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REPORT ON THE DEVELOPMENT OF THE NATIONAL IMPLEMENTATION PLAN FOR KENYA'S FAMILY PLANNING PROGRAM: 1995 - 2000

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TABLE OF CONTENTS

I. Introduction 2

II. Objectives of Developing the NIP 3

III. NIP Development Process 3

IV. Lessons Learned 5

V. Next Steps 7

VI. Annexes 9

Annex A: A Vision for the Year 2000

Annex B: Strategic Questions Relevant to Kenya's NIP

Annex C: Members of the NIP Task Force

Annex D: Proposed Timeline for the Completion of the NIP

Annex E: Recommendations from the Task Force: Goals and Strategic Directions

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I. INTRODUCTION

The Kenyan Ministry of Health, in collaboration with the National Council for Population and Development and Kenyan NGOs, has been developing over the past year a 5-year plan for Kenya's national family planning program. Technical assistance for this effort has been provided by Management Sciences for Health through its Family Planning Management Development project, funded by the U.S. Agency for International Development. This report summarizes the process of developing the plan through July 1995. (Four previous FPMD consultant reports on the NIP development process, covering the period August 1994 through January 1995, are also available).

In 1992, during an evaluation of AVSC activities in Kenya, it was suggested that Kenya develop a comprehensive five-year plan for family planning. Already by 1992 Kenya's family planning program had expanded to the point where government, NGOs, the private sector, and major donors were operating in an uncoordinated way, each organization trying to do its best but not linking its activities with those of the other players. It was thought that a single integrated national plan would be able to identify priority areas and ensure that everyone was pulling in the same direction rather than stepping on each other's toes. Also, a Kenyan plan would enable the Kenyan government to approach potential donors in a proactive manner, so that individual components of the NIP could be funded by specific donor organizations.

There was little progress towards creating such a plan until April 1994. At that time a meeting was held, involving a number of the most important organizations involved in family planning in Kenya, to brainstorm regarding what to do. It was decided to organize a national workshop, with all the key "stakeholders" in family planning in Kenya invited, to begin a dialogue aimed at eventually producing a plan that would focus on implementation rather than on policy. Such a national workshop was indeed held in June 1994 in Naivasha. The major outcomes of this workshop included a "vision" of what family planning in Kenya should look like in the year 2000, the critical constraints that would prevent the vision from becoming a reality, and the selection of a small group of experienced family planning leaders to constitute a Task Force to actually draft the Kenyan National Implementation Plan for Family Planning.

The NIP Task Force met for the first time in August 1994 and created four working committees, covering the four key areas: FP Expansion, FP Quality, FP Financing, and IEC. By December 1994, the four committees, working in a very participatory manner, had completed their recommendations regarding what strategic directions the Kenyan FP program should take during the next five years. When compiled into a single document in January 1995, the Kenyan government had a clearly articulated strategic plan which represented the inputs and contributions of a wide variety of senior Kenyan family planners from government, the NGOs, and the private sector.

Beginning in February 1995, the NIP Task Force and its working committees met frequently to complete the second phase of the plan, namely the specific implementation steps needed to ensure achievement of the major goals and objectives of the strategic component of the NIP.

The specific implementing steps included the actual activities that needed to be accomplished, the date by which each activity should be completed, and who the responsible individual or organization would be to make sure that the activity was performed well and on time.

In order to obtain input into the NIP from district level government officials concerned with family planning as well as from district-level NGOs and private sector representatives, a district workshop was held in April 1995 with participants from seven districts from all regions of Kenya. A draft NIP document was completed by the Task Force by June 1995. It was then reviewed by a number of individuals in Nairobi. By July 1995 a "final product," representing the views of a wide variety of Kenyans, was being reviewed by Kenyan government officials for their final approval.

II. OBJECTIVES OF DEVELOPING THE NIP

Over the last ten years, the Family Planning Program in Kenya has made tremendous strides in improving service delivery and raising the contraceptive prevalence rate. It was therefore thought that developing the NIP would help the government to:

- Improve program coordination by harnessing inputs from the government and from the private sector;
- To identify priority areas where the government wants to focus its attention and which are critical to the success of the program;
- To assess the resources required to improve the program over the next five years;
- To provide a tool for strengthening the institutional capacity of the government in planning and strengthening capacity at the district level; and
- For the government to use NIP as tool for negotiating with health and population donors.

III. NIP DEVELOPMENT PROCESS

The process of developing the NIP began with identifying the lead government agency which would act as the anchor for the plan. A meeting between the Division of Family Health and NCPD agreed that since the DFH had the responsibility to coordinate family planning service delivery in the country, it was best placed to take the lead role in developing the NIP. NCPD was to play a supportive role and to strengthen government's commitment to the process. The next step in the process was to identify the key stakeholders who would be involved in the process. The key NGOs, a few CAs providing assistance in service delivery and a few donor representatives were felt to be a good team to start with and a meeting to map out a

strategy for developing the NIP was held in April 1994. Other key players would be brought on board as the process progressed.

The diversity and multiplicity of players in the Kenya Family Planning Program meant that a consensus had to be sought where all these agencies would feel part of and make contributions to the process. A meeting was called in June 1994 of the key players including the government, NGOs, CAs and a few donors to develop a vision for the family planning program which they hoped to achieve by the year 2000. The workshop also identified the major areas where the program needed to be strengthened in order to meet the unmet need in family planning. A Task Force was also set up to guide the process on behalf of the service providers.

The Task Force designed the process to take place in two phases:

Phase I - the development of Strategic Directions
Phase II - the development of Implementation Steps

In order to achieve its goal, the Task Force saw the vision as focusing on the following four main areas:

Service Expansion
Quality of Care
IEC
Resource Requirements

It set up four Working Committees to review the current situation of family planning with regard to these areas and make recommendations on the strategic direction that the program should take. The Committees worked from October through to December, collecting data through hired researchers and submitted their recommendations to the Task Force in December 1994. These recommendations were presented for approval to senior officials of the DFH and the NCPD. The draft report for Phase I was informally presented to the donors (USAID) in January 1995 while the Drafting Committee set up by the Task Force continued to work on the Implementation Steps which were finalized in April 1995.

The process of developing the NIP had revealed that the FP Program in Kenya is weak at the district level. This is a critical link in the program as the majority of the Kenyans live in rural areas plus the fact that the district teams have the heaviest responsibility for program success. A workshop was therefore held for district teams in April 1995 in order to involve them in the process and to get their contribution on how they think the program can be improved. Their recommendations were incorporated into the report and provide useful insights into the issues that need to be resolved to improve the program at the district level.

The final major activity of FPMD has been to monitor the process of approval by higher authorities in the government and to assist with the printing of the document.

IV. LESSONS LEARNED:

FPMD/Kenya's experience over the past year in developing a national 5-year plan for family planning in Kenya has resulted in a number of "lessons learned" that might be relevant to other developing countries attempting to do something similar. What follows is a listing of some of these "lessons learned."

(1) There should be a lead agency to facilitate the process and another agency to ensure that the process moves well and has official approval at every stage. The first thing that was done was to identify which government agency would have this responsibility. The DFH provided the "home" for the plan and will be responsible for ensuring its implementation with the other service providers. The role of FPMD as facilitator and catalyst helped to bring together the wealth of experience and diversity from the government, the NGOs and the CAs.

(2) The important part about the planning process is making it participatory--getting the active involvement of as many organizations and individuals as possible. If the only thing that counted were the plan document itself, then all one would need to do would be to hire some consultants, lock them in a room for a week, and collect the "plan" when they were finished. But what counts much more than a mere finished product is the process that was required to produce the document and the active participation of a wide variety of people. Without a truly participatory approach there is no "ownership," and without ownership there is little likelihood that the plan will actually be implemented. It is important therefore to get the participation and involvement of all the key stakeholders both for the ownership of the plan and for commitment in its implementation. Those who will be involved in its implementation need to be involved in the development of the plan.

(3) Another important lesson learned in Kenya was the necessity of taking enough time to do it "right." A rush job is likely to leave everyone participating in the planning process feeling unsatisfied and frustrated. People will feel that their input had not been properly taken into account and that the "product" was of poor quality.

(4) The plan should be based (anchored) in the reality of the current situation so that it is realistic and addresses the concerns of the service providers. The Task Force hired researchers who spoke with service providers and got them to identify those areas of the program that need to be addressed over the next five years. The district teams were also consulted and made their input rather than being presented with a finished plan for implementation. Besides the inputs that were gotten from them, they felt that the important work they are doing in the districts is being acknowledged by the government.

(5) It is important that the plan is aligned to related government policy documents so that it becomes complementary rather than in competition. Deliberate efforts were made to

align the NIP to the *Kenya Health Policy Framework* so it does not appear as if the government is implementing two different policies. It has also been made flexible to accommodate any future demographic and policy changes.

(6) The NIP process in Kenya has demonstrated unequivocally that the Kenyan government was able to work effectively with the private sector (including NGOs) in developing a consensus 5-year plan for family planning. There had been some skepticism expressed by those who felt that the government would not be willing to treat NGOs as equal partners in developing a national plan. But the government (especially the Division of Family Health of the Ministry of Health and the National Council for Population and Development) turned out to be willing to go more than half-way in meeting the needs and concerns of key private sector groups.

(7) Of fundamental importance to producing a useful document that all the key actors could accept was the involvement of local (district-level and below) health and population workers, both from government and the private sector. Without the active participation of "front-line" workers, the plan would have been a theoretical document, without validation from those who know best what is needed to be done to improve the delivery of family planning services.

FPMD/Kenya has also learned a few other ways that the process could have been improved:

(8) Although the NIP was written specifically for family planning, on reflection, it should have been made to fit within the broader context of reproductive health. This is because the AIDS crisis and shrinking donor resources have made it impossible to run two parallel systems. The major concern now for service providers is how they can integrate STD/HIV/AIDS into the current family planning and health delivery system.

(9) There should be donor willingness and commitment to fund the NIP in whole or in part such as:

- strengthening district level management;
- taking inventory of the status and capacity of the existing facilities; and/or
- strengthening the SDPs.

This would generate more interest in the NIP from other donors and increase the possibility of attracting more funding for the family planning program.

(10) Related to (9) above, there should be donor encouragement for the government to adopt the NIP as a policy. It will ensure that the plan plays its intended role in improving the family planning program. Without any funding attached to the plan, it may not have much chance of influencing government policy.

V. NEXT STEPS

The development of the NIP document represents the beginning rather than the end of the process. What really counts, of course, is the implementation of the plan rather than the writing of it. Since the NIP says relatively little about where the funds will come from to pay for the ambitious activities envisaged in the plan, it is very important for the MoH, as the lead agency in developing the NIP, to actively seek government and donor funds to implement critical elements of the plan. Since the NIP is organized in such a way that discrete sections of it could be funded by individual donors, the MOH can use the NIP when discussing with prospective donors what the Kenyan government's priorities are in the area of family planning. A "concept paper" has been written which proposes funding for an essential aspect of the NIP, namely the strengthening of district-level management and coordination of family planning, especially in the larger districts of Kenya. Now that the NIP exists, possible "next steps" include the following:

(1) The existing "concept paper" should be shown to potential donors, so that at least partial funding of the NIP can begin as soon as possible. A major selling point could be that a great deal has already been accomplished in that a district-level workshop has already been held, candidate districts have already been identified, and the specific implementing steps required at the district-level necessary for expanding services and improving their quality have already been listed in the NIP. A prospective donor could leverage a relatively small grant into something which could achieve a very significant impact on Kenya's contraceptive prevalence rate.

(2) Another important step that needs to be taken by the MOH and the NCPD would be to convince those government officials responsible for allocating budget priorities that more funds need to be made available for family planning in Kenya overt the next five years. Kenya has already committed to doing exactly that when the Kenyan delegation at the International Conference on Population and Development in Cairo signed the final Conference document in September 1994. Also, the major population and family planning donors have made it very clear that the current levels of development assistance cannot be maintained for very much longer. In any case population and family planning activities are far too important for Kenya's future to be left wholly to bilateral or multilateral funding sources.

(3) Even if no donor or additional government funding can be found to fund the "concept paper," and assuming that charging user fees for family planning clients in government clinics is still several years away, there is still much that the MOH and the NCPD can still do. For example, the Division of Family Health of the MOH could meet with provincial and district staff and discuss what steps could be taken (not requiring additional funds) which might improve the coordination of government and NGO/private providers in the delivery of family planning services. During the District-level workshop which took place in Baringo in April 1995, the workshop participants identified a number of interventions that could be made which would have

a significant impact on the contraceptive prevalence rate in specific districts yet would not require adding anything to existing budgets.

(4) Since NIP was specifically developed for family planning only, there is a need to reconcile and integrate it with the current thinking on a reproductive health strategy.

(5) As a first step towards consolidating program achievements over the last ten years, it is important at this stage to critically review the existing capacity at the Division of Family Health as it has a major responsibility for ensuring successful implementation of the NIP. The responsibility and the workload that it has to carry over the next five years makes it imperative that it is in a position to rise to the occasion.

VI. ANNEXES

ANNEX A: A Vision for the Year 2000

1. Expansion of FP Services

a. national strategy needed to focus the underserved communities
b. increase SDPs from 1800 to 2400 by the year 2000
c. establish an effective social marketing program (SMP)

2. Improved Quality of Service

a. availability of quality services from national down to all sub-locational level
b. established quality training
c. all SDPs equipped and provided with expendable supplies
d. high quality FP services
e. national indicators of quality assurance "standards" in place and being used
f. all FP providers to have skills, equipment materials, as well as supervision and management support to give quality services
g. staff at all SDPs get client inputs in defining quality services
h. integration STD, HIV/AIDS and FP

3. Improved Program Management

a. FP program coordinated by N.I.P.
b. established institutional capacity for FP services delivery
c. implemented and functioning national MIS
d. district management teams effectively managing and coordinating the F.P. program at district level

4. Develop Materials that equally target Men and Women

a. FP program that equality targets men and women for IEC and services
b. moving from less than 5% of men using FP methods to 50% (using/supporting)
c. availability of fp methods for men
d. develop a national strategy to focus on the involvement and participation of men

5. Mobilize Local Resources

a. establish and expand local resource base
b. explore ways of local financing
c. local generation of resources for fp program
d. 10% of FP funding should come from local sources
e. established Research & Development Division on contraceptives within the MOH

6. Address Youth Family Planning and Health Needs

a. establish a youth FP policy and program
b. set up a comprehensive youth reproduction health program
c. sex education to be incorporated in the school curriculum

7. Develop Effective IEC

a. all potential clients to know the correct facts and benefits of FP methods and where to get services
b. clients are able to make informed choices
c. effective IEC materials in all clinics and CBD programs

8. Formulate Measures of Program Impact

a. increase CPR from 33% to 43%
b. reduced TFR from 5.4 to 4.0
c. all eligible persons will be using modern FP methods
d. by the year 2000 the growth rate will be 2.5

9. Policy Review and Formulation

a. revised national population policy guidelines being implemented
b. policy guidelines for the remuneration of CBD workers
c. integrated population policy

10. Increase Capacity Building

a. 2000 additional service providers trained
b. district training teams operational
c. skilled FP managers and service providers

ANNEX B:STRATEGIC QUESTIONS RELEVANT TO KENYA'S NATIONAL IMPLEMENTATION PLAN FOR FAMILY PLANNING (1995 - 2000)

COMMITTEE A : SERVICE EXPANSION

1) Which option should be the higher priority - to increase Service Delivery Points for FP from 1,800 to 2,400 by the year 2000 or to focus on improving access and quality of service in the existing 1,800 SDPS?

Information Needed:

- What is the capacity of the existing SDPS.
- Current status of the 1800 SDPs (location, services/methods actually available)
- Number of clients projected to be served in the next 5 years by the implementing agencies.
- Plans and projections of the implementing agencies to meet unmet need for FP

2) Should a higher priority be given to provide FP to remote and underserved areas even though this means that more densely populated areas will receive fewer inputs on a per capita basis?

Information Needed:

- Population (numbers and locations) currently without access to FP
- Approximate costs (per capita per year) to reach remote communities compared with more densely populated areas
- Where is there demand (comparing sparsely & densely populated areas)

3) Which service delivery approaches & what locations should be emphasized over the next 5 years to improve access to FP services (e.g. should we emphasize mobile or fixed clinic services or CBDs, for example)?

Information Needed:

- Number and locations of active CBDs - effectiveness of CBDs?
  Overlaps? Sustainability? Donor Priorities?
- Fixed and mobile clinics Locations and relative effectiveness)

- CBD inventory: Dr. Achola DFH, Mr. P. Kagwe NCPD

- Innovative approaches (such as a pilot project testing the feasibility of a Bamako Initiative - that is program with a revolving fund which includes FP services).

- Population Council: Study of Activity and Impact of CBDs (concept paper only)

4) Should there be an expanded role for CBDs and, if so, what should their role be?

Information Needed:

- Current role(s) of CBDs in both government and NGO sectors.

- Possible expanded roles for CBDs in different settings

5) What changes in the existing method mix are proposed for the year 2000? Are any contraceptives or methods to be added or deleted/or emphasized? Any changes in 'Policy Guidelines and Standards for Service Providers'?

Information Needed:

- Experience with current method mix - what is included & what isn't

- New methods that could be added to mix over next 5 years or information suggesting any methods or contraceptives be deleted.

- Review of current service delivery policy guidelines.

- What are major medical barriers and how can they be removed?

6) Should there be any major changes in the way contraceptive logistics are currently being managed in government, NGO, & private sectors? If yes, what should these major changes consist of?

Information Needed:

- Current situation regarding contraceptive logistics

- Major problems & proposed solutions (what works and what doesn't work & why)

7) What additional FP supplies and equipment will be needed by SDPs by the year 2000 & how (and by whom) will these be procured, distributed, and maintained?

Information Needed:

- Current inventory of FP supplies and equipment
- Existing shortages and gaps
- Maintenance now and future projections
- Sources of funding (now and in future) for procurement (Use FAMPLAN Projections from NCPD)

MALE INVOLVEMENT

8) What approaches are likely to be most effective in getting men more involved in FP through supporting female partners and direct use of the services themselves (e.g male only clinics, IEC targeted to men, etc.)

Information Needed:

- Status of current efforts to involve men in FP
- How effective are those approaches?

YOUTH

9) What should be the roles of NCPD, the MoE, MoH, & NGOs concerning the incorporation of Family Life Education and Population Education into the school curriculum? What should be the role of NGOs/churches regarding out-of-school programs?

Information Needed:

- Current roles of the 4 (NCPD, MOE, MOH and NGOS) regarding FLE Population Education
- Current role of NGOs/churches regarding out-of-school programs.

10) Should the GOK develop a comprehensive Youth Reproductive Health Program? Who should manage it? What would it do?

Information Needed:

- Information from the Kenya Youth Initiative Project - 22 youth serving organizations
- Views of MOH, NCPD, NGOS, and Churches regarding this question

- Plan of action for the Cairo Conference (International Conference on Population & Development)

11) Should unmarried youth be able to receive FP services at government health facilities? (age of consent 18 years old)

Information Needed:

- Legal options on who is considered as youth and who is not.

- DHS results on public opinion regarding this question; also views of political leaders and government officials

INTEGRATION WITH STD/HIV/AIDS

13) Should there be full integration of FP and STD/HIV/AIDS at all SDPs, despite the fact that STD diagnosis and treatment together with AIDS IEC will add significantly to overall costs (including additional requirements, supervision, supplies and equipment, and longer client waiting times)? How can such integration be phased in?

Information Needed:

- Current status of FP integration with STD/HIV/AIDS

- Estimated additional costs and supervision requirements

- Other options (e.g phasing-in full integration, either in terms of number of SDPs or what activities will be included in integrated SDPS)
  (Feedback from meetings on this subject attended by AID and CAs).

COMMITTEE B: (QUALITY OF CARE)

1) Should the MOH/DFH develop national indicators of quality assurance for FP and ensure that "standards" based on these indicators are in place & used by all implementing agencies? This would require a major commitment to both monitoring and feed back to FP providers and managers. It would also require decentralized monitoring at the district level.

Information Needed:

- Existing capacity of MOH/DFH to provide monitoring and feed back for quality assurance indicators.
- Existing quality indicators for FP
- What systems need to be put in place for this to work.
- Agreed upon definition of "quality" FP services (e.g. Bruce's system).

2) How should client perspectives be included in defining quality of FP services?

Information Needed:

- Existing information on client perspectives.

3) Should the MOH invest significant resources in strengthening the system for ensuring quality of contraceptives from point of purchase to point of service delivery?

Information Needed:

- Current status of quality control for contraceptives.
- NGO policies maintaining quality control.

4) Should the MOH/DFH and NGOs continue to implement a Total Management (TQM) approach for the entire FP service delivery system?

Information Needed:

- Current status of TQM efforts in the MOH and NGOs.
- If TQM were to be implemented throughout the FP program what additional inputs would be required?

TRAINING

5) Should the MOH/DFH and NGOs make a major commitment to ensure that service providers have the necessary skills to do their jobs effectively? Should the government require that those it trains commit to a minimum period (say 2 years) of working in the same location/facility?

Information Needed:

- Current training curriculum used to train service providers
- What does the MOH/DFH do now to assess on-the-job competency?
- What are current requirements for staying on-the-job after training.

6) How many additional service providers need to be trained in family planning by the year 2000 for both the public and private sectors?.

Information Needed:

- Current number of trained providers, attrition rate, deployment rate.
- Current numbers being trained in FP (government & NGOs) for recent years and future projections.

7) Should the districts establish a pool of experienced trainers (made up of government & NGO trainers) thereby reallocating more resources devoted to training at the district and site levels?.

Information Needed:

- Current status of training facilities at district level. Who is doing training? Is training standardized.

8) Should these be a comprehensive system of refresher training for government & NGO sector FP providers by the year 2000 (to ensure up-to-date knowledge & skills) Once again, this would require sustained resources for its accomplishment.

Information Needed:

- Current status of refresher training in MOH & NGO sectors
- Resource requirements for a comprehensive, nationwide system of refresher training.
- Capability of MOH & NGO sectors to implement and manage such a system.

SUPERVISION

9) Should the MOH/DFH and NGOs establish a supervision system at the site level over the next 5 years to improve the quality & increase the frequency of field supervision of family planning services? "Quality improvement" requires training so that supervisors are supportive rather than fault-finders. Is there a need for an overall supervision strategy?.

Information Needed:

- Current status of supervision (quality & frequency).
- What sort of feed back system is required?
- Approximate level of resources required for such a system? Is it feasible?

IMPROVED PROGRAM MANAGEMENT:

A. NATIONAL LEVEL MANAGEMENT:

10) Should the DFH establish a national FP MIS to assist in monitoring & coordinating FP service delivery? Who would manage this process?.

Information Needed:

- What is current status of MIS within DFH, NCPD, & major NGOs?
- What other databases managed by NGOs are **not** linked to NCPD?
- What is known of service delivery on a national level?
- What other data bases are also available.

B. DISTRICT LEVEL MANAGEMENT:

11) Should sufficient resources be made available to make district health management teams and district health management boards operational & effective in coordinating & managing FP activities in all districts? Some districts?. How can inputs be phased in so that gradually all districts are covered?

Information Needed:

- Current status of district health management teams and district health management boards regarding FP activities.

- Role of District Population and FP Committees, District Development Committee -- How are they operating and how they are strengthened

- Reporting, Supervision, the role of the DPOs

COMMITTEE C: RESOURCE REQUIREMENTS

Proposed definition of "Sustainability" is as follows:
A goal of the GOK is to providing quality FP services to meet client needs on a continuing basis. This goal can be achieved through (1) adequate financing to support chosen services; (2) appropriate Government policies, laws and regulations to support FP service provision; (3) appropriately trained manpower to deliver services; (4) well trained management to oversee delivery; (5) adequate infrastructure to deliver services; (6) consumer demand and willingness to assume some responsibility for obtaining services; (7) All service providers working together in a coordinated manner.

1) What level of resources are currently committed now and what level of resources will be required by the year 2000 to provide FP services through government, NGO & private sectors? (Based on FAMPLAN projections). How much of this will be provided by government, donors, user fees, etc?

Information Needed:

- Cost projections for numbers of clients and method mix predicted by FAMPLAN
- Different options for "shifting" of sector utilization (e.g. what if government's share of providing FP services drops from 68% to 50% [or 40%] by the year 2000)
- Estimates of user fee totals by the year 2000
- Government budget for PHC (proportion for FP services)

2) What will be the magnitude of donor & GOK funding available (1995 - 2000) and what will be their priority areas to focus their support?

Information Needed:

- Current plans of donors for FP funding (1995-2000). Donors include: UNFPA, World Bank, AID, ODA, GTZ, SIDA, JICA, DANIDA (through World Bank) and CIDA.
- Geographical priorities
- Functional categories (e.g. CBDs, Commodity Support, Training, etc.)
- Treasury's priority for FP
- Sustainability study by NCPD
- Study by social Marketing Project

3) What is the resource gap between the expected resources required for FP in the year 2000 and those resources which are expected to be available?

Information Needed:

- The difference between resources required for the year 2000 and resources actually available in the year 2000.

4) What are the alternative revenue sources to meet this resource gap?

Information Needed:

- Potential new donors
- Funds from user fees
- Increase in local resources for FP

5) What proportion of funding for family planning should come from "local resources" (i.e. from government & non-governmental sources within Kenya? Note: Naivasha workshop recommended 30%)

Information Needed:

- Proportion of FP funding currently coming from "local resources"
- Estimates of potential local funding for 1995 - 2000

6) What can the MOH, NCPD and NGOs do to stimulate increased generation of local resources for family planning?

Information Needed:

- What can the private sector (including NGOs) provide over the next 5 years?
- Any evidence of private sector willingness to be involved in FP activities?
- Information on the private sector's willingness to pay for FP services/contraceptives
- Thoughts on the year 2000 regarding funding increases from FPAK, FPPS, Marie Stopes, KMA, etc.

7) Should community participation/involvement in the FP program be a high-priority by the year 2000? If so, what level of resources should be spent to mobilize community support?

Information Needed:

- Current community involvement/participation in FP activities (including FINNIDA's and Maendeleo's experience)
- What kinds of community involvement are possible or desirable?

8) What is the impact if the GOK starts charging for FP services for those who can afford them? If so, who would pay, how much, for what services?

Information Needed:

- Current status and past experience with experimental charging of user fees for FP
- Experience with user fees in other (non-FP) Kenyan health programs

9) What resources will be required to enable districts to have sustainable FP programs? Will financial sustainability be possible at the district level by the year 2000?

Information Needed:

- Current status of the financing of FP service delivery in selected districts
- Information on the community's likely willingness to pay for FP services/contraceptives.
- What additional resources are needed to increase management capacity.

POLICY

10) What policies, guidelines, laws, and regulations would be required to support FP service delivery with relation to financial sustainability by the year 2000?

Information Needed:

- Current policies, laws, guidelines and regulations
- Examples of policy changes (e.g. free air time on KBC for FP advocacy or allowing hospital insurance to reimburse for FP services)

COMMITTEE D: EFFECTIVE IEC

1) What should be the major focus of an overall IEC strategy for FP by the year 2000? Who should be responsible for coordinating this strategy? What should be the role of NGOs, MOH/DFH & the NCPD?

Information Needed:

- Is there a long-term IEC plan for FP that currently exists or is being developed?
- What are the major options for a 5 year IEC strategy?
- What kinds of resources will be required to implement such a strategy/plan?

2) Should there be a major government - coordinated IEC campaign through a multi-media approach to change peoples' behavior toward family planning by the year 2000. If yes, what media, what messages, what target audiences?

Information Needed:

- Proportion of the population that can be reached by different kinds of media
- Current status of media - based IEC campaigns for FP
- Evidence of media impact on FP knowledge and behavior

3) Should all FP IEC messages be standardized at the national level and should materials be packaged in different ways for specific target audiences by various organizations (both NGOs and GOK)?

Information Needed:

- Current FP messages and materials being developed by government and NGOs. Who is providing what sort of messages/materials?
- What are the distribution systems for FP materials & how are agencies monitoring their use.
- What support is being given to FP service providers in the use of IEC messages/materials?

4) Should the resources invested in increasing male involvement in FP be equal to resources used to involve women, or should women continue to be the primary target for IEC?

(Note: Resources for IEC provided to women should not be reduced).

Information Needed:

- What resources are currently being expanded used to involve men (compared with women)
- Who is currently providing services to men?
- Level of support/practice of FP by men

5) Should all men be equally targeted with FP IEC or should more emphasis be put on reaching male policy-makers?

Information Needed:

- Current or proposed FP IEC targeted at male policy makers.

6) Should the youth be a separate target group for FP IEC?

Information Needed:

- Current Kenyan government policy on youth
- What is being done now to reach youth with FP messages from government or NGOs.

7) What role can IEC play in facilitating responsible sexual behavior among the youth?

Information Needed:

- What IEC is currently being directed to youth.
- What are the major areas of concern.
- What is government policy on dealing with youth sexuality.
- Existing programs for youth and the strategy adopted to teach youth.
- What does population education for youth address.

8) What are the emerging issues in population education that IEC programs ought to address?

Information Needed:

- What emerging concerns are being currently dealt with in IEC projects (Examples: Environment, FLE, Human Sexuality, AIDS, Education, Gender Issues, Responsible Parenthood, Old Age, etc.)

9) Should service providers play a significant role in the development of IEC materials for themselves and their clients? If so, what should be their involvement?

Information Needed:

- Current role of service providers in developing IEC materials.
- Options for involving service providers in IEC materials development.

10) How can service providers be trained to make more effective use of IEC materials when meeting FP clients?

Information Needed:

- What are the skills required to prepare FP service providers so that they make effective use of IEC materials?
- What are existing training materials for FP providers.
- Need to review current curriculum for training FP providers in IEC.
- Current training of FP service providers regarding IEC.
- Usage of IEC materials at point-of-service.
- Options for increasing the use of IEC materials at SDPs.

ANNEX C: MEMBERS OF THE NIP TASK FORCE:

Division of Family Health
Dr. David Mulinge, Director, DFH
Dr Ominde Achola, FP Program Manager
Mr Anthony Ophwette
Mrs Lydia Chege
Mrs Dorsilla Sande

National Council for Population and Development (NCPD)
Amb. S.A. Bullut, Director, NCPD
Mr Peter Thumbi, Senior Deputy Director
Mr. K. K. Waithiru, Planner

Family Planning Association of Kenya (FPAK)
Mr. Godwin Mzenge, Executive Director

Maendeleo Ya Wanawake Organization (MYWO)
Mrs. Jane Adar, Program Manager

Christian Health Association of Kenya (CHAK)
Dr. N. Olembo, Executive Director

A.V.S.C.
Mr. Joseph Dwyer, Regional Director

Pathfinder International
Mr. Nelson Keyonzo, Associate Regional Representative

Family Planning Private Sector
Mr. Daudi Nturibi, Deputy Director
Ms. Nester Theuri, Clinical Management Specialist

FPMD/Kenya was the Secretariat for the NIP and the Task Force

Note: Other members of staff of these organizations participated in the various committees of the Task Force.

ANNEX D: PROPOSED TIMELINE FOR THE COMPLETION OF THE NIP

ACTIVITY	DATE TO BE COMPLETED
STRATEGY	
1. First meeting of NIP Task Force Working Committees	October 27, 28 and November 3, 4, '94
2. Initial collecting of relevant information for Working Committees	1st week December '94 and ongoing
3. Second meeting of Working Committees - recommendations for NIP Task Force	1st week December '94
4. 2nd NIP Task Force meeting to decide on Strategic Directions for 1995 - 2000	2nd week December '94
5. Finalize NIP Strategy Document Draft	3rd week January '95
6. NIP Strategy Document presented to Task Force for review and approval	4th week January '95
7. Presentation of NIP Strategy Document to Donors	1st week Feb. '95
IMPLEMENTATION	
1. NIP Task Force meets to discuss Implementation Steps for (1995 - 2000)	1st week March '95
2. Working Committee develops specific Implementation Steps	2nd week April '95
3. District Level Planning Workshop	2nd week April '95
4. Task Force reviews Working Committee' recommendations	3rd week April '95
5. Draft Implementation Steps 1995 - 2000	2nd week May '95
6. 3rd NIP National Workshop to finalize Implementation Steps (1995 - 2000)	3rd week May '95

ANNEX E: RECOMMENDATIONS FROM THE TASK FORCE: GOALS AND STRATEGIC DIRECTIONS

INTRODUCTION:

Beginning in 1993, the Ministry of Health/Division of Family Health together with the National Council for Population and Development and Kenyan NGOs, have been actively engaged in developing a 5 - year National Implementation Plan (NIP) for the Kenyan Family Planning Program. The process to develop the plan has been very participatory; all major "stakeholders" in Family Planning in Kenya have been asked for their views & suggestions.

There are two major objectives in developing the NIP:

(1) To provide a means whereby the MOH/DFH can manage the implementation of family planning services over the next five years in a coordinated manner, including the programs of the Kenyan government, NGOs, and the private sector.

(2) To enable the Kenyan government to approach potential family planning donors with a plan that has clearly defined components and specific priorities, so that donors can be asked to fund particular portions of the family planning program

An effective, practical, flexible plan should help prevent overlap and duplication in FP service delivery through balanced coverage in the different provinces and districts of the country. It also should provide a clear focus for all organizations working in family planning, so that both the direction of the program and its basic philosophy & policies are understood by all.

As part of the process to develop this Family Planning National Implementation Plan for Kenya, a national workshop was held in Naivasha in June 1994. Workshop participants articulated their "vision" of where the Kenyan FP program should be by the year 2000. In addition, they recommended that an NIP Task Force be established to identify the gap and oversee the development and drafting of the plan document.

The NIP Task Force, led by the MOH/DFH and actively assisted by the NCPD, also included representatives of NGOs and international cooperating agencies. In August 1994 the Task Force established four "Working Committees", each tasked with identifying key strategic directions for the year 2000 for a major component of the FP program. The four committees covered the following areas:

(1) Expansion of FP Services by the Year 2000

(2) Improving the Quality of FP Services

(3) Resource & Sustainability Requirements for FP by the year 2000

(4) Information, Education, & Communication for FP

On December 9, 1994 the four NIP Working Committees submitted their reports to the NIP Task Force. These reports identify the essential elements of a strategy which should be implemented by the year 2000. The reports also make a series of recommendations relevant to the implementation of the proposed strategy.

The four reports, taken together, constitute the basis for a strategic plan for family planning for Kenya covering the period 1995 - 2000. The actual draft strategic plan will be completed by the end of January 1995. The second part of the NIP, the detailed implementing steps required to translate the strategic plan into real programs, will be complete by June 1995.

This document, therefore, contains the reports of the four NIP Task Force Working Committees. These reports were approved by the NIP Task Force. They provide a clear picture of the proposed strategic direction of family planning in Kenya during the next five years.

Besides the NIP Task Force Working Committee reports, this document also contains the goals of the Kenya Family Planning Program and the specific objectives of the program. These can be seen the following page. If the plan is implemented effectively, these demographic objectives should be achieved and the overall goal as well. Whether the plan succeeds or not will greatly affect the future of Kenya.

OVERALL GOALS

GOAL # 1: To provide quality family planning services to all Kenyans desiring them, in order to meet the unmet need in family planning by the year 2000.

GOAL # 2: Increase local contribution to the family planning program (government budgetary and other local sources) from the current level of 8% in 1993 to 15% by the year 2000.

OBJECTIVES

1 Increase CPR for all methods from 26% in 1993 to 43% among all women 15 - 49, by the year 2000

2 Increase CPR for modern methods from 21% in 1993 to 38% among all women 15 - 49, by the year 2000

3 Reduce TFR from 5.4 in 1993 to 4.0 by the year 2000

4 Reduce the population growth rate from 3.0% in 1993 to 2.5% by the year 2000

KEY STRATEGIC ISSUES FOR NIP:

1. Strengthen the **institutional capacity** of both the public and the private sectors

2 The Focus for **increasing access** to family planning services over the next five years: The focus will be on improving the existing facilities.

The three options that will need to be considered in increasing access:
Option 1: Improve existing facilities
Option 2: Bring in 500 dispensaries
Option 3: Build new facilities

The recommendation by the Task Force is that the focus for the next five years: Options 1 & 2 and also ensure that there is in place a good supervisory system.

Any expansion should be backed up by a strong supervision system to ensure delivery of quality service.
It is also important to have a geographical mapping of the existing demand and the location of facilities in the first year of the plan.

3. **Policy on Youth**

The Task Force recommendation is that the government should address the issue of reproductive health needs of the young people. There are many studies which shows that the youth in general lack good quality information and often rely on the media for information on sexuality. These studies also show that there is a sizeable percentage of young people who are sexuality active (the study by AMREF indicated that 10,000 teenage girls drop out of school each year due to pregnancy.) The research by the Center for the Study of Adolescence for the Kenya Youth Initiative Project shows that the youth are disadvantaged both legally and socially.
The Task Force recommended that a small group be set up by NCPD to deliberate on the problems facing the youth and make recommendations to the government. This committee will also make recommendations on how advocacy work can be done to encourage the government and the policy makers to consider the plight of the sexually active youth with a view to protecting the youth from STD/HIV/AIDS. Parents will be empowered to take an active role in educating the youth.

4. **Level of dependency:**
The Task Force has recommended that the strategy for the next five years should be to increase government contribution to the family planning program from the current level of 8% to 15% and translate this to numbers of locally generated support. Also those people who are willing to pay for quality service should be encouraged to do so.

5. Institutionalization of the planning process within MOH and NCPD to have a continuous process of planning and review.

6. While the **CBD program** has made a significant contribution to the family planning program, there are there are basic flaws in-built into the program and which are likely to impact on its future role. Issues of honorarium, the workload and the future role of the CBD should be resolved before the program can be expanded.

7. **Integration with HIV/STDs/AIDS**
While integration is the current buzz word, it is important to consider that addressing AIDS through IEC is only a small part of the problem.
The focus should be on high risk groups such as truck drivers and prostitutes.
Community care to the AIDS patients at their homes should be the emphasis in view of the high cost of keeping AIDS patients in the hospitals.

SUMMARY OF RECOMMENDATIONS TO THE TASK FORCE by the WORKING COMMITTEE ON EXPANSION OF SERVICES (COMMITTEE "A")

INTRODUCTION:

The 1993 DHS indicated clearly the level of unmet need in family planning. There is a large number of women who indicated that they would like to space or limit their families yet they are not using any form of contraception. Currently, the family planning program is providing services to approximately 1.5 million clients and this number is expected to increase to about 3.2 million by the year 2000. The program focus in the next five years will therefore be on meeting this need as well as meeting the needs of special groups such as youth and men. The government has over 500 facilities which are not currently providing family planning services and most of the existing SDPs do not provide quality service due to lack of essential equipment, trained personnel and sometimes expendables. The Working Committee found that in order to meet the unmet need in family planning, attention will need to be paid to giving adequate information to potential clients and making contraceptives accessible and affordable to encourage continued use.

RECOMMENDED OVERALL STRATEGY ON EXPANSION OF SERVICES:

The overall strategy for increasing access to family planning services over the next five years will focus on meeting the unmet needs in family planing and will have three major initiatives:

a) improving the quality at the existing sites;
b) increasing the number of SDPs;
c) building new facilities;

This strategy will have the following elements:

1. Increasing access to family planning services by improving the existing facilities and increasing the number of SDPs;

2. Increasing the participation of the private sector;

3. Reassessing the current roles and costs of the CBD programs and determining their future roles and sustainability;

4. Integration of family planning services with STD/HIV/AIDS;

5. Providing family planning services to special groups such as youth and men;

6. Improving contraceptive procurement and logistics to ensure adequate supply of all contraceptive methods;

7. Strengthening government commitment and support to family planning;

8. Capacity building for service provider agencies

SUMMARY OF RECOMMENDATIONS:

1. INCREASING ACCESS TO CONTRACEPTIVES:

Currently the government is providing 68% of the family planning services in the country through 953 facilities which includes the hospitals and health centers. At the same time, there are more than 500 dispensaries which do not provide family planning services. The main thrust of government focus for the next five years will be to ensure that these dispensaries have the necessary equipment and are appropriately staffed to deliver the services. However, attention will mainly be directed to those areas where the demand for family planning services is high.

Although the government has no plans at the moment to build new facilities this will be evaluated on the basis of providing services to those areas which are far from the present sites and yet have no other sources of family planning services such as the CBDs. Attention will also be paid to those areas where population growth is high and yet there is low demand for family planning services. Unfortunately, the delivery of family planning services has been adversely affected by lack of expendables and supplies in most of the government facilities and sometimes lack of transport from the district depots to the SDPs.

Recommendations:

1. IEC activities to provide knowledge on all FP methods in order to enable clients make informed choice of the method.

2. The GOK and NGOs should develop criteria for prioritizing expansion of services

3. Training for service providers should include attitudinal issues and how to deal with different groups such as men and youth.

4. CBD programs should be evaluated to determine future roles and sustainability. The government should make alternative arrangements to provide for the services that the CBDs are doing in the event that the CBD programs are discontinued or limited.

5. A funding strategy should be developed to support the improvement and expansion of SDPs of GOK and NGOs.

2. INCREASE THE PARTICIPATION OF THE PRIVATE SECTOR:

The private sector provides about 28% of the fp services either through the hospitals, health centers, mobile or free standing clinics such as those of FPAK. On the whole, NGOs are said to provide better quality of care than what is available from the government facilities. Most clients therefore prefer the private sector facilities even when they have to pay a small fee as they spend less time waiting in the queue. Also because of the increase in the population of those who will be seeking fp services, the government would like to see the NGOs take on more responsibility than they are doing at the moment.

Recommendations:

1. Increase the participation of the private sector in family planning service delivery - local companies, private doctors etc.

2. Expand the capability of NGOs already working in hard to reach areas to include the FP component through provision of funds.

3. REEXAMINING THE ROLE OF THE CBDs

Recent studies show that the CBD workers are the primary source of information for 35% of the family planning users and supply 28% of the current users with fp services. Although the DHS showed the contribution of the CBD to the national CPR to be only 3%, it is no doubt that the CBDs' contribution has been more than this as they do a lot of referrals which are not credited to them. The Committee therefore recommends :

1. The issues on the CBD program which have been unresolved for a long time should be addressed now before the program can be expanded further. These include specific duties and responsibilities, the workload, the referral system, and remuneration.

2. Funding and expansion of CBD program to continue until an alternative service delivery approach is developed and in place.

3. Organizations sponsoring CBD programs need to improve the supervision of the CBD workers.

4. Consideration to be given to alternative methods of sustaining the CBD program such as through developing a scheme for CBDs to charge fees for service.

5. A strong link should be developed between the CBDs and the clinics for effective referrals.

4. INTEGRATION OF FP WITH STDS/HIV/AIDS:

The magnitude of the AIDS pandemic in Kenya has implications for the family planning program not only because of the impact on health care budget but also because it places new demands on health facilities and service providers while they are not properly equipped with the relevant skills to deal with the new demands from their clients. The Committee has recommended that :

1. All organizations delivering integrated services should identify what they can do at each level, taking into account the level of skills and amount of workload of the staff including such things as IEC, infection prevention measures, referrals, testing, counseling, etc.

2. Service providers should be trained to handle the needs of those clients who will be seeking services related to STD/HIV/AIDS. They should be trained to provide counselling as testing and treatment are expensive and will only be available in selected facilities.

3. Phasing in of the integration of FP and STD/HIV/AIDS can depend on available resources and geographical location of SDPs in areas of high HIV prevalence.

4. Emphasis should be directed toward training for support on home-based care.

5. FP SERVICES FOR SPECIAL GROUPS - YOUTH AND MEN

While the existing government policy has not been clear in relation to the reproductive health needs of the young people, studies show that women aged 15 - 19 contribute more than a quarter of total births in the country. At the same time, the current set up of the fp facilities are not suited to provide services to youth and men who feel embarrassed to go to facilities labelled MCH/FP. The training of service providers have not incorporated skills to deal with these clients. The Committee therefore makes the following recommendations:

Recommendations relating to the youth

1. The GOK should review the policy on services to youth and give clear guidelines on issues regarding the youth.

2. There is a need to promote skills that are aimed at dealing with the information as well as reproductive health needs of young people including contraceptives for those who are sexually active.

3. The youth should be involved in planning and implementation of their programs

4. There is need for collaboration between GOK and agencies involved in youth activities.

5. Give clear policy guidelines to organizations involved in youth programs to avoid conflicting voices.

6. Train peers and parents on counselling techniques to assist in giving proper information to the youth.

7. Review of FLE programs to document the contents and identify the gaps in knowledge among the youth.

Recommendations relating to the Men:

1. More CBD workers should be men so that they are able to reach other men.

2. Use IEC to promote male methods such as condoms and vasectomy.

3. Promotion of work site FP programs since the majority of workers in this country are men

4. MOH should consider how to create space for men in the existing facilities which are at present geared towards providing services meant for women and children only.

6. IMPROVEMENT IN CONTRACEPTIVE LOGISTICS AND SUPPLIES:

While the logistics system has improved greatly, there is still a lot of improvement needed to the program especially when clients go the clinics and cannot get the method of their choice either because it is not available or there are no expendables. The Committee recommends that the problem of expendables be resolved to ensure adequate choice of methods.

Recommendations:

1. Expendables must be available on a reliable basis at SDPs, either through an increase in the GOK budget line for expendables or by using part of the cost recovery money for the purchase of expendables for each site.

2. GOK should improve the system of vehicle maintenance in order to make possible the delivery of commodities at the SDPs.

3. Delivery of contraceptives should be pooled with transporting of other related health supplies. The distribution of the IEC materials should be linked to this system.

4. Persons responsible for store keeping should be trained to monitor required supplies in time.

5. Contraceptives should be ordered in appropriate amounts and shipments cleared efficiently to prevent stockouts.

6. Improvements should be made in storage of commodities to avoid wastage through expiring before use.

7. The possibility of setting up a factory for condoms and gloves for the Africa region should be reexamined.

INCREASING GOVERNMENT COMMITMENT AND SUPPORT FOR FAMILY PLANNING

The FP Program in Kenya is heavily dependent on donor funding as they provide 90% program costs and 100% of commodities. In addition to reviewing those policies which are not supportive of family planning, the government will be expected to increase its financial commitment to the program over the next five years. The Committee has recommended that the government can assist through:

1. Removal of medical and policy barriers to family planning services

2. Increasing financial commitment to the family planning program

3. Removal of duties and other charges for commodities and other imported goods for family planning use.

4. Reviewing and amending the acts of parliament that are invoked to prohibit the youth from access to reproductive information and services.

SUMMARY OF RECOMMENDATIONS TO THE TASK FORCE by the WORKING COMMITTEE ON QUALITY OF CARE (COMMITTEE B)

INTRODUCTION

The generally recognized definition of "Quality" family planning services is: "The provision of standard services that are safe, effective, accessible, ready available, acceptable and affordable and which are provided in a socio-physical environment that is conducive to the improvement of quality of life."

RECOMMENDED ESSENTIAL ELEMENTS OF THE STRATEGY FOR QUALITY OF CARE

In order to achieve the overall goals and objectives of the Kenya family planning program for the next five years, the Working Committee on **Quality of Care** recommends that the strategy to achieve quality of care should contain the following elements:

1. National standards of quality for family planning services are established, as well as the means to monitor adherence to these standards.

2. The quality of FP services is assured through self-assessment at the service delivery points (SDPs) and supported by management systems which are supportive of self assessment and continuous improvement efforts

3. Management systems at all levels provide the support (logistics, supply, supervision, accountability) required by SDP staff to provide client focused, quality services.

4. Sufficient numbers of appropriately trained personnel are deployed to meet client demand at SDPs.

5. A national Family Planning Management Information System (FP-MIS) which consolidates the existing service statistics and logistics systems, and promotes monitoring and coordinating of FP service delivery.

6. The physical infrastructure of SDPs guarantees privacy in the delivery of services, convenient access for clients, and efficient client flow.

1. NATIONAL STANDARDS OF QUALITY FOR FAMILY PLANNING SERVICES ARE ESTABLISHED, AS WELL AS THE MEANS TO MONITOR ADHERENCE TO THESE STANDARDS

Kenyan national standards should be based upon the IPPF "Rights of the Client and Needs of the Provider."

MOH and NGOs should get together and define the indicators for adherence to minimum standards and requirements for quality of care.

GOK should make quality assurance a priority.

DFH should monitor to ensure that the national standards of quality of care are followed by all service providers to avoid poor services and possible abuse of professional ethics.

Medical Officers for Health and the District Public Health Nurses monitor quality of care for both GOK and NGO service delivery facilities as well as those facilities belonging to private practitioners.

2. THE QUALITY OF THE FP SERVICES IS ASSURED THROUGH SELF ASSESSMENT AT THE SERVICE DELIVERY POINTS (SDPs) AND SUPPORTED BY MANAGEMENT SYSTEMS WHICH ARE SUPPORTIVE OF SELF ASSESSMENT AND CONTINUOUS IMPROVEMENT EFFORTS

Train all staff at service delivery facilities in self assessment techniques such as COPE; expand capability in these self assessment techniques to the service delivery level;

Within the DFH, institutionalize the COPE working approach at SDP and district level;

Establish adequate monitoring systems and feedback mechanism so as to review progress and quality of services;

The capabilities of static clinics to provide quality services must be assessed and improved as needed to handle anticipated large increases in numbers of clients due to increased demand for FP.

3. MANAGEMENT SYSTEMS AT ALL LEVELS MUST PROVIDE THE SUPPORT (LOGISTICS, SUPPLIES, SUPERVISION, ACCOUNTABILITY) REQUIRED BY SDP STAFF TO PROVIDE CLIENT FOCUSED, QUALITY SERVICES.

Strengthen the institutional capacity of the Division of Family Health and NGOs to effectively manage and coordinate the delivery of family planning services through sufficient and qualified staff, adequate training for supervisory and program staff, functional transportation and logistics systems.

DFH should establish a supervision system at the regional and site levels which will improve the quality and increase the frequency of field supervision. Review SDP-Supervisor ratio

District level management:

- Review the roles of the DHMT to ensure that the responsibilities are manageable and effective in identifying and monitoring district family planning needs and priorities, e.g. project sites, training etc. Additional personnel (assistant DPHN) should be deployed if required to accomplish required tasks.

- New FP activities should be identified in consultation with DHMT to avoid overlaps, duplication and competition among services providers.

- The roles, responsibilities, and relationships between the DDC, DHMB, DHMT, and DPFP Committee should be defined clearly, so that they can work closely together in the identification and implementation of fp activities in the district.

Following systems or procedures should be in place:

- In-service training programs of refresher courses, update sessions; on-the-job training for services providers, supervisors and program managers. These should be held on-site whenever needs are identified and on-site training is appropriate.

- Monitoring systems and feedback mechanisms to review progress of improvements and quality of services.

- Adequate IEC campaigns/materials and education for client.

- Removal of medical barriers and policy and/or legal barriers.

- Operations research and evaluation on: cost effectiveness of service delivery; adherence to quality of care by service providers; youth perspective on reproductive health, etc.

4. SUFFICIENT NUMBERS OF APPROPRIATELY TRAINED PERSONNEL ARE DEPLOYED TO MEET CLIENT DEMAND AT SDPs

To increase effective deployment of staff, MOH/DFH policy should assign staff for a minimum of two years at their SDP in their skill areas upon completion of training.

Review client-provider ratio, especially with regard to the planned integration of HIV/AIDS.

MOH/DFH need to carry out continuous training to cater for turn-over of staff.

MOH should review the workload of DPHN with a view for additional assistance.

Strengthen the collaboration between the DFH and the Division of Nursing so that District Public Health Nurses who do not have adequate skills to do their work effectively at service delivery level may receive further training.

5. A NATIONAL FAMILY PLANNING MANAGEMENT INFORMATION SYSTEM (FP-MIS) WHICH CONSOLIDATES THE EXISTING SERVICE STATISTICS AND LOGISTICS SYSTEMS, AND PROMOTES MONITORING AND COORDINATING OF FP SERVICE DELIVERY.

A national FP MIS to assist in monitoring and co-ordinating FP service delivery.

The standard format for reporting service statistics should also be used by service providers to indicate their need for IEC materials. The forms should be used by NGOs, private sector SDPs and DFH for the national FP MIS

All service providers, whether funded through government or donors should send their service statistics to the national FP MIS

The FP MIS should provide timely feedback or other incentives to ensure submission of service statistics reports.

All service providers should be educated on the need to report whether they get funding through the government or not.

6. THE PHYSICAL INFRASTRUCTURE OF SDPS GUARANTEES PRIVACY IN THE DELIVERY OF SERVICES, CONVENIENT ACCESS FOR CLIENTS, AND EFFICIENT CLIENT FLOW.

To accommodate increased numbers of clients while still adhering to the "Rights of the Client," there is a need to review the facilities of SDPs to ensure adequate space for efficient client flow and privacy for clients.

New clinics should be sited so as to be as convenient for as many clients as possible.

SUMMARY OF RECOMMENDATIONS TO THE NIP TASK FORCE by the WORKING COMMITTEE ON RESOURCE REQUIREMENTS (COMMITTEE "C")

INTRODUCTION

The NIP Task Force Working Committee on Resource Requirements was able to generate a great deal of data on projected costs of family planning services (1995 - 2000). Much of this information came from the TARCOST and FAMPLAN Models as well as data on current expenditures for the family planning program. The Resource Requirements Committee, however, has not been able to cost out the recommendations of the other three committees. This task remains to be done. The tables that accompany this report show that a great deal of additional funds will be required by the year 2000 if the unmet need for family planning is in fact going to be met.

For the purpose of this report to the NIP Task Force, the Resource Requirements Committee has identified four essential elements of a strategy to assure funding for quality fp services. The overall strategy can be stated as follows:

The overall strategy over the next five years will be to ensure sufficient resources for quality family planning services to meet the unmet need for family planning by the year 2000. The Strategy will also include possible approaches to generate more funds for the family planning program locally to reduce the donor dependency and to increase government,s financial commitment to the family planning program. Efforts on local resource generation which have been made on pilot basis will be studied to see the impact and the possibility of having national programs.

The major elements of the strategy should therefore include:

1. Identify the interventions/inputs required for providing quality fp services;

2. Prioritize the activities recommended by all the other committees to accomplish the goal of providing quality family planning services, given the fact that there are never enough resources or time to do all that needs to be done;

3. Project the estimated costs for program activities and commodities over the next five years;

4. Identify sources of funding to cover the cost of providing family planning services during the next five years;

SUMMARY OF RECOMMENDATIONS:

1. **IDENTIFYING THE INTERVENTIONS/INPUTS REQUIRED FOR PROVIDING QUALITY FP SERVICES:**

   - Review the recommendations of the three committees in order to identify interventions and inputs required for providing quality family planning services

2. **PRIORITIZE THE ACTIVITIES RECOMMENDED BY ALL THE OTHER COMMITTEES TO ACCOMPLISH THE GOAL OF PROVIDING QUALITY FP SERVICES, GIVEN THE FACT THAT THERE ARE NEVER ENOUGH RESOURCES OR TIME TO DO ALL THAT NEEDS TO BE DONE:**

   - Determine the different options available and choose those of highest priority to meet the goals of the family planning program

3. **PROJECT ESTIMATED COSTS FOR PROGRAM ACTIVITIES AND COMMODITIES OVER THE NEXT FIVE YEARS:**

   - Identify what it would cost to carry out activities under the proposed strategies in the other three committees.

4. **IDENTIFY SOURCES OF FUNDING TO COVER THE COST OF PROVIDING FP SERVICES DURING THE NEXT FIVE YEARS:**

   - Implement a pilot study to determine the feasibility of user fees for the fp program

   - Maximize the use of available resources by integrating fp with STD/HIV/AIDS

   - Introduce a fee for private practitioners obtaining SDP registration numbers

   - Explore alternative ways of generating funds locally to meet the resource gap

TABLE 1

Current Cost of the Kenyan FPP based on 1993 Expenditures		
	Amount in US $	% Contribution
Donors Contribution	24,050,986.00	91.7%
GOK/IDA Expenditures	1,480,359.00	
GOK recurrent Expenditures	694,114.00	8.3%
Total	26,225,459.00	
Commodity Cost		Percent of TC of FPP
3,570,000.00		13.6%
SOURCE: FAMPLAN TARCOST MODEL		

NIP 1995

TABLE 2

DONOR - Contributions to FP Projects: 1993	
DONORS	AMOUNT IN US $
USAID	13,820,941.00
ODA	3,310,799.00
UNFPA	1,423,641.00
IPPF	1,261,674.00
GTZ	624,835.00
GERMANY	526,409.00
JICA	290,280.00
FINNIDA	69,649.00
TOTAL	21,328,228.00
SOURCE: FAMPLAN TARCOST MODEL	

TABLE 3

	Estimated Resources Requirement (1995 - 2000)			
	by Constant and Moderate Scenarios			
	(FAMPLAN MODEL) Cost per Acceptor = $21.7			
Year	Constant Scenario	Resource Required	Moderate Scenario	Resources Required
1995	1,593,544.00	34,579,904.80	1,741,209.00	37,784,235.30
1996	1,659,823.00	36,018,159.10	1,903,349.00	41,302,673.30
1997	1,727,957.00	37,496,666.90	2,094,898.00	45,459,286.60
1998	1,798,317.00	39,023,478.90	2,291,292.00	49,721,036.40
1999	1,871,047.00	40,601,719.90	2,492,321.00	54,083,365.70
2000	1,945,954.00	42,227,201.80	2,697,288.00	58,531,149.60
Assumptions:				
1. Constant Scenario: The CPR Remains constant at 26%				
2. Moderate Scenario: CPR rises to 50%				
3. The goal for NIP is CPR of 43%				

NIP 1995.

SUMMARY OF RECOMMENDATIONS TO THE TASK FORCE by the WORKING COMMITTEE ON EFFECTIVE IEC (COMMITTEE "D")

INTRODUCTION

Although the most recent KDHS indicates an extremely high level (97%) of awareness of family planning in Kenya, this should not be interpreted to mean that there is no longer any need for an IEC program. On the contrary, generalized and vague IEC messages such as "small family happy family" are no longer valid. The effective IEC strategy for the next five years must make the first step into family planning easy, giving clients information on where to go to get further information and services. The messages should help people change their behavior and dispel rumors and misinformation.

RECOMMENDED OVERALL IEC STRATEGY:

In order to reach the overall goals and objectives of the Kenya family planning program for the next five years, the Working Committee on IEC recommends that the Task Force adopts the IEC strategy containing the following elements:

1. Clearly identified target audiences;

2. IEC programs designed to meet the specific needs of the various target groups;

3. Multi-media approach, using a combination of electronic media, print media, and individual counseling;

4. Involvement of both clients and service providers in developing the materials;

5. Coordination of the IEC strategy on a national level, under the leadership of NCPD;

6. Coordination of IEC campaigns with service delivery providers, both DFH and NGOs, to confirm that SDPs are adequately prepared (staffed and supplied) to accommodate increased demand;

7. IEC should have a multi-sectoral focus, integrating FP with STD/HIV/AIDS and addressing reproductive health and rights; and

8. Every IEC campaign should have an ongoing evaluation mechanism to assess both the IEC process itself and the impact on family planning demand, uptake, and continuity.

1. CLEARLY DEFINED TARGET AUDIENCES:

The Committee recommends that the major focus of IEC over the next five years should be to reach the following eight target groups:

1. **Potential users**: This is the group which indicated during the DHS that they want to space their children or do not want any more children, yet they are not using contraception. This group represents a large part of the unmet demand for family planning.

2. **Current users**: The family planning program has a problem of discontinuation. There is therefore the need for IEC to support the users by reinforcing their knowledge of contraceptives and potential side effects; allaying fears and misconceptions; and addressing clients' changing contraceptive needs.

3. **Factory and plantation workers**: These are the people who are very busy and need to be met at their place of work, an approach currently being used by FPPS, Mkomani, PHS and the Ministry of Labour.

4. **Men**: There is a need to stimulate and expand male support for practice of contraception by women on one hand and accelerating efforts to promote increased male use of contraceptives on the other hand. The emphasis should be on recognizing family planning as a fundamental right for both sexes and contraceptive decision making as a joint responsibility of men and women.

5. **Service providers**: Staff at all levels of SDPs should receive initial and refresher training on the use of the IEC materials, as well as the information needed to speak knowledgeably about all methods and to counter rumors and misinformation, in particular before the start of IEC campaigns.

6. **"Difficult to reach"**: These are people with little or no access to mass media - the urban poor in slum areas and the illiterate who cannot afford a radio or TV, and newspapers. Alternative approaches to reach them might include the use of Village Health Committees, chief's "barazas", or folk media, and individual contacts by CBDs or TBAs.

7. **Policy makers and opinion leaders**: These people influence the opinions of the people and can help eliminate/remove policy barriers (such as access to and payment for media time for education and information purposes). This group includes politicians, opinion leaders, religious leaders, and the media, including journalists, radio and TV executives.

8. **Youth**: This group needs to be empowered with the correct information, counseling, and access to non-judgmental and "user friendly" services.

2. IEC PROGRAMS DESIGNED TO MEET THE SPECIFIC NEEDS OF THE VARIOUS TARGET AUDIENCES

General Recommendations:

1. There should be audience segmentation on the basis of the needs of different target groups.

2. Counselling should be an important part of IEC to enable the client to exercise their right to make informed choices, based on their reproductive needs and intentions.

3. Publicity should be given to the new methods, including vasectomy and Norplant

4. People should be informed about the safety of family planning and given information about all methods, including accurate information on potential side effects.

5. The language and messages used should be appropriate for the target group.

6. IEC should motivate the people to go to the family planning service delivery sites and there should be clear directions on which types of services are available where.

7. IEC should educate people to dispel myths, rumors and misinformation.

8. There should be a variety of themes for IEC messages, agreed to on a national level. While the messages may vary, they should not be contradictory. Themes for different groups should be based upon the reproductive intentions of the target audience.

9. Research should be carried out on different communities to know how they perceive and assess messages before they are used and to ensure that they serve their purpose.

10. Develop IEC materials toward less educated clients, e.g., posters and pamphlets in simple language, as well as radio programs, songs and dramas in vernacular languages.

Recommendations for Targeting Men:

1. An IEC strategy must be designed specifically for men.

2. Messages to men should be both motivational (e.g., support wife's use of methods) and offer information on male methods. (Men's support or opposition to their partners practice of FP has a strong impact on a family's contraceptive practice.)

3. Messages to men must be practical, explaining where to go for what kinds of services, and should encourage communications about family planning between partners.

4. The value of a planned family should be wholly emphasized to all men, and strongly endorsed by policy makers, politicians, and opinion leaders.

5. IEC campaigns for men must be coordinated with the development of convenient SDPs that cater to men's needs and service providers who are appropriately trained

6. The resources needed for men's campaigns should not diminish funding for IEC campaigns for other target groups (women).

7. MOH/DFH and NGOs should look into having more men serve as CBDs and FHEs.

8. In addition to mass media, individuals can be used for motivating men, including Village Health committee members, opinion leaders, and "satisfied customers."

Recommendations for Targeting Youth:

1. In reviewing/revising the Population Policy Guidelines, the Government should accommodate provision of information to the youth and consider services to those who are sexually active.

2. There must be clear, supportive government policy at the highest levels regarding youth.

3. Before undertaking any IEC campaign targeted to the youth, support for youth programs must be created among policy makers and opinion leaders and the media.

4. IEC and services for the youth must be provided in a manner that is non-judgmental, informative and empowering.

5. Research should be done on the best way to reach the youth with acceptable messages, working through peers, music, folk heroes, papers they read, clubs they visits, programs that they listen to and view.

6. IEC materials should contain information on reproductive health - the physiology and anatomy of the reproductive system, conception/contraception - the role of the man and the woman in the reproductive system.

7. Teachers should be provided with current information about sexuality and sexual practices in this country and trained and empowered to handle sex education in school well.

8. Sexually active youth should be given information, counselling, and services through special adolescent clinics or special clinic hours with specially trained service providers.

9. Peer counseling should be examined as an effective way of disseminating factual information the youth.

10. There should be post-partum and post-abortion counseling programs.

11. STDs/HIV/AIDS information must be included in IEC for the youth.

3. MULTI MEDIA APPROACH USING A COMBINATION OF ELECTRONIC MEDIA, PRINT MEDIA, AND INDIVIDUAL COUNSELING:

Recommendations:

1. There should be a multi-media approach to IEC, with emphasis on both mass approaches and interpersonal communications.

2. The use of radio has proved very effective and should be further developed. Since air time for mass media is very expensive, NCPD, the Ministry of Planning, and Ministry of Health should liaise with appropriate ministries to get free air time for family planning messages.

3. The messages must contain specific information as to where people should go to get more information and services.

4. Once support for electronic media has been secured, make use of existent market research to discover when less educated women and men usually listen to the radio and use these times to broadcast radio programs and spots publicizing FP services.

5. The newly created family planning logo (still being finalized) for use by all family planning organizations should be widely publicized and distributed. Companion signs to the logo should be designed to indicate clinics which services are offered and which cater to the needs of specific groups, such as men and the youth.

6. All IEC activities should have a built-in evaluation mechanism which not only evaluates the process of producing and distributing materials, but involves service providers to measure behavior change.

4. INVOLVEMENT OF BOTH CLIENTS AND SERVICE PROVIDERS IN IEC:

Recommendations for Involvement in IEC Materials Development:

1. Service providers should be involved in all phases of IEC: development of the messages; pretesting; distribution and feedback because they are the interface between the clinic and the client.

2. Service providers can identify the attitudes and cultural values of the clients and would-be clients. They should provide guidance on what kind of packages would have an impact (make sense and be appealing) on various communities.

3. Clients in the target audiences should be involved in the development of the contents and design of the messages to insure appropriateness as describe in recommendation #2.

4. To increase the use of IEC materials at SDPs, there should be pamphlet stands which are replenished regularly; materials displayed in a way that clients can see them well and be motivated to pick "please pick one."

Recommendations for IEC as a Part of Service Providers' Training:

1. IEC should be included in all initial and refresher training curricula for all service providers, including both nurses and CBDs. This training should include updates on new methods; communications and counselling, especially in STDs and AIDS; for dealing with specific target groups such as men and youth; use of IEC and A-V materials. The training should be conducted site/on-site whenever possible.

2. Service providers should be given sufficient information to enable them to dispel myths, rumors, and misinformation.

3. Use of IEC materials should be included in the training and update curricula.

4. The use of radio should also be explored as an effective method for updating service providers on new methods, etc.

5. Service providers should have the following skills to be able to make effective use of IEC materials:

   - Good communication skills - interpersonal communication.
   - Appreciate the use of audio - visual materials
   - Familiarity with the new innovative approaches video, folk media
   - Interactive teaching
   - Counselling skills
   - Reference skills, asking skills, follow-up skills

5. COORDINATION OF IEC STRATEGY AT A NATIONAL LEVEL, UNDER THE LEADERSHIP OF NCPD:

1. The committee recommends that NCPD continue to coordinate the national IEC strategy for family planning. NCPD should set the priorities for IEC for the next five years and these priorities should define the parameters of all IEC campaigns designed

for the eight target audiences. NCPD should facilitate and encourage the involvement of NGOs in developing messages, disseminating results of IEC campaigns run by NCPD and the various NGOs.

2. The Kenya IEC Working Group should be opened to all organizations involved in family planning IEC and should be strengthened.

3. Attention should be given to advocacy work for policy makers and opinion leaders before beginning IEC programs. This could include, for example, establishing a Parliamentarians' group in support of family planning, or using a professional public relations firm for advocacy.

4. NGOs, DFH and NCPD should share information on campaigns targeted for the same audiences. (As part of the Client - Provider Project, for example, several organization came together - CHAK, MYWO, FPAK FPPS and came up with an IEC working group. This is cost effective, eases duplication, it is easy to co-ordinate the message and distribution.)

5. The Government and NGOs should also use IEC for advocacy on issues such as the status of the girl-child.

6. COORDINATION OF IEC CAMPAIGNS WITH SERVICE DELIVERY PROVIDERS, BOTH DFH AND NGOs, TO CONFIRM THAT SDPs ARE ADEQUATELY PREPARED (STAFFED AND SUPPLIED) TO ACCOMMODATE INCREASED DEMAND FOR SERVICES.

1. The committee believes that increasing demand will prove ineffective and ultimately counterproductive unless SDP facilities and staff are in a position to accommodate increased demand for services.

2. For any IEC campaign involving materials such as pamphlets and posters, the storage, distribution, display, and restocking must be provided for.

7. WHENEVER POSSIBLE AND APPROPRIATE, FAMILY PLANNING IEC CAMPAIGNS SHOULD BE INTEGRATED WITH OTHER DEVELOPMENT ISSUES TO MAXIMIZE USE OF IEC RESOURCES.

1. Whenever possible, IEC messages should address integrated reproductive health needs, including STDs, HIV/AIDS in particular.

2. The idea should be explored of integrating family planning into other development issues/messages, such as the environment, unemployment, education, gender issues, etc.

8. **EVERY IEC CAMPAIGN SHOULD INCLUDE AN ONGOING EVALUATION MECHANISM TO ASSESS BOTH THE IEC PROCESS ITSELF AND THE IMPACT UPON FP DEMAND, UPTAKE, AND CONTINUITY.**

1. Mechanisms should be built into the design of IEC campaigns to measure behavioral change, which is the ultimate goal of such campaigns.

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