IRRIGATION BOARD	973	918	65	1	355	342	13	NO	YES	-----
PAN VEGETABLE PROCESSORS LTD.	592	270	322	N/A				NO	NO	DO NOT KNOW
PYRETHRUM BOARD OF KENYA	1121	971	150	N/A				YES	NO	YES

APPENDIX F

PARASTATALS' RESPONSES (EXPANDED VERSION)

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PARASTATALS - RESPONSES (EXPANDED VERSION)

PARASTATAL	P.O. BOX	CITY	TELEPHONE	CONTACT PERSON	TITLE	TOTAL # EMPLOYEES	MALE	FEMALE
AGRICULTURAL DEVELOPMENT CORPORATION	47101	NAIROBI	338530, 222684	MARY C.A. OTIENO	SENIOR PERSONNEL OFFICER	17500	15000	2500
AGRICULTURAL FINANCE CORPORATION	30367	NAIROBI	333733	WELTON, MRS.	PRINCIPAL ADMIN. OFFICER	1200		
COFFEE BOARD OF KENYA	30566	NAIROBI	332896	PAUL KIVILA	PUBLIC RELATIONS OFFICER	2176	1626	550
COFFEE RESEARCH FOUNDATION	4	RUIRU	(0151) 21047	E.K. MAINA, MR.	ADMINISTRATIVE MANAGER	984	800	184
E.A. FINE SPINNERS LTD.	78114	NAIROBI	556144	H.G. MATHENGE	INDUSTRIAL ENGINEER	1107	1041	66
KENYA COMMERCIAL BANK LTD.	48400	NAIROBI	339441	J.F. KENANI, MR.	WELFARE OFFICER	3386	2434	952
KENYA MEDICAL RESEARCH INSTITUTE	54840	NAIROBI	722541/4	J.N. KARIUKI	PRINCIPAL ADMIN. OFFICER	1000+	500	500
KENYA NATIONAL ASSURANCE COMPANY, LTD.	20425	NAIROBI	338660	ZENNAH BIWOTT, MRS.	SENIOR EXECUTIVE ASST.	2500	1600	900
KENYA RAILWAYS CORPORATION	30121	NAIROBI	221211	R.M. KARURI	SENIOR PERSONNEL OFFICER	21032	20292	740
KENYA SEED COMPANY, LTD.	553	KITALE	(0325) 20941-3	S.N. OMAMO, MR.	COMPANY SECRETARY	1000	650	350
KENYA TAITEX MILLS LTD.	581	THIKA	(0151) 21671-5	R.M. MUTHUI	CHIEF ACCOUNTANT	761	636	125
KENYA TEA DEVELOPMENT AUTHORITY	30213	NAIROBI	221441	PETER A. OKORE	PERSONNEL OFFICER	10813	6210	4603
KENYA UTALII COLLEGE	31052	NAIROBI	802540	M.K. SIO, MP.	PRINCIPAL	623	448	175
MOUNT KENYA TEXTILE MILLS	115	NANYUKI	(0176) 22003/8	KANDIE, MR.	MANAGING DIRECTOR	1200	1180	20
NATIONAL IRRIGATION BOARD	30372	NAIROBI	722590-4	S.K. KIMANI	FIELD MEDICAL TECHNOLOGIST	973	918	65
PAN VEGETABLE PROCESSORS LTD.	248	NAIVASHA	(0311) 20488	WAMBUGU, MR.	PERSONNEL ASSISTANT	592	270	322
PYRETHRUM BOARD OF KENYA	420	NAKURU	(037) 40311	LUCY H. GIKOMYO	WELFARE OFFICER	1121	971	150

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PARASTATALS - RESPONSES (EXPANDED VERSION)

# OF BRANCHES 250+ EMPLOYEES	# OF EMPLOYEES LARGEST BRANCH	MALE	FEMALE	COMPANY CLINIC	OUTSIDE CLINIC	DEPENDENTS	OTHERS	FAMILY PLANNING	CONTRACEPTIVES	COUNSELLING	INTEREST
52	1300	1000	300	YES	YES	YES	YES	NO	NO	NO	YES
1	400	224	176	NO	YES	YES	N/A	NO	N/A	N/A	NO
1	2176	1626	550	NO	YES	YES	NO	NO	NO	NO	YES
1	834	650	176	YES	NO	YES	NO	YES	YES	YES	N/A
N/A				YES	NO	NO	NO	NO	N/A	N/A	DO NOT KNOW
1	1104	747	357	NO	YES	YES	N/A	NO	N/A	N/A	YES
1	750	375	375	YES	YES	YES	YES	NO	N/A	N/A	YES
1	700	400	300	NO	YES	YES	NO	YES	YES	NO	-----
SEVERAL				YES	YES	YES	YES	YES	YES	YES	YES
3	500	180	320	NO	YES	YES	N/A	NO	N/A	N/A	YES
N/A				YES	YES	YES	NO	NO	NO	NO	YES
1	600	400	200	NO	YES	YES	N/A	YES	YES	YES	YES
N/A				YES	-----	YES	NO	YES	YES	YES	YES
N/A				NO	YES	YES	N/A	NO	N/A	N/A	DO NOT KNOW
1	355	342	13	NO	NO	N/A	N/A	YES	YES	YES	-----
N/A				NO	YES	YES	N/A	NO	N/A	N/A	DO NOT KNOW
N/A				YES	NO	YES	NO	NO	N/A	N/A	YES

APPENDIX G
PARASTATALS (OTHER)

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PARASTATALS - FEWER THAN 250 EMPLOYEES

KENYA INDUSTRIAL ESTATES

(585 TOTAL EMPLOYEES, LARGEST SITE HAS 225 - QUESTIONNAIRE ANSWERED BY TELEPHONE)

KERIO VALLEY DEVELOPMENT AUTHORITY

(604 TOTAL EMPLOYEES, NO SITE HAS 250, INTERESTED IN F.P. - RETURNED QUESTIONNAIRE)

NATIONAL BANK OF KENYA

(1000 TOTAL EMPLOYEES, NO SITE HAS 250 - QUESTIONNAIRE ANSWERED BY TELEPHONE)

PARASTATALS - NO RESPONSE

ASSOCIATED VEHICLE ASSEMBLERS LTD.

KENYA MARINE & FISHERIES RESEARCH INST.

LAKE BASIN DEVELOPMENT AUTHORITY

APPENDIX H
QUESTIONNAIRE FOR HEALTH FACILITIES

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- H1 -

Family Planning Private Sector Programme

7th Floor, Longonot Place, Kijabe Street, P O Box 46042, Nairobi, Kenya.
Telephone: 24646, 24655, 27614, 29159. Telex: 25342 "JSI GROUP".

November 6, 1990

The Director

Dear Sir or Madam:

The Family Planning Private Sector programme (FPPS) was created in 1984 to provide family planning services in the private sector. FPPS operates under the guidance of the National Council for Population and Development (NCPD) of the Ministry of Home Affairs and National Heritage. The NCPD is the government organization that provides policy guidance and coordinates family planning activities in Kenya. Under the FPPS programme, financial, logistical, and training assistance have been offered to approximately 70 private nursing homes and clinics to introduce or expand family planning services offered to clients. Assistance has also been provided to private companies and parastatals that offer family planning to employees and dependents. The programme is funded primarily by the United States Agency for International Development (USAID).

As the current project is scheduled to end in September 1991, USAID is now determining if there is need for a follow-on phase of the programme. USAID would like to estimate the potential demand for family planning assistance that exists among organizations that have not yet been involved in the project. In order to do this we are sending the attached questionnaire to a sample of privately owned nursing homes, maternity homes, and clinics in Kenya. The purpose of the questionnaire is to find out if private health facilities are offering family planning services. Your assistance in completing the attached questionnaire would be extremely helpful.

Please be assured that the questionnaire is informal, and is meant to serve as a guide for USAID's planning. Your responses will be kept confidential. We hope that you will take a few minutes to complete the questionnaire and will return it as quickly as possible in the enclosed, stamped envelope. We appreciate your assistance. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mary Ibutu', written in a cursive style.

Mary Ibutu
Programme Administrator

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QUESTIONNAIRE

1. Name of Health Facility: _____

Postal Address: _____

Telephone Number: _____

Name of Contact Person: _____

Title of Contact Person: _____

2. Please indicate which of the following best describes the health facility by marking a check in the appropriate space:

- | | | | |
|-------------------------------------|-------|------------------|-------|
| a) Hospital | _____ | d) Health Centre | _____ |
| b) Maternity and/or
Nursing Home | _____ | e) Dispensary | _____ |
| c) Clinic | _____ | f) Other | _____ |

3. Please indicate who administers the health facility by marking a check in the appropriate space:

- | | |
|--|-------|
| a) local or national government | _____ |
| b) religious organization (mission) | _____ |
| c) commercial firm or company | _____ |
| d) private individual(s) or partnership | _____ |
| e) non-governmental organization (non-religious) | _____ |
| f) other (please specify) | _____ |

4. Please estimate the average number of clients served by the health facility in a week and mark a check in the appropriate space:

- | | | | |
|---------------|-------|----------------|-------|
| a) 0 to 99 | _____ | c) 200 to 299 | _____ |
| b) 100 to 199 | _____ | d) 300 or more | _____ |

QUESTIONNAIRE - Page Two

Name of Facility _____

5. Please estimate the percentage of total clients served that is female and mark a check in the appropriate space.

- a) 0 to 25% _____
- b) 26% to 50% _____
- c) 51% to 100% _____

6. Are the following services offered at the health facility?

- | | <u>YES</u> | <u>NO</u> |
|---------------------------------|------------|-----------|
| a) family planning services | _____ | _____ |
| b) maternal & child health care | _____ | _____ |
| c) delivery services | _____ | _____ |
| d) surgical services | _____ | _____ |

7. If family planning services are provided, are the following services available?

- | | <u>YES</u> | <u>NO</u> |
|-------------------|------------|-----------|
| a) contraceptives | _____ | _____ |
| b) counselling | _____ | _____ |

8. (FOR THOSE FACILITIES THAT DO NOT AT PRESENT PROVIDE FAMILY PLANNING SERVICES):

If resources were available, would the health facility be interested in introducing family planning services?

YES _____ NO _____ DO NOT KNOW _____

THANK YOU!

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APPENDIX I

HEALTH FACILITIES - RESPONSES

The questionnaire that was sent to private health facilities turned out to be very straight forward. Very few responses required telephone follow-up for clarification.

Question #2

This question asked respondents to identify the type of health facility. If a health facility that responded by mail indicated more than one type of facility, the first type marked was recorded in the chart. Since the choices of facility types were arranged in descending order of size on the questionnaire, this means that the largest type was marked in the chart.

Question #6

A positive response to the question on provision of family planning services does not indicate details on the types, quality and amounts of family planning offered. Additional notes on some of the questionnaires provide more information. (For responses received by telephone, a "Yes" was marked even if the family planning services offered were minimal.) For this reason even those health facilities that already provide family planning could be considered to be potentially in need of assistance to improve services.

Question #7

The question on availability of contraceptives and counselling was phrased to be dependent upon provision of family planning. This question technically should not apply to health facilities that do not provide family planning. (For responses received by telephone, "N/A" for "Not Applicable" was marked for Question #7 for facilities that do not provide family planning.)

Question #8

The last question asked about interest in introducing family planning services, for facilities that do not at present provide family planning. As for companies, this question is subjective and might not be a meaningful guide for planning future assistance strategies. In addition, the question was phrased to apply only to health facilities that do not currently provide family planning. Technically, the response for facilities that already have family planning should be "N/A". Many facilities that already provide family planning left this question blank. Facilities that marked "Yes" despite already having family planning might be interested in expanding family planning services or in receiving assistance for them.

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09/20

HEALTH FACILITIES - RESPONSES (CONDENSED VERSION)

HEALTH FACILITY	TYPE OF FACILITY	ADMINISTRATION	# CLIENTS PER WEEK	% CLIENTS FEMALE	FAMILY PLANNING	MCH	DELIVERY	SURGICAL *	INTEREST
AGA KHAN HOSPITAL, THE	HOSPITAL	NGO	300+	0-25%	YES	YES	YES	YES	-----
AGA KHAN HOSPITAL, THE	HOSPITAL	NGO	300+	51-100%	YES	YES	YES	YES	N/A
AGA KHAN HOSPITAL, THE	HOSPITAL	NGO	200-299	51-100%	YES	YES	YES	YES	N/A
ALPHA MATERNITY HOME	MAT/NURSING HOME	PRIVATE	0-99	51-100%	NO	NO	YES	NO	YES
AVENUE NURSING HOME	NURSING HOME	PRIVATE	0-99	0-25%	YES	YES	YES	YES	YES
BETHANY HOSPITAL	HOSPITAL	PRIVATE	300+	51-100%	NO	YES	YES	YES	YES
BOYA RURAL NURSING HOME	MAT/NURSING HOME	PRIVATE	300+	51-100%	YES	YES	-----	-----	YES
BUNGOMA NURSING HOME	HOSPITAL	PRIVATE	0-99	51-100%	YES	YES	YES	YES	YES
BURHANI FOUNDATION CLINIC	CLINIC	RELIGIOUS ORG.	100-199	26-50%	NO	YES	NO	NO	DO NOT KNOW
CENTRAL MEMORIAL HOSPITAL	HOSPITAL	PRIVATE	0-99	0-25%	YES	YES	YES	YES	-----
CHRISTA MARIANNE NURSING HOME	HOSPITAL	PRIVATE	0-99	26-50%	YES	YES	YES	YES	-----
CITY NURSING HOME	NURSING HOME	PRIVATE	0-99	0-25%	NO	NO	NO	YES	YES
GALANA HOSPITAL	HOSPITAL	COMMERCIAL FIRM	100-199	0-25%	YES	YES	YES	YES	-----
GURU NANAK CLINIC	HEALTH CENTRE	RELIGIOUS ORG.	300+	26-50%	NO	YES	NO	NO	YES
GURU NANAK HARAMBEE DISPENSARY	DISPENSARY	RELIGIOUS ORG.	0-99	51-100%	YES	NO	NO	NO	N/A
GURU NANAK RAMGARHIA HOSPITAL	HOSPITAL	RELIGIOUS ORG.	0-99	26-50%	YES	YES	YES	YES	YES
HURUMA MEDICAL CENTRE	DISPENSARY	PRIVATE	200-299	26-50%	NO	NO	NO	YES	YES
IDEAL NURSING HOME	MAT/NURSING HOME	PRIVATE	100-199	26-50%	YES	YES	YES	YES	-----
INDER NURSING HOME	MAT/NURSING HOME	PRIVATE	0-99	26-50%	YES	YES	YES	YES	-----
JAMAA MATERNITY HOSPITAL	MAT/NURSING HOME	RELIGIOUS ORG.	200-299	51-100%	YES	YES	YES	YES	-----
KERICHO NURSING HOME	MAT/NURSING HOME	PRIVATE	0-99	26-50%	YES	YES	YES	NO	-----
KIBIRICHIA MATERNITY HOME	MATERNITY HOME	PRIVATE	0-99	26-50%	YES	YES	YES	YES	YES
KIKUYU NURSING HOME	MAT/NURSING HOME	PRIVATE	100-199	0-25%	YES	NO	NO	YES	-----
KITALE NURSING & MATERNITY HOME	HOSPITAL	PRIVATE	300+	0-25%	YES	YES	YES	YES	-----
KORU NURSING HOME	MAT/NURSING HOME	PRIVATE	200-299	26-50%	YES	YES	YES	YES	YES
LAKE NURSING HOME	MAT/NURSING HOME	PRIVATE	300+	26-50%	YES	YES	YES	YES	YES
LIMURU NURSING HOME	MAT/NURSING HOME	PRIVATE	200-299	26-50%	YES	YES	YES	YES	-----
MACHAKOS NURSING HOME	MAT/NURSING HOME	PRIVATE	100-199	26-50%	YES	YES	YES	YES	-----
MENENGAI NURSING & MATERNITY HOME	MAT/NURSING HOME	PRIVATE	100-199	26-50%	YES	YES	YES	YES	YES
MERU NURSING HOME	HOSPITAL	PRIVATE	0-99	51-100%	YES	YES	YES	YES	-----
MILIMANI MATERNITY & NURSING HOME	MAT/NURSING HOME	PRIVATE	100-199	51-100%	YES	YES	YES	YES	-----

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HEALTH FACILITIES - RESPONSES (CONDENSED VERSION)

HEALTH FACILITY	TYPE OF FACILITY	ADMINISTRATION	# CLIENTS PER WEEK	% CLIENTS FEMALE	FAMILY PLANNING	MCH	DELIVERY	SURGICAL	INTEREST
MOMBASA HOSPITAL ASSOCIATION	HOSPITAL	ASSOCIATION	300+	26-50%	YES	YES	YES	YES	-----
MOUNT ELGON HOSPITAL	HOSPITAL	NGO	0-99	0-25%	YES	NO	YES	YES	-----
MAKURU WAR MEMORIAL HOSPITAL	HOSPITAL	NGO	100-199	51-100%	NO	NO	YES	YES	YES
ORUBA NURSING & MATERNITY HOME	MAT/NURSING HOME	PRIVATE	200-299	26-50%	YES	YES	YES	NO	YES
PANDYA MEMORIAL HOSPITAL	HOSPITAL	-----	200-299	26-50%	YES	YES	YES	YES	-----
PARK ROAD NURSING HOME	MAT/NURSING HOME	PRIVATE	200-299	26-50%	YES	YES	YES	YES	YES
RADIANT HEALTH CLINIC, THE	MAT/NURSING HOME	PRIVATE	100-199	51-100%	YES	YES	YES	YES	-----
RAMGARHIA SIKH DISPENSARY	HOSPITAL	RELIGIOUS ORG.	100-199	0-25%	YES	YES	-----	-----	YES
SOCIAL SERVICE LEAGUE M P SHAH HOSPITAL	HOSPITAL	NGO	300+	26-50%	NO	NO	YES	YES	YES
THIKA NURSING HOME	MAT/NURSING HOME	PRIVATE	0-99	0-25%	YES	YES	YES	YES	-----
UASIN GISHU MEMORIAL HOSPITAL	HOSPITAL	PRIVATE	0-99	0-25%	NO	YES	YES	YES	YES
VIBHAKAR'S, DR. MAT/NURSING HOME	MAT/NURSING HOME	PRIVATE	100-199	26-50%	YES	YES	YES	YES	YES
WANGU MATERNITY HOME	MAT. HOME/DISP.	PRIVATE	200-299	51-100%	NO	YES	YES	NO	YES
WEBUYE NURSING HOME	MAT/NURSING HOME	PRIVATE	200-299	26-50%	YES	YES	YES	YES	-----
YOUNG MUSLIM DISPENSARY	DISPENSARY	RELIGIOUS ORG.	0-99	0-25%	NO	YES	NO	YES	YES

APPENDIX J

HEALTH FACILITIES' RESPONSES (EXPANDED VERSION)

HEALTH FACILITIES - RESPONSES (EXPANDED VERSION)

HEALTH FACILITY	P.O. BOX	CITY	TELEPHONE	CONTACT PERSON	TITLE	TYPE OF FACILITY
AGA KHAN HOSPITAL, THE	530	KISUMU	(035) 43516	MR. S.F. RASHID	ADMINISTRATOR	HOSPITAL
AGA KHAN HOSPITAL, THE	83013	MOMBASA	(011) 312953/4/5	KHUSHNGODA SHIVJI	ASST. ADMINISTRATOR	HOSPITAL
AGA KHAN HOSPITAL, THE	30270	NAIROBI	740000	MR. A. VISRAM	ADMINISTRATIVE DIRECTOR	HOSPITAL
ALPHA MATERNITY HOME	16022	NAIROBI	760035, 332150	DR. OMONDI	DOCTOR	MAT/NURSING HOME
AVENUE NURSING HOME	45280	NAIROBI	744012	MRS. NDOTO	DIRECTOR NURSING SERVICES	NURSING HOME
BETHANY HOSPITAL	434	MACHAKOS	(0145) 21983	DR. C.A. NZOKA	MANAGING DIRECTOR/ADMIN.	HOSPITAL
BOYA RURAL NURSING HOME	1207	KISUMU	(035) 43301/6	DR. D.O. OLIMA	MEDICAL DIRECTOR	MAT/NURSING HOME
BUNGOMA NURSING HOME	797	BUNGOMA	(0337) 20076	DR. ORWENYO	DIRECTOR/ MED. OFF. I/C	HOSPITAL
BURHANI FOUNDATION CLINIC	69515	NAIROBI	227955	DR. ISA	DOCTOR IN CHARGE	CLINIC
CENTRAL MEMORIAL HOSPITAL	1734	THIKA	(0151) 22884	MR. MUNYASYA	ADMINISTRATOR	HOSPITAL
CHRISTA MARIANNE NURSING HOME	335	KISII	(0381) 20592	DR. C.M. OTARU	DIRECTOR	HOSPITAL
CITY NURSING HOME	14591	NAIROBI	337843, 337513	DR. ENASS AYAG	DOCTOR IN CHARGE	NURSING HOME
GALANA HOSPITAL	47	MALINDI	(0123) 20837	DR. MUSTAFA KAMANI	MEDICAL DOCTOR	HOSPITAL
GURU NANAK CLINIC	98024	MOMBASA	(011) 490737	DR. VARINDER SINGHSUR	PROJECT DIRECTOR	HEALTH CENTRE
GURU NANAK HARAMBEE DISPENSARY	180	KISUMU	(035) 44111	DR. ANIL RUPARELIA	MEDICAL OFFICER I/C	DISPENSARY
GURU NANAK RAMGARHIA HOSPITAL	33071	NAIROBI	763481/2	SISTER SHARMA	MATRON	HOSPITAL
HURUMA MEDICAL CENTRE	29003	NAIROBI	766293	MRS. MAINA	SISTER IN CHARGE	DISPENSARY
IDEAL NURSING HOME	31417	NAIROBI	764539	DR. MOHAMED	MEDICAL DOCTOR	MAT/NURSING HOME
INDER NURSING HOME	31416	NAIROBI.	766131, 760926	DR. MEHTA	MEDICAL OFFICER I/C	MAT/NURSING HOME
JAMAA MATERNITY HOSPITAL	17153	NAIROBI	792579	RACHAEL M. MAINGI	SECOND IN CHARGE	MAT/NURSING HOME
KERICHO NURSING HOME	510	KERICHO	(0361) 20270	DR. PRAKASH KOTECHEA	MEDICAL OFFICER	MAT/NURSING HOME
KIBIRICHIA MATERNITY HOME	974	MERU	KIBIRICHIA 4	EVANGELINE MTWARUCHIU	REGISTERED MIDWIFE	MATERNITY HOME
KIKUYU NURSING HOME	305	KIKUYU	(0154) 32045	DR. P.H. PARMAR	MEDICAL OFFICER	MAT/NURSING HOME
KITALE NURSING & MATERNITY HOME	1825	KITALE	(0325) 20775	DR. A.R. MAHIDA	MEDICAL OFFICER/ADMIN.	HOSPITAL
KORU NURSING HOME	151	KORU	KORU 5, 70	DR. VIRAM GODHANIA	MEDICAL OFFICER	MAT/NURSING HOME
LAKE NURSING HOME	151	KORU	KORU 5, 70	DR. VIRAM GODHANIA	DIRECTOR	MAT/NURSING HOME
LIMURU NURSING HOME	359	LIMURU	(0154) 41298	DR. R.K. PATEL	MEDICAL OFFICER I/C	MAT/NURSING HOME
MACHAKOS NURSING HOME	456	MACHAKOS	(0145) 21091	DR. KIGONYA WOTTO	RESIDENT MEDICAL OFFICER	MAT/NURSING HOME
MENENGAI NURSING & MATERNITY HOME	2811	NAKURU	(037) 40187	DR. B. ABCNGO OKOKO	DOCTOR	MAT/NURSING HOME
MERU NURSING HOME	497	MERU	(0164) 20110	DR. E.N. WANGAI	DOCTOR IN CHARGE	HOSPITAL
MILIMANI MATERNITY & NURSING HOME	326	MERU	(0164) 20125	DR. J.M. KITAVI	DOCTOR IN CHARGE	MAT/NURSING HOME

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HEALTH FACILITIES - RESPONSES (EXPANDED VERSION)

HEALTH FACILITY	P.O. BOX	CITY	TELEPHONE	CONTACT PERSON	TITLE	TYPE OF FACILITY
MOMBASA HOSPITAL ASSOCIATION	90294	MOMBASA	(011) 312191	DR. ROGARTH LEMA	RESIDENT DOCTOR	HOSPITAL
MOUNT ELGON HOSPITAL	339	KITALE	(0325) 20025	DR. JAMES K. MURGOR	CONSULTANT PHYSICIAN	HOSPITAL
NAKURU WAR MEMORIAL HOSPITAL	240	NAKURU	(037) 43444	ROSE AOKO	MATRON	HOSPITAL
URUBA NURSING & MATERNITY HOME	472	SUNA MIGORI	SUNA 169	GEORGE S. WEMA	CHAIRMAN	MAT/NURSING HOME
PANDYA MEMORIAL HOSPITAL	90434	MOMBASA	(011) 314140/1	-----	MATRON	HOSPITAL
PARK ROAD NURSING HOME	45981	NAIROBI	764003, 764514	DR. H.S. GHATAURA	MEDICAL OFFICER I/C	MAT/NURSING HOME
RADIANT HEALTH CLINIC, THE	31278	NAIROBI	760404, 760096	MRS. F.M. MACHARIA	ADMINISTRATOR	MAT/NURSING HOME
RAMGARHIA SIKH DISPENSARY	132	KISUMU	(035) 43506	DR. A.H. PRAJAPATI	MEDICAL OFFICER	HOSPITAL
SOCIAL SERVICE LEAGUE M P SHAH HOSPITAL	14497	NAIROBI	742763-7	MR. D.K. DEY	ADMINISTRATOR	HOSPITAL
THIKA NURSING HOME	429	THIKA	(0151) 22188	DR. CHARLES ANDAI	RESIDENT MEDICAL OFFICER	MAT/NURSING HOME
UASIN GISHU MEMORIAL HOSPITAL	180	ELDORET	(0321) 32261	DR. B. OSORE	MEDICAL OFFICER	HOSPITAL
VIBHAKAR'S, DR. MAT/NURSING HOME	90422	MOMBASA	(011) 26306	DR. M.D. VIBHAKAR	M.B.B.S.	MAT/NURSING HOME
WANGU MATERNITY HOME	420	NAIVASHA	44Y3 N/KINANGOP	MRS. H. WANGU NGARI	ENROLLED NURSE/MIDWIFE	MAT. HOME/DISP.
WEBUYE NURSING HOME	1122	WEBUYE	(0337) 41246	NAM RICHARD	MEDICAL OFFICER	MAT/NURSING HOME
YOUNG MUSLIM DISPENSARY	49	GARISSA	(0131) 2147	FARAH ALI IDOW	CLINICAL OFFICER	DISPENSARY

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HEALTH FACILITIES - RESPONSES (EXPANDED VERSION)

ADMINISTRATION	# CLIENTS PER WEEK	% CLIENTS FEMALE	FAMILY PLANNING	MCH	DELIVERY	SURGICAL	CONTRACEPTIVES	COUNSELLING	INTEREST
ASSOCIATION	300+	26-50%	YES	YES	YES	YES	YES	YES	-----
NGO	0-99	0-25%	YES	NO	YES	YES	YES	NO	-----
NGO	100-199	51-100%	NO	NO	YES	YES	N/A	N/A	YES
PRIVATE	200-299	26-50%	YES	YES	YES	NO	YES	YES	YES
-----	200-299	26-50%	YES	YES	YES	YES	YES	NO	-----
PRIVATE	200-299	26-50%	YES	YES	YES	YES	YES	YES	YES
PRIVATE	100-199	51-100%	YES	YES	YES	YES	YES	YES	-----
RELIGIOUS ORG.	100-199	0-25%	YES	YES	-----	-----	YES	YES	YES
NGO	300+	26-50%	NO	NO	YES	YES	NO	NO	YES
PRIVATE	0-99	0-25%	YES	YES	YES	YES	YES	YES	-----
PRIVATE	0-99	0-25%	NO	YES	YES	YES	N/A	N/A	YES
PRIVATE	100-199	26-50%	YES	YES	YES	YES	YES	YES	YES
PRIVATE	200-299	51-100%	NO	YES	YES	NO	N/A	N/A	YES
PRIVATE	200-299	26-50%	YES	YES	YES	YES	YES	YES	-----
RELIGIOUS ORG.	0-99	0-25%	NO	YES	NO	YES	N/A	N/A	YES

APPENDIX K
HEALTH FACILITIES (OTHER)

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HEALTH FACILITIES - NO RESPONSE

ALHAD HATIMY, DR. CLINIC
ARYA SAMAJ DISPENSARY
KEROKA MATERNITY & NURSING HOME
KIBOS ROAD NURSING & MATERNITY HOME
KISII MATERNITY & NURSING HOSPITAL
LADY MARGRET MATERNITY PAVILLION
MASABA NURSING HOME
MOUNT SINAI MATERNITY & NURSING HOME
MUGUGA NURSING HOME
MUTHIGA MEDICAL CENTRE
NAIROBI HOSPITAL
NAIROBI WEST NURSING HOME
NEW BUSIA MATERNITY & NURSING HOME
NYAMIRA MATERNITY & NURSING HOME
SAIFEE FOUNDATION CLINIC
SHREE CUTEH SAT SANG SWAMINARAYAN TEMPLE
VISA OSHWAL DISPENSARY & NURSING HOME
WESTLANDS COTTAGE HOSPITAL

1972

HEALTH FACILITIES - ELIMINATED FROM SURVEY

AGA KHAN CLINIC, NAIROBI	(PART OF THE AGA KHAN HOSPITAL, NAIROBI)
GERTRUDES GARDEN CHILDREN'S HOSPITAL	(CHILDREN'S HOSPITAL ONLY)
LIGHT HOUSE FOR CHRIST EYE CLINIC	(EYE CLINIC ONLY)
KITUI HOSPITAL	(DISTRICT HOSPITAL)
MATER MISERICORDIAE HOSPITAL	(FAMILY LIFE EDUCATION, NATURAL FAMILY PLANNING)

APPENDIX L

SUMMARY OF DATA

I. QUESTIONNAIRE RESULTS

A. PRIVATE COMPANIES

Mailed to 106.

Eliminated 15; sample = 91.

Responses = 56. (Response rate = 56/91 = 62%)

46 responses eligible by size.

1) PRIVATE COMPANIES WITH COMPANY CLINIC = 28

a) 15 do not provide FP

i)	11	Yes Interest in FP			
ii)	1	Do Not Know	"	"	"
iii)	3	No	"	"	"

b) 13 provide FP

i)	8	Yes Interest in FP			
ii)	4	Blank	"	"	"
iii)	1	Do Not Know	"	"	"

B. PARASTATALS

Mailed to 23.

Sample = 23.

Responses = 20. (Response rate = 20/23 = 87%)

17 responses eligible by size.

1) PARASTATALS WITH COMPANY CLINIC = 8

a) 5 do not provide FP

i)	4	Yes Interest in FP			
ii)	1	Do Not Know	"	"	"

b) 3 provide FP

i)	2	Yes Interest in FP			
ii)	1	N/A	"	"	"

C. SUMMARY FOR COMPANIES (PRIVATE AND PARASTATALS)

1) FIRMS WITH COMPANY CLINIC:

- DO NOT PROVIDE FAMILY PLANNING
- YES INTEREST IN FAMILY PLANNING

11 Private + 4 Parastatals = 15

2) FIRMS WITH COMPANY CLINIC:

- DO NOT PROVIDE FAMILY PLANNING
- (INTEREST IN FP IRRELEVANT)

15 Private + 5 Parastatals = 20

3) FIRMS WITH COMPANY CLINIC:

- YES INTEREST IN FAMILY PLANNING
- (WHETHER OR NOT PROVIDE FP)

19 Private + 6 Parastatals = 25

4) FIRMS WITH COMPANY CLINIC:

- (WHETHER OR NOT PROVIDE FP)
- (INTEREST IN FP IRRELEVANT)

28 Private + 8 Parastatals = 36

D. HEALTH FACILITIES

Mailed to 69.

Eliminated 5; sample = 64.

Responses = 46. (Response rate = $46/64 = 72\%$)

1) 11 do not provide FP

- a) 10 Yes Interest in FP
- b) 1 Do Not Know " " "

2) 35 provide FP

- a) 12 Yes Interest in FP
- b) 20 Blank " " "
- c) 3 N/A " " "

E. SUMMARY FOR HEALTH FACILITIES

1) - DO NOT PROVIDE FAMILY PLANNING
- YES INTEREST IN FAMILY PLANNING = 10

2) - DO NOT PROVIDE FAMILY PLANNING
- (INTEREST IN FP IRRELEVANT) = 11

3) - YES INTEREST IN FAMILY PLANNING
- (WHETHER OR NOT PROVIDE FP)

10 do not provide FP + 12 provide FP = 22

4) - (WHETHER OR NOT PROVIDE FP)
- (INTEREST IN FP IRRELEVANT)

11 do not provide FP + 35 provide FP = 46

II. SUMMARY OF ALL DATA

1) HAVE A CLINIC - DO NOT PROVIDE FAMILY PLANNING
- YES INTEREST IN FAMILY PLANNING

15 Companies + 10 Health Facilities = 25

2) HAVE A CLINIC - DO NOT PROVIDE FAMILY PLANNING
- (INTEREST IN FP IRRELEVANT)

20 Companies + 11 Health Facilities = 31

3) HAVE A CLINIC - YES INTEREST IN FAMILY PLANNING
- (WHETHER OR NOT PROVIDE FP)

25 Companies + 22 Health Facilities = 47
+ 8 Companies from 1988 Survey = 55

4) HAVE A CLINIC - (WHETHER OR NOT PROVIDE FP)
- (INTEREST IN FP IRRELEVANT)

36 Companies + 46 Health Facilities = 82
+ 8 Companies from 1988 Survey = 90

III. POTENTIAL ADDITIONAL DEMAND

20 Teacher Training Colleges
80 Health Facilities of CHAK, Crescent, SDA
Branches of FPPS Assisted Companies (8 or more such companies)
8 Requests Received by FPPS from Companies
28 Requests Received by FPPS from Health Facilities

Private Sector Family Planning Project
Detailed Illustrative Budget for A.I.D. Contributions
Amounts in US Dollars

Annex G (i)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total	FX	LC
TECHNICAL ASSISTANCE & MGT SUPPORT										
Salaries										
Project Director	40,000	44,000	48,400	53,240	58,544	64,420	70,862	379,487		379,487
D/Project Director	40,000	44,000	48,400	53,240	58,544	64,420	70,862	379,487	379,487	0
IEC Specialist	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
Training Specialist	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
Medical/Clinical	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
Logistics/Commodities/MIS	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
Research/Evaluation	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
Accountant	20,000	22,000	24,200	26,620	29,282	32,210	35,431	189,743		189,743
3 Secretaries	30,000	33,000	36,300	39,930	43,923	48,315	53,147	284,615		284,615
4 Drivers	13,200	14,520	15,972	17,569	19,326	21,259	23,385	125,231		125,231
1 Messenger/Clerk	2,500	2,750	3,025	3,328	3,660	4,026	4,429	23,718		23,718
Total Salaries	245,700	270,270	297,297	327,027	359,729	395,702	435,273	2,330,998	379,487	1,951,511
Fringe Benefits (20% of Salary)	49,140	54,054	59,459	65,405	71,944	79,140	87,055	466,200	75,897	390,302
Travel & Transportation										
Entry/Exit	10,000						10,000	20,000	20,000	
RBR/Home Leave		20,000		20,000		20,000		60,000	60,000	
Incountry Travel	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000		70,000
Local Per Diem	15,000	15,000	15,000	15,000	15,000	15,000	15,000	105,000		105,000
Total Travel & Transportation	35,000	45,000	25,000	45,000	25,000	45,000	35,000	255,000	80,000	175,000
Education Allowance										
House Allowance	14,000	14,000	14,000	14,000	14,000	14,000	14,000	98,000	98,000	
Guards	5,000	5,000	5,000	5,000	5,000	5,000	5,000	35,000		35,000
Total Other Allowances	29,000	203,000	168,000	35,000						
External Consultants										
3 months/yr@22@6300	19,800	19,800	19,800	19,800	19,800	19,800	19,800	138,600	138,600	
International Travel	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000	70,000	
Per Diem/Local Travel	14,400	14,400	14,400	14,400	14,400	14,400	14,400	100,800	100,800	
Local Consultants										
3 months/yr@22@6150	9,900	9,900	9,900	9,900	9,900	9,900	9,900	69,300		69,300
Incountry Travel	5,000	5,000	5,000	5,000	5,000	5,000	5,000	35,000		35,000
Per Diem	14,400	14,400	14,400	14,400	14,400	14,400	14,400	100,800		100,800
Total Consultants	73,500	514,500	309,400	205,100						
Total TA & Mgt Support	432,340	471,824	484,256	539,932	559,175	622,343	659,827	3,769,697	1,012,784	2,756,913
TRAINING										
7 Weeks FP Course	125,000	125,000	250,000	250,000	125,000	125,000	125,000	1,125,000		1,125,000
1 Week Refresher	7,000	7,000	14,000	14,000	7,000	7,000	7,000	63,000		63,000
2 Weeks Field Educators(IEC)	8,400	8,400	8,400	8,400	8,400	8,400	8,400	58,800		58,800
2 Weeks CBD	4,200	4,200	4,200	4,200	4,200	4,200	4,200	29,400		29,400

C/An

3 Days Field Edu Workshop	5,400	5,400	5,400	5,400	5,400	5,400	5,400	37,800		37,800
Total Training	150,000	150,000	282,000	282,000	150,000	150,000	150,000	1,314,000	0	1,314,000
EQUIPMENT & SUPPLIES										
4 Vehicles	100,000	0	0	0	0	0	0	100,000	100,000	
Vehicle Maintenance	20,000	20,000	20,000	20,000	20,000	20,000	20,000	140,000		140,000
4 Computers & Software	28,000							28,000	28,000	
Computer Supplies	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000		70,000
Photocopier	7,500							7,500	7,500	
Fax	3,000							3,000	3,000	
Other Office Equipment	60,000							60,000		60,000
Office Supplies	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000		70,000
CBB Supplies @100/person	6,000	6,000	6,000	6,000	6,000	6,000	7,000	43,000		43,000
IEC Equipment/Materials	25,000	10,000						35,000	25,000	10,000
Total Equipment & Supplies	267,500	56,000	46,000	46,000	46,000	46,000	47,000	556,500	163,500	393,000
SUBPROJECTS										
Basic Grant exc training	130,851	472,922	582,864	478,256	118,817	0	0	1,783,710	356,742	1,426,968
Subproject enhancement	20,000	20,000	20,000	20,000	20,000	20,000	20,000	140,000		140,000
FPPS I	15,000	15,000	15,000	15,000	15,000	15,000	15,000	105,000		105,000
Health Insurance & other studies	0	40,000	0	30,000	0	0	0	90,000	45,000	45,000
Total Subprojects	165,851	547,922	617,864	543,256	153,817	35,000	35,000	2,118,710	401,742	1,716,968
OTHER DIRECT COSTS										
Office Rent	20,000	20,000	20,000	20,000	20,000	20,000	20,000	140,000		140,000
Communications	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000		70,000
General Expenses	5,000	5,000	5,000	5,000	5,000	5,000	5,000	35,000		35,000
National Conference	0	0	10,000	0	0	15,000	0	25,000		25,000
International Conference	0	13,000		15,000				28,000	28,000	
FP Articles		500		1,000		1,000		2,500		2,500
Total Other Direct Costs	35,000	48,500	45,000	51,000	35,000	35,000	35,000	300,500	28,000	272,500
EVALUATION & AUDIT										
Site Audits		10,000		10,000		15,000		35,000		35,000
Non-Federal Audits				50,000			60,000	110,000	110,000	
Evaluation-mid/final				60,000			70,000	130,000	130,000	
ATB Financial Analyst (25%)	6,500	6,500	6,500	6,500	6,500	6,500	6,500	45,500		45,500
Cost effect/Sustain OR	0	25,000	25,000	25,000	25,000	0	0	100,000	100,000	0
Total Evaluation & Audit	6,500	41,500	31,500	131,500	31,500	21,500	136,500	420,500	340,000	80,500
OVERHEAD										
15% of TA & ODC	79,101	78,049	79,308	88,640	89,126	101,001	104,224	610,530	156,118	454,412
SUBTOTAL	1,129,292	1,393,795	1,586,009	1,722,328	1,664,619	1,826,644	1,167,551	9,090,437	2,102,144	6,988,293
CONTINGENCY/INFLATION (10%)	112,929	139,379	158,601	172,233	166,462	182,664	116,755	909,044	210,214	698,829
GRAND TOTAL	1,242,221	1,533,174	1,744,610	1,894,561	1,831,081	1,929,529	1,284,306	9,999,481	2,312,358	7,687,123

Revised 04/16/91
Exchange Rate: 25 KSh=1 US Dollar

HTZ

Private Sector Family Planning Project
Subproject Actual & Estimated Costs by Organization Type

Annex G (ii)

Private Co. or Commercial Organization	Total Grant		Grant Months	2 Years Ave Cost	Addition Grant (\$)
	Kshs	\$			
1.Voi Sisal Estates	240,200	10,008	24	10,008	0
2.KTGA (Karirana)	348,800	14,450	24	14,450	0
3.KTGA (Kericho)	714,000	29,750	24	29,750	0
4.Kilifi	278,000	11,583	24	11,583	0
5.Broks Bond	3,848,680	152,028	24	152,028	0
6.Omerian	327,018	13,828	24	13,828	0
7.Panpaper II	491,820	20,484	24	20,484	0
8.KTGA (Gotik)	859,800	35,825	24	35,825	0
9.Kenya Cannery	882,544	35,939	24	35,939	0
10.Nagadi	787,880	32,828	24	32,828	0
11.Goldsmith Seeds	279,200	11,633	24	11,633	0
12.KTGA (Handi)	1,154,800	48,117	24	48,117	0
13.R.A.Portland	388,444	15,352	24	15,352	0
14.RAI	323,802	13,483	24	13,483	0
15.Panpaper I	292,880	12,203	24	12,203	0
16.Kenya Breweries	768,855	32,036	24	32,036	0
17.Kakuzi	218,900	9,038	24	9,038	0
18.Ngayo Saw Mills	129,485	5,394	24	5,394	0
19.BAT	388,814	15,284	24	15,284	0
20.A.H.Produce	893,225	37,218	24	37,218	0
21.Niwani Sugar	180,000	8,867	24	8,867	0
22.Bata Limuru	208,000	8,583	24	8,583	0
Subtotal Private Firms	13,716,727	571,530	528	25,979	0
Average Cost	823,488	25,979			
Add 10% for PSPP				28,577	
NGO's					
1.NDA (1,2,3)	6,448,435	352,018	69	122,441	229,577
2.CHAK(1,2,3)	11,303,464	470,978	36	313,985	156,993
3.CMA(1,2)	1,404,288	58,512	78	18,004	40,508
Subtotal NGO's	21,156,187	881,508	183	115,808	427,078
Average Cost	7,052,062	293,836			
Add 10% for PSPP				127,168	
Parentals					
1.V.P.L.*					

7. Nzoia Sugar	342,800	14,283	24	14,283	0
8. Mumias Sugar	470,000	19,583	24	19,583	0
9. Chemilil Sugar	888,885	28,620	24	28,620	0
Subtotal Parastatals	5,915,718	246,488	220	26,890	11,040

Average Cost 857,302 27,388
 Add 10% for PSFP 25,579

Training Inst					
1. Nairobi Univ	789,200	32,883	24	32,883	0
2. Machakos TC	291,000	12,125	24	12,125	0
3. Moi Univ	751,000	31,292	24	31,292	0
4. Siriba TC	178,000	7,417	24	7,417	0
5. Kagumo TC	296,000	12,333	24	12,333	0
Subtotal Training Inst	2,305,200	98,050	120	19,210	0

Average Cost 461,040 19,210
 Add 10% for PSFP 21,131

Private Nurs Homes					
1. Malindi NH	496,800	20,700	24	20,700	0
2. Machakos NH	291,000	12,125	24	12,125	0
3. Nakuru NH	427,320	17,805	24	17,805	0
4. Kangaru Clinic I	332,166	13,840	24	13,840	0
5. Nyavita NH	301,000	12,542	24	12,542	0
6. Manyuki CH	927,520	38,647	48	19,323	19,323
7. MSA-Ukunda	1,143,414	47,642	24	47,642	0
8. Voi Changamwe	1,477,009	61,542	54	27,352	34,190
9. Gotamba NH	498,400	20,767	24	20,767	0
10. Canaan Medical	448,092	18,587	24	18,587	0
11. Kariobangi NH	487,200	20,300	24	20,300	0
12. Kangaru Clinic II	280,500	11,888	18	15,583	(3,896)
13. Eldoret NH	274,800	11,450	24	11,450	0
Subtotal Private Nurs Homes	7,383,221	307,634	360	20,509	49,618

Average Cost 567,940 23,664
 Add 10% for PSFP 22,560

Community Projects					
1. Karima C C	288,320	11,097	24	11,097	0
2. Naivasha W Lake	418,242	17,427	24	17,427	0
3. Homa Hills	294,000	12,250	24	12,250	0

19/12/20

GRAND TOTAL	51,455,815	2,143,984	1,483	34,697	487,736
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Private Sector Family Planning Project
 Detailed Illustrative Budget for Private Sector Contributions
 Amounts in US Dollars

Annex G (iii)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
PERSONNEL								
FP Nurse (100% Salary)	4,800	4,800	4,800	4,800	4,800	4,800	4,800	33,600
Field Educator/CED (100% Salary)	2,400	2,400	2,400	2,400	2,400	2,400	2,400	16,800
Other Personnel (50%)	1,200	1,200	1,200	1,200	1,200	1,200	1,200	8,400
Total Personnel	8,400	8,400	8,400	8,400	8,400	8,400	8,400	58,800
HEALTH FACILITY								
Total ave cost Kshs 300,000 per site with FP utilization 40%	38,400	163,200	187,200	158,400	28,800			576,000
MCH EQUIPMENT								
Total ave cost Kshs 100,000 per site	32,000	138,000	156,000	132,000	24,000			480,000
OFFICE EXPENSES								
Total ave cost Kshs 10,000 per month	4,800	4,800	4,800	4,800	4,800	4,800	4,800	33,600
SUBTOTAL	83,800	312,400	356,400	303,600	66,000	13,200	13,200	1,148,400
CONTINGENCY/INFLATION (10%)	8,380	31,240	35,640	30,360	6,600	1,320	1,320	114,840
GRAND TOTAL	91,960	343,640	392,040	333,960	72,600	14,520	14,520	1,263,240

Exchange Rate: 25 KShs=1 US Dollar

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Private Sector Family Planning Project
GOK Contributions Detailed Illustrative Budget
Amounts in US Dollars

Annex G (iv)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
PERSONNEL								
Chairman MCPD (5%)	480	480	480	480	480	480	480	3,360
Director MCPD (5%)	360	360	360	360	360	360	360	2,520
Director DPH (5%)	360	360	360	360	360	360	360	2,520
District Personnel	360	360	360	360	360	360	360	2,520
Total Personnel	1,560	10,920						
CONTRACEPTIVES								
Condoms	244,800	244,800	244,800	244,800	244,800	244,800	244,800	1,713,600
VFT	4,320	4,320	4,320	4,320	4,320	4,320	4,320	30,240
IUD's	2,544	2,544	2,544	2,544	2,544	2,544	2,544	17,808
Pills	21,600	21,600	21,600	21,600	21,600	21,600	21,600	151,200
Injectables	87,200	87,200	87,200	87,200	87,200	87,200	87,200	470,400
Total Contraceptives	340,464	2,383,248						
SUBTOTAL	342,024	2,394,168						
CONTINGENCY/INFLATION (10%)	34,202	239,417						
GRAND TOTAL	376,226	2,633,585						

Notes:

1. Contraceptive Consumption per month

Condoms	425,000
VFT	3,000 cycles
IUD's	200
Pills	12,000 cycles
Injectables	5,600

2. Contraceptive Unit Price (\$)

Condoms	0.048
VFT	1.060
IUD's	0.120
Pills	0.150
Injectables	1.000

3. Exchange Rate: 25 KSh=1 US Dollar

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Private Sector Family Planning Project
Breakdown of Project Outputs

Annex G (v)

Project Output	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
SUB-PROJECTS	5	10	15	15	5			50
Private Companies	3	4	4	4	1			16
NGOs	0	2	2	1	0			5
Parastatals	0	2	2	2	0			6
Training Institutions	0	0	2	2	0			4
Nursing Homes/Community Clinics	2	2	5	6	4			19
Total	5	10	15	15	5			50
SITES	8	34	39	33	6			120
Private Companies	8	8	8	8	2			32
NGOs	0	14	14	7	0			35
Parastatals	0	10	10	10	0			30
Training Institutions	0	0	2	2	0			4
Nursing Homes/Community Clinics	2	2	5	6	4			19
Other								
Total	8	34	39	33	6			120
TRAINING								
7 Weeks FP Course	50	50	100	100	50	50	50	450
1 Week Refresher	50	50	100	100	50	50	50	450
2 Weeks Field Educators	10	20	20	20	10	10		90
3 Days Field Educators W/Shop	140	140	140	140	140	140	140	980
2 Weeks CBD	30	30	30	30	30	30	30	210
STUDIES & ANALYSIS								
Machakos Model		2	2	2				6
FP addition to health Insu		1						1
Cost effect/Sustain OR		1	1	1	1	1	1	6
DISSEMINATION & EVALUATION								
Regional Workshop	3	3	3	3	3	3	3	21
National Workshop			1			1		2
International Conference		1		1				2
FP Articles		1		1		1		3
Midterm/final evaluation				1			1	2

DRAFT
MEMORANDUM OF UNDERSTANDING
ON THE PRIVATE SECTOR FAMILY PLANNING II PROJECT (615-0254)
BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT
of
THE UNITED STATES OF AMERICA
and
THE REPUBLIC OF KENYA

The U.S. Government, acting through the U.S. Agency for International Development and the Government of the Republic of Kenya, acting through the Ministry of Finance, have entered into the following understanding:

I. The Private Sector Family Planning II Project

The Private Sector Family Planning II (PSFP II) Project is a seven-year activity with the goal of helping to reduce Kenya's population growth rate. Its purpose is to increase the availability, use and sustainability of family planning services offered in the private sector. The project will enable 50 new and 60 continuing private sector firms and organizations to routinely provide family planning services to their employees, dependants or clients, approximately doubling the number of organizations offering these services. USAID/Kenya will provide \$10 million over the seven year life of this project.

It is agreed that the PSFP II Project will involve four major components, as follows:

A. Expansion of Family Planning Services Provided by the Private Sector

The PSFP II Project collaboratively will develop and support activities with a wide variety of organizations such as commercial firms, parastatals, non-governmental organizations (NGOs), private clinics and training institutions to expand their capability to deliver high-quality family planning services to employees, dependants or clients. The organizations will agree to continue with provision of family planning services after support from PSFP II ends. Availability of quality services near the work place will increase the acceptance and use of family planning.

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B. Establishment of a Network to Maintain Previously Established Private Sector Family Planning Services

The PSFP II Project will also support the network of private organizations which were assisted under the PSFP I to develop their capabilities to deliver family planning services. These private organizations would benefit from linkages and continued limited support from this project. This mechanism will stimulate and help maintain their interest and participation in the national family planning program, and will assist them to stay abreast of contraceptive technology and innovations in service delivery methods.

C. Implementation of a Series of Innovative Activities to Develop New or Improved Ways for Delivering Family Planning Services Through the Private Sector

The PSFP II Project will finance, develop and test experimental models of service delivery to enable additional private organizations to participate in the national program. Investigative studies and operational research studies will be supported to identify and remove barriers to acceptance of family planning, and to develop more efficient, acceptable and cost-effective family planning delivery mechanisms.

D. Dissemination of Information on the Kenyan Program

The PSFP II Project will support workshops within Kenya to exchange information and share private sector family planning experiences. Kenya is breaking new ground in increasing the participation of the private sector in family planning, but a need exists for greater regional and international awareness and recognition of the Kenyan experience for possible replication elsewhere. PSFP II will finance preparation of articles and support presentations concerning the PSFP II experience for Kenyan audiences and for the international family planning community.

II. Implementing Methods and Responsibilities

A. The PSFP II Project resulted from an A.I.D. Project Paper developed in consultation with principal Kenyan family planning authorities. USAID/Kenya will obligate funds through a direct cooperative agreement with a nonprofit organization or organizations (the Implementing Organization) selected on the basis of full and open competition.

B. Under this cooperative agreement, the Implementing Organization will be directly responsible for the overall implementation of the activity, in consultation with a Technical Advisory Committee (TAC) established as part of the project. The TAC will be chaired by the Chairman of the National Council for Population and Development or a designee, and shall be comprised of the Director of the National Council for Population and Development (or a designee) in the Ministry of Home Affairs and National Heritage, the Director of the Division of Family Health of the Ministry of Health, a representative of the USAID Office of Population and Health, the Project Director of the Implementing Organization, a representative of a not-for-profit NGO, and a private medical practitioner. The latter two individuals will be appointed by the Chairman of the TAC. Additional members may be appointed as mutually agreed by the Chairman and A.I.D. representative. The TAC will meet semi-annually, and at such other times as determined by the Chairman. It will provide policy and technical guidance, review project progress and semi-annual project reports, review and approve annual workplans (including identification of potential subprojects), and resolve any technical, legal, policy, or organizational issues that may arise.

C. The Government of Kenya agrees to exempt the four vehicles, four micro-computers and printers, photocopier, fax machine, four UPS and computer spares, four typewriters, film projector and other equipment and family planning service commodities specifically financed by USAID/Kenya, the Implementing Organization (IO) or an NGO receiving a subgrant from the IO, and imported for this activity from all customs duties and sales taxes. The Government's usual DA-1 process will be followed to obtain written approval of all specific exemptions.

D. The Government of Kenya agrees to exempt from income tax and National Social Security contribution all the income or other emoluments received by personnel (other than citizens and permanent residents of Kenya) employed by the Implementing Organization for this Project, for the period of this Project.

E. The Government of Kenya agrees to approve work permits for any individual(s) employed for this activity by the Implementing Organization for the period of this Project. The Government of Kenya also agrees to exempt from customs duties the shipments of any such individuals who may serve on the Project long term (two years or more). Such shipments exempt from customs duties would include personal household effects and personal vehicles. In the event such goods are sold or disposed of in Kenya other than to a person or organization similarly privileged, customs duty and value added tax shall then be payable in accordance with the appropriate rates.

F. The Government of Kenya, through its Ministry of Health, will provide contraceptives to support the implementation of the activity. In addition, it is anticipated that Kenyan organizations receiving grants for subprojects will each contribute 25 percent of the total value of the subproject.

III. Interpretation and Modification

This Memorandum of Understanding constitutes the agreement of the parties hereto with respect to the Private Sector Family Planning II Project. This Memorandum of Understanding may be amended in writing by mutual agreement of the parties.

THE GOVERNMENT OF KENYA

THE UNITED STATES OF AMERICA

BY: _____

BY: _____

Permanent Secretary
Office of the Vice
President and Ministry
of Finance

Director
USAID/Kenya

Date: _____

Date: _____

BY: _____

Permanent Secretary
Ministry of Home Affairs
and National Heritage

Date: _____

BY: _____

Permanent Secretary
Ministry of Health

Date: _____

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ILLUSTRATIVE SELECTION CRITERIA
FOR CA IMPLEMENTATING ORGANIZATION

CRITERIA

A. Proposal

<u>Criteria</u>	<u>Points</u>
<u>Understanding of Requirements and Technical Approach</u>	35
1. Degree to which proposal reflects full understanding of the problem and of the assistance required.	10
2. Thoroughness and appropriateness of methods proposed for conducting the project and the potential for reaching project objectives, e.g., the technical feasibility of the implementation plan, the subproject selection plan, the training arrangements, and the plan for liaison with MOH for contraceptive distribution.	15
3. Understanding of the Kenyan family planning program, methods proposed for coordinating with GOK and TAC, and understanding of the technical assistance requirements for continued support following termination of subgrant funding.	10

B. Personnel

Points

<u>Technical Competence and Experience of Key Staff</u>	40
1. Technical expertise of key staff in the areas of family planning program service delivery, medical oversight, training, IEC, management and administration, financial management and accounting, MIS, logistics, operations research/evaluation. (Technical areas identified in Administrative Analysis, Annex E).	15
2. Experience of proposed staff in developing, implementing and monitoring family planning service delivery projects in Africa particularly in Kenya, that involve a broad range of governmental and non-governmental organizations, including private businesses.	15
3. Majority of Kenyans proposed on staff, including Director.	10

<u>C. Organization Capabilities</u>	<u>Points</u>
<u>Institutional Capacity and Experience to Undertake Cooperative Agreement</u>	25
1. Experience administering U.S. Government financed AID grants, cooperative agreements or contracts.	10
2. Capability to provide local administrative management, direction and oversight to the project on a day-to-day basis. This includes effectively liaising with GOK parties, (e.g., MOH, NCPD and the TAC); establishing administrative, financial and procurement systems relating to subgrant management; implementing a management information system for project monitoring and evaluation and assuring that the project is properly staffed (short and long-term personnel), equipped procurement) and managed.	15
Total possible points	<hr/> 100

ANNEX K

Project Commodity List

A. <u>Vehicles</u>	- in 000's -	
	<u>U.S.\$</u>	<u>Ksh.</u>
-4 4WD vehicles @ \$25,000 each	100.0	
Sub total	100.0	
B. <u>Office Equipment*</u>		
10 Executive chairs @ Ksh. 3,500 each	-	35.0
12 Office chairs @ Ksh. 2,500 each	-	30.0
6 Secretarial chairs @ Ksh. 2,500 each	-	15.0
10 Executive desks @ Ksh.7,500 each	-	75.0
3 Secretarial desks @ Ksh. 7,000 each	-	21.0
1 Conference table @ Ksh. 15,000	-	15.0
10 Bookcases (4 shelves) @ Ksh. 3,750 each	-	37.5
10 File cabinets @ Ksh. 4,500 each	-	45.0
6 Metal cabinets @ Ksh. 4,500 each	-	27.0
12 Conference chairs @ Ksh. 3,000 each	-	36.0
4 IBM selectric typewriters @ \$500	2.0	-
4 Typewriter trolleys @ Ksh. 2,000 each	-	8.0
6 Calculators @ \$100 each	0.6	-
4 Micro computers & printers @ \$7000 each	28.0	-
4 Computer tables @ Ksh. 15,000 each	-	60.0
4 UPS plus other computer spares @ \$1,000	4.0	-
4 Computer chairs @ Ksh. 4,000 each	-	16.0
1 Fax machine	3.0	-
1 Photocopy machine	7.5	-

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Computer supplies per year	-	250.0
Misc. office supplies per year	-	250.0
Repair & maintenance of equipment	5.0	250.0
Air freight & other misc. expenses	21.5	-
Sub Total	71.6	1,170.5

*Cost Estimates from K.J Office Supplies (K) Ltd.
P.O. Box 44215,
Tel. 228934 Nairobi

C. <u>IEC Equipment*</u>	<u>U.S. \$</u>
1. Slide projector	620
2. 24" Color T.V.	550
3. VCR	500
4. Overhead projector	620
5. Cassette recorder (2)	400
6. Film screen	480
7. 16mm film projector	2,200
8. Shipping @ 50%	2,685
9. Printing & Distribution of IEC Materials e.t.c.	16,945
Total	25,000

*Cost Estimates from "Pioneer Cine"
P.O. Box 46513
Tel. 226846
Nairobi

D. Illustrative Commodity "Standard list" per clinic

	- in 000's -	
	<u>U.S.\$</u>	<u>KSH.</u>
1. IUD insertion kit Ksh. 50,000 per kit	2.0	-
2. Sphygmonometer	0.1	-
3. Stethoscope	0.1	-
4. Angled lamp	0.2	-
5. Featoscopes	0.1	-
6. Salt's scale	0.1	-
7. Adult scale	1.0	-
8. Disposable gloves (1500 pairs)	0.6	-
9. Hand held calculators	-	0.1
10. Desk	-	3.0
11. 3 chairs	-	7.5
12. Exam couch	-	4.0
13. Drape and stand	-	1.0
14. Small table/stand	-	1.0
15. Pelvic model	-	4.5
16. File cabinet	-	5.0
17. Stationery, wastebaskets Office supplies	-	5.0
Shipping & transport	(50%) 2.1	(20%) 6.2
	-----	-----
	6.3	37.3
Sub Total	756.0	4,478
Total for 120 sites		

ANNEX L

Private Sector Family Planning II
Project (615-0254)

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

ROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

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

N/A.

2. **U.S. Private Trade and Investment**
(FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A.

3. Congressional Notification

a. **General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A):** If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

b. **Notice of new account obligation (FY 1991 Appropriations Act Sec. 514):** If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

A Congressional Notification was sent to the Congress in April 1991, and expired without objection in May 1991.

c. **Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b) (3)):** If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A.

4. **Engineering and Financial Plans (FAA Sec. 611(a)):** Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

a) Yes.

b) Yes.

5. **Legislative Action (FAA Sec. 611(a) (2)):** If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A.

6. Water Resources (FAA Sec. 611(b) FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A.

7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A.

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

N/A.

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

The project is a family planning project and will not directly affect any of these objectives. It is expected that Kenyan firms participating in the project will achieve increased labor productivity as a result of lower fertility rates among employees, (e.g. reduced expenses for maternity and sick leave and dependent benefits).

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

The Project is social service in orientation and not designed to stimulate U.S. or other country investment and trade. The project's procurement of goods and services include U.S. based procurement. The project will be financed under a cooperative agreement awarded on a competitive basis with U.S. and Kenyan nonprofit firms competing.

11. Local Currencies

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The local contribution to this project is provided by private sector organizations in the form of financing facilities, personnel and operating costs. The GOK also contributes contraceptives and personnel. Their combined contribution represents approximately 28% of project costs. The U.S. owns no excess Kenyan shillings that could be used in lieu of dollars.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No. The U.S. does not own excess Kenyan currency.

c. **Separate Account** (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? N/A.

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A.

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes? N/A.

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A.

12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A.

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b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No.

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? No.

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

15. PVO Assistance

a. Auditing and registration (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N/A.

b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A.

16. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

The project will be obligated under an A.I.D. Handbook 13 direct cooperative agreement. Notification of funds obligation will be sent to State and A.I.D. LEG via cable, and a copy of the cooperative agreement will be sent to the offices.

17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume; capacity, mass and weight), through the implementation stage?

N/A.

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18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Women will participate equally with men in the project's ultimate output, which is increased use of family planning methods by couples. It is possible that female participants will experience a relatively greater improvement in their socio-economic status than males, because the burden of child-rearing falls mainly on women in Kenya.

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No. The project is a country specific activity. Information on the project approach, methods and experience will be disseminated through international conferences and media.

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

b. Will any funds be used to lobby for abortion?

No.

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

The project will improve private sector family planning services that directly assist many low income wage earners in both rural and urban areas. NGOs, including cooperatives, will be eligible for technical assistance provided under the project.

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22. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. N/A.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

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

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

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.). N/A.

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible N/A.

under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. Cargo preference shipping

(FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No.

g. Technical assistance

(FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

The project will be obligated under an A.I.D. Handbook 13 Cooperative Agreement with a U.S. or Kenyan nonprofit organization on a joint venture basis between U.S. and Kenyan nonprofit institutions.

h. U.S. air carriers

(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

i. Termination for convenience

of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes.

j. Consulting services

(FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

N/A.

k. Metric conversion

(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss or markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic states, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

N/A.

l. Competitive Selection

Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

The project will be financed under an A.I.D. Handbook 13 Cooperative Agreement and will follow the applicable selection procedures.

24. Construction

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A.

b. Construction Contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A.

c. Large Projects,

Congressional approval (FAA Sec. 620(k):

If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

N/A.

25. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Controller General have audit rights?

N/A.

26. Communist Assistance (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

N/A.

27. Narcotics

a. Cash reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

Yes.

b. Assistance to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

Yes.

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? N/A.
29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? N/A.
30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? N/A.
31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.
32. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? N/A.
33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? N/A.
34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? N/A.
35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? N/A.

36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.

37. **Publicity or Propaganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No.

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes.

39. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? N/A.

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A.

2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No.

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A.

4. **Indigenous Needs and Resources** (FAA Sec. 281(b): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The project addresses the need of local private sector organizations to institutionalize and improve their provision of family planning services. Policy guidance will be provided to the project by a Technical Advisory Committee made up of public and private individuals, including members of the Government of Kenya's National Council for Population and Development (NCPD).

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5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

The project's goal, to reduce fertility and the population growth rate, will promote sustained and broad-based economic growth in Kenya.

a) The project will improve private sector family planning services that directly assist many low income wage earners in both rural and urban areas. Some priority will be given in the selection of sub-projects for assistance to facilities in areas that lack alternative sources of family planning, which will benefit rural populations. Sustainability will be promoted by improving the capacity of private local organizations to maintain services.

b) N/A.

c) Some support will be provided under the project to community based family planning schemes that rely on local participation.
d) Improved access to family planning will meet the growing demand by Kenyan women for such services, and will increase women's options for participating in the national economy and improving their status.

e) Some support under the project will finance dissemination of lessons-learned in international fora.

Yes. Participating private sector organizations and the Government of Kenya together will cover approximately 28% of project costs.

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8. **Benefit to Poor Majority (FAA Sec. 128(b)):** If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes.

9. **Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):**

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No.

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes.

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? No.

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

No.

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Competitive selection procedures applicable to A.I.D. Handbook 13 Cooperative Agreements will be followed.

11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

None.

12. Biological Diversity (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

a) No.

b) No.

c) No.

d) No.

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g):

a. A.I.D. Regulation 16: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes.

b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities

N/A.

N/A. (1-13)

of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

N/A. - (1-6)

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A.

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e. Environmental impact

statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

N/A.

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A.

15. **Sub-Saharan Africa Assistance** (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to

a) Yes. The project's target beneficiaries include the poor, in particular families of low-income wage earners. The project will provide them with access to services that will permit them a wider range of choices for participating in the national economy.
b) Yes. Project helps to expand role of Kenyan private sector in family planning services delivery in areas underserved by GOK.
c) Yes.
d) Yes. Kenyan non-governmental organizations with effective grassroots programs will be included as sub-projects to serve local populations.
e) Yes. The project supports Kenya's voluntary family planning policy which is critical to addressing its extremely high fertility and population growth rates.
f) Yes. The project will provide increased access to voluntary family planning services. It will also help to improve health conditions

establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resources base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

especially for mothers and children by exploring the possibility of incorporating selected Maternal & Child Health Care interventions in some areas.

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A.

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and senate appropriations Committees been properly notified?

N/A.

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18. Loans

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A.

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A.

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A.

d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A.

19. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of

(1) Project effectively reaches the rural and urban poor, and will meet unmet demand for family planning services.
(2) Project will make technical assistance in voluntary family planning available to NGOs, including cooperatives.
(3) Some technical assistance from the project will directly benefit self-help community based family planning schemes.
(4) Improved access to family planning services will directly meet the needs of Kenyan women and enhance their options for participating in the Kenyan economy.

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developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

(5) The project will disseminate its experience in international conferences and publications.

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

N/A.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A.

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21. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

The project emphasis is on provision of family planning and critical maternal and child health care service through existing medical facilities of Kenya private sector institutions. Thus, it does not require capital intensive investments and provides a means for effectively reaching under-served populations.

22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A.

23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

N/A.

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- b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations; N/A.
- c. research into, and evaluation of, economic development processes and techniques; N/A.
- d. reconstruction after natural or manmade disaster and programs of disaster preparedness; N/A.
- e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; N/A.
- f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. N/A.
24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A.

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ANNEX M.

ACTION AIT-3 INFO ECON POL/PLC

VZCZCNAO936
PP RUEHNR
FF RUEHC #5136 1302027
ZNP UUUUU ZZF
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FM SECSTATE WASHDC
TO AMEMBASSY NAIROBI PRIORITY 2448
BT
UNCLAS STATE 155136

RECEIVED

13 MAY 91 09 09Z

C&R
USAID/KENYA

TOP: 03:45
CN: 36261
CERG: AID
DIST: AIT
ADD:

urgent
Original to HQ

AITAC

T.C. 12356: N/A

TAGS:

SUBJECT: INITIAL ENVIRONMENTAL EXAMINATION FOR FAMILY PLANNING IN THE PRIVATE SECTOR (615-0245)

1. BUREAU ENVIRONMENTAL OFFICER CONCURS WITH CATEGORICAL EXCLUSION UNDER REGULATION 16 SECTION 216.2(C)(2)(I) FOR THE TECHNICAL ASSISTANCE AND TRAINING ACTIVITIES, AND UNDER SECTION 216.2(C)(2)(VIII) FOR FAMILY PLANNING SERVICES.

2. GC/APR HAS CLAREL THIS CABLE. BAKER

BT
#5136

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LIST OF ACRONYMS

A.I.D	AGENCY FOR INTERNATIONAL DEVELOPMENT
AMREF	AFRICAN MEDICAL AND RESEARCH FOUNDATION
AVSC	ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION
CA	COOPERATIVE AGREEMENT
CAFS	CENTER FOR AFRICAN FAMILY STUDIES
CBFP	COMMUNITY BASED FAMILY PLANNING
CHAK	CHRISTIAN HEALTH ASSOCIATION OF KENYA
CO	CLINICAL OFFICERS
CPR	CONTRACEPTIVE PREVALENCE RATE
CPSF	COUNTRY PROGRAM STRATEGIC PLAN
CMA	CRESCENT MEDICAL AID
CRS	CONTRACEPTIVE RETAIL SERVICES
CYP	COUPLE YEARS OF PROTECTION
DFH	DIVISION OF FAMILY HEALTH
DH	DIRECT HIRE
DHS	DEMOGRAPHIC AND HEALTH SURVEY
ECN	ENROLLED COMMUNITY NURSE
FOPS	END OF PROJECT STATUS
EPI	EXPANDED PROGRAM ON IMMUNIZATION
FE	FIELD EDUCATORS
FP	FAMILY PLANNING
FPAK	FAMILY PLANNING ASSOCIATION OF KENYA
FPIS	FAMILY PLANNING INFORMATION SYSTEM
FPSS	FAMILY PLANNING SERVICES AND SUPPORT PROJECT
GOK	GOVERNMENT OF KENYA
HIS	HEALTH INFORMATION SYSTEM
IEC	INFORMATION/EDUCATION/COMMUNICATION
IO	IMPLEMENTING ORGANIZATION
JSI	JOHN SNOW INCORPORATED
KDHS	KENYA DEMOGRAPHIC AND HEALTH SURVEY
KFS	KENYA FERTILITY SURVEY
KRN	KENYA REGISTERED NURSE
LMIS	LOGISTICS MANAGEMENT INFORMATION SYSTEM
LOE	LEVEL OF EFFORT
LOP	LIFE OF PROJECT
MCH	MATERNAL AND CHILD HEALTH
MIS	MANAGEMENT INFORMATION SYSTEMS
MOH	MINISTRY OF HEALTH
MOL	MINISTRY OF LABOR
MOU	MEMORANDUM OF UNDERSTANDING
MSCU	MEDICAL STORES COORDINATING UNIT
MWRA	MARRIED WOMEN OF REPRODUCTIVE AGE
MYWO	MAENDELEO YA WANAWAKE ORGANIZATION
NCPD	NATIONAL COUNCIL FOR POPULATION & DEVELOPMENT
NGO	NON-GOVERNMENTAL ORGANIZATION
O/PH	OFFICE OF POPULATION AND HEALTH
ORS	ORAL REHYDRATION SALTS
PACD	PROJECT ASSISTANCE COMPLETION DATE
PCS	JOHN HOPKINS UNIVERSITY POPULATION COMMUNICATION SERVICES PROJECT

PSC	PERSONAL SERVICES CONTRACTOR
PSFP	PRIVATE SECTOR FAMILY PLANNING
PVO	PRIVATE VOLUNTARY ORGANIZATION
RTP	REQUEST FOR TECHNICAL PROPOSAL
SDA	SEVENTH DAY ADVENTIST
SDP	SERVICE DELIVERY POINT
TAC	TECHNICAL ADVISORY COMMITTEE
TFR	TOTAL FERTILITY RATE
TTI	TEACHER TRAINING INSTITUTION
UNFPA	UNITED NATIONS FUND FOR POPULATION ACTIVITIES
U.S.	UNITED STATES
USAID/K	UNITED STATES AGENCY FOR INT. DEVELOPMENT/KENYA
VSC	VOLUNTARY SURGICAL CONTRACEPTION

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MEMORANDUM OF RECORD

FROM: *Stafford Baker*
Stafford Baker, Chief, Office of Projects

SUBJECT: PSFP II Project Paper (PP) (615-0245)
USAID Mission Review

DATE: April 2, 1991

REF: Project Review Committee (PRC) Meeting -
March 25, 1991

The Project Review Committee (PRC) Meeting to review the Private Sector Family Planning (PSFP) II Project Paper (615-0245) was held on March 25, 1991. The meeting was chaired by the USAID/Kenya Director. Following a summary presentation of the Project Paper, discussion centered on the "Issues" memo that had been prepared by the Projects Office. Several new issues were also raised.

The Committee unanimously agreed that the project should be approved, pending the fulfillment of several recommendations.

ISSUES

1) Women in Development

The Committee agreed that the project clearly addresses the needs of women, and that women's participation and representation among beneficiaries is high. However, the Project Paper lacks a concise summary of gender-related issues and indicators that would be monitored and evaluated over the LOP, e.g., sex-disaggregated data. O/PII was also asked whether information on the socio-economic characteristics of project beneficiaries would be collected (eg., a description of the target population of eligible couples). O/PII noted that this type of data would be more difficult to collect, but might yield useful information on strategies for targeting different population subgroups.

Recommendation: The Program Office should review the Project Paper to make sure that it satisfies the requirements contained in the Agency's Women in Development guidelines (gender indicators), particularly with regard to collecting data for monitoring and evaluation. A summary discussion of gender issues should be included in the Social Soundness Analysis section of the PP.

2) Administration

a) GOK Role

The Committee discussed the nature of the changes that have occurred with regard to the Government of Kenya's (GOK) participation in project implementation through the Technical Advisory Committee (TAC). O/PH explained that under PSFP I the TAC had to approve proposed subprojects individually, which proved to be difficult logistically. In order to correct this problem, in PSFP II the TAC will approve annual workplans that provide details on all subprojects to start during the year. The TAC will be required to meet only two times per year, to review semi-annual progress reports and carry out other duties. O/PH noted that the Government's approval of the project was anticipated, since the Ministry of Health and the head of the National Council for Population and Development (NCPD) support a PSFP II. Nevertheless, the PRC agreed that the GOK's approval should be secured by signing the Memorandum of Understanding (MOU) before USAID/Kenya issues the Request for Technical Proposals. O/PH noted that while the NCPD had suggested it should sign the MOU, as in PSFP I the Ministries of Finance, Home Affairs and Health remain the appropriate signatories.

Recommendation: The Mission should ensure that the GOK signs the Memorandum of Understanding before issuing the Request for Technical Proposals for the Implementing Organization.

b) Budget

O/PH explained that the project budget was revised to add salary increases of 10% per year for IO staff, which resulted in elimination of the Administrative Assistant position and a reduction of the amount budgeted for the 7 week training course in family planning and Maternal and Child Health care to \$2,500 per person. Since the only approved training course available in Kenya for the private sector is offered by AMREF and costs \$3,600 per person, O/PH was asked to comment on the reasonableness of this adjustment. O/PH noted that the reduced amount appears to be reasonable. Alternative training resources are currently being developed by other Kenyan organizations and the MOH supports this.

Several questions were asked about the legitimacy of the 10% allowance for contingencies and inflation, since the annual inflation rate in Kenya is currently 15%. In addition, the project budget does not compound the interest. These factors suggest that the project budget may not be sufficient to cover all costs. On the other hand, it was suggested that the 10%

Controller's office should review cost estimates for these, and other, project elements to determine reasonableness and define adjustment if necessary.

Recommendation: The Office of Population and Health and the Controllers Office should review the budget to ensure that the allowances for salary increases, inflation and contingencies are adequate to cover costs, given the expected future devaluation of the Kenya shilling.

c) Implementation Mechanism

O/PH was asked to clarify the rationale for implementing the project through a cooperative agreement (CA) instead of a contract. O/PH explained that substantial involvement is anticipated between USAID and the recipient. Furthermore, the principal purpose of the relationship is the transfer of funds in order to accomplish a public purpose - rather than acquire or purchase services for the benefit of U.S.G.

A question was also asked about the degree to which the heavy emphasis on local expertise might preclude full and open competition in the RFTP. Given the fact that the project is so closely modelled on PSFP I, the PRC also discussed whether the current IO for the PSFP I project would have an unfair advantage in bidding for the agreement. However, O/PH explained that several additional Kenyan organizations are considered to be in a good position to bid and successfully compete for the Project. The PRC agreed that the rationale for implementation through a CA and the expectation of sufficient local competition among potential implementing organizations should be described in the Project Paper.

Recommendation: A paragraph should be added to the PP section "Project Management and Implementation" explaining why a cooperative agreement was selected as the implementation mechanism instead of a contract. In addition, the PP should state that the degree of competition in the bidding process is expected to be adequate to meet USAID's requirements.

d) Implementing Organization Role in Training

The issue of a potential conflict of interest related to the Implementing Organization's (IO) role in training was raised. On the one hand the IO is expected to ensure that training in the project is delivered through the most effective and efficient means possible by selecting the best training programs through subcontracts. On the other hand, there is the likelihood that the IO might design and carry out training activities itself. The A member of the PRC noted that the Implementing Organization might

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subcontracts. On the other hand, there is the likelihood that the IO might design and carry out training activities itself. The A member of the PRC noted that the Implementing Organization might not necessarily have an incentive to be objective in selecting training programs, and, if the IO carries out training itself, the programs might not be of the highest possible quality. However, O/PH clarified that the Ministry of Health will provide quality control since it must approve proposed training programs in FP and MCH. In addition, USAID/Kenya will be able to ensure that the selection of training programs and arrangements is competitive through its approval process for subcontract awards. Nevertheless, it was agreed that the conditions and criteria that would affect the possible implementation of a training program by the IO should be spelled out in the RFTP.

(The possibility that there might be problems in getting the MOH to approve a proposed training program was discounted by O/PH.)

Recommendation: The RFTP should include a description of the circumstances and criteria that would govern the implementation of training programs by the Implementing Organization and language regarding USAID's role in approving subcontracts should be clearly reflected in the "substantial involvement" section of the CA.

e) Procurement

The Project Paper highlights the fact that the DFA procurement plan shows that a somewhat low level of the goods and services financed under the project will have their source and origin in the United States. It was agreed that the Regional Legal Advisor should be consulted about requirements for detailing source/origin in the PP per DFA rules.

Recommendation: The RLA should be consulted regarding 1) PP requirements for DFA Procurement Planning; 2) the appropriateness of estimated 000 source/origin levels, and 3) the requirements, if any, for cabling AID/W on DFA procurement plans reflected in PPs.

3) Sustainability

a) Financial Sustainability - Support for NGOs

The ability of NGO-supported subprojects to sustain programs after the end of subgrant assistance was discussed. (NGOs account for a large portion of project activity, as they were responsible for a large proportion of CYPs achieved in the original project and are scheduled to receive approximately 41% of subgrant assistance in PSFP II.) Experience in PSFP I showed that NGOs have considerable difficulty in maintaining programs

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It was acknowledged that there are substantial differences between the project assumptions regarding companies and NGOs. Companies appear to have a high potential to achieve financially sustainable family planning programs, because it is anticipated that the savings resulting from employee use of FP will be greater than the costs of providing the services. However, it was pointed out that these assumptions regarding the long-term benefits and costs of providing FP services for companies have yet to be conclusively demonstrated, and that further study should be a priority in PSFP II. (For private clinics, the assumption is that demand for services is high enough to ensure that people will pay for them.) The situation for NGOs is substantially different, since they are service organizations devoted to assisting disadvantaged people, often in poor rural areas. Their ability to recover costs may be restricted.

O/PII stated that most of the NGO subprojects have continued to provide FP services at reasonable cost, but have needed help to continue IEC activities and outreach. The PSFP project is working with the NGOs to explore possibilities for cost recovery. The PRC agreed that monitoring and evaluation in PSFP II should carefully analyze the costs to NGOs of offering family planning services, their ability to maintain services after assistance ends, and the marginal benefits of offering enhanced services. Another issue to be examined is the relative cost effectiveness of delivering family planning services through NGOs as opposed to other types of organizations assisted under the project.

A related issue of the difficulty encountered by the NGOs in retaining staff after they receive FP training was discussed. It was agreed that this is one other aspect of the sustainability issue that should be addressed during PSFP II.

Recommendation: The Project Paper should provide a more detailed explanation of how PSFP II will assess the ability of NGOs to operate sustainable family planning services. The paper should also discuss the issue of determining when the returns to further assistance become slight enough to justify terminating aid to these organizations.

b) Role of the Implementing Organization

Questions were asked about expectations regarding the possible role of the IO after the project. It was agreed that at this stage the Mission does not envision the need to create or support an organization that will continue to need AID funding beyond the PACD. A possible scenario is that the IO would develop into a self-sufficient entity acting as an intermediary between service providers and sources of financial and technical assistance. A preferred outcome would be that the IO's intermediary role would gradually become superfluous, and service providers would be able to access assistance directly. O/PII believes that this is a

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PACD. A possible scenario is that the IO would develop into a self-sufficient entity acting as an intermediary between service providers and sources of financial and technical assistance. A preferred outcome would be that the IO's intermediary role would gradually become superfluous, and service providers would be able to access assistance directly. O/PH believes that this is a realistic outcome to expect for companies and private health facilities. The possible need of NGO supported clinics for continuing assistance could be met through the type of grant assistance that is provided to the umbrella organizations through other USAID projects. It was agreed that the PP should include some discussion of expectations on the need for an IO after the project ends.

Recommendation: The PP should include discussion of the anticipated role of the Implementing Organization after the project ends, citing the above scenarios.

c) Sustainability - General

It was agreed that the Project Paper should contain a concise summary discussion of sustainability issues.

Recommendation: The Project Paper should contain a separate section that summarizes the main issues regarding sustainability.

4) PID Approval Cable Issues

The issues raised in AID/Washington's PID approval cable were reviewed. The PRC agreed that the PP covered all of the points adequately. A separate memorandum will be prepared by the Projects Office as an annex to the Project Paper, that highlights where the issues are addressed.

Drafted:PRJ:Ainserra

Clearance:PH:DOot (draft)
 PRJ:CBarbiero (draft)
 PROG:CSteele (draft)
 D/DIR:EZallman (draft)
 DIR:JWestley (draft)

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