

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete) Amendment Number: **2** DOCUMENT CODE: **3**

COUNTRY/ENTITY: **Kenya** 3. PROJECT NUMBER: **615-0232**

4. BUREAU/OFFICE: **Africa** 5. PROJECT TITLE (maximum 40 characters): **Family Planning Services & Support**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY **08 22 95** 7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4):
A. Initial FY **85** B. Quarter **2** C. Final FY **94**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 85			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total	4,000	5,100	9,100	26,789	31,411	58,200
(Grant)	(4,000)	(5,100)	(9,100)	(26,789)	(31,411)	(58,200)
(Loan)	()	()	()	()	()	()
Other U.S. 1. AID/W Central Projs	1,331	0	1,331	28,627	0	28,627
2. Host Country	0	2,504	2,504	0	77,472	77,472
Other Donor(s)/NGOs	278	4,963	5,241	10,347	88,511	98,858
TOTALS	5,609	12,567	18,176	65,763	197,394	263,157

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	483	550		46,200	-0-	400	-0-	58,200	-0-
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 410 | 420 | 430 | 450 | 520

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code B. Amount

13. PROJECT PURPOSE (maximum 480 characters):
To increase prevalence of contraceptive use

14. SCHEDULED EVALUATIONS: Interim MM YY **06 91** Final MM YY **05 94**

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000 941 Local Other (Specify) **935**

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)
A two year PACD extension with additional financing of \$12 million is justified in this amendment.

Methods of implementation and financing have been approved by Mission Controller

17. APPROVED BY: **John R. Westley**, USAID/Kenya, Director

Signature: *[Signature]* Date Signed: MM DD YY **05 29 94**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/Kenya

FROM: *S. Baker*
Stafford Baker, Chief, Office of Projects

SUBJECT: Family Planning Services and Support Project (615-0232)
Amendment

Date: May 29, 1992

ACTION: Your approval is requested for: (1) the attached Project Paper (PP) Amendment for the Family Planning Services and Support (FPSS) Project; and (2) the attached Project Authorization Amendment No. 2 which increases total planned life-of-project (LOP) funding from \$46.2 million to \$58.2 million and extends the Project Activity Completion Date (PACD) from September 30, 1993 to August 22, 1995.

BACKGROUND: The FPSS Project was authorized on August 23, 1985 for a seven year period with a PACD of September 30, 1992. AID financing of \$43 million was authorized and the GOK's planned contribution to the activity was estimated at \$54,578,000. In August 1988, the Project was amended to include a child survival component and to increase LOP financing by \$3.2 million for a new total LOP of \$46.2 million. With this amendment, the GOK's contribution was increased to \$63,730,000. In April 1990, the PACD was formally amended in a Project Implementation Letter with the GOK to September 30, 1993 at no additional cost to provide sufficient time for implementation of the community-based services and child survival components, and in order to reallocate Project funds from two components, subsidized commercial marketing and ovulation awareness, to cover the budget requirements for ongoing Project components.

As noted in the Mission's FY 1993 Annual Budget Submission to AID/W, the Office of Population/Health (O/PH) originally planned to design a new project, FPSS II, as a follow-on to the current activity. However, in February 1992, the Mission determined that a two year funded extension/amendment of the Project instead should be initiated. This decision was based on the conclusions and advice of a design team, including AID/W/R&D/POP specialists and the Mission Project Development Committee representatives, that (a) monitoring and evaluation results of the Project indicated that no major changes in objectives or methods were warranted; and (2) currently projected OYB levels over the next two to three years did not support an augmented scale of effort that would be required in a new design.

PROJECT DESCRIPTION: The attached PP amendment will allow for consolidation and intensification of the Mission's family planning program effort. The Project strategy remains focused on increasing the availability and quality of family planning services in order to

increase prevalence of contraceptive use. To accomplish this objective, this amendment will provide an additional \$12 million in AID financing and a two year extension of the Project timeframe.

The PP amendment includes a revision/refinement of the original Project goal and purpose to more clearly define these elements in measurable, objectively verifiable terms. **The amended Project goal is to reduce fertility and population growth rate. The amended purpose is to increase prevalence of contraceptive use.** These modifications are consistent with the objectives(s) and targets contained in the USAID/Kenya CPSP and in other official Mission documentation, including the USAID/Kenya Assessment of Program Impact (API) report.

The revised End of Project Status indicators at the purpose level against which achievement will be measured are:

- Contraceptive prevalence rate (CPR) for all married women of reproductive age increased from 17% in 1984 to 35% in 1995; and
- CPR for all women of reproductive age increased from 14% in 1984 to 31% in 1995.

The PP amendment provides a detailed discussion of:

* Project components planned for completion by September 30, 1993 that will not require any additional Project funding beyond currently authorized and obligated levels, i.e., NCPD Administration, Information and Planning Systems and Child Survival; and

* Project components that have been discontinued either because of legislative factors, i.e., Ovulation Awareness, or because of their development as free-standing, Mission-funded efforts, i.e., Subsidized Commercial Marketing.

The Project's ongoing components to be financed under the proposed two year amended Project period represent programmatic elements that were cited in the 1990 AID/W/PPC/CDIE Impact Evaluation as areas that should be emphasized and continued under the extended Project. These are: (1) Clinical Training and Contraceptive Logistics; (2) Voluntary Surgical Contraception; (3) Community Based Services; (4) Information, Education and Communication; and (5) Planning, Monitoring and Institutional Strengthening.

MANAGEMENT, OBLIGATION ARRANGEMENTS AND EXTENSION BUDGET: Under the proposed amendment and over the remaining LOP, the MOH/Division of Family Health and the National Council for Population Development (NCPD) will continue to be the lead GOK implementing entities for the Project effort. The responsible A.I.D. Mission officer responsible for the overall Project is Deputy Chief, Gary Leinen, in the Office of Population and Health.

The additional \$12 million in AID financing over the LOP will be obligated through amendments to the Project Agreement with the GOK. The obligation schedule for the Project amendment is as follows: FY 1992, \$400,000; FY 1993, \$5.8 million; and FY 1994, \$5.8 million. The overall Project budget summary presented below is solely inclusive of A.I.D. and GOK costs over the amended Project period. It does not include funding provided by AID/W, NGOs and other donors that support the Project elements.

OVERALL PROJECT BUDGET SUMMARY (\$000)

	Current		Amendment		Combined LOP		Total
	AID	GOK	AID	GOK	AID	GOK	
Clin. Train.	11,166	14,647	4,900	910	16,066	15,557	31,623
Contra. Log.							
Vol. Surg.	8,815	1,804	2,510	22	11,325	1,826	13,151
Contracep.							
CBS	9,037	21,200	2,245	0	11,282	21,200	32,482
Sub. Com. Mkt.	30	0	0	0	30	0	30
Ov. Aware.	314	0	0	0	314	0	314
NCPD Admin.	454	2,149	0	4,210	454	6,359	6,813
PMIS	3,298	0	530	219	3,828	219	4,047
IEC	3,831	0	150	0	3,981	0	3,981
IPS	5,850	15,473	0	560	5,850	16,033	21,883
Child Surv.	3,250	7,457	0	6,572	3,250	14,029	17,279
Aud/Eval/Mgt.	155	0	575	0	730	0	730
Cont./Inflat.	0	1,000	1,090	1,249	1,090	2,249	3,339
Totals	46,200	63,730	12,000	13,742	58,200	77,472	135,672

ANALYSES AND OTHER REQUIREMENTS: The Project Paper Amendment contains updated analyses that demonstrate that:

- o The Project is technically, economically and socially sound, and administratively feasible;
- o The technical design and cost estimates are reasonable and adequately planned, thereby satisfying the requirements of Section 611(a) of the Foreign Assistance Act, as amended;
- o The timing and funding of Project activities are appropriately scheduled and the implementation plan is realistic and establishes a reasonable timeframe for carrying out the Project; and
- o Adequate provision has been made for evaluation and audit.

The original Initial Environmental Examination (IEE) for the Project requested and obtained a Categorical Exclusion for the Project. A continuation of the Categorical Exclusion was obtained by AID/W when the Project was amended in August 1988 and has been obtained for this proposed Project Amendment (State 129538).

CONGRESSIONAL NOTIFICATION (CN): The CN for this Project Amendment totalling \$12.0 million in increased LOP costs expired without Congressional objection on May 13, 1992.

CONDITIONS AND COVENANTS: There are no additional conditions and covenants.

GOK LETTER OF REQUEST: The GOK has requested USAID to extend the Project period by two years and provide additional funding for the activity per MOH letter dated April 22, 1992 and NCPD's letter of April 8, 1992.

WAIVERS: None.

PROJECT REVIEW COMMITTEE ACTION: The Mission's Project Review Committee reviewed the PP Amendment on May 27, 1988. Based on the PRC's discussion and recommendations the following modifications were made to the draft PP:

* **FAA Section 110 contribution:** The financial narrative section of the PP was revised to specify that while the estimates of GOK contribution are substantially higher than the required 25% for this Project, the Mission's monitoring of the GOK contributions for this activity and verification of the GOK's compliance is focussed on ensuring compliance with the minimum legislated requirement, i.e., 25 of total project costs.

* **Evaluation and Analysis:** The evaluation section narrative of the PP has been expanded to include PRC recommendations that the final Project evaluation include a more thorough economic analysis of the cost-effectiveness on the various Project elements. The scope for this evaluation will also include an examination of related sector or subsector requirements, e.g., HIV prevention, child survival, etc., and assist the Mission in defining what additional activities might be included within the parameters of a new program design effort. As suggested by the PRC, the narrative elaborates on the rationale for defining purpose-level EOPS indicators consistent with the stated strategic objective in the Assessment of Program Impact document.

* **Proposed Conditionality:** As the PRC recommended, the Mission's Project Development Committee revisited the intent and validity of initially proposed conditionality relating to clinical training activities. Based on their review, the Committee concluded that the substance of the condition's intent is better addressed by including a provision within JHPIEGO's contract scope of work to the effect that disbursement of funds to cover the local costs of training after July 1993 would be subject to USAID's approval of the MOH/DFH's plan (to be produced with JHPIEGO's technical assistance) outlining the selection criteria for the category of health worker to receive training, and estimates by region and district of the Service Delivery Points (SDPs) to be staffed by nurses certified in family planning. No additional conditionality is recommended for inclusion in the Project Agreement Amendment.

AUTHORITY: Under Delegation of Authority (DOA) No. 551, Section 4.A.(2), Principal Officers of field posts have the authority to amend a project authorization only when (1) the amendment will result in a total life of project funding of not more than \$30 million, (2) the amendment does not present significant policy issues or deviate from the original Project purpose; or (3) the amendment does not require the issuance of waivers which must be authorized at a higher level. The first two proviso's were applicable in this case.

In March 1992, the Mission requested AID/W/AFR/AA to approve an ad hoc delegation of authority to amend the Project in the field. On April 16, 1992, the Acting Assistant Administrator for the Africa Bureau approved a redelegation of his authority per the terms of DOA 400, as revised, to you as Mission Director to increase the Project's life of project costs to \$58.2 million. Since the life of project will remain under 10 years, as Mission Director, you have the authority under DOA 551, Section 4.A.(3) to extend the PACD by two years.

RECOMMENDATION:

That you sign the attached project authorization amendment and Project Paper facesheet, and thereby approve a two year extension of the FPSS Project and an increase in A.I.D. grant financing of \$12.0 million for a new LOP total of \$58.2 million, subject to the availability of A.I.D. funding.

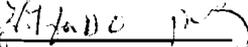
Approved: 

Disapproved: _____

Date: 5/29/92

Drafted: PRJ:  Barbiero: 5/22/92: Revised 5/29/92

Clearances:

O/PH: Doot/MGingerich 

PROG: CSteele 

CONT: TTotino

RLA: CBrown (Draft with Changes 5/27/92)

D/DIR: RSimmons 

PROJECT AUTHORIZATION AMENDMENT NO. TWO

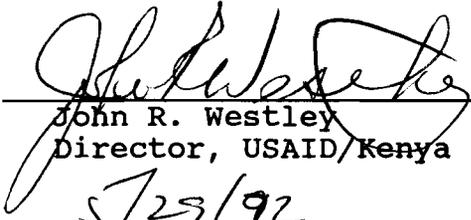
NAME OF COUNTRY: Kenya
NAME OF PROJECT: Family Planning Services and Support Project
PROJECT NUMBER: 615-0232

1. **Background.** Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Family Planning Services and Support Project was originally authorized on August 23, 1985 at a total planned level of financing of Forty Three Million United States Dollars (\$43,000,000) in grant funds over a five (5) year period from the date of original obligation. Pursuant to Section 104 of the Foreign Assistance Act, as amended, and the 1988 Continuing Resolution (Title II Sub-Saharan Africa Development Assistance Account), the original authorization was amended to increase the planned level of financing to Forty Six Million Two Hundred Thousand United States Dollars (\$46,200,000) in grant funds and extend the planned life of project period to seven (7) years. On May 4, 1990, the planned life of project period was further extended by an additional year for a new PACD of September 30, 1993.

2. **Amendment.** Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize an additional Twelve Million United States Dollars (\$12,000,000) in Development Fund for Africa (DFA) grant financing for said Project, for a revised total financing level not to exceed Fifty Eight Million Two Hundred Thousand United States Dollars (\$58,200,000) in planned obligations, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to finance the foreign exchange and local currency costs of the Project. The planned life of project (i.e., Project Activity Completion Date) is also hereby extended to August 22, 1995.

3. **Status of Original Authorization.** The original Authorization, as previously and hereby amended, remains in full force and effect.

Signature: _____


John R. Westley
Director, USAID/Kenya

Date: _____

5/29/92

USAID.PRJ\DOCS\AUTFPSS: CEB: PRJ: 5/29/92
Clearances:
RLA:CBrown: Draft w/changes, 5/27/92
PROG:CSteele: CS
O/PH:DOot/MGingerich: 11/10/92 mg
D/DIR:RSimmons: RS
PRJ:SBaker: SB

Family Planning Services & Support Project Amendment

Table of Contents

	<u>Page</u>
I. Background	
A. Population Trends	1
B. Government of Kenya Policy	4
C. USAID Strategy and Relationship to Country Program Strategic Plan (CPSP)	5
D. Other Donors	7
II. Rationale	7
III. Progress to Date	
A. Overall Project Status	11
B. Clinical Training and Support Services	12
C. Voluntary Surgical Contraception	14
D. Community Based Services	16
E. Subsidized Commercial Marketing	17
F. Ovulation Awareness	18
G. NCPD Administration	18
H. NCPD Policy, Planning and Evaluation	19
I. NCPD Information and Communication	21
J. MOH Information and Planning Systems (formerly Information, Planning & Reporting)	22
K. Child Survival	24
IV. Project Description	
A. Relationship to Original Goal and Purpose	26
B. Clinical Training & Logistics Management (formerly CTSS)	28

	<u>Page</u>
C. Voluntary Surgical Contraception	33
D. Community Based Services	35
E. Program Monitoring and Institutional Strengthening (formerly PPE)	39
F. Information, Education and Communication	40
V. Project Management & Implementation	
A. Administration Arrangements - USAID and GOK	42
B. Methods of Implementation	45
C. DFA Procurement and Methods of Financing Plan	48
D. Illustrative Implementation Schedule	50
E. Monitoring/Evaluation/Audit Plan	52
VI. Revised Financial Plan	
A. Summary	58
B. AID Contribution	60
C. GOK Contribution	61
D. Expenditure Projections	66
E. Obligation Schedule	66
F. Reasonableness of Cost Estimates	69
VII. Summary of Feasibility Analyses	
A. Administration	74
B. Social Soundness	75
C. Economic	82
D. Technical	87
VIII. Legislative Requirements, Conditionality and Negotiating Status.	
A. Legislative Requirements	90
B. Negotiating Status	91
IX. Annexes	
A. Cables requesting/approving Ad hoc Delegation	
B. Statutory Checklist	
C. Revised Logframe	
D. GOK Requests for Assistance	
E. Environmental Determination Cable	
F. USAID/Kenya BIG Country Strategy and AID/W Approved Cable	
G. Summary of Component Evaluations	

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 fertility, from a high of 7.9 in 1984 to a current estimate of 6.7, the population growth rate at 3.6% remains one of the highest in the world.

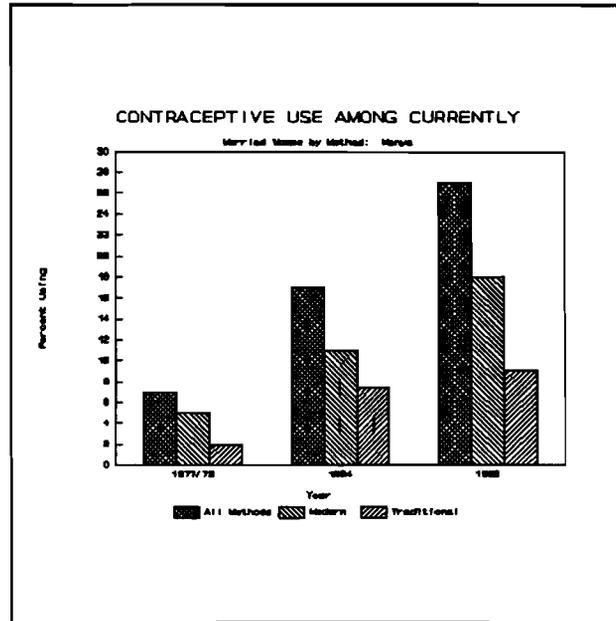
While this recent downward trend is encouraging, continued growth at this rate will cause the population of Kenya to double in only 19 years. Furthermore, because 50% of Kenyans are under 15 years of age, at best, only modest declines in Kenya's population growth rate can be expected during the next 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.

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. For example, 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 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: Kenya

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	NA	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, Oct. 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 major reduction in mean ideal family size of almost three children between 1977-78 and 1989, from 7.2 to 4.4. 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 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 a 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.

Knobbe/Kelly 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 support this strategy.

B. Government of Kenya Policy

The Government of Kenya (GOK) was the first in sub-Saharan Africa to articulate concern about the effects of population growth on 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 maternal/child health (MCH) services.

C. USAID Strategy and Relationship to 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 improvements in the availability and quality of services will help respond to the considerable unmet demand for contraceptive services which exists in Kenya.

Since 1979, USAID has been supporting GOK programs to increase information and expand accessibility to quality family planning services. USAID's approach is centered on three major strategies which taken together cover the spectrum of family planning assistance channels; i.e., 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. However, despite recent gains, many public and private health facilities still do not routinely offer family planning services.

Under the 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.

The 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 sublocations (smallest administrative unit) were served by such programs. Since 1988, there has been a major expansion in the community-based family planning programs implemented by among others 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. In 1992, it is estimated that over 35% of the sublocations are served by a community-based program.

Complementing the FPSS Project have been Mission-funded programs to introduce and/or strengthen family planning services in private clinical facilities. The major project has been 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 non-governmental organizations' (NGO) hospitals and health centers. A follow-on PSFP II Project (615-0254) was approved by the Mission in 1991 for \$10 million over a seven-year period to continue support to increase the availability, use and sustainability of family planning services in Kenya's private sector. In addition, both bilateral and central funds are being used to introduce family planning into the clinics of private medical practitioners.

The newest intervention in USAID's strategic approach supports efforts to enhance the availability of reasonably priced condoms and oral contraceptives sold through commercial retail outlets. Since 1990, under the Contraceptive Social Marketing (CSM) Project (615-0251), USAID has provided grant financing for the activities of a U.S. NGO in marketing and distribution of four products to be obtained through a commercial arrangement between a local marketing firm and commercial suppliers.

D. Other Donors

While 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 in this area 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 and the formal school system.

Until recently, USAID has been the sole supplier of condoms, vaginal foaming tablets (VFTs), and IUDs in support of both public and private sector organizations implementing the national family planning program. These contraceptives are 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 injectables and VFTs as well as the contraceptives implant (Norplant) with FINIDA funding provided through the Population IV Project. ODA has agreed, in principle, to help finance injectables as well.

USAID continues to provide condoms, IUDs, and until CY 1992, VFTs. In CY 1992 and CY 1993, the Office of Population, AID/Washington, will provide 6,500 NORPLANT sets to Kenya through the Association of Voluntary Surgical Contraception (AVSC) to begin the NORPLANT introduction program in the NGO/private sector.

II. RATIONALE FOR AMENDMENT

As noted above, Kenya is at the "turning point" in reducing its fertility. With the support and collaboration of the GOK, USAID's special emphasis has been on expanding family planning services and improving their quality. The 1990 CDIE Impact Evaluation concluded that "AID support has been a major reason for the

overall impact and recent success of Kenya's family planning program."

Because the FPSS Project is the major element of AID assistance to Kenya (complemented by the PSFP and CSM Projects, and by additional work of R&D/POP centrally-funded cooperating agencies), and because USAID's strategy and program are proving to have an impact, a two year amendment/extension of the Project is proposed.

The rationale for the Project amendment is also based on the fact that after six years of Project implementation, refinements and adjustments have been made to the Project and its components. These modifications have resulted from such factors as:

- findings and recommendations derived from individual component evaluations;
- data and new information derived from the Mission's management information system;
- increased Mission capacity and sophistication to define and assess quantifiable and qualitative targets of Project achievement;
- restructuring or elimination of Project components in order to achieve greater management efficiencies; and
- unforeseen obstacles or constraints in implementation of select elements of the original Project design.

As a consequence, included in this amendment are revised/refined indicators relating to the individual components (outputs), purpose and goal of the Project. These indicators represent meaningful targets on which evidence/data will be available to base a verification and measurement of Project impact and progress. The amendment also clarifies and updates the scope of effort being financed under the Project.

An additional benefit of a Project amendment/extension, as opposed to a development of a new PP, is to allow the incoming USAID direct-hire staff scheduled to arrive in the Office of Population and Health (O/PH) in mid-1992 to become acquainted with the situation and then subsequently direct the design of an anticipated new 10-year effort. Furthermore, the period of political uncertainty which now exists in Kenya, and has affected overall AID funding levels in the country, argues for an extension as opposed to a new project design.

The CDIE Evaluation cited a number of program elements which were pioneered or emphasized by the Project which need to be continued under the extended Project. The key elements cited follow:

Clinical Training and Contraceptive Logistics (CTLM)

Clinical training has been critically important because of its "leveraging" potential. The cadre of health workers being trained, the enrolled community nurses (ECNs), has been accurately described as the "backbone" of the clinical family planning program. Improving their knowledge and skills will result in better informed, more motivated providers who can correct misinformation, provide quality services, and make referrals for VSC and Norplant. USAID and the MOH will need to review in-service FP training requirements, and attempt to re-orientate the approach to get more ECNs: 1) trained in basic FP methods, e.g. pills, VFTs, condoms and injectables, and 2) providing services at the dispensary level.

Assuring the timely and reliable provision of contraceptive commodities is a *sine qua non* of a smooth, functioning, successful family planning program. This activity has appropriately been a Mission priority, and is still in a nascent stage. The services of a resident technical advisor are still needed and will be provided for under the planned amendment.

Voluntary Surgical Contraception (VSC)

The CDIE Impact Evaluation labelled this activity as "a major success story". Female sterilization (minilaparotomy under local anesthesia - ML/LA) has been institutionalized as a routinely available program method. ML/LA has been taught in all sectors of the national family planning program and is widely accepted in Kenya.

However, there has been a plateauing of procedures performed annually in AID-supported sites in the public sector. Furthermore, the overall number of procedures performed falls far short of the need implied in the 1989 DHS. Forty-nine per cent of married women indicated they wanted no more children - representing over 2 million women, yet only 200,000 to 300,000 are protected by long-term permanent methods. Further support is required, with particular attention to various management interventions, to increase service delivery at existing sites.

A five year field trial in Kenya has documented that the general introduction of NORPLANT as a family planning method is indicated because of its potential to be very popular and to fill an important niche in Kenya, particularly among women who want long-term contraceptive protection, are inappropriate candidates for the IUD, and are not ready to permanently limit their fertility.

The area of long-term and permanent contraception will have to be increasingly emphasized as the Kenya program matures, and demand continues to increase. AID has a comparative advantage in this

area. Because of its importance, most of the other FPSS components and the activities financed, e.g. IEC, training, logistics management, clinic and CBD worker referral, will be explicitly linked to improving long-term and permanent contraception.

Community-based Services

Community-based counselling and distribution of contraceptive supplies (CBD) has proven to be an effective way to extend family planning services beyond fixed clinic facilities in Kenya. The CDIE Impact Evaluation concluded that "in Kenya, CBD has made a major contribution to increasing contraceptive use." Where CBD has shown positive impact, a number of NGOs will be supported to expand and improve services, and increase effective referrals for long-term or permanent methods.

Information, Education and Communication (IEC)

IEC has proven to provide "multiplier" and "leveraging" effects. Mass media channels that already exist in Kenya will continue to be used to provide cost-effective ways to get information and appropriate and correct family planning messages to large numbers of people. Production of client and provider materials which various needs assessments have highlighted as needed and currently lacking will also be financed. This effort will not only improve knowledge but it will also improve quality of service delivery, through counselling about a wide range of methods. With approved, method-specific IEC, the long-term and permanent contraceptive information and referral needs can increasingly be met.

Planning, Monitoring and Institutional Strengthening (PMIS)

The 1989 KDHS has been one of the most widely utilized and quoted documents on the status of Kenya's family planning program. NCPD is preparing to undertake the next KDHS in 1993 to monitor fertility trends which are critical to program planning. The DHS survey and in-depth analyses to be financed under the amendment, with complementary funding from the Office of Population, AID/Washington, will assist NCPD, the MOH, USAID, and other donors to identify requirements and "leverage" support and resources for the overall Kenya program. Additionally, continued financing of institutional strengthening work with NCPD and key NGO family planning service providers will, as noted in the CDIE Evaluation, significantly enhance their capabilities in the areas of Management Information Systems (MIS), strategic planning and financial planning/management 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.

In summary, this amendment will allow for consolidation and intensification of program effort. At the same time, it will provide the additional resources and extended time to enable the Mission and the GOK implementing agencies to focus on those areas which are working well, but need strengthening, as documented in the CDIE Impact Evaluation and individual component evaluations. Essentially, the Project will be staying a proven course that has been emphasized over the past three years.

III. PROGRESS TO DATE

A. Overall Project Status

The FPSS Project was designed to assist the GOK to reduce very high fertility and population growth through improving access to family planning information and quality services. It was felt that this major effort "will improve equity of access for over income groups and improve the status of women; it will lower maternal and infant mortality and morbidity; and it will lessen the growing dependency burden that forces low savings and diminishing investment in social and economic development."

The Project was authorized on August 23, 1985 for a seven year period with a PACD of September 30, 1992. AID financing of \$43 million was authorized and the GOK's planned contribution to the Project was estimated at \$56,273,000.

In August 1988, the Project was amended to include a child survival component and to increase life of project (LOP) financing by \$3,200,000 for a new total of \$46,200,000. With this amendment, the GOK's contribution to the Project was increased to \$63,730,000. In April 1990, the Project Activity Completion Date (PACD) was formally amended to September 30, 1993 at no additional cost to provide sufficient time for implementation of two components, i.e., CBS and child survival, and in order to reallocate funds from two components, Subsidized Commercial Marketing (SCM) and Ovulation Awareness (OA). This reallocation provided for sufficient funding to cover the requirements for CTSS, VSC and other components.

Based on several component evaluations, the broader CDIE evaluation of the overall program, results of the 1989 DHS, and monitoring of service statistics, the Project is clearly contributing to declines in fertility and increased contraceptive use, primarily through rapid expansion of family planning services. The status of activities financed to date and related accomplishments and results are presented below in relation to the individual Project components.

B. Clinical Training Support & Services (CTSS)

During the Project period the major objective of "increasing access to quality clinical services" has continued as the focus of assistance in the CTSS component. In the original Project Paper (PP), "access" was broadly defined as availability of family planning services in static health facilities. The increase in numbers of facilities, i.e., service delivery points (SDPs), was to be achieved by massively increasing the number of trained FP workers available to be deployed in these facilities, and by ensuring an adequate and steady supply of contraceptive commodities.

The original PP estimated that in 1984 there were 758 registered family planning SDPs. By 1992, there were already an estimated 1,650 registered family planning SDPs, exceeding the original Project target of 1,424. Couple Years of Protection (CYP) attributable to clinic services increased from an annual average of 665,000 in 1985 to 1.4 million in 1992. Cumulative CYP for the period 1985-92 was estimated to be in the range of 8.4 million¹, well above the original Project target of 5 million.

At the inception of the Project, both targets were ambitious compared to the scope of the national family planning program at that time. However, the program's capacity, particularly increases in number of SDPs, has exceeded original expectations owing in part to the considerable donor inputs, as well as GOK commitment and GOK/donor cooperation. Additionally, rapid expansion of SDPs in the NGO/private sector has greatly contributed to this growth.

Even so, a more indepth understanding of the service environment, as gained over the past 6-8 years, makes it necessary to qualify these achievements. In spite of the favorable performance against the original PP targets, optimum potential for making quality clinic services available has not yet been fully realized.

There are currently an estimated 3,200 health facilities in the country. Thus, the 1,650 registered SDPs represent about 50% in the total, a proportion that was similar to 1985. Additionally, there is likelihood that some of the registered SDPs may not be currently providing family planning services, while other outlets, particularly in the growing category of private practice clinics, may be providing services but are not registered. Among other things, these observations point to serious deficiencies in

¹ Source: "The Family Planning Programme in Kenya, Demographic Impact and Expenditure Implications", National Council for Population and Development, March, 1992.

the facilities/SDPs data base of the MOH, making it difficult to accurately plan, implement or measure growth and requirements in facility-based services.

In the area of FP manpower training, the MOH's capacity to staff SDPs with trained workers improved considerably, with annual output increasing from 163 in 1985, to 878 by 1989. The 1989 figure approaches full annual output capacity for the MOH's 12 Decentralized Training Centers.

However, given the lack of a clear data base on the number of SDPs and requirements, it has been difficult for the MOH and USAID to evaluate future training targets. Are we training too few - or possibly too many? In addition, a number of family planning manpower dynamics are emerging which challenge earlier assumptions about the role of the certified facility-based provider and training targets.

For example, demand for clinic-based service is increasingly being supplanted by community-based services and demand for long-term and more permanent methods. Also, in the near future, it may be possible to substantially reduce the numbers of health workers receiving the in-service certificate course, as increasing numbers of graduating ECNs qualify in family planning as a routine part of their pre-service course. Furthermore, there are indications that the family planning qualifying standards for clinic personnel need to be reviewed and, possibly, streamlined.

Given the fact that the MOH now authorizes non-medical community volunteers, to issue basic commodities (condoms, vaginal foaming tablets, and pills), there seems to be little justification for continuing to prohibit otherwise qualified health personnel in clinics from also providing at least these basic services. These are but a few of the factors and policies that have not as yet been reviewed affecting the in-service training program.

An independent evaluation of the training program conducted in 1990 identified a number of structural management deficiencies within the training unit which also negatively affect the quality of training. As a first step in responding to the evaluation recommendations, during 1991-92, the Project financed the assistance from the Johns Hopkins Program in Reproductive Health (JHPIEGO), to work intensively with a curriculum development team of the MOH/Division of Family Health (DFH) to conduct a task analysis of FP service provider skills. The team also developed learning objectives and produced a comprehensive base curriculum and instructor's manual.

In addition, the Population Council helped the MOH/DFH to develop new service delivery guidelines in the form of a booklet and wall chart which were completed and widely distributed in 1991.

Prior to JHPIEGO's efforts, the MOH/DFH had also received periodic assistance from Program for International Training in Health (INTRAH) in Training of Trainers (TOT). Notwithstanding all of these efforts and support, additional improvements to the curricula are needed, particularly in refresher courses and standard TOT courses. In addition, the course period/timeframe needs to be shortened to gain efficiencies comparable to the approach used in community-based services. Physical infrastructure, including facilities and equipment, for the training program also requires upgrading and financial management/accounting capacity within the MOH/DFH is in serious need of improvement.

In the contraceptive supply area, since Project initiation, the MOH's capacity to plan and make commodities available to service outlets has consistently improved. In addition, Project technical assistance to the MOH has vastly improved the reliability of contraceptive supplies for which it is responsible, and has been instrumental in coordinating supply inputs of other supply donors.

As a major contraceptive supplier, during the Project period USAID has taken an active role in ensuring that its donated commodities reached their intended destinations at the service level. From time-to-time, USAID arranged for logistics management consultancies and training of supplies officers through the Family Planning Logistics Management (FPLM-I) Project. However, by 1988, it became increasingly obvious to USAID, other contraceptive supply donors, as well as the MOH, that more intensive technical assistance would be needed in order to make any substantial improvements in the contraceptive logistics system.

Accordingly, a \$1.0 million, long-term (2-year) contraceptive logistics management assistance effort was begun under the Project in August 1991 through the FPLM-II project. By mid-1993, this effort will have established a fully staffed Logistics Management Unit within the DFH and the Medical Supplies Coordinating Unit, and established vertical contraceptive commodities information, procurement, warehousing, and distribution system.

C. Voluntary Surgical Contraception (VSC)

The original PP estimated that 250,000 procedures would be performed in 170 sites offering VSC services by September 1992. These estimates were overly ambitious given that VSC services were just beginning in Kenya at the time.

While tremendous progress has been made since 1985 in establishing a solid VSC program in Kenya, the current LOP objective is 80,000 procedures and 60 operational sites (24

public sector; 36 private sector), based on revisions made in 1990. At this stage, some sites are hampered by management difficulties and are not functioning at full capacity. However, most of these sites have appropriately trained physicians, nurses and nurse counselors, renovated facilities and minilap equipment. At this time, approximately 11,000 AVSC supported ML/LA procedures are performed annually, for a cumulative total of 65,000 procedures since the Project began.

Planned public sector expansion has been delayed and hampered by services management problems in the MOH/DFH program. AVSC, USAID, and DFH recently agreed that the DFH management problem of supervision, monitoring quality assurance, reporting and replenishment of expendable supplies must be resolved if services at the 24 MOH sites can be maintained.

To address this difficulty, AVSC recruited an in-country financial management advisor to work closely with the DFH to manage the reporting, expendable supplies and financial requirements of the VSC in the public sector. Additionally, AVSC hired a second Kenyan medical doctor to monitor the public sector VSC sites. This assistance should improve the quality and timeliness of reporting from MOH VSC sites for reimbursement of expendable supplies directly from a supplier contracted by AVSC, thereby helping to ensure that quality VSC services can be provided at the existing sites.

In the NGO/private sector, the VSC program has expanded to 36 sites, but performance is of varying quality. FPAK has 8 operational sites and has continually reported increasing numbers of procedures, with the exception of Mombasa. The CHAK program has 13 operational sites, but 6 sites perform 75% of all the procedures. Financial difficulties, high turnover of missionary staff and non-assertive management of the family planning program at CHAK headquarters are major factors in the disappointing performance of CHAK VSC services.

The private sector VSC program has been established in 13 sites, mostly private, for-profit nursing/maternity homes or clinics. At present, it holds the most promise for expansion since the for-profit nursing homes are a growth industry in Kenya.

Beginning in 1992, AVSC began a NORPLANT introduction program with FPAK to train 36 doctor/nurse teams in 18 sites for the NGO and private sector. To complement these local training costs being provided by the Project, the AID/W/Office of Population is providing 6,000 NORPLANT sets for this two-year introduction program.

There are plans in the World Bank Population IV project to support the public sector NORPLANT training/introduction, but to date little progress has been made by the Bank and the MOH to get

the activity started. The Dept. OB/GYN and JHPIEGO have worked collaboratively since 1988 with Project assistance to integrate ML/LA training into the Medical Resident's curriculum in 12 teaching hospitals. JHPIEGO, AVSC, FPAK, the MOH and the Dept. standardized the ML/LA training curriculum in mid-1990. Since that time, all pre- and in-service ML/LA training in Kenya has been taught in a standardized approach with uniform messages.

Additionally, Infection Prevention Guidelines for the ML/LA program were developed by the Dept. OB/GYN and an infection prevention specialist. The infection prevention procedures have been introduced at Kenyatta National Hospital (KNH) and the 12 teaching hospitals are being monitored routinely as part of the ML/LA training program for medical students.

D. Community Based Services

The Community Based Services (CBS) component of FPSS was designed to increase awareness of the benefits of modern methods of preventive health, encourage use of modern family planning methods, and make supplies and other services accessible by drawing on Kenya's extensive national network of community development leaders and organizations. The CBS component aims to reach urban poor and rural Kenyans who have limited access to the formal health sector. NCPD coordinates the CBS component.

Implementation of the CBS component was delayed for almost three years, because of lack of agreement between NCPD and USAID on funding modalities. In late 1987, NCPD finally agreed that USAID could do direct funding and/or use Pathfinder International as an intermediary.

In early 1988, AID direct grants under the Project were awarded to support the community based distribution of contraceptives (CBD) projects of FPAK and Chogoria Hospital. Subsequently, CBD projects were established with seven additional NGOs representing rural and urban networks of women's groups, church and mission hospitals, clinics and dispensaries, low-cost urban clinics and the national family planning association.

Currently, nine CBS-funded programs cover 982 (28%) of the over 3,500 sublocations in Kenya through the activities of 2,500 CBD agents and over 100 supervisors. As a result, in 1991 approximately 228,000 new clients were seen, 346,000 revisits were made and 120,000 couple years of protection were provided.

Other NGOs' CBD projects, funded by AID/W centrally or through other non-AID sources, cover an additional 279 (8%) sublocations with an estimated 13,000 CBD agents. The German Development Agency, GTZ, also supports an extensive CBD program through the MOH. However, no data are available on the location or numbers of their CBDs.

The community-based, family planning services approach has been found to be highly effective in reaching couples who previously did not have access to FP information or services. The program has worked successfully through community-level infrastructures with support of chiefs and other local leaders, the Village Health Committees and community groups. Community-level individuals and groups have been involved in selecting the CBD agents who provide services to community members, thereby greatly enhancing the likelihood that CBDs are accepted by the community and seen as leaders. Since the majority of CBDs are women, the result is enhancement of their status in the community.

The "face-to-face" contact that the CBDs make with couples seems to be an important factor in changing attitudes about family planning, especially in the area of VSC. Both FPAK and MYWO have made effective use of satisfied TL clients as CBD workers. Their service statistics document the number of "effective" referrals for VSC services made by the CBDs.

E. Subsidized Commercial Marketing (SCM)

In the original PP, it was anticipated that this component would finance support for a recently created SCM company to operate under an AID/W funded contract with SOMARC, a U.S. NGO, for the first four years of the Project. Over the LOP it was estimated that 6,000 retail and pharmaceutical outlets would be selling three kinds of contraceptives at subsidized prices.

In 1986, NCPD decided not to work through SOMARC, but instead work through a subcommittee of NCPD to develop a pilot project to test the feasibility of utilizing commercial marketing techniques to distribute contraceptives in urban Nairobi. A Project-financed consultant worked on the preparation of a detailed proposal, implementation plan and budget, together with NCPD staff and selected members of the newly formed NCPD sub-committee on Contraceptive Social Marketing (CSM). However, NCPD's Executive Committee ultimately rejected the proposal as being too sensitive to be a program of NCPD, and recommended that the GOK not be involved in a private sector project of this nature. Instead, the Executive Committee recommended that assistance could, perhaps, be provided directly to the commercial sector where there was considerable interest and expertise.

NCPD's decision not to implement the SCM component resulted in agreement between the GOK and USAID to drop this component from the bilateral Project and reallocate the SCM budget to other components of the FPSS Project and to work with the commercial sector directly. In July 1990, on the basis on an unsolicited proposal, USAID entered into an A.I.D. Handbook 13 Cooperative Agreement with Population Services International, a U.S. PVO and a local commercial firm to begin a contraceptive social marketing program with resources provided by A.I.D. Washington. The

proposal was financed with additional funding of \$2,683,000 provided by AID/Washington under the initiative "Private Provision of Social Services".

F. Ovulation Awareness (OA) for Periodic Abstinence

The OA component was designed to enable the Kenya Catholic Secretariat (KCS) and the Family Life Counseling Association of Kenya (FLCAK) to train 3,600 teachers and up to 7,200 volunteers to provide information and counseling to over 10,000 couples on use of natural family planning methods. Between 1986 and 1989, more than 65 OA teachers were trained, who in turn trained more than 760 community-level volunteers. It is estimated that nearly 39,000 couples received training in OA during that period. These activities were financed under the Project under grant arrangements with the NGOs administered by NCPD.

In December 1988, FLCAK and KCS withdrew their respective Memoranda of Understandings governing these grant arrangements with the NCPD because of the A.I.D. legislative requirement on inclusion of language regarding "informed choice" contained in the MOUs. Under the U.S. Foreign Assistance Act, AID is required, by law, to ensure that any organization receiving financial assistance for family planning related activities agrees to inform prospective clients about other methods of family planning and where they can be obtained. The law does not require that the recipient organization, in this case FLCAK and KCS, endorse, promote, or provide other methods of family planning.

However, KCS and FLACK were unwilling to accept the language mandated by the U.S. Congress on "informed choice". Consequently, the funding for this component ceased on December 13, 1988 and the balance of funds were reallocated to other components. Project financing provided to December 1988, supported accomplishments of the following outputs:

- * 3,600 teachers and 7,200 volunteers trained in natural family planning and OA methods of contraception; and
- * 10,860 cumulative users of natural family planning and OA methods of contraception.

G. NCPD Administration Strengthening

This component was intended to strengthen the capacity of the NCPD Secretariat to carry out its mandate of coordinating the national family planning program through increased capacity to monitor, supervise, manage and formulate policy. Major outputs were anticipated to be a modification of the legal status of the Secretariat to a more independent Permanent Commission, internal

reorganization, increased staff levels and strategic planning capabilities.

In the first two years, the Project financed staff salaries and other personal emoluments, after which time the Mission and GOK agreed upon the use of USAID counterpart funds for this purpose. In GOK FY 89/90, the GOK assumed 25% of the NCPD recurrent costs directly. It is anticipated that the GOK will assume all recurrent cost financing in GOK FY 92/93.

In terms of its management capacity, the number and status of NCPD professional staff has increased from 11 in 1985 to 57 in 1992. NCPD has not paid sufficient attention to updating/upgrading staff skills on a coordinated basis with USAID, the World Bank and UNFPA, and the process continues to be somewhat ad hoc. Furthermore, while the NCPD Secretariat continues to aspire to become a more independent organization, the former Permanent Secretary of the Ministry of National Heritage and Home Affairs and the former Chairman of the NCPD Council did not endorse this aim. It is not anticipated that any decisions on changing the status of NCPD will be likely within the next calendar year.

Continued Project financing for this component is not planned beyond July 1992. At that time, the GOK will be expected to have assumed full financial responsibilities for recurrent costs. Some short-term training will continue to be supported under the Planning, Monitoring and Institutional Strengthening component.

NCPD Administration Summary Outputs

It is expected that the inputs provided under this component within already established Project budget levels will result in the following outputs.

- * NCPD job descriptions developed and staff hired.
- * Staff training plan completed.
- * Significant yearly increases in GOK budget allocations to NCPD.

H. NCPD Policy Planning and Evaluation (renamed Planning, Monitoring and Institutional Strengthening)

This component was originally envisioned to strengthen policy, planning and evaluation capacity within the NCPD Secretariat. Anticipated outputs were development of an evaluation plan; two Demographic and Health Surveys (DHS); a joint UNFPA/USAID evaluation of NCPD and the NGOs; and related social science and biomedical/research activities.

In February 1988, a Project-financed review of NCPD Policies and the management and administrative systems of the Secretariat was carried out and recommendations made on ways in which the NCPD could be further strengthened. Among the recommendations made was the need for NCPD to include more attention to implementation of a management information system (MIS) for planning, monitoring and administration, and more attention to strategy planning and policy relevant research.

During 1988-89, USAID and NCPD agreed that establishment of a program MIS was a pre-requisite to further development of NCPD's policy planning capacity. USAID arranged for technical assistance to be provided by the Family Planning Management Training (FPMT) project, (renamed Family Planning Management Development, FPMD, in 1991), for development of an MIS to facilitate overall program monitoring, and specific program and financial monitoring of sub-grants supported by USAID and other donors.

Steady progress in creating a rational, target-specific information and monitoring system is being made by NCPD. The assistance is successfully engaging senior NCPD management staff in acquiring data analysis and interpretive skills. FPMD has assisted selected NGOs to strengthen their program information systems, making them more relevant to NCPD, Ministry of Health and donor reporting requirements.

As a complement to these institutional strengthening activities supported by FPMD; USAID has arranged for periodic consultancies by the Research Triangle Institute (RTI) which had guided NCPD senior management and staff through a series of FAMPLAN analyses. The combination of FPMD and RTI assistance has improved NCPD's capacity to perform the policy-informing role originally envisioned as the centerpiece of its mandate.

In 1988-89, USAID arranged for Family Health International (FHI) to assist in establishing a major reproductive health research project with a direct link between the University of Nairobi, Department of Obstetrics and Gynecology (OB/GYN), and NCPD. The purpose of this effort was two-fold: (1) to undertake research in support of NCPD's policy-informing role, and (2) to build OB/GYN's institutional capacity in reproductive health research. This effort, financed under the Project, has also benefitted from central AID/W funding to Family Health International (FHI).

An external mid-project review of the FHI-OB/GYN Reproductive Health Research Institutional Development Project (RHR-IDP) was conducted in 1991. Among major findings, it was noted that the link between NCPD and OB/GYN was weak (technical advisory committee meetings were infrequent and proforma), and the leadership role that might be played by OB/GYN in the area of national reproductive health policy needed to be strengthened.

In addition, a number of constraints were identified regarding the University's ability to recruit, provide office space for, and retain staff specifically concerned with reproductive health research undertakings and output. These various project concerns are being addressed in part by placement of a resident FHI advisor at the Dept. OB/GYN. Several studies, including a family planning Knowledge, Attitude and Practice (KAP) study of physicians, and a 3-method Contraceptive Continuation Study - both offering policy information - were completed.

In 1988-89, NCPD and the Central Bureau of Statistics (CBS) carried out a national level DHS, with technical assistance from the Institute for Resource Development (IRD). The survey questionnaire was finalized, translated, sample selected and pre-testing was begun in 1988. Field work began in December 1988 and continued through mid 1989. From June to August, the analysis was done, and in October 1989 at the 2nd Leader's Conference, the President announced the major findings of the DHS; i.e., a decline in TFR from 7.9 in 1984 to 6.7 in 1989, and the increase in CPR for all methods from 17% in 1984 to 27% in 1989.

The DHS has proven to be one of the most valuable exercises undertaken by the FPSS Project to focus national and international attention on the progress of Kenya's family planning program.

I. NCPD Information and Communication

Per the original PP, the purpose of this component was to increase the demand for family planning by using a blend of selected mass media and interpersonal channels to reach target audiences with service-related messages. From 1986 to mid-1990, the FPSS Project supported this element by financing NGO proposals for activities in general population awareness and family life education through NCPD.

A 1988 UNFPA evaluation, conducted concurrently with an USAID evaluation of NCPD, revealed that to a degree population awareness had been raised in Kenya. The evaluations concluded, however, that due to the lack of a focused IEC strategy, only a marginal difference had been made in creating demand for family planning services. While the NGOs had played a role in providing general family planning information, the gap between the knowledge and use of family planning methods was large. The evaluations also confirmed that IEC activities historically had not been well integrated into national family planning activities.

The 1989 KDHS noted that desired fertility had changed significantly and that general knowledge about family planning was higher. However, it indicated that the desire for spacing

and limiting births was not being followed-up with use of modern family planning methods.

In March 1990, at the request of USAID, Johns Hopkins University/Population Communication Services (PCS) carried out an assessment of the family planning IEC situation in order to develop viable options for USAID providing continued FPSS Project assistance for IEC activities that would contribute to the national IEC strategy for increasing contraceptive prevalence. Based on the PCS assessment, it was clear that IEC activities needed to focus on: increased linkage between IEC strategy design and the national family planning program; improving the quality of information on family planning services between family planning providers and clients; providing accurate method specific information; disseminating correct information to users and non-users; and dispelling rumors.

On the basis of the assessment's findings/recommendations, in February 1991, Project financing for this component was reprogrammed to support the initial two-year phase of the FPAK Client-Provider Education project. To date, the following activities have been undertaken: 1) an IEC Working Group comprised of FPAK, CHAK, MYWO, FPSS, KMA, NCC, NCPD and the MOH has been established; 2) audience and market-based research has been conducted and psychological profiles developed based on user surveys; 3) a rapid training needs assessment has been completed; 4) fourteen Client Provider Master Trainers have been trained in preparation for training of MOH and NGO trainers; and 5) the CBD Training Manual was finalized.

It is anticipated that in 1992-1993 the following activities will be undertaken and materials produced: 1) training of trainers of CBD agents on how to use the revised CBD Training Manual and training of NGO clinic providers in interpersonal communication and counseling skills; 2) production of a variety of family planning print materials to include methods-specific leaflets, CBD reference guides, family planning flip charts, counseling posters/charts, demonstration models and users manuals, booklets with answers to the "Most Commonly Asked Questions about Family Planning" and handbills promoting family planning; and 3) a 52-episode series of a weekly 30-minute radio program with a family planning theme.

J. MOH Information, Planning and Reporting (IPR) (Renamed, Information and Planning Systems (IPS))

The purpose of the IPS component was to assist the MOH to design and implement systems and procedures for improving national and district planning and budgeting. It was assumed that this improved capacity would, over the long term, lead to more equitable/efficient distribution of government resources for

preventive/primary (Maternal/Child Health, and Family Planning) services.

Planned outputs of the IPS included: (1) enhancement of vital health, family planning, and management information systems, through computerization; (2) design and implementation of national and district planning and budgeting protocols (entailing extensive management training); (3) strengthening the Health Information Systems (HIS) Unit within the MOH; (4) funding of health management operations research grants, and; (5) establishment of a computerized library and information resource center in the MOH.

The primary implementation modality for the IPS component was a 56-month Host Country Contract (HCC) between the MOH and a U.S. contractor, Thunder and Associates, Inc., with Tulane University as a subcontractor. The HCC, funded at a level of \$5.7 million, will be completed in May, 1992.

A mid-term evaluation of the component conducted in May, 1989 indicated that good progress was being made at that time towards meeting the health information systems objective of the Project. The evaluation noted that the MOH's progress in linking the information systems to decision-making and strengthening planning and management systems was less satisfactory.

The effort did achieve good results in the development of prototype information and planning systems at the district level. It also performed well in all activities not predicated upon establishment of certain MOH headquarters structures, staffing, and functions. For example, the MOH, with contractor assistance, completed the technical design of all health information subsystems and trained a number of MOH managers/users, data programmers, and data processors.

However, by the contract's PACD, a number of the systems developed were still not being fully utilized because of serious operational difficulties in the MOH's information unit and the absence of a designated MOH HIS manager to interface with the contractor over the life of the effort. In 1991, the MOH requested a further extension of the IPS/HCC effort. USAID's approval of this extension was predicated on the MOH's designation of such an individual. Based on this conditionality, the MOH finally did appoint a Health Information Systems Unit Manager in September 1991.

The mixed results of the MOH's performance under the IPS component indicated the importance of ensuring host country senior management support and responsiveness to the requirements of the project, particularly when there are structural/staffing requirements that are critical to the successful intervention and operations of a technical assistance contractor. In retrospect,

it is likely that IPS component outcomes could have been improved by placing more stringent and formal conditionalities on the MOH, prior to approval of the HCC and initiation of the technical assistance effort.

K. Child Survival (CS)

In August 1988, the FPSS Project was formally amended to add \$3.2 million in DFA funding to finance the child survival activities as a new service delivery component of the program. The CS component has provided targeted support to the MOH's Kenya Expanded Program on Immunization (KEPI) and Control of Diarrheal Diseases (CDD) Program. An additional element of this component, child survival/family planning training activities, managed through a buy-in to the AID/W centrally-funded Family Planning Management (FPMT) Project, was completed in 1990.

The activities were identified jointly with the MOH/Division of Family Health as principal areas where well-defined, discrete technical assistance and additional resources could make critical contributions to achieving GOK goals of improved child health and survival and increased demand for family planning services through an integrated MCH/FP approach. Although no bilateral funds are allocated to acute respiratory infection (ARI) and malaria, USAID has also participated in policy and technical meetings on the control of these important diseases.

Assistance to KEPI is in three forms: 1) the procurement of measles vaccine; 2) the provision of counterpart funds for non-wage recurrent costs; and 3) technical assistance through a buy-in to the AID/W centrally-funded REACH project.

The KEPI Management Unit of the DFH identified the procurement of measles vaccine starting in calendar year 1989 as a priority need. A DANIDA review of the KEPI program in 1988 confirmed the importance of measles mortality as a major component of infant mortality in Kenya and the critical need for an adequate supply of measles vaccine to ensure that KEPI coverage and disease reduction targets are met.

Procurement for vaccine financed by the Project has been done directly through a Project Implementation Order/Commodities (PIO/C) authorizing the purchase of vaccine through UNIPAC at levels defined by KEPI. By September 1993, approximately 970,000 vials or 9.7 million doses of measles vaccine will have been procured for the program at an approximate cost of \$1.87 million, with the final shipment of vaccine expected to cover requirements through January 1993.

Continued provision of measles vaccine to KEPI beyond January 1993 under the FPSS Project is not planned at this time. The MOH has been formally advised that it should identify and schedule

alternative funding sources for the KEPI program's measles vaccine and that it should budget counterpart funds in its forward budget to cover a portion of these procurement requirements.

Roughly 60 percent of KEPI's non-personnel, recurrent costs have been financed with local currency funds generated under other Mission-funded activities provided to the Project. It is unlikely that additional local currency funds will be available beyond September 1992.

The Project has also financed technical assistance through a buy-in to the AID/W centrally-funded REACH project which has provided a long-term, Kenyan resident advisor to the MOH to assist KEPI develop social mobilization and communications strategies for EPI. Targeted technical assistance has been provided which has aimed at increasing KEPI capability in the areas of surveillance, monitoring, supervision, and operations research. This assistance has included training of KEPI staff in computerized monitoring and surveillance techniques, assistance in planning an upcoming national accelerated control of measles workshop, design and conduct of a neonatal tetanus study and active participation in long-term planning exercises conducted by the KEPI central management unit.

Future activities to be funded under this REACH buy-in include a KEPI Unit costing exercise and a national accelerated control of measles workshop. FPSS Project funding of REACH technical assistance activities concludes in September 1992. AID/W central funds will be available from October 1992 through September 1993 to continue the services of locally-hired REACH personnel at KEPI.

In addition to the above support to KEPI, a Memorandum of Understanding for a special measles initiative was signed by the Mission and GOK in March 1992 for technical assistance to KEPI to promote a rapid decrease in measles and other vaccine-preventable diseases. AID's contribution to this effort, valued at \$1.0 million over an 19-month period, comes from AID/W central RD/Health funds and will be coordinated in-country by REACH.

USAID assistance to the Control of Diarrheal Diseases (CDD) Program is in two forms: 1) local currency funds made available for CDD non-personnel costs (nearly 100 per cent of such recurrent costs); and 2) technical assistance financed through a buy-in to the AID/W central Primary Health Care Technology Support (PRITECH) Project of Management Sciences for Health.

The PRITECH mechanism has provided support for administrative and operational costs of communications and operations research, technical assistance for the development and implementation of a communications strategy, and targeted short-term training and

observation tours. FPSS Project funding for this element of the Child Survival component concludes in September 1992. AID/W central PRITECH funds will be available starting in February 1992 to augment the bilateral funding and extend the effort through August 1993.

During this period, the Project will focus on four areas identified as promising by CDD, PRITECH and USAID/PH personnel: 1) CDD communications activities targeting in-school youth; 2) improved outreach to and liaison with NGOs; 3) partial financing of initiatives to increase ORS production and distribution in Kenya via the private commercial sector; and 4) follow-up support for the Kenyatta National Hospital-based Lactation Management Training Center. AID/W central funding for the MOH/CDD Program beyond August 1993 is not planned due to the limited success in working in this area with the public sector.

The final element of this component, child survival/family planning training activities, has been successfully implemented under the Project through a buy-in to the AID/W central FPMT project. Technical assistance has been provided to the FPAK, MYWO, CHAK, World Vision, MIHV, Aga Khan, CORAT, Salvation Army, AMREF, other local NGOs and public sector MCH/FP program managers develop and strengthen management capabilities and skills. Specifically, FPMT conducted a series of three management training workshops over 18 months with a focus to update technical skills in immunization, CDD, FP and breastfeeding and to develop better management system to implement child survival/family planning programs in rural/urban communities.

Child Survival Support Outputs

The inputs to be financed under this component with funding available under the current Project are expected to result in the following outputs.

- * 9.7 million doses of measles procured and administered to a minimum of 5 million children under age one.
- * Measles vaccine coverage increased from 58% in 1987 to 80% in 1994 of children under age one.
- * ORS/ORT usage rate increases from 5% in 1987 to 85% in 1993.
- * 75 NGO and public sector personnel trained in child survival/family planning management.

IV. PROJECT DESCRIPTION

A. Relationship to Original Goal and Purpose

In this PP amendment, the original Project goal and purpose have been formally refined and restated to more clearly define these elements in measurable, objectively verifiable terms. The modifications are consistent with the objective(s) and targets contained in the USAID/Kenya CPSP and in other official Agency documentation, including the Mission's Assessment of Program Impact (API) report.

The amended goal of the FPSS Project is **"to reduce fertility and population growth rate."** A key assumption relating to this goal is that increased contraceptive prevalence will lead to lower fertility and population growth. The indicators of goal achievement are:

- total fertility rate decreased from 7.9 in 1984 to 5.8 in 1995; and
- growth rate decreased from 4.1% in 1984 to 3.3% in 1995.

The original project purpose, per the Project logframe, was "to increase user rates of quality fertility regulation methods." In the original PP, the purpose was "to increase user rates of high quality family planning methods." The original Project Authorization contained no specific purpose statement, simply stating that "the Project consists of various activities to improve and expand family planning service delivery throughout Kenya and to increase Kenya public and private capacity to support and promote family planning."

In this amendment, the Project purpose and EOPS indicators have been formally revised to reflect the higher-level purpose of the Project which is **"to increase prevalence of contraceptive use."** As a consequence the EOPS indicators of purpose-level achievement have been modified to go beyond service-level or output-oriented results, e.g., Couple Years of Protection (CYP), and will now be based on:

- Contraceptive Prevalence Rate (CPR) for all married women of reproductive age increased from 17% in 1984 to 35% in 1995; and
- CPR for all women of reproductive age increased from 14% in 1984 to 31% in 1995.

A key assumption relating to achievement of the amended Project purpose is that GOK policies support expansion of family planning services in the public and private (NGO) sectors. It is also assumed that latent demand for contraception can be activated through the increased availability of quality family planning information and services.

In sum, the FPSS Project strategy is to increase the availability and quality of family planning services, which will be made possible by the existence of an extensive network of facilities in Kenya, a strong private sector, and effective cooperating agencies and intermediaries. These factors provide strong evidence that the additional \$12.0 million to be provided under the proposed two-year extension can be effectively absorbed and utilized to enable the Project to achieve its objectives. While not essential to achieving the Project's purpose, it is also expected that additional AID/W financial resources will complement the bilateral FPSS Project effort.

Based on the modifications discussed in Section III., Project components planned for completion by September 30, 1993 are NCPD Administration, Information and Planning Systems and Child Survival. The Ovulation Awareness component was discontinued in December 1988. The related outputs for these components were presented in Section III and are detailed in the Project's Logical Framework Matrix. In mid-1989, the Subsidized Commercial Marketing component was discontinued under the Project, but was authorized as a free-standing Mission-funded project in August 1990.

The Project's ongoing components to be financed under the amended Project period are: (1) Clinical Training and Contraceptive Logistics; (2) Voluntary Surgical Contraception; (3) Community Based Services; (4) Information, Education and Communication; and (5) Planning, Monitoring and Institutional Strengthening. A description of the activities to be undertaken and anticipated outputs is provided below.

B. Clinical Training & Contraceptive Logistics (formerly CTSS)

The new component title, "Clinical Training and Contraceptive Logistics (CTCL)", more accurately describes the nature of activities that will be financed and implemented during the extended Project PACD. While the original PP objective of "increasing access to clinical services" remains valid, the focus and expected output of this component during 1993-95 is **"increased quality and quantity of clinic-based services and contraceptive supplies."**

Project financing will continue to concentrate on in-service certificate training of clinic-based service providers and contraceptive commodities procurement. However, financing will expand from these inputs to include targeted support for strengthening management capacities of government implementing offices.

Clinical Training

In planning for continued Project assistance through 1995, the training subcomponent of the CTCL presents special concerns. Over the past two decades, the major portion of family planning services, (and attributable increases in contraceptive prevalence), can be credited to GOK and non-government clinic service providers, especially certified medical personnel such as ECNs and Clinical Officers (COs).

The service environment since the early 1990's has been rapidly changing with increasing numbers of private practitioners, community distributors and specialists in more permanent contraceptive methods. Nonetheless, free clinic services in government and non-government health facilities remain the backbone of the family planning service delivery in Kenya for the foreseeable future. The Training Unit operated by the MOH/DFH is the singlemost important source of certificate training for clinic-based family planning service providers in the country.

Based on the 1990 external evaluation recommendations, a major priority for technical assistance to the Training Unit is in the area of manpower planning. Given the unmet demand, as well as the rapidly changing patterns of family planning service demand, the MOH needs to carefully re-examine the role of the certificate family planning provider and the type of training required. Up to now the Training Unit has not had the data and analytical planning tools with which to identify, set targets and prioritize training activities that are efficient and cost-effective approaches to producing the quantity and quality of trained facility-based workers needed in the national program.

Starting in 1992, the Project will finance technical assistance to the MOH/DFH in undertaking an exercise to identify all health facilities in the country that do not currently provide any type of family planning service because of the absence of a certified worker. Based on this effort, personnel in those facilities will receive a short 3-5 day introductory family planning course (precedent to the certificate course) that will prepare them to provide at least basic services and back-up medical assistance to clients.

During 1992-93, a more comprehensive manpower information and planning system within the MOH/DFH will be developed with Project assistance. This system would provide information on where certificate workers are currently deployed and where critical staffing gaps exist. The effects of attrition on the manpower pool will be analyzed, as well as the effects of introducing a new category of about 600 Enrolled Community Health Nurses annually (beginning in June, 1992) who have been trained in family planning methods at the pre-service level.

The MOH/DFH also needs to assess such factors as the emerging role of the clinic-based service provider as a front-line

referral contact for surgical methods, as a back-up for complications, and as a supervisor of community workers. The results of such an assessment are expected to have implications for the specific types of training provided, numbers of trainees and, possibly, geographic targeting and deployment of trained manpower.

The Project will continue to finance the local costs for training of health workers in the Certificate in Reproductive Health course and various types of refresher courses. For planning purposes, the Project budget includes costs for financing up to the maximum of current output capacity of the 12 MOH Decentralized Training Centers (i.e., approximately 840 certificate trainees, and 420 refresher trainees, annually). However, the actual level of financing will be refined on the basis of the MOH/DHF's training plan resulting from the assessment and development of the manpower information and planning system. The MOH/DHF will be expected to submit this plan to the Mission by May 1993.

The Project will continue to support the MOH/DHF's curriculum re-design efforts begun in 1991 with assistance of from JHPIEGO. It is estimated that the Certificate in Reproductive Health curriculum will have been field tested and ready for implementation in all GOK-approved family planning in-service training institutions in early 1993.

During 1993-95, JHPIEGO's assistance will include Training of Trainers, equipping of training facilities, evaluating the certificate curriculum, and evaluating/streamlining the refresher course training approaches and content. In addition, JHPIEGO will assist the MOH to develop, publish and distribute a quarterly Reproductive Health Update Newsletter for service providers, using a combination of international literature and local-interest articles and news items.

Institutional Strengthening - MOH/DHF In-service Training Unit

The 1990 evaluation identified a number of structural and management deficiencies which negatively affect the Training Unit's ability to provide the highest quality of training and to efficiently manage its operations. During 1990/91 the MOH/DHF responded to the weaknesses noted by establishing the following functional sub-units at the headquarters level: Training Materials Development, Training Management, and Supervision and Monitoring. Job descriptions and work plans have been developed for key staff in each of the sub-units. However, as yet, the Training Unit has not thoroughly assessed the appropriateness of its organizational structures and redefined functional responsibilities for its 50-odd management and technical staff.

During the Project extension, technical assistance will be financed to support the MOH/DFH in undertaking such an assessment/planning exercise, including development of a long-range staff development plan. The Project will also support short-term local, U.S., or third-country training of 8-10 trainers and/or program managers/supervisors, annually in such subject areas as family planning curriculum development, personnel information systems development, and monitoring/evaluation of services.

During the course of Project implementation, the Training Unit's most serious deficiency has been in the area of financial management. Since 1985, the Project has been financing the operational costs for conducting courses in the 12 Decentralized Training Centers (DTC's). Under this arrangement, the GOK advances the costs from its own resources, and later bills USAID for reimbursement.

This arrangement requires a relatively high degree of GOK initiative and internal cooperation. It would be USAID's first choice of a financing mechanism if it could be made to work reasonably well. However, significant billing delays and inaccuracies have been commonplace, thereby requiring the Mission to become increasingly involved in GOK budgeting and financial management processes, including periodic field verification of claims in an effort to facilitate financing.

Since 1991/92, the MOH's cash flow problems have also become a serious problem adversely affecting program implementation. The MOH/DFH has requested USAID to assist in identifying an alternative funding arrangement.

To address this issue, prior to July 1992, and thereafter, USAID will arrange for a U.S. cooperating agency (CA) to serve as the intermediary financing and accounting agent for USAID funds under the training element. The CA will be expected to place at least one full-time accounting officer to work in the Training Unit to make financial commitments on behalf of the 12 DTCs, issue payments, and account for funds to the Mission. This accounting officer would also engage his counterpart in the MOH/DFH to assist management on follow-up to these efforts.

Contraceptive Logistics

A long-term contraceptive logistics management assistance project was begun in August, 1991 through the Family Planning Logistics Management (FPLM-II) Project. By mid-1993, the effort is expected to have assisted in establishing a fully-staffed Logistics Management Unit within the DFH and the Medical Supplies Coordinating Unit. The Unit, with FPLM assistance, will also have established vertical contraceptive commodities information, procurement, warehousing, and distribution systems.

During the period 1993-95, the Project will continue to finance technical assistance to the DFH and Medical Supplies Coordinating Unit under the FPLM-II Project. Special focus will be on refinement and strengthening of organizational systems already established, with the ultimate objective of institutionalizing the MOH's capacity to maintain adequate contraceptive supplies (oral pills, IUCDs, injectables, condoms, spermicidals, etc.), at all facilities and levels of the family planning delivery system.

CTLM Support Outputs

It is expected that the inputs to be provided in support of the CTLM component will result in the following magnitude of outputs over the amended LOP:

Field Capacity

- * Number of MOH and NGO SDPs offering family planning services increases from approximately 758 in 1984 to 2,212 in 1995.
- * By 1995, a minimum of 4,950 ECNs, KRNs or COs and supervisors trained, certified, and deployed; a minimum of 1,270 FP workers recertified through refresher training.

Headquarters Training Capacity

- * Organizational development plan prepared and implemented; including definition of job responsibilities and update of job descriptions.
- * MOH/DFH and CA produce and implement annual action plan detailing training of trainers schedules, technical, administrative, monitoring/supervision requirements for DTCs.
- * Standard Reproductive Health in-service and refresher training curriculums revised, field tested, implemented and evaluated.
- * 8-10 program managers/supervisors trained annually in short-term FP program management courses in-country, U.S. or other developing countries.

Contraceptive Supplies/Logistics

- * MOH/DFH and MSCU Logistics Management Unit fully staffed and functional.
- * LMIS covering all GOK and NGO SDPs established and used routinely by MOH to guide commodity procurement/distribution.

- * MOH/DFH and MSCU assure effective procurement and supply of national contraceptive requirements; i.e., 6-12 months at MSCU, 4-6 months at regional warehouses/district stores, 2-5 months at SDPs.

C. Voluntary Surgical Contraception

In just nine years since its introduction in Kenya in 1982, VSC, specifically minilaparotomy with local anesthesia (ML/LA), has been accepted in increasing numbers, has been offered at an increasing number of SDPs, and has been taught in the GOK, University of Nairobi, NGO and for-profit private sectors with AVSC and JHPIEGO assistance to over a thousand physicians, nurses and counselors in both in-service and pre-service settings.

VSC has proven to be a safe, popular, and effective method which has been institutionalized and routinely offered as a family planning method in both the public and the private sectors. AVSC and JHPIEGO have worked effectively to introduce and diffuse important and appropriate VSC and other reproductive health-related technologies and concepts such as ML/LA, counselling and infection prevention into the Kenyan family planning program. By the end of 1991, over 65,000 VSC procedures had been supported by AVSC at over 60 sites, and over 1,641 physicians, nurses and counsellors had been trained through JHPIEGO and AVSC. The great majority of these procedures have been female sterilization (tubal ligation), although there are indications that vasectomy and NORPLANT (5-year, reversible, subdermal contraceptive implants for women) could be popular as well.

However, between 1990-1991 a plateauing of the number of AVSC-supported procedures performed, particularly in the public sector, became evident, as well as the need to improve program management. Therefore, in 1992 and 1993 the program's emphasis will be on:

- improving VSC program management in such areas as supervision and timely reporting in order to be reimbursed for expendable supplies;
- recruitment of a VSC coordinator for the DFH/MOH; and
- addressing the need to have viable VSC service sites at high-volume service points, (e.g., KNH and Pumwani Maternity Hospital), in order to increase efficiency and productivity per SDP.

Relatively less emphasis during this period will be given to expanding the number of VSC service sites. Instead, the emphasis on training, quality, supervision and monitoring, IEC, more effective referral systems, and counselling for VSC will be continued. Attention to expanded service delivery systems of

NORPLANT, vasectomy, and other related reproductive health activities will also be increased.

The refined output for the VSC component is **"increased availability of quality VSC services."** It is expected that between August 1993 to the amended Project PACD, AVSC will support 35,000 tubal ligations and expand services to a minimum of 16 or more sites. Using management tools AVSC developed (e.g., "In-Reach" activities, and the Client Oriented Provider Efficient Self-Assessment of VSC sites), it will seek to increase efficiency and productivity at existing sites.

Enhanced referral efforts as part of the CBD activities and clinical training activities will further enhance efficiency and output, complemented by various bilateral and AID/W centrally-funded IEC activities of a general and a method-specific nature. AVSC will also train 90 surgeons and 65 theater assistants in ML/LA, 180 VSC counselors and 445 Information and Education workers.

During this same period, in parallel with AVSC's activities, JHPIEGO will continue to provide important VSC and other reproductive health training to the Ob-Gyn Department of the University of Nairobi and KNH. This is expected to result in more than 300 additional medical interns trained in ML/LA, and 100 Ob/Gyn specialists, faculty members, service providers, and other physicians trained in clinical, teaching and other skills.

JHPIEGO will also carry out a number of evaluation activities documenting the impact of its training support on service delivery. In particular, JHPIEGO will evaluate its medical intern trainees to document their activities, and to confirm that at least 70% of these trainees are providing VSC services within three years of training.

Regarding NORPLANT, AVSC will provide training of 55 new physician-nurse teams in the private and NGO sectors. Its support is expected to result in the conduct of 12,000 procedures at 18 on-going and 16 new sites for total of 34 sites which are capable of providing high-quality NORPLANT services.

Start of implementation of the World Bank-funded introduction of NORPLANT into the public sector is currently delayed. Funds were committed in the World Bank Population III Project for the Dept. OB/GYN to train approximately 65 public-sector physicians. However, funds have not yet been received from the GOK/Ministry of Finance to initiate these activities, nor has it approved the order for the 6,000 NORPLANT sets to be provided to the MOH with WB funds. If this situation continues, expansion of this activity in the public sector may have to be reconsidered.

JHPIEGO and AVSC will continue to work in tandem and in concert with other appropriate organizations working in Kenya to advance the position of vasectomy, postpartum IUD insertions and other related reproductive health and family planning aspects, as needed.

Given the considerations noted in the technical feasibility section, as well as continued strong support of this program from the GOK, USAID, and AID/W, this Project element and related Mission-funded and AID/W centrally-funded activities are expected to make a major contribution to the overall Project purpose and goal.

VSC Support Outputs

It is expected that the inputs to be provided under this component will result in the following magnitude of outputs over the amended LOP:

- * AVSC-assisted VSC sites expand from 4 in 1984 to 78 in 1995.
- * Cumulative number of AVSC-supported VSC procedures increases from 6,500 in 1986 to 110,000 in 1995.
- * Number of medical interns trained in ML/LA by Dept. of OB/GYN/JHPIEGO increases from 0 in 1985 to 900 in 1995 with a minimum of 70% providing VSC services within 3 years of training.
- * Number of NGO/Private Sector sites providing NORPLANT increases from 10 in 1992 to 32 in 1995.
- * Number of AVSC-supported NORPLANT procedures increases from 0 in 1991 to 14,000 in 1995.
- * Client-Oriented Provider Efficient (COPE) self assessment of VSC sites being implemented and recommendations acted upon in 80% of AVSC-supported facilities.

D. Community Based Services

During the Project extension, the CBS component will continue to increase the availability and effectiveness of community-based, non-clinical family planning services. The refined output of this component is **"increased availability and effectiveness of community based, non-clinical family planning services."** The CBS element has proven effective in increasing awareness of the health benefits of birth spacing and small families, encouraging use of effective modern methods of contraception and improve accessibility to clinic and community-based, NGO family planning services.

During the amended LOP, continued grant financing will be provided to nine (9) NGOs with community-based distribution networks. AID/W central funding to several NGOs will continue to complement this bilateral assistance.

Continued emphasis will be placed on consolidating the coverage of large, nationwide programs, e.g., FPAK, MYWO and CHAK, that represent a network of current and potential areas for community-based distribution of contraceptives (CBD) programs with good clinical back-up. Increasing the effectiveness of the CBD workers to provide proper counselling information about all modern family planning methods will also be a priority.

Where the absorptive capacity of an NGO will allow, the Project will support expansion of the activities to new geographical areas. In the programs of smaller NGOs, activities will be intensified to increase the use of modern family planning methods. The CBS component will emphasize:

- 1) quality of care of community based family planning services;
- 2) institutional development of the NGO service provider; and
- 3) use of long-term/permanent methods through referrals.

The Mission views community-based distribution as a temporary approach to providing services that enhances and broadens communication members in the early stages of family planning intervention. In Kenya it is expected that the CBD approach will remain valid at least until the end of the century. Until it is phased out, continued support for the CBD program is required. Eventually, once contraceptives are made accessible and affordable through commercial outlets, it is believed this support will no longer be needed.

Under the amended Project several implementation issues will be examined. These include strengthening referral mechanisms for long-term and voluntary surgical contraception and assisting the MOH to formally publish and distribute the CBD policy guidelines on distribution of oral contraceptives which are currently in draft.

Project-financed inputs include limited commodity support (e.g., condoms and IUDs), equipment, supplies, salaries, supervision, training, evaluation, technical assistance consultancies and local operating costs. Participating NGOs will provide facilities, complementary staff, some support services and other operating support. The GOK and other donors are expected to provide additional contraceptive commodities support (pills,

VFTs, injectables) for contraceptive logistics and local management, and district-level planning and coordination.

Table 1A summarizes the major nationwide CBD programs by NGO including funding modalities, scope of geographical coverage, and estimated budgets for the activities in relation to current and planned FPSS Project levels during the extension period.

FPAK will expand its coverage from 527 sublocations to an estimated 600 sublocations, with an increase from 564 to 850 part-time CBD workers who receive an honorarium of KShs. 450 per month. FPAK has eight clinics (which are also VSC sites) and 95 outreach (mobile) clinics that provide FP services and serve as referral points of the CBD worker. In areas where the CBD program is well established in the community and many clients have shifted to long-term or permanent methods, FPAK will intensify its efforts to shift its approach from house-to-house distribution to a depot holder program.

CHAK will extend CBD to a minimum of 25 sublocations with an estimated total of 300 volunteer CBD workers. The activities will be centered around CHAK facilities with activities in a minimum of three area sublocations. CBD workers will be expected to place greater emphasis on family planning with less emphasis on other health interventions, e.g., nutrition.

PCEA Chogoria Hospital will continue to maintain CBD services in the established catchment area of approximately 350,000 people around the hospital, while at the same time intensifying development of CBD activities in the semi-arid Tharaka Division. Some expansion of CBD sites is planned and by 1995, the project will include 550 CBD workers in 65 sublocations.

MYWO will continue to increase coverage in districts where the program is currently active. In total, the project will be operating in 475 sublocations with 1,100 CBD workers who receive an honorarium of KShs. 300 per month. It will focus on improving clinical linkages to FPAK, CHAK or MOH facilities, especially for referral of VSC clients, since they do not run their own clinics.

Mkomani Clinic Society will continue its urban-based, clinic and community-based service expanding to cover the remaining uncovered sublocations in the Mombasa area. It expects to have a total of 30 full-time paid CBD workers in 27 urban sublocations by 1995.

CPK Eldoret will slowly expand the area it covers, while intensifying the number of volunteer CBD workers per sublocation. During the amended Project, CBD workers are expected to increase from 270 in 14 sublocations to 525 in 25 sublocations. Emphasis will be placed on improving effective referrals to FPAK, CHAK or

MOH clinics for long-term or permanent methods as CPK Eldoret runs only 12 mobile outreach clinic has no static facilities.

Crescent Medical Aid will continue to provide services in selected urban slum areas of Nairobi. The number of full-time, paid CBDs will increase from 22 to 50 to enable the program to cover 5 sublocations. CMA's emphasis will be on shifting clients to long-term and permanent methods. CMA serves referral clients in its two static clinics.

CPK Maseno West/Saradidi will consolidate two community-based programs in Siaya District and intensify the focus on quality family planning services increasing from 180 CBDs in 9 sublocations. It will cover 50 sublocations through 320 CBDs with three project facilities serving referral clients. Technical assistance is planned to undertake a management audit that will result in a workplan for institutional strengthening through development of or improvements of critical management systems, i.e, financial, MIS, strategic planning as part of a new redesigned project funded through CBS.

Kabiro Kawangware will expand its modest urban slum program and replicate it in one additional sublocation for a total of two, backstopped by their clinic in Kawangware. The number of CBDs is expected to increase from 24 to 50. Emphasis will be increasing the number of effective referrals to clinics for long-term or permanent methods.

In addition, the Project will finance ten to twelve individuals selected from the implementing NGOs to attend in-country management or technical training courses, such as those offered by the Center for African Family Studies (CAFS), to improve management skills. This funding will be administered separately from the grants made to the NGOs.

Finally, in order to ensure the NGOs can provide quality family planning services in the long-term, technical assistance will continue to be provided by FPMD to increase NGO capacity to expand and deliver quality CBD and clinical family planning services.

CBS Support Outputs

It is expected that the inputs to be supported under this component will result in the following magnitude of outputs over the amended LOP.

- * 3,775 community-based distributors and 130 supervisors trained/deployed and providing non-clinical family planning services including pills, condoms and foaming tablets to 325,000 new clients and 500,000 revisits for

an estimated 200,000 couple years of protection each year.

- * Number of confirmed referrals for VSC increased from approximately 6,000 in 1991 to 20,000 in 1995 and for NORPLANT from 0 in 1991 to 2,000 in 1995.
- * Number of sublocations with active USAID-supported, community-based workers increases from 10% in 1985 to 37% in 1995.

E. Planning, Monitoring and Institutional Strengthening (formerly Policy Planning and Evaluation)

This component, originally called NCPD Policy, Planning and Evaluation, has been renamed to more accurately reflect the content and results of activities that have and will be financed in the Project. The component's output, which has been refined, is **"strengthened institutional capabilities to plan and monitor national population policies and programs."**

The major activity of this component has been and will continue to be, the planning, implementation, dissemination and further analysis of the Kenya DHS. Based upon the collaborative working relationships established for the 1989 KDHS between NCPD, CBS and the Institute for Research and Development (IRD), a methodology is in place to undertake another DHS in 1993. The commitment of NCPD to undertake periodic monitoring of the impact of the family planning program at a national level is critical to GOK, donor and NGOs undertaking of how Kenya is doing in reducing fertility and population growth rate. It is expected that the results of the 1993 DHS will be announced at the second Leader's Conference on Population scheduled for late 1993. The survey will provide time series data on national fertility estimates as well as direct level estimates of contraceptive use and indicators of mortality and morbidity.

Under this component, a series of in-depth analyses will be undertaken to further examine the unmet need for family planning and analyze regional differences and other issues that are relevant to management of the national family planning program. The NCPD Secretariat will continue to improve its capacity to implement and sustain its MIS developed between 1989 and 1992. The FPMD project will continue to provide technical assistance at a level appropriate to ensure that the systems currently installed are utilized by NCPD management program officer and financial staff. A full-time computer specialist will be provided by FPMD to assist NCPD maintain the computer equipment, modify systems and train/retrain NCPD staff.

FPMD will also continue to provide selective technical assistance to major NGO family planning service organizations with whom

USAID and NCPD are working. Institutional strengthening of NCPD and NGO management capacity and development of more effective systems to manage family planning programs will continue to be a major focus of this component and the CBD component, to include short-term participant training for NGO and NCPD staff, both in-country, in other developing countries or in the U.S.

The on-going Institutional Development Program (IDP) being implemented collaboratively by the University of Nairobi, Dept. of OB/GYN and Family Health (FHI) will be refocussed. While no additional funds will be added to this activity, it is anticipated that a no-cost extension will allow several carefully selected reproductive health research issues to be undertaken between October 1993 - June 1995. The research focus will be shifted away from contraceptive research to applied questions related to medical/social barriers to family planning acceptance in the Kenyan context. For example, research would address current pressing questions, such as determinants of postpartum contraceptive for unmarried prima grava adolescents of policies for family planning program managers and/or the question of how to deal with the increase in adolescent pregnancy.

Technical assistance support for local costs and short-term participant training will be the major inputs of this component. NCPD, NGOs and the Dept. OB/GYN will provide counterpart staff and office space.

PMIS Support Outputs

It is expected that the inputs to be financed under this component will result in achievement of the following magnitude of outputs over the amended LOP:

- * NCPD/CBS, with CA support, implements two national DHS' (1989 and 1993).
- * NCPD establishes MIS by 1993 which is routinely used for program monitoring by 1995.
- * OB/GYN publishes two major studies on reduction of medical or social barriers to contraception and disseminates findings nationally.
- * 8-10 NGO and/or NCPD staff trained annually in short-term FP program management.

F. Information, Education and Communication

The IEC component's revised output is "increased availability of correct information about family planning methods through IEC efforts." Over the extended Project period, this component will seek to build upon the successful introduction of phase one of

the Client-Provider Education Project, initiated in 1991-1992 with FPSS Project and AID/W central funds. Project financing will continue to support the development of local IEC expertise, development and dissemination of correct messages/information about family planning methods and utilization of family planning services.

It is expected that the pressing need to develop and disseminate method-specific print materials used by clients and service providers can be initially achieved in mid-1992. At the same time, development and production of a radio soap-opera will have begun.

In addition, the IEC Working Group, comprised of FPAK, CHAK, MYWO, FPPS, KMA, NCC, ICS, NCPD and MOH, will have an in-country capability for: 1) collaborating with the key family planning service providers in Kenya on design and development of IEC materials for clients and providers; 2) training clinic-based and community-based providers and outreach workers in interpersonal communication, counselling and the use of print and audio-visual support materials; 3) overseeing the design, implementation and evaluation of a focused mass media campaign to increase utilization of existing family planning services; 4) upgrading the quality of CBD IEC activities through development and distribution of a core CBD training manual, improved training capabilities of CBD trainers, and basic support materials for CBD workers; and 5) overseeing the implementation/evaluation of audience-based research.

Using the JHU/PCS sub-contract relationship with FPAK, USAID will continue through August 1995 to support the next two-year phase of the Client-Provider Education Project. This phase will emphasize intensified use of radio as the pivotal medium for increasing utilization of existing family planning services with television as backup. Simultaneously, the expanded production of print materials will be supported, as will continued training of clinic and CBD providers in counselling, interpersonal communication, and training in use of available support materials/visual aids. A video on family planning methods for use in clinics will be supported. IEC outreach activities in low-prevalence areas, e.g., stimulation of local initiatives such as barazas and folk media, will be intensified together with popular entertainment to educate youth about sexual responsibility.

These activities will be funded largely under the AID/W Cooperative Agreement with PCS managed by the Office of Population. Under the FPSS Project, the Mission will finance some commodities, supplies and equipment.

IEC Support Outputs

It is expected that the inputs to be financed under this component will result in achievement of the following magnitude of outputs over the amended LOP:

- * Client/Provider IEC print materials produced/distributed and evaluated to assess impact on client's knowledge and use of family planning methods.
- * A minimum of 6 IEC/Counselling workshops for CBD and clinic providers held.
- * 200 CBD training manuals produced/distributed to NGO CBD programs.
- * A minimum of 52 thirty minute radio programs with a family planning theme developed and nationally broadcast.
- * IEC Working Group established and meeting quarterly to coordinate selected IEC activities in public and private sectors.

V. PROJECT MANAGEMENT AND IMPLEMENTATION

A. Administrative Arrangements - USAID and GOK

1. Government of Kenya

Under the amended Project and over the remaining LOP, NCPD and the MOH/DFH will continue to be the lead implementing GOK entities for the Project effort. Considerable progress has been made during the first 6 1/2 years of the Project related to the development of management systems, training of staff and in establishing viable working relationships between NCPD and DFH/MOH staff with A.I.D. Cooperating Agencies. Much of the effort in the extension period will be to intensify this initial effort and to concentrate on activities that are working well and have the greatest potential to expand family planning services.

It is essential that both NCPD and DFH/MOH, in coordination with the MOF, continue to improve upon and ensure for adequate and timely provision of funds from the GOK's Revenue Budget for Project activities. Increased attention is also needed to enhancing the capability of both DFH/MOH and NCPD to plan their annual budget requirements for local expenditures, i.e., local training of in-service FP workers, recurrent costs of distributing contraceptive supplies, supervision/monitoring of VSC and selected CBD programs, etc.

Based upon the administrative difficulties the DFH/MOH and NCPD encountered during the Project life in accessing funds through the GOK's Revenue Budget on a timely basis to support a number of activities, it has been decided mutually that, where possible, administrative arrangements be made by USAID on their behalf to directly administer Project funds through A.I.D. Direct Contracts, Handbook 13 Cooperative Agreements, purchase orders, or where possible, buy-in's or add-on's to AID/W centrally-funded projects. It is anticipated that all technical assistance, most commodities procurement and the majority of training will be financed directly by the Mission.

The bulk of this funding will be channelled through U.S. NGOs with proven administrative and technical capabilities in providing the required goods or services. These NGO Cooperating Agencies have well-established working relationships with their GOK counterparts in the DFH/MOH and NCPD under this Project.

Liaison between USAID's O/PH and representatives of A.I.D. Cooperating Agencies will be conducted primarily between the Director and Deputy Director of the DFH/MOH, Director and Deputy Director of NCPD, and the Chief and Deputy Chief of O/PH, USAID/Kenya. Country Representatives of A.I.D. Cooperating Agencies implementing selected project components will liaise principally with GOK and USAID/Kenya officers in charge of the activity they are implementing. For example, the Chief of Party for the FPLM project will liaise principally with the Deputy Director DFH/MOH and the officer in O/PH managing the CTLM component of FPSS.

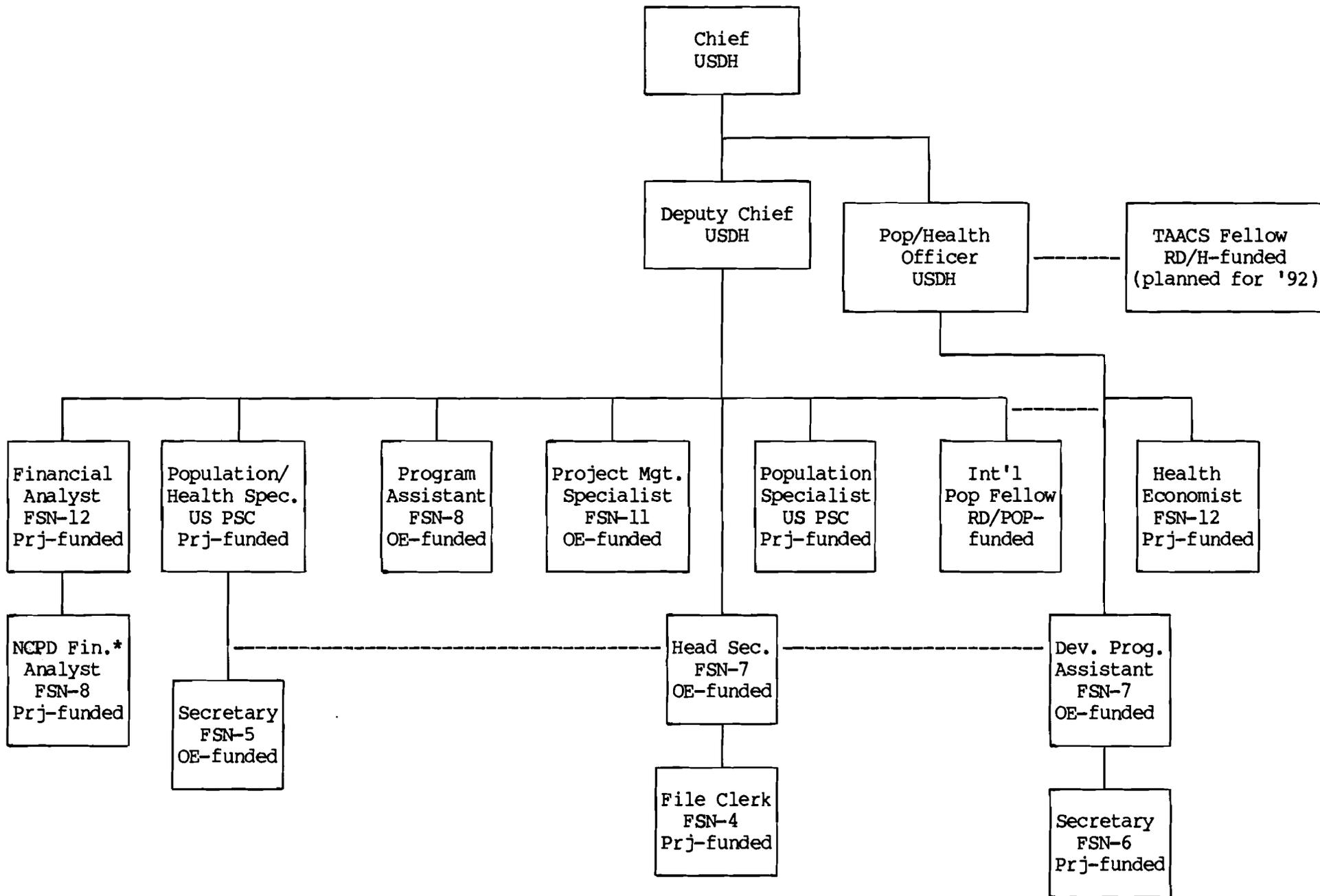
2. USAID/Kenya

USAID/Kenya continues to give this Project the highest priority in its development assistance portfolio. Project management will continue to be the responsibility of USAID/Kenya's O/PH which will be supported as required by other offices of USAID/Kenya and REDSO, including the Mission's Office of Projects, Program, Controller and the Regional Legal Advisor. Within the O/PH, the Deputy Chief, working under the supervision of the Chief, will be the designated Project Officer with primary responsibility for monitoring Project progress from both a technical and administrative perspective.

O/PH is adequately staffed (see attached organization chart) to manage the FPSS Project. Besides the Chief and Deputy Chief (both U.S. Direct Hires), there are two U.S. Personal Services Contractors, four Kenyan professionals (two Project Specialists) and two Financial Management Specialists, and

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
 OFFICE OF POPULATION AND HEALTH - USAID/NAIROBI

54



- 44 -

* Attached to National Council for Population & Development

one International Population Fellow assigned management responsibility for specific components.

Because various management functions cut across Project components, e.g., financial management, procurement and training, all Project staff will continue to actively coordinate their efforts, operating as a team with full cooperation and transparency between them. This collaborative working style characterizes the nature of Project management under which the FPSS Project has been implemented successfully to date and which will be maintained throughout the extension period.

B. Methods of Implementation

"Buy-ins" and/or "add-ons" under the Project to AID/W centrally-funded projects are planned at an estimated total of \$7.3 million for in-country local costs and technical assistance. With assistance from AID/W/RD/POP Cognizant Technical Officers (CTOs), USAID will issue PIO/Ts to AID/W for these "buy-ins/add-ons" to existing projects (e.g., FPLM-II for support to contraceptive logistics; JHPIEGO for support to DFH and Dept. OB/GYN; AVSC for support to surgical contraception, including NORPLANT; PCS for support to IEC; Pathfinder International for support to NGO CBD programs; FPMD for support to NCPD and NGO institutional strengthening). An OYB transfer will be made for procurement of contraceptive commodities (condoms and IUDs). Implementation and procurement procedures for each component of the Project will be detailed in the Project Agreement Amendment with the GOK as follows:

1. Clinical Training and Contraceptive Logistics (CTCL)

a) Contraceptive Supply

Based upon estimates prepared by the Contraceptive Logistics Unit of the DFH/MOH, about \$3.0 million will be required to purchase and transport condoms and IUCDs for the two year period October 1993 - September 1995. USAID will do two OYB transfers to AID/W RD/POP/CPSD to procure the contraceptives from the U.S. (Geographic Code 000).

b) In-Service FP Training

A PIO/T will be issued by USAID/Kenya for an add-on to the AID/W centrally-funded JHPIEGO project. It is anticipated a commitment of \$1.0 million will be required to undertake management and administration, technical assistance and service support of the in-service FP clinical training program of the DFH/MOH. Depending upon the availability of funds, this add-on may be tranche-funded.

c) Contraceptive Logistics

A PIO/T will be issued by USAID/Kenya for a buy-in to the AID/W centrally-funded FPLM-II project. It is anticipated a total of \$700,000 million will be required to continue the services of the long-term Logistics Advisor and to undertake management of the technical assistance and logistics management service support required. Depending upon the availability of funds, this buy-in is likely to be tranche-funded.

2. Voluntary Surgical Contraception (VSC)

a) National Long-term and Permanent Contraceptive Program

A PIO/T will be issued by USAID/Kenya for an add-on to the AID/W centrally-funded AVSC project. It is anticipated \$1.5 million will be required to continue provision of management, technical assistance, training and supplies to both the public and NGO/private sector. VSC permanent methods (tubal ligation and vasectomy) will be supported for the public and private sectors and a long-term method (NORPLANT) for the NGO/private sector. Depending upon the availability of funds, this add-on may be tranche-funded.

b) Reproductive Health and Minilaparotomy/Local Anesthesia Training

A PIO/T will be issued by USAID/Kenya for an add-on to the AID/W centrally-funded JHPIEGO project (total estimated at \$1.0 million). Technical assistance, management, administration and service support to the Department of OB/GYN, University of Nairobi will be supported. Depending upon the availability of funds, this add-on may be tranche-funded.

Note: For the AVSC and JHPIEGO activities, AID/W central funds will complement the bilateral Project funds, especially for support of home office and regional offices costs. USAID/O/PH, AVSC, JHPIEGO and the respective CTOs in AID/W will jointly agree upon the use of any central funds.

3. Community-based Services

A PIO/T will be issued by USAID/Kenya for an add-on to the AID/W centrally-funded Pathfinder International project. This add-on for an anticipated \$685,000 will support CBD programs of MYWO, Mkomani and CPK Maseno West/Saradidi. AID/W central funds will complement the bilateral Project funds for these activities as jointly agreed between USAID/O/PH, Pathfinder International and the Pathfinder CTO in AID/W. It is anticipated that four A.I.D. direct H.B. 13

grants (total estimated at \$1.2 million) will be awarded to FPAK, PCEA Chogoria Hospital, CHAK and Crescent Medical Aid. Two NGOs, CPK Eldoret and Kabiro Kawangware, are expected to receive continued funding through host-country grants made by NCPD based upon P.I.L.s issued by USAID/Kenya agreeing to reimburse eligible expenditures. Again, depending upon the availability of funds, all or some of these actions may be tranche-funded.

4. Information, Education and Communication

One PIO/T will be issued by USAID/Kenya for an add-on to the AID/W centrally-funded Population Communication Services (PCS) project (total estimated at \$150,000). The balance of funds needed for this activity are expected to be financed as part of the "BIG Country Strategy" initiative administered by AID/W/RD/POP, to be added to the PCS Cooperative Agreement by AID/W. In turn, PCS will enter into a sub-agreement with FPAK who will manage and disburse funds for local expenditures according to the workplan agreed upon by the IEC Working Group.

5. Program Monitoring and Institutional Strengthening

The major activity of this component, the 1993 Kenya DHS, will be fully funded by AID/W/RD/POP as part of the "BIG Country Strategy" initiative in late FY 1992/early FY 1993 when the new DHS-II project becomes operational. USAID/Kenya will issue one PIO/T to the AID/W centrally-funded Family Planning Management Development (FPMD) project (total estimated at \$530,000) to continue development of the MIS at NCPD as a complementary activity to the DHS, to assist with routine monitoring of national population trends, and to continue management assistance to major NGO family planning service providers, i.e., FPAK, CHAK, MYWO, Mkomani, SDA, CPK Maseno West and CMA. The existing PIO/T for an add-on to the AID/W centrally-funded Family Health Initiative (FHI) project will be amended at no-cost through April 1993, at which time no further funding is anticipated or planned.

6. Participant Training

Funded or non-funded PIO/Ps will be issued by USAID/Kenya to AID/W's Office of International Training (OIT) for all U.S.-based, short-term training. Participant training cuts across the five components of the Project and will be coordinated by an FSN Project Management Specialist in O/PH with the Training Division of USAID's Program Office. In-country training will be provided by the Centre for African Family Studies (CAFS) and will be agreed upon by means of PILs committing funds, with USAID issuing Travel

Authorizations and G.T.R.'s for transportation and per diem, and CAFS invoicing USAID directly for the training costs.

C. DFA Procurement and Methods of Financing Plan:

Under the proposed Project amendment, U.S. \$12.0 million in goods and services support is planned. A.I.D. Geographic Code 935 source/origin procurement will be authorized according to standard DFA policies. It remains A.I.D. policy, however, to maximize U.S. procurement wherever practicable. USAID/Kenya will require, for example, that any travel to and from the U.S. be on U.S. carriers. USAID/Kenya also will required conformance with the 50/50 requirements of the Cargo Preference Act for ocean shipments from the United States. Table A represents USAID/Kenya's procurement plan and analysis of the expected source and origin of goods and services.

It is expected that U.S. \$5.6 million of Project goods and services will be procured through buy-in's or add-on's to existing AID/W centrally-funded projects awarded in AID/W as institutional contracts or cooperative agreements to U.S. institutions. An estimated total of \$3.0 million in OYB transfers will be made to AID/W/RD/POP/CPSD for the procurement of contraceptives from a U.S. supplier.

In addition, AID Hdbk. 13 grants to Kenya NGOs that meet A.I.D. eligibility requirements and have been registered with the Kenya Mission are expected to total U.S. \$1.2 million. A total of U.S. \$160,000 is expected to finance host country grants to NGOs awarded by NCPD, thru the Ministry of Home Affairs and National Heritage and the Ministry of Finance.

Approximately U.S. \$600,000 in participant training financing will be processed through funded or non-funded PIO/Ps, to be handled directly be the Mission. The expected source for the training will be Kenya, the U.S. (000) and the region (935). In support of Project management functions, it is anticipated that U.S. \$290,000 will finance two direct personal services contracts (PSCs) for U.S. services. In addition, two Kenyan PSCs will be financed for an estimated total of U.S. \$90,000. Direct A.I.D. contracts or Indefinite Quantity Contracts (IQCs) for evaluation will be financed at approximately U.S. \$145,000. Nonfederal audit services will also be procured at an estimated total of U.S. \$50,000 from certified Kenyan firms on the basis of direct USAID/Kenya cost reimbursement contracts.

Table A

PROCUREMENT SOURCE/ORIGIN, IMPLEMENTATION/FINANCING PLAN (\$000)

Item	000	935	Kenya	Totals	Method of Implementation	Method of Financing
1. Contraceptive Procurement	3,000	0	0	3,000	OYB Transfer	Direct Pay
2. FPLM Contract	200	0	500	700	Buy-in	Direct Pay
JHPIEGO Cooperative Agreement	1,010	0	1,000	2,010	Add-on	Direct Pay
AVSC Cooperative Agreement	681	0	819	1,500	Add-on	Direct Pay
PCS Cooperative Agreement	0	0	150	150	Add-on	Direct Pay
Pathfinder International	685	0	0	685	Add-on	Direct Pay
FPMD Contract	105	0	225	330	Add-on	Direct Pay
3. CBS - H.B.13 Grant	0	0	1,200	1,200	Grant Agreement	Direct Pay
4. CBS - Host Country Grant	0	0	160	160	MOU, PIL	GOK prefinance; USAID reimburse
5. Participant Training	600	0	0	600	PIO/P	Direct Pay
6. Evaluation/Audit/Project Mgt.	485	0	90	575	Buy-in, PSC, IQC	Direct Pay
7. Contingency/Inflation	527	0	563	1,090		
Totals	7,293	0	4,707	12,000		

In conformance with the requirements to be defined by AID/W, USAID/Kenya will ensure that all financing agreements with contractors/grantees/cooperating agencies, etc., provide detailed breakdowns of source/origin for all efforts elements financed by the Project. On a quarterly basis, the Mission will collect and present data on source/origin derived from vouchers submitted to the Mission Controller.

D. Illustrative Implementation Schedule

The implementation schedule for the five components of the FPSS Project is illustrative of when major actions to be taken during the two year amendment and one-year "bridging" period.

TASK ELEMENT	TIMING	ACTION
Project Amendment Approval	May 92	USAID
ProAg Amendment Signed	Jun/Jul 92	MOF/USAID
IEC Country Plan 93-95 Developed	Jul/Aug 92	PCS/FPAK/USAID/ IEC Working Group
VSC Assessment	Aug/Sept 92	AVSC/USAID/MOH/ FPAK/CHAK/FPPS
FPLM Mid-term Project Review	Sept 92	DFH/MOH/FPLM/ USAID/AID/W
PIO/T for Evaluation Consultant	Sept 92	USAID
PIO/T for PCS add-on	Oct 92	USAID/AID/W/PCS/ FPAK
USAID Semi-annual PIR	Oct 92	USAID
PIO/T for FPLM-II buy-in	Oct 92	USAID/DFH/MOH
PIO/T for Pathfinder add-on	Oct 92	USAID/PF/NCPD/ Maseno West
FPAK Evaluation	Oct/Nov 92	USAID/NCPD
AVSC Country Plan 93-95	Oct/Dec 92	AVSC/USAID/MOH/ FPAK/CHAK/FPPS
PIO/T for PSC (FP Specialist)	Dec 92	USAID

60

1993

CMA Evaluation	Jan 93	USAID/NCPD
JHPIEGO Mid-term Project Review on in-service training	Jan 93	USAID/MOH/AID/W
PIO/T for CMA	Jan 93	USAID/CMA/NCPD
PIO/T for AVSC add-on	Jan-Feb 93	USAID/DFH/MOH
PIO/T for JHPIEGO add-on	Jan-Feb 93	USAID/Dept. OB/GYN
PIO/T for FPMD buy-in for NCPD and NGO institutional strengthening	Jan-Feb 93	USAID/NCPD/NGOs
FPLM Mid-term Evaluation	Feb 93	USAID/MOH/RD/POP/ External Consultants
PIO/T for 10-12 in-country training participants	Feb 93	USAID/NCPD/NGOs
MYWO Evaluation	Feb 93	USAID/NCPD/PF
PIO/T for FPAK H.B.13 Grant	Feb-Mar 93	USAID/FPAK/NCPD
No-cost extension CHAK H.B.13 Grant	Mar 93	USAID/CHAK/NCPD
PIO/T for Pathfinder add-ons to Mkomani and MYWO	Mar 93	USAID/PF/NCPD/ Mkomani/MYWO
Review/Reprogram IDP with Dept. OB/GYN (Any supplemental funding to come from AID/W)	Mar 93	USAID/AID/W/ Dept. OB/GYN
PIL for CPK Eldoret host country grant	Apr 93	USAID/ NCPD/ Eldoret
PIO/T for Quality of Care consultant	Apr 93	USAID
PIO/T for Chogoria H.B.13 Grant	Apr 93	USAID/Chogoria/ NCPD
USAID Semi-annual PIR	Apr 93	USAID
Final Evaluation of IPS	Jun 93	USAID/MOH

USAID Semi-annual PIR	Oct 93	USAID
<u>1994</u>		
Mkomani Evaluation	Jan 94	USAID/NCPD/PF
PIO/T face sheets as required, AVSC, JHPIEGO, FPLM-II	Jan-Mar 94	USAID/MOF
USAID Semi-annual PIR	Apr 94	USAID
Final Evaluation FPSS Project	May 94	USAID/AID/W/ External Evaluators
PID for FPSS II Designed/ Approved	Aug/Nov 94	USAID/AID/W/ CAs/MOH/NCPD/NGOs
USAID Semi-annual PIR	Oct 94	USAID
<u>1995</u>		
CHAK Evaluation	Jan 95	USAID/NCPD
PP Design FPSS-II	Jan-Mar 95	USAID/AID/W/ Design Team/CAs/ MOH/NCPD/NGOs
USAID Semi-annual PIR	Apr 95	USAID
FPSS II Project Amendment Signed	Jun-Jul 95	MOF/USAID
FPSS I Project Ends	Aug 95	MOF/USAID/MOH/NCPD
USAID Semi-annual PIR	Oct 95	USAID

Note: Throughout the amendment period, all component managers will continue to hold quarterly and/or semi-annual review meetings with host-country GOK counterparts, NGO project managers, representatives of A.I.D. Cooperating Agencies, and other USAID/Kenya staff, as appropriate. Also for the NGOs receiving assistance for CBD projects, a schedule for evaluations/assessments will be established by USAID, NCPD and the NGO as part of the buy-in, grant agreement or host-country grant.

E. Monitoring/Evaluation/Audit Plan

The impact of the FPSS Project will be examined and measured at the goal level in relation to the extent to which it contributes to a reduction in Kenya's fertility and population growth rate.

It aims to assist Kenya to achieve a total fertility rate of 5.8 and a growth rate of 3.3% in 1995. At the goal level, data to verify the extent to which these indicators are met include: the 1989 Census; Bucen and CBD Projections; the 1989 and 1993 KDHS; the 1984 Contraceptive Prevalence Survey (CPS); and the NCPD/RAPID/FAMPLAN analysis and projections (1991 and 1994).

At the purpose-level, two refined indicators of achievement have been defined focussing on Contraceptive Prevalence Rates (CPR). Specifically, it is expected that CPR for all married women of reproductive age will have increased to 35% and for all women of reproductive age to 31% in 1995. Data on which to base an assessment of purpose-level achievement include: the 1984 CPS; the 1989 and 1993 KDHS; the final Project impact evaluation; and to varying degrees, the NCPD/RAPID/FAMPLAN 1991 and 1994 Projections.

These purpose-level EOPS indicators are the same as the "overall population program" as contained in the Mission's "Assessment of Program Impact" document, to reflect the fact that essentially the related Mission-bilateral projects, CSM and PSFP II, are complementary and contributing efforts that are free-standing because of historical and administrative factors.

1. Monitoring

Monitoring performance and the progress of the FPSS Project will continue to be the function of the Office of Population and Health (O/PH), the Division of Family Health of the Ministry of Health (DFH/MOH) and the National Council for Population and Development (NCPD) during the planned extension.

In 1989-90, O/PH established an internal Management Information System (MIS) to develop goal, purpose and project level indicators to assist O/PH monitor and evaluate its overall population program and this specific Project. Project-level data contain indicators related to components of FPSS and include, the number and percent of public and private facilities offering family planning; number of health workers receiving family planning training; voluntary surgical contraception sites and client data; CBD service statistics and geographical database of distributors and sublocations; Information, Education and Communications (IEC) activities; oral rehydration knowledge, doses of measles vaccine procured by USAID; measles coverage and other selected data.

An FSN Project Management Assistant will continue to coordinate the maintenance of the PH MIS and databases, along with an FSN Project Assistant who does the data entry and maintains a file of printouts, diskettes and back-up

diskettes. New data are received in quarterly or semi-annual reports from local implementing agencies, Cooperating Agencies, or Contractors responsible for specific components of the FPSS Project.

The Logistics Management Information System (LMIS) operated by the DFH, with assistance from the Family Planning Logistics Management Project (FPLM-II), collects, analyzes, and publishes data on disbursements and current stock levels of contraceptives and family planning consumable supplies for all 1,650 family planning Service Delivery Points in the country. The LMIS is the major source of information on method mix and geographical variations in contraceptive use, and provides the database for monitoring and evaluating the performance of the national family planning program and the FPSS Project through time-series calculations of CYP. LMIS information is reviewed monthly by a joint committee of relevant MOH offices and donors, including USAID, who coordinate international procurements and deliveries, and provide guidance to the DFH in its management of warehousing and distribution of contraceptive commodities and supplies to service outlets.

NCPD monitors trends in fertility through the 1989 Kenya DHS and upcoming KDHS planned for 1993. Fortunately, there are time-series data available on fertility from two other national representative population related surveys in Kenya: 1979 Kenya Fertility Survey (KFS) and 1984 Kenya Contraceptive Prevalence Survey (KCPS). These surveys were instrumental in calling Kenyan policy makers' attention to the urgency of Kenya's population problem, and in monitoring progress of the national family planning program.

Additionally, these surveys have had enormous importance in increasing GOK support for family planning. The KFS also provided a baseline for measuring the family planning knowledge, attitudes and practice (KAP) of Kenyan couples. The 1989 KDHS provided solid evidence of a demographically significant decline in fertility during the previous five years, a continued increase in contraceptive prevalence to 27% of married couples (four times the 1977/78 level), and a drop in desired family size to 4.4 children per family. The data further confirmed that there is a high unmet demand for family planning services in Kenya and reinforced the belief that O/PH and GOK are monitoring appropriate indicators to assess program impact.

In March 1992, through AID/W/RD/POP central resources, USAID supported the RAPID IV Project of the Research Triangle Institute (RTI), assisted NCPD to carry out a cost-benefit analysis of the Kenya Family Planning Program utilizing the FAMPLAN Microcomputer Model. The IMPACT module projects

family planning users, calculates the impact on fertility rates and calculates population projections based on the fertility rates.

NCPD staff will update the model as additional data become available since the **IMPACT** module uses annual acceptors to derive the number of continuing users by age, age specific fertility rates and the contraceptive prevalence rates in order to define the overall achievements of a national family planning program. The upcoming 1993 KDHS and the on-going LMIS will provide an opportunity for NCPD to update the **IMPACT** model and to track the projects based on national population data.

In the two year extension period, all five Project components will be actively monitored by the component managers and the overall FPSS Project Manager, the Deputy Chief, O/PH. Each component will be monitored jointly by O/PH and the Division of Family Health (MOH) and/or NCPD through a combination of regular reports, review meetings, field visits and assessments and evaluations.

Activities implemented through A.I.D. Cooperating Agencies or Contractors, e.g., FPLM-II, JHPIEGO, AVSC, FPMD, DHS, will be further monitored by quarterly progress reports, site visits and meetings between NCPD and/or DFH, O/PH and a representative of the Cooperating Agency or Contractor. The CBS component coordinated by NCPD will also be monitored by monthly meetings between NCPD and the O/PH component manager to review each NGO CBD project's status, actions required and responsibility for each. During these meetings joint field visits and semi-annual review meetings will be scheduled. USAID Mission Management will also review the overall implementation status of the entire FPSS project and each specific component at the Mission's semi-annual Project Implementation Reviews (PIRs) held every April and October in relation to the output indicators defined in the Project Logframe Matrix.

For the CBS component, each NGO will submit quarterly progress reports to NCPD and USAID. These reports will be reviewed, data entered into USAID and NCPD's databases in relation to tracking this component's indicators and feedback sent to the NGO. Twice a year, the NGO will prepare a more detailed semi-annual progress report which will be presented and discussed at a semi-annual meeting between the NGO, NCPD and O/PH.

In addition to meetings and reports, USAID and NCPD will use regular field visits to monitor Project activities. USAID staff will make a minimum of two field trips per year to each project. Brief written site visit reports will be

prepared for Project files noting staff observations, recommendations and follow-up actions. As in the past, NCPD staff will accompany USAID staff as often as possible. Also, each Project will be assessed periodically by a joint USAID/NCPD/Consultant team. This assessment will provide a more in-depth look into the Project and make recommendations for improving the implementation of the CBD program.

2. Evaluation

FPSS was originally designed in 1985 with nine components and was amended once in 1989 to add a tenth component, Child Survival. Of the six service delivery-oriented components, two were never implemented (Subsidized Commercial Marketing and Ovulation Awareness/Natural Family Planning). The components of Clinical Training and Support Services, Voluntary Surgical Contraception, Community Based Services and Child Survival are ongoing and all but Child Survival have been evaluated or assessed separately. A summary of the evaluations conducted is provided in Annex G.

In October 1990, the Center for Development Information and Evaluation (CDIE), AID/Washington undertook an A.I.D. Impact Evaluation Report of "A.I.D. Assistance to Family Planning in Kenya". While the evaluation looked at A.I.D.'s assistance to Kenya in population and family planning since 1972, it focused on the bilateral program since 1983, which was comprised of the FPSS Project (1985) and the Private Sector Family Planning Project (1983). The Impact Evaluation reviewed the FPSS Project components and cited several findings that (1) stand out as having had a very positive impact, and (2) are clearly attributable to A.I.D. and specifically FPSS. They include: national demographic surveys which provide data for program management and political consensus building; FP clinical training of health workers; voluntary surgical contraception; community-based family planning; management assistance to NGOs; and contraceptive logistics management.

Given number of the component evaluations conducted and the 1990 CDIE Impact Assessment of the larger population program, the Mission determined that a comprehensive mid-project evaluation would not be cost-effective or programmatically necessary.

Meanwhile, component-specific evaluations/assessments will continue to be carried out to allow for modifications in implementation and management of the activities and to assess impact of the individual components. Planned component evaluations include: August/September 1992 evaluation of long-term and permanent contraception (VSC); February 1993 mid-term evaluation of FPLM-II; April 1993

retrospective evaluation of the IPS project; and various evaluations of CBD projects - October/November 1992 FPAK; January 1993 Crescent Medical Aid; February 1993 MWYO; January 1994 Mkomani; January 1995 CHAK. JHPIEGO, PCS and FPMD will plan evaluations as part of their 1993-1995 workplans.

Under the proposed amendment a final impact evaluation of the Project is planned for May 1994. This evaluation will be performed by external consultants including a health economist based on a scope of work prepared by O/PH with assistance from the Program Office. The scope of work for this effort will focus on the extent to which progress has been achieved in meeting the redefined EOPS indicators contained in the logframe. It will include a substantive analysis/assessment of the administrative/management arrangements being employed under the Project in relation to their efficiency (technical and financial).

In particular, as part of the evaluation a more thorough analysis of the cost-effectiveness of the various components/elements, e.g., clinical training, community based services, etc., will be performed. Such an analysis would examine among other things, regional variations, social costs and benefits, and financial variables such as subsidization of public sector services. It will be broad enough to include a definition of required follow-on activities that would form the basis for justification of a follow-on project/program, including an analysis of related sectors or subsectors such as child survival, HIV prevention and preventive health care financing. A four week level of effort for at least two external consultants is anticipated to be required.

3. Audit Plan

A non-federal audit (NFA) is currently being conducted for the NCPD and CTSS components of the Project. In addition, RIG/A/N is conducting an audit of the expendable and non-expendable commodities purchased with Project funds.

Per the new audit requirements effective May 1, 1991, all foreign NGOs \$25,000 per year or more of A.I.D. funds will be required to have an independent audit performed of the grant in order to determine whether the receipt and expenditure of funds provided under the Grant are presented in accordance with generally accepted accounting principles and whether the grantee has complied with the terms of the agreement. Since all NGOs supported under the CBS component of the FPSS Project and funded under A.I.D. HB 13 grant receive more than \$25,000 per year, annual financial audits will be conducted for these NGOs following the new

guidelines. The independent auditor will be selected in accordance with the "Guidelines for Financial Audits Contracted by Foreign Recipients" issued by the A.I.D. Inspector General (IG).

As per A.I.D. HB 13, Appendix 4(c), for U.S. Cooperating Agencies and Contractors, financial auditing responsibilities still remain the function of AID/W IG. These audits will also be done once a year.

Finally, it is anticipated that a RIG/A/N audit will be conducted in third quarter of FY 93. Depending on the findings of this audit, a NFA may also be conducted in late FY 94 or early FY 95.

VI. REVISED FINANCIAL PLAN

A. Summary

This Project Paper Amendment will increase A.I.D.'s LOP funding by \$12 million from \$46.2 million to \$58.2 million. The GOK contribution is estimated to increase from \$63.7 million to about \$ 77.5 million. Contributions from other donors and NGOs will increase to \$98.9 million from \$72.2 million and A.I.D./W contributions are estimated to increase from \$9.7 million to \$28.6 million, including funding for the "BIG Country Strategy". (See Table VI (i) below).

Table VI (i)

Summary Total Budget
(000's US Dollars)

Project Component	Original LOP Authorization					This Amendment				
	AID	GOK	AID/W	OTHERS	Total	AID	GOK	AID/W	OTHERS	Total
Clinical Training & Contraceptive Logistics Voluntary Surgical Contraception	11,166	14,647	375	40,167	66,355	16,066	15,557	1,395	52,341	85,359
Community Based Services	8,815	1,804	1,866	1,590	14,075	11,325	1,826	4,486	1,806	19,443
Contra Social Marketing	9,037	21,200	440	1,833	32,510	11,282	21,200	1,851	2,600	36,933
Ovulation Awareness	30	0	3,833	0	3,863	30	0	3,833	0	3,863
NCPD Administration	314	0	0	1,867	2,181	314	0	0	1,867	2,181
Plan, Monitoring & Institutional Streng	454	2,149	0	247	2,850	454	6,359	0	8,237	15,050
Inform, Education & Communication	3,298	0	850	2,973	7,121	3,828	219	6,628	2,973	13,648
Inform Planning Systems	3,831	0	250	0	4,081	3,981	0	6,120	338	10,439
Child Survival	5,850	15,473	0	14,412	35,735	5,850	16,033	0	14,412	36,295
Audit, Evaluation & Project Management	3,250	7,457	673	0	11,380	3,250	14,029	1,173	2,775	21,227
Contingency/Inflation *	155	0	0	0	155	730	0	0	0	730
	0	1,000	1,421	9,083	11,504	1,090	2,249	3,141	11,509	17,989
TOTAL	46,200	63,730	9,708	72,172	191,810	58,200	77,472	28,627	98,858	263,157

* Includes adjustments for statistical differences.

B. A.I.D. Contribution

As noted above, the two year FPSS Project amendment will increase A.I.D. funding by U.S. \$12 million in grant financing to support the following Project components:

1. Clinical Training & Contraceptives Logistics (CTCL)

Project financing for the CTCL component for the two year extension is estimated at \$4.9 million. A.I.D. will continue to support the Contraceptive Logistics Management (CLM) project in collaboration with the MOH/DFH and will also continue purchasing condoms/IUDs for the national family planning program. Most of the support for CLM will go to training and external TA. In addition, assistance will be given to the MOH/DFH to finance the seven weeks and/or revised in-service family planning training course. Finally, the Project will support external (mostly U.S.-based) short-term training for 8-10 mid-level MOH managers in project management and implementation.

2. Voluntary Surgical Contraception (VSC)

Project support to the VSC component for the two years is estimated at \$2.5 million. This component will continue to support TA, training and limited commodities for permanent methods (mainly TL, vasectomy) of contraception through buy-ins to both AVSC (for the methods) and JHPIEGO (for medical intern training).

3. Community Based Services (CBS)

Total estimated A.I.D. contribution to CBS is \$2.3 million which is expected to continue support of 9 NGOs involved in community-based distribution (CBD) of contraceptives. Funding will support salaries for the CBD staff, training, monitoring, evaluation and other office-related direct costs. The component will also support 8-10 CBD middle-level managers for short FP management courses locally, in the Africa region or in the U.S.

4. Planning, Monitoring & Institutional Strengthening (PMIS)

This component is estimated at \$530,000 and will continue to support the ongoing work with FPMD in the development of MIS' to strengthen NCPD's planning, monitoring and supervision activities. This continued assistance will fund both local and external TA, management training, system development and a limited number of computers and a related software.

5. Information, Education & Communication (IEC)

In addition to the current Client-Provider project with FPAK, this component will support printing and distribution costs of various IEC materials identified as useful to the project. The total estimated A.I.D. contribution is \$150,000 million.

6. Audit, Evaluation and Project Management

A non-federal audit (NFA) is currently being conducted for the CTSS and NCPD-related components. If required, additional NFAs will be financed. It is also anticipated that special studies and a final Project evaluation will be financed and conducted. In addition, direct A.I.D. contracts will finance the services of four PSCs (2 US and 2 FSN) who will be involved in Project management, financial management and control. Finally, secretarial support for the Project extension will be financed under this component.

7. Contingency/Inflation

A provision of 10% contingency/inflation has been included in the budget.

(See Annex 1 for a detailed breakdown of the A.I.D. Project budget by project component and expense categories for this increase in LOP financing) during the two year extension.

C. GOK Contribution

The GOK contribution to this Amendment is estimated to increase by \$13.7 million or 19.3% of the total contribution. This amendment will increase the total GOK estimated contribution to total A.I.D. LOP financing of \$58.2 million both on an in-kind and cash basis from \$63.7 million to \$77.5 million. Table V[ii] below shows a detailed estimate of the GOK contribution.

The nature of the GOK contribution to each of the Project components in relation to the 2 year funded extension period is described briefly below, and has been broken down between the Ministries of Health (MOH) and Home Affairs and National Heritage (MOHANH).

Table VI (ii)

Estimated GOK Contributions Fiscal Years 1993 to 1995				
(US Dollars)				
A. Ministry of Health	FY 93	FY 94	FY 95	Total
1. Clinical Trng & Contra Log				
i. Salary Support				
PS (5%)	800	800	800	2,400
DMS (5%)	600	600	600	1,800
Director/Deputy DFH (20%)	2,000	2,000	2,000	6,000
Others (100%)	124,800	124,800	124,800	374,400
ii. Participant Training				
One-Way Fares	15,000	15,000	15,000	45,000
iii. SDP's (800)				
Space Utilization	133,333	133,333	133,333	400,000
Supplies	26,667	26,667	26,667	80,000
Subtotal CTCL	303,200	303,200	303,200	909,600
2. Voluntary Surg Contra				
Space Utilization (22)	7,333	7,333	7,333	22,000
3. Infor Plan & Systems				
HIS (CPF)	500,000	0	0	500,000
Computer Maintainance	0	30,000	30,000	60,000
Subtotal IPS	500,000	30,000	30,000	560,000
4. Child Survival				
	FY 93	FY 94	FY 95	Total
i. KEPI	1,072,069	2,241,380	2,758,621	6,072,070
ii. CDD (CPF)	500,000	0	0	500,000
Sutotal CS	1,572,069	2,241,380	2,758,621	6,572,070
Total MOH	2,382,602	2,581,913	3,099,154	8,063,670
B. Ministry of Home Affairs				
1. Plan, Monitor & Inst Streng				
i. DHS II				
Salary Support	172,625			172,625
ii. FHI/UON				
Office Space	100	100	100	300
Staff Costs	15,300	15,300	15,300	45,900
Subtotal PMIS	188,025	15,400	15,400	218,825

Table VI (ii) cont'd.

2.NCPD Administration	FY 93	FY 94	FY 95	Total
NCPD Recurrent Costs	635,625	699,188	769,107	2,103,920
WB Loans-Vehicles (20%)	40,000	13,333	6,667	60,000
POP III (20%)	160,000	133,333	66,667	360,000
POP IV (20%)	240,000	200,000	200,000	640,000
NCPD Hq (20%)	426,667	360,000	260,000	1,046,667
Subtotal NCPD Admin	1,502,292	1,405,855	1,302,440	4,210,587
Total MOHANH	1,690,317	1,421,255	1,317,840	4,429,412
Subtotal	4,072,919	4,003,168	4,416,994	12,493,082
C.Contingency/Inflation (10%)	407,292	400,317	441,699	1,249,308
GRAND TOTAL	4,480,211	4,403,485	4,858,694	13,742,390

1. Ministry of Health

a. Clinical Training and Contraceptive Logistics

The GOK contribution to this component is estimated at \$900,000, consisting mainly of the proportion of the time various GOK officials spend on family planning related matters. It also includes an estimate of the space utilization in approximately 800 MOH service delivery points offering family planning and the cost of related FP expendable supplies. In addition, the GOK will be expected to meet the one-way air fare costs for all GOK participants being sponsored to the U.S. for short-term training.

b. Voluntary Surgical Contraception

The GOK contribution to the VSC component consists of the cost of space utilization in approximately 22 MOH SDPs, KNH and Pumwani Hospitals offering VSC services, in addition to the time spent by various GOK officials (nurses, MOHs, etc.) on provision of VSC services.

c. Information Planning Systems

FPSS Project support to IPS is scheduled to end in May 1992. Hence the GOK will be expected to take over the operation and costs of this activity at MOH. The GOK contribution includes estimates for office space, staff costs and computer maintenance. It is anticipated that the GOK will contribute approximately \$560,000 to this component.

d. Child Survival

FPSS Project support to child survival activities in Kenya has consisted mainly of provision of measles vaccines for children aged 0-5 years. Through an amendment to the FPSS Project in 1988, \$1.9 million worth of measles vaccines has financed requirements through September 1993. It is anticipated the GOK will take over the purchasing of the measles vaccines as required after September 1993 and those costs are reflected in the calculations. In addition, the GOK contribution also includes some of the operational costs of the KEPI and the CDD units at the DFH. The GOK contribution of \$6.5 million (vaccine purchase and operating costs) has been included in the GOK Forward Budget for GOK FY 92/93 to 94/95.

2. Ministry of Home Affairs & National Heritage

a. Planning, Monitoring & Institutional Strengthening

The GOK contribution to this component consists mainly of the staff costs of the GOK personnel (NCPD, MOH and CBS) who will be involved in the second KDHS anticipated to take place in early 1993.

b. NCPD Administration

Beginning in GOK FY 92/93, the GOK will finance all the recurrent costs for the NCPD Secretariat. In addition, the GOK is expected to contribute at least 20% to the World Bank projects within NCPD. These include the Population III and IV Projects, purchase of motor vehicles and construction of NCPD headquarters. The GOK contribution to this component is estimated at \$4.2 million.

3. Associated Financing

In addition to the increased financing provided by this amendment of \$12 million, and the GOK's increased contribution of \$13.7 million, it is anticipated that other donors and NGOs will contribute \$26.7 million and A.I.D./W \$18.9 million. Other donors, A.I.D./W and NGOs contributions are briefly discussed below:

a. Other Donors

1a. World Bank:

Total World Bank contribution in both grant and loan financing is estimated at \$12.7 million. The Bank's support will finance purchase of contraceptives for the MOH (\$3.7 million), and upgrading of the facilities used for the FP in-service training program (\$1.0 million).

In addition, the Bank will support the construction of NCPD headquarters, purchase of motor vehicles for NCPD, and assist in the building of FP clinics and District Population Officers (DPO) offices (\$8.0 million).

2a. SIDA:

SIDA purchases all the oral contraceptives for the Kenya FP Program. It is anticipated that 9 million cycles of different oral contraceptives will be purchased each year at an estimated cost of \$1.8 million per year; and a total estimated cost of \$5.3 million.

3a. ODA:

ODA supplies approximately 800,000 of injectable contraceptives per year. It is anticipated that this support will continue during the Project extension period at a total estimated cost of \$2.2 million.

4a. Other:

UNFPA and JICA are expected to contribute approximately \$338,000 for the IEC project, and other related Population education projects respectively with NCPD. In addition all NGOs supported under the CBS component will be expected to contribute/cost-share at least 25% towards the total A.I.D. contribution. (See Annex 2 for a detailed breakdown of donors and NGO contribution).

5a. A.I.D./W

The total A.I.D./W contribution is estimated at \$18.9 million and includes \$17.4 million in "BIG Country Strategy" funding. A detailed description of the activities to be supported are discussed extensively in the "BIG" Strategy for Kenya (See Annex F). Annex 3 contains a detailed breakdown of A.I.D./W contribution.

D. Obligations To Date and Expenditures Projections

To date, total LOP funding of \$46.2 million has been obligated to the GOK. As of March 30, 1992, a total of \$37.1 million had been committed, of which \$29.1 million had been expended. These expenditures include recorded actual and accrued expenses. The projected expenditures by fiscal year are shown below in Table VI (iii).

E. Obligation Schedule

The additional \$12 million will be obligated in FY 92 (\$400,000), FY 93 (\$5.8 million) and FY 94 (\$5.8 million) as shown in the Table VI (iv) below.

Table VI (iii)

Expenditures by Fiscal Years 1992 to 1995
(000's US Dollars)

Project Component	Cum to	Balance					Total
	3/92 *	FY 92	FY 93	FY 94	FY 95		
Clinical Training & Contraceptive Logistics	5,770	2,000	2,500	3,000	2,796	16,066	
Voluntary Surgical Contraception	5,104	500	1,500	2,000	2,221	11,325	
Community Based Services	4,812	900	1,500	2,000	2,070	11,282	
Contra Social Marketing	30	0	0	0	0	30	
Ovulation Awareness	305	9	0	0	0	314	
NCPD Administration	453	1	0	0	0	454	
Plan, Monitoring & Institutional Streng	1,596	80	700	800	652	3,828	
Information, Education & Communication	3,345	486	150	0	0	3,981	
Information Plan Systems	5,717	133	0	0	0	5,850	
Child Survival	1,968	400	882	0	0	3,250	
Audit, Evaluation & Project Management	48	80	200	200	202	730	
Contingency/Inflation	0	0	300	300	490	1,090	
TOTAL	29,148	4,589	7,732	8,300	8,431	58,200	

Table VI (iv)
Obligations by Fiscal Years 1993 to 1995
 (000's US Dollars)

Project Component	Cum to FY 92	Balance FY 92	FY 93	FY 94	Total
Clinical Training & Contraceptive Logistics	11,166	0	2,500	2,400	16,066
Voluntary Surgical Contraception	8,815	0	1,200	1,310	11,325
Community Based Services	9,037	250	1,000	995	11,282
Contra Social Marketing	30	0	0	0	30
Ovulation Awareness	314	0	0	0	314
NCPD Administration	454	0	0	0	454
Planning, Monitoring & Institutional Streng	3,298	0	300	230	3,828
Information, Education & Communication	3,831	150	0	0	3,981
Information Planning Systems	5,850	0	0	0	5,850
Child Survival	3,250	0	0	0	3,250
Audit, Evaluation & Project Management	155	0	300	275	730
Contingency/Inflation	0	0	500	590	1,090
TOTAL	46,200	400	5,800	5,800	58,200

F. Reasonableness of Cost Estimates

1. A.I.D. Contribution

The A.I.D. cost estimates developed for the two year Project extension are based on the average costs and expenditures of the FPSS Project for the last six years. No major expansion of the current activities is anticipated, thus a total yearly expenditure budget of \$5-7 million is deemed reasonable based on previous experience as noted above. In addition, a contingency/inflation factor of 10% has been included to cater for any cost overruns.

2. GOK Contribution

Most of the GOK's contribution both "in-kind" and cash has been estimated on the basis of O/PH's verification (e.g., site visits, financial reports, etc.) of the staff levels, time spent, space, etc. allotted for family planning activities. Various other documents, e.g., donor project proposals to the GOK and the GOK Forward Budgets, will also be used to define the estimates. The GOK's costs also include a contingency/inflation factor of 10%. Per legislated requirements, i.e., FAA Section 110, O/PH's monitoring of these contributions seeks to ensure the minimal compliance on the part of the GOK vis-a-vis the 25% contribution.

The GOK contribution has been calculated in relation to this \$12 million amendment to cover three additional years (FY 93-95) because the previous GOK contributions were calculated up to FY 92.

3. Other Donors, NGOs and A.I.D./W Contributions

Various project proposals from other donors and GOK Forward Budgets have been used to estimate contributions by other donors. Firm commitments for A.I.D./W central funds have also been included as A.I.D./W's contribution, in addition to the "BIG Country Strategy" funds. Based on the Project's planned grant support to NGOs, the NGO contribution has been calculated as 25% of total A.I.D. funding and these contributions will be verified in the NGO's financial reports to USAID.

The costs estimates also assume that the other donors, the GOK and the NGOs will continue to support family planning activities in Kenya at the same estimated levels for this program. With this major concern noted, the financial plan presented in this section is deemed to be feasible.

Annex 1

Family Planning Services and Support Project 615-0232					
Estimated AID Budget Fiscal Years 1993 to 1994					
(000'S US Dollars)					
Project Component	FY 93	FY 94	Total	FX	LC
<u>1. Clinical Trng & Contra Log</u>					
i. Contraceptives					
Condoms/IUD's	1,500	1,500	3,000	3,000	
ii. Logistics Management					
TA	200	0	200	200	
Training	300	0	300		300
Other Direct Costs	200	0	200		200
iv. In-Service Training					
Travel	200	200	400		400
Accommodation	200	200	400		400
Other Direct Costs	100	100	200		200
v. Participant Training					
	100	100	200	200	
Subtotal CTCL	2,800	2,100	4,900	3,400	1,500
<u>2. Voluntary Surg Contraception</u>					
i. AVSC Buy-in					
TA	293	293	585	351	234
Commodities	330	330	660	330	330
Training	128	128	255		255
ii. JHPIEGO					
TA	90	112	202	202	
Training	360	448	808		808
Subtotal VSC	1,200	1,310	2,510	883	1,627
<u>3. Community Based Services</u>					
i. NGO's Support					
FPAK	300	300	600		600
CHAK	200	200	400		400
P.C.E.A Chogoria	60	60	120		120
MYWO	260	265	525		525
Mkomani	40	40	80		80
CPK Eldoret	40	40	80		80
Saradidi	40	40	80		80
Kabiro Kawangware	40	40	80		80
Crescent	40	40	80		80
ii. Participant Training					
	100	100	200	200	
Subtotal CBS	1,120	1,125	2,245	200	2,045

Annex 1 (cont'd.)

4. Plan Monitor & Insti Strengt	FY 93	FY 94	Total	FX	LC
i. FPMD MIS					
TA	250	0	250	75	175
Commodities	30	0	30	30	
Training	50	0	50		50
ii. Participant Training	100	100	200	200	
Subtotal PMIS	430	100	530	305	225
<u>5. Infor, Educ & Communication</u>					
i. Client Prov-Commodities	150	0	150		150
<u>6. Audit, Eval & Project Mgt</u>					
i. Audit & Evaluation					
NFAs	50	0	50	50	
Special Studies/Evaluation	70	75	145	145	
ii. Project Mananagement					
Project Specialists (2)	140	150	290	290	
Financial Analysts (2)	40	50	90		90
Subtotal AEPM	300	275	575	485	90
Subtotal	6,000	4,910	10,910	5,273	5,637
7. Contingency/Inflation (10%)	600	490	1,090	527	563
GRAND TOTAL	6,600	5,400	12,000	5,800	6,200

Annex 2

Family Planning Services and Support Project 615-0232				
Estimated Other Donors/NGO's Contribution Fiscal Years 1993 to 1995				
(US Dollars)				
A.Ministry of Health	FY 93	FY 94	FY 95	Total
1.Clinical Trng & Contra Log				
i.World Bank				
Condoms (20 Million/Yr)	1,000,000	1,000,000	1,000,000	3,000,000
VFT (2.4 Million /Yr)	225,600	225,600	225,600	676,800
Upgrade Trng Facilities	1,000,000	0	0	1,000,000
ii.SIDA- Pills	1,755,000	1,755,000	1,755,000	5,265,000
iii.ODA -Depo (0.8 Million/Yr)	744,000	744,000	744,000	2,232,000
Subtotal CTCL	4,724,600	3,724,600	3,724,600	12,173,800
2.Voluntary Surgical Contra				
World Bank -Norplant	72,000	72,000	72,000	216,000
3.Child Survival				
i.KEPI				
UNICEF	800,000	900,000	1,000,000	2,700,000
JICA	75,000	0	0	75,000
Subtotal CS	875,000	900,000	1,000,000	2,775,000
Total MOH	5,671,600	4,696,600	4,796,600	15,164,800
B.Ministry of Home Affairs				
1.Community Based Services				
NGO's Contributions (25%)	255,000	256,250	256,250	767,500
2.Infor, Education & Commu				
i.UNFPA (Grant)				
Population OR	92,429	41,453	0	133,883
ii.JICA				
Population Education	203,667	0	0	203,667
Subtotal IEC	296,096	41,453	0	337,549
3.NCPD Administration				
i.World Bank (Loan)				
Contracted Prof Services	466,667	200,000	33,333	700,000
Motor Vehicles	200,000	66,667	33,333	300,000
Other Ministries	200,000	133,333	100,000	433,333
NCPD Building	2,133,333	1,800,000	1,300,000	5,233,333
POP III/IV Add	774,400	441,067	107,733	1,323,200
Subtotal NCPD Admin	3,774,400	2,641,067	1,574,400	7,989,867
Total MOHANH	4,325,496	2,938,770	1,830,650	9,094,916
Total MOH & MOHANH	9,997,096	7,635,370	6,627,250	24,259,716
Contingency/Inflation (10%)	999,710	763,537	662,725	2,425,972
TOTAL	10,996,806	8,398,907	7,289,975	26,685,688

Annex 3

Family Planning Services and Support Project 615-0232							
Estimated AID/W Contributions Fiscal Years 1993 to 1995							
(000'S US Dollars)							
Project Component	FY 93		FY 94		FY 95		Total
	AID/W	BIG*	AID/W	BIG*	AID/W	BIG*	
1. Clinical Trng & Contra Log							
JHPIEGO-TA	0	395	0	325	0	300	1,020
2. Voluntary Surg Contraception							
i. AVSC							
TA	130	590	130	410	130	400	1,790
Norplant Sets	0	120	0	150	0	260	530
ii. JHPIEGO-TA	100		100		100		300
Subtotal VSC	230	710	230	560	230	660	2,620
3. Community Based Services							
FPAK-CEDPA	0	84	0	0	0	0	84
Mkomani-PFinder	0	160	0	200	0	200	560
Rural Church-PFinder	0	150	0	200	0	200	550
FLPS-CEDPA	0	108	0	109	0	0	217
Subtotal CBS	0	502	0	509	0	400	1,411
4. Plan Monitor & Insti Streng							
DHS II-TA	0	400	0	180	0	0	580
OR-Pop Council	0	200	0	220	0	250	670
NGO Inst Strength-FPMD	0	235	0	250	0	250	735
Moni Syst-FPLM/FPMD/RAPID	0	200	0	200	0	200	600
Moni Syst-RAPID	0	200	0	150	0	150	500
Sample Surveys-IRD/DHS	0	110	0	0	0	0	110
Other Support Activites	0	838	0	870	0	875	2,583
Subtotal PMIS	0	2183	0	1870	0	1725	5778
5. Infor, Education & Commun							
Client Provider-PCS	190	500	0	500	0	500	1,690
KMA-PFinder	0	300	0	350	0	350	1,000
Urban FP-PFinder	0	360	0	690	0	800	1,850
Youth Programme-PFinder	0	260	0	510	0	560	1,330
Subtotal IEC	190	1420	0	2050	0	2210	5,870
6. Child Survival							
Measles Initiative TA	500	0	0	0	0	0	500
Subtotal	920	5,210	230	5,314	230	5,295	17,199
6. Contingency/Inflation (10%)	92	521	23	531	23	530	1,720
GRAND TOTAL	1,012	5,731	253	5,845	253	5,825	18,919

* BIG funds are expected to be available after final approval of USAID/K's Strategy and Budget.

VII. SUMMARY OF FEASIBILITY ANALYSES

A. Administrative

The MOH's Division of Family Health (DFH) and the NCPD Secretariat are the key GOK implementing agencies responsible for coordinating and providing support to the FPSS Project. In addition, selected NGO family planning service providers are also essential to implementing the five components of the FPSS Project, in close cooperation with selected A.I.D. Cooperating Agencies and USAID/Kenya's O/PH.

The DFH already has the institutional responsibility for the implementation of maternal and child health, and family planning services in Kenya. USAID assistance to the Family Planning Division, which consists of the Contraceptive Logistics Unit and the in-service Training Unit, is intended to strengthen these units by increasing the skills and responsibilities of their staff. Technical assistance to develop the requisite skills for development implementation and support of the FP in-service training program and the national contraceptive supplies system is key to ensuring that a national family planning program, capable of providing family planning services on a routine basis, is firmly in place.

With the placement of a long-term technical advisor in the DFH in August 1991, O/PH and DFH have placed a high priority on establishing a national logistics management system for the procurement, distribution and replenishment of national and District level contraceptive supplies. A staff member of the DFH is currently in the U.S. for M.P.H. training (under a World Bank scholarship) and will be returning on/about September 1992 to assume a senior position in the Contraceptive Logistics Unit.

Within the in-service Training Unit, the "master" FP trainers for the country have worked very collaboratively with a JHPIEGO team of short-term consultants to undertake a major revision of the current seven weeks in-service FP Certification Program for health workers. The willingness of these trainers to open up to alternative ways of certifying health providers in FP is promising. It is anticipated that a new modularized curriculum will expand certification to all providers completing a one-week course (pills, condoms, VFTs and injectables), thereby greatly expanding the number of SDPs at the dispensary level which will be able to offer basic FP education and services.

The DFH still needs to recruit a Medical Supervisor of the VSC program. Meanwhile adequate supervision is being provided by the regional supervisors hired on a consultant basis by AVSC. AVSC's hiring of an in-house Financial Manager, with specific responsibility to ensure that VSC units submit reports and are reimbursed in-kind with expendable supplies, should greatly

reduce some of the previous implementation difficulties the VSC program had which hampered the expansion of public sector sites.

The NCPD Secretariat, as currently constituted with a qualified Deputy Director and Finance/Administrative Director, is well positioned to utilize the MIS established in the current phase of the FPSS Project. Frequent staff turnover at the junior officer level, however, continues to plague NCPD senior management. Human resource capability has increased, although there is still need for additional staff training within the Secretariat. Individual program officers have actively participated with the NGOs and USAID/O/PH staff in CBD project monitoring visits, quarterly review meetings and bi-annual project assessments/evaluations. Their understanding of what is required to run and maintain community-based family planning services has improved markedly and has made the use of A.I.D. Cooperating Agencies, as intermediaries in working with NGOs, an accepted implementation modality.

O/PH is well staffed to manage and implement the FPSS Project with two Direct-hire officers, two Project-funded U.S. PSCs, four FSNs (two Project-funded), an International Population Fellow, and support staff including three secretaries and a Project-funded clerk typist. These positions are critical to the successful implementation of the FPSS Project and need to be maintained throughout the LOP.

In sum, the administrative analysis concludes that: 1) the DFH's Family Planning Unit needs to recruit and deploy a full-time VSC Medical Supervisor/Manager to properly institutionalize management of VSC services within public sector facilities; 2) NCPD senior management needs to continue to utilize their MIS to provide guidance to junior program officers on Project management; and 3) the Mission needs to ensure that the Project is adequately staffed by continuing to employ two U.S. PSCs and two FSN PSCs to assume major project management responsibilities; i.e., Clinical Training and Logistics Management, Community-based Services and Financial Management/Audit.

B. Social Soundness Analysis

1. 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% 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. The relatively stable political environment and steady growth in the economy - driven by the agricultural exports and tourism -

have to some degree isolated the people of Kenya from the consequences of a high level of population growth. However, this situation cannot continue. Shortages of arable land, increased in rural landlessness, urban unemployment, high costs of education, increasing political instability and a slow down in economic growth will precipitate serious social consequences for Kenya over the next 20 years.

Nonetheless, it is clear that Kenya is undergoing a demographic transition, which 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 could play an important role in the demographic situation in Kenya.

Migration has not been a major factor in determining the population size of Kenya. Recently, as economic and political stability are reached in Uganda and Tanzania, increasingly both political and economic refugees can be expected to leave Kenya. On the other hand, the deteriorating political situation in Somalia and Sudan suggests that Kenyan support for refugees will not come to an end at any time in the immediate future. In Kenya, internal migration is following the path traditionally set by a developing country of rural to urban migration. The growth of 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 increase.

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. Infant mortality is estimated to be about 65/1000 live births, a relatively good rate for Africa. About 80% of mothers are receiving ante-natal 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 having received all of the major vaccinations. The results of success in reducing infant mortality imply increased survivorship and the associated response by parents of smaller desired family size (KDHS Summary, 1990).

There are other demographic changes which deserve brief mention. The 1989 KDHS found that the portion of women who had never been married had increased since the Kenya fertility survey in 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. The same mean for women aged 20-24 was 19.8 years. Likewise the age of marriage is currently higher for urban women than for rural

women, suggesting that increased age of marriage will be a continuing trend. Changes in marriage patterns could heavily influence future fertility and contraceptive demand (KDHS, 1989).

b. Fertility Trends in Kenya

The KDHS Survey clearly shows that fertility has experienced its first substantial decline in Kenya. The total fertility rate (TFR) declined from 8 children in the later 1970's and the mid-1980's to about 6.7 in 1989. Though 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 KDHS also reports that the percentage of women who are currently pregnant declined from 13% in 1977 to 11% in 1984 and was 8.9% during the 1989 survey (KDHS, 1989).

Another indicator of changes in fertility practices are the changes in desired family size and the desire for additional children. The KDHS found that the stated ideal number of children in 1989 was 4.4, as compared to 5.8 only five 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. This would indicate that recent fertility declines would continue for the foreseen future, as younger women attempt to achieve their lower desired family size.

There is also geographic variation in desired family size which could be expected to influence future levels of fertility. Both Coast and Western provinces have considerably higher desired family size norms and can be expected to show smaller declines in fertility unless major interventions are taken in these areas.

The declines in fertility are further supported by the data from KDHS on unwanted fertility. For women having a baby in 1988, 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 the 49% of the 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 pregnancies is the use of abortion. While illegal in Kenya, there is a growing body of data to suggest that Kenyan women are using abortion to limit family size (Harbison, 1990).

The declines in fertility which have been previously discussed are generally accepted in Kenya because of the concomitant changes in marriage patterns, increased availability of comprehensive health services, dramatically declining infant mortality rates and substantial increases in the use of contraceptives.

c. Trends in Family Planning Practices

There is also a dramatically changing trend in family planning practices in Kenya. The changes, some of which are documented below, reflect increasing demand for contraceptives, an increasing focus on the quality of services being provided, a gradual shift toward long-term contraceptive methods, an expanded demand for family planning services for non-contraceptive purposes, primarily focusing on prevention of sexually transmitted diseases, improving policy environment for the provision of family planning and no evidence of potential increases in government or donor resources available for family planning services commensurate with projected increasing demand or potential demand. The following progress provides some of the documentary support for the current changes in family planning practices which will influence the success of the FPSS Project extension and potential demand on the limited resources available.

The 1989 KDHS found that 27% of all currently married women in Kenya were using contraception. This represents a 50% increase over the rate observed in 1984 (17%) and almost 4 times the rate observed in 1977/8 (7%). The use of modern methods has doubled since 1984, from 9-18%, 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 would continue to be major opportunities to influence the demographic future of Kenya through family planning services. The use of traditional and less effective methods of currently married women represents a significant target for the Mission's population program in general and the FPSS Project in particular. Also the high levels of contraceptive use are still substantially below the reported percentage of women that want no additional children (50%), suggesting a considerably unmet need for family planning services (KDHS 1989).

In a survey of two contrasting rural areas in Kenya, Alan Ferguson found that contraceptive prevalence had increased from 12% in January 1987 to 21% in October 1990. In the second area the earlier rate was 34%, rising to 51% in December 1990. Ferguson also found that in the study

period, there was a significant shift in methods from the pill to injectables. During the same period, there was also a dramatic increase in the use of sterilization. In the second year, and the high prevalence area, the IUCD was the most prevalent method followed by the pill. This area, during the study period, showed rapid gains in the proportion of women using injections. The study found strong evidence that in both areas women are selecting more effective long-term methods as prevalence increases. In the high prevalence area, the high concentration of Catholics in the population did not seem to affect contraceptive use. In fact, the study found that three quarters of Catholic users had selected modern methods of contraception. The study found evidence that clinical service providers provide wrong information on methods and risks resulting in non-adoption, unnecessary method changes or discontinuation. This is especially true for hormonal methods where, despite widespread use of low dose pills, the hypertensive risks of the pills were widely communicated by the clinic service provider.

In both clinic- and community- based programs in Nairobi and in Coast Province, there has been good acceptance of all modern methods by Muslims. One Muslim NGO has established a network for clinics in the vicinity of the local mosques and focuses on attracting Muslim clients to the program. Likewise, the Protestant churches, through their network of mission hospitals, clinics and dispensaries, continue to expand their provision of FP services both at the clinic and community level. The only group opposed to the provision of modern family planning methods, continues to be the Catholics, who promote natural family planning and birth spacing. However, they are not opposed to advocacy of smaller, planned families.

2. Social Context for Family Planning in Kenya

a. Issues Influencing Acceptability of Family Planning

In considering any large-scale family planning program, one must take the special situation currently prevalent in the country into account. The social context determines not only the level of acceptability, but the likely future demands for services. Described below are some of the current social issues which are likely to have an impact on the demand for family planning services and FPSS Project resources.

Kenya is experiencing gradual improvement in the status of women. The increased availability of public education has raised educational levels for women. Also the breakdown of traditional familiar roles between men and women have

resulted in women assuming a larger share of household support and economic activities. A large number of income generating programs operated by the Government of Kenya and non-governmental organizations have resulted in the entry of women 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 play an ever-increasing role in household economic decision-making and family formation decisions. Inevitably the results of these changes will be continuing declines in fertility and increased demand for FP services to allow them to achieve their lower desired family size.

Kenya is also experiencing changing perceptions about the economic value of children. As Kenyans move from subsistence agriculture to a cash economy, the real cost of child raising is becoming readily apparent at the household level. The high cost of child raising is further brought home by the high fees of mandatory education. The cost of education is almost the 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 suggests that future families will make child bearing decisions based on economic resources and will demand contraceptives services to help meet their family size goals (Dumm, et al., 1990).

In Kenya, the role of men in seeking family planning services or making family size decisions has generally been a negative factor in declining fertility and contraceptive use. However, there are some preliminary indications that men may be changing their attitudes toward family planning. The 1989 KDHS found that 95% of all men surveyed knew at least one method of contraception. Almost 93% knew a source for a method. When asked if they intended to use a method in the future, 42% of those currently using one indicated that they would. A sub-national survey carried out in 1988 found that 88% of all men surveyed approved of family planning (Inambao and Lewis, 1988). In a study of two rural populations, Ferguson found that while men still had a strong pro-natalist views, 80% of the women had discussed family planning with their husbands, and, in the two areas, 59% and 71% of the women reported that their husbands approved their use of family planning (Ferguson 1991). All indicators are that family planning services are beginning to make gradual in-roads among men, even vasectomy, the male permanent method.

The spread of AIDS in Africa can be expected to have a substantial impact on demand for family planning services, especially for condoms. Service providers working in AIDS high risk areas have already reported substantial demand for condoms (Lewis 1991). Even though the purpose of commodities will be to prevent sexually transmitted diseases, rather than limiting fertility, any use of contraceptives can be expected to have some impact on fertility and method acceptability regardless of the intent of the user.

b. FPSS Project Beneficiaries

The social soundness analysis of the original PP done in 1985 identified the immediate beneficiaries of the Project to be an estimated 2.5 million couples nationwide who would have increased access to family planning services, and a large number of infants and children who would subsequently benefit from being part of smaller families. This analysis remains valid for the period of the proposed FPSS amendment.

It is well established that the main beneficiaries of family planning services are the men and women who use them to regulate their fertility. Family planning services provide particular benefits to women by providing them with choices in controlling their fertility. Women derive direct health benefits from delaying or limiting pregnancies and have greater economic opportunities to participate in the work force when they are not constantly restricted to child bearing and child care. Likewise, couples derive direct benefit from having smaller, healthier families whom they can adequately feed and educate. The long-term beneficiary is the larger society which can make greater progress in overall socio-economic development with a smaller population growth rate.

The Project will directly benefit certain groups. A cadre of health workers (mainly women) will receive specialized training and subsequently be certified as family planning service providers. Physicians and nurses will receive training to certify them to perform minilaparotomy, vasectomy and NORPLANT insertion procedures including counselling. Staff members of the MOH, NCPD and selected NGOs will receive short-term training in logistics management, family planning program management, financial management and other specialized subjects. Community members (the majority of them women) will receive training as CBD workers, a community level position that elevates their status with community. NGO staff will participate in in-country training, workshops and meetings as part of the process to strengthen the management and organizational structure of key NGO FP service providers supported by the

project. The Project also will benefit existing FP service providers, CBD workers and FP clients by providing them training and IEC materials to enable provision of correct and standardized information about FP methods.

In sum, the main groups that can be expected to benefit from the FPSS Project are men and women among the eligible couples, NGOs, GOK (especially MOH and NCPD), private health facilities, private firms, parastatals, and private practitioners.

3. Acceptability of the FPSS Project Extension Components

Acceptability of the FPSS Project extension components is not an issue because most of the activities have been ongoing for the last six years. While some aspects of the focus of the FPSS extension will change from the original Project, the nature of service delivery, technical support, training and funding levels remain basically the same. There is no reason to assume the beneficiaries of FPSS Project resources, including the NGO community, the GOK and the Kenyans who receive family planning services through FPSS-funded activities will have any reason to object to the minor changes and focus anticipated for the FPSS extension.

At this point in time, both the MOH, NCPD and the NGO/private sector appear to be quite aware of the dangers of Kenya's rapidly growing population, the unmet demand for FP services from clients, the demand for a reliable source of contraceptive and expandable supplies (gloves, disinfectant, cotton wool), the demand for more certified FP services providers and for correct, standardized information and counselling about modern methods. The FPSS extension period will allow additional time and resources required by the public and private sector organizations to focus on these critical FP program elements and to maximize the impact of the already considerable investments made in strengthening their FP service delivery systems.

C. Economic Analysis

According to findings from studies conducted by the World Bank (IBRD 1980, 1983), lowering population growth rates in Kenya by the year 2000 could make vital contributions to social and economic development. It is acknowledged that rapid population growth is a development problem. Because a nation's population forms both producers and consumers of the gross output of goods and services, a rapidly increasing population diminishes per capita Gross National Product (GNP). Thus, reductions in fertility rates could be expected to yield benefits in the form of higher per capita incomes than would be achievable if there were no effort to help reduce population growth rates.

Additionally, benefits from slowing the rate of growth of Kenya's population would follow from better services offered by the GOK and improvement in the health status of mothers and children.

Four benefits can be identified as consequences of reduced population growth:

1. Reducing the effect of diminishing returns in agriculture associated with population growth pressure on land and other natural resources, which work to lower agricultural output per capita.
2. Minimizing the effect of labor force growth on the aggregate employment situation. Findings by the IBRD (1980) show that the Kenyan economy cannot provide gainful employment for all workers at constant fertility. Their analysis showed that successful implementation of FPSS and fertility control programs associated with it would mean a Kenya laborforce smaller by 1,840,000 in 2000 and smaller by 5,629,000 in 2010 than if fertility rates remained constant. The social and economic gains obtained would be reflected in the reduction of the absolute number of people seeking to earn a livelihood in the rest of the economy, and in the increase in the proportion of workers expected to gain better-paying salaried employment in the modern sector.
3. Achieving savings and a shift in the pattern of public expenditures especially on basic needs such as education, health, urban housing and rural services. According to IBRD (1980), the GOK savings would total K£472.40 million by 2000 if the total fertility rate (TFR) declined to 4.0² in the year 2000 at a cost of about US\$500 million or K£400 million between 1985-2000. This will include savings in the operating-budget alone, not to mention the resultant gains from the impetus for social and economic development. (See table 1 for sectoral disaggregation of savings.)
4. Achieving increase in per capita income through increase in 'capital deepening' (spread of capital per person or member of the laborforce).

² Savings in education remain highest (at TFR of 4.0) because more school-age children in the absence of fertility control effort would require more spending in education.

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

	(KE Million, 1970 prices)				Total
	Education	Health	Urban Housing	Rural Water	
1985-90	7.43	9.23	20.15	7.45	
1990-95	55.05	18.46	50.06	10.28	
1995-2000	138.38	35.64	107.82	12.44	
Total	200.87	63.33	178.03	30.17	472.40

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

The economic return on investments in the Kenya family planning program is in the process of being estimated by NCPD using a microcomputer-based Family Planning Program Evaluation, Planning and Financial Analysis Model³ (FAMPLAN), which has been developed recently by the Research Triangle Institute. This model estimates the impact, cost, effect and benefits of expenditures on and implementation of the family planning program.

³ The model includes four sub-models: IMPACT, which calculates the contraceptive prevalence rates and fertility rates based on assumptions about the number, characteristics, and method mix of contraceptive acceptors; COST, which estimates the resources required to implement the type of family planning program contained in the assumptions for the impact sub-model; EFFECT, which determines the cost-effectiveness based on assumptions of two alternative scenarios of family planning program effort; BENEFIT, which calculates projected expenditures for various social sectors and the benefit-cost ratio and savings based on the level of family planning program effort.

In Kenya, it was established in a study conducted with the assistance of the Research Triangle Institute (under the RAPID III project) in 1991/92 that under "high" level of program effort, contraceptive prevalence⁴ would reach 42% in the year 2000, and 62% in 2010. This level of program effort would require doubling family planning program expenditures during these time periods. Assuming a "moderate" level of program effort, prevalence would reach 35% by the year 2000 and 40% by the year 2010. This would require family planning expenditures to be 1.8 times greater in 2000 than they were in base year 1990, and 2.8 times greater in 2010 than in 1990.

The cost and benefit models estimate the resource requirements to implement a particular level of family effort over a given period of time. The benefit model calculates projected expenditures for health, education, and other social services. The model then calculates the cost-benefit ratio and gross/net savings in expenditures based on two assumptions; high program effort and moderate program effort.

Despite these cost projections, the model shows that potential long-term savings in GOK expenditures for education and health due to lower fertility will exceed projected costs. Table 2 shows the costs and savings for the models: "high" program effort vs no program; and "high" program effort vs "moderate" program effort both for the period 1990-2008.

⁴Contraceptive prevalence refers to the rate of use of various contraceptive methods. In Kenya, contraceptive prevalence increased from 7% in 1977/78 to 27% in 1989. About two thirds of this increase in contraceptive prevalence is due to use of modern methods (attributable to program performance). Fertility rate refers to the average number of children a woman will have by end of child-bearing period. Thus, increased contraceptive prevalence is inversely related to fertility rate.

Table 2 Family Planning Costs and Savings in Health/Education Expenditures Due to Family Planning: Kenya, 1980 - 2008 (KShs. millions)

YEAR	GROSS SAVINGS	FP COSTS	NET SAVINGS*
Scenario A (High Program Effort vs. No Program)			
1980	0.3	66.4	(66.1)
1985	12.9	127.3	(114.4)
1990	159.8	251.3	(91.5)
1995	716.1	380.9	335.2
2000	1,691.2	553.1	1,138.1
2005	2,907.7	795.9	2,111.8
2008	3,837.0	989.0	2,848.0
Scenario B (High vs. Moderate Program Effort)			
1990	0.1	3.2	(3.1)
1995	5.8	38.6	(32.8)
2000	71.5	108.4	(36.9)
2005	389.9	226.1	163.8
2008	769.5	329.0	440.5

* Net Savings = Gross Savings minus FP Costs.

Using the two scenarios of program effort, the high level (with a 7.5% annual increase in acceptors), and the moderate level (with a 5% annual increase in acceptors) for the period covering 1990-2008, the projected net savings in GOK expenditures due to the presence of the family planning program prove positive. The estimated net savings total 335 million Kenyan shillings by 1995, with cumulative savings of approximately 2.8 billion shillings by 2008.

The "high" program effort scenario produces a cost-benefit ratio⁵ of 1.7. This means that by the year 2008 the GOK will save 1.7 shillings for every shilling it invests in family planning program (or that the net present value of benefits by the year 2008 will exceed the present value of costs by 70%). In the "moderate" level program effort model, net savings become positive by the year 2002, and reach a maximum of 441 million shillings annually by 2008. The cost-benefit ratio with

⁵ This is one of the measures Project's worth. It is a ratio of discounted stream of benefits and costs. In general, when the benefit-cost ratio is greater than one, the Project is considered acceptable.

this model stands at 1.14 with an internal rate of return (IRR)⁶ of 14.7%.

In both models, the analysis suggests that increased levels of investment in family planning in Kenya are likely to be profitable. Substantial net savings in education and health expenditures will be derived. This, together with other indirect economic and social benefits such as increased returns in agriculture, increased opportunities for employment, and higher per capita incomes alluded to earlier makes expenditures in family planning programs justified on both economic as well as social grounds.

D. Technical Feasibility Analysis

The extension of the Family Planning Services and Support Project is a continuation of a successful program whose interventions are proven and impact has been significant. In October 1990 the external evaluation, AID/CDIE Impact Evaluation Report, "A.I.D. Assistance to Family Planning in Kenya" was highly laudatory, concluding that "A.I.D. has provided effective support and had a major positive impact on Kenya's family planning program. Reasons include both the technical program elements that USAID/Kenya has emphasized and the nature and style of A.I.D. assistance."

The following general and component-specific observations are drawn from this Report as well as other documents and studies, most notably the 1989 Kenya Demographic and Health Survey. They pertain to technical considerations in the design for those components of the Family Planning Services and Support Project which will be continued during the period of the extension, as follows:

General Considerations:

- o There is strong government support for family planning.
- o There is very high knowledge of family planning methods (over 90%).
- o There is relatively (for sub-Saharan Africa) high use of family planning (27% current users; 45% ever-users).

⁶ This is a measure of the opportunity cost of capital investment. The opportunity cost of an investment is the rate of interest on savings. If the IRR is greater than the rate of interest on savings, then the project is acceptable. The current rate of interest for most savings account in Kenya is between 12-14% per annum. This means that this IRR of 14.7% is greater than the current rate of interest on savings in Kenya, so investment in the family planning program is worthwhile.

- o There is high "unmet demand" for contraception, only 18% using modern family planning methods, yet almost 50% wanting no more children and an additional 26% wanting to delay their next birth for at least 2 years. This translates into more than 3 million couples.
- o There is a fairly wide network of family planning service delivery points (SDPs) currently providing services.
- o There is an even larger pool of potential SDPs to accommodate planned expansion in service delivery.

Component-Specific Considerations:

Clinical Training

- o Training inputs result in improved service delivery.
- o An adequate training infrastructure exists.
- o There is need for further training to meet expanded service delivery needs; significant training outputs have already been produced (e.g., over 4,000 FP providers certified by MOH), demonstrating feasibility and technical capability; i.e., it's been shown to be doable.
- o There is a strong commitment by the GOK to developing a national pre-service and in-service FP training capability
- o An improved and technically sound curriculum has been developed jointly by units of the MOH and AID-funded CAs and the Project extension will provide time and resources needed to further streamline the FP Certification Program.
- o During the Project extension, the MOH will with technical assistance address the need to identify the universe of current and potential service delivery points.
- o JHPIEGO has an established relationship of mutual understanding and trust with the DFH/MOH and has the requisite expertise and experience to provide the necessary technical assistance.

Contraceptive Logistics Management

- o There is a strong GOK commitment to improve the availability of contraceptives in all MOH and NGO/private sector SDPs.
- o It has been proven that contraceptive logistic systems work, and that without a well-functioning logistics system, a family planning program will be unable to provide family planning services.

- o The JSI/FPLM project has an internationally proven track record of improving the contraceptive logistics of national FP programs. After having worked in Kenya for 3 years, it is well-regarded and appreciated by Kenyan counterparts.

Voluntary Surgical Contraception

- o There is high demand in Kenya on the part of women and couples to limit their fertility. According to the 1989 Kenya DHS, 49.4% of currently married women want no more children. This translates into over 2 million couples.
- o VSC and NORPLANT are proven, safe, acceptable, and highly effective contraceptive methods.
- o There is an adequate pool of trained trainers and potential service providers in ML/LA.
- o VSC is well-known in Kenya (70% according to the 1989 KDHS.)
- o NORPLANT fills an important niche, since IUDs are problematic due to the high incidence of STDs, and many women, though desiring long-term contraception, still are hesitant to adopt a permanent method.
- o There is strong support for ML/LA and NORPLANT among medical policymakers in the GOK and University system.
- o NORPLANT is approved by the GOK as a family planning method.
- o There is a standardized curriculum for ML/LA and NORPLANT for the GOK and NGO private sector training programs.
- o JHPIEGO and AVSC have worked effectively, individually and in tandem, together with other AID-funded Cooperating Agencies working in Kenya, and with Kenyan counterpart organizations. They have the recognized competence and track record, and requisite trust, respect and entree to work well in all sectors in the future.

Community-based Distribution

- o CBD is approved by the GOK and an important component of the national FP program (25% of national couple years of protection were provided by CBD programs in 1991.)
- o There is documented evidence that CBD via effective referrals, is making, and could increasingly make, a significant contribution to increased acceptance of long-term and permanent methods of FP.

- o Because being a CBD worker enhances a woman's status, there is an ample supply of women eager to participate in expanded service delivery programs.

Information, Education & Communication

- o There is an inadequate supply of appropriate information for providers and acceptors of family planning in both clinic and community-based programs.
- o An IEC Working Group exists composed of NGOs which are major FP service providers and representatives of the MOH and NCPD. It is proceeding actively with the first phase of a workplan to develop print materials and a radio drama for FP.
- o JHU/PCS has worked effectively with Kenyan counterpart organizations and AID-funded CAs.
- o It has been demonstrated in other countries that mass media efforts, particularly those utilizing entertainment for education and social change, are efficient and cost-effective vehicles for increasing contraceptive prevalence, i.e., mass media changes behavior.

Planning, Monitoring and Institutional Strengthening

- o The GOK remains committed to monitoring changes in fertility and population growth through the national DHS survey.
- o The NCPD Secretariat is becoming increasingly capable of effectively interpreting and relating information/data from the MIS to its management decisions on population activities it coordinates.
- o Research on social/medical barriers, and data from the national surveys, have and will continue to contribute to greater acceptance and revalidation of national family planning guidelines and policies.

VIII. LEGISLATIVE REQUIREMENTS, CONDITIONALITY AND NEGOTIATING STATUS

A. Legislative Requirements

The key legislative requirements of relevance to the Project amendment are those concerning abortion, involuntary sterilization, and "informed choice". The provisions of the 1991 Foreign Assistance Act contain restrictions regarding population funds. Specifically, 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 family planning 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 Project Agreement Amendment with the GOK, as well as all related contract/grant agreements, will include standard provisions to be agreed upon in writing by the Implementing Agencies in order to assure compliance.

USAID/Kenya will also ensure that the Project Grant Agreement Standard Provisions contain the most recent guidance from AID/W (State 100508, dated 3/31/92) regarding the "Reports, Accounting Records, Audits and Inspections".

B. Negotiating Status

The Ministry of Health, NCPD, the implementing NGOs and the Cooperating Agencies under this Project have been consulted and have contributed to defining the requirements for this Project amendment. The implementation plans for specific components that affect these entities have also been developed collaboratively.

The GOK has formally requested USAID/Kenya to amend this activity in order to provide additional resources and time to achieve the Project's objectives and contribute to the aims of Kenya's national family planning program.

REFERENCE SECTION

Dumm J., Cornelius R., Jacobstein R., Pillsbury B., "AID Assistance to Family Planning in Kenya", AID Impact Evaluation Report, CDIE, AID/W, October 1990.

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Ferguson, Alan, Family Planning Adoption, Change and Discontinuation: A Retrospective Study from 2 Rural Areas of Kenya, GTZ and the Ministry of health, 1991.

Harbison S., and Robinson W., Components of Recent Fertility Decline in Kenya, Population Council, Nairobi, 1990.

Inambao, A. and Lewis, G., A Report on the Family Planning Association of Kenya IEC Survey - 1988, Center for African Family Studies, Nairobi, 1990.

Keyonzo N, Lewis G, Kekovole J., Report on the Evaluation of the Family Planning Association of Kenya CBD Program, Volume 1, Center for African Family Studies, 1989.

Lewis G., Kekovole J., Shumba P., Report on the Evaluation of the Maendeleo Ya Wanawake Community-Based Distribution Project, Center for African Family Studies, Nairobi, 1991.

National Council for Population and Development and the Demographic and Health Survey Project, Demographic and Health Survey in 1989.

Population Reference Bureau, World Population Data Sheet, Washington D.C., 1990.

ACTION MAIL - POL/PLD

OFFICIAL FILE Project 615-0232

VZCZCTR0287140133
PP RUEHNR
DE RUEHC #1905 1242337
ZNR UUUUU ZZH
P 172838Z APR 92
FM SECSTATE WASHDC
TO AMEMBASSY NAIROBI PRIORITY 6862
BT
UNCLAS STATE 121925

18-APR-92 TOR: 23:58
CHRG: AID
DIST: AID

AIDAC

F.O. 12356 N/A

TAGS:

SUBJECT: KENYA - FAMILY PLANNING SERVICES AND SUPPORT -
PROJECT AD HOC DELEGATION OF AUTHORITY TO AMEND PROJECT

1. ACTING AA/AFR HEREBY DELEGATES AUTHORITY TO THE DIRECTOR, USAID/KENYA, TO AUTHORIZE AN AMENDMENT IN AN AMOUNT NOT TO EXCEED DOLS. 12 MILLION TO THE FAMILY PLANNING SERVICES AND SUPPORT PROJECT, FOR A NEW TOTAL AUTHORIZED LIFE OF PROJECT NOT TO EXCEED DOLS. 58.2 MILLION. THIS AD HOC DOA SHALL BE EXERCISED IN ACCORDANCE WITH ALL THE TERMS AND CONDITIONS OF DOA 551, EXCEPT FOR THE DOLLAR AMOUNT LIMITATION.

2. UNDER DOA 551, THE MISSION HAS AUTHORITY TO APPROPRIATELY EXTEND THE PACD FOR THIS AMENDMENT, SINCE IT WILL BE LESS THAN 10 YEARS.

3. IT IS UNDERSTOOD THAT THIS AMENDMENT, RATHER THAN A NEW PROGRAM DESIGN, IS BEING DONE TO FIT WITHIN THE SCALED DOWN LEVEL PLANNED FOR KENYA--ONE THAT FOCUSES EXCLUSIVELY ON PEOPLE LEVEL IMPACT PROGRAMS. BAKER

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DMB	
C & R	
C&R BB	
RF	1
CHRON	
TOTAL	1

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Action taken... *CB*

No action necessary... *CB* 4/24
(Initials) (Date)

Julie - Please ask C&R to change action to PRS. Carol

BEST AVAILABLE COPY



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

April 15, 1992

ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/EA, David Lundberg *D. Lundberg*

SUBJECT: Kenya - Proposed Family Planning Services and Support Project - Ad Hoc Delegation to Amend Project

Problem: USAID/Kenya requests an ad hoc delegation of authority to approve a \$12.0 million amendment to the subject project, for a new total life-of-project of \$58.2 million.

Discussion: The Mission has revised its plan to design a new Family Planning Services and Support II project and would like to instead extend the current Project Assistance Completion Date (PACD) from September 30, 1993 (which includes a 1-year no cost extension) to August 22, 1995 (within the 10 year LOP limitation) and increase LOP financing from the current level of \$46.2 million dollars to \$58.2 million dollars. The Mission's decision not to proceed with a new project and instead go forward with an amendment to the current project is based upon: (a) the recent monitoring and evaluation results that indicate that no major changes in objectives or methods are necessary at this point, and that a continuation of current activities with only minor modifications is appropriate; and (b) the current projected OYB level of \$19.1 million for fiscal year 1992 which supports a scaling down of the effort to a point that a new design is not required.

This revision reflects the advice of a design team which met in Kenya from February 3 to February 19. The team effort was led by the Kenya Mission's Office of Population and Health (O/PH) with assistance and involvement of the Mission's Project Development and Controller Offices; REDSO/RLA and Population and Health Officers, including the Health Economist; RD/POP Officers Willa Pressman and Roy Jacobstein; and USAID/Kenya's O/PH Chief-Designate, Gary Newton.

Under the proposed amendment USAID would maintain a focus on increasing the availability and quality of FP services in order to increase the prevalence of contraceptive use. To accomplish this objective, FPSS would continue to support activities in the private and public sector to expand clinic-based and community-based services and improve the quality of care, primarily by reducing barriers to access. To support these efforts, and to continuously assess the impact of our assistance, operations

research, monitoring and evaluation will form a critical element of the amended program. The expanded project would be obligated by an amendment to the existing bilateral project agreement with the GOK/Ministry of Finance.

An ad hoc delegation of authority to the USAID/Kenya Director is requested to expedite the programming process for this amendment. The technical office in AID/W fully endorses this proposed approach to amend the subject activity. There are no significant policy considerations or issues presented by this amendment or deviations from the original project purpose. The Mission has the full complement of staff sufficient to authorize and implement the amendment.

Authorities: Under Delegation of Authority No. 551, Section 4.A. (2), Principal Officers of field posts have the authority to amend a project authorization only when the amendment will result in a total life of project funding of not more than 30 million dollars. However, under Delegation of Authority 400, as revised on August 16, 1991, you may redelegate authority to authorize an amendment in excess of this amount. Since the life-of-project will remain under 10 years, the mission has authority under DOA 551, Section 4.A.(3), to appropriately extend the PACD.

Recommendation: That you delegate authority to the director, USAID/KENYA, to approve a \$12.0 million amendment to the Family Planning Services and Support Project, for a new total life of project of \$58.2 million, by signing the attached cable.

APPROVED: *[Signature]*

DISAPPROVED: _____

DATE: 4/16/92

Clearances:

GC/AFR:MAKleinjan (draft) Date 4/9/92
R&D/POP:WJohnson (draft) Date 4/7/92
AFR/EA:BBahl (draft) Date 4/10/92
DAA/AFR:RCobb (draft) Date 4/15/92
AFR/DP:JGovan (draft) Date 4/10/92
LEG/CL:JFredericks (draft) Date 4/13/92

Drafted: CTerry:AFR/EA:647-5581:JEC

PROJECT-615-0232

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CLASS: UNCLASSIFIED
 OFFCL: AID 23/00/92
 APPRY: SIP:JWESTLEY
 DEFTD: FFI:CHARPIERO:NMV
 CLEAR: 1. PH:DOOT
 2. FFI:SEANIE
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RECID FOR AFR/EA/A, CARLTON TERRY; AFR/DF

E.O. 12356: N/A
 SUBJECT: AD HOC DELEGATION OF AUTHORITY TO USAID/FFNYA
 DIRECTOR-PROPOSED FPSS PROJECT (615-0232) AMENDMENT

REF: USAID/FFNYA FY-1993 ANNUAL BUDGET SUBMISSION

1. USAID/FFNYA REQUESTS AA/AFR AUTHORITY TO AMEND LCF
 FINANCING AND PASS FOR FAMILY PLANNING SERVICES AND
 SUPPORT PROJECT.

2. AFR/EA SHOULD BE AWARE THAT PRELIMINARY PROJECT
 DESCRIPTION PROVIDED IN REFERENCED AFS PRESENTS THE KEY
 COMPONENTS OF THE PROPOSED FOLLOW-ON PROJECT. HOWEVER,
 MISSION HAS REVISED ITS PLAN TO DESIGN A NEW PROJECT
 (I.E., FPSS II) AND IS INSTEAD PLANNING TO EXTEND THE
 CURRENT PROJECT TO AUGUST 22, 1995 (WITHIN THE 12 YEAR
 LOP LIMITATION) AND INCREASE LOP FINANCING FROM THE
 CURRENT LEVEL OF DOLS 40.2 MILLION TO DOLS 52.2
 MILLION. THE MISSION'S DECISION NOT TO PROCEED WITH A
 NEW PROJECT AND INSTEAD GO FORWARD WITH AN AMENDMENT WAS
 (A) BASED ON MONITORING AND EVALUATION RESULTS THAT
 INDICATE THAT NO MAJOR CHANGES IN OBJECTIVES OR METHODS
 WERE NECESSARY AT THIS POINT, AND THAT A CONTINUATION OF
 ACTIVITIES WITH ONLY MINOR MODIFICATIONS IS APPROPRIATE,
 AND (B) IN LIGHT OF CURRENTLY PROJECTED OYB LEVELS,
 WHICH SUPPORT A SCALE OF THE EFFORT THAT IS NOT GOING TO
 BE SO AUGMENTED THAT A NEW DESIGN IS REQUIRED.

3. THIS REVISION REFLECTS THE ADVICE OF A DESIGN TEAM
 WHICH MET IN KENYA FEBRUARY 3 THROUGH 19. THE TEAM
 EFFORT WAS LED BY KENYA MISSION'S O/PE WITH
 ASSISTANCE/INVOLVEMENT OF MISSION'S PROJECT DEVELOPMENT
 AND CONTROLLER OFFICES; REDSO/RLA AND PE OFFICERS,
 INCLUDING HEALTH ECONOMIST; PD/POP OFFICERS
 BRITILLA PRESSMAN AND ROY JACOBSTEIN; AND USAID/K O/PE
 CHIEF DESIGNATE, GARY NEWTON.

4. IN SUMMARY, UNDER PROPOSED AMENDMENT USAID WOULD
 MAINTAIN FOCUS ON INCREASING AVAILABILITY AND QUALITY OF
 FP SERVICES IN ORDER TO INCREASE PREVALENCE OF
 CONTRACEPTIVE USE. TO ACCOMPLISH THIS OBJECTIVE, FPSS
 WOULD CONTINUE TO SUPPORT ACTIVITIES IN BOTH THE PRIVATE

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AND PUBLIC SECTOR TO EXPAND CLINIC-BASED AND COMMUNITY-BASED SERVICES AND IMPROVE THE QUALITY OF CARE, PRIMARILY BY REDUCING BARRIERS TO ACCESS. TO SUPPORT THESE EFFORTS, AND TO CONTINUOUSLY ASSESS THE IMPACT OF OUR ASSISTANCE, OPERATIONS RESEARCH, MONITORING AND EVALUATION FORM A CRITICAL ELEMENT OF THE AMENDED PROGRAM.

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6. SUBJECT ACTIVITY WOULD BE OBLIGATED UNDER AMENDMENT TO THE EXISTING PILATERAL PROJECT AGREEMENT WITH THE GOV/MINISTRY OF FINANCE.

7. AN AD HOC DELEGATION OF AUTHORITY TO THE USAID/KENYA DIRECTOR IS REQUESTED TO EXPEDITE THE PROGRAMMING PROCESS FOR THIS AMENDMENT. THE TECHNICAL OFFICE IN AID/W FULLY ENDORSES THIS PROPOSED APPROACH TO AMENDING SUBJECT ACTIVITY. THERE ARE NO SIGNIFICANT POLICY CONSIDERATIONS OR ISSUES PRESENTED BY THIS AMENDMENT OR DEVIATIONS FROM THE ORIGINAL PROJECT PURPOSE. THIS PROPOSED AMENDMENT DOES NOT REQUIRE THE ISSUANCE OF ORDERS THAT MAY ONLY BE APPROVED BY THE AA OR ADMINISTRATOR. THE MISSION HAS THE FULL COMPLEMENT OF STAFF SUFFICIENT TO AUTHORIZE AND IMPLEMENT THE AMENDMENT.

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7. AUTHORITIES: UNDER DELEGATION OF AUTHORITY NO. 551, SECTION 4.A.(2) AND 4.A.(3), THE ASSISTANT ADMINISTRATOR FOR AFRICA HAS REDELEGATED TO PRINCIPAL OFFICERS OF FIELD POSTS THE AUTHORITY TO AMEND A PROJECT AUTHORIZATION WHEN THE AMENDMENT WILL RESULT IN A TOTAL LIFE OF PROJECT FUNDING OF NOT MORE THAN DOLS.30 MILLION. UNDER DCA 420, DATED FEBRUARY 10, 1986, THE AUTHORITY OF THE AA/AFR TO REDELEGATE AUTHORITY TO AMEND PROJECT AUTHORIZATIONS IN EXCESS OF THIS LIMIT CAN BE DONE ONLY ON A PROJECT BY PROJECT BASIS. THE REQUESTED REDELEGATION, ON AN AD HOC BASIS, IS THEREFORE WITHIN THE AUTHORITY OF AA/AFR.

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8. AFR/EA'S ASSISTANCE IN OBTAINING AA/AFR'S CONCURRENCE FOR THIS REQUEST IS APPRECIATED. PLEASE ADVISE IF ADDITIONAL INFORMATION IS NECESSARY. SEPARATE CABLE WILL BE SENT SHORTLY REQUESTING CONCURRENCE FOR

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GENERAL SECTION 22 OF 22 NAIROBI 25665

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1-1-CATEGORICAL EXCLUSION. SEMESTONE

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**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 Funds resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

Yes.

A. 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. The Project aims to increase the availability and quality of family planning services in Kenya, which will be made possible by the existence of an extensive network of public and private facilities.

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. As noted above, the Project is a social service delivery activity, and the assistance to be provided thereunder is not anticipated to directly encourage investment and trade, per se.

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)?

The Congressional Notification for the proposed amendment to this activity expired without Congressional objection on May 13, 1992.

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?

N/A.

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

N/A.

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?

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(s)(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. No further legislative action is required.

6. Water Resources (FAA Sec. 611(b); FY 1991 Appropriations Act SEC. 501): If project is for water or water-related land resource construction, has 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) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

N/A. The project will finance the expansion of family planning services in Kenya. It is not intended to encourage private trade.

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).

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.

Under the proposed amendment, the GOK's contribution to the activity has been increased to provide for their sharing in the project costs at the level of 25% of total project costs over the life of project.

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. owns no excess Kenyan shillings that could be used.

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

N/A.

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?

(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.

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

N/A.

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?

N/A.

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?

14. 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.?

Yes.

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

USAID/Kenya will ensure that any U.S. PVO receiving project assistance is in compliance with the 20% requirement.

organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

15. 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 amendment will be obligated under an amendment to the bilateral agreement with the GOK on an incremental basis. Notification of funds obligation will be sent to State via cable and a copy of the ProAg will be sent to LEG, AFR/DP, and other appropriate offices.

N/A.

16. 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?

17. 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?

18. 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.

19. 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?

b. Will any funds be used to lobby for abortion?

20. Cooperatives (FAA Sec.

Kenyan women will substantially and directly benefit from the activities to be financed. Reduced fertility rates should allow for their greater participation in the labor force. Women will also be key providers of family planning services to be financed under the Project.

No. The Project is a country-specific activity.

No.

No.

N/A.

111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

21. U.S.-Owned Foreign Currencies

N/A.

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.

No.

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?

22. Procurement

N/A.

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?

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

Yes.

the United States against marine risk with such a company?

N/A.

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 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.)

No.

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?

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?

Yes. The Project's financing provides for technical assistance which will be provided at significant levels under cooperative agreement arrangements with U.S. family planning NGO intermediaries.

Yes.

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)?

k. Metric

N/A.

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 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?

Yes.

1. 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?

N/A.

23. 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?

Yes.

24. 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.

25. 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?

Yes.

26. 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?

N/A.

27. 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?

No.

28. 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?

Yes.

29. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities?

Yes.

30. 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.

31. 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? Yes.

32. 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? Yes.

33. 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)? Yes.

34. 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? Yes.

35. 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? No.

36. 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?

Yes.

37. 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?

No.

38. 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?

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

N/A.

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?

No.

2. Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

N/A.

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)?

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

The Project activity has been designed to respond to the increasing demand for family planning services of Kenyans, as evidenced in the 1989 Demographic and Health Survey. The Project activities make significant use of Kenyan NGOs in the delivery of services and

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.

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.

of the Ministry of Health capacity to expand the provision of services.

Reduction in fertility rates anticipated as an output of this Project are expected to yield benefits in the form of higher per capita incomes for Kenyans.

a.) The Project will continue to actively involve and benefit the poor (rural and urban) through their increased access to quality family planning services, which should result in decreased family size and enhancement of options for use of their income.

b.) N/A.

c.) N/A.

d.) The Project is expected to significantly contribute to increased participation of women in the national economy and relatedly result in improvements to their status, by providing them with greater access to the labor force due to decreased responsibilities in the home.

e.) N/A.

Yes.

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)?

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?

N/A.

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?

a. 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?

b. No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or

c. No.

participates in the management of a program of coercive abortion or involuntary sterilization?

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?

d. 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?

e. Yes.

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?

f. 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 any involuntary sterilization?

g. 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?

Yes.

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 how are
economically or socially
disadvantaged (including
women)?

N/A.

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. thru 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?

a.) Yes.

b. Conservation:

Does the assistance place a high priority on conservation and sustainable management of tropical forests?

b.) N/A.

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 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

c. N/A.

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?

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?

d. N/A.

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?

e. 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

N/A.

planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

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 being about appropriate sectoral restructuring of the Sub-Saharan African economies,

a.) Yes.

b.) Yes. The Project aims to enhance economic growth by reducing the demands placed on the national economy as a result of overpopulation.

c.) Yes.

d.) U.S. and Kenyan PVOs are actively engaged in providing services financed under this Project and have been part of the design process for this activity.

e.) Yes. The Project promotes the critical A.I.D. sector priority of voluntary family planning/population services.

to support reform in public administration and finances and to 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 resource 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?

f.) N/A.

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

N/A.

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.

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.

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 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?

1.) N/A.

2.) N/A.

3.) N/A.

4.) The primary beneficiaries of the activities to be financed under this Project are women of reproductive age that will have increased access to family planning services/methods and will be able to make informed choices about limiting their family size and in turn gain greater freedom to engage in the labor force.

5.) N/A.

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.

a.) 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.

b.) 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

c.) N/A.

poor, through measures encouraging food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

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 makes extensive use of the national NGO network of family planning services providers who utilize community health workers to deliver information and services to the rural poor.

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, and strengthens management capability of institutions enabling the 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

a.) Project financing, particularly for community based service delivery efforts, makes extensive use of nonformal education methods for training of village and community health worker in family planning methods and information and communication technologies.

b.) N/A.

planning and implementation of public and private development activities.

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:

N/A.

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.

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

N/A.

infrastructure and related projects funded with earlier U.S. assistance;

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.

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. Military Purposes (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. Commodity Grants/Separate Accounts (Faa Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

4. Generation and Use of Local' Currencies (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities

consistent with the objectives of FAA sections 103 through 106?

5. Cash Transfer

Requirements (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. Separate

account: Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

b. Local

currencies: Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. U.S. Government

use of local currencies: Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the

purposes for which new funds authorized by the FAA would themselves be available?

d. Congressional notice: Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Project Title and Number: Family Planning Services and Support
(816-0232)

Life of Project: From FY 88-FY 95
Total U.S. Funding:
Date Revised: May 1992

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Goal: To reduce fertility and population growth rate	Measures of Goal Achievement: - Total fertility rate decreased from 7.9 in 1984 to 5.8 in 1995. - Growth rate decreased from 4.1% in 1984 to 3.3% in 1995.	- 1989 Census - Bacon and CBD Projections - 1989 & 1993 Demographic and Health Surveys (DHS) - 1984 Contraceptive Prevalence Survey (CPS) - HCFPS/RAPID/FAMPLAN Analysis and Projections 1991 and 1994	- Increased contraceptive prevalence will lead to lower fertility and population growth.
Purpose: To increase prevalence of contraceptive use	End of Project Status: - Contraceptive Prevalence Rate (CPR) for all married women of reproductive age increased from 17% in 1984 to 35% in 1995. - CPR for all women of reproductive age increased from 14% in 1984 to 31% in 1995.	- 1984 CPS - 1989 and 1993 DHS - HCFPS/RAPID/FAMPLAN Analysis and Projections 1991 and 1994. - Final Project Evaluation	- 80% population policies support expansion of family planning services in the public and private (NGO) sectors. - Latent demand for contraception can be activated through increased availability of quality family planning information and services.
Outputs	Magnitude of Outputs		
Clinical Training and Contraceptive Logistics (CTCL)			
Increased quality and quantity of clinic-based services and contraceptive supplies	A. Field Capacity A.1. Number of MOH and NGO SDPs offering family planning services increases from approximately 750 in 1984 to 2,212 in 1995. A.2. By 1995, a minimum of 4,950 ECNs, ERNs, or COs and supervisors trained and certified, a minimum of 1,270 FP workers recertified through refresher training.	A.1. MOH monthly Logistics Management Information System (LWIS) Report; ORAID/OPN database. A.2. Cooperating Agency Training MIS data; DPN's FP Manager Planning and Training Information System; Pre- and Post-training questionnaires/tests; 1994 in-service training evaluation.	- MOH revises and streamlines its in-service and refresher curricula for training FP service providers. - Information from the FP Manager Planning and Training Information System provides regular data for validating and adjusting training requirements.

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Outputs	Magnitude of Outputs	Means of Verification	Assumptions
	B. Headquarters Training Capacity		
	B.1. DPH Organizational development plan prepared and implemented.	B.1. Cooperating Agency/HOH/DPH management assessment; HOH/DPH official personnel documentation and records.	
	B.2. HOH/DPH, with Cooperating Agency support, produces and implements annual Action Plan.	B.2. HOH/DPH official records; Cooperating Agency reports; USAID site visits; Cooperating Agency quarterly financial reports; 1994 in-service training evaluation.	
	B.3. Standard Reproductive Health in-service and refresher training curriculums revised, field tested, implemented and evaluated.	B.3. HOH/DPH official curriculums, Cooperating Agency reports, 1994 in-service training evaluation.	
	B.4. 6-10 program managers/supervisors trained annually in short-term FP management courses.	B.4. DPH training records; FP manpower Planning and Training Information System; USAID training records.	
	C. Contraceptive Supplies/Logistics		
	C.1. HOH/DPH and HSCU Logistics Management Unit fully staffed and functional.	C.1. Monthly LMIS reports; USAID site visits; Cooperating Agency reports.	C.1. HOH commitment (financial and policy) to support DPH and HSCU contraceptive logistics requirements is maintained.
	C.2. LMIS covering all GOK and NGO SDPs established and used routinely by HOH to guide contraceptive procurement/distribution.	C.2. Monthly HSCU Stock and Delivery Schedule Reports; Cooperating Agency Reports; USAID site visits; external evaluations.	C.2. HOH/DPH assigns staff to the Logistics Management Unit as agreed upon with USAID under terms of the Family Planning Logistics Management Project.
	C.3. HOH/DPH and HSCU assure effective procurement and supply of national contraceptive requirements; i.e., 6-12 months at HSCU, 4-6 months at regional warehouses/district stores, 2-5 months at SDPs.	C.3. Monthly HSCU Distribution and LMIS Reports, Cooperating Agency reports; 1992 and 1994 Annual Facilities Stock Inventory Survey Reports; USAID site visits.	C.3. Other donors fulfill commitments to supply commodities as agreed upon with HOH/DPH.

Outputs	Magnitude of Outputs	Means of Verification	Assumptions
Voluntary Surgical Contraception			
Increased availability of quality VSC services	<ul style="list-style-type: none"> - AVSC-assisted VSC sites expand from 4 in 1984 to 70 in 1995. - Cumulative number of AVSC-supported VSC procedures increases from 0,500 in 1986 to 110,000 in 1995. - Number of medical interns trained in HL/LA by Dept. OB/GYN/JNPI/NGO increases from 0 in 1985 to 900 in 1995 with a minimum of 70% providing VSC services within 3 years of training. - Number of NGO/Private Sector sites providing Norplant increases from 10 in 1992 to 32 in 1995. - Number of AVSC-supported Norplant procedures increases from 0 in 1991 to 14,000 in 1995. - Client-oriented Provider Efficient (COPE) self assessment of VSC sites implemented and recommendations acted upon in 80% of AVSC-supported facilities. 	<ul style="list-style-type: none"> - LHS Reports; Cooperating Agency Reports and records; USAID site visits; evaluations/assessments; and HON, Dept. OB/GYN, NGO training records. 	<ul style="list-style-type: none"> - Continued strong GOX support for family planning and long term and permanent methods of voluntary surgical contraception. - Continued demand of Kenyan men and women for VSC services. - Adequate supply of Norplant sets provided by World Bank and other donors and made available to NGO/private sector. - Trained VSC physician-nurse teams and counselors are deployed in public and private sector VSC sites.
Community Based Services (CBS)			
Increased availability and effectiveness of community-based, non-clinical family planning services	<ul style="list-style-type: none"> - Number of sublocations with active USAID-supported community-based workers increases from 10% in 1985 to 37% in 1995 - 3,775 CBS workers and 130 supervisors trained and deployed providing non-clinic FP services including pills, condoms and foaming tablets to 325,000 new clients and 600,000 revisits for an estimated 200,000 CYP's annually. - Number of confirmed referrals increased for VSC from approximately 6,000 in 1991 to 20,000 in 1995 and for Norplant from 0 in 1991 to 2,000 in 1995 	<ul style="list-style-type: none"> - USAID O/PN database; quarterly reports from NGOs and Cooperating Agencies (CA); USAID/Cooperating Agencies/HCPD semi-annual review meetings; USAID site visits; periodic project assessments; evaluation(s). 	<ul style="list-style-type: none"> - Continued support of local leaders for NGO-managed community based family planning programs. - Continued participation of community members in NGO programs as depot holders and home visitors for non-clinical FP services. - HON continues to make adequate supplies of contraceptives available to NGO CBS programs.

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146

Outputs	Magnitude of Outputs	Means of Verification	Assumptions
Information, Education and Communication (IEC)			
- Increased availability of correct information about family planning methods through IEC efforts	<ul style="list-style-type: none"> - Client/Provider IEC Print materials produced/distributed/evaluated to assess impact on client's knowledge and utilization of family planning methods. - A minimum of 8 IEC/Counselling workshops for CBD and clinic providers held. - 200 CBD Training Manual produced/distributed to NGO CBD programs. - A minimum of 52 thirty-minute radio programs with a family planning theme developed/broadcast nationally. - IEC working group established and meeting quarterly to coordinate selected IEC activities in public and private sectors. 	<ul style="list-style-type: none"> - Cooperating Agency reports and evaluation of print material effectiveness, USAID site visits; 1989 and 1993 DHS; evaluation. - Pre- and post-training questionnaires. - USAID site visits to NGO CBD training programs. - Cooperating Agency Reports on audience research. - Minutes of IEC working group meeting. 	<ul style="list-style-type: none"> - GOK continues to support development and dissemination of quality FP information to clients and providers, potential clients, including youth. - Continued collaboration of NGOs, MOH and NCPD on IEC working group. - Improved information on modern methods will increase demand for and compliance with contraceptives.
Planning, Monitoring and Institutional Strengthening			
Strengthened institutional capabilities to plan and monitor national population policies and programs.	<ul style="list-style-type: none"> - NCPD/CBS, with Cooperating Agency support, conducts and completes two national Demographic and Health Surveys (1989 and 1993). - NCPD Management Information System (MIS) established by 1993 and routinely used for program monitoring by 1995. - OB/GYN publishes two major USAID-supported studies on reduction of medical or social barriers to contraception and disseminates findings nationally. - 8-10 NGO and/or NCPD staff trained annually in short-term FP program management courses. 	<ul style="list-style-type: none"> - 1989 and 1993 DHS Reports; NCPD and Cooperating Agency technical and financial reports. - Cooperating Agency technical/financial reports; NCPD MIS systems; USAID site visits; evaluation. - Dept. of OB/GYN and Cooperating Agency published research reports; Cooperating Agency reports and financial records; evaluation. - NGO/NCPD Training records; USAID training records. 	<ul style="list-style-type: none"> - GOK remains committed to monitoring changes in fertility and population growth through regular national surveys. - NCPD Secretariat uses information from MIS to make management decisions on population activities they coordinate. - Research on social/medical barriers can contribute to acceptance and revitalization of national family planning guidelines/policies.

Outputs	Magnitude of Outputs	Means of Verification	Assumptions
(Components completed by/before September 30, 1993)			
Subsidized Commercial Marketing of Contraception			
Utilization of commercial outlets to increase availability at subsidized prices	0,000 retail and pharmaceutical outlets selling three different contraceptive products at affordable prices.	Reports from the Kenyan marketing organization, and CA reports; analysis of contraceptive prevalence surveys.	<ul style="list-style-type: none"> - A new independent marketing organization will be established which will pay salary levels commensurate with the private sector. - The contraceptive products will be registered by GOK, advertising will be allowed and OCs will be allowed to be distributed beyond the pharmacies to other retail outlets.
<p>Note: Component discontinued mid-1989; Separate Bilateral Mission Project approved August 1990.</p>			

Ovulation Awareness (OA)

Increased understanding and use of OA to promote periodic abstinence for those persons for whom other methods of FP are not acceptable	ICS and VLCAK train 3,600 teachers and 7,200 volunteers; total 10,800 estimated, cumulative users.	MOU reports; USAID records.	<ul style="list-style-type: none"> - National FP project organizations will adhere to AID Population Policy regarding referral of clients and informed choice among methods. - FPSS support is contingent on these organizations eschewing unscientific criticism of other FPSS project components.
<p>Note: Component discontinued December 1988.</p>			

HCPD Administration

Improved capability of HCPD to handle increased program monitoring, supervision, management and policy formulation	<ul style="list-style-type: none"> - Job descriptions developed and staff hired. - Staff Training Plan completed. - GOK budget allocation for HCPD operating budget increased from 0 in 1985 to 100K in GOK FY 92-93. 	<ul style="list-style-type: none"> - HCPD reports; GOK budget; component evaluation; FPSS evaluation. 	<ul style="list-style-type: none"> - GOK will continue to provide budget allocations to HCPD.
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Note: To be completed September 30, 1993.

Information Planning Systems (IPS)

Improved MOU capacity in national and district level planning, budgeting and management of health and FP programs.	<ul style="list-style-type: none"> - Enhancement of tea health, FP and management information systems, thru computerization. 	<ul style="list-style-type: none"> - HCC; HCC reports/records; PILs; USAID site visits; USAID evaluations, DHSIS, DRAH 	<ul style="list-style-type: none"> - Enhanced systems/procedures in MOU for planning and budgeting will lead to more equitable/efficient distribution of GOK resources for HCH and FP services.
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Outputs	Magnitude of Outputs	Means of Verification	Assumptions
	<ul style="list-style-type: none"> - Design and implementation of prototype District Health Management Information Systems (DHMIS) and Direct Health Annual Report (DHAR) in 4 pilot districts - 8 health management operations research activities completed. - Computerized library and information resource center established in MOH. 		<ul style="list-style-type: none"> - MOH assigns full-time HIS manager and technical staff to HIS unit.

Note: To be completed May 29, 1992

Child Survival Component

Increased availability of measles vaccine to national KEPI program; increased use of OHS in Public/NGO/Private Sector; increased access to training for Management of Child Survival/Family Planning programs

A. Measles			
A.1. 9.7 million doses of measles procured and administered to a minimum of 5 million children under age one.	A.1. Shipping documents, bill of lading, KEPI records, USAID site visits.	GOK and donors continue to support the National KEPI program.	
A.2. Measles vaccine coverage increased from 64% in 1987 to 89% in 1994 of children under age one.	A.2. Nationwide coverage surveys; computerized Epidemiological Information System; 1993 DHS.		
B. Control of Diarrheal Diseases			
OHS/OBT usage rate increases from 5% in 1987 to 8% in 1993 respectively.	B. 1993 DHS; 1992 WHO-CDD Household Survey; Cooperating Agency report/records; MOH/DPH records; USAID site visits.	GOK and donors continue to support the National CDD Program.	
C. CS/FP Training			
75 NGO and public sector personnel trained in Child Survival/Family Planning Management.	C. Cooperating Agency reports/records; Final Training Report and materials submitted to USAID.	MOH and NGOs make suitable personnel available for training.	

Note: To be completed September 30, 1993.

Inputs

1. USAID

- Clinical Training & Contraceptive Logistics (CTCL)	Contraceptives, TA Training (\$16.1 million)	AID/W Reports, Contractor Reports, Field Monitoring Visits
- Voluntary Surgical Contraception (VSC)	TA, Training & Commodities (\$11.3 million)	AID/W Reports, Contractor Reports, Field Monitoring Visits
- Community Based Services (CBS)	NGO Grants, TA, Training, other direct costs (\$11.3 million)	NGO Reports, GOK Reimbursement requests, Field Monitoring Visits
- Subsidized Commercial Marketing	Discontinued mid 1989 (\$30,000)	
- Ovulation Awareness (OA)	Discontinued (\$314,000)	
- NCPD Administration	Activity completed (\$454,000)	
- Planning, Monitoring & Inst. Strengthening (PMS)	TA, commodities (\$3.0 million)	Contractor reports, Review Meetings
- Information, Education & Communication (IRC)	TA, Commodities other direct costs (\$3.9 million)	GOK Reimbursement requests, field monitoring visits
- Information, Planning System (IPS)	TA, Commodities other direct costs. Activity to be completed May 30, 1992 (\$5.9 million)	Contractor Reports, field monitoring visits, Review Meetings
- Child Survival	TA, Commodities (\$3.3 million)	HOW/DPI Commodities Receipt reports, Contractor reports, Review Meetings, Field Monitoring Visits
- Audit, Evaluation & Project Management	Individual USAID direct Grants (\$730,000)	Contractor Reports
- Contingency/Inflation	\$1.1 million	

2. GOK

Salary support, space utilization, commodities	\$77.5 million	GOK Reimbursement Requests, Field Monitoring Visits
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3. AID/W

AID/W Central & "Big Country Strategy" Funding	TA commodities (\$28.6 million)	Contractor reports, AID/W Reports
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4. OTHER

Other Donors, e.g., World Bank, SIDA, ODA, UNFPA & JICA plus NGOs cost share attributions	TA, commodities (\$98.0 million)	NGO Reports, quarterly donor meetings, Field Monitoring Visits
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OFFICIAL MINISTRY OF HEALTH

Project 615-0235

ANNEX C

4/7/92

Telegrams: 'MINHEALTH', Nairobi
Telephone: Nairobi 718870
When replying please quote



OFFICE OF THE PERMANENT SECRETARY
AFYA HOUSE
CATHEDRAL ROAD
P. O. Box 30016
NAIROBI

Ref No. _____ and Date _____

22nd April, 1992

ATR REGD
A-24

REPLY DUE
A-07

ACTION OFFICE
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INDEX

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TOTAL 6 #

The Representative,
USAID Mission to Kenya,
P.O. Box 30261,
NAIROBI.

Dear Sir,

RE: EXTENSION OF USAID ASSISTANCE TO DIVISION OF FAMILY HEALTH DFH PROGRAMMES

As you recall, since 1985, USAID has been supporting DFH's programmes through the Family Planning Services and Support (FPSS) Project. Among these, FPSS has provided valuable support to our immunization, diarrhoeal control and Family Planning activities.

It is our understanding that the current USAID funding to the Ministry of Health, DFH, under the FPSS project will end in September, 1993. It is our sincere hope and expectation that USAID will continue to support our efforts, and we look forward to discussions and planning for a possible new, long term bilateral project agreement.

In the meantime, and in view of the valuable assistance received to date, we hereby request that USAID extend the FPSS Project for a further two (2) years until such time that more detailed planning and discussions can be undertaken. For the Child Survival and Development component, we badly need measles vaccine supplies at current levels with effect from January, 1993.

I look forward to your favourable consideration of this request.

Yours sincerely,

Daniel M. Mbiti
DANIEL M. MBITI
PERMANENT SECRETARY

ACTION COPY

Action taken _____
No action necessary _____

92/9007

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151

Project 615-0232

RECEIVED



MINISTRY OF HOME AFFAIRS AND NATIONAL HERITAGE
NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT

Telegrams: "Home", Nairobi
Telephone: Nairobi 34411
When replying please quote



P.O. Box 30473
NAIROBI, KENYA

Ref. No. NCPD 6/2/1F Vol. VI/(32)
and date

8th April, 1992

The Director
USAID/Kenya

DATE RECD	4-10
REPLY DUE	4-23
ACTION OFFICER	PH
FILE	
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PR	
TOTAL	6

Dear Sir,

RE: FAMILY PLANNING SERVICES AND SUPPORT (FPSS) PROJECT

As you are aware, USAID funding to NCPD through the above project is due to expire soon. This funding ranks among the most valued donor support to NCPD.

The FPSS project has been the backbone of NCPD's programme almost since its inception. The project has enabled NCPD to grow as an institution and has on the whole contributed positively to the various components of the population programme.

In this regard, therefore, we would like to request USAID to extend the FPSS project for two years while discussions take place on a new funding arrangement. This will ensure that the promising achievements in the population programme are sustained.

We hope you will consider our request favourably.

Yours faithfully,

M.K. Chemengich
M.K. Chemengich
For: DIRECTOR, NCPD

92/8777

UNCLASSIFIED STATE 129538

PRJ
ACTION AID-3 INFO ECON POL/RLO

Project 615-0238

VZCZCTH0190NA0974
PP RUEENR
DE RUEHC #9538 1142255
ZNR UUUUU ZZE
P 232256Z APR 92
FM SECSTATE WASHDC
TO AMEMBASSY NAIROBI PRIORITY 7169
BT
UNCLAS STATE 129538

24-APR-92 TOR: 03:59
CHRG: AID
DIST: AID

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: REQUEST IEE CATEGORICAL EXCLUSION FOR THE FPSS AMENDMENT

1. THE BUREAU ENVIRONMENTAL OFFICER CONCURS IN MISSION REQUEST FOR AN IEE CATEGORICAL EXCLUSION UNDER REGULATION 16, SECTION 216.2 (C)(2)(VIII) FOR THE FPSS PROJECT AMENDMENT.

2. GC/APR HAS CLEARED THIS CABLE. BAKER

BT
#9538

NNNN

UNCLASSIFIED STATE 129538

DATE RECD	4-24
REPLY DUE	4-27
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ACTION AID-3 INFO ECON POL/RLO

720207P0420NAC262

OP RUSINE

RUZEC #2784 1227127

DIR UUUUU ZEH

121272 MAY 92

SECSTATE WASHDC

TO AMEMBASSY NAIROBI PRIORITY 7405

UNCLAS STATE 137784

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: KENYA - BIG COUNTRY POPULATION STRATEGY

1. THE SUBJECT POPULATION STRATEGY WAS REVIEWED AND APPROVED AT A PROJECT REVIEW COMMITTEE ON APRIL 6, 1992. THE MEETING WAS CHAIRED BY AFR/EA AND ATTENDED BY REPRESENTATIVES FROM R&D/POP, AFR/ONI AND AFR/ARTS. THE MISSION IS TO BE COMPLIMENTED FOR SUBMITTING A WELL WRITTEN AND COMPREHENSIVE STRATEGY. THE BUREAU WAS FORTUNATE IN DECEMBER 1991 TO HAVE HAD DAVID OOT HERE ON TDY TO PROVIDE US A DETAILED PREVIEW OF WHAT THE STRATEGY WOULD ENTAIL. THIS INFORMATION WAS USEFUL AT THAT TIME AND HELPFUL IN THE REVIEW OF THE FINAL PAPER. WE ENDORSE THIS STRATEGY FOR MEETING THE GROWING DEMAND FOR FAMILY PLANNING SERVICES IN KENYA. CONCERNS AND ISSUES RAISED DURING THE REVIEW ARE NOTED BELOW.

2. FUNDING: THERE WAS GENERAL AGREEMENT THAT THE FUNDING LEVELS FOR FY 1992 THROUGH FY 1995 IN THE STRATEGY BUDGET ARE REASONABLE. GIVEN THE CURRENT POLITICAL SITUATION, HOWEVER, FUTURE BILATERAL FUNDING LEVELS ARE UNCLEAR. IF THE POLITICAL SITUATION AFFECTS THE MISSION'S OYD, IT MAY AFFECT THE MISSION'S ABILITY TO IMPLEMENT THE STRATEGY AS PLANNED. REGARDING CENTRAL SUPPORT, RD/POP INTENDS TO

MEET THE FUNDING LEVELS PROJECTED IN THE STRATEGY, SUBJECT OF COURSE TO OVERALL AVAILABILITY OF POPULATION FUNDING.

3. LONG-TERM STRATEGY: THE COMMITTEE NOTED THAT A.I.D. HAS BEEN PROVIDING POPULATION ASSISTANCE IN KENYA FOR ABOUT TWO DECADES, AND THAT THE SUBJECT FOUR-YEAR STRATEGY CALLS FOR GRADUAL EXPANSION OF POPULATION SUPPORT. IT IS UNCLEAR, HOWEVER, HOW THE SUBJECT STRATEGY PROMOTES SUSTAINABILITY OR FITS INTO A LONGER-TERM POPULATION STRATEGY OF THE MISSION. IS THE GCK IN A POSITION TO PROVIDE AN INCREASING PROPORTION OF THE FINANCIAL SUPPORT FOR ITS NATIONAL FAMILY PLANNING PROGRAM? WHAT IS THE POTENTIAL FOR AN INCREASING ROLE OF THE PRIVATE AND COMMERCIAL SECTORS? THE COMMITTEE SUGGESTS ADDING A SECTION TO THE STRATEGY ADDRESSING THE ABOVE ISSUES IN ORDER TO PROVIDE CLARIFICATION AS TO THE MISSION'S

21-MAY-92 TCR: 24:31
 CHFG: AID
 DIST: AID

DATE RECD	5-4
REPLY DUE	5-6
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CONF	1

LONGER-TERM POPULATION STRATEGY. POSSIBLY, THE NEW
POPULATION/ HEALTH TEAM COMING ON BOARD THIS SUMMER COULD
DEVELOP THIS SECTION.

4. COLLABORATIVE RELATIONSHIP: THE COMMITTEE COMMENDS
THE MISSION FOR ITS EFFECTIVE AND COLLABORATIVE USE OF
COOPERATING AGENCIES. WE BELIEVE YOUR SUPPORT OF A WIDE
SPECTRUM OF NGO FAMILY PLANNING SERVICE PROVIDERS HAS MADE
A MAJOR AND IMPORTANT DIFFERENCE ON THE QUALITY OF SERVICE
PROVIDED TO KENYANS. BAKER

BT
#7734

NNN

Evaluation Summaries

The support-oriented components, i.e., NCPD Administration, NCPD Policy, Planning and Evaluation, Information, Education and Communication, and Information, Planning Systems have all had component-specific evaluations/assessments performed during the first six and a half years of Project implementation.

In August 1990, external consultants prepared "A Summary Description of Ongoing USAID Bilateral Population Assistance to Kenya - 1990" (G. Lewis and L. Wedeen). This paper synthesized and commented on the recommendations of the 1989/90 evaluations done of the in-service FP training program of CTSS; the May/June 1988 evaluation of VSC; the January/February 1990 assessment of the Medical Intern Minilaparotomy Training Program of the Dept. OB/GYN and JHPIEGO; and the September/October 1989 evaluation of the FPAK Community Based Distribution (CBD) program.

Assessments have been completed or are currently underway of the MYWO CBD program (September/October 1990), Saradidi CBD program (March/April 1991), Chogoria CBD program (June 1991), CHAK (March 1992) and Kabiro Kawangware (April 1992). All assessments of CBD projects guided program design, modification and management decisions for the next phase of activities for NGO CBD activities.

In 1988 an evaluation of the NCPD was conducted by J. Phillips of the Population Council and K. Kiragu of Coopers and Lybrand to analyze the organizational capability of NCPD to fulfill its role. The evaluation noted that NCPD appeared to provide an effective forum for discussing population strategies but that the structure of NCPD was a major constraint to its effectiveness. The report recommended an organizational model of the NCPD similar in design to national science academies, research councils and policy boards. The evaluation noted that the proposed changes may be inconsistent with the present legal status of the NCPD. No action was ever taken by the NCPD Council or Secretariat on this report.

In April/May 1991 an evaluation was done of the Family Health International (FHI) assistance to the Dept. OB/GYN, University of Nairobi to strengthen the Department's capacity to carry out reproductive health research. Based on the evaluation, a decision was made to place an FHI country representative at the Department to help resolve problems contributing to past project delays (e.g., research data processing and lack of appropriate facilities for research staff and equipment).

In 1990, O/PH requested The Johns Hopkins University Population Community Services (JHU/PCS) to assist USAID to define strategic IEC options in support of family planning services and, to a limited extent, programs for youth. The subprojects of NGO IEC activities supported by FPSS were not individually assessed. The PCS report, "Strategic Options for IEC Interventions in Kenya", March 1990, reviewed and analyzed the current IEC picture in Kenya, identified long-term strategies for improving communication support for family planning services, and presented a detailed short-term two year action plan for the first phase of implementation. The Client-Provider Education project, which is the first two year phase of this long-term strategy for USAID, NCPD and MOH, has a built-in evaluation procedure for each element of this FPSS-financed activity.

In June 1989, Oyoo and Yoder completed a "Formative Evaluation of the Information and Planning Systems" project which guided the restructuring of the IPS project for the remaining two years.

The Child Survival component has never been separately evaluated. However, O/PH does monitor and track the shipments of measles vaccine, and the KEPI Unit monitors national immunization coverage through the computerized EPI reporting system. Both PRITECH and REACH, the implementing organizations for the buy-ins for technical assistance and support for Control of Diarrheal Diseases (CDD) and Kenya Expanded Programme on Immunization (KEPI), have had AID/W centrally-funded program reviews of the worldwide PRITECH and REACH projects in 1982 and 1990 respectively, and Kenya has been included in these.

Family Planning Services and Support (FPSS)
A.I.D. Project Number 615-0232
Project Paper Amendment
Issues Memo

1. **Sustainability:** Over the last six-seven years of FPSS Project implementation, what degree of progress has the GOK achieved in decreasing dependence on external financing for family planning delivery systems and increasing cost-recovery and or other efficiencies?

2. **Social Soundness/Technical Analyses:** Are particular strategies being designed under the Project or with other financing that will focus on influencing greater male participation in and acceptance of family planning?

3. **GOK Contribution Section 110 of FAA:** With what frequency and level of detail does O/PH verify the GOK's counterpart contributions to this Project?

4. **Conditionality:**

FP Inservice Training Program: The implementation plan (p. 45) notes that \$1 million of the proposed amendment is planned as an add-on to the AID/W centrally-funded JHPIEGO project for management, administration, technical assistance and training support of the in-service FP clinical training program. In addition, about \$2 million remains in unexpended already obligated funding in the CTCL component.

What portion of the already obligated and planned additional funding is attributable to the proposed Condition Precedent (p. 91)? Does the CP and PP contain sufficient details on what would need to be included in the MOH's training plan in order for the CP to be satisfied? In the event the CP is not satisfied, would JHPIEGO's technical assistance to the MOH/DFH continue to be financed under the Project?

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FPSSISS:CEB:5/26/92

Family Planning Services and Support (FPSS)
A.I.D. Project Number 615-0232
Project Paper Amendment
Issues Memo

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Evaluation Summaries

The support-oriented components, i.e., NCPD Administration, NCPD Policy, Planning and Evaluation, Information, Education and Communication, and Information, Planning Systems have all had component-specific evaluations/assessments performed during the first six and a half years of Project implementation.

In August 1990, external consultants prepared "A Summary Description of Ongoing USAID Bilateral Population Assistance to Kenya - 1990" (G. Lewis and L. Wedeen). This paper synthesized and commented on the recommendations of the 1989/90 evaluations done of the in-service FP training program of CTSS; the May/June 1988 evaluation of VSC; the January/February 1990 assessment of the Medical Intern Minilaparotomy Training Program of the Dept. OB/GYN and JHPIEGO; and the September/October 1989 evaluation of the FPAK Community Based Distribution (CBD) program.

Assessments have been completed or are currently underway of the MYWO CBD program (September/October 1990), Saradidi CBD program (March/April 1991), Chogoria CBD program (June 1991), CHAK (March 1992) and Kabiro Kawangware (April 1992). All assessments of CBD projects guided program design, modification and management decisions for the next phase of activities for NGO CBD activities.

In 1988 an evaluation of the NCPD was conducted by J. Phillips of the Population Council and K. Kiragu of Coopers and Lybrand to analyze the organizational capability of NCPD to fulfill its role. The evaluation noted that NCPD appeared to provide an effective forum for discussing population strategies but that the structure of NCPD was a major constraint to its effectiveness. The report recommended an organizational model of the NCPD similar in design to national science academies, research councils and policy boards. The evaluation noted that the proposed changes may be inconsistent with the present legal status of the NCPD. No action was ever taken by the NCPD Council or Secretariat on this report.

In April/May 1991 an evaluation was done of the Family Health International (FHI) assistance to the Dept. OB/GYN, University of Nairobi to strengthen the Department's capacity to carry out reproductive health research. Based on the evaluation, a decision was made to place an FHI country representative at the Department to help resolve problems contributing to past project delays (e.g., research data processing and lack of appropriate facilities for research staff and equipment).

In 1990, O/PH requested The Johns Hopkins University Population Community Services (JHU/PCS) to assist USAID to define strategic IEC options in support of family planning services and, to a limited

extent, programs for youth. The subprojects of NGO IEC activities supported by FPSS were not individually assessed. The PCS report, "Strategic Options for IEC Interventions in Kenya", March 1990, reviewed and analyzed the current IEC picture in Kenya, identified long-term strategies for improving communication support for family planning services, and presented a detailed short-term two year action plan for the first phase of implementation. The Client-Provider Education project, which is the first two year phase of this long-term strategy for USAID, NCPD and MOH, has a built-in evaluation procedure for each element of this FPSS-financed activity.

In June 1989, Oyoo and Yoder completed a "Formative Evaluation of the Information and Planning Systems" project which guided the restructuring of the IPS project for the remaining two years.

The Child Survival component has never been separately evaluated. However, O/PH does monitor and track the shipments of measles vaccine, and the KEPI Unit monitors national immunization coverage through the computerized EPI reporting system. Both PRITECH and REACH, the implementing organizations for the buy-ins for technical assistance and support for Control of Diarrheal Diseases (CDD) and Kenya Expanded Programme on Immunization (KEPI), have had AID/W centrally-funded program reviews of the worldwide PRITECH and REACH projects in 1982 and 1990 respectively, and Kenya has been included in these.