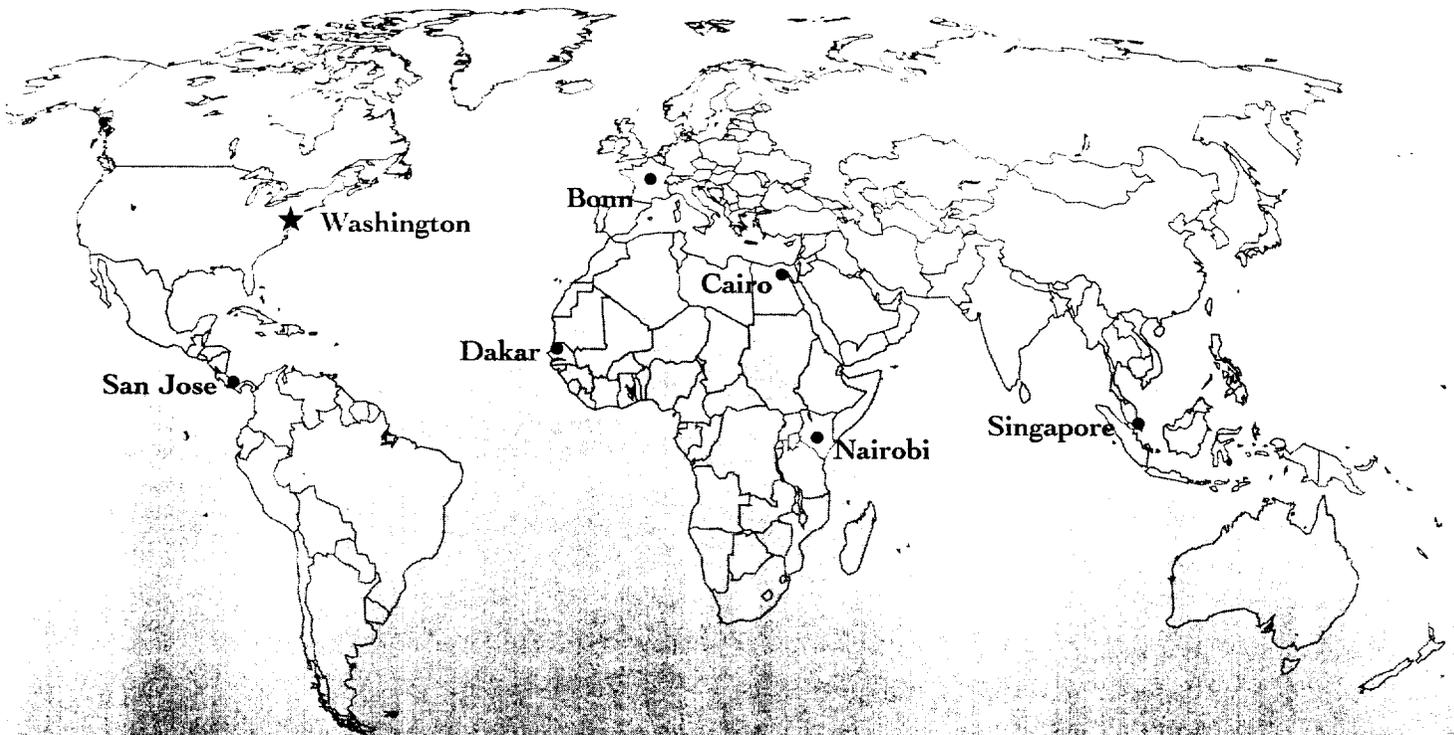

Audit of
USAID/Kenya's Population Activities

Report No. 3-615-96-006
May 31, 1996



**INSPECTOR
GENERAL**

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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USAID/Kenya's Population Activities**

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U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MEMORANDUM

TO: Director, USAID/Kenya, George Jones

FROM: RIG/A/Nairobi, Everette Orr *Everette B. Orr*

SUBJECT: Audit of USAID/Kenya's Population Activities, Report
No. 3-615-96-006.

*Regional
Inspector General
for Audit/Nairobi*

Enclosed are five copies of the final report on the subject audit. We considered your comments to the draft report in preparing the final report. Also, we have included your comments in their entirety as Appendix II.

The report contains four recommendations for your action. Based on your comments/actions, we consider the recommendations to be resolved/closed/open.

I appreciate the cooperation extended to my staff during the audit.

EXECUTIVE SUMMARY

Background

When the first Kenyan census was done in 1948, the population numbered 5.4 million people. The country's total fertility rate, the average number of children born to Kenyan women during their lifetime, was high, at 6.7. However, that high fertility rate was somewhat offset by an equally high infant mortality rate of 184 per 1,000 live births and an average life expectancy of only 34 years. Combined, these factors contributed to an annual population growth rate of 2.5 percent.

Forty-one years later, in 1989, the Kenyan census showed that the country's population had more than quadrupled to 23 million people. With the increased quality of the country's medical care over the intervening years, the infant mortality rate dropped by two-thirds and the average life expectancy increased to 56 years. While the population was healthier and living longer, Kenyan women were still having babies at the same rate (6.7) they were in 1948.

This combination of factors boosted Kenya's population growth rate to 3.5 percent, making it one of the highest in the world in 1989. Population experts estimated then that Kenya's population could triple in 30 years.

Partially through USAID/Kenya's intervention, the country's total fertility rate has dropped dramatically, from one of the highest in the world to one of the lowest in sub-Saharan Africa. A 1995 analysis conducted by USAID/Kenya indicates that this rate may have dropped below 5.0, which Mission officials believe to be one of the most dramatic drops in fertility ever recorded in the world. The USAID/Kenya Mission officials consider the results of its work in this field to be one of the success stories of USAID in Africa.

Audit Objectives

This audit was designed to answer the following questions:

What progress has USAID/Kenya made towards achieving its strategic objectives for Population?

Has USAID/Kenya progressed towards output targets for Population activities as intended in its project papers?

The audit was conducted from October 2, 1995, through January 19, 1996, in Nairobi, Nakuru, Eldoret, Kisumu, and Mombasa, Kenya. A discussion of the audit's scope and methodology is included in Appendix I.

Summary of Audit Findings

Regarding the first objective, our audit found that USAID/Kenya has made significant progress toward achieving its strategic objective for population as determined by a comparison of planned versus reported progress. This objective is included in its strategic objective for population and health; *to decrease national fertility and reduce HIV/AIDS high risk behaviors in Kenya*. The country's total fertility rate has seen a significant drop since the 1984 baseline year from 7.7 children per woman to an estimated 4.9 in 1995.

With respect to the second objective, USAID/Kenya has made excellent progress towards achieving its output targets for the population activities of the two projects reviewed. In some cases, the Mission exceeded its planned targets as determined by a comparison of planned versus reported progress. However, the Mission did not always establish interim targets or benchmarks to measure project progress. Also, improvements are needed in the contraceptive supply delivery system and inventory controls.

Summary of Recommendations

We recommended USAID/Kenya:

- Develop a plan that leads to establishing interim targets for the Private Sector Family Planning II Project through the Project's authorized completion date of October 30, 1998;

- Work with the Government of Kenya and other donors to find a solution to the transportation problems impeding delivery of contraceptive commodities from district stores to the clinics;
- Assess operational needs for improving regional warehouse and district store management, inventory control practices, and record keeping and assist in implementing improvements;
- Ensure that the regional warehouses are fully incorporated into the Logistics Management System, including clearly defining their role, to prevent overstocking of regional warehouses and non-utilization by the district stores; and
- Bring to the attention of the Kenya Health/Population Donors Forum the complaints received concerning the inadequate supply of pre-packaged medical kits.

Management Comments and Our Evaluation

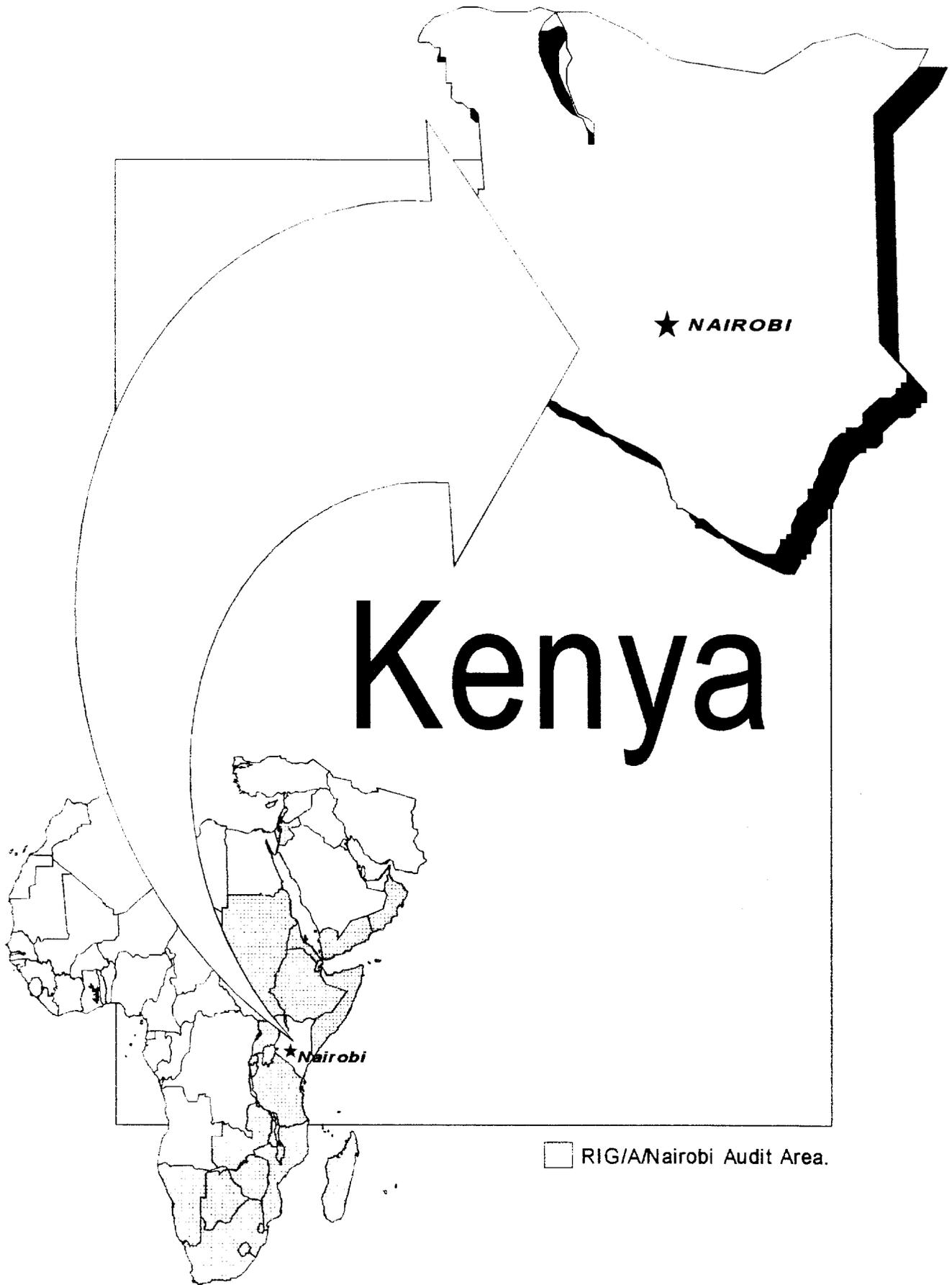
Other than editorial comments, USAID/Kenya agreed with the report's findings and recommendations.

Office of the Inspector General
Office of the Inspector General
May 31, 1996

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Kenya

□ RIG/ANairobi Audit Area.

INTRODUCTION

Background

When the first Kenyan census was done in 1948, the population numbered 5.4 million people. The country's total fertility rate, the average number of children born to Kenyan women during their lifetime, was a high 6.7. However, that high fertility rate was somewhat offset by the equally high infant mortality rate of 184 deaths for every 1,000 live births and an average life expectancy of only 34 years. Combined, these factors contributed to an annual population growth rate of 2.5 percent.

Forty-one years later, in 1989, the Kenyan census showed that the country's population had more than quadrupled to 23 million people. This growth was in part a result of the increased quality of the country's medical care, which helped to reduce the infant mortality rate by two-thirds (to 60 deaths per 1,000 live births). In addition, these healthier babies were living longer, to an average life expectancy of 56 years. While the population was healthier and living longer, Kenyan women were still having babies at the same rate (6.7) they were in 1948.

This combination of factors boosted Kenya's population growth rate to 3.5 percent, making it one of the highest in the world in 1989. Population experts estimated at that rate of growth, Kenya's population would triple in 30 years.

Kenya's mushrooming population growth rate poses problems for its development. As more people occupy the same space, the strain on land and water becomes greater as people jostle to establish homesteads and farms on a finite amount of land. For the ever-increasing number of people without land, the urban areas offer a lure of jobs. But as people move to the urban areas in search of employment, the influx strains the urban infrastructure capacity to provide enough hospitals and schools, housing, roads, potable water, and electricity.

USAID/Kenya, realizing that this unbridled population growth would be a major constraint to sustained and broad-based economic growth in Kenya, developed projects to address the problem. Two of the projects the Mission developed and nurtured included

the Family Planning Services and Support Project and the Private Sector Family Planning Project.

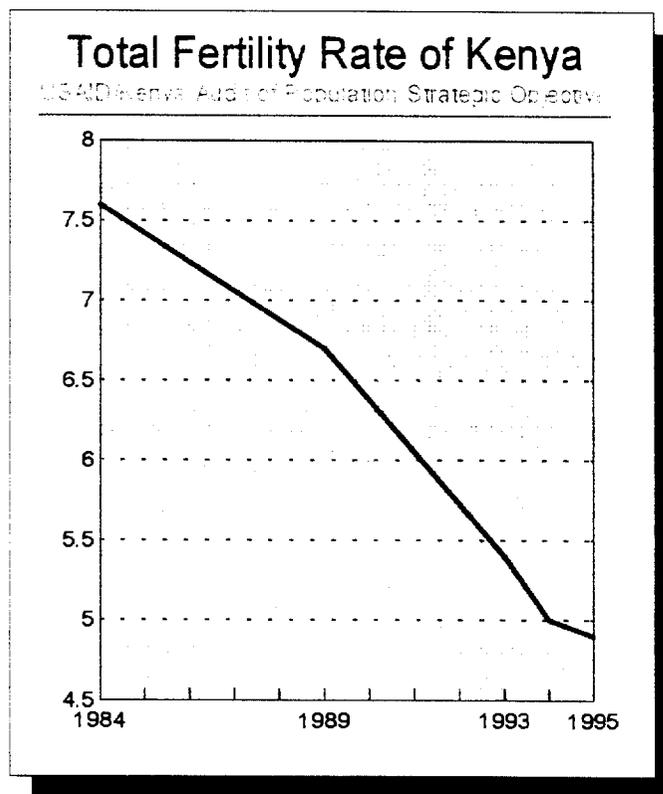
Family Planning Services and Support Project

Under this project, the Mission sought to lower the country's population growth rate by enhancing the opportunity for individuals and couples to choose the number and spacing of their children. The purpose of the project was to increase user rates of high-quality family planning methods. The project focused on: (1) deferring first births by young adults; (2) spacing births among those in the middle of their reproductive years; and (3) completing fertility at earlier ages with a smaller family size. This project was started in September 1985 with a life of project funding of \$58.2 million and ended in August 1995. As of September 30, 1995, project expenditures totaled \$49.67 million.

Private Sector Family Planning Project

The goal of this project is to reduce fertility and the population growth rate by increasing the availability, use, and sustainability of family planning services in the private sector. The project was broken into two phases: Phase I was started in September 1983 with a life of project funding of \$8.4 million and terminated December, 1991; Phase II began in December 1991 with a life of project funding of \$10 million and an authorized completion date of October 30, 1998. As of September 30, 1995, Phase II had expenditures of \$4.613 million.

Since 1989, Kenya's total fertility rate has dropped dramatically, from one of the highest in the world to one of the lowest in sub-Saharan Africa, in part due to the efforts



SOURCE: USAID/Kenya Office of Population and Health

of the two Mission projects.¹ A 1995 analysis conducted by USAID/Kenya indicates that this rate may have dropped below 5.0, which Mission officials believe to be one of the most dramatic drops in fertility ever recorded in the world.

Audit Objectives

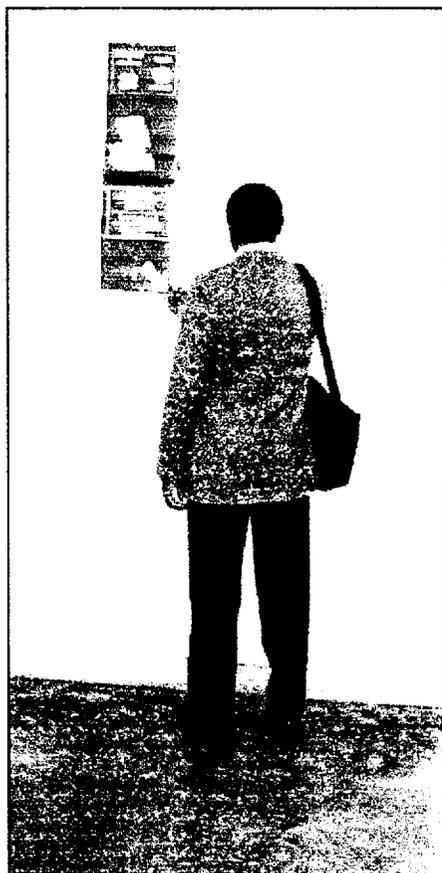
This audit was designed to answer the following questions:

What progress has USAID/Kenya made towards achieving its strategic objectives for Population?

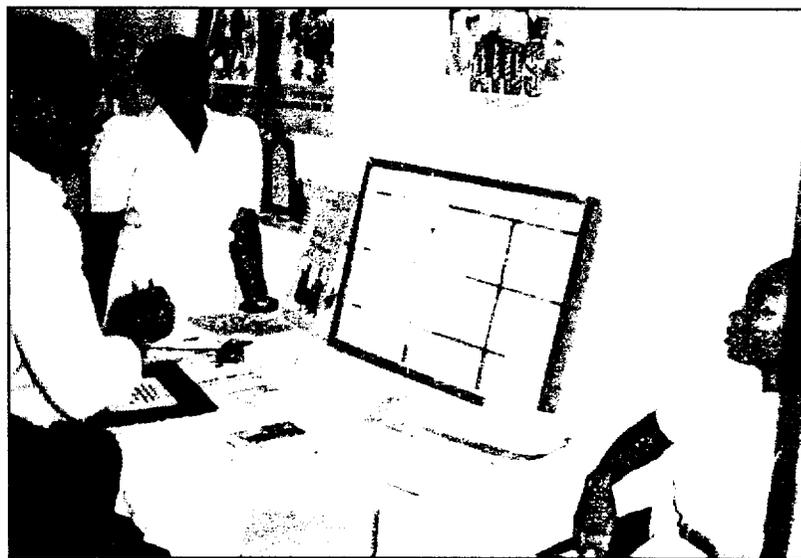
Has USAID/Kenya progressed towards output targets for Population activities as intended in its project papers?

The audit was conducted from October 2, 1995, through January 19, 1996, in Nairobi, Nakuru, Eldoret, Kisumu, and Mombasa, Kenya. A discussion of the audit's scope and methodology is included in Appendix I.

¹ While USAID/Kenya is one of the largest donors in the Kenya population field, other donors and nongovernmental organizations are also involved. Therefore, it was not possible to quantify USAID/Kenya's exact contribution to the decline in the total fertility rate with any precision.



The boxes of condoms (above) at the Kisumu Regional Warehouse had accumulated because of the inefficiencies noted in the contraceptive supply delivery system funded by USAID/Kenya. As part of the Mission's population program, contraceptives and family planning counseling are being made available throughout Kenya, such as the condom dispensing machine (left) at the Nakuru Provincial General Hospital and the display of training aids (below) at the Likoni Health Center in Mombasa.



REPORT OF AUDIT FINDINGS

What Progress Has USAID/Kenya Made Towards Achieving Its Strategic Objectives for Population?

USAID/Kenya has made significant progress towards achieving its strategic objective for population as reflected by a comparison of the Mission's planned versus reported progress. This objective, encompassed within the Mission's strategic objective for population and health, is to *decrease National Fertility and reduce HIV/AIDS high risk behaviors* in Kenya. This audit focused only on the results of the Mission's population activities and not on the health and HIV/AIDS component of this strategic objective.

USAID/Kenya's overall population program contributed to the reduction of Kenya's total fertility rate by funding the following and other activities over the past several years:

- Development of a contraceptive distribution system with a central Nairobi warehouse supplying a network of regional and district warehouses, who in turn distribute contraceptives to local hospitals and clinics;
- Establishment of voluntary surgical sites;
- Dissemination of family planning information through both radio and print media; and
- Training of community-based contraceptive distributors tasked with providing family planning information and contraceptives on a local basis.

According to information supplied by the Mission, the Kenyan total fertility rate has decreased steadily from the baseline year, while the contraceptive prevalence rate, the percentage of women using modern birth control methods, has increased over the same period. The following two tables show the population performance indicators for this objective, as well as, the Mission's baseline and actual progress.

Performance Indicator	1984 Baseline	1989 Actual and Verified Progress	1993 Actual and Verified Progress
Strategic Objective Total Fertility Rate	7.7	6.7 (based on 1989 Demographic Health Survey)	5.4 (based on 1993 Demographic Health Survey)
Program Outcome Contraceptive Prevalence-modern methods	9.0 percent	14.7 percent (based on 1989 Demographic Health Survey)	20.9 percent (based on 1993 Demographic Health Survey)

SOURCE: USAID/Kenya Office of Population and Health

Performance Indicator	1994		
	Planned Per Action Plan	Reported Progress	Variance
Strategic Objective Total Fertility Rate	5.0	5.0 (based on extrapolations of 1993 Demographic Health Survey)	nil
Program Outcome Contraceptive Prevalence-modern methods	21.7 percent	21.7 percent (based on extrapolations of 1993 Demographic Health Survey)	nil

SOURCE: USAID/Kenya Office of Population and Health

The Mission's Strategic Objective on population is a measurable outcome of primarily two projects: (1) the Family Planning Services and Support Project and (2) the Private Sector Family Planning Project. But the Office of Population and Health has several other projects which indirectly contribute to the reduction of the total fertility rate. In addition, there are USAID centrally-funded activities which also contribute to the fertility rate reduction. This audit focused only on the two projects cited above.

To find out the status of certain population statistics, the Mission conducts Demographic and Health Surveys usually once every five years. Surveys were conducted in 1989 and 1993, and

the Mission is planning another in 1997. The 1989 and 1993 population statistics/results cited in this report are based on Surveys done in those years.

The 1994 figures cited in this report are based on projections or extrapolations of the 1993 results done by USAID/Kenya's Office of Population and Health. Although there is no independent source for the 1994 reported progress, the projections made by USAID/Kenya, using sophisticated agency-wide computer models, appear reasonable based on the results of the 1993 Survey. In reviewing the Mission's reported progress, the audit team assessed key elements of its program performance measurement system and found it to be generally adequate. We concluded there is no material difference between planned and reported progress for 1994.

Going by the two Demographic and Health surveys in 1989 and 1993, the data indicates a significant change in the total fertility rate within a five to eight-year time frame in Kenya. The total fertility rate in 1989 was 6.7 children per woman, while in 1993 it had declined to 5.4. By 1994, the Mission had estimated that the total fertility rate had dropped even further to an estimated 5.0, which matches the Mission's performance target for 1995. A recent study by the Mission indicates the 1995 Kenyan fertility rate may have dipped below 5.0 to 4.9 children per woman. Based on this drop in fertility, the Mission has estimated that the overall population growth rate in Kenya has dropped to 2.7 percent in 1995. Mission officials consider the USAID/Kenya population program to be one of the biggest success stories in USAID's African Bureau.

It should be noted that the Mission made a significant change in focus in 1993 when it changed the reduction of the total fertility rate from a sub-goal to a strategic objective. This change is highlighted in the 1993 Mission Assessment of Program Impact and, according to copies of available correspondence, the Africa Bureau concurred with the change.

The Mission's progress on the Sub-Program Outcomes are presented in the table on the next page. The Sub-Program Outcomes show significant progress towards the overall achievement of the Strategic Objective to reduce the total fertility rate, as well as, for the planned Program Outcome to increase modern contraceptive use. Again, although we were unable to verify the reported figures for 1994, we consider the Mission's performance measurement system for its population strategic objective to be adequate, including its establishment of the required elements—strategic objective, program outcomes, performance indicators, targets, and baselines.

USAID's strategies for sustainable development states that USAID missions will employ support for sustainable development in all its endeavors. Although USAID/Kenya's population and health strategy has emphasized service delivery over the years, sudden sharp budget cuts proposed for fiscal year 1996 and beyond make it imperative to heighten the focus on sustainability. Therefore, according to Mission officials, the allocation of USAID/Kenya's future resources will shift from roughly two-thirds devoted to service delivery to two-thirds devoted to sustainability. The sustainability strategies will focus on:

- Increasing financial contributions from other donors, the Government of Kenya (Government), and customers;
- Improving the viability of key nongovernmental organization service providers.

and selected public sector service delivery support systems(e.g. training, supervision, logistical); and

- Maximizing the potential of the national cost-sharing program.

USAID/Kenya's Progress on Sub-Program Outcomes of the Population Strategic Objective

SUB-PROGRAM OUTCOME	PERFORMANCE MEASURE	BASE-LINE DATA	1989 actual	1993 actual	1994 planned	1994 actual
1.1 Improve Availability of Family Planning Services.	Number of sites offering voluntary surgical contraception	4 (1984)	49	65	100	115
	Percent of district stores maintaining adequate stock (more than 3 months) of:					
	• low dose oral contraceptives	35.5% (1989-90)	70.6%	74%	70%	70%
	• condoms	18.9% (1989-90)	34%	70%	63%	70%
	Number of public sector facilities offering family planning services	577 (1984)	750	1,004	1,086	1,088
	Number of private sector or nongovernmental organization sites offering family planning services	181 (1984)	--	800	838	838
1.2 Reduce unmet demand for contraceptives.	Discrepancy between actual and desired total fertility rate	--	2.7	1.6	1.3	1.3

Has USAID/Kenya Progressed Towards Output Targets for Population Activities as Intended in Its Project Papers?

USAID/Kenya has made excellent progress towards output targets for the population activities of the two projects reviewed and, in some cases, exceeded its planned targets according to a comparison of planned versus reported progress. For example, 15 percent more voluntary surgical sites had been established over the life-of-project target and 22 percent more Norplant service sites had been established (See Appendices III and IV). However, the Mission did not always establish interim targets or benchmarks to measure project progress. Also, improvements are needed in the contraceptive supply delivery system and inventory controls.

Additionally, the Mission's life-of-project output targets for the Family Planning Services and Support Project, which ended in 1995, generally met the requirements of being stated in explicit and precise terms and objectively verifiable. Also, the Project's life-of-project sub-output targets, for the most part, met those requirements. In all, the Project had 25 of 29 life of project outputs and sub-outputs that were measurable in precise terms.

For the Private Sector Family Planning II Project, all 13 of life of project output targets met the requirements for being stated in explicit and precise terms, objectively verifiable, and measurable.

USAID/Kenya Should Establish Interim Targets to Measure Project Progress

The Foreign Assistance Act (Section 621 A (b)) requires USAID to implement a management system that includes the definition of objectives for its foreign assistance program, the development of quantitative indicators of progress toward those objectives, and the adoption of methods of comparing actual program and project results with those anticipated when they are undertaken.

In line with these requirements at the project level, USAID Handbook 3 (Appendix 3K) emphasizes the need for establishing baseline data and indicators (targets and interim progress indicators) for use in measuring progress from when the project objectives were established. Appendix 3K states that these elements should be incorporated into all project designs from their earliest stages so the design will permit and facilitate: (1) measurement of progress toward planned targets; (2) determination of why the project is or is not achieving its planned targets; and (3) determination of whether the project purpose continues to be relevant to the country development needs. In October 1994, USAID issued a Project Development Interim Directive which replaces Appendix 3K in Handbook 3. However, the interim directive does not eliminate the requirement for establishing indicators for monitoring progress. This directive will remain in effect until new guidance implementing the re-engineering effort is issued.

The Mission did not establish interim targets or benchmarks to measure progress of the Private Sector Family Planning II Project except for one output. This one output was the "Increase in Couple Years Protection", which had a baseline of 350,000 in 1991, and a life-of-project target of 800,000 before its scheduled completion in 1998. Also, the Mission established interim targets (estimated percentages of completion) for 1995 for only 7 of the 29 measurable life-of-project outputs and sub-outputs established for the Family Planning Services and Support Project. With regard to the Family Planning Services and Support Project, we are not making a recommendation because the Project's authorized completion date was in 1995. However, the Mission should establish interim targets or benchmarks for the Private Sector Family Planning II Project through the project's authorized completion date of October 30, 1998. Also, even though we are not making a formal recommendation, the Mission should consider obtaining baseline data for the outputs established for the Private Sector Family Planning II Project to be in line with Handbook 3 requirements.

Recommendation No. 1: We recommend USAID/Kenya develop a plan that leads to establishing interim targets for the Private Sector Family Planning II Project through the Project's authorized completion date of October 30, 1998.

Improvements Needed in Contraceptive Delivery System and Inventory Controls

According to Handbook 13, Chapter 1, the Kenyan Government has the responsibility to maintain effective record keeping to safeguard USAID-financed property and other assets.

USAID/Kenya's Family Planning Services and Support Project funds the National Logistics Management System, which is responsible for the delivery of contraceptive commodities from the Central Warehouse in Nairobi to 5 regional warehouse depots and to 47 district stores located throughout Kenya. Delivery of the contraceptives from the district stores to public and private sector clinics and hospitals in the various districts is then the responsibility of the Government. As well as funding the storage and delivery of contraceptives down to the district store level, USAID also provides funding to the Logistics Management System for a technical advisor, vehicles, equipment, training in warehouse control practices, and monitoring and supervision.

To test the integrity of the delivery system and inventory controls we visited three regional warehouses, five district stores, and eight public and private hospitals and clinics in both Western Kenya and the Coast Province (Mombasa). During these visits, we sought to find out: (1) If the logistical contraceptive commodity system supported by the USAID/Kenya population program was capable of effectively and efficiently delivering commodities to its customers; and (2) If training was adequate in inventory controls.

Our visits indicated that a logistical system for the distribution of contraceptive commodities is in place and working fairly well down to the district level. However, a major weakness in the delivery system exists from the district store level to the clinics and hospitals because of a general lack of reliable transportation. Also, confusion exists in the logistical system regarding the role the regional warehouses play in serving the district stores. It was our observation that personnel in both the regional warehouses and district stores, as well as the clinics we visited, needed additional training in inventory control management. In addition, it was our observation that kits and medical equipment needed to perform physical examinations and IUD insertions were in short supply.

Transportation Problems

The major problem that surfaced during our visits to four district stores—Nakuru, Eldoret, Kisumu, and Mombasa—in October and November 1995 was the delivery of contraceptive commodities to the clinics and hospitals, which was the responsibility of the Government. Vehicles necessary to deliver the contraceptives to clinics were often unavailable, out of service, or could not be used because of a lack of money to pay for fuel and maintenance. If the commodities can not be delivered to the clinics and hospitals where they are to be distributed, then the effectiveness of the USAID/Kenya effort as a whole suffers.

Nakuru: The district store manager said the main problem with delivery of contraceptives to clinics was the lack of transportation. The district nurse told us the contraceptive supply delivery system was operating fairly well from the central warehouse in Nairobi to the district store level, but that lack of transportation was a problem in moving the commodities from the district store to the clinics.

Eldoret: The Eldoret district store manager said that the Kenya Expanded Programme of Immunization vehicle on which the store relied to deliver commodities to the clinics had been out of service since July 1995. For the most part, the staff of clinics had to come to the district store to pick up their commodities. For this reason, and the overall poor management of the store, contraceptives were stacking up at the store. As an example, the store inventory showed there were 60,500 cycles of Microgynon, an oral contraceptive, on hand, but only 700 cycles had been distributed in the two months prior to our visit. At that rate of distribution, the store had enough of that contraceptive to last 14 years. However, the Microgynon in stock had an expiration date of June 1996. Also, the store had 342,000 condoms in stock, but only 51,000 had been delivered to clinics during the last two months. Therefore, the store was holding over a year's supply of condoms as well.

Kisumu: The district store manager said it was the responsibility of the clinics to pick up the contraceptives they need, because transportation to deliver the

commodities to the clinics is not available. The store's records indicated that only 5 of 83 clinics served by the district store were getting condoms. When we visited the Muharoni Demonstration Clinic served by the Kisumu district store, we found the clinic had no stock of either condoms or Microgynon. This demonstrates the seriousness of the transportation problems, especially given that the Kisumu regional warehouse, located only a few miles away, had a physical stock of about 4 million condoms on hand.

Mombasa: This district store did not have the money to purchase fuel for vehicles to deliver its contraceptive supplies to local clinics. The staff of most clinics they serve had to go to the store to pick-up commodities.

At the regional level, the Kisumu regional warehouse had trouble delivering contraceptives to the district stores it serves because money to buy fuel for its truck was often not available. At the Mombasa regional warehouse, the staff did not have the funds available to maintain its vehicle.

This area of transport from the district stores to the end-user clinics and hospitals is a weak link in the contraceptive delivery chain which needs to be addressed if this distribution system is to be sustainable.

Recommendation No. 2: We recommend USAID/Kenya work with the Government of Kenya and other donors to develop and implement a plan to solve the transportation problems impeding delivery of contraceptive commodities from district stores to the clinics.

Inventory Control Weaknesses Noted at Several Warehouses

Two of the regional warehouses we visited—Nakuru and Mombasa—had accurate inventory records and overall good warehouse and inventory control management. However, the Kisumu Regional Warehouse, which serves 14 district stores, had serious inventory control and warehouse management problems. This was discovered during a comparison of a physical count of commodities on-hand with the warehouse's inventory records. For example, the warehouse's inventory records showed a stock of 201,200 units of Depro-Provera, an injectable contraceptive, which had been provided by two other foreign donors, but we counted only 22,300 units, about one-tenth of what should have been there. The unaccounted for 178,900 units had a value of about \$250,000. Also, approximately 700,000 condoms and 26,000 cycles of Microgynon were unaccounted for by our physical count when compared to the warehouse's inventory records. Even with these shortages, the Kisumu Regional Warehouse had a physical stock of about 4 million condoms—enough to last about four years at the rate records showed the condoms were being distributed.

We could not determine if the problems at the Kisumu Regional Warehouse were attributable solely to poor management and record keeping, or if contraceptive commodities were being diverted for unauthorized purposes. However, we did note an overage of 27,000 cycles of Nordette, an oral contraceptive, in stock compared to what was reported in the warehouse inventory records. This indicates that record keeping was a major problem at the warehouse since there were discrepancies both ways, although it does not rule out the possibility of theft. Based on our observations, we believe the management personnel located at this warehouse need additional training in warehouse inventory control practices.

The Eldoret and Kisumu district stores (two of the five district stores visited) also had inventory management problems, and, in our opinion, the personnel operating these stores need additional training in inventory control practices. At the Eldoret District Store, which serves 33 clinics, the inventory control records were not up to date. The store manager was not there and, apparently, according to staff, does not show up for work on a regular basis. The other people working at the store were not well-trained in maintaining adequate inventory control records. Our inspection of the inventory records at the Kisumu District Store, which serves 83 clinics, and our physical count revealed discrepancies. The amount of Microgynon on hand was over by 18,000 cycles, Depro-Provera was short by 9,800 cycles, and condoms were short by 150,000 when comparing our count to the inventory records.

In addition to inventory control weaknesses, we found the Logistics Management System not as efficient or effective as it could be due to confusion regarding the role and utilization of the regional warehouses in the system. The Central Warehouse in Nairobi delivers contraceptive commodities directly to the district stores and only the overflow is stored at the regional warehouses. The regional warehouses are bypassed in the system, because the district stores send their quarterly reports directly to Nairobi (the regional warehouses do not get a copy). This causes confusion between the regional warehouses and the district stores, because neither one knows what the other has in stock. As a result, the district stores do not generally use the regional warehouses for resupply, even though the regional warehouses are closer. For example, the Kisumu district store manager went to the Nairobi Central Warehouse in early 1995 to pick up condoms when at that time the Kisumu regional warehouse, which is located close to the district store, was well-stocked with condoms. This causes overstocks at the regional warehouses due to non-utilization and can lead to expiration of commodities in the warehouses before they can be distributed. In addition to the Kisumu regional warehouse being oversupplied with commodities, the Mombasa regional warehouse was also oversupplied with commodities at the time of our visit.

Recommendation No. 3: We recommend USAID/Kenya:

- 3.1 Assess operational needs for improving regional warehouse and district store management, inventory control practices, and**

record keeping and assist in implementing improvements; and

- 3.2 Ensure that regional warehouses are fully incorporated into the Logistics Management System, including clearly defining their role, to prevent overstocking of regional warehouses and non-utilization by the district stores.

Clinics Report Shortage of Physical Examination Equipment

We were told by a district store manager, a district nurse, and the staff at four clinics there was a shortage of pre-packaged essential pharmaceutical and physical examination (family planning) equipment, which prevented proper examinations and advice being given to patients on family planning matters. The Nakuru District Nurse mentioned that IUD insertion training was inadequate, as did staff at one of the clinics we visited.

With respect to IUD insertion training, we are not making a recommendation because training is an on-going component of the Mission's projects. However, we suggest the Mission review the situation to determine if there is in fact a problem with training and distribution of information on this activity.

As for the complaints concerning the adequacy of pre-packaged essential pharmaceutical supplies and physical examination equipment, USAID/Kenya does not provide these commodities. However, we believe the Mission can bring this shortage to the attention of the Kenya Health/Population Donors Forum for their corrective action.

Recommendation No. 4: We recommend USAID/Kenya bring to the attention of the Kenya Health/Population Donors Forum the complaints concerning the adequacy of pre-packaged essential pharmaceutical supplies and physical examination (family planning) equipment and request Forum members investigate the complaints and review current availability and distribution of the kits.

MANAGEMENT COMMENTS AND OUR EVALUATION

Other than editorial comments, USAID/Kenya agreed with the report's findings and recommendations.

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APPENDICES

**SCOPE AND
METHODOLOGY**

Scope

We audited USAID/Kenya's management of its population activities in accordance with generally accepted government auditing standards. The audit was conducted from October 2, 1995, through January 19, 1996, primarily in Nairobi, but with field trips to the following Kenyan cities: Nakuru; Eldoret; Kisumu; and Mombasa. In these locations, we visited three regional warehouses, five district stores, and eight public and private hospitals and clinics. This audit only focused on the Mission population activities and not on the health and HIV/AIDS component of this strategic objective.

Our audit covered from 1984 population baseline data through current population data generated in 1995. We focused on the two largest population projects to answer audit objective number two—the Family Planning Services and Support Project and the Private Sector Family Planning Project. The amount of expenditures audited as of September 30, 1995, for the two projects was \$62.7 million. We encountered no scope limitations in the conduct of this audit.

The audit evidence gathered included verbal explanations and documentation provided by USAID/Kenya officials, private nongovernmental organization officials and private contractors, and Government of Kenya employees located at public hospitals, clinics, warehouses, and district stores. Additionally, verbal and documentary evidence was also gathered from employees providing family planning services at private sector hospitals and clinics.

In addition to the methodology described in the following section, we obtained a written representation letter from USAID/Kenya management confirming information we considered essential for answering our audit objectives and for assessing internal controls and compliance. We also obtained and reviewed USAID/Kenya's management control certification for 1994.

Methodology

The methodology for each objective follows.

Audit Objective One

The purpose of the first objective was to determine whether USAID/Kenya had made progress towards achieving its strategic objectives for population. To answer this objective, we collected and analyzed population-related plans, reports, and evaluations and we interviewed the appropriate USAID/Kenya Population/Health project officers.

Audit Objective Two

The purpose of the second objective was to determine whether USAID/Kenya had progressed towards output targets for population activities as intended in its project papers. To answer this objective, we analyzed project papers, agreements and amendments, progress reports, and evaluations; and interviewed USAID/Kenya project officers, private nongovernmental organization officials, and private contractors to find if project output and sub-output targets were successfully being met. To find out if the contraceptive logistical supply system was functioning properly, we conducted field trips to Western Kenya and Mombasa. In those locations, we interviewed and observed both public and private sector employees who receive and utilize contraceptive supplies provided through the Government's logistical system. Additionally, we interviewed and observed how Government of Kenya employees manage the logistical system at the regional warehouse and district store level.

UNITED STATES GOVERNMENT
memorandum

DATE: May 14, 1996
TO: Everett Orr, RIG/A Director
FROM: George Jones, USAID/Kenya Director 
SUBJECT: Audit of USAID/Kenya's Population Activities,
Report No. 3-615-96-XXX.

Per your request, please find attached some suggested changes for the draft report, audit of USAID/Kenya's Population Activities, Report No. 3-615-96-XXX.

I again apologize for the lateness of this response.

CHANGES REQUESTED IN THE AUDIT REPORT

<u>PAGE</u>	<u>PARA</u>	<u>TEXT CHANGE</u>
ii	2	Summary of Audit Findings use the term:...contraceptive supply delivery system ¹ ...
4		delete: This mountain of condoms (above) at the Kisumu Regional Warehouse had accumulated because of the inefficiencies noted in the contraceptive delivery system funded by USAID/Kenya. add: Condoms are in high demand in Kenya. This large volume of condoms (above) are being held at the Kisumu Regional Warehouse because of shortage of floor space at the central warehouse in Nairobi.
13	1	delete In addition, it was our observation that medical examination (family planning) kits are in short supply. add: In addition, it was our observation that kits and medical equipment needed to perform physical examination and IUD insertions were in short supply.
14	last	add: ...Depo-Provera, and injectable contraceptive supply by UNFPA and ODA.
15	1	delete: ...missing 178,900 units had... add: ...unaccounted for 178,900 units have...
15	1	delete: Even with these shortages... [entire sentence] (Note: the volume of condoms found in the Kisumu warehouse were NOT due to poor planning/distribution. They were placed there intentionally because of overflow at the central warehouse).
15	2	delete: However, we... add: We...

¹ A suggestion: it would be better to use the term, "contraceptive supply delivery system" wherever it appears in the text, since this makes it clear the author is referring to commodities. "Contraceptive delivery system" could simply mean family planning services, and may be confusing to the reader.

APPENDIX II

USAID/Kenya's Management Response

15	2	delete:	...although it does not rule out the possibility of theft.
15	2	add:	practices, and commodity management/accountability.
16	1	delete:	This causes overstocks at the regional warehouses... [entire sentence]
16	3.2	delete:	Ensure that regional warehouses are fully incorporated into the Logistics Management System.
		add:	Facilitate more efficient use of regional warehouses in conjunction with Ministry of Health plans to strengthen decentralized management of drugs contraceptives and other medical supplies, ...
16		delete:	<u>Clinics Report Shortage of Medical Examination Kits</u>
		add:	<u>Clinics Report Shortage of Physical Examination Equipment</u>
16	third to last	delete:	...add medical examination (family planning) kits.
		add:	...and physical examination (family planning) equipment.
17	1	delete	medical kits,...
		add:	essential pharmaceutical supplies/equipment,...

**Family Planning Services and Support Project
Outputs and Sub-outputs**

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion(% completed)			
		1992 (actual)	1993 (actual)	1994 (actual)	1995 (target)
Number of Service Delivery Point sites established.	2,212	75%	80%	80%	82%
Kenyan Enrolled Community Nurses, Registered Nurses, and Clinical Officers trained to date:					
. certificate	4,950	-	82%	82%	
. refresher	1,270	-	34%	34%	
Training unit organogram.	"developed"	-	100%	100%	
Annual action plan.	"submitted"	100%	100%	100%	
In-service curricula.	"implemented"	-	30%	90%	
Ministry of Health Department of Family Health participants trained annually.	8-10/year	50%	150%	150%	
Logistics unit staffed.	"fully"	60%	80%	100%	
Information systems operational	"fully"	40%	80%	85%	
Contraceptive supplies available.	"adequate"	50%	80%	80%	

APPENDIX III

Family Planning Services and Support Project

**Family Planning Services and Support Project
Outputs and Sub-outputs (continued)**

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion(% completed)			
		1992 (actual)	1993 (actual)	1994 (actual)	1995 (target)
Voluntary surgical sites established.	78		87%	115%	137%
Voluntary surgical contraception (VSC) procedures performed.	110,000	71%	75%	98%	107%
Interns trained in voluntary surgical contraception.	900	56%	74%	90%	
Graduated interns performing voluntary surgical contraception.	70	To be determined	To be determined	To be determined	
Norplant service sites established.	32	9%	100%	122%	203%
Norplant procedures performed.	14,000	4%	14%	89%	
Association for Voluntary and Safe Contraception/ Client-Oriented Provider Efficient sites established.	62		50%	85%	

Family Planning Services and Support Project
Outputs and Sub-outputs (continued)

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion(% completed)			
		1992 (actual)	1993 (actual)	1994 (actual)	1995 (target)
Number of sub-locations with community-based distributor (CBD) sites	37	To be determined (TBD).	TBD.	TBD.	TBD.
Number of CBDs trained	3,775	90%	TBD.	96%	100%
Number of CBD supervisors trained	150	79%	TBD.	98%	100%
Annual couple year protection achieved	200,000	53%	TBD.	88%	93%
CBD referrals for: -Voluntary surgical contraception -Norplant	20,000 2,000	38% 4%	TBD. TBD.	28% 18%	TBD TBD
Information, Education, Communication (IEC) materials produced and evaluated	"widely"	50%	-	100%	
IEC counselling workshops held	6	-	-	100%	
CBD training manuals distributed	200	-	75%	100%	
Radio programs broadcasted	52	-	100%	100%	
IEC working group meeting	"quarterly"	100%	100%	100%	

**Family Planning Services and Support Project
Outputs and Sub-outputs (continued)**

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion(% completed)			
		1992 (actual)	1993 (actual)	1994 (actual)	1995 (target)
1993 Demographic Health Survey	"completed"			100%	
National Council for Population and Development Management Information System.	"established"	-	90%	95%	
National Council for Population and Development participants trained, annually	8-10 a year	150%	150%	150%	

**Private Sector Family Planning II Project
Outputs and Sub-outputs**

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion(% completed)			
		10/93 to 03/94 (actual)	04/94 to 09/94 (actual)	10/94 to 03/95 (actual)	04/95 to 09/95 (target)
50 new subprojects representing 120 service delivery points offering family planning services.	50	22 of 50 (44%)	37 of 50 (74%)	37 of 50 (74%)	
Voluntary surgical contraception services added to 15 subprojects.	15	12 of 15 (80%)	10 of 15 (67%)	10 of 15 (67%)	
Community-based family planning and/or information and education component added to 30 subprojects.	30	22 of 30 (73%)	29 of 30 (97%)	29 of 30 (97%)	
Maternal Child Health interventions added to 10 subprojects.	10	10 of 10 (100%)	10 of 10 (100%)	10 of 10 (100%)	
450 clinical officers, nurses and midwives receive family planning training.	450	100 of 450 (22%)	152 of 450 (34%)	202 of 450 (45%)	
450 clinical personnel receive refresher courses.	450	28 of 450 (6%)	52 of 450 (12%)	65 of 450 (15%)	
90 field educators receive basic training.	90	60 of 90 (67%)	60 of 90 (67%)	60 of 90 (67%)	

**Private Sector Family Planning II Project
Outputs and Sub-outputs (continued)**

PROJECT INDICATORS	LIFE OF PROJECT TARGET	Status of completion (% completed)			
		10/93 to 03/'94 (actual)	04/94 to 09/'94 (actual)	10/94 to 03/95 (actual)	04/95 to 09/95 (target)
980 managers and Information, Education, and Communication committee members attend orientation workshop.	980 (changed from 150)	60 of 150 (40%)	500 of 980 (51%)	650 of 980 (66%)	
300 community-based distributor workers trained and deployed.	300 (changed from 210)	90 of 210 (43%)	168 of 210 (80%)	281 of 300 (94%)	
Up to 6 diagnostics studies and/or projects completed.	Up to 6	4 of 6 (67%)	4 of 6 (67%)	4 of 6 (67%)	
Two national seminars held.	2	1 of 2 (50%)	1 of 2 (50%)	4 of 2 (200%)	
Presentations made at two international conferences.	2	2 of 2 (100%)	2 of 2 (100%)	2 of 2 (100%)	
Cumulative increase in couple years protection from 1991 baseline level of 350,000.	Increase from 350,000 (baseline in 1991) to 800,000.	38%	40%	70%	

**Regional Inspector General
for Audit, Nairobi, Kenya**

**Tim Elkins, Audit Manager
Sheldon Schwartz, Auditor-in-charge
David Karite, Auditor
Carlos Cabrera, Referencer**