

PDBBN 727

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____	DOCUMENT CODE 3
2. COUNTRY/ENTITY Kenya		3. PROJECT NUMBER 615-0223		
4. BUREAU/OFFICE AFR <input type="checkbox"/> 06		5. PROJEC. TITLE (maximum 40 characters) Private Sector Family Planning		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 08 31 87		7. ESTIMATED DATE OF OBLIGATION (Under 'B' below, enter 1, 2, 3, or 4) A. Initial FY 83 B. Quarter 4 C. Final FY 83		

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1930	2570	4500	0	4500	4500
(Grant)	(1930)	(2570)	(4500)	(0)	(4500)	(4500)
(Loan)	()	()	(0)	(0)	()	()
Other U.S.:						
1.						
2.						
Host Country	0	1500	1500	0	1500	1500
Other Donors)						
TOTALS		6000	6000	0	6000	6000

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPRO-PRIMATE PURPOSE	B. PRIMARY CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PE	440	440				4500		4500	
(2)									
(3)									
(4)									
TOTALS						4500		4500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)					11. SECONDARY PURPOSE CODE				
430	510	580						530	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code	DEL	PVON	3WW	TNG					
B. Amount:	130	130	130	60					

13. PROJECT PURPOSE (maximum 480 characters)

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

14. SCHEDULED EVALUATIONS				15. SOURCE/ORIGIN OF GOODS AND SERVICES				
Interim	MM YY	MM YY	Final	MM YY	<input type="checkbox"/> 000	<input type="checkbox"/> 941	<input type="checkbox"/> Local	<input checked="" type="checkbox"/> Other (Specify) 935
	1 08 85			03 87				

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment)

17. APPROVED BY	Signature Allison B. Herrick	Date Signed MM DD YY 09/13/83	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY / /
	Title Director, USAID/Kenya		

Attachment I

Changes to the text of the Project Paper
Authorized August 3, 1983

Emphasis on increased Collaboration between USAID, the Government and the Recipient of the Cooperative Agreement	Clarification of Meaning or source of information provided	Material which could be interpreted as being critical to the Government of Kenya
2 (Summary)	4	1
5	5	3
13	6	4
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Revised Budget*ARTICLE VI - Financial Plan:

The following budget outline represents the financial plan for management of costs applicable to the effort covered hereunder. Standard Provision No. 6 "Revision of Financial Plans" shall govern with respect to any changes which may be required during the period of this Agreement.

	Yr 1.	Yr 2	Yr 3	Yr 4	Total
Salaries including Fringe Benefits 21%	\$140,274	\$153,835	\$168,720	\$185,059	\$647,888
Consultants	15,972	17,569	19,326	21,259	74,126
Travel & Transp.	41,846	15,779	25,740	56,272	139,637
Allowances	32,116	34,042	36,996	40,245	143,399
Other Direct Cost	29,411	58,852	44,537	64,271	197,071
Subprojects	300,000	600,000	600,000	387,983	1,887,983
Equip, Mat'l, Supplies	201,900	36,960	40,656	44,722	324,238
Subagreement (Training)	209,135	235,729	235,518	-0-	680,382
Overhead (70% of US salaries)	87,325	96,058	105,664	116,229	405,276
Grand Total	\$1,057,979	\$1,248,824	\$1,277,157	\$916,040	\$4,500,000

*The Financial Plan was developed in discussions between the Regional Contracting Office and John Snow Inc. the intended Recipient of the Cooperative Agreement.

PRIVATE SECTOR FAMILY PLANNING

SUMMARY

Kenya is experiencing one of the highest population growth rates in the world. The goal of this project is to help slow Kenya's high growth rate by increasing the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and related Maternal and Child Health (MCH) services. Private, in this context, is broadly defined as non-governmental and refers to institutions and facilities whose operations are not wholly financed by Central Government revenue. To date, the major strategy in Kenya has been to offer family planning services in all the standard free Government health facilities. However, this approach will not cover the country nor will the first preference of all potential users be to use public health facilities.

This project will increase the range of options available to potential female and male users of natural and other family planning services. Under this project family planning service delivery will be added to or improved in selected private enterprises (factories and plantations) which employ significant numbers of men and women and provide basic health care to employees and their families. Support will also be given to health care facilities sponsored by religious groups, health facilities which are already supported on a fee paying basis (such as those provided by county councils) and national private and voluntary organizations whose support for women's group development activities includes community-based distribution of contraceptives. It is anticipated that by the end of this four year project the feasibility of privately-supported family planning service delivery will have been demonstrated on a national basis, and that 30,000 clients will be using family planning services provided by project-supported organizations.

In accordance with USAID and Government of Kenya overall strategy, the project will aim to increase service delivery without increasing recurrent cost and administrative burdens for the Government. Emphasis will be placed on programs that are innovative, self-financing, and selective (as opposed to comprehensive) in the health services provided. Programs will be established in viable and autonomous institutions with the intention that family planning service delivery will continue following the project without external donor support. Monitoring, evaluation,

selected operations research activities and national seminars will be funded to assess and disseminate lessons learned. Thus, under this project family planning service delivery on a sustained basis will have been achieved using existing institutions and the potential for replication of such activities will have been established.

The six million dollar project (AID contribution, \$4.5 million and Government of Kenya and participating institutions' contribution, \$1.5 million) will support a series of subprojects to be identified and developed by an implementation agent (Recipient) in cooperation with Government. The Recipient will be funded under a Cooperative Agreement. Training of service delivery staff, monitoring, evaluation and operations research, and commodities will be provided. Subprojects will be developed by the Recipient based on the criteria established by the Government in consultation with USAID, as might be subsequently modified following recommendations by the Recipient, and with the approval by a Technical Advisory Committee of the National Council on Population and Development (NCPD). The Government will monitor the project progress and findings on a regular, systematic basis, through the Government's machinery at various levels.

PRIVATE SECTOR FAMILY PLANNING

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Project Paper Design Team

Edward H. Greeley/USAID - Design Officer/Social Analyst
Spencer Silberstein/USAID - Population Officer
Satish P. Shah/USAID - Financial Analyst
Helen Soos/REDSO/ESA - Economist

Project Review Committee

ABHerrick - Director, USAID/K
RGreene - Program Economist USAID/K
RBritanak - Chief, Health, Nutrition & Pop., USAID/K
EDragon - Regional Legal Advisor
LMartin - Regional Financial Management Office
CMantione - Health Officer, USAID/K

Project Paper Consultant Feasibility and Design Team

Freeman Pollard - Team Leader and Management
Specialist, Consultant
Merrill Shutt, MD - Chief Technical Resource and
Design Specialist, Consultant
Milicent Odera - Research, Evaluation and
Institutional Analysis Specialist,
Head of Research and Evaluation
Department, Family Planning
Association of Kenya
Diana Altman - Contraceptive Supply Analyst,
Consultant
Margaret Mwiti - Contraceptive Supply Analyst,
Public Health Nurse, National
Family Welfare Center

ABBREVIATIONS

B/C	Benefit /cost (ratio)
BCA	Benefit Cost Analysis
CBS	Central Bureau of Statistics
CDSS	Country Development Strategy Statement
CMS	Central Medical Stores
CORAT	Christian Organization Research Advisory Trust
DANIDA	Danish Agency for International Development
FPAK	Family Planning Association of Kenya
FPIA	Family Planning International Assistance
FX	Foreign Exchange
GDP	Gross Domestic Product
GOK	Government of Kenya
HNP	Health Nutrition and Population Division
IPPF	International Planned Parenthood Federation
IQC	Indefinite Quantity Contract
IRH/FP	Integrated Rural Health and Family Planning
IUD	Intrauterine Device
KCS	Kenya Catholic Secretariat
LC	Local Currency
MCH/FP	Maternal Child Health/Family Planning
MDS	Management Unit of Drug Supplies
MOH	Ministry of Health
NCPD	National Council on Population and Development
NFWC	National Family Welfare Center
NGO	Non-Governmental Organization
PCMA	Protestant Church Medical Association
PID	Project Identification Document
PVO	Private and Voluntary Organization
SDP	Service Delivery Point
SIDA	Swedish International Development Authority
TAT	Technical Assistance Team

I. Project Rationale:

A. Recipient Country Strategies and Programs:

1. Public Sector Programs:

On a continent which is noted for a relatively slow response to rapid population growth, Kenya has been a de facto leader in the recognition that rapid population growth is a basic constraint facing Sub-Saharan countries; yet its own yearly population growth rate has risen from an estimated 3.3% to 3.8% in the past decade. For the past 15 years Government of Kenya development plans have explicitly made reference to the adverse consequences of Kenya's high rate of population growth on family welfare and on the attainment of broad development objectives. Analysis carried out at the University of Nairobi Population Studies and Research Institute (PSRI), using the World Fertility Survey and one of the most extensive and comprehensive national integrated rural survey programs on the continent, has in recent years greatly increased understanding of the magnitude of the problem. Government concern over the negative consequences of a rapid population growth rate is growing as the severity of the problem is better understood. President Moi regularly makes reference to the necessity of reducing the rate of population growth through use of family planning. Similar statements are made with increasing frequency and frankness by Government officials and community leaders throughout Kenya.

The \$61 million multi-donor Integrated Rural Health and Family Planning (IRH/FP) Program being launched this year is tangible evidence of Kenya's increased commitment to reducing the birth rate. USAID has provided a grant of \$4 million for the family planning component of this project. Under IRH/FP, a National Council on Population and Development (NCPD) has been established within the Office of the Vice President and Ministry of Home Affairs. This Council will serve as the Government's coordinating mechanism for information and education efforts for family planning both within the Government structure and among participating public and private voluntary agencies. The current Council mandate, also includes responsibility for oversight of the supply of family planning services in both the Government and non-governmental sectors.

The Ministry of Health is responsible for implementing a family planning service delivery program to meet the anticipated increased demand for family planning services.

With support from the two-phased IRH/FP Program, the Ministry plans to more than double the current number of Ministry MCH/FP service delivery points, train additional family planning service staff and test alternative family planning service delivery systems at some government and non-governmental health facilities. By the end of the program, the Ministry aims to have introduced family planning services into all Government rural health facilities and 60 non-governmental rural health clinics and dispensaries; yet the effort will still fall far short of providing readily accessible, adequate coverage nationwide.

2. Private Sector Activities

Private sector activities play an important role in easing Government's burden in the provision of health care services. About one-third of all rural health facilities are operated by non-governmental organizations (NGOs), most of which are affiliated with churches. Private companies and private practitioners provide most of the remaining services in the private sector. Church hospitals provide about 30% of rural hospital beds, but are chronically short of funds. The Ministry of Health provides approximately 4% of its budget in grants to the Medical Department of the Kenya Catholic Secretariat (KCS) and Protestant Churches Medical Association (PCMA) for distribution to member institutions. Over 50% of the recurrent costs of church hospitals are financed through service fees and drug charges. Overseas donations are required to bridge the remaining gap in recurrent cost financing.^{1/}

The Kenya Government acknowledges that even if economic growth increases, Government revenues are unlikely to grow at the same substantial rate as in the past and certainly will fail to keep up with the population growth rate.

^{1/} World Bank, Kenya, Staff Appraisal of an Integrated Rural Health and Family Planning Project 1982:8

B. Relationship to the FY 1984 CDSS

The importance of agriculture in the Kenyan economy, the need to conserve the land while intensifying its use, the handicap to development posed by rapid population growth and the need for more employment opportunities and expanded basic social services have led to the selection of the following three objectives for the U.S. assistance program to Kenya: (1) increased rural production, employment and income, (2) reduced population growth, and (3) anticipated efficient delivery of basic social services. Ultimately, a sustainable balance between Kenya's population and land resources at a higher productivity level must be attained if development objectives are to be realized.

This project, contributes toward the attainment of each of three objectives in varying degree. It contributes most directly to reduced population growth through the provision of family planning information and delivery of family planning services. To the extent that family planning as well as related MCH services will be delivered efficiently through this project, the project contributes to the social services objective. Family planning and MCH practices resulting from this project will result in a healthier and more productive rural population, including the women who play a key role in small-holder production.

The CDSS and Government of Kenya policies favor a strong role for the private sector in economic and social development. The private sector has inherent efficiencies whose use reduces the burden upon the Government of Kenya recurrent budget and managers. This project is designed to utilize and strengthen private sector institutions to implement project activities.

C. Problem Statement:

This project addresses the problem of Kenya's rapidly increasing population which is due in large part to an exceptionally high birth rate. The yearly population growth rate of 3.8% is one of the highest recorded in the world. The fertility rate is extremely high (over eight live births per woman) and may go higher as practices which currently serve to space births -- such as prolonged breastfeeding -- become less widespread. Mortality rates are declining, and family planning is practiced by a relatively small proportion of the population. The current modern contraceptive prevalence rate is about 5%. An additional 5% utilize traditional birth spacing methods.^{1/} Most women use family planning to space children rather than to limit family size.

^{1/} Family Planning II Project Paper 615-0193 and the Kenya Social and Institutional Profile.

1/x

One of the most important barriers to increased, effective family planning in Kenya is lack of ready access to family planning services for males and females who are most likely to use them most effectively. A basic step to providing increased effective access is to offer family planning services in all the standard free Government health facilities. This step is being taken under the IRH/FP Program.

The problem of population growth is of such magnitude, however, that additional efforts complementary to the provision of family planning services at existing Government and non-governmental facilities would increase availability of family planning services in various institutional environments in Kenya particularly for Kenyans who already have access to some health services. GCK and USAID, with assistance from various sources, has explored a number of alternatives to free government health and family planning delivery.^{1/} Two major potential delivery systems are at present underexploited: the health care facilities operated by religious groups, and the health care programs conducted by private enterprises for their employees. Review of current estimates of numbers of health facilities in Kenya indicates that the Government supports an estimated 1182 health institutions and runs 555 family planning service delivery points. Church missions support 379 health facilities, with 44 family planning service delivery points, and private enterprises support 132 health facilities with very few family planning service delivery points.^{2/}

The size of the unmet potential for adding family planning service delivery to existing company-supported health facilities will be made clear when the number of clients now using these facilities is known. Small dispensaries provide services, for example, to a few hundred pickers of tea, while other facilities, such as those supported by the sugar-processing factories in Western Kenya, provide health care for 7000 employees and families. It has been determined, based on design team assessment, that companies welcome assistance in provision of family planning as a means to reduce working days missed due to maternity leave and to reduce costs

^{1/} These alternatives, and the rationale for their selection, are discussed in several documents including the Interim Report "Contribution by and Future Potential of the Protestant Church Medical Association (PCMA) in the Delivery of Health Services" June, 1982 and the report "Opportunities for Private Sector Family Planning Information and Service Activities in Kenya", Lyle Saunders, July 1982.

^{2/} Government of Kenya Gazette Notice No 3211 "Health Institutions in Kenya, 1982," dated October 29, 1982; and World Bank, Kenya "Staff Appraisal of An Integrated Rural Health and Family Planning Program, 1982."

due to reduced demand for MCH services. Families in which at least one member is a wage earner are also likely to experience changes in aspirations that reinforce the trend to smaller family size.

Church-related facilities are also promising. Most charge fees and yet maintain high levels of use. Over 50% of the recurrent costs of church-related facilities are met through fees charged for services and drugs. Research in Kenya, and elsewhere in Africa has indicated that rural families participating in church organizations are among those in a community who first experience changes in values and attitudes which support adoption of family planning ideas and practices^{1/}. Yet this potential has not been fully met. An example among church-related facilities is seen in the hospital-based Protestant health systems offering family planning services. Two systems combined (Chogoria and Tumu Tumu) report 10,000 active family planning clients; the nine other hospital systems belonging to the PCMA combined report only 538 active clients.

The unrealized potential for provision of family planning services in non-clinical non-governmental contexts is also considerable. The best example is seen in women's groups involved in income-generating and other development activities. In one district, for example, the contraceptive prevalence rate among members of women's groups with access to family planning information and services and involved in income-generating activities (with total membership of 338 women) jumped in two years from 25% to 75%^{2/}. Pilot programs undertaken by intermediaries supported by USAID (such as Pathfinder Project PIN 6438) have demonstrated the potential impact that can be achieved through community-based distribution of family planning services provided under the auspices of Maendeleo ya Wanawake, the national women's association that has an active membership of over 5,000 rural women's groups.

Other underexploited options include support for the Kenya Medical Association, support for physicians in private practice with plans to introduce provision of family planning and related services on an innovative or expanded basis, and additional assistance to current pilot programs such as those utilizing traditional birth attendants and industry-based health insurance schemes.

1/ Ndeti, Kivuto and C. Ndeti, Cultural Values and Population Policy in Kenya. Nairobi: Kenya Literature Bureau 1980:139.

2/ Research and Evaluation Unit, Family Planning Association of Kenya, Nyeri Women's Development Project, Baseline Survey Report, October 1980:8

II. Project Description:

A. Goal and Purpose

The broader target, or goal of this project, is to lower the birth rate in order to reduce the rate of population growth. Achievement of the goal at the macro-level will establish a better balance between population and national resources and on the micro-level, will result in improved health status for women and children.

The project purpose is to demonstrate and increase the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and related maternal child health services. The private sector in this context refers to organizations (or individuals) which do not receive their funding for health services from Central Government, and includes private for-profit organizations, parastatals, private and voluntary organizations and others. The private sector targets are those organizations which already are providing health services to their clients, employees, and/or dependants of employees, and which are willing to add family planning to their services delivery package, or to augment existing services. Because methodologies for donor assistance to for-profit organizations are not well developed, and because assessments to date show great unmet demand from companies throughout Kenya, the project will give emphasis to this portion of the private sector.

B. Project Strategy and End of Project Status:

The intent of the project is to design and conduct a series of demonstration subprojects with private sector organizations. The short-term (two year or less) subprojects, will be designed to demonstrate that with relatively small infusion of additional resources, private sector organizations can add or augment family planning services within their organizations' health services, and that the added services will be perceived by the organizations to be of sufficient benefit that the organization will assume continuation costs upon cessation of project assistance to sustain the level of services achieved. The demonstrations will encompass organizations of widely varying employee/client size, different service provider mixes, differing delivery systems, and varying contraceptive methods provided. Provided the strategy is successful, the end of the project status achievements will be:

- 30,000 new users of family planning services;

- 35 institutions operating new or improved family planning programs;
- an institutional capacity within the Ministry of Health to support participating institutions with dependable and ready access to adequate contraceptive supply;
- the capability and commitment of participating organizations to maintain or expand the level of family planning service delivery upon termination of external assistance; and
- other private sector organizations not directly assisted by this project have added family planning to their services.

The information used to develop this design is based on the considerable data and analysis of family planning acceptors in country, and on extensive interviews with personnel representing participating institutions, Government personnel in the Ministry of Health and Home Affairs, National Council on Population and Development, and donors. The linkages between the various project objectives of the goal, purpose and output levels are readily apparent. It is assumed that a significant number of acceptors of family planning will use the service to limit births rather than to simply space births according to the prevailing patterns in Kenya. This assumption is made with the understanding that the beneficiaries to whom service delivery is being provided under this project are those most likely to support decisions favoring small family size. The basis for this assumption is presented in the Social Analysis, Annex. It is similarly assumed, based on assessments of the design team, that private institutions are interested in participating in project activities, and that the Government is able and willing to provide the requisite support through life of project, and beyond.

C. Project Beneficiaries:

About 30,000 new users of family planning services are expected as a result of successful implementation of this project.

Calculation of this figure must remain imprecise. The basis for the estimate follows: In each of the eight identified likely subprojects, (described in Annex J) the approximate numbers of couples of childbearing age were calculated. An extremely conservative assumption was made that

project activities would permit an additional five percent of couples to accept family planning during the two year subproject life. Although five percent may prove in retrospect to have been too small an estimated increase, it must be remembered that the national contraceptive prevalence rate (modern methods) in 1978, after more than a decade of a national family planning policy, was only approximately five percent. With well-trained and motivated providers, and convenient access to private services developed during this project, it seems reasonable to at least match that figure in each of the subprojects.

An average number of new acceptors per subproject was calculated (about 650, excluding Lake Basin Development Authority which projects in excess of 5000 new acceptors), and this figure was extrapolated to the 35-40 subprojects. Assuming that most organizations would sustain family planning activities after subproject assistance, this total was increased by twenty percent to adjust for family planning acceptors added by these organizations after implementation of the subproject, but during the life of the project. This magnitude of new users of family planning services appears reasonable, and if attained or exceeded, will be a significant contribution to Government population objectives.

An important assumption in achieving this or any other level of users of modern contraception is the linkage between client demand and resulting service utilization. This project is designed primarily as a service project to provide wider options for those desiring family planning services. Persons of child-bearing age who otherwise might now choose to use contraception may not be able to do so conveniently because they have little access to service delivery points or because they may strongly prefer using private versus non-private facilities.

While the project is primarily a service project, there are specific linkages to motivational activities. The training of providers under this project will be designed to include motivational content as highly motivated health service providers are a powerful factor in educational efforts leading to increased contraceptive acceptance. In addition, there will be systematic coordination and to the extent possible, collaboration of the service delivery efforts initiated under this project with the motivational activities of the multi-donor Government of Kenya funded IRH/FP Program. The structure of such linkages (outlined below in section VI.D) will be developed in cooperative fashion over life of project. AID's participation in the IRH/FP Program, specifically in the areas of training for family planning service providers and motivational efforts under the National Council on Population and Development (NCPD), will help ensure mutually beneficial cooperation.

The success of this project in meeting the minimal target of 30,000 beneficiaries, however, is not dependent on any external efforts to promote rapid increases in demand for services. Rather, achievement of project purpose should result from careful selection of subproject activities which provide services to families already experiencing the conditions supporting decisions favorable to achievement of smaller family size. Significant numbers of families in these environments should adopt readily-available services with modest motivational efforts. Where necessary, such utilization should also stimulate efforts by organizations supporting subprojects to seek additional resources for motivation on an activity by activity basis.

D. Project Elements

There are six major elements of the project. All are briefly described below. Responsibility for establishing these elements, and for ensuring their direct linkage to purpose and goal attainment lies with the implementation team.

1. A set of 30 discrete demonstration subprojects designed, implemented and evaluated

Since some private sector organizations have more than one service delivery point, in the aggregate probably 40-50 facilities delivering family planning services will be involved in the 30-35 demonstration subprojects. Fifteen to twenty subprojects are envisaged with for-profit organizations, five with parastatals, five with NGOs, and about five with women's organizations, professional organizations, private practitioners and others. Most of these activities will serve as demonstrations to other organizations. Assistance will be provided for two years or less. Most subprojects will be initiated in the first two years to permit completion and evaluation. Eight highly-likely subprojects have been identified during the project design: Protestant Church Medical Association (PCMA); Kenya Cannery Limited; Vipingo (sisal) Estates Limited; Nzoia Sugar Company Limited; Kenya Cashewnuts Limited; Mivani Sugar Limited; Lake Basin Development Authority; and Associated Sugar Growers. Summary descriptions of these potential subprojects prepared by the design team are appended in Annex J. In addition, an inventory of potentially interested firms and organizations compiled by the design team is appended as Annex K.

2. An efficient contraceptive supply and management system for access by the private sector is in place and operating efficiently

The contraceptives to be utilized in subproject activities will not be project-supplied, but will be those made available by the National Family Welfare Center (NFWC) through the medical logistics system. For fourteen years the Kenya Government has had an arrangement with SIDA for SIDA to provide nearly all contraceptives used in the national family planning program, including pills, IUDs, vaginal spermicides, injectables, diaphragms, etc. The Kenya Government does not wish to have parallel logistic channels established to serve the needs of this or any other project. There are clearly established precedents for the NFWC to provide a full range of contraceptives free to private sector organizations which utilize service providers certified as appropriately trained by the Ministry of Health and which have applied for NFWC recognition as a service delivery point. The Ministry of Health has assured full availability of contraceptives for those demonstration subprojects which fulfill the foregoing criteria. Accordingly, the project will utilize fully the established Ministry of Health logistics system for subproject-related contraceptive supplies. The relatively small numbers of added service delivery points planned for the subproject demonstration activities should therefore not severely tax the existing system.

As in all logistic systems, there have been periodic deficiencies in the past. The Ministry is well aware of the deficiencies and has made substantial efforts to improve the system. In the fall of 1982, contraceptives fell under the aegis of the Management Unit of Drug Supplies (MDS) within the Ministry, which handles all drugs, medical equipment and supplies for the Government of Kenya. DANIDA provides technical assistance and drugs to the MDS, and an evaluation of a newly established prepackaging system of drugs (including contraceptives) will be carried out in June 1983. If found effective, this system of facility supply and resupply should significantly improve ease of contraceptive access by subproject facilities.

Arrangements will be made to facilitate contraceptive availability and access by the project facilities. For example, funds will be budgeted in the subprojects to provide for private carrier transport of contraceptives from the Central Medical Stores to the subproject facilities in the event of emergency or temporary disruption of the Ministry of Health transport system. The presence of an Administration and Procurement Specialist on the team providing resident technical assistance can monitor the system closely, identify any problems early on, and help mobilize resources for resolution. Additionally, the

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project has provided for short term technical assistance in contraceptive management to the Ministry of Health if desired. Provision has been made for operational research in supply management. Finally, if emergencies in contraceptive supply should occur, the NCPD and USAID can request assistance from FPIA, Pathfinder, or the IPPF, as has happened infrequently in the past.

With the experience gained in implementation of this project and others, the Ministry of Health can be expected to have developed a highly efficient system by the end of the project. For a full description of the existing contraceptive logistic system and project-related information, see Annex F, Contraceptive Logistics Analysis.

3. Two hundred enrolled community nurses, midwives, clinical officers, and others trained in family planning motivation, clinical services, and management

One of the most important barriers to increased, effective family planning use in Kenya is the shortage of trained personnel to deliver services at health facilities. Enrolled Community Nurses are chiefly responsible for family planning and are authorized to insert IUDs, prescribe pills and distribute condoms, foams and jellies. Clinical Officers also provide services. Because basic training at schools for nurses and clinical officers is deficient in clinical family planning skills, both cadres must attend in-service family courses before being certified as competent in family planning service delivery. Other graded and ungraded cadres of health personnel are being trained to resupply contraceptives by the Ministry of Health.

Four important practical constraints must be considered in implementation of the training element:

a. The number of trainees from each subproject will be small, perhaps only one or two. Training design must therefore take the needs of individual working conditions and institutions and the socio-cultural characteristics of the recipient population into account while still providing cost-effective courses for a reasonable number of people. Eight three month courses for 25 persons are planned.

b. Clinical facilities for practice of techniques are essential. The training will therefore require access to facilities with sufficient numbers of clients to provide an acceptable level of practice for all trainees.

c. Training should be accomplished incountry, by locally-based institutions in collaboration with the Ministry of Health.

d. Provision of training must precede provision of contraceptives. The sequence to be followed would be introduction of information and education (if not adequately provided from other sources): provision of equipment and improvement of facilities; training and certification of family planning service delivery personnel; and finally, provision of contraceptive services. In order to preserve the integrity of this sequence, provision will be made where necessary for temporary placement of trained family planning service delivery personnel in clinics while full time staff are away for clinical training.

4. An improved training methodology developed, tested and imolemented for training family planning service providers

The Recipient of the Cooperative Agreement in consultation with the Kenyan Government will be required to prepare a detailed plan for the training of family planning service providers in each of the private sector subprojects. Such training arrangements must be approved by the Ministry of Health. The two major objectives of the training program are to provide certified staff for the subprojects capable of providing family planning services, and to develop a model or prototype training activity parts of which may be adopted for future training in this discipline.

Conceptually, the training design will be influenced by four factors:

- a. the need to meet Ministry of Health standards for certification;
- b. the need to address identified shortcomings in existing health workers' training (e.g., program management, target setting, operating procedures);
- c. the need to extend family planning programs beyond the delivery of clinical services to an integrated approach which responds to community and cultural needs; and
- d. the need to improve on a model for family planning training appropriate for Kenya.

In operational terms, this means that the training must incorporate the NFWC's family planning syllabus and also build on that syllabus so that the training is grounded in a problem solving and program management approach. The training curriculum will likely require modular unit design, be competency-based and firmly based in community diagnosis. The Ministry of Health will provide trainers to train trainers for the technical aspect of training.

It is anticipated that the training will cover three main areas:

- a. Program Management: including catchment population estimations, target setting, administration, record-keeping, reporting and evaluation and effective management of service delivery (two weeks).
- b. Operational Approach: including the importance of family planning in development and thus the need for family planning; family planning services as a direct response to cultural and community awareness and needs; creation of demand for family planning as a concept as well as a service; and family planning as part of an integrated service (two weeks).
- c. Technical Procedures: Nurses and clinical officers will be assisted to develop knowledge, skills, and attitudes to prepare them to function effectively in the MCH/FP setting through eight weeks of training. Two weeks will be theoretical work and the remaining six weeks will be practical training.

5. Four to five discrete operational research activities completed and reported:

In a demonstration activity of this nature which will explore new programmatic territories, opportunity must be provided to conduct, report, and disseminate results on operational research activities in order to clarify specific actions which impact on attainment of project objectives. During the first project year, the NCPD, USAID and the proposed Technical Assistance Team responsible for project implementation will identify four or five such activities. Section IV B. includes six specific suggestions for operational research in the areas of perceptions of management, methods preference, records adequacy, management input, client flow analysis, and contraceptive logistics/management.

6. Means for evaluating and disseminating results:

The Technical Assistance Team, in cooperation with the NCPD and USAID, will be responsible for developing an adequate data

collection system, including record keeping. The Technical Assistance Team will also be responsible for reporting on project results to the NCPD and following NCPD review, for disseminating results through conferences, at least two seminars, and other activities, as appropriate. The participants of the seminars will be private sector personnel related to on-going or completed demonstration subprojects, private sector personnel representing firms or organizations which are potential candidates for subproject or self initiated family planning activities, Government of Kenya personnel, and related donor representatives. The purposes of the conferences will be to exchange information on project experience, including progress of subprojects and reports of operational research, and to stimulate additional private sector family planning activities in both project-related and non-project-related firms and organizations.

E. Inputs:

From the USAID/Kenya perspective, the basic input is a grant to the Technical Assistance Team. Participating organizations, and the Government will provide at least 25% of the required resources - to the extent possible on a subproject by subproject basis. The Government will provide in kind contributions, primarily through project oversight, training and provision of contraceptives. The details of the inputs, including linkages to project outputs and purposes, are presented in the following sections.

III. Cost Estimate and Financial Plan

1. Summary Cost Estimate

The total estimated project is \$6,000,000 of which USAID will finance \$4,500,000 and the private sector and Government of Kenya combined \$1,500,000 in local currency equivalent (Kenya shillings). USAID's share will be in grant funds. The Kenya-based contribution is approximately 25% of the overall project cost. The table below indicates the estimated project costs:

Table - 1: Summary Project Cost (\$ 000)

	AID			Private Sector	GOK	Total
	FX	LC	Total	LC	LC	
a. Technical Assistance	1,355	565	1,920	-		1,920
b. Training		672	672	-		672
c. Demonstration Sub-projects	370	1,122	1,492	898	421	2,811
d. Evaluation	64	20	84	-		84
e. Contingencies	141	191	332	102	79	513
	<u>1,930</u>	<u>2,570</u>	<u>4,500</u>	<u>1,000</u>	<u>500</u>	<u>6,000</u>
			(75%)	(17%)	(8%)	(100%)

All foreign exchange costs include an inflation factor of 7.5% per annum and local currency costs include an inflation factor of 15% except that Government of Kenya costs include an inflation factor of 7.5% per annum because the costs associated with Government of Kenya contribution (contraceptives and services) are not expected to rise as rapidly as private sector costs.

The contributions of each party will be implemented as follows (see Annex C for details):

USAID will sign a Cooperative Agreement with a non-profit organization or a joint venture (Recipient). The Agreement will be for a period of four years to enable complete implementation of the project. The Agreement will cover the following costs:

a) Technical Assistance Team: The team will consist of three professionals of which one will be Kenyan and one Kenyan secretary, each for a period of four years, based in Nairobi. In addition, three person months of external and nine person months of Kenyan short term technical assistance will be required in such areas as management information services, contraceptives, commodity management and operations research. The estimate for the Technical Assistance Team includes the following costs: salaries, fringe benefits, overhead, transportation to and from Kenya for U.S. based families, in-country transportation & travel allowance, housing, furnishings, guard services, other allowances normally provided to U.S. employees in Kenya, office rental in Nairobi and its maintainance, four vehicles, (two for

the use of the team and two for subprojects), office equipment and supplies and workmen's insurances.

b) Training: The Recipient will provide training to subgrantee personnel directly or through a sub-contract with a Kenya based firm eligible for AID financing. It is estimated that 200 personnel each for a period of three months, will be trained over the life of project. The estimate includes the services of two trainers recruited locally, administrative support, maintenance of trainees, development of training materials and a sub-contractor's overhead.

c) USAID funds have been provided for midterm and final evaluations. Each evaluation will be conducted by a team consisting of two U.S. and two Kenyan specialists for a period of one month.

d) Demonstration subprojects: It is proposed that the Recipient provide support to approximately 35 demonstration subprojects. To estimate the cost of subprojects, the Project Paper design team prepared cost estimates for three prototype subprojects out of eight highly-likely subprojects, each subproject to run for a period of two years. The three prototype subprojects are as follows:

i) Protestant Church Medical Association: This organization, under a subgrant, will manage family planning services to 1600 acceptors in 10 clinics. USAID contribution will be for costs related to one Kenyan Project Director, one secretary, conferences, equipment and travel. The subgrantee will provide personnel, facilities, vehicles office and MCH equipment. The Government of Kenya Ministry of Health will provide contraceptives. An estimated total of five such organizations will be provided subgrants.

ii) Kenya Cannery: This private firm will provide family planning services to 300 acceptors. USAID will finance the costs of one Kenyan records clerk, supplies and equipment, and travel. The subgrantee will provide personnel (nurses), facilities, one vehicle and office and MCH equipment. The Ministry of Health will provide contraceptives. Approximately 15 organizations similar to Kenya Cannery are expected to participate in the project.

iii) Associated Sugar: This firm will provide family planning services to 225 acceptors. USAID will finance the costs of one enrolled nurse, supplies and equipment, and travel. The subgrantee will provide one medical officer for 10 percent of the time, facilities, vehicle and MCH and office equipment. The Ministry of Health will provide contraceptives. Approximately 15 organizations similar to the Associated Sugar are expected to participate in the project.

The cost estimate for the demonstration subprojects is as follows:

Table -2 Cost of Demonstration Subprojects (\$000)

Prototype	No of Subprojects	Grantee	Subgrantee	Ministry of Health (Contraceptives)	Total
1. PCMA	5	614.0	343.5	64.0	1021.5
2. Kenya Cannery	15	369.0	196.5	36.0	601.5
3. Associated Sugar	15	189.0	138.0	27.0	354.0
Total	35	1172.0 (59%)	678.0 (34%)	127.0 (7%)	1977.0

For costing purposes, in 1983 prices, the average subproject costs are: Grantee \$33,485, Subgrantee - \$19,371 and Ministry of Health - \$3,628 or a total of \$56,484. It is estimated that 12 subprojects will start six months after the Agreement is signed and will run for two years. If the rate of inflation is estimated at 7.5% per year for foreign exchange costs and 15% for local currency costs, the cost of these 12 subprojects will attract an average inflation rate of 9.4% for FX costs and 22.5% for LC costs. The remaining 23 subprojects are expected to begin 18 months after the Agreement is signed. Therefore, these 23 subprojects will attract an average inflation rate of 16.9% for FX costs and 37.5% for LC costs. The average costs for 12 and 23 subprojects are as follows:

Table - 3 Cost of Demonstration Projects with Inflation Factor
(8000)

	12 Subprojects		23 Subprojects		Total	
	FX	LC	FX	LC	FX	LC
Grantee	121.4	356.1	248.7	766.2	370.1	1122.3
Subgrantee		284.8		612.6		897.4
Ministry of Health		47.6		97.5		145.1

The cost of Ministry of Health and the National Council on Population and Development personnel participating in the project is estimated at \$29,000. In addition, Ministry of Health will provide contraceptives after the demonstration period of subprojects at a cost of \$247,000. The time required by Government of Kenya personnel is estimated as follows:

- 5% time spent by Director, National Council on Population and Development in panel meetings.
- 5% time spent by National Family Welfare Center in panel meetings.
- 5% time spent by National Family Welfare Center Trainers to train project trainers.
- 5% time spent by 8 district health and other personnel.

2. Financial Plan

a) The USAID grant contribution of \$4,500,000 will be disbursed as noted in Table 4, assuming that the project is authorized and obligated in late FY 1983.

Table - 4: Disbursement of AID contribution (\$000)

	FY 84	85	86	87	Total
a) Technical Assistance	550	400	500	470	1920
b) Training	120	180	160	212	672
c) Demonstration Subprojects	120	490	620	262	1492
d) Evaluation	-	-	40	44	84
e) Contingency	70	90	100	72	332
Total	860	1160	1420	1060	4500

b) Private Sector

The private-sector contribution of \$1,000,000 will be disbursed as shown in Table 5 (See Annex F for details).

Table - 5 Disbursement of Private Sector Contribution (\$000)

	FY 84	85	86	87	Total
Private Sector (sub-grantee)	72	296	378	152	898
Contingency	<u>10</u>	<u>33</u>	<u>41</u>	<u>18</u>	<u>102</u>
Total	82	329	419	170	1000

c) Government of Kenya Contribution

The Government of Kenya contribution consists of the cost of contraceptives and the cost attributed to time spent by Government of Kenya personnel.

Table - 6: Government of Kenya Contribution (\$000)
(See Annex C for details)

	FY 84	85	86	87	Total
Contraceptives	12	48	119	225	404
Personnel	6	6	8	9	29
Contingency 10%	<u>2</u>	<u>5</u>	<u>13</u>	<u>23</u>	<u>43</u>
Total	20	59	140	257	476
					Say 500

IV. Implementation Plan:

A. Responsibilities:

1. USAID:

The Health, Nutrition and Population Division of USAID has responsibility for project implementation and will implement the project following award of a Cooperative Agreement. The Population Officer is the project officer of the Private Sector Family Planning Project. The Projects

Division will provide necessary support as part of overall project management functions. The Government of Kenya will be fully involved in project activities, principally through establishment of and participation in the Project Technical Advisory Committee, described below.

2. Ministry of Health:

The National Family Welfare Center (NFWC) through the Ministry of Health medical logistics system will provide contraceptives and reporting forms to those demonstration subprojects which are designated by it as service delivery points after service delivery personnel are trained by the project to certificate level. The NFWC also will make family planning trainers available to instruct project personnel in the implementation of the NFWC in-service family planning syllabus. A representative from the NFWC will serve on the Technical Advisory Committee.

3. Office of the Vice President and Ministry of Home Affairs:

The National Council on Population and Development within the Office of the Vice President and Ministry of Home Affairs, shares overall responsibility with the NFWC for population activities in country. The Council will ensure oversight of the project through a Technical Advisory Committee of the Council led by a Chairman appointed by the Council. Membership on the Committee will include representation from the Ministry of Health (NFWC), USAID, the Technical Assistance Team (in an advisory capacity), and private and voluntary organizations with private sector activities in Kenya. The Technical Advisory Committee will meet at least once every three months, or more often if requested by the Chairman, to keep informed regarding project progress to date, to discuss problems and to review and approve plans for subprojects and research activities for the forthcoming six-month period.

B. Project Procurement Plan:

The following goods and services are to be obtained under the project:

1. Technical Assistance:

Long Term:

A Technical Assistance Team will be recruited for four years. The Grant will be by USAID award of a Cooperative Agreement selected from competing proposals from firms, non-profit organizations, and joint ventures of both.

2. Short term consultants:

a. Approximately three person months of external and nine person months of Kenyan short term technical assistance, in such areas as management information services, contraceptives, commodity management and operations research, will be secured by the Technical Assistance Team subject to USAID approval.

b. Approximately three person months of U.S. and two person months of Kenyan short term assistance for project evaluation will be procured by USAID through contract, IQC, personal services contract, or access to AID/W-provided resources.

3. Training:

The project training component includes provision of clinical, motivational and managerial training for about three months to approximately 200 health related personnel, the development and testing of new training methodologies for these personnel, and materials production. Training services will be provided by the Technical Assistance Team directly or through a sub-contract subject to approval of the Technical Advisory Committee.

4. Commodity Procurement:

a. Project Related Vehicles:

Four vehicles will be provided by project funds, two for the Technical Assistance Team and two for subprojects, such as those proposed by the Protestant Church Medical Association and the Lake Basin Development Authority. The vehicles required are right hand drive models such as Volkswagen Kombi minivans or equivalent. A source/origin waiver has been prepared for procurement of these vehicles; the waiver is appended as Annex P. The Technical Assistance Team will procure the vehicles locally or through a purchasing agent.

b. Other Project Related Commodities:

The Technical Assistance Team will be responsible for procurement of equipment and supplies for their office, and for equipment and supplies to be used in an estimated 30-35 sub-projects involving 40-50 separate health facilities. Office equipment will be the standard types of equipment found in a commercial office facility and will include a microcomputer, with supporting hardware, software, and an uninterruptible power supply. The 40-50 facilities which are part of subproject demonstration activities will be furnished MCH/FP clinical equipment and supplies and necessary

project-related record keeping and storage materials by the Technical Assistance Team. In general, such equipment and supplies must be of U.S. or Kenyan source and origin and must follow the Standard Provisions for procurement included as a part of the Cooperative Agreement. A commodity list appears as Annex H and a Procurement Schedule as part of Annex G.

c. Contraceptives:

Contraceptives used by the project will be provided by the Ministry of Health through its logistics system. The NCPD and USAID will call upon FPIA, Pathfinder, or IPPF in the emergency event the Ministry of Health is unable to regularly supply project-related service delivery points. (see discussion under Project Description, part II B.3.e and Annex J.)

d. Sub-project Selection and Management:

The Technical Assistance Team will identify, using criteria established after consultation with NCPD and USAID, potential subprojects and assist in subproject development monitoring, and evaluation. The Technical Advisory Committee, with NCPD and USAID participation, will approve selection of subprojects following procedures reviewed in the Administrative Analysis Section VI.D below.

Selection:

A preliminary outline of eight proposed subprojects appears in Annex N, with an inventory of other likely contacts for subproject development. The Technical Assistance Team will use for subproject selection criteria a format such as appears in Annex L, or similar guidelines acceptable to USAID and the Technical Advisory Committee. Terms and conditions of Grant Award and a proposed Grant Award form will be developed along the lines of those found in Annex L.

Implementation:

After Grant Awards are made, the Technical Assistance Team will arrange for the collection of baseline data (see Evaluation Arrangements, Part V, below), set up monitoring and reporting procedures, and begin arrangements for commodity procurement, training, technical assistance, operations research and project-related evaluations.

V. Evaluation Arrangements And Operational Research:

A. Evaluation:

At the beginning or soon after this project is

implemented, project-specific baseline data will be collected and analysed to establish a base against which additional activities related to private sector family planning can be measured as the project progresses. The Technical Assistance Team will be responsible for conducting the baseline survey and where necessary, the services of local consultants will be engaged. Baseline survey reports will include data on the following:

1. Monthly average family planning users by method per subgrantee;
2. Total population served by each subgrantee, and age/sex estimate;
3. Stock of contraceptives and source of supply per subgrantee;
4. Capacity to provide family planning services by each subgrantee;
5. Subgrantee's staffing and their family planning and maternal and child health needs;
6. Subgrantee's record keeping systems; and
7. The number of private sector health facilities offering family planning services to their worker/ workers and their dependents.

In consultation with the NCPD and USAID, the Technical Assistance Team will develop a comprehensive project evaluation plan during the first year of project activity. The project will be evaluated at two levels: namely, the project and subproject levels. The project has built in internal evaluations and monitoring to ensure that the implementation process conforms to plan in terms of inputs, work schedules and target outputs. The Technical Assistance Team will provide subgrantees with relevant forms, charts and plans of action that are time and target specific which will serve as a yardstick to measure on-going or completed project activities as evidence of achievements. At regular periods (to be determined by the Technical Assistance Team), the subgrantee will submit a report to the Technical Assistance Team. The report will cover numbers of family planning acceptors and users, contraceptive supply availability, and expenditures and will list problems, including those related to contraceptive supply.

At project level, one external evaluation with the collaboration of NCPD, the Technical Assistance Team and USAID (leading to a USAID Project Evaluation Summary), and four or five operational research activities will be completed. The

summary will be prepared about October, 1985, approximately two years after the project commences.

The external evaluation is scheduled for the first quarter of 1987, about three and a half years from the project start date. USAID will be responsible for preparing the Project Evaluation Summary, calling upon appropriate consultants (an estimated two local consultants, two weeks each for each appraisal), and the Technical Assistance Team as necessary. The periodic reports from the subgrantee will provide useful data for the evaluations as will the Technical Assistance Team's regular reports. The midterm evaluation is intended to show project progress and expose problems which are likely to have impact on project activities and purpose, particularly negative impact. Of special interest will be analysis of the cost effectiveness of alternative delivery systems, including those with and without subsidies and those which utilize income generated by institutions for family planning service delivery operating costs. The evaluation should provide recommendations for necessary midcourse project adjustments.

At least six months before the 1987 external evaluation, the Technical Assistance Team, in cooperation with the NCPD and USAID, will prepare scopes of work for the evaluation, and identify the types of expertise needed on the evaluation team. An estimated four person team, working for one month is anticipated.

The prime task of the evaluation will be to determine whether the project has achieved its purpose. The status of the project will be assessed against the project baseline survey report and the intended end of project status, as stipulated in the Logical Framework, Annex B. This evaluation will provide recommendations which will help determine any future follow-on activities to this project.

B. Operational Research:

An illustrative list of potential operations research activities appears below:

1. What are the perceptions that cause management to support family planning services?

One assumption of the project is that the private sector will perceive that benefits to it from family planning services outweigh its costs. Presumably, if this were true, the likelihood of sustainability after

external assistance increases. It is important for sustaining and for attracting other private sector involvement, to identify the favorable and unfavorable perceptions of management.

2. What methods of contraception are preferred?

National figures show the pill as the modern contraceptive most frequently in use (Kenya Fertility Survey, 1977-78:132). In some areas, however, IUDS are relatively more common than is the case in the national average. In other areas condoms are apparently second in preference. Variables such as geographical locality, type of private sector organization providing services, average distance from services, and hours of clinic operation may be identified as significant. If so, the findings will be useful for such purposes as future subproject design, estimation of requirements, types of training needed and project targeting.

3. How adequate are standard Ministry of Health client records for programmatic use?

The standard Ministry of Health client records forms for enrolling new acceptors and estimating continuation rates appear complex for clinical use. If they are, they could be a deterrent to accurate and complete recording.

4. Of the various delivery systems to be utilized, which systems are cost effective and require the least amount of management input?

A number of different MCH/FP delivery systems, e.g., commodity based distribution, clinic-based services and mobile units, have been tried as demonstrations in Kenya. Subprojects of this activity will also utilize varied delivery systems. Cost considerations will be important. The project should identify sustainable methods of delivery which can be replicated throughout Kenya. A comparison of the costs of the subprojects for each new family planning acceptor, each continuing family planning user, each couple-year of protection, and each birth averted is required. The project should demonstrate that there are low-cost models for the delivery of family planning services that can be replicated.

5. Client Flow Analysis :

About 200 clinical personnel, mostly nurses and clinical officers, will be trained in maternal and child health/family planning in anticipation that upon completion of their training, they will be able to efficiently serve family planning clients. After they return to their clinics following training, client flow analysis might be done during the second year of the project in order to determine:

- a. The work-load of the clinic staff,
- b. The number and nature of contacts with clients how much time is given to each client, and the overall length of time the client spends at the clinic. This study would show how much of nurses or clinician's time (particularly the time of those who are trained) is spent providing family planning services and how best the management is using the family planning skills of their trained personnel.
- c. The routing of family planning clients at the clinic, availability of space, and the privacy available at the clinic.

The above factors are important because a busy, crowded clinic, lacking privacy is less likely to attract many clients even if it is well staffed and located close to the residential area. Long waiting hours before a client receives services also are likely to discourage many from coming for services. The client flow analysis is therefore a management tool used to identify problem areas in clinic operations which need improvement to increase clinic attendance.

6. Contraceptive logistics and management

The objective of operations research on the contraceptive logistics and management system is to determine how the system is working; and, if it is not working effeciently, to identify problem areas and take corrective action.

a. Contraceptive audit

There should be routine checks to trace the flow of supplies from orders placed by the project service selivery points to the end

user, the acceptor. This will help to determine if goods are arriving at service delivery points in sufficient quantities and if the balance of stock on hand at service delivery points reflects contraceptive shipments, less contraceptives provided to acceptors. Problems related to shipping losses or theft, deployment to other facilities or lending/borrowing among service delivery points can be identified. This would be especially pertinent for methods in demand and in short supply (or commanding high commercial prices).

b. Inspection of subproject inventory records, ordering procedures and storage practices

Project-related inventory records, ordering procedures, and storage practices should be reviewed approximately once every 8-9 months and, in the initial grant year, within three months of implementation. The records of each project site should yield concise information on supplies ordered and received. Inventory records and ordering procedures should show methods and amounts ordered, quantities delivered, date of receipt, condition, method of transport, cost, etc/ Inventory record also should show monthly and quarterly release of stocks, by method from the storeroom.

Storage practices could be checked to ensure a first-in-first-out draw down system and clean, vermin-free facilities.

c. SURVEY SUBPROJECT CONTRACEPTIVE MANAGEMENT SYSTEM:

1. The Technical Assistance Team could develop a system with concise forms which would allow a spot check, by method of all goods on hand, monthly dispensing patterns, and adequacy of stock levels in past months. A minimum-maximum system could be established for each site, after method-specific stock needs are identified these should be maintained at a level of, for example, three months minimum and four months maximum need.

2. Review of records on the number of acceptors, method, and quantity provided to each person would yield information on the validity of projected needs. This data could be matched with information on quantities supplied to a

site to ascertain if requests for stocks are realistic and adequate to maintain the 3-4 months' supply. Such a review would indicate if projections of the needs are matching the demand for each method.

3. Part of the management system should include an automatic means for triggering requests for procurement to SIDA to avoid shortages of stocks. A lead time of at least 8-9 months is suggested for project planning and management purposes.

4. The Ministry of Health will need information on annual project needs at least one month prior to placement of its yearly order to SIDA, and contraceptives usually are expected to arrive within three to four months. Another month is required for delivery. Thus, analysis of past contraceptive use by site, and aggregation to an annual total, should begin three months prior to the date Ministry of Health expects to place its order with SIDA.

VI. Project Analysis

The set of analyses below presents a summary of the significant technical, economic, social and administrative aspects of the project. Details are available in the project annexes. During project development, a number of drafts of the Project Identification Document (PID), feasibility studies, and sections of the Project Paper were submitted for review by USAID/Kenya staff, Government of Kenya personnel, and USAID/Washington reviewers. The analyses take into account the issues raised throughout this process and reflect the conclusions that underlay the project design.

A. Technical Analysis:

The project comprises a significant number (30-35) of discrete subprojects which in the aggregate will take place at 40-50 separate health facilities in the private sector. Each subproject involves relatively minor commodity inputs, but each requires considerable investment of technical and management assistance in subproject design, record keeping and evaluation. No new clinical or managerial technologies are being developed, (with the exception of developing and testing various methodologies for training clinical officers and nurses), but the concept of direct donor assistance to for-profit organizations in family planning service delivery is new in Kenya. This analysis will examine the technical feasibility of assisting the private sector to provide family planning services through demonstration subprojects which are labor intensive, yet involve minor resource transfers. It will first present three illustrative subprojects, one in which

family planning activities will be introduced for the first time (Kenya Cashewnuts Ltd.), one in which family planning activities will be improved (Kenya Cannery), and one in which a church-related association will identify and support a number of different activities in church parishes across the country (Protestant Church Medical Association). The analysis will then look at the various technical inputs in relationship to feasibility.

1. Illustrative Subprojects

a. Kenya Cashewnuts Limited

The Kenya Cashewnuts Limited is located just off highway B.8 about 5 kilometers north of Kilifi, Coastal Province. The plant employs nearly 2000 personnel in its processing plant and plantation. It provides curative health services in its small dispensary. The company plans to double the physical size of the dispensary soon. The present facility is staffed by one clinical officer, two enrolled nurses, and five ungraded staff. Company health staff live mainly in the surrounding area, as only senior staff are housed at the headquarters.

The health care staff are interested in providing family planning services, but lack the resources and training to do so. The nearest source of family planning is five kilometers away at Kilifi. The source is considerably further away for those who live in the outlying areas. Over half of the employees are women.

Presuming a five percent new contraceptive acceptance rate during the two year subproject, it should be possible to recruit and serve one hundred new acceptors among the 2000 employees.

The company will provide 80 square feet of space designated for family planning in a new addition to be added to the present dispensary. It will make a vehicle available as needed for family planning. The company will be credited with depreciation for such vehicles as well as for depreciation on health/MCH equipment. Contraceptives will be provided by the Ministry of Health.

The Recipient will provide:

- up to two person weeks of technical assistance in such areas as records keeping

and information management, contraceptive -
logistics, planning, clinic management,
evaluation etc.

- training funds for up to three months of motivational and clinical training for each of two enrolled nurses, as well as up to three months of such training for the clinical officer.
- funds for supplies, office equipment, hand calculators and contraceptive-related equipment including an examining couch, IUD insertion kits, baby scales, etc.
- a fixed - rate reimbursement of Ksh three per kilometer for family-planning-related travel.

The actual budget (found in Annex J) will be part of the Grant Agreement to be negotiated between the Recipient and Kenya Cashewnuts Ltd. The Agreement is conditional on approval by the Private Sector Family Planning Technical Advisory Committee, in consultation with USAID.

b. Kenya Cannery Limited

The Kenya Cannery Limited (Del Monte) is the largest American-financed employer in Kenya, with a staff of about 6000. Its headquarters and main plantation are at Thika, about 55 kilometers north of Nairobi. Curative medical services are provided at a factory dispensary by a clinical officer, who receives supervision one hour daily by a part time contract physician. Four other dispensaries spaced along a 30 kilometer road extending from the headquarters are staffed by an aggregate of six enrolled nurses and four ungraded nurses. These four dispensaries are under the medical supervision of a second physician, (under contract) a pediatrician with public health training and a long and active interest in family planning including surgical contraception. Her practice is a general one. Her office, about 10 kilometers away, is adjacent to a privately run family planning service delivery point. Kenya Canner workers now seeking family planning services must take off work, pay Kshs 30 for round trip fare to Thika, and visit either the Ministry of Health hospital (long queues) or relatively expensive private facilities.

The company at one time provided family planning services under the auspices of a social worker. After her departure, however, the replacement apparently did not share her interest, and the services 'disappeared.' Management is keen to introduce family planning in order to reduce time away from work on (pregnancy) maternity leave. The supervising physician, who will be the general medical supervisor, is fully supportive.

Of the 6000 employees, 4000 (half women) work on the plantation, and 2000 (1420 women) at the plant. Assuming a five percent increase in acceptance of family planning services among these 5000 employees, approximately 300 new acceptors should be added during the two year sub-project.

Kenya Cannery will provide the following under the proposed activity:

- medical supervision by the medical consultant throughout the life of the subproject and the additional services of four enrolled nurses, who will spend one-fourth time on family planning.
- transportation to clinics (150 km/week).
- a total of 100 square feet designated for family planning service delivery.
- general MCH equipment and vehicles.

The Ministry of Health will provide contraceptives.

The Recipient will provide:

- a record keeping officer to help develop an efficient method of record keeping. After the subproject ends, this function may no longer be needed. Alternatively, Kenya Cannery may extend his/her employment.
- up to three person months of technical assistance in such areas as medical and contraceptive logistics, clinic management, supervisory techniques, baseline data gathering, information management, evaluation, planning, etc.

- family planning motivation and clinical training for up to three months each for each of the six existing enrolled nurses, and for four additional enrolled nurses if hired (as planned) by the company. Such training will assure that there will be a motivated and trained person at all times at each of the five facilities. Additionally, two months of similar training will be provided by the clinical officer.

- funds for office equipment and furniture (including file cabinets), flip charts, and contraceptive related supplies and equipment, including IUD insertion kits, rubber gloves, examining couches, pelvic models, pregnancy testing kits, etc. Additionally, should the supervising physician obtain refresher training as planned, a minilaparoscope kit will be provided for her clinic use.

C. Protestant Church Medical Association

The PCMA, an affiliation of most of the Protestant medical providers in Kenya, currently comprises 15 hospitals and 51 clinics/dispensaries under separate management. The PCMA managerially has been very weak (Contribution by and Future Potential of the PCMA in the Delivery of Health Services in Kenya, Dr. Gordon W. Brown, CORAT, 8 December, 1982) a situation which should change markedly in June, 1983 when Dr. Geoffrey Irvine (now Director of Chogoria Hospital) becomes full time medical Director of an expanded PCMA management structure made possible by funds from the multidonor Integrated Rural Health and Family Planning Programme. In addition to improving management capability, the IRH/FP will upgrade 18 PCMA service delivery points. Many others of the PCMA dispensaries have indicated willingness to provide family planning services but lack the trained staff, supplies and equipment to do so. This subgrant will enable PCMA to introduce or augment family planning services in ten of the facilities not being assisted by the multidonor Program. It is the intent of this activity to provide PCMA with staff, funds, supplies, transport equipment, and technical assistance to enable these ten as yet unidentified sites to become service delivery points efficiently providing modern family planning services.

After USAID selects the Recipient of the Cooperative Agreement, in consultation with the Kenyan Government, the Recipient will negotiate a subgrant with the PCMA. The PCMA, in turn will select the ten service points with its constituent members, in collaboration with the Recipient Technical Assistance Team. The requirements for the facilities of the constituent members vary as will contributions of each entity selected.

Most participants will contribute the following:

- space designated for family planning services
- staff for training, and provision of services
- MCH related health equipment, i.e.
 - sphygmomanometers
 - laboratory services
 - stethoscopes
 - baby scales
- participation in baseline surveys and records keeping.

The PCMA will provide:

- office space for two staff
- duplicating machine (depreciation)
- back-up administrative support
- motor vehicles (depreciation)

The Ministry of Health will provide contraceptives.

The Recipient will provide:

1. To PCMA

- a Project Director and secretary for the grant period. It is anticipated that at the end of the Project, the ten sites will be self-sufficient. The need for these personnel will cease unless PCMA continues funding the positions to establish additional service delivery points.
- up to four man months of technical assistance in such areas as medical and contraceptive supply management, information management, supervisory techniques, planning of community outreach, etc.

- family planning motivation and clinical training for two persons from each facility for two months each (40 person months). Additionally, funds will be provided for three - 3-day conferences to be held in Nairobi or elsewhere for clinical and/or managerial short courses and information exchange among the subproject personnel and other interested parties.
- funds for office supplies, postage, telephone, office equipment, desks, chairs, wastepaper baskets, file cabinets, an electric typewriter, flip charts, and desk calculators.
- a fixed rated mileage reimbursement at the rate of Ksh 3/- per kilometer, and a per diem of Ksh 300/- per day to permit the project director to visit each site at least once monthly for administrative, supervisory and data coordination purposes.

2. To each of 10 sub units

- Prior to implementation, the ten subproject sites will be identified and a needs assessment made by PCMA of selected facilities not being assisted by the IRH/FP Program. A Grant Award will be prepared by the Technical Assistance Team, and approval sought from USAID. The following supplies and equipment list is illustrative only.
 - Hand held calculators with batteries, (2 per unit)
 - IUD inserting kit (2 per unit)
 - pelvic models (1 per unit)
 - examining table (1 per unit)
 - desk (1 per unit)
 - chairs (3 per unit)
 - file cabinet (1 per unit)

- sterilizer (1 per unit)
- rubber gloves (1500 per unit)

3. To Hospitals

- In the event one or more hospitals are selected as service delivery points, needs likely will be more extensive, and in addition to items similar to above, may include additional surgical equipment, minilaparoscope kits, etc.

2. Feasibility of Assisting the Private Sector Provide Family Planning Services:

The need for expansion of service points for delivering family planning services beyond Ministry of Health facilities has been well established, most recently in the multidonor World Bank's Staff Appraisal of an Integrated Rural Health and Family Planning Program. Indeed, assistance has already been provided to these organizations by, among others, the Family Planning Association of Kenya, women's organizations, health facilities of non-governmental organizations (mostly church-related), and intermediaries funded by AID/Washington such as Family Planning International Assistance (FPIA), Pathfinder, and the Center for Development and Population Assistance (CEDPA). What has not been tested by USAID is whether private-for-profit organizations which provide general curative services to their employees and/or their dependents would be willing, with minimal assistance, to add on family planning to their service package.

After gaining from the Government of Kenya general approval of the concept of increasing private sector capacity to provide family planning services, the USAID Mission explored feasibility through a study, Opportunities for Private Sector Family Planning Information and Service Activities in Kenya (Lyle Saunders, American Public Health Association, June 15 - July 20, 1982.) During that brief consultancy, approximately 50 private organizations known to have expressed an interest in some aspect of family planning were identified. USAID/Kenya proceeded to PID development. During development of the PID, the receptivity of women's organizations and church-related health organizations was confirmed, as expected. Initial enthusiasm by the for-profit organizations was sufficient that the emphasis of the proposed project approved in the PID (February, 1983) was directed to the for-profit portion of the private sector.

The Project Paper design team confirmed that most for-profit firms contacted agreed readily to participate in short-term (usually two years) demonstrations and agreed as well to make in-kind contributions, with relatively little project infusion of physical resources. The firms recognized the requirements for significant assistance in training, project management, and evaluation, but agreed in principle to take responsibility for maintaining services after the demonstration period. They did this with the knowledge that it is very difficult in Kenya to eliminate a health benefit (in this case family planning services) from company-provided health services once they are established.

Accordingly, the conclusion of this analysis is that the for-profit organizations are willing to participate and contribute to a demonstration activity that has recognized and accepted continuation costs even before the expected results of the demonstrations are realized. The project design includes provision for confirming both sustainability for project-assisted demonstrations and for spread-effect to non-assisted private organizations which may add family planning to existing services.

Technical Inputs in Relationship to Project Feasibility:

1. Technical Assistance:

The resident Technical Assistance Team will provide competence in management, evaluation, administration and procurement, which are the predominant skills needed in a demonstration activity of the type proposed. There is no dearth of available clinical skills in Kenya, thus no overriding requirement that such competence be provided through technical assistance. Moreover, identified needs for additional short-term consultants (management information system, contraceptive logistics, and operational research) will address specific at-risk points in project implementation, and thus will contribute to project feasibility.

2. Training:

The training needs identified (clinical, motivational and managerial), are appropriate. The Ministry of Health will ensure that unless the providers are trained to the point of Government certification, the demonstration activities will not be conducted. The proposed training program affords the opportunity to develop training methodologies which not only will benefit this project, but which may have long term implications to Ministry training programs. The anticipated

educational methodologies (competency-based training based on needs assessment and modular curriculum development) are not new, but have not yet been utilized in Kenya for training this category of personnel.

3. Operational Research:

The recognition that needs will exist for operational research has been addressed during project design and discussed in Section V. B. This research will afford a mechanism for examining issues which might impact upon achieving the project purpose, and which cannot be fully delineated during design. Examples of possible research activities are included in the design, however, the implementors of the project, with approval of the Private Sector Family Planning Technical Advisory Committee, will be responsible for identifying appropriate research areas.

4. Commodities:

The provision of commodities, while important, is not absolutely critical for project success, except in the case of contraceptives, particularly orals. The contraceptives to be utilized in the project are neither procured by USAID nor will they be under any direct control by the Technical Assistance Team. The commodities will be provided by another donor (SIDA) to the Ministry of Health, and will be supplied to the subprojects through the Ministry's medical logistical supply system. The system, like all such systems, has had deficiencies. To the extent possible, project design has established mechanisms to help provide continued contraceptive supply in the event of temporary system disruption. Because the contraceptive supply management system is outside the control of both USAID and the Technical Assistance Team, however, there would be a real risk to achieving the project objectives if any Ministry of Health supply system deficiencies, which might arise during implementation, were not resolved in relatively short order.

The obvious alternative of USAID supply of contraceptives, bringing with it within project control, suggested itself very early on, but was rejected due to strongly expressed Ministry of Health concerns. The Ministry is concerned about program disruptions which would likely occur with introduction of a new contraceptive logistics system utilizing unfamiliar contraceptives. USAID honours this sensitivity.

5. Summary:

This analysis concludes that the fundamental project hypothesis, namely that it is possible, through bilateral

assistance, to assist the private sector "demonstrate and increase the institutional capacity to carry out sustainable programs for the delivery of family planning and related maternal and child health services", is technically sound. Technical components of the project, including training, are well designed and should contribute positively to project success. To the extent possible, the project design has fully taken into account the technical resources needed. Some concern (and associated risk) attaches to continued project access to contraceptive supply, but the facts that the Government of Kenya has a clear policy on family planning, has no legislation harmful to private sector provision of family planning services, has a policy of regular and free provision of contraceptives to certified private-sector organizations (including for-profit organizations), and has encouraged USAID to develop this project, makes the risk an acceptable one.

A. Economic Analysis:

1. Theoretical Overview:

Performing a Benefit Cost Analysis of population projects constitutes a complex economic task which to date has yielded inadequate results. The standard Benefit Cost Analysis (BCA) approach, developed by S. Enke in the early 1960's, considers as benefits the present value of the private and public costs of raising a child. The major benefit is the reduced level of expenditure, both public and private, for consumption related to raising the child into a productive entity. Costs include the provision of family planning services and the opportunity cost of the child's foregone, life-time productive output.

The standard BCA approach has been criticized, even by its supporters, for the uniformity with which it predicts high positive benefit cost ratios, since the benefits in terms of the costs of raising a child accrue in the early years of the project, while the costs in terms of earnings foregone occur only after fifteen or more years, and are greatly reduced by the process of discounting. Thus, the standard Benefit Cost Analysis technique concludes uniformly that no births are better than births. The tautological nature of this approach, combined with its implausible conclusions for all societies and families, requires that fundamental aspects of the approach be reconsidered. The reader is referred to Annex D, Part I, for a discussion of the shortcomings of the standard Benefit Cost Analysis technique, and the modifications which have been adopted for the present analysis.

Owing to the inherent bias of the standard Benefit Cost Analysis approach, the analysis presented below also considers cost effectiveness analysis. Cost Effectiveness Analysis does not attempt to quantify benefits; instead, Cost Effective Analysis assumes the appropriateness of an ultimate goal within a predetermined budget. The question then becomes "Which use of funds will provide the most progress toward the goal over a given time frame?" Cost Effective Analysis compares costs in the numerator with non-monetized benefits in the denominator. Clearly, the best ratio is the one which maximizes benefits by maximizing the number of family planning acceptors, births averted, delivery points established, etc.

2. Relevant Project Characteristics:

The project addresses a specific target population composed of the 20% of the labor force which is employed in the modern sector. Studies have shown that employed women are more receptive to family planning than other women, and that women employed in the formal sector already record lower fertility rates than the average Kenyan woman. (See Annex D, part II.) Wage employment among men may also be related to reduced family size, since clothes, education, health care and other costs of raising a child may be subjected to higher standards as incomes increase. Furthermore, the existence of pension plans for employees in the formal sector eliminates one traditional motivation for large family size, the need for children to assure security in old-age. Thus, it is probable that the project will show an acceptance rate higher than the 5% which represents the present acceptance rate in Kenya. As a result of such selective targeting delivery costs per birth prevented will be lowered, a principle feature of project design.

3. Conclusions of the Benefit Cost Analysis:

The Benefit Cost Analysis for one birth averted is summarized in Table 1 of Annex D. The assumptions and data on which each item discussed in the table is based are discussed in Part III of that Annex. The analysis has been carried out for 55 years, or the average life expectancy in Kenya in 1980. The table below sets forth the conclusions of the analysis at discount rates of 10% and 15%.

Table 6: Benefit/Cost Summary of One Birth Averted

Year	<u>At 10% Discount</u>		<u>At 15% Discount</u>	
	First Birth	Subsequent Births	First Birth	Subsequent Births
20	2.17	3.36	2.12	4.36
30	1.34	1.60	1.59	2.37
40	1.17	1.34	1.47	2.08
50	1.09	1.23	1.43	2.00
55	1.06	1.19	1.42	1.98

NOTE: The analysis for first births by new acceptors is based on the figures set forth in Table 1 of Annex D. Subsequent births are defined as births averted after year three, when project start-up funds have been expended. Table 2 in Annex D summarizes the benefits and costs of subsequent births averted.

Making the transition from new family planning acceptors to the number of births averted represents a difficult step in carrying out a BCA. There is no precise, quantifiable relationship between the number of family planning users and the number of births averted. If family planning is used to maintain the present average Kenyan birth interval of 30 to 33 months (depending on the data set utilized), the project would serve primarily to prevent further increases in fertility, rather than to reduce the fertility rate. The project could also result in a time pattern of delayed births, with a longer birth interval. This would ultimately result in smaller family size as women pass the years of child-bearing. There also exists a problem of substitution, or of separating the impact of family planning service delivery from changes in fertility that would occur without intervention as socio-economic conditions improve. However, in Kenya, improved socio-economic conditions have been accompanied by a desire for, and ability to have, larger families. These problems render quantitative estimates less precise, but do not reverse the overall trends and conclusions.

The average reproductive life of a Kenyan woman is estimated at 25 years, since the onset of menopause tends to occur early. Only 58% of women over the age of 35 are able to bear children^{1/}. Dividing the average reproductive life by the average number of live births per woman, it is estimated that three years of contraceptive use is equivalent to one birth aversion. Given the actual periods of pregnancy and amenorrhea, however, it would not be unreasonable to assume

Mosley, Henry, L. Werner and S. Becker, "The Dynamics of Birth Spacing and Marital Fertility in Kenya" Scientific Reports, 1982.

that two years of protection is equivalent to one birth averted. Nonetheless, this analysis is based on a more conservative estimate of three years of protection for one birth averted. The following assumptions were adopted to make the transition from the years of contraceptive protection provided by the project to the number of births averted:

1. Three years of contraceptive protection is equivalent to averting one birth.
2. There will be 30,000 family planning acceptors (male or female) by the end of the project. This number will remain constant in subsequent years; as previous acceptors drop out of the program to have children, new acceptors will replace them, since the services supported under the project will continue to function.

Under this set of assumptions, the project has an acceptable Benefit/Cost ratio over the three year active life of the project (that is, year 2, 3, and 4). This ratio includes the discounted stream of costs and benefits for the average 55-year life time of all births averted during the four year life of the project. Assuming that the program continues to operate for 20 and 20 years after its inception, the Benefit/Cost ratio increases, as shown in the table below.

Table 7: Benefit/Cost Summary for Overall Project

	10% Discount rate	15% Discount rate
Four-year LOP	1.23	1.43
After 10 Years	1.36	1.58
After 20 Years	1.38	1.74

Owing to the predictable nature of Benefit Cost Analysis for population projects, various modifications have been posited. Most suffer from the same basic biases which afflict the classical Enke/Zaidan approach. However, one modification, the elimination of discounting, is worthy of mention. Discounting produces an inherent bias against all development programs which are predicated on enhancing future productive capacity, such as education and child health programs. While eliminating discounting runs counter to the basic economic tenet that resources have an inherent opportunity cost and should therefore be put to work to generate future wealth, it does serve to remove the bias against the future.

If discounting is eliminated, the analysis contained herein would carry a Benefit Cost ratio of 0.19. This low ratio should be predictable, as most people earn more over a lifetime than they personally consume, especially if they have children. Without discounting, a Benefit Cost ratio would be positive only if a person consumed more than he produced, e.g., if he/she were on welfare or were supported by his family throughout his lifetime.

4. Sensitivity Analysis:

The role of sensitivity analysis is to test variations in key assumptions to determine the sensitivity of overall conclusions. One standard sensitivity test regards the discount rate. This test has already been met, with alternative discount rates of 10% and 15% utilized throughout the analysis. If the discount rate were to be increased, the B/C ratio would improve further, owing to the relatively greater impact of discounting on the early years of the project which favors benefits in terms of consumption foregone.

A second sensitivity test relates to decreases in project benefits. If consumption for an unborn child were increased by 10%, reducing the benefits of a birth foregone, the B/C ratio for one birth averted would decline to 0.98 by year 50, with a discount rate of 10%. Using a discount rate of 15%, the B/C ratio for a birth averted would be 1.28 at the end of a 55 year life. If costs for a birth averted were to increase by 10%, the B/C ratios would follow a similar pattern, as shown in Annex D.

For the overall project, if benefits were reduced by 10 percent, the B/C ratio using a 10% discount rate would fall to 1.24. If costs were increased by 10%, then the B/C ratio would fall to 1.25. If both costs and benefits were to change by 10%, the B/C ratio would be 1.12. Since a 10% discount rate yields lower results than a 15% rate for population projects, this ratio is acceptable from an economic perspective.

5. Cost Effectiveness Analysis:

Cost effectiveness analysis is predicated on two basic criteria: 1) the selection of the most cost effective approach to achieve a given objective within a defined time period, and 2) the maximizing of the benefits and beneficiaries to which project supported services are extended.

The project focuses on private sector delivery of family planning services to wage earners and their families, who are considered to constitute the most receptive target group in Kenya. Alternative delivery systems include public health services and voluntary, non-governmental organizations (NGO) such as church groups. Experience with public service delivery shows that approach to be inefficient in reaching large portions of the population owing to waiting and travel time, and supply problems with contraceptives. Furthermore, public services create an operating cost burden which the Government of Kenya cannot presently afford. NGO's, while more efficient, also must be subsidized by charitable contributions and may involve a distance factor which has been shown to reduce acceptance.

Since NGO's are private and do not require public funds, they are included in the proposed project. However, the primary focus of the project is the private for profit sector. Health service delivery in this sector is generally efficient, with minimal waiting time and/or travel time for employees, since services are on the work premises, or transport is provided by the company. Furthermore, no subsidies are required, since companies recognize that efficient health services increase productivity, in part by reducing time away from the job. Thus, the project has selected the most cost effective and time efficient method to achieve project objectives of reaching 30,000 new family planning acceptors over a four year implementation period.

With regard to maximizing benefits, it is self-evident that cost effectiveness improves as fixed project costs are spread among more beneficiaries. In this context, it should be reiterated that utilizing the average Kenyan acceptance rate of five percent, which prevails in an environment of poor service delivery, large distance factors and lower income women, represents an extremely conservative estimate of acceptors for a target population, especially if their inherent acceptance is reinforced with efficient service delivery and appropriate work-related incentives. Thus, the project should be considered cost effective with respect to both criteria governing cost effectiveness considerations cited above.

C. Social Analysis

This project has been designed with reference to a number of data sources, including the 7th Chapter of the Kenya Social and Institutional Profile entitled "Fertility in Kenya" appended as the Social Soundness Analysis Annex E. The Annex presents an overview of development processes relevant to fertility change in Kenya. It therefore provides the basis for the proposed project approach which focuses very specifically on certain categories of likely users of family planning services, and on the various institutional frameworks countrywide which show promise as service delivery points but have yet to be fully exploited. Below is a brief summary of the central factors considered in the process of ensuring the social soundness of the effort from the very outset of project conceptualization and design.

1. Socio-cultural context:

The socio-cultural context supporting the current low level of aspirations regarding fertility control is described in Annex E. Perhaps the clearest illustration of the current situation is seen when the impact of family planning service delivery is compared with the practice of prolonged breast-feeding on fertility patterns in Kenya. Currently only about 5% of all women use modern contraceptives, and there has not

yet been measurable impact on fertility rates outside of major metropolitan areas attributable to family planning practices. Virtually all women in Kenya breastfeed, and the mean duration of breastfeeding is 16.7 months. Breastfeeding retards onset of menstruation and ovulation ("postpartum amenorrhea"). The mean duration of postpartum amenorrhea (and thereby protection from pregnancy) is 11.2 months. If the duration of breastfeeding continues to decline in the face of modernizing influences and comes to approximate the level of two months found in Western populations, for example, "fertility in Kenya would rise by 25% unless compensated for by contraceptive practice. (CBS 1981:5)¹

A recent study (1980) of women working in three enterprises in Kenya (Kenya Cannery Ltd., Kenya Cashews Ltd and British American Tobacco) provides preliminary data which illustrate the interaction between modernizing influences, duration of breastfeeding and family planning acceptance. Of the women surveyed who had given birth while a member of the labor force, 56% breastfed their newborn less than seven months. Current use of family planning among the women (not including the Kenya Cannery subsample) was 15%. While the 15% figure of family planning use is well above the national average, its resulting impact on fertility must be considered in relation to the decline in duration of breastfeeding among these women. This decline in breastfeeding significantly increases the vulnerability of these working women to pregnancy. (C. Robins - Personal Communication 6/83).

A recent nationwide study of fertility in rural Kenya reinforces the view that fertility change in Kenya is only at the very earliest stages of a transition to birth limitation. The study focuses on the perceptions of rural household heads which reflect the relatively ineffective family planning information and education efforts undertaken to date. Clear examples of these discrepancies are found in relation to the expectations fathers hold for provision of education for their children and land for their sons. Fathers desire, on average, 4.5 sons (the mean number of live births among Kenyan women is 3.1). For sons, fathers expected to provide an average of 13.0 years of education. (For daughters, the average is 12 years of education). Given comparable expectations in each rural

1. Central Bureau of Statistics "Modernization, Birth Spacing and Marital Fertility in Kenya" Social Perspectives Vol 6 No. 5, 1981.

household, it is clear that at current fertility levels the financial resources are inadequate for the full realization of this expectation (Dow and Werner 1983: 89-90). ^{1/}. The study team also asked fathers who had land (jointly or individually owned) if they expected to give land to each son. "87.2% expected to give land to each son while only 12.8% expected to give land to some but not all sons." (Ibid:90). As the average land holding among respondents was 5.13 acres, a desired son would be inheriting only an acre from his father. In the words of the authors:

At the moment, while most fathers would like to make a generous economic and educational provision for their children, they are not willing to confront the fact that their own current fertility precludes the full accomplishment of these objectives (Ibid:91).

An inference to be drawn from recent studies, then is that given current conditions supporting high fertility in Kenya, maintenance of existing fertility rates may be the most likely prospect in the near term despite existence of the national family planning program.

2. Beneficiaries:

Women will be the prime beneficiaries of the project; men will also be encouraged to participate. The number of families expected to benefit from subproject activities over the life of project is conservatively estimated at 30,000. As the scope of the project includes demonstration, an unspecified number of additional beneficiaries is anticipated during life of project, and to an increasingly extent, beyond end of project. As initiatives taken under this project will improve or may even stimulate introduction of health care integrated with family planning, additional health benefits will accrue to families using subproject services.

Profit-making institutions will expect to benefit through reduced levels of maternity leave and/or sickness as a result of effective MCH/FP services, as will organizations which effectively utilize resources provided by the project. To the extent that fertility is reduced in the country, benefits will extend indirectly to all those who must compete

^{1/} Thomas E Dow & Linda H Werner, "Prospects for Fertility Decline in Rural Kenya, in Population & Development Review 9 No.1 March, 1983.

for limited resources. The project focus on for-profit activities will mean that many beneficiaries will come from segments of the population having wage employment who will be in a position to pay for health services in non-government fee-for-service facilities. A second significant number of beneficiaries will be members of women's groups and other voluntary associations who are involved in income-generating activities. A third will be those, particularly in rural areas, who are involved in and/or utilize church-related health services. All of these categories represent categories of families more fully involved in the modernizing forces which are rapidly transforming Kenya rather than the average rural farm family. As such, they are from the relatively better-off segment of the population rather than from the "very poor" rural segment. Thus prime beneficiaries of this project are not, nor are they intended to be, the very poor rural population.

(3) Participation

An essential feature of the project is the requirement that institutions involved in subproject activities provide a considerable portion, at least 25%, of the total resources necessary to implement subprojects. The project strategy provides for selection of institutions for subprojects which show ability and commitment to carry on family planning activities after completion of USAID support. Thus participation under this project will not be confined to recipients of services, but will also stem from active involvement and resource commitment of participating institutions.

In the course of preparing the Project Paper, the design team interviewed a large number of potential project participants, as well as Government of Kenya personnel and professionals working in family planning intermediary organizations based in Nairobi. The team members reported a very positive response to the project concept and work plan particularly from managers of private enterprises whose response was often, to wit, "its about time we got started on something like this". This positive tone and, importantly, the accompanying willingness to allocate company resources to support the subproject is evident in the subproject summaries appended in Annexes J and K. This interest, which is shared by staff on the National Council on Population and Development and National Family Welfare Center, bodes well for continuation of a high degree of participation during implementation and beyond.

4. Socio-Cultural Feasibility:

The project is based on extensive analysis of locally-generated data, and years of experience gained incountry. The applied research component included within the project will provide the Technical Assistance Team with a means to improve the selection and design of subprojects. Subprojects will be developed on an individualized basis, thus enabling local variations to be taken fully into account.

Overall, however, this family planning project, as with others in contemporary Kenya, must be initiated in light of a cautious appraisal of what can be accomplished in the near future given the conditions which support confirmed high fertility in Kenya. A recent paper prepared under the auspices of the Population Studies and Research Institute (University of Nairobi) and the Central Bureau of Statistics underscores this need for caution, even as it reinforces the appropriateness of the proposed approach of the project:

It seems clear that greater use of modern contraception can only be anticipated if (a) the supply of children exceeds the demand, (b) desired birth intervals are not being achieved by current non-contraceptive practices such as breastfeeding, and (c) the perception of family planning methods (in terms of safety, direct and indirect costs, availability and reliability) is such as to encourage, or at least not inhibit, their use. Unfortunately, for most rural women one or more of these conditions is not met. The Family Planning Programme can boost contraceptive use by initiatives in the following directions: increasing the access of potential clients to family planning users; building communication about family planning around the specific conditions which are found to be the most acceptable within individual communities; correcting errors and misperceptions regarding various methods and raising the levels of information about modern contraception and the programme; identifying and directing special attention to the categories of women who are most likely to want to adopt contraception and avoid another pregnancy; reaching women who are reducing their period of breastfeeding with information and services to help them achieve longer intervals between births. (Dow and Werner. 1982:1)^{1/}

^{1/} Thomas E Dow and Linda H Werner "Perceptions of Family Planning Programme held by Rural Kenyan Women, 1981" for the Central Bureau of Statistics Government of Kenya, 1982.

Nonetheless, until there is a change in the fertility aspirations of rural women and men, widespread adoption of contraception and its use to lower fertility are unlikely to occur.

5. Impact

In summary, to achieve impact in a generally unfavorable environment, this project will set in motion a wide range of service delivery programs in selected environments. These programs will increase access to family planning services for current and potential users. They will also increase the users' choice of family planning facilities, practitioners, and methods. Programs will be established in institutions which demonstrate the capability and commitment necessary to sustain them beyond life of project; research and evaluation of such institutions and programs will identify the factors leading to successful activities and promote replication elsewhere. Impact will be especially widespread to the extent that dissemination of project success (through word of mouth, workshops, conferences, Chamber of Commerce meetings etc.) can set into motion a spread effect which will continue beyond the life of the project.

Success of the project will be especially dramatic if the hypotheses regarding the suitability of the major institutional frameworks (for-profit enterprises, church-related health institutions, associations of women's groups) hold true. Research in Kenya has showed that a particular configuration of forces are required to promote the trend in decisions towards smaller family size. These are discussed in Annex E, and the paper "Prospects for Fertility Decline in Rural Kenya" cited above. Essentially, economic factors alone are insufficient to promote change. However there are identifiable processes underway which lead to fertility change. These include a trend towards "emotional nucleation" (the concentration of the time and emotion on one's spouse and children) which often precedes "economic nucleation" (the concentration of expenditure on one's spouse and children) which in turn flows from a process of Westernization (i.e. the local acceptance of Western ideas regarding family structure) which do appear to promote fertility change toward smaller family size (Dow and Warner 1983:79).

The institutional frameworks to be supported under this project all are associated with such processes. More importantly, they are widely distributed in urban and rural Kenya and, as such, should easily and efficiently support rapid expansion to meet additional demand for family planning. Annex

I includes the gazetted list of all health facilities registered by the Ministry of Health in Kenya. There are some 130 firms registered, which provides considerable scope for expansion. In the USAID-funded study of private church-related health care in Kenya referred to in Section I.C above, a local firm (CORAT) found the potential and needs in these institutions for introduction of family planning service delivery to be great, particularly for Protestant-supported facilities. A spread effect through this institutional framework looks to be very promising, as is evidenced in Table 8, below.

Table 3: Health Care Coverage, Kenya 1982

	Numbers			% of National Coverage		
	Ministry of Health (MOH)	Protestant Medical Association (PCMA)	Kenya Catholic Secretariat (KCS)	MOH	PCMA	KCS
Beds	12,458	2,084	4,858	64%	11%	25%
In-Patient Days	3,425,950	573,100	1,335,950	64%	11%	25%
Out-Patient Visits	39,400,000	900,000	5,581,000	86%	2%	12%

Source: Brown 1982:7

In another AID activity funded in 1982, an inventory of the women's groups in Maendeleo ya Wanawake, the National Womens Association was made. This inventory gathered data on over 5,000 womens groups. Average group size was over 40 members; most groups reported at least one development activity underway and a strong commitment to development activities. As this is only one national set of women's groups, the potential for introducing information and services through women's groups under this project or other activities, is great.

In sum there is excellent chance for success under this project despite the prevailing socio-cultural conditions. The contexts on which this project will focus are appropriate for the introduction of effective family planning practice. They also promise significant potential for spread effect in the medium and long term.

D. Administrative Analysis:

This project differs from most USAID/Kenya bilateral activities in that there is no direct counterpart relationship established with any line ministry. The project will be administered by USAID through a Memorandum of Understanding signed by the Office of the Vice President and Ministry of Home Affairs, and the Ministry of Health and co-signed by Ministry of Finance. In addition to USAID, however, the administrative capabilities of other organizations require mention: the National Council on Population and Development, the National Family Welfare Center of the Ministry of Health, the Recipient of the Cooperative Agreement's Technical Assistance Team, and the various private sector organizations with which subprojects will be developed and implemented.

1. USAID:

The USAID Population Officer will be the USAID project officer. He will have as backup two other U.S. and two Kenyan professionals in the HNP Division, as well as support from the Projects Division. Implementation will be through a Cooperative Agreement whose Recipient will provide a resident Technical Assistance Team. Accordingly, USAID will have review/approval options at each stage of the project, will review and approve any grant or subcontract which might be designed, will be involved in selection of key Recipient staff, will collaborate or participate with the Recipient in presentation of subproject proposals and progress reports to the GOK, and will monitor activities to permit specified kinds of project direction or redirection. This Cooperative Agreement arrangement will permit USAID, to participate as it deems necessary to ensure project objectives are attained.

The Recipient, and USAID also through the Private Sector Family Planning Technical Advisory Committee, and regular contact with the staffs of the National Council on Population and Development and the National Family Welfare Center has a special responsibility to ensure involvement of the Government of Kenya.

2. National Council on Population and Development: (NCPD)

This newly created Council was established to coordinate all family planning information and education activities and to provide oversight of family planning service delivery. It was created as part of the multidonor Integrated

Rural Health and Family Planning program, to which USAID is a contributor. It is housed as a semi-autonomous body in the Office of the Vice President and Ministry of Home Affairs, and was constituted essentially as described in a Consultants' Report, National Council on Population and Development, Structure, Function, Administrative and Financial Procedures, N. Gathinji and P.M. Mbithi, October, 1982 (available in USAID project files). As a new organization, the Council has very little of an administrative track record. The Chairman, who is well known to USAID, is the respected Deputy Vice Chancellor of the University of Nairobi. He has expressed considerable interest in this project and has provided essential guidance to the Project Paper design team.

The Council and its Chairman, will play a critical role in the establishment and implementation of the oversight functions for the project. As soon as the Technical Assistance Team has been selected, the Council will appoint the members of the a Technical Advisory Committee. This committee will be established for the purpose of providing ongoing oversight of project activities from technical, policy and coordination perspectives. It will convene at least once every three months. The Chairman will call additional meetings of the committee when necessary. Membership of the Committee will include among others, representation from the Council, the National Family Welfare Center, USAID, the Technical Assistance Team leader, and private and voluntary organizations involved in family planning service delivery.

The tasks of the Technical Advisory Committee will be determined by the Executive Committee of the Council, in consultation with AID, and will include review of project progress, approval of project workplans, in particular, proposed subprojects, research, and dissemination activities. AID and the Executive Committee of the Council will develop guidelines, with the Technical Advisory Committee, when formed, to ensure an expeditious review of project plans and progress. Guidelines will cover responsibilities of the Technical Assistance Team for providing documentation of activities to committee members prior to meetings, responsibilities of the Chairman of the Committee to schedule meetings, set the Agenda, and provide followup minutes within an agreed upon time frame, and responsibilities of Committee members to maintain a quorum for decision making.

3. The National Family Welfare Center of the Ministry of Health

The Ministry of Health itself already is a member of the NCPD which has the leadership role on the Technical Advisory Committee responsible for oversight of project activities. A representative of the National Family Welfare Center will be a member of the Technical Advisory Committee. This presentation will ensure that the Ministry of Health, and the NFWC within the Ministry, will be fully aware of family planning service activities, and be able to keep the Chairperson adequately informed of its involvement in project implementation. The NFWC will maintain direct collaborative links with the Technical Assistance Team regarding training and contraceptive supply of subproject activities.

It is the NFWC's syllabus for training Enrolled Community Nurses and Clinical Officers which must form the basis of project training and which will be the basis for certification of all service providers trained in the project's subprojects. The NFWC, then, must be satisfied that training provided through the project meets its requirements.

The Center will be the source of contraceptives for the project, thus the subprojects will be dependent on the Ministry of Health for regular supply of contraceptives. The Ministry of Health logistics system should not be administratively taxed by the additional 40-50 service delivery points added to the the existing service delivery points it now serves. Adequate monitoring methods have been considered and included within the project design to permit the administration of this important element.

The Ministry of Health is the implementing agency of the IRH/FP Program. The National Family Welfare Center will play a pivotal role in this implementation.^{1/} About 30 NGO dispensaries and health centers will be upgraded into maternal child health and family planning service delivery points, in a manner similar to that proposed in this Private Sector Family Planning project. The need for close coordination between the

1/ (For discussion, see PP 19-23, Kenya Family Planning II Project Paper, and the World Bank's Staff Appraisal of an Integrated Rural Health and Family Planning Program).

IRH/FP Program the Private Sector Family Planning Project is apparent. The National Family Welfare Center will play a key role in this coordination.

4. The Recipient's Technical Assistance Team:

The guidelines for the Technical Assistant Team's Scope of Work (see Annex M) provides for ample administrative skills for two of its three members, the Senior Family Planning Management Specialist and the Administration and Procurement Specialist. Assuming the selected Team meets the criteria described in the proposed scope, the Team should be able to cope well with the administrative tasks required by USAID, and also with the considerable amounts of administrative technical assistance which will be required by the subprojects (see below).

5. Various Subproject Private Sector Organizations:

The administrative capabilities of the variety of private sector organizations which will conduct subprojects will also vary widely. Some for-profit enterprises with well-established health clinics will require relatively little additional administrative assistance, others may require extensive periodic assistance. All subprojects will be expected to contribute data on their activity to further the demonstration aspects of the overall project, and so will have some need for administrative assistance in record keeping and other monitoring activities. The project has provided sufficient technical assistance capability to meet these exigencies, in the form both of the members of the resident Technical Assistance Team and of programmed short-term consultants, as needed.

Conclusion:

This administrative analysis concludes that the administrative capabilities of all agencies and organizations are sufficient to meet the administrative requirements of the project, with the probable exception of the private sector organizations with which demonstration subprojects will be implemented. This contingency has been adequately countered by inclusion in the project design of sufficient and appropriate provision of technical assistance. An assumption is made that the Private Sector Family Planning Advisory Panel is formulated more or less along the lines described in project design.

E. Environmental Analysis

A Categorical Exclusion in accordance with section 216.2 was approved by George Thompson, Bureau Environmental Officer on January 28, 1983, and is appended as Annex 0.

HNP

CLASSIFIED Project 615-0223

-EE RUEFC #0258 0550732
 -ZNR UUUUU ZZU
 -P 242551Z FEB 83
 -FM SACSTATE WASHDC
 -TO AMEMBASSY NAIROBI PRIORITY 9572
 -BT
 -UNCLAS STATE 050258

Annex A

24 FEB 83
 TOR: 0724
 CN: 15618
 CERGE: AI

-AIDAC

-E.C. 12355: N/A

-TAGS:

-SUBJECT: PRIVATE SECTOR FAMILY PLANNING PID (615-0223):
 -ECPR RESULTS

-1. THE PRIVATE SECTOR FAMILY PLANNING PID WAS APPROVED FOR
 PP DEVELOPMENT AND FIELD AUTHORIZATION WITH LIFE OF PRO-
 -JECT FUNDING OF DOLS \$4.5 MILLION AT THE ECPR CHAIRED BY
 -DAA LOVE ON 12 FEBRUARY.

-2. ECPR GUIDANCE TO MISSION FOR PP PREPARATION AND PROJECT
 -IMPLEMENTATION IS AS FOLLOWS:

-A. IN DEVELOPING THE MONITORING AND EVALUATION SYSTEMS FOR
 -SUBPROJECT ACTIVITIES, MISSION AND PP CONSULTANTS SHOULD
 -BUILD IN THE CAPABILITY TO MAKE COMPARISONS OF THE VARIOUS
 -APPROACHES TO SUPPLYING FP SERVICES/CONTRACEPTIVES BY SUB-
 -PROJECT INSTITUTIONS. IN PARTICULAR, IT WILL BE USEFUL TO
 -GATHER INFORMATION ON THE USE AND IMPACT OF SUBSIDIES AND
 -VARIOUS TYPES OF PROMOTIONAL ACTIVITIES. THESE MONITORING
 -SYSTEMS SHOULD NOT UNEQUIVOCALLY BURDEN SUBPROJECT IMPLEMENTERS
 -BY ESTABLISHING RIGOROUS CONTROL GROUPS BUT SHOULD TAKE

-ADVANTAGE OF THE OPPORTUNITY TO MAKE SOME JUDGMENTS ABOUT
 -THE SUCCESS OR FAILURE OF DIFFERENT APPROACHES OVER THE
 -LIFE OF THE PROJECT.

-B. TO THE EXTENT THAT INCOME IS GENERATED BY INSTITUTIONS
 AS A RESULT OF PROJECT ASSISTANCE, A PROCEDURE SHOULD BE
 ESTABLISHED FOR THE UTILIZATION OF THESE FUNDS FOR OPERA-
 -TING COSTS TO DELIVER ADDITIONAL FP SERVICES OR CONTRA-
 -CEPTIVE SUPPLIES OR ANOTHER RELATED AND SPECIFIED PURPOSE.

-C. IF MISSION PLANS TO PROCURE CONTRACEPTIVES FROM AID
 CENTRAL SUPPLIES, AID/W SHOULD BE NOTIFIED AS SOON AS
 -POSSIBLE BECAUSE OF THE LONG CONTRACEPTIVE PIPELINE.

-3. MISSION IS REQUESTED TO REVIEW AND ADVISE AID/W AS SOON
 -AS POSSIBLE OF THE TIMING FOR PP DEVELOPMENT AND THE
 MECHANISM/TIMING FOR OBLIGATION (I.E., PROAG WITH GOV
 FOLLOWED BY RFP AND SELECTION OF CONTRACTOR OR RECIPIENT
 OF COOPERATIVE AGREEMENT VERSUS OBLIGATION THROUGH COOP-
 -ERATIVE AGREEMENT WITHOUT PROAG WITH GOV). FYI, AID/W
 SUGGESTS PROAG WITH GOV MAY BE PREFERABLE BECAUSE OF THE
 OFFICIAL GOVERNMENT MANDATE OF APPROVAL OF PROGRAM AND CON-
 -TRACTOR ACTIVITIES, AND (BY AVOIDING THE NEED TO DELIBERATE

613/SP

UNCLASSIFIED

STATE 50252

ALL ASPECTS OF PROJECT THROUGH CONTRACTOR.

4. THE DECISION ON THE AMOUNT OF FY 83 FUNDING FOR THIS PROJECT WAS DEFERRED BY THE ECPR UNTIL BUREAU AND AGENCY-WIDE REQUIREMENTS FOR POPULATION FUNDS THIS FY HAVE BEEN REVIEWED FURTHER. MISSION IS REQUESTED TO ESTIMATE FUNDING REQUIREMENTS BY YEAR IN CONJUNCTION WITH OBLIGATION TIMETABLE INFORMATION REQUESTED IN PARA 3.

5. MISSION IS TO BE COMPLIMENTED ON THE TIMELY SUBMISSION, PREPARATION AND PRESENTATION OF THIS PID. SHULTZ.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Private Sector Family Planning
615-0223

Life of Project:
From FY 83 to FY 86
Total U.S. Funding 4.5
Date Prepared: 11/82

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes:	Measures of Goal Achievement:		Assumptions for achieving goal
Reduce the birth rate	Reduction in total birth rate Improved health status of women Improved health status of children	Analysis of national health & population data	Families use family planning to limit family size as well as to space births
Project Purpose:	Conditions that will indicate purpose has been achieved: End of project status.		Assumptions for achieving purpose:
To demonstrate and increase the institutional capacity of private sector organizations to carry out sustainable programs for the delivery of family planning and related maternal child health services	<ul style="list-style-type: none"> - 30,000 number of clients using family planning services; - 35 institutions operating new or improved family planning activities; - Resources of participating institutions adequate to maintain program; - The capacity and commitment of participating organizations to maintain or expand the level of family planning service delivery upon termination of external assistance; and - Other private sector organizations not directly assisted by this project have added family planning to their services. 	Records kept at service delivery points - Inspection	Potential clients use and financially support (where required) service delivery programs.

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Outputs:	Magnitude of Outputs:	Inspection/Evaluation	Assumptions for Achieving Outputs:
- Set of discrete subproject activities	40-50 activities	Inspection/Evaluation	Institutions have interest in committing resources to service programs
- Family Planning Service Deliverers trained	200 enrolled community nurses, midwives, clinical officers, and others	Inspection/Evaluation	
- An improved training methodology	Methodology will have been developed tested and implemented	Inspection/inspection	
- Operational research findings	4-5 discrete activities, completed and reported		
- Means for evaluating and disseminating results	Data collection system and at least 2 national workshops		
Inputs:	Implementation Target (Type and Quantity)	Inspection	Assumptions for providing inputs:
1. Grant to project implementor for: Tech. Asst. (8 persons years, full time; 12 person months, parttime) Subproject development Subproject implementation Operations Research, incountry travel	Cooperative Grant for \$4.5 million	Inspection	Grantee can be identified acceptable to USAID and GOK
2. Contribution from implementors of subprojects	25% of subproject cost \$1.5 million		
3. USAID Participation - Travel			

ANNEX C

DETAILED FINANCIAL ESTIMATES

All foreign exchange costs include 7.5 percent annual inflation and local currency costs include 15 percent annual inflation.

1. Technical Assistance

a. Technical Assistance Team	<u>\$(000) KShs.(000)</u>
1. 2 long term U.S. technicians (8 person years) in Nairobi	
a. Salary base \$47.5 x 2.	424.9
b. Payroll overhead 30% of (a).	127.4
c. General and Administration overhead 60% of (a)	254.9
d. Defence Base Act Insurance 5% of (a)	21.3
e. International travel (2 families each consisting of 2 adults & 2 children)	
i) 3.5 tickets/family, 2 families x 2RT (includes one home leave)	57.0
ii) Excess baggage	3.4
iii) Per diem, international travel	4.8
iv) Mobilization (medical)	2.8
v) Airfreight (700 lbs)	35.1
vi) Surface freight to include one car per family	46.7
vii) Storage at U.S. residence	14.0
f. Educational allowance	101.8
g. Initial and terminal temporary quarters and Kenya per diem for families.	7.6

	<u>\$(000) KSH.(000)</u>	
h. Guard services @ sh. 1950/month/family		254.4
i. Housing and utilities@ sh. 13000/month/ family		1780.0
j. Appliances and furnishings	22.0	
k: Kenya travel and vehicle maintenance		880.6\
l. Kenyan per diem \$50/day x 20/month		678.4
m. Vehicles (3) (One vehicle for a subgrantee)	47.0	
n. Office equipment	36.9	92.5
o. Office rental, 500 sq.ft. @ sh.135/sq.ft./annum		337.1
p. Phone, telex, utilities, maintenance @ sh. 4500/month		293.5
q. Office supplies	9.0	17.9
r. One person from Home Office to Kenya per year	21.1	
s. Kenyan professional K.sh. 150,000/ month per year + 10 percent payroll tax		988.7
t. Secretary sh. 5500/month + 10 percent payroll tax		329.6
u. Messenger/drivers (2) @ sh. 1300 each per month + 10 percent payroll tax		155.8
v. Per diem for Kenya professional \$25/day x 30 days/month		534.3
w. Per diem for driver/ messengers		534.3
x. U.S. short term T.A. (7 person-month)	115.6	
y. Kenyan 5-7 consultants (5 person-month)		<u>492.6</u>
<u>Total for 4 years</u>	<u>1353.7</u>	<u>7369.7</u>
In US Dollars		<u>566.9</u>
		1920.6
Say		1920.0

2. Training (Subcontract)

	SH.(000)
a. Personnel (2) @ K.sh. 12,000/month	1438.1
b. Administrative support 3 person month/year	67.4
c. Training 25 trainees x 90 days x K.200 + travel costs	4368.6
d. Materials development	620.0
e. Overhead at 25%	1748.5
Subtotal training	5742.6
US equivalent	\$672,000

<u>Summary:</u>	Total from 1.	-	\$1,920,000
	Total from 2.	-	\$ 672,000
	Grand Total	-	\$2,592,000

3. Demonstration subproject costs

Table I shows the total cost at 1983 prices (excluding technical assistance and training) for each prototype subproject. The cost basis for each prototype subproject cost is explained in more detail in Tables V, VI and VII.

Table I (1983 prices)
(\$ 000)

PROTOTYPE PROJECTS	GRANTEE	SUBGRANTEE	MOH	TOTAL
1. PCMA	122.8 (60%)	68.7 (34%)	12.8 (6%)	204.3
2. Kenya Cannery	24.6 (61%)	13.1 (33%)	2.4 (6%)	40.1
3. Associated Sugar	12.6 (53%)	9.2 (39%)	1.8 (8%)	23.6

While it is not possible to anticipate with absolute accuracy the inputs for the 35 subprojects to be developed over the next four years, it is likely that five will be at the magnitude of the PCMA, fifteen like Kenya Cannery and fifteen like Associated Sugar.

Table II shows the total estimated demonstration subproject costs, and as extrapolated from the data in Table I and multiplied by the number of subprojects in each category.

Table II(in \$ Thousands)

PROTOTYPE	NO OF SUBPROJECTS	GRANTEE	SUBGRANTEE	MOH	TOTAL
1. PCMA	5	614.0	343.5	64.0	1021.5
2. Kenya Canners	15	369.0	196.5	36.0	601.5
3. Associated Sugar	15	189.0	138.0	27.0	354.0
Total	35	1172.0 (59%)	678.0 (34%)	127.0 (7%)	1977.0

For costing purposes, in 1983 prices, the average subproject costs are: Grantee \$33,485, Subgrantee - \$19,371 and MOH - \$3,628 or a total of \$ 56,484. It is estimated that 12 subprojects will start six months after the Agreement is signed and will run for two years. If the rate of inflation is estimated at 7.5 percent/year for foreign exchange costs and MOH costs, and 15% for local currency costs the cost of these 12 subprojects will attract an average inflation rate of 9.375% for FX costs and MOH costs and 22.5% for LC costs. The remaining 23 subprojects are expected to begin 18 months after the Agreement is signed. Therefore, these 23 subprojects will attract an average inflation rate of 16.875% for FX costs and MOH costs and 37.5% for LC costs. Table III shows average costs for 12 and 23 subprojects.

Table III(in \$ thousands)

	12 SUBPROJECTS		23 SUBPROJECTS		TOTAL	
	FX	LC	FX	LC	FX	LC
Grantee	121.4	356.1	248.7	766.2	370.1	1122.3
Subgrantee		284.8		612.6		897.4
MOH		47.6		97.5		145.1

The costs in Table III are further distributed to each year of the project life as shown in Table IV. Also MOH costs for contraceptives after the demonstration period and other services (personnel) are included.

Table IVSUMMARY FINANCIAL OR "IN-KIND" CONTRIBUTION
(in \$ thousands)

	1	2	3	4	TOTAL
Grantee	120.0	490.0	620.0	261.4	1491.4
Subgrantee	71.2	295.5	377.5	153.2	897.4
MOH(I)	(10.0)	(46.0)	(68.0)	(21.0)	(145.1)
MOH(II)			(47.1)	(199.8)	(246.9)
MOH(III)	(5.7)	(6.2)	(8.3)	(8.9)	(29.1)
Total MOH	15.7	52.2	123.4	229.8	421.1

Notes: MOH(I) includes cost of contraceptive during the demonstration period of subprojects.
MOH(II) includes cost of contraceptive after the demonstration period of subprojects - see Table VIII.
MOH(III) includes "in-kind" cost of MOH and the Council for Population and Development personnel - see Table VIII.

Table VPrototype Subproject Costs (excluding T.A. and Training)Example No.1:Subgrantee: Protestant Church
Medical Association (PCMA)
(in thousands)

	GRANTEE		SUBGRANTEE	MOH	TOTAL	
	FX \$	LC Sh	LC Sh	LC Sh	FX \$	LC Sh
a) Personnel		352.8	480.0			832.8
b) Conferences		135.5				135.5
c) Equipment	31.2	199.0			31.2	199.0
d) Travel Support		504.0				504.0
e) Facilities			84.0			84.0
f) Depreciation			330.0			330.0
g) Contraceptives				166.4		166.4
Total	31.2	1191.3	894.0	166.4	31.2	2251.7
Equivalent in US \$ (\$1.00=Sh.13.0)	31.2	91.6	68.7	12.8	31.2	173.1

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Total Subproject Cost - \$204,300

USAID share = \$122,800 - 60%
PCMA share = \$ 68,700 - 34%
MOH share = \$ 12,800 - 6%

Detailed calculations follow:

Note:

1. Technical Assistance (Grantee) = 4 person months
2. Number to be trained = 20

Calculations of Subproject Costs- PCMA
(in thousands)

1. Grantee costs (U.S.A.I.D. share)

	FX(\$)	LC(Sh)
1. a) Personnel		
Project Director 24 months at 10,200/month		244.8
Secretary 24 months at sh.4500/month		<u>108.0</u>
		352.8
b) 3 conferences x 20 people x 3 days		
Travel - Ksh 400x2x3x20		48.0
Per diem - Ksh 375x3x20x3		67.5
Other expenses		<u>20.0</u>
		135.5
c) Equipment - (See Standard list, Annex H)		
- for 10 facilities (clinical) -	22.0	199.0
- microcomputer	<u>9.2</u>	
	31.2	<u>199.0</u>
d) Travel support		
To PCMA 15d/mo x 200km x shs.3.0/km x 24 month		216.0
To 10 clinics: 10d/mo x 40km/day x KShs.3.0 x 24 mo x 10		<u>288.0</u>
		504.0

2. Subgrantee costs (PCMA share)

a)	Personnel-PCMA director, 1/20 time x sh3000,000x2yr	30.0
	-service point directors, 1/10 x sh225,000x2yr	<u>450.0</u>
		480.0

e) Facilities

	PCMA:80 sq. ft x shs 150/sq ft x 2 yr.	24.0
	10 units - 40 sq ft x Ksh 75 x 2 yr x 10	<u>60.0</u>
		84.0

f) Depreciation

(i) Vehicles - Acquisition cost sh.150,000,
5 year life.

Depreciation/yr = sh.30,000.

1/3 of total to project use = Ksh 10,000

PCMA - 1 vehicle; 10 service points - one
vehicle each = 11-x Ksh 10,000 x 2

220.0

(ii) Office equipment and MCH equipment

Estimated acquisition shs. 75,000

5 yr life. Depreciation/year = sh.15,000

1/2 of total to project = Ks 5,000/year

PCMA and 10 clinics = 11 x 5000 x 2

110.0
330.0

3. Ministry of Health costs

g) Contraceptives

From MOH Ksh.104/acceptor x 1600 x one year
average use

166.4

Table VI

Prototype Subproject Costs (excluding T.A., and Training)
Example No.2.
Subgrantee: Kenya Cannery
(in thousands)

	GRANTEE		SUBGRANTEE	MOH	TOTAL	
	FX \$	LC Sh	LC Sh	LC Sh	FX \$	LC Sh
2. Kenya Cannery						
a) Personnel		96.0	126.0			222.0
b) Supplies Equipment	9.0	59.7			9.0	59.7
c) Travel Support		46.8				46.8
d) Facilities			15.0			15.0
e) Depreciation			30.0			30.0
f) Contraceptives	—			31.2		31.2
Total	9.0	202.5	171.0	31.2	9.0	404.7
Expressed in US \$ (\$1.0-sh.13.0)	9.0	15.6	13.1	2.4	9.0	31.1

Total subproject cost = \$40,100
USAID share = \$24,600 - 61%
Kenya Cannery share = \$13,100 - 33%
MOH share = \$ 2,400 - 6%

Note:

1. Technical Assistance (Grantee) - 3 person months.
2. Number to be trained - 11

Calculation of subprojects - Kenya Cannery
(in thousands)

1. Grantee Costs (U.S. A.I.D. Share):	FX \$	LC Sh
a) Personnel		
Records Officer at Ksh.4000 x 24 months		96.0
b) Supplies, equipment		
1) 3 sets per standard list, Annex H	6.6	59.7
2) 1 minilaparoscope	.4	
3) 1000 programming testing kit @ \$ 2.00 = \$ 2,000	2.0	
	<u>9.0</u>	

c) Travel support	150 km/wk x 104 wk x sh 3.0/km	46.8
2. Subgrantee Costs (Kenya Cannerys)		
a) 6 ECN x 1/4 time: 1.5 ECN x sh.3,500 x 2		126.0
b) Facilities	100 sq ft x 75 Ksh/ft ² x 2 yr	15.0
c) Depreciation		
	Sh.	
Vehicle acquisition	=	150,000
MCH and Office equipment	=	75,000
		225,000
5 year expected life, Depreciation/year =		45,000
1/3 project use x 2 yr		30.0
3. MOH Costs		
a) Contraceptive - 300 users x 104 Ksh/user		31.2

Table VII

Prototype Subproject Costs (excluding T.A. and Training)
Example No. 3
Subgrantee: Associated Sugar
 (in thousands 000)

	GRANTEE		SUBGRANTEE	MOH	TOTAL	
	FX	LC			LC	FX
	\$	Sh	Sh	Sh	\$	Sh
a) Personnel		84.0	45.0			129.0
b) Supplies, Equip	2.2	19.9			2.2	19.9
c) Travel support		31.2				31.2
d) Facilities			45.0			45.0
e) Depreciation			30.0			30.0
f) Contraceptives				23.4		23.4
Total	2.2	135.1	120.0	23.4	2.2	278.5
Equivalent in US \$	2.2	10.4	9.2	1.8	2.2	21.4
(KSh 13.0 = US \$ 1.0)						

Total subproject cost = \$23,600
 US portion = \$12,600 = 53%
 Subgrantee = \$ 9,200 = 39%
 MOH = \$ 1,800 = 8%

Note: 1. Technical Assistance (Grantee) - 1 person-month
 2. Number to be trained = 1

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Calculations of Subproject Costs - Associated Sugar Co. Ltd
(in. thousands)

	FX	LC
1. Grantee Costs (U.S.A.I.D. Share)		
a) Personnel		
Enrolled Community Nurses for 2 yr at Ksh. 3500 per month.		84.0
b) Supplies, equipment - standard list, Annex H	2.2	19.9
c) Travel support - 100 km/wk x Ksh 30/km x 104 weeks		31.2
2. Subgrantee Costs (Associated Sugar)		
a) Medical Director 1/10 time x 2 yrs: - 1/10 x 225,000 Ksh x 2		45.0
b) Facilities 300 ft ² x Ksh 75/ft ² x 2 yr		45.0
c) Depreciation		
Vehicle Acquisition	= Ksh.150,000;	
MCH and office equipment	= Ksh. 75,000;	
estimated life = 5 years		
Depreciation per year	= KSh. 45,000	
1/3 project use x 2 years.		
3. MOH costs		30.0
d) Contraceptives - 225 acceptors @ 104 Ksh		23.4
4. <u>Government of Kenya Contribution not Directly Attributed to Specific Subprojects</u>		

a. Contraceptives

After subprojects are completed, users will continue using contraceptives throughout project life. 12 of 35 subprojects will be completed by year 2 1/2, and perhaps another 23 by the end of year 3 1/2. Thus 12/35 or 34 percent of the 30,000 potential acceptors might continue using contraceptives an additional 1.5 years, and an additional 66 percent will have 6 months use.

C-11

1983 cost = Sh.104 (allow inflation at 7.5 percent per year)
 Year 3 costs = Sh.104x1.075x1.075x0.34x30,000x0.5
 = 612,943
 Year 4 costs = Sh.104x1.075x1.075x1.075x(0.34x30,000
 + 0.66x 30,000x0.5) = 2,596,897

b. Personnel

1. Director, Council for Population and Development

2. Director, National Welfare Training Center

(includes panel meetings, other consultations)

5 percent x Ksh 260,000/yr x 2x4 yrs =Ksh 104,000

3. National Family Welfare Center Trainers

4x5 percent

4xKsh.60,600x4 yr x 4.10

96.960

4. District health personnel

4x 5 percent

4 x Ksh 60,600 x 4yr x .10

.96.960

Total (4 years)

297,920

or

74,480 per year (1983 prices)

Table VIII

Summary MOH Contribution
(in Sh. thousands)

Year ^{1/}	01	02	03	04	Total
Contraceptives			612.9	2596.9	3209.8
Personnel	74.5	80.1	107.5	115.5	377.6
Total	74.5	80.1	720.4	2712.4	3587.4
Equivalent US \$	5.7	6.2	55.4	208.7	276.0

5. External Evaluation

2 evaluations, each requiring two person months of US, and 2 wks of Kenyan technical assistance

^{1/} at 7.5 annual inflation.

C-12

		\$	Ksh
a.	US - Salary	\$6000/mo	
	Transport, and PER Diem	\$3700	
	Per Diem in Kenya @ \$75		Sh29250
	Travel in Kenya		Sh 5850
	US Overhead @60%	\$ 3600	
	One person month	<u>13300</u>	<u>Sh35100</u>
	2 needed year 3 @ 7.5% inflation/yr	30.7	81.1
	2 needed year 4 " "	33.0	87.2
b.	Kenyan Salary	13000	
	Per Diem in Kenya	2275	
	Travel in Kenya	<u>1400</u>	
	1 Kenyan, 2 wks	<u>16675</u>	
	2 needed yr 3 @ 15% inflation/yr		50.7
	2 needed year 4		<u>58.3</u>
	Subtotal Evaluation	63.7	<u>277.3</u>
	\$ equivalent of Ksh in \$	<u>21.3</u>	
		<u>84.0</u>	

Annex D

1. Theoretical Overview: Benefit/Cost Analysis and Cost Effectiveness Analysis

A. Benefit Cost Analysis (ECA)

Assessing the benefits and costs of population projects constitutes a complex economic task which to date has yielded inadequate results. The standard Benefit/Cost approach, developed by S. Enke in the early 1960's, considers as benefits the present value of the private and public costs of raising a child. The major benefit is the reduced level of expenditure, both public and private, for consumption related to raising the child into a productive entity.

Costs include the provision of family planning services and the opportunity cost of the child's foregone, life-time productive output. The major cost is represented by the output foregone through a reduction of the labor force. The actual cost of delivering the family planning services is generally a secondary expenditure by comparison, although if overhead expenses are included, as in the proposed project, these costs can be considerable.

The standard ECA approach has been criticized, even by its supporters, for the uniformity with which it predicts high positive benefit/cost ratios, since the benefits accrue in the early years of the project, while the costs in terms of earnings foregone occur only after fifteen or twenty years. Thus, the standard ECA technique concludes uniformly that no births are better than births, even if a family has no children or if a developed society is experiencing negative population growth. The tautological nature of this approach, combined with its implausible conclusions for all societies and families, requires that fundamental aspects of the approach be reconsidered.

The shortcomings of the standard ECA approach can be attributed, inter alia, to three factors 1) discounting or placing a value on the present without adequate regard to the future, 2) the comparison of average consumption with marginal, rather than average, product, and 3) the principle of maximizing quantitative economic returns, combined with the difficulty of including broader social or private criteria, many of which are non-quantifiable.

Says one expert with regard to discounting, "The value of the consumption stream...is always far larger than the discounted productive contribution of an individual plus the costs of preventing a birth. This holds true for two reasons. The first is that the consumption and productivity streams are discounted. Since

consumption starts immediately after birth, and production is delayed for at least ten to fifteen years, even moderate discounting leads to large differences between the present values of the two streams." (See Zaidan, 1971.) As long as discounting for the present value is utilized, little economic weight is attached to the future, and the results will be biased toward the present. For example, the present value of \$1.00 discounted at 15 per cent in year 15 is 12 cents; after 25 years, it declines to 3 cents.

The second reason, to quote our expert, "is that average consumption is being compared with marginal product. In the long run, average consumption and average production are identical." (There is a caveat to this argument, however, in that the production of an adult also provides for the consumption of his or her children until they are capable of producing for their own consumption.) "Whereas an unborn child would have consumed as much as the average person through its lifetime, his marginal output falls short of the average. Insofar as the difference between the average and marginal output is a measure of the extent of the pressure of population on limited resources, this source of bias is legitimate." This analysis corrects for the bias by considering average rather than marginal output, and by recognizing that average production and consumption are not equal, since an adult's production supports dependents, is taxed, etc..

The third reason relates to the fact that the approach is based purely on maximizing economic returns without regard to a variety of factors such as the utility of children, the current child-dependency ratio, unemployment, the availability of public services, and future productive capacity. The use of such a narrow welfare function distorts the analysis. Many additional variables should be included to provide for both social circumstances and private preferences. As a social objective, the desirability of population growth varies according to socio-economic conditions. During the previous century, European governments viewed population as a factor of production, and sought to increase growth rates. As many European countries have attained zero or even declining population growth, additional economic incentives have been introduced to encourage population growth. These countries are placing a more nearly equal priority on the future and the present, and can absorb additional population at low marginal cost owing to the availability of essential services such as schools, medical care, housing, water, etc.

In applying a BCA to the proposed project, an effort has been made to adapt the standard approach to the Kenyan situation. The first step is to analyze social objectives, defined as the objectives of the Kenya government, which is based on perceptions relating to the national economy and the national welfare, both present and future. Subsequently, private considerations from the perspective of the Kenyan family are set forth.

1. The National Perspective: Social Benefits

The causal relationship between national welfare or national income and population growth is a complex one. While population (e.g., a labor force) is essential to the generation and growth of national income, population can also reach such dimensions that it becomes a drain on national income and resources for investment. This occurs because people are both producers and consumers of resources. Thus, national income is not only determined by population and its rate of growth; it also constitutes one of several determinants of population growth, even though there is no direct relationship between the two variables.

There are at least three basic circumstances which determine the benefits of population growth from a social perspective. These are 1) the child dependency ratio, 2) the employment situation and future productive capacity and 3) the availability of basic social services related to the education, health and social upbringing of the individual.

Child Dependency Ratio. When a few adults produce for the consumption of many dependents, then per capita income is bound to be lower than if there were fewer dependents. During the initial years of a person's life, he or she is consuming more of society's resources than he or she is producing. At a young age, a person consumes food, clothing, shelter and social services without contributing to their production. While these expenditures are also building a person's productive capacity, the fact remains that there is a considerable gap between the time that society makes these investments and the time it can expect to reap benefits from them. Under high dependency circumstances, reductions in population are likely to result in increased per capita income, as adults will be able to consume a greater share of their production. The reduction of unproductive consumers can also potentially increase national income by resulting in higher savings (both public and private) and a better fed, healthier labor force. Kenya has a high child dependency ratio, with over 60 per cent of its population under the age of 20 in 1979, and nearly 50 per cent under the age of fifteen. An additional 5 per cent of the population is aged 60 or over. While the 15 to 19 year age group is often considered to be working population in developing countries, there are compelling reasons to treat this age group as dependent population. It is generally known that unemployment is the highest within this age group, with employment opportunities limited to sectors of the economy characterized by underemployment, such as agriculture or the nonformal sector. Furthermore, a small but increasing proportion of this age group is beginning to attend school, as secondary school enrollment increases and the age of primary school leavers becomes higher.

For the purposes of this analysis, the 15 to 19 age group is considered at least in part a dependent population. Thus, about 35 per cent of the population in Kenya presently support the remaining 65 per cent of the population, assuming full employment among adults. If some unemployment is assumed among adults, then it becomes obvious that every working adult supports two additional dependents on the average. Clearly, such a high dependency ratio has a large, depressive effect on per capita income. This effect should be taken into account in attempting to perform a BCA analysis for Kenya.

Employment Situation and Future Productivity. A high degree of unemployment or underemployment among adults has a similar negative effect on per capita income. The lack of full employment results in low marginal products for persons who are either unemployed or underemployed. Low productivity is reflected in low salaries. Conversely, in a diminishing labor force, the marginal productivity of labor would increase dramatically, as shortages are experienced and labor becomes the scarce, limiting factor of production.

Since labor is one of Kenya's abundant resources, its efficient utilization has posed a difficult problem. With limited arable land, some of which is not utilized to capacity, and a low level of agricultural technology, agriculture has not been able to employ productively the available adult labor force. Labor force data show that over 90 per cent of the rural employed working population in 1979 continued to be employed in agriculture, with a mean annual cash income of Sh 3500. Only 60 percent of the population, which included urban as well as rural residents, considered themselves to be employed. (See CBS, Integrated Rural Surveys 1976 -1979, 1981.)

The non-agricultural sector has not been able to absorb productively the excess labor from the agricultural sector. Employment in the modern sector stood at nearly 1.2 million in 1980, of which wage employment constituted 82.5 percent. About 20 percent of all adults aged 20 and over are employed in the modern sector, including the self-employed and informal sectors. Private sector employment in 1980 stood at 534,300, down 2.4 percent over the previous year (CES, Economic Survey 1981, published in 1982). Average earnings in 1979 were Sh 890/- for males, who constituted 79 percent of wage laborers, and Sh 556/- for females, who comprised the remaining 21 percent of wage laborers.

The non-formal sector, along with agriculture, is thus obliged to absorb the 80 percent of Kenya's labor force which is not engaged in the modern sector. Government and donor efforts in this sector tend to be concentrated on industry, rather than services, even though services tend to account for considerable non-formal employment as well as for a larger proportion of GDP as national

incomes increase in developed countries. Thus, the non-formal sector tends to absorb inefficiently much of the excess labor force. Its efficiency is not likely to improve until more resources are devoted to developing the capital base and the technical skills of the nonformal sector, which has an important contribution to make to national development.

The prevalence of unemployment and underemployment in Kenya inevitably leads to lower than average productivity within a large proportion of the labor force. This in turn tends to reduce per capita income. The inability to absorb efficiently its present labor force should constitute a significant factor in planning for future population growth.

Basic Service Delivery. The cost of delivering basic services in health, education, housing, water supply, etc. constitutes a considerable burden on the governments of developing countries. Kenya is no exception. The World Bank estimates that the cost of providing such essential services to Kenya's population, even if the population growth rate declines at a slow rate, will amount to some 324 million Kenyan pounds between 1980 and 2000, in constant 1970 prices. Thus, the cost of social services should constitute a basic social consideration in the formulation of a family planning strategy. In many developed countries, these services already exist in adequate supply and quality, so that the cost of basic service delivery does not constitute a negative social consideration. For Kenya, however, basic service delivery constitutes a major consideration.

For the three reasons set forth above, developing countries such as Kenya face a set of socio-economic circumstances which argue compellingly for reduced population growth. Public investments required to sustain the present population are already insufficient, as evident from service delivery capability in health, education, water supply and housing. Furthermore, employment is not available for large numbers of the present population; the likelihood that the future young adults of Kenya find productive employment is even lower than at the present time, if the population continues to expand at the present rate of about 4 per cent per annum. All of these factors must therefore be considered in assessing the economic benefits and costs of population planning in Kenya. However, owing to limited availability of data and analytical resources, no attempt is made to quantify these considerations in this analysis.

2. The Family Perspective: Private Considerations

The desire of a Kenyan family to have additional children is dependent on a variety of social and economic factors, many of which are not known. One factor is clearly the size of the family already achieved. Logically, families with no children would place

a high priority on having children. Available data show that the desired family size is about eight children, equally divided among boys and girls. Another factor is the economic benefits of having children, particularly as regards social security of the parents when they reach old age. It is probable that this factor is changing with modernization; however, its impact cannot be assessed with accuracy. A third factor relates to the prestige traditionally accorded men and women with large numbers of children. While this factor may also change with modernization, it is presently considered to constitute an important factor for the large majority of Kenya's population. Finally, the cost of having additional children may be a consideration in more modern Kenyan families. Costs include the psychic/emotional costs in terms of the time necessary to raise a child; the direct economic costs for consumption of food, shelter, education, health; and the indirect economic costs of income or consumption foregone during the childbirth and nurturing period. These considerations are believed to be acquiring greater significance. However, it is generally accepted that all of these factors combine into a private, family preference for large family size in Kenya at the present time.

b. Cost Effectiveness Analysis

Cost effectiveness analysis (CEA) does not attempt to quantify benefits; instead, CEA assumes the appropriateness of an ultimate goal within a predetermined budget. The question then becomes "Which use of funds will provide the most progress toward the goal over a given timeframe?" In other words, CEA compares costs in the numerator with non-monetized benefits in the denominator. Clearly, the best ratio is the one in which there is most benefit, because of the largest possible number of family planning acceptors, births averted, delivery points established, etc..

This economic analysis will attempt to modify the present approach to benefit-cost analysis to suit the Kenya situation. Because of the inherent tautological nature of benefit-cost analysis, consideration will also be given to cost effectiveness analysis.

II. Relevant Project Characteristics

The project addresses the problems of Kenya's exceptionally high population growth rate of about four percent per annum, one of the highest in the world. This growth rate results from a high fertility rate of over eight live births per woman, combined with a declining mortality rate. The fertility rate could increase further as traditional practices which serve to space births, such as prolonged breast-feeding and polygamy, become less frequent, and the desire to have eight or more children persists among Kenya's population.

The project addresses a specific target population of the 20 percent of the labor force currently employed in the modern sector. Relevant data show that there exists a strong, direct relationship between knowledge or approval of family planning and female wage employment. These data also show that the great majority (95 percent) of women do not presently use contraception, and that access to family planning facilities constitutes a major obstacle to greater use (Dow and Werner, 1982). The average Kenyan woman requires 3.8 hours of travel time (round trip) and 1.8 hours of waiting time, or a total of 5.6 hours, to receive contraceptives. With the widespread use of the pill, this investment of time and effort must be repeated every three months. Clearly, women working for wages with fixed working hours would be deterred by the difficulty of access, possibly to a greater extent than women employed on their farms.

Data also show that formal employment status among females is associated with lower fertility (by 13 percent), child mortality (by 24 percent), number of living children (by 11 percent), and number of children desired (by 9 percent). Reduced fertility would be a logical concomitant of female wage employment, since child care becomes more expensive, and work productivity may decline as the woman becomes more tired owing to family pressures. These data indicate, therefore, that formally employed women would constitute a more responsive target group for family planning than the average Kenyan woman.

Wage employment among men may also be related to reduced family size, although there are no data available to test this relationship. As incomes rise, clothes, education, health care and recreation may be subjected to higher standards, and hence probably become more costly. Furthermore, the existence of a pension plan reduces the need for security in old-age, which is cited as a traditional reason for having many children.

A variety of factors therefore combine to render the proposed target group more receptive to family planning than other target groups. The project may show an acceptance rate in excess of the modest five percent projected, which coincides with the overall acceptance rate for Kenya at the present time.

III. Benefit/Cost Analysis

A. Costs of Averting a Birth

1. Project Costs

The costs of the proposed project total \$6 million over a three year implementation period. AID will contribute \$4.5 million, with the GOK providing contraceptives, and private companies and NGOs providing in-kind contributions of staff time, facilities and supplies/equipment. The estimated beneficiaries of the project are 30,000 new family planning acceptors, their families and their companies. The average project cost per acceptor is \$200.

The on-going operating costs of the project are estimated at \$8 per year for contraceptives, and \$12 per year for services related to the distribution of contraceptives. This average cost is weighted for the value of all contraceptives. It assumes that pills will continue to constitute the most prevalent method. While IUDs cost more initially, they do not require follow up visits for three years, except when problems are experienced. The analysis assumes that 10,000 acceptors will be reached during each of the last three years of project implementation. It also assumes that as acceptors drop out in order to have additional children, they will be replaced by new acceptors, so that by the end of the project, there will be 30,000 regular acceptors.

2. Opportunity Cost of Earnings Foregone

The major cost of the project is the opportunity cost of the productive output of a Kenyan over his/her life time. Since the target group constitutes Kenya's formally employed population, it is assumed that children born to them will be educated and will find employment similar to that of their parents. It is further assumed that females will work as well as males, and that life time earnings will begin to accrue at age 18, (after one year of unemployment), and continue until age 55, which is the average life expectancy in Kenya. Rather than utilizing the marginal product of the individual's output, this analysis will be based on average product, as measured by actual income. This approach avoids the imbalance of utilizing average consumption and marginal output, while eliminating the measurement problems associated with marginal productivity. As shown in Table 1, earnings begin to accrue at age 18, and increase to the average level of Sh. 11,000 at age 31. No provision is made for inflation, since inflation is expected to affect costs and benefits uniformly thereby cancelling out its effects. It should be noted that this set of assumptions with regard to life time earnings is very optimistic, since it is assumed that employment will be found at the average rate prevailing in the modern sector, and that every child would find such employment. Should earnings be lower, then the costs related to foregone production would also be lower. Therefore, these assumptions are in fact the most conservative possible with respect to this economic analysis.

Since life-time earnings foregone constitute the basic component of the cost side of the equation, it would be prejudicial to end the analysis after 20 or 30 years. The analysis has therefore been carried out to 55 years, or the average life expectancy of a Kenyan born in 1980. Two discount rates within a probable range have been utilized. A set of B/C analyses was also carried out on births averted after the effects of the high start-up costs have worn off.

3. Other Costs

In societies where birth rates and child dependency ratios are already low, considerations regarding future productive capacity would argue against birth aversion. In such situations, the cost of averting a birth should be included in the analysis, based on the high future marginal product of labor. While this data would be hard to verify, it would help to eliminate the predictability of the outcome of the economic analysis. For Kenya and other developing countries with high birth rates, this factor does not constitute a cost. Other factors discussed in Section I.A. above are discussed as benefits below.

Other costs could also include the private considerations of the family, based on how many children they have and their financial situation. This analysis has not developed a model to incorporate these private considerations.

B. Benefits of Averting a Birth

1. Consumption

The largest quantifiable benefit of averting a birth is the saving of the consumption expenditures which that person would consume over his/her lifetime. Consumption includes the value of food, clothing, shelter and recreation. Since these expenditures vary by income category, weights developed for urban middle income households (Sh 700 - 2499 per month) were utilized. Unlike the classical ECA analysis, this analysis does not assume that consumption equals income, since there may be other dependents supported from this income, as well as taxes, etc. Initially, consumption is assumed to be about 80 percent of income. As salaries increase and family responsibilities are incurred, consumption declines gradually to about one-third of income. These estimates are based on the fact that a young employee would consume most of his/her income prior to marriage, but subsequently, would devote greater shares to dependents. With an average dependency ratio of one working adult per three dependents, it is logical to estimate that a working adult would consume one-third of his production. However, it is probable that the employed adult would consume a greater share of his production than his dependents. Nonetheless, utilizing a third of his/her production constitutes the most conservative estimate possible, since higher consumption would increase the benefit side of the ECA.

2. Wage Productivity

The wage productivity effect is traditionally defined as the increase in output resulting from better nutrition of small families. This effect may be substantial in countries with a low per capita level of caloric intake. There are additional wage productivity effects such as paid maternity leave of two months, and

lower productivity resulting from the demands of nurturing an additional child, childhood illnesses and other inevitable demands related to parenting which result in tiredness and less than optimal job performance. Many companies interviewed by the design team also mentioned that fathers generally are granted a week of leave for the birth of a child, in addition to annual leave. These factors have been included in calculating wage productivity effect. During the year of birth, only maternity/paternity leaves were included, based on employed mothers accounting for half of birth averted. Thereafter the wage productivity effect is estimated at 3 percent of earnings in initial years, declining to 1 percent, by year 11, and ceasing after year 15. This includes both nutritional and parenting factors.

3. Health Expenditures

The health expenditures which are saved in averting a birth include hospitalization costs for the mother and subsequent health services throughout a life time. These expenses are both public and private. The estimate for public costs is derived from World Bank projections and from overall GOK expenditures on health, while private expenditures are derived from Consumer Price Index data and weights. The expenses in year 0 are for child birth, and are based on GOK expenditures for health, combined with the statistic that one-third of health services relate to childbirths (CBS, Economic Survey 1981).

4. Education Expenditures

The cost of education constitutes another benefit or potential savings related to averting a birth. As with health expenditures, these costs are both public and private. The estimate for public and private costs is based on a recent study of GOK expenditures on basic needs (Vandemortele, 1983), and on available survey data. This analysis also assumes no repetition in school: Repetition would raise both public and private expenditures.

5. Other Benefits

Other benefits of averting births in Kenya include a number of factors which bear concrete economic results, but which are difficult to quantify. Nonetheless, it would be possible to quantify some of these benefits, should adequate data and analytical resources be available. These factors include:

Child Dependency Ratio. This ratio is high in Kenya, with roughly two dependents supported by each adult, assuming all adults work. Thus, the production of each adult is shared among three people. Averting births would reduce the dependency ratio.

Employment and Future Productive Capacity. The employment situation in Kenya is tight, with significant underemployment and unemployment. This results in low marginal productivity of labor. Averting births would serve to improve the productivity of the future labor force. There is no need to worry about future productive capacity, since there is presently sufficient population growth to ensure the future labor force.

C. Conclusions

The Benefit/Cost Analysis for one birth averted is summarized in Table 1. The assumptions and data on which each item is based have been discussed above. The analysis attempts to depict the average consumption and earnings of a working-class Kenyan. Consumption is assumed to be less than earnings since dependents generally exist, as well as other expenses such as taxes and remittances. The benefit side of the equation is considerably reduced by lowering the imputed value of consumption. The cost side of the equation is also higher than in similar analyses (Zaidan, 1971), since project costs are high in terms of acceptors, and foregone incomes are based on wage employment, which is far above the average Kenyan income. Thus, the Benefit/Cost ratio is considerably lower than in comparable analyses. Two discount rates within a probable range have been utilized. A set of B/C analyses was also carried out on births averted after the effects of the high start-up costs have worn off. This analysis is represented in Table 2. Table 3 below sets forth the conclusions of this analysis at discount rates of 10 and 15 percent, for first and subsequent births averted, at 10 year intervals. The B/C ratio remains positive in all cases.

Table 1 : Kenya Private Sector Family Planning:
Benefit/Cost Analysis of Averting One Birth
(In Kenya Shillings at 1980 Prices)

Year	Benefits:						TOTAL BENEFITS	Costs		TOTAL COSTS
	Consumption Foregone	Wage Effect	Productivity	Health		Education		Service Delivery	Earnings Foregone	
			Private	Public	Private	Public				
0	-	725	20	365	-	-	1110	2600	-	2600
1	552	330	10	40	-	-	932	260	-	260
2	552	330	10	40	-	-	932	260	-	260
3	552	330	10	40	-	-	932	-	-	-
4	552	330	10	40	-	-	932	-	-	-
5	552	330	10	40	-	-	932	-	-	-
6	773	220	10	60	200	20	1283	-	-	-
7	773	220	10	60	200	20	1283	-	-	-
8	773	220	10	60	200	20	1283	-	-	-
9	773	220	10	60	200	20	1283	-	-	-
10	773	220	10	60	200	20	1283	-	-	-
11	883	110	10	60	200	20	1283	-	-	-
12	883	110	10	60	200	20	1283	-	-	-
13	883	110	20	60	1500	80	2683	-	-	-
14	883	110	20	60	1500	80	2683	-	-	-
15	883	110	20	60	1500	80	2683	-	-	-
16	883	-	20	60	1500	80	2683	-	-	-
17	883	-	20	60	-	-	963	-	-	-
18	5760	-	20	60	-	-	5840	-	7200	7200
19	5760	-	20	60	-	-	5840	-	7200	7200
20	5760	-	20	60	-	-	5840	-	7200	7200
21	5760	-	20	60	-	-	5840	-	8400	8400
22	5760	-	20	60	-	-	5840	-	8400	8400
23	5760	-	20	60	-	-	5840	-	8400	8400
24	5760	-	20	60	-	-	5840	-	8400	8400
25	5760	-	20	60	-	-	5840	-	8400	8400
26-30	5760	-	20	60	-	-	5840	-	8400	8400
31-40	5760	-	20	60	-	-	5840	-	9600	9600
41-50	5760	-	20	60	-	-	5840	-	11000	11000
			20	50	-	-	5840	-	15000	15000
TOTAL							189976			974730
Discounted at 10 percent							22457			21825
Benefit/Cost = 1.06										
Discounted at 15 percent							11897			8359
Benefit/Cost = 1.42										

Table 2 : Kenya Private Sector Family Planning:
Benefit/Cost Analysis of Averting One Birth
(In Kenya Shillings at 1980 Prices)

Year	Benefits:						TOTAL BENEFITS	Costs		TOTAL COSTS
	Consumption Foregone	Wage Productivity Effect	Health		Education			Service Delivery	Earnings Foregone	
			Private	Public	Private	Public				
0	-	725	20	365	-	-	1110	260	-	260
1	552	330	10	40	-	-	932	260	-	260
2	552	330	10	40	-	-	932	260	-	260
3	552	330	10	40	-	-	932	-	-	-
4	552	330	10	40	-	-	932	-	-	-
5	552	330	10	40	-	-	932	-	-	-
6	773	220	10	60	200	20	1283	-	-	-
7	773	220	10	60	200	20	1283	-	-	-
8	773	220	10	60	200	20	1283	-	-	-
9	773	220	10	60	200	20	1283	-	-	-
10	773	220	10	60	200	20	1283	-	-	-
11	883	110	10	60	200	20	1283	-	-	-
12	883	110	10	60	200	20	1283	-	-	-
13	883	110	20	60	1500	60	2683	-	-	-
14	883	110	20	60	1500	80	2683	-	-	-
15	883	110	20	60	1500	60	2683	-	-	-
16	883	-	20	60	1500	80	2683	-	-	-
17	883	-	20	60	-	-	963	-	-	-
18	5760	-	20	60	-	-	5840	-	7200	7200
19	5760	-	20	60	-	-	5840	-	7200	7200
20	5760	-	20	60	-	-	5840	-	7200	7200
21	5760	-	20	60	-	-	5840	-	8400	8400
22	5760	-	20	60	-	-	5840	-	8400	8400
23	5760	-	20	60	-	-	5840	-	8400	8400
24	5760	-	20	60	-	-	5840	-	8400	8400
25	5760	-	20	60	-	-	5840	-	8400	8400
26-30	5760	-	20	60	-	-	5840	-	9500	9500
31-40	5760	-	20	60	-	-	5840	-	11000	11000
41-55	5760	-	20	60	-	-	5840	-	15000	15000
TOTAL							199976			972337
Discounted at 10 percent							22457			18375
Benefit/Cost = 1.19										
Discounted at 15 percent							11897			6915
Benefit/Cost = 1.98										

Table 3 : Benefit/Cost Summary of One Birth Averted

Year	At 10 Percent Discount		At 15 Percent Discount	
	First Birth	Subsequent Births	First Birth	Subsequent Births
20	2.17	3.36	2.12	4.36
30	1.34	1.60	1.59	2.37
40	1.17	1.34	1.47	2.08
50	1.09	1.23	1.43	2.00
55	1.06	1.19	1.42	1.98

NOTE: The ECA for first births is based on the figures set forth in Table 1. Subsequent births are defined as births averted after year 3, when project start-up funds have been expended. Table 2 summarizes the benefits and costs of subsequent births averted.

Making the transition from new family planning acceptors to the number of births averted represents a difficult step in carrying out a B/C analysis. There is no precise, quantifiable relationship between the number of family planning users and the number of births averted. If family planning is used to maintain the present average Kenyan birth interval of 30 to 33 months (depending on the data set), the project would serve primarily to prevent further increases in fertility, rather than to reduce the fertility rate. The project could also result in a time pattern of delayed births, with a longer birth interval, which would ultimately result in smaller family size as women pass the years of child-bearing.

In addition to translating the impact of family planning services, there is also a problem of substitution, or of separating the impact of family planning from changes in fertility that would occur without intervention, as socio-economic conditions improve. In Kenya, improved conditions have been accompanied by a desire for and ability to have larger families, although better educated urban families are beginning to limit their family size. These problems make quantitative estimates less precise, but do not reverse the overall trends and conclusions. The average fertility of a Kenyan woman is 8.1 children over a 30 year period. However, only 80 percent of women aged 15 to 44 are able to conceive at any given time and only 58 percent of women over the age of 35 are able to conceive (Moseley et al, 1982). Thus, the average reproductive years per woman is closer to 25 years than to 30 (Fow and Werner, 1982). The live birth interval is from 30 to 33 months, including the period of pregnancy, post-partum amenorrhea, breast feeding and contraception, if any. Eased on a 25 year reproductive period, with 8 live births per woman, it is estimated that three years of contraceptive use is equal to one birth averted, or one year of contraceptive protection is equivalent to one-third of

a birth aversion. Given the actual periods of pregnancy and amenorrhea, which are included in calculations of live birth intervals, but should be additive to contraceptive protection, it would not be unreasonable to assume that two years of protection is equivalent to one birth aversion. Nonetheless, for the purposes of this analysis, the more conservative estimate of three years is utilized.

In developing a Benefit/Cost estimate for the entire project, the following assumptions were adopted:

1) Three years of contraceptive protection is equivalent to averting one birth.

2) There will be 30,000 family planning acceptors (male or female) by the end of the project, accruing at a rate of 10,000 acceptors per year beginning in the second year of the project. This number will remain constant in subsequent years; as previous acceptors drop out of the program to have children, new acceptors will replace them, since the services supported under the project will continue to function.

Under this set of assumptions, the project has an acceptable Benefit/Cost ratio over the four year life of the project. This ratio includes the discounted stream of costs and benefits for the average 55-year life time of all births averted during the four year life of the project. Assuming that the program continues to operate for ten and twenty years after its inception, the Benefit/Cost ratio increases, as shown in the table below.

Table 4: Benefit/Cost Summary for Overall Project

	10 Percent Discount Rate	15 Percent Discount Rate
Four-year LOP	1.23	1.43
After 10 Years	1.36	1.58
After 20 Years	1.38	1.74

D. Modifications

Owing to the predictable nature of ECA for population projects, various modifications have been posited. Most suffer from the same basic biases which afflict the classical Zaidan/Enke approach, although one variation is based on a percentage reduction in the birth rate rather than births averted. Another modification, originally adopted by Coale and Hoover in 1958, is to remove the bias toward the present and against the future by eliminating discounting. Discounting produces an inherent bias against all development programs which are predicated on enhancing future productive capacity, such as education and child-health/vaccination programs. While eliminating discounting runs counter to the basic economic tenet that resources have an inherent opportunity cost

and should therefore be put to work to generate future wealth, it does serve to remove the bias against the future.

If discounting is eliminated, the analysis contained in this paper would carry a B/C ratio of 0.19. This low ratio should be predictable, as most people earn more over a lifetime than they personally consume, especially if they have children. Without discounting, a B/C ratio would be positive only if a person consumed more than he produced, e.g., if he were on welfare or were supported by his family. However, the ratio would improve with different assumptions regarding increased consumption or decreased income. It would be plausible, or even more accurate, to assume lower income, since only 20 percent of the present labor force has a modern sector job.

E. Sensitivity Analysis

The role of sensitivity analysis is to test variations in key assumptions to determine the sensitivity of overall results. One basic sensitivity test regards the discount rate. This test is presented in Table 2, with discount rates of 10 percent and 15 percent both showing acceptable results. Furthermore, it is evident from this test that the B/C ratio improves as the discount rate increases, owing to the relatively greater impact of discounting on the early life of the project, which in this case consists disproportionately of benefits attributed to foregone consumption. A second sensitivity test relates to decreases in project benefits. If project benefits were reduced by 10 percent, for example, the B/C ratio would be 1.05 for a birth averted for 40 years, and decline to 0.98 by year 50. With a discount rate of 15 percent, the B/C ratio for a birth averted would be 1.28 at the end of the life-time, if benefits were reduced by 10 percent. In terms of the entire project, the E/C ratio would decline to 1.24 with a 10 percent discount rate, but would be 1.57 at a 15 percent rate.

A final sensitivity test relates to project costs. If costs were to increase by 10 percent, the B/C ratio for a birth averted would decline to 1.06 by year 40, and to 0.99 by year 50. Using a 15 percent discount rate, the B/C ratio would be 1.29 if project costs were increased by 10 percent. If both costs were increased, and benefits were decreased by 10 percent, the E/C for one birth averted at a 15 percent discount rate would be 1.16.

For the overall project, if benefits were reduced by 10 percent, the E/C ratio with a 10 percent discount rate, which yields lower results in this analysis, would fall to 1.24. If costs were increased by 10 percent, then the B/C ratio would fall to 1.25. If both costs and benefits were to change by 10 percent, the E/C ratio would be 1.12. This ratio is acceptable from an economic view point.

IV. Cost Effectiveness Analysis

Cost effectiveness analysis is predicated on two basic criteria: 1) the selection of the most cost effective approach to achieve a given objective within a defined time period, and 2) steps to reach the maximum number of beneficiaries to which project supported services are extended.

The project focuses on private sector delivery of family planning services to wage earners and their families, who are considered to constitute the most receptive target group in Kenya. Alternative delivery systems include public health services and voluntary, non-government organizations (NGO) such as church groups. Experience with public service delivery shows that approach to be inefficient in reaching large portions of the population owing to waiting and travel time, and supply problems with contraceptives. Furthermore, public services create an operating cost burden which the GOK cannot presently afford. NGO's, while more efficient, also must be subsidized by charitable contributions and may involve a distance factor which has been shown to reduce acceptance. Since NGO's are private and do not require public funds, they are included in the proposed project. However, the primary focus of the project is the private for profit sector. Health service delivery in this sector is generally efficient, with minimal waiting time and/or travel time for employees, since services are on the work premises, or transport is provided by the company. Furthermore, no subsidies are required, since companies recognize that efficient health services increase productivity, in part by reducing time away from the job. Thus, the project has selected the most cost effective and time efficient method to achieve project objectives of reaching 30,000 new family planning acceptors over a 3 to 4 year implementation period.

With regard to reaching the maximum number of beneficiaries, it is self evident that cost effectiveness improves as fixed project costs are spread among more beneficiaries. In this context, it should be reiterated that utilizing the average Kenyan acceptance rate of five percent, which prevails in an environment of poor service delivery, large distance factors and lower income women, represents an extremely conservative estimate of acceptors for a target population, especially if their inherent acceptance is reinforced with efficient service delivery and appropriate work-related incentives. Thus, the project should be considered cost effective with respect to both criteria governing cost effectiveness considerations cited above.

Annex E

SOCIAL SOUNDNESS ANALYSIS*

Kenya's population growth rate--at 4.0 percent perhaps the world's highest national rate--is well-documented in population censuses and sample surveys. Further, fertility has risen in the last 30 to 40 years and the overall rate of population growth has increased (Social Perspectives 4(2); Henin 1979). Such demographic processes clearly constrain Kenya's potential for development. Increased population makes it more difficult to find solutions for the country's major development challenges: increasing agricultural production, providing productive employment for a growing labor force, maintaining the quality of the resource base, and improving access to basic social services.¹

This chapter examines ways that development interventions in a range of sectors, especially the key areas of employment generation and agriculture, along with family planning, can be focused to create and expand the social and economic conditions supportive of fertility decline in Kenya. The intent is to define feasible development interventions which are most likely to accelerate changes conducive to smaller families at the same time that they lead to economic growth. We begin with a review of the economic, social and institutional processes which appear to be sustaining extremely high fertility in Kenya, or which are operating where fertility is declining. We then isolate significant categories of individuals, groups and communities for whom processes may differ or for whom particular actions might be more appropriate, and, using this framework, discuss implications for AID interventions.

A. The Context of High Fertility in Kenya

Kenya's higher fertility is linked to four main factors. First, children provide substantial economic support for the majority of Kenyan households who are smallholder farmers. Second, the status of Kenyan women is extremely low, the majority of them have limited opportunities for employment outside of the poorly-rewarded informal sector, many can only gain prestige through the rearing of large families. Third, cultural traditions, although varying by ethnic group, tend to place extremely high value on a woman having children early and continuing to bear them throughout her reproductive life.

1. The role of population growth in constraining Kenya's development potential is detailed in a recent World Bank publication, Population and Development in Kenya (1980).

* This analysis is taken from Chapter 7 "Fertility in Kenya" of Kenya Social and Institutional Profile (SIP), USAID/Kenya 1982. The SIP was written by Patrick Fleuret and Ned Greeley; Chapter 7 was drafted by Rosalie Fanale.

These traditions are changing in urban areas but not much if at all in rural areas. Each of these three conditions, along with a fourth, major shortcomings in service delivery, are interrelated and form the context for high fertility in Kenya.

We can begin our analysis of fertility increase in Kenya by looking at changes in the total fertility rate, (defined as the number of live births by a woman reaching the end of her reproductive cycle). This rate has steadily increased, as shown in Table 1.

Table 1. TOTAL FERTILITY BY TIME PERIOD

<u>Period</u>	<u>Total Fertility Rate</u>
1941 - 1945	6.1
1946 - 1950	6.6
1951 - 1955	6.6
1956 - 1960	7.0
1961 - 1965	7.5
1966 - 1970	7.7
1972	7.9
1973	8.0
1979	8.1

Source: (Henin 1979:3 Table 3; 1979 census.)

This increase is fueled by the extremely high value placed on children in Kenya, and fits a pattern of high population growth seen throughout Sub-Saharan Africa. For the average Kenyan family, desired family size has kept step with fertility potential. In 1967, for example, a survey among women showed that desired fertility was 6 children; in a survey of similar women (age 15-49) in 1977-78, desired fertility was 8 (Dow and Werner, 1981:276).

The reasons for this rise are linked to modernization, which has intensified some of the conditions which made fertility high in the first place, and which has brought a decline in practices which traditionally served to space births. Better health has brought improved fecundity, reduced infertility and more surviving children (Henin 1979); the incidence and duration of breastfeeding has declined, resulting in earlier onset of ovulation (Mosely, Becker and Werner 1981); and, there has been a widespread reduction in traditional practices of postpartum abstinence and polygamy, in part triggered by the spread of modern attitudes through education. This situation has been exacerbated by limited access to and availability of family planning services due to inadequacies in public sector delivery systems and constraints to expansion of private sector mechanisms.

1. Women, Men and Children: Household Economic Roles

The majority of Kenyan women are rural smallholder farmers whose agricultural labor on family holdings and financial support for the household make major contributions to the rural economy. Women's cultivation of cash crops as well as subsistence crops often enables men to obtain temporary urban or rural employment (including seasonal agricultural off-farm employment), or to engage in rural enterprise. Women's financial support for the household may free men to invest their income in other endeavors (Mott, F. 1980). Virtually all women also perform domestic work, including childrearing, food preparation and obtaining fuel and water. From 85 to 90 percent of rural women living on small farms work on a family holding, compared to 55 to 60 percent of males in the same category; greater than 95 percent of rural women work in agriculture; and women provide 75 percent of all on-farm labor (Social Perspectives 3(3); Kenya Fertility Survey I:11-12).

Many women work off of their family holdings, but such work tends to be limited to the poor-paying, informal sector. According to a 1969 survey, women form less than 20 percent of the adult labor force active in permanent, non-agricultural rural enterprise, with one-half of them working in a family business likely to be owned by a male relative (Social Perspectives 3(3)). As for wage work, less than 5 percent of females in the smallholder rural group are employed in an off-farm wage job, as compared with 21 percent of the men. Women are 17 percent of modern sector employment (both skilled and unskilled) and 28 percent of urban, self-employed informal and unpaid family labor. Women's participation in the wage labor force as a whole between the years 1964 and 1976 ranged from 13 to 18 percent, and it was far less in rural areas (Social Perspectives 3(3); Mott, F. 1980).

In comparison with precolonial times, women's farm labor has most likely increased while their status relative to men has diminished (Pala 1974). Although, traditionally, women and girls were responsible for the bulk of agricultural and domestic work, more recently the development of cash crops, mechanization and modern sector employment have intensified women's orientation to the domestic sphere while giving men disproportionate access to the modern sector, to the agricultural market and to new technologies. Further, women's labor on subsistence crops is less highly valued in the modernizing economy, since it contributes little cash to the household.

Children contribute much in support of farm families in Kenya. The need for children's labor has probably gone up in the last few decades, due to increased work burdens for women and a higher economic situation which forces all to work, both on- and off-farm (Monsted n.d.). Children provide farm labor, especially during seasons of peak demand, and perform household tasks such as fetching firewood and water, they care for each other; and they assist in food preparation among other tasks. They are especially called upon for family support when men are away (and their contribution may be even more important in women-headed households) or when women spend time in cash-earning activities (Pala-Okeyo 1979); Monsted n.d.; Feldman 1981).¹

2. Fertility Attitudes and Family Context

What has been called "prolific procreation" is traditionally valued as appropriate and natural behavior, essential to survival of the family and larger social units (Ssenyonga 1975). These values persist, although modernization has changed to some extent the role of family members, diminished the importance of the linkage, brought husbands and wives closer together, affected the system of economic rights and obligations within the family, and brought an orientation to the cash economy.

Traditions are widespread which encourage males to increase their land base, increase their wives, and increase their children. This is aptly described for the Gusii (LeVine, S. 1979) and for the Maragoli of Western Kenya (Ssenyonga 1975) and holds despite widely held values of child-spacing. In traditional Maragoli, land was held by the clan, not the individual or household. Male children were valued for the defense and support they could provide and female children valued for the assets they would bring through bridewealth. In-marrying wives, in turn, were valued for the children brought to the family and clan. In this situation there is no rational purpose to reducing fertility. Inter-ethnic land strife is not infrequent in the present day, and so pressures to increase lineage and tribe membership, thereby staving off demands of outsiders, remain strong.

1. Community studies also show that, in Kenya as elsewhere, the attitude is widespread that having many children enlarges the chances that one or more will succeed, as is the concept that children will provide support in old age (Ssenyonga 1975; Kabwegyere 1976).

For the Gusii -- a group which represents an extreme case of high fertility -- "all the conditions favorable to fertility are present and all the obstacles to it.... absent," despite land shortages and fragmentation of holdings, and growing need for cash income to supplement farm production. People are "not oblivious to the fact that population growth has made land scarce and will make it scarcer." Men keep their fathers' reproductive goals, and envision a future of economic success to be gained through education, employment and trade, and purchase of new land. These values are widespread, even though in reality most Gusii are low-income smallholders whose plots of land are dwindling in size and whose access to employment is minimal. (Levine, Dixon and Levine 1976).

Although some aspects of social change have brought the perpetuation of traditional fertility values, the familial and biological context in which these values operate has changed significantly. In part because education has spread new ideas of family roles, practices such as breastfeeding, polygyny, postpartum and other periods of abstinence -- which traditionally served to limit family size -- have diminished. But, although most of the community-sanctioned practices which constrained fertility are gradually losing their effectiveness, two traditional practices, prolonged breast-feeding and polygamy, are still prevalent. Both continue to have a significant although largely unintended constraining effect on fertility. In fact, it is the combined effect of both these practices which has the most important limiting effect on current fertility; the current level of modern contraception use is so low that it is not possible to detect an effect on the overall fertility rate (Mosley, Werner, and Ecker 1981:11).

Modernization has also caused changes in family relationship; husbands' and wives' social domains have become closer, with one likely result a higher frequency of intercourse which results in higher fertility (Greeley 1977; Whitting 1977). At the same time, common prohibitions on communication about sexual matters between adjoining generations (eg. child/parent, parent/grandparent) reinforce traditional beliefs and inhibit the spread of scientific information on topics such as menstruation and sexual intercourse, which in turn significantly limits acceptance and continuation of contraceptive use.

Improved health over time leading to greater fecundity is another factor. But the risks of parenthood, are still keenly felt by parents, the precipitous decline in infant mortality

notwithstanding.¹ What might be termed "partial modernization" has meant that familiar values of high fertility are matched by a new ease in meeting them: social change to date has affected some but not all fertility-related practices, with a rise in fertility the result.

The rise comes about through changes in the interval between births. Although the traditional period of spacing varied among ethnic groups, proper spacing was nearly universally seen as essential to the health of mothers and children.

Typically breast-feeding and prolonged sexual abstinence were practiced following birth; other customs such as the maintenance of separate living and sleeping quarters for husband and wife, polygamy and prohibition of sex for the uncircumcised and those in mourning also limited the period when a woman was at risk of pregnancy.

In addition, there were among many groups specific cultural norms which sanctioned gaps of two or three years between births. Among the agricultural Meru and the nomadic pastoralist Galla, the period during which an adult fecund woman could appropriately bear children was socially defined, and limited to the years when she held the status of "mother," as opposed to the uncircumcised "girl" or elderly "grandmother." In these groups, the concepts of child spacing and family size limitation were explicitly endorsed, and the period of socially acceptable childbearing was considerably restricted (Greeley 1977 and Prins 1960). In other groups, such as the agricultural Kisii, there were virtually no cultural constraints on childbearing. In most ethnic groups, however, child spacing in association with breast-feeding was accepted as desirable and enforced by social sanctions. Indeed in many parts of Kenya the birth intervals of today would have been judged inappropriate two to three generations ago; older men and women in many communities interpret today's fertility as too high and births as too closely spaced (Greeley 1977). Perhaps the most critical factor in closer birth intervals now is the decline in breast-feeding which shortens the period of postpartum

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1. It can be argued that fear of child loss remains because even though infant mortality has declined precipitously, births have increased precipitously. Thus the contemporary parent may be aware of as many infant deaths in the community today as his/her grandparent was two generations ago.

infecundability.¹ Since modern contraceptive use is very low, the decline in breastfeeding is having a dramatic effect on fertility. If breastfeeding continues to decline, as appears to be happening among younger and better-educated women, up to a 25 percent rise in marital fertility could be expected unless compensated by increased contraception (Mosley 1980:7-8).²

3. Education of Women

A topic which has been of increased concern to observers of population in Kenya is the fertility rise associated with primary education. Women with to four years of schooling have higher fertility than both women with no education and women with full primary or secondary education (Henin 1979; Kenya Fertility Survey I). Table 2 shows cumulative fertility by levels of education.

Table 2. Mean Number of Children Ever Born By Current Agea/

Level of Education	Current Age			
	15-24a/	25-34	35-44	45+
None	1.0	4.4	6.9	7.7
1-4 years	1.0	4.7	7.6	8.5
5-8 years	1.0	4.6	7.2	(8.9)

Source: Kenya Fertility Survey I:97.

a/ Standardized by age at marriage and proportion never married.

1. There is a distinction between "full breastfeeding" and "breastfeeding." Most Kenyan women full breastfeed for about two months. From then until weaning supplemental food is given. Breastfeeding intervals include both periods. Postpartum abstinence, which often extended beyond the breastfeeding period, is of little significance now in affecting the birth interval, since the mean for the country is only 3.4 months. The duration of breastfeeding has decreased for younger women: it is 14.5 months for women in the 15-24 age group, rises to 16.9 months for women 25-35, and up to 20.7 months for women 35-44 years (Mosley, Werner and Becker 1981:38).
2. Bongaarts (1979:17-25), quoted in Nag 1980) has noted that if an infecundability interval of two years is cut in half, a 40 percent rise in fertility can be expected, unless compensated by a 30 percent contraceptive prevalence rate.

Since relatively few women go beyond primary levels, the overall result is a rise in fertility. Only in urban areas does fertility not rise with primary education; there it stabilizes throughout the primary levels and falls off with secondary education.

Through the new values and ideas it brings, schooling contributes to certain changes in lifestyle which influence fertility. Improved nutrition and health, and a decline in traditional spacing practices such as breastfeeding and polygamous marriage are closely linked to education (Mosley, Werner and Becker 1981). This is especially true for breastfeeding:

The most consistent effect of education on the birth interval components relates to breast feeding and contraceptive practice. There is a 2.2 month decline in the average duration of breast feeding among women with 5-8 years of education resulting in over a 25 percent shorter duration of lactational amenorrhea (Mosley, Werner and Becker 1981:17).

Only among the highest educated women does contraceptive use compensate for the reduced duration of breastfeeding. The education-fertility relationship remains unclear, and it is difficult to state with certainty what the long term effect on fertility will be as young women with 1 to 4 years of primary education move through their reproductive years. There are still many unknowns as to why greater contraceptive use -- a modern idea -- has not accompanied other new ideas brought by education. Clues lie, of course, in the persistence of traditional fertility values, the great economic worth of children, and perhaps in the quality and content of schooling; but these factors would not fully explain why fertility has risen and why compensatory contraception has not served to stabilize fertility. To examine this further we now discuss the adequacy of service delivery.

4. Family Planning Services: Historical Context

Kenya is the first sub-Saharan African country to have an official family planning program. Voluntary family planning has been part of several government development plans and private family planning associations have been active since the early 1960's. Prior to that time, as early as 1955 in the metropolitan areas, family planning was promoted by voluntary organizations in the private sector (World Bank 1982:15). The major public family planning effort has been implemented by the Ministry of Health, although private channels, primarily church-based, have remained important.

By 1978 the public sector program had 500 government sponsored maternal child health/family planning clinics in operation and the Ministry of Health had nearly met numerical targets for service delivery points and trained staff in place for the 1974 to 1979 program. However, contraceptive use remains far too low to have any appreciable impact on the overall level of fertility in Kenya. In the Kenya Fertility Survey, 5.9 percent of respondents reported using modern contraception and another 3.3 percent reported using a traditional method at the time of survey (Kenya Fertility Survey I:133). This represents 7 percent of currently-married women, or 6 percent of over-married women. Table 3, which shows the current low use of contraception, also reveals no consistent pattern of use by age group.

Table 3. Current Usage of Contraception by Age Groups^{a/}

Type	Current Age				
	15-24	25-34	35-44	45+	All
Traditional	3	3	4	5	3
Modern	3	7	7	7	6

Source: Kenya Fertility Survey I: 133.

a/ Percent of currently-married women.

Comparison of family planning data from 1967/1968 survey and the 1977/1978 Kenya Fertility Survey reveal changes in contraceptive knowledge and use (Dow and Werner 1981a). For rural areas, there was a substantial increase in numbers of women who know about modern contraceptive methods, but there was little increase in the proportion. The percentage using modern methods is similar for both time periods, with, perhaps, a slight rise over time. For Nairobi, there was a significant change in contraceptive use and knowledge over the period in question, but fertility remained approximately the same. The conclusion is that in urban areas contraceptive use is still largely in the context of complementing and maintaining traditional fertility values, with family planning a spacing mechanism rather than a route to (significantly) smaller families. In rural areas, since contraceptive use did not rise, it could not reach a level adequate to compensate for the dropoff in breastfeeding.

Kenya Fertility Survey findings amplify this analysis of differentials in modern contraceptive use: less than one-half of ever-married women know where to obtain family planning advice or supplies; 12 percent of women had visited a family planning source; and about one-fifth of currently-married fecund women who had tried contraception stated an intent to use contraception in the future (Kenya Fertility Survey I: 142).

It is not unlikely that shortcomings in the program itself have served to limit the spread of family planning, and so condition a rise in fertility. Reasons why this may have been so center around limitations in the availability, reliability and quality of services. Clinics have been noted to be unevenly dispersed or poorly located, open infrequently or part-time, short staffed and short of materials, and lacking in privacy and amenities. Staff competence is also an issue: the criticism has been leveled that staff have frequently been delinquent in follow-up of visitors and in some cases both unable and unwilling to even answer questions about contraceptive side-effects (Mott and Mott 1980:32; Migot-Adholla 1981). Performance of field staff has been generally disappointing, each field educator having recruited only about 15-18 new family planning acceptors per year.

This program has been characterized as an "extremely hopeless environment for family planning" (Migot-Adholla 1981:13).

Evidence for a positive relationship between quality approaches to service delivery in Kenya and popular use of services is most likely to be found in an examination of those private channels which have been operating in the country for some time. Because of their limited coverage, their impact is unlikely to show up in national statistics, but they may have, in fact, helped lead to widespread contraceptive use among pockets of the population and perhaps among at least one ethnic group, the Meru (Greeley 1977; Mott, S. 1981).

The Meru example suggests why this may be so. A network of church-based health facilities has been operating since the 1950's with family planning services now including hospital, clinic and outreach facilities. Services are very widely available, compared to most of rural Kenya, and their accessibility, reliability and quality are much greater than in government clinics. Further, because these have been linked to the broader community development efforts of church missions, their approach to population has set them apart from government service delivery. The impact of church development organizations on family life has been considerable. Health and

family planning services have been paired with family life education which emphasizes shared decision making and planning between husbands and wives, attention to the care of children, and quality between men and women. The overall community development effort has included education, agricultural inputs, savings and credit institutions, as well as health services, plus a deliberate spreading Christian and Western values, and active promotion of individual and community involvement in the programs.

Today, church missions throughout Kenya are being joined by a range of private groups interested in expanding rural service delivery. Most of these organizations stress local involvement and have an outreach philosophy. Reasons for focusing more on private sector groups go beyond the fact that they form an in-situ basis for expansion: they may serve as successful models for replication at a time when constraints in the public sector leads us to search for such models. The history of private family planning efforts in Kenya may offer lessons about efficient and appropriate service delivery and about the wide development context for contraceptive innovation.

5. Summary

Between 1967 and 1977 in Kenya there has been an increase in modern contraceptive use at the same time that fertility has risen in rural areas. Even in urban areas, where fertility has remained stable, high fertility values persist and family planning is primarily used to maintain fertility and to space--not limit -- births. A complex of forces over several decades has brought a decline in traditional customs that prolonged the interval between births, and has thus conditioned a rise in fertility. Overall, the use of contraception is not compensating for the decline of traditional fertility-limiting practices (Dow and Werner 1981a). This rise in fertility is linked to continued extremely high desired family size and perhaps to historical limitations in the availability of contraceptive services.

While education has been a contributing factor in hastening the decline of traditional spacing, it has not (at least not yet) brought widespread changes in attitudes about family size. The current state of social and economic development for most of the population perpetuates the context for high fertility. Children are key to household production and reproduction, and remain, even today, the primary channel by which women achieve high social status. The economic setting for much of the population is one of increasing poverty and heavy work burdens and the market economy although only at its marginal fringe. Although some people have taken on modern, western values, the transition to modern family lifestyles is incomplete.

Table 4. MEAN NUMBER OF CHILDREN EVER BORN BY CURRENT AGE
SELECTED SOCIAL CHARACTERISTICS a/

	Current Age			
	15-24	25-34	35-44	45+
Level of Education				
none	1.0	4.4	6.9	7.7
1-4 yrs	1.0	4.7	7.6	8.5
5-8 yrs	1.0	4.6	7.2	(8.9)
9+ yrs	0.9	4.5	*	*
Type/Place of Residence				
rural	1.0	4.6	7.2	8.0
urban	1.0	4.2	(6.9)	*
metropolitan	1.1	4.0	6.0	(5.7)
Region of Residence	--			
Nairobi	0.9	4.4	6.8	*
Central	1.0	4.7	7.5	8.2
Coast	0.9	3.8	5.8	5.0
Nyanza	0.9	4.3	7.3	8.6
Rift	1.1	4.6	7.1	7.6
Western	1.0	4.5	7.5	7.9
Eastern	1.2	4.6	6.8	7.9
Ethnic Group				
Kikuyu	1.1	4.9	7.5	8.2
Luo	0.8	4.0	6.9	8.0
Luhya	1.0	4.6	7.7	8.0
Kamba	1.1	4.4	6.8	7.7
Kisii	0.8	5.0	7.7	(8.7)
Meru/Embu	1.2	4.6	6.7	7.7
Mijikenda	0.8	3.8	5.5	(5.8)
Kalenjin	1.1	4.6	6.9	(8.1)
Other	1.0	3.7	6.3	(5.9)

Source: Kenya Fertility Survey I:97.

a/ Standardized by age at marriage and proportion never married.

B. Fertility Variations: Significant Groupings:

In this section we show the extent of, and the reasons behind, diversity of fertility in Kenya. The first step is to characterize those who have the lowest fertility, and suggest what causal processes are operating upon which development planners can build. Then we look at the country in terms of regional/ethnic and occupational/productive categories and try to glean from these some clues about variation in fertility change. Based on still conjectural evidence we suggest an alternate way to group the majority population of smallholder farmers which is more consistent with other parts of the SIP and which might prove more useful for planning purposes. It is important to try to discern subgroups where existing development trends imply different fertility effects, and where different processes of fertility change suggest the appropriateness of different development interventions. We conclude with a summary of significant dimensions and groups for which there are particular implications for development strategy. Before continuing it is necessary to make two points. First, the fertility differentials under discussion are not large. Table 4 shows the size of differentials based on various socio-economic categorizations.

Note that children ever born by both region and ethnic group (most regions are inhabited by just one, or in some cases two, ethnic groups) ranges from a high of 8.5 children to a low of 5.0 children. The low figure, for the Mijikenda of the Coast, is anomalous; low fertility here is largely a result of greater infecundity and poor health conditions.

Secondly, much of the variation reflects differentials in degree and duration of breastfeeding and the extent to which breastfeeding declines are compensated for by contraceptive use (Mosley, Werner and Becker 1981:30). Conversely, where fertility rates are similar, variation in breastfeeding and other components of the birth interval may imply that quite different processes are operating to generate surface similarities. We will try to clarify such differences when appropriate, using an existing analysing of components of the birth interval (Mosley, Werner and Becker 1981).

1. Family Planning Innovators

Although the trend toward effective family planning is weak, there are sufficient data to allow a characterization of the kinds of women and families who are now, and are likely to be, the leaders in a gradual transition to smaller family size. These include: urban residents, the highest income and occupational classes, the best educated women, women with wage employment, and those from ethnic groups and social classes which were the first to, and still are the most likely to,

adopt western family lifestyles. The categories cut across the Kenyan population in different ways, but there are reasons to believe that similar processes are operating in each case to lower fertility.

(a) Urban-rural fertility differences are relatively large. Kenya Fertility Survey data show that women in Nairobi or Mombasa have a total fertility rate 2.5 births lower than rural women. Current contraceptive use is much higher in urban areas (19 percent) than in rural areas (8 percent) (Kenya Fertility Survey I:102, 140), although the effects of increased contraception are partially offset by decreased duration of breastfeeding.

(b) Both higher education and husbands' employment in white collar and professional categories tend to correlate with decreased breastfeeding, but among the best educated women, and especially among those who also have husbands in the most modern occupational category, higher levels of contraceptive practice more than offset the decrease and there is a net decline in fertility (Mosley, Werner and Eecker 1981:51). There is a dramatic increase in knowledge of, ever use of and current use of contraception among each incremental group of educated women (Kenya Fertility Survey I.140).

(c) Significant variations in contraceptive awareness and use are shown for particular ethnic groups, with Meru and Kikuyu women two to three times more likely to be using a method of contraception than women from other groups (Mott, S. 1981). An important part of this is the effect of greater access to family planning services, but equally important is that

the gradual inculcation of some Western values by the Kikuyu and Meru (independent of their education, literacy, urbanization and ease of access to family planning) over several generations of contact with the west... has led to their exceptional behavior with regard to family planning (Mott, S. 1981:12).

Among the Meru it is families which are most involved in the cash economy and where the husbands are salaried professionals which are most likely to use contraception. In these families, wives are well-educated and the level of children's education is such that they are nearly certain to be as successful as their parents (Greeley 1977). Even among groups which are far less westernized, a similar category of families may be the first contraceptors (Ssyenyonga 1975).

TABLE 5. DIFFERENTIALS IN CONTRACEPTIVE KNOWLEDGE AND USE FOR EVER-MARRIED WOMEN AGED 25-34 YEARS, BY ETHNIC GROUP

A. % who had heard of any method.
 B. % who had heard of any family planning facility.
 C. % who had ever used any method
 D. % current users a/

	Kikuyu	Luo	Luhya	Kamba	Kisii	Meru/Embu	Mijikenda	Kalenjin
A.	97	93	92	94	90	94	83	88
B.	62	45	50	50	28	74	20	36
C.	48	25	14	35	23	57	12	28
D.	17	10	4	8	6	16	3	5

Source: Kenya Fertility Survey I:140

a/ Traditional and modern methods included; figure based on currently-married non-pregnant fecund women.

(d) Although the proportion of women in Kenya who are working in a wage or salaried job is small, these women have a fertility level 15 percent lower than other women, and a (modern) contraceptive use rate which is greater than four times that of those not so working (Mosley, Werner and Becker 1981:24). Working women breastfeed only slightly less than the average Kenyan woman (Kenya Fertility Survey I:67).

A recent analysis of Kenya Fertility Survey data divides Kenyan women into modern, transitional and traditional types, depending on whether they desire more or less than six children and on whether they have ever used contraception (Dow and Werner, 1981).¹ The authors conclude that demographic and

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1. Modern women (group A) are defined as those who desire less than six children and are "ever-users" of modern contraception. Transitional women include two groups; those who desire less than six children, but have never used modern contraception (group B), and those who desire more than six children but are "ever-users" (group C). The fertility of group B women exceeds their stated desires; this is not a surprise since they breastfeed no longer than those women who desire more than six children. Group C women are using contraception effectively, but to space their children at a higher fertility rate. Traditional women (*Group D), who are in the majority, desire more than six children and have never used modern contraception. (The percentage of women in each category is as follows: A - 4.4 percent; B - 19.8 percent; C - 8.2 percent; D - 67.6 percent).

contraceptive innovation is strongest among younger women, and that the complex of factors associated with development -- greater education, better jobs, more urbanization, increased family nucleation and a "western cultural perspective" -- should reduce traditional reproductive behavior and lead to smaller family size desires and greater contraceptive use (Ibid.:14). But the same study shows that most women (67%) still retain a traditional perspective towards fertility, and that almost two-thirds of women ever using effective contraception are doing so while retaining large family preferences.

2. Socio-Economic Groups and Demographic Variation

This discussion will focus on the majority of the rural population, the smallholder farmers whose fertility behavior sets them apart from the small group of innovators.¹ To get a range of measures, we use data on actual fertility, desired fertility and contraceptive use. First, we compare fertility measures by ethnic group² and by husband's occupation. Then we suggest alternate ways to categorize the population which might prove more useful.

(a) Ethnic/Regional Differentiation (see Table 6)

Two groups with very high fertility are the Kalenjin of the Rift Valley and the Kisii of Nyanza. Both have very low contraceptive use rates (5 percent and 6 percent respectively) and relatively long breastfeeding intervals (15.9 months and 16.6 months).³ Kikuyu fertility, along with Meru/Embu, Kamba and Luhya, can be classed as intermediate. The relatively high

1. We do not address pastoralist groups per se. Fertility data for the pastoralists is relatively limited in comparison to the wealth of data on agricultural groups, but we know that their fertility is generally lower by comparison. Pastoralists are a small proportion of the population.
2. There is correspondence between ethnic groups and regions, and since ethnicity may condition differences in key factors affecting fertility, e.g. breastfeeding, polygyny, age at marriage (LeVine, Dixon and LeVine 1976) we will use the data for ethnic groups.
3. Contraceptive use rates do not necessarily parallel fertility rates, with groups where use rates are low having low fertility (Mijikenda) or high fertility (Kalenjin) and groups with relatively high use rates showing a wide range in fertility. The Luo, with a lower contraceptive use rate than either Kikuyu or Meru/Embu, have lower fertility than both groups. Reasons for these seeming discrepancies derive from differences on breastfeeding intervals as well as other factors not easily discernible in the figures.

Table 6. Ethnic Differentials for Fertility and Fertility-Related Variables, from Kenya Fertility Survey, 1977/78

	Kikuyu	Luo	Luhya	Kamba	Kisii	Meru/Embu	Mijikenda	Kalenji
Percent of KFS Sample	24.8	17.6	14.7	12.1	6.7	7.2	5.2	6.7
% Polygynously Married	12	43	35	26	33	22	39	23
% No Schooling	36	55	48	46	62	46	89	59
Breastfeeding Interval <u>a/</u>	14.4	16.9	16.2	17.5	16.6	18.3	22.8	15.9
Mean No. of Children Ever-Born to Women								
Aged: 25-34	4.9	4.0	4.6	4.4	5.0	4.6	3.8	4.6
<u>b/</u> 35-44	7.5	6.9	7.7	6.8	7.7	6.7	5.5	6.9
45+	8.2	8.0	8.0	7.7	(8.7)	7.7	(5.8)	(8.1)
Current Fertility <u>c/</u>	8.4	7.6	8.3	8.0	8.6	8.2	7.4	8.9
Desired Family Size for Women Under 25	5.8	5.7	6.5	6.6	6.9	5.9	8.5	7.1
% Women who Desire no More Children <u>d/</u>	19	15	15	18	8	14	6	11
% Contraceptors (All Methods)	17	10	4	8	6	16	3	5
% Contraceptors (Modern Only)	8.1	2.4	3.0	4.3	1.4	9.4	1.5	2.3
% Ever-Users of Contraception	48	25	24	35	23	57	13	28

Source: Kenya Fertility Survey, Volume I:60, 81, 97, 101, 111, 118, 140; Mosely, Werner and Becker 1981: Table 14.

a/ Duration of breastfeeding in months.

b/ Standardized by age at marriage and proportion never married.

c/ Estimates 5-year total fertility rate: number of children ever born by age 50 for hypothetical woman experiencing current age-specific rates throughout her reproductive life.

d/ Percent of currently married fecund women aged 25-34 who want no more children.

size desires are lower than fertility. Although the Kikuyu and Luo show higher fertility in older age groups and relatively high fertility overall, there is some evidence for a reduction family size and lower desired family size among younger women. (In other ways these two groups differ: Kikuyu measure low and Luo high on percentage polygynous marriage; the Kikuyu are contraceptive innovators while the Luo are not).

Differentials in fertility-related variables by ethnic/regional group, especially as clarified by data on components of the birth interval, suggest certain implications for fertility trends and for the likely impact of variations in contraceptive use on fertility. First, groups where breastfeeding intervals are long, the rate of polygamy is high and greater proportions of women have no schooling, fertility is likely to rise, in some cases dramatically, in the absence of increased contraception. This will occur as continued modernization brings changes whereby breastfeeding intervals are reduced, polygamy decreases, health is improved and greater proportions of women enter primary school. In this category are the Mijikenda, Luhya and Kisii. With their low fertility, high fertility aspirations and low contraceptive use, Mijikenda fertility is particularly likely to rise in the near term. Second, instead of reducing fertility, increased contraceptive use in the near term is likely to serve only as compensation for the decline of other traditional spacing mechanisms among all groups, but especially for the Mijikenda, Kamba, and Meru/Embu (where breastfeeding intervals are the longest).

Third, family size desires among Kikuyu, Meru/Embu and Luo are noticeably lower than those for other groups. This is especially interesting in the case of the Luo, where a high proportion of women have no schooling. Fertility and family size desires are remaining the highest among the Kisii and Kalenjin.

But such comparison by ethnic groups can go only so far. First, the Kenya Fertility Survey data do not tell enough about social, economic and cultural factors which condition fertility processes; for this the findings of community-type studies are far more useful. In addition, relevant categories for fertility processes will only in part be based on ethnic groups. It is far more important to consider aspects of household production and economy, which give a better grasp of fertility dynamics.

(b) Occupational Categories

Comparison of fertility measures by husband's occupational class is possible with KFS data, but examination of the breastfeeding-contraception tradeoff is critical to interpret the differences. Analysis of birth interval components shows

that, for most occupational categories, there is a decrease among all age groups in the duration of breastfeeding, and although contraceptive use rises consistently with each occupational category, the net result is a very slight rise in fertility produced by a decline in breastfeeding. Thus, families in the white-collar, professional category have approximately the same fertility as skilled/unskilled workers and agrarian families, but reach it "by different mechanisms." There is some evidence that younger couples in the modern sector will achieve smaller families as they move through their lives (Mosley, Werner and Becker 1981:21-22).

Other relationships between fertility and occupation are illustrated in Table 7. The largest family size desires, the lowest contraceptive use, as well as the highest current fertility, are for those in the agricultural sector and for unskilled manual laborers. Workers in sales and service and skilled manual workers are an intermediate category in terms of desired fertility, current fertility and contraceptive use. Professional and clerical workers -- the highest educated group -- exhibit the greatest use and the lowest family size lowered desires. Thus, there is a consistent relationship between fertility and the progression from professional to technical to agricultural occupations.

3. Significant Groupings: Conclusion

The above discussion has examined fertility differentials along a number of dimensions in order to attempt to isolate significant variations in fertility dynamics. Demographic and contraceptive innovators were described, in order to gain clues about the conditions that promote innovation. Innovator families are a small percentage of the population, who are better-off economically, and who are fully incorporated into the cash economy (where women's work may be channelled to better-paying wage employment). This group is only one to achieve a family size significantly less than six children per woman.

Table 7. Fertility and Fertility-Related Variables by Husband's Occupational Class, from Kenya Fertility Survey, 1977/1978

	Profes- sional	Cleri- cal	Sales	Ser- Vice	Skil. Manual	Unsk. Manual	Agri. Labor	Self-Empl. Agri..
Percent of KFS Sample	9.4	5.0	8.0	9.4	17.2	5.0	29.3	8.0
% Polygynously Married	27	23	32	31	26	25	22	35
% No Schooling	19	27	47	46	48	40	65	66
Mean No. of Children Ever- Born to Women								
Aged: 25-34	4.7	4.4	4.7	4.6	4.7	4.6	4.6	4.5
a/ 35-44	7.6	7.2	7.2	7.3	7.1	7.5	7.3	7.0
45+	(8.7)	*	7.9	7.5	8.6	(6.2)	8.1	7.9
Recent Fertility b/	6.4	6.6--	6.6	6.7	6.6	6.8	7.1	5.4
Desired Family Size for Women Under 25	6.0	5.4	6.7	6.3	6.1	6.5	6.9	7.0
% Women who Desire no More Children d/	17	23	17	20	17	6	16	10
% Contraceptors (All Methods)	21	19	18	11	7	8	6	6
% Ever-Users of Contra- ception	55	47	41	41	38	26	21	26

Source: Kenya Fertility Survey, p. 60, 81, 98, 101, 112, 119, 141.
Mosely, Werner and Becker 1981: Table 6.

a/ Standardized by age at marriage and proportion never married.

b/ Shows differentials in recent marital fertility; estimated mean number of children that would be born between 5th and 25th year of marriage to women continuously married during this period, at current fertility levels.

c/ Percent of currently married fecund women aged 25-36 who want no more children.

Smallholder farmers were divided into subgroups for whom different demographic and economic processes are operative. Ethnic variations are linked to variation in demand for contraception and in fertility dynamics. In addition, ethnic identity sometimes implies important value differences regarding the spacing of children. However, there are far more similarities than differences in fertility behavior among the categories analyzed here, and current economic and social differences are not great enough to have much impact on fertility. The implication is that real changes in family size will come only with significant development in economy and society.

D. Conclusion

We have shown that fertility trends do no support and even threaten Kenya's development. The most effective practice limiting the present high rate of fertility is prolonged breast-feeding, but the effect on family fertility is unintended and is declining with modernization. Similarly the practice of polygamy, which is a non-intentional but nevertheless significant constraint on fertility, will probably decline over time. Modernization is promoting the conditions which support voluntary use of contraceptives, but by and large only among families with a considerable degree of educational attainment, higher levels of income, better status of women, and, in many cases, urban exposure and professional level of occupation. Current family planning use among married couples in Kenya is less than 5 percent, average desired family size among rural couples has increased in the last decade and the National Family Planning Program has remained essentially stagnant since 1978. In brief, current conditions suggest that for the vast majority of rural smallholders in Kenya, limiting fertility is simply not a desirable or attainable option.

Two major conclusions derive from the previous sections' discussion. First, fertility is not likely to drop much below a six-child-per-woman average without significant economic and social change among the majority population of rural smallholders. Thus, a resolution of the fertility issue will require increased employment, productivity, and modernization among Kenya's rural population. Meeting economic and employment goals will therefore contribute to fertility reduction goals.

Second, without a dramatic increase in the access to and availability of family planning services, fertility is likely to continue to rise in the near term. This is because only modern contraception can compensate for ongoing changes in traditional practices that have in the past kept fertility under control. Compensation through modern contraception will not happen without an improvement in the performance of service delivery institutions.

Our final comments relate to institutional mechanisms for service delivery. As described above, the existing network of government services is inadequate, and family planning and maternal-child health have tended to be given low priority within the government health bureaucracy. Politicians, too, are reluctant to commit themselves publicly to fertility control measures. Ethnic rivalries as well as few of conservative elements in their constituencies render most politicians very cautious in the family planning area. In general, those who make decisions in Kenya, from the national level to the family, will lose little if high fertility continues, but have considerable stake in avoiding the negative consequences associated with supporting fertility limitation. The politician, the Ministry of Health official, the religious leader, and the male household head in most circumstances are far more likely to be threatened by the implications of fertility limitation than by rapid population growth.

Since constraints will take time, and because public sector absorptive capacity is limited, and also because public mechanisms have always been complemented by private ones, a logical conclusion is to look toward private channels in this area.

Private profit-making family planning activities in Kenya have been limited, and largely confined to the urban areas, with the exception of the sale of condoms. The present government policy looks very consciously at community-based distribution of the pill and IUD, although there have been some small, closely-supervised initiatives. A pilot marketing scheme to provide the sale of condoms for family planning was undertaken in Meru district in the mid-seventies, but despite positive evaluations (see for example Rogers: 1973), this program is seen as having generating harmful controversy and is characterized as a failure.

It appears that private and voluntary organizations offer promise in helping to promote effective family planning, although considerable resources and time will be required to realize this. Christian church-related institutions are one such

example. Although at present they account for a very small fraction of contraception service delivery, they provide about 40 percent of health services in rural areas. Certain Christian beliefs severely restrict the acceptability of contraceptive practices, but most Christian teachings promote family life-styles (eg. husband-wife communication and shared decision-making, responsibility for the development of children, participation in community and group activities) which are favorable to the spread of family planning. These teachings especially effective in changing male attitudes towards the family in rural areas. Many church organizations have a long history of development-related activities in the communities they serve, and retain the kind of creditability and local leadership which can create and sustain an accepting environment for family size limitations and contraceptive use. While examples of the potential are few, the cases analyzed within Kenya show considerable promise (Kabwygere and Mbula 1979, Greeley in Ndeti and Ndeti 1980: 139-140).

A second area of promise in rural places lies with women's groups. Women participating in groups can be exposed to family planning messages relatively efficiently, leaders of these groups are often those most likely to adopt family planning and hence may serve as role models, and the benefits of women's groups (eg. increased education and understanding of the modern world, greater income in some cases) can be supportive of family planning practices. A preliminary study of 10 income-generating women's groups in Nyeri district, for example, found family planning use among group members increased from 25 percent to 75 percent over a two year period (Odera Personal Communication). A third area of promise lies with initiatives undertaken by groups promoting breast-feeding, and a fourth area would include family planning promotion and service delivery among co-operative members, labor and teachers' union members and other worker organizations.

In sum, high fertility will continue to pose a threat to Kenyan development for some time. Only broad socio-economic development will reduce fertility levels, and that only slowly. A necessary complement to improving agricultural and employment conditions will be easing access to family planning services, since only this way can we expect modern contraception to effectively take the place of traditional practices in keeping birth intervals appropriately wide. Government will necessarily play a role in this, but we see a place for private sector involvement as well. Only with such an integrated attack on the socio-economic and institutional context of high fertility in Kenya can we reasonably expect progress to be made.

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ANNEX F

CONTRACEPTIVE LOGISTICS ANALYSIS

I. BACKGROUND

A. Relationship to Private Sector Family Planning Project

The purpose of this assessment is to identify possibilities for a commodity logistics and management system which will ensure a dependable, steady supply of all contraceptive methods to be used in subprojects. The supply system also should have viability for servicing:

1. subgrantees beyond the grant period;
2. other private sector organizations or companies who wish to provide family planning services; and
3. the private sector service delivery program beyond the four year project period.

The proposed project is an untested concept in family planning service delivery in Kenya. As such, neither the ideal form for commodities management nor level of contraceptive demand is known. Since a dependable, smoothly operating system with capability for meeting the needs of expanding demand by the private sector is the cornerstone of the proposed service delivery program, special attention should be given to a viable system as part of the comprehensive project plan.

B. Contraceptive Methods To Be Used

The methods selected include oral contraceptives, condoms, vaginal spermicides (foams, jellies, creams and tablets), diaphragms, Depo Provera, IUDs and, for rare instances, minilaparoscope kits. Based on past patterns of use in Kenya, it is probable oral contraceptives will be most popular. Demand levels for other methods are less certain, although provider bias (common in all countries) likely will affect individual subprojects. There appears to be latent, unmet user demand for Depo Provera. This method is still controversial, however, and its future in public and private sector programs is uncertain. There is a wide variety of oral contraceptive formulations and company products in Kenya, and numerous brands of condoms (British, American and Japanese). Available spermicides include foam Delfan and Emko jelly (Coromex and Ramses) and foaming tablets (Neo Sampoos and Rendalls).

Diaphragms are in good supply although they are infrequently used. Depo Provera is in short supply, in the public sector because of a new Swedish International Development Authority policy decision not to supply it; and in the private sector because shortage of foreign exchange has resulted in severe restrictions in importation. Several types of IUDs are available (Lippes Loops, CuT, Cu7, NovaT). Minilaparoscope kits are confined to the public sector and underutilized.

C. Present Suppliers in Kenya

Swedish International Development Authority has provided contraceptives to the Government of Kenya since 1969 as part of its bilateral aid. USAID does not expect to bring in contraceptives as part of its support to the family planning program.

Non-Government Organizations and the commercial sector are the other major importers and suppliers.

D. Current Family Planning Service Delivery

Family planning service delivery in Kenya is primarily provided by Ministry of Health facilities and Family Planning Association of Kenya Clinics. The commercial retail sector is active only in the major cities (Nairobi, Kisumu, Nakuru, Eldoret and Mombasa), in most developing countries since it is not profitable for companies to distribute contraceptives outside urban centers. The commercial sector usually supplies private clinics and hospitals. Some hospitals operated by religious groups provide family planning services as part of their MCH programs; less than a handful stress family planning. City councils in larger urban centers provide contraceptives in municipal clinics. A few factories include but do not promote family planning services in their clinics. Community based distribution demonstration projects are planned by five organizations, and a small, two year old community based distribution project is run by the University of Nairobi Department of Community Medicine. Other family planning oriented non-government organizations provide supplies to projects they sponsor but do not provide delivery services directly.

E. Legal Issues

There appear to be few laws and regulations which impinge on or may restrict contraceptive procurement and distribution for the project. Non-government organizations and non-profit organizations, e.g., may import contraceptives for their own use duty free and without import licenses. No import licenses

are required for commercial companies, which currently are hard pressed to get approval for licenses for goods which are not considered critical. As nearly as could be determined in this brief overview, all contraceptive products now used in Kenya are already properly registered with the Government of Kenya. As to restrictions on distribution, none exist for condoms or spermicides, but, by law, only pharmacies or medically trained personnel may provide oral contraceptives, IUDs, diaphragms and Depo Provera.

F. Policy Issues

The Ministry of Health recently notified all non-government organizations involved with proposed community based distribution projects that only those contraceptive methods and oral contraceptive brands used by Government health services may be provided to community based distribution clients, and that the Ministry of Health will supply such projects with commodities upon request.

The Ministry of Health, as stated earlier, has advised United States Agency for International Development that it wishes to supply the proposed private sector program as well. It has further advised all organizations that Ministry of Health supplied commodities may not be sold at any price.

The Ministry of Health has requested that all service delivery points for this project be registered with the Ministry of Health.

G. Infrastructure and Communications

Kenya has a well established transport and communications infrastructure to support logistics and distribution. Most of the population is rural, but good or adequate roads are in place at sites where service delivery points most likely will be located. Telephone communication with all or most subproject headquarters will be possible, and mail services are fairly quick and dependable. Rising petrol prices over recent years, however, have curtailed distribution services by many companies except to major towns, which are supplied by private companies. This has resulted in a fairly passive marketing system. Entry ports reportedly have good facilities and are well located. Good warehouse space in Nairobi and other sizeable towns is available, if needed, for safe, clean storage.

II CURRENT SITUATION REGARDING CONTRACEPTIVE SUPPLY

A. Ministry of Health Contraceptive Supply System

Procurement: The locally based Swedish International Development Authority office sends requests to the home office

in Stockholm each year for specific quantities of each type of contraceptive or manufacturing firm's product. A new policy decision this year by Swedish International Development Authority precludes their providing Depo Provera in the future. Requests are based on projected needs estimated by the National Family Welfare Center and provided to Swedish International Development Agency by the Ministry of Health each July. The Swedish International Development Authority will accept emergency orders during the year if demand has exceeded supply on hand. Normally, shipments arrive three to six months from the date of order. Shipments come in to Mombasa by sea; emergency shipments usually arrive by air at Jomo Kenyatta Airport, Nairobi. The Ministry of Health has a borrowing agreement with the Family Planning Association of Kenya and the International Planned Parenthood Federation for emergency stocks which are repaid from Swedish International Development Authority stocks. Family Planning International Assistance will provide contraceptives free of charge with no conditions for repayment in kind. For items not available from these sources, the Ministry of Health can (and occasionally does) purchase from commercial supplies.

B. Duty Free Status: In the past, shipments have cleared customs free of duty and customs charges at both Mombasa and Nairobi. The Ministry of Health customs document which authorizes duty free clearance expired, however, just before a condom shipment arrived this spring; and clearance at Jomo Kenyatta Airport was delayed for some time. As a result of a disagreement between the Ministry of Health and the Ministry of Finance over liability for duty, the latter is requesting that Swedish International Development Authority sign with them an agreement similar to one it has with Danish Agency for International Development for drugs. This would stipulate that the Ministry of Health recognizes duty free status of Swedish International Development Authority donated contraceptives.

C. Warehousing: The National Family Welfare Center has a warehouse assigned to it at the Central Medical Stores (CMS) complex in the Nairobi Industrial Area. The entire complex is fenced and guarded. The Central Medical Stores Annex building appears adequate to hold quantities normally used by the National Family Welfare Center. There is separate space for offices and for storage of goods. Adequate metal shelving is available for smaller boxes or more fragile items. The Ministry of Health is building a new warehouse for contraceptives, rural health drugs and of printed materials. The Ministry already expects that this facility will be inadequate and that extra space will be needed. This conclusion appears valid considering on expected new shipments

of more recent orders, imminent arrival of two types of contraceptive now out of stock, and the quantity of expired goods not yet disposed of. There are depots at Kisumu and Mombasa for all drug storage, including contraceptives. Although space currently is available because of drug shortages, it is unclear if future space needs will be satisfied by these depots.

D. Inventory Management: The Central Medical Stores maintains a file on stock level for each item warehoused. The Storeman reports they use a "first-in-first-out" system to maintain fresh stocks. Quantities received at the warehouse are recorded upon arrival, and information on each shipment sent is transferred from the order form to the respective card on that item. This card file provide the information needed for additional or annual orders given to Swedish International Development Authority. The Central Medical Stores Annex uses this information, plus quarterly returns of balance on hand from facilities receiving contraceptives, to make annual projections for submission to Swedish International Development Authority. The projection form includes: 1) stocks on hand; 2) needs of Ministry of Health hospitals; 3) needs of all other service delivery points; 4) total needs; and 5) the difference between commodity needs and stocks on hand. The National Family Welfare Center reports that they have great difficulty getting quarterly reports from service delivery points on a regular and timely basis (or even at all, in some cases). This makes projections difficult for commodity and warehouse space requirements as well as related transportation costs to service delivery points.

E. Shipping: A shipping plan calls for regular, weekly schedule of delivery of drugs and contraceptives to depots at Kisumu and Mombasa with drop-offs at larger service delivery points along the way. Special requests can be made by more remote districts for delivery; but, typically, service delivery points are expected to pick up supplies from the District Hospital. There are two vehicles posted at the Central Medical Stores and, reportedly, one at each of the depots. The National Family Welfare Center reports the plan has not worked well recently because the vehicles will not leave without an adequate load of drugs (there are severe shortages at present) and petrol is not available due to high prices. The Central Medical Stores resolved shipping problems by contracting with a transport company, shipping by train, or sending small, emergency orders via private carrier service. It reports there is a regular system of borrowing among district Ministry of Health facilities as a stop gap measure when supplies run short.

Orders are received by the National Family Welfare Center headquarters directly from the District Hospitals, which are expected to order for and supply service delivery points in their respective district. All service delivery points registered with the Ministry of Health may receive supplies on request. In addition to Ministry of Health facilities, 28 other service delivery points are on the National Family Welfare Center list as eligible (or having asked for) for contraceptives: 20 or so private (usually Mission hospitals), 4 non-government organizations, 3 parastatals and 2 private sector companies (Kenya Cannery and Brooke Bond). The National Family Welfare Center also intends to supply those organizations who operate or plan to implement community based distribution projects. Goods cannot be released unless authorized by the Director, National Family Welfare Center or his designee. Copies or orders (6 in all) are kept at various points along the line, and a copy goes with the order when shipped.

The entire logistics management system is fairly well designed, but slippage appears to be fairly common. Frequent shortages at the Central Medical Stores Annex (and presumably depots, too), quantities of expired warehoused goods, and chronic shipping problems place enormous burdens on the National Family Welfare Center logistics system.

One means of overcoming past problems is a recent Ministry decision to package "kits" in set quantities of various items to a shipping carton. The standardized package scheduled to be sent to all district Ministry of Health rural facilities is being tested in two areas close to Nairobi. The National Family Welfare Center recognizes that need for different quantities of different items will vary by location; it will continue to ship individual orders on request. Preference, however, appears to be for supplying the standard "kit" to more rural, smaller facilities.

F. Contraceptive Supplies: The National Family Welfare Center has ordered the following items for 1983:

Oral Contraceptives in 100 cycle boxes:

Eugynon
Microeugynon
Nordette
Trinordial

Condoms in gross (144 pieces) boxes:

Chapeau
Million Gold

Spermicides:

Neo Sampoo (tubes of 20)
Delfen

Injectables:

Depo Provera
Noristerat

IUD:

Lippes Loop (Sizes A-D)
CuT
Multiload
Nova "T"

Disposable gloves

G. Policies and Practices of Other Contraceptive Suppliers

1. Family Planning Association of Kenya (FPAK): The Family Planning Association of Kenya provides services in clinics located in the major cities. They charge a small fee. Family Planning Association of Kenya receives supplies from International Planned Parenthood Federation Regional Headquarters in Nairobi. Pathfinder supplies two Syntex OC products to the Family Planning Association of Kenya. CuT and Cu7 IUDs, however, are purchased locally from a commercial supplier. The Family Planning Association of Kenya offers clients 9 different OC brands, 2 condoms, 3 types of IUDs, diaphragms, spermicides in creams, jellies and tablets, and Depo Provera. (Brands are the same as those listed below for International Planned Parenthood Federation.) Supplies are warehoused in Nairobi. Goods are sent by public transport from the Nairobi headquarters upon request.

2. International Planned Parenthood Federation (IPPF): The regional office of International Planned Parenthood Federation is headquartered in Nairobi. Large stocks of contraceptives are warehoused locally for shipment to the Family Planning Association of Kenya affiliates in Africa. Supplies are purchased by the International Planned Parenthood Federation Central Office in London although commodities are shipped from the factory to Nairobi. Goods are sent to affiliates upon request, preferably by the least costly means, but for speed, and when more practical, they are sent by air. International Planned Parenthood Federation routinely supplies

the Family Planning Association of Kenya from regional stocks. Its policy is not to supply any other Kenyan family planning programs. The director of one community based distribution project scheduled to be launched this year, however, is negotiating with the International Planned Parenthood Federation for supplies.

3. Family Planning International Assistance (FPIA): This family planning organization is also regionally headquartered in Nairobi. It receives orders and sends these on to its New York Headquarters for shipment throughout Africa. Goods are sent C.I.F. from the U.S.A. and are usually shipped either by sea or air at the request of the recipient. The receiver is responsible for in-country transport, duty, clearance or storage charges. Port of entry for Kenya is either Mombasa or Nairobi. Inventory and distribution records must be kept, and any use of income from sales must be approved by the Family Planning Association of Kenya.

4. PATHFINDER: Most of the contraceptives Pathfinder supplies to those family planning projects it supports come from the Ministry of Health. They choose to rely on the Ministry of Health primarily because of the National Family Welfare Center policy that the same brands of oral contraceptives should be uniformly provided to all service delivery programs in Kenya. Pathfinder maintains a small stock of contraceptives it receives from Boston headquarters. These are stored locally to be used for emergency supplies.

5. United Nations Children's Fund (UNICEF): UNICEF does not provide any contraceptives in Kenya.

6. United Nations Development Program (United Nations Fund for Population Activities): The organization does not supply in Kenya.

7. Swedish International Development Authority (SIDA): This major donor of contraceptives to Kenya has supplies bilateral commodity aid for the past 14 years. All methods except Depo Provera are available from Swedish Agency for International Authority.

8. USAID: USAID does not provide contraceptives in Kenya except through contractors or grantees.

9. Commercial Sector

Several importers handle contraceptives for distribution to chemists and, for condoms, to supermarkets and smaller shops. Oral contraceptives are the primary contraceptives

sold, and Schering A.G. products unquestionably dominate the Kenyan oral contraceptive market, as they do most non-U.S. markets. Condoms, a less important contraceptive appear to be purchased primarily by tourists. The importer for LRI products, the dominant condom company in Kenya, states that sales have slowed substantially in recent years, and he has dropped several brands from his line. IUDs (CuT and Cu7), Depo Provera, and a British firm's vaginal spermicide are imported and available from manufacturers' local agents. Prices for all contraceptives are uniformly high and similar to European markets.

H. Recipients' Experience with Contraceptive Supplies

Ministry of Health facilities, of course, experience shortages soon after the Central Medical Stores Annex runs out of any method or product. Even under the best circumstances, supply problems naturally increase proportional to distance from District Hospitals or depots in Nairobi, Kisumu and Mombasa. More recently, curtailment of vehicle use and shortage of drugs have exacerbated the problem. While most District Hospitals report delays in receiving orders, a few had no supply of one or more types of contraceptive while others had far too many of other types. Ideally, they try to keep about 6 months supply on hand to serve all facilities, (Ministry and other) in the District. Any facility needing supplies is expected to secure them directly from the District Hospital facilities, which usually must pick up supplies from the District Hospital. Because of problems with delays and shortages of more popular items, not all facilities routinely stock and supply all methods. Depo Provera is in short supply or out of stock almost everywhere, both in government and non-government facilities. One District Hospital visited reported they couldn't stock Depo Provera because only doctors could give injections. The same hospital reported it had no speculums.

Parastatals and City Councils which received supplies were uneven in what they routinely stocked, and not all City Councils provide family planning services. One parastatal with predominantly male employees reported it had not had condoms for some time; Depo Provera, used by wives, also was not available. Nairobi City Council, however, said it generally could get supplies: The Central Medical Stores Annex is easily accessible to most of their clinics.

Non-government organizations which plan to operate community based distribution projects, hopefully, will have the same generally experience with Ministry of Health supplies as

two of the present two community based distribution pilots. Both Chogoria Hospital and the University of Nairobi Department of Community Health, for example, have adequate stocks although there is consistent unevenness in availability. Both collect supplies from the warehouse with their own vehicle.*

A number of private religious hospitals receive Ministry of Health supplies. The reasons why some place major orders and others few or why others have never requested are unclear. Generally, the few which take substantial amounts of supplies from the only two health facilities run by private-for-profit companies have recently requested contraceptives from the National Family Welfare Center. Brooke Bond gets supplies from Kericho District Hospital. The Chief Physician reported they received oral contraceptives and IUDs but thought Depo Provera was banned. (One of the head nurses, who was enthusiastic about family planning, expressed frustration over lack of response to requests for training from the Provincial Hospital. She felt lack of training was the reason for the lukewarm commitment to provision of family planning services by many health staff). Kenya Cannery in Thika receives supplies from the local District Hospital. Although they had experienced some problems with getting supplies in the past, management was interested in participating in a subproject.

I. Potential Limitations of the Public System for Private Sector Program

Many facilities supplied by the Ministry of Health expressed similar gaps in contraceptive supply. In addition to the occurrence shortages, delayed response to requests time and expense required to pick up supplies at District Hospitals,

*The University project personnel initially stated that the Family Planning International Assistance supplied the project. When prompted, they named as a source also. Central Medical Stores Annex accounts for most of the supplies issues to the 20 or more such hospitals which the Ministry of Health supplies. It is a fair guess that some hospitals supported by churches or mission groups overseas have drugs sent in from their home country. This may also be true for family planning supplies. More likely, most are over burdened providing curative services and do little with family planning. The proposed Protestant Churches Medical Association project, with 10 hospital service centers, should increase interest among fellow members. This network could become a major source of orders for the Central Medical Stores Annex.

two other potential limiting factors were identified. As might be expected with any supplier, public or private sector, the Ministry of Health gives priority to its own facilities, and District Hospitals tend to reserve items in short supply for the Ministry of Health's health network. The potential demand on Ministry of Health of a new, expanding, untested, demonstration project, with the potential for reaching a minimum of 30,000 acceptors may at times strain the procurement and supply system at all points. Secondly, several persons pointed out that frequent changes of top management in government in the past often meant changes in policies. The Government of Kenya and Ministry of Health presently appear to favor the private sector approach. Possible changes in personnel and policies could greatly impact either positively or negatively on the entire logistics system.

II. CONTRACEPTIVE SUPPLY AND MANAGEMENT FOR THE PROJECT

The Ministry of Health has made substantial improvements recently in its entire commodities system. Management of supplies of drugs and medical equipment to rural areas is the responsibility of the Management Unit of Drug Supplies (MDS) within the Ministry of Health. The Management Unit of Drug Supplies also is taking over the management of all contraceptive supplies for the National Family Welfare Center. As part of their contribution to the Integrated Rural Health/Family Planning, the Danish Agency for International Development and the Swedish International Development Authority provide the Management Unit of Drug Supplies with drugs, vehicles, a full-time adviser (DANIDA) and occasional consultancies, such as for the start-up of a refined contraceptive distribution program. (An evaluation of distribution of the new prepacked "kits" of drugs and of contraceptives, to rural health facilities will occur in June 1983). It is anticipated that this level of donor assistance will continue for at least the first three years of the Integrated Rural Health/Family Planning program. To ensure supply contraceptives to subprojects of the project certain may need special attention. The following suggestions, which should facilitate steady supply, focus on the four main areas of supply logistics -- procurement, storage, distribution and management control -- and how possible trouble spots might be overcome. Any contraceptive supply plan for the project will be cleared with the Director, National Family Welfare Center, according to USAID policy.

A. Procurement

It is anticipated that Swedish International Development Authority (SIDA) will continue to supply contraceptives according to the level of need defined by the Ministry of Health. The Swedish Agency has provided contraceptives as part of its bilateral aid to the Kenya for the past fourteen years. The Danish Agency instead of the Swedish Agency, will supply injectables this year; the first order was placed in mid-April. The goal of the Ministry of Health, the Swedish and Danish Agencies is to order sufficient supplies to meet annual needs. The order was placed the beginning of 1983 based on projected needs developed by the National Family Welfare Center and Management Unit of Drug Supplies. Additional orders still will be accepted, if necessary, during the year. Shipments are scheduled to arrive in several allotments beginning in April/May, 1983. The project, through contraceptive operations research data, should be able to begin annual, method - specific needs. Information should be gathered on acceptors from all service delivery points of the project on a quarterly basis, collated by method used, and analyzed for projected needs in the following year. Submission of these forms can be part of the subproject grant agreement. Projected annual needs should be developed at least six weeks prior to the date the Ministry of Health plans to request contraceptive supplies from the Swedish International Development Authority. In past years, this has been in July; if the old schedule continues, the project should submit requests to the National Family Welfare Center by June 1. It appears the Management Unit of Drug Supplies may shift its ordering schedule permanently to January 1. The initial project procurement order will be less precise than following orders since there will be no program experience on which to base method-specific contraceptive needs. The Technical Assistance Team will need to define carefully the potential acceptor targets and probable date of implementation with subproject personnel during the project planning process. Once subprojects are funded, the grantee, as part of the agreement, might tie release of funds to timely submission of quarterly reports by the subgrantee. Thus, the grantee would be able to develop relatively realistic procurement needs and match the Ministry of Health order cycle.

B. Storage

A new warehouse at the Central Medical Stores Annex (CMSA) is scheduled for completion before mid-summer 1983 to replace the present outdated storage buildings. It is expected that both contraceptives and rural health drugs will be stored there. An addition to the new Central Medical Stores Annex is

in the planning stage, since it appears the new facility will not be able to accommodate contraceptives, National Family Welfare Center printed material and stationery as well as rural health facility drugs. Since contraceptives, cartons of printed matter, and drugs will compete for storage space in the same Central Medical Supplies, and since the Management Unit of Drug Supplies plans to schedule incoming orders through out the year, the technical assistance team should specify scheduled, desired arrival dates along with annual needs. A minimum of four to five months supply should always be in the warehouse at Central Medical Stores Annex to avoid shortages or the need to tap into the emergency procurement back-up system.

It is suggested that the Ministry of Health, National Family Welfare Center, United States Agency for International Development, Swedish International Development Authority and Danish Agency for International Authority discuss earmarking supplies ordered and stored for the project. Although borrowing from such earmarked procurements might be anticipated from time to time, a system which designates certain quantities for the project, per their annual order request to the National Family Welfare Center, would help assure a steady supply level for the project.

C. Distribution

While contraceptives usually are sent from Central Medical Stores to District Hospitals for dispersement to service delivery points in their respective districts, the National Family Welfare Center can and does release goods from Nairobi Central Medical Stores directly to certain health facilities, e.g., mission hospitals which collect their own supplies. Ministry will ship, if the facility needs emergency supplies, and pay for transport. The National Family Welfare Center, in fact, has used means besides Ministry of Health vehicles to transport contraceptives. Buses and trains as well as private sector carrier services are utilized. The Private Sector Family Planning Project presumably can arrange with the National Family Welfare Center and Ministry of Health to release goods to private carriers upon request. It is probable the Central Medical Stores will box supplies for shipment if shipping cartons and labels are provided. If not, there are packing services in Nairobi. Goods packed in shipping cartons can then be sent by private carrier companies. Many such services operate from Nairobi to urban centers close to anticipated subproject sites almost daily almost daily. All will pick up packages in Nairobi, and most will deliver "to the door" for a substantial extra charge. The usual practice is to telephone the destined receiver upon arrival at the nearest town or deliver to a postal box. It is expected that subproject grant recipient normally not receiving direct postal delivery will have post boxes at a nearby town. They also will have telephones (and in a few cases, telex facilities).

Delivery costs will vary by subproject. One carrier service quoted a minimum charge of Kshs. 10 up to ten kilos and Kshs. 1/- per plus extra charges, based on overall size, for larger boxes. Based on these quotations, a 6 medium-sized box would cost about Kshs. 35 (\$2.70), including a 40% inflation factor, to areas such as Kisumu and Mombasa. Costs for boxing and shipping would consume a relatively small amount of the total project budget. This small cost bears no relation to possible delays related to moving contraceptives through the Ministry of Health district hospital supply system. Shipping costs by private carriers have been taken into consideration in the cost projections for each of the eight proposed subprojects suggested by the present consultant team.

D. Management

One of the principal tasks the Ministry of Health has undertaken to facilitate drug and contraceptive logistics is to improve management of the entire system. In addition to developing what Management Unit of Drug Supplies believes is a rationalized ordering system for procurement of supplies in 1983, constructing and planning for new storage space, and securing additional vehicles (supplied and managed by Danish Agency for International Authority for the Management Unit of Drug Supplies), it has refined management and feedback methods. Procurement, for example, will be facilitated by the aforementioned method-specific quarterly reports on acceptors required of the subprojects. Reports also will help service delivery points maintain stock levels at a minimum of three and maximum six months' need. Management of warehousing, inventory control, and storage of contraceptives for the project, of course, would be the sole responsibility of the Ministry. Authorization by the National Family Welfare Center for release of goods is triggered by receipt of Government of Kenya Form S12, Requisition and Issue Voucher, stipulating specific quantities required of each contraceptive method. The Management Unit of Drug Supplies expect to receive a copy of the order from the National Family Welfare Center as part of its refined management system. Minimum time required from the day Form S12 is posted by the service delivery points until receipt of goods is three week (10 days for the post, 1 day for authorization by the National Family Welfare Center, 3 days to fill the order, 1 day to box and arrange transport, 3 days to deliver to requesters postal box, 3 days until pick up). It will be another 10 days to two weeks before the Form S12 packing slip (shipping receipt) copy reaches the Ministry of Health by post from the recipient. Thus, even if all goes smoothly, at least two weeks would pass before the technical assistance team either would know an order has been placed or hear from the Ministry of Health that the order has been received by the service delivery points. Neither would it

know of any delays along the order-supply chain. Except for project control over delivery, the process is within the Ministry of Health system (and outside the project system). The new notification to Ministry of Health (the order copy to the Management Unit of Drug Supplies) will help identify placement of orders, but there is no absolute assurance that project management will be aware of all orders from subprojects. A parallel project control system should be instituted as follows: When the subproject submits For S12 to the National Family Welfare Center, it simultaneously will post a notice to project offices on a specially designed internal management form. The project will mail a shipment notification form to the service delivery points and a copy will go with the shipping container. The copy then is to be sent by return mail from the recipient to the project. Thus, if any problems occur along the way, the project management can trace the source and initiate corrective measures.

Development by the project of an internal control system to facilitate procurement of contraceptives and earmarking of such orders by the Ministry of Health should assure sufficient stocks in the Central Medical Stores Annex for all subproject needs. If not, there are supply sources available to quickly bring in emergency contraceptives for every contraceptive needed by the project. If no agreement is reached with Ministry of Health to use Danish Agency for International Development vehicles, distribution from Central Medical Stores Annex to subproject facilities can be arranged by project using private carriers in much the same way the Ministry of Health now transports emergency supplies. A project management system parallel to that of the Ministry to track movement of goods from order to receipt by the service delivery points will identify trouble spots and allow the project to trace any misplaced or lost orders. In short, it is feasible to use the Ministry of Health contraceptive supply system backed by viable contingency supply from other local sources available to the project.

The Danish Agency for International Development supported Manager, Drug Supplies and Logistics - Rural Health, Mr. Gerald Moore, indicated that the Management Unit of Drug Supplies unit could consider transporting contraceptives to project sites subproject service delivery points on Danish Agency for International Development vehicles, which will be supplied to the Ministry of Health for its rural health facility program. Danish Agency for International Development will provide a vehicle for each of the six Provinces and one for the CMS in Nairobi. All are expected to be in country by early 1984. The plan is to use the Danish Agency for International Development fleet to distribute drugs as well as contraceptives from Central Medical Stores to Provincial Hospitals. From there, provincially stationed vehicles will transport to all District

health facilities. He suggested Danish Agency for International Development vehicles could drop supplies at project related service delivery points or at the nearest pick-up point. This clearly would facilitate dependable and ready access to contraceptive supply. If an agreement can be made between Ministry of Health, Management Unit of Drug Supplies, Danish Agency for International Development and the technical assistance team, the distribution system described above need only be used for back-up emergency purposes.

ANNEX G

IMPLEMENTATION SCHEDULEPrior to Cooperative Agreement Signature

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
1. CBD notice requesting expressions of interest	USAID	3/17/83
2. Preselection of firms to receive Request for applications	USAID	4/30/83
3. Request for applications issued	USAID	5/20/83
4. Project Paper approved	USAID	7/1/83
5. Applications for Cooperative Agreement received and logged	USAID	7/15/83
6. Memorandum of Understanding with Treasury Signed	GOK/USAID	7/15/83
7. Applications ranked; contenders invited for negotiations	USAID	7/22/83
8. Negotiations begin	USAID	8/1/83
9. Final selection	USAID	8/10/83
10. Cooperative Agreement signed	USAID/RECIPIENT	8/15/83

or Four Year Private Sector Family Planning ProjectYear I

1. Private Sector Family Planning Advisory Panel selected	GOK	8/15/83
2. Advisory Panel meets	GOK	8/22/83
3. Vehicles, office equipment/supplies ordered	RECIPIENT	8/22/83
4. Office space arranged for 10/1/83	RECIPIENT	8/31/83
5. Technical Assistance Team (TAT) arrives	RECIPIENT	10/1.83
6. Temporary vehicles leased	TAT	10/3/83
7. Office established & locally supplied equipment/supplies delivered	TAT	10/7/83

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
8. Subproject selection criteria, terms, etc. submitted to USAID	TAT	10/14/83
9. Project work plan, including Operations Research, drafted in cooperation with USAID	TAT/USAID	10/26/83
10. Subproject selection and terms approved	USAID	10/31/83
11. Training arrangements approved	TAT/MOH/USAID	11/1/83
12. Vehicles, U.S. source office equipment arrive	RECIPIENT	11/7/83
13. Evaluation plan submitted to AID	TAT	11/7/83
14. Project work plan finalized	TAT/USAID	11/10/83
15. Training arrangements finalized	TAT	11/11/83
16. First four to five subprojects identified, designed, submitted to USAID	TAT	11/30/83
17. Subproject commodities ordered	TAT	12/1/83
18. Evaluation plan approved	USAID	12/5/83
19. First subproject approved	USAID	12/10/83
20. Contraceptive order provided to MOH	TAT	12/15/83
21. First subproject grants negotiated, signed	TAT	12/20/83
22. Baseline data collection for first subproject begins	TAT	1/6/84
23. First training cycle begins	TAT	1/9/84
24. Registration process subproject SDPs begins	GOK/TAT	1/15/84
25. Forms subproject evaluation designed	TAT	1/31/84
26. Advisory Panel meets	GOK	2/15/84
27. Contraceptive needs new SDPs provided to MOH	TAT	3/1/84
28. Second round subproject designed submitted USAID	TAT	3/1/84

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
29. Subproject commodities arrive	TAT	3/1/84
30. Second round subprojects approved	USAID	3/10/84
31. First training class graduates certified	GOK	3/31/84
32. First subprojects SDPs registered	GOK	3/31/84
33. Commodities, forms delivered to subproject SDPs	TAT	4/1/84
34. Second round subproject grants negotiated, signed	TAT	4/1/84
35. Baseline data collection on new subproject begins	TAT	4/7/84
36. Second training cycle begins	TAT	5/1/84
37. Contraceptive needs additional SDPs provided MOH	TAT	5/1/84
38. Third round subprojects submitted AID	TAT	6/1/84
39. Third round subprojects approved	USAID	6/9/84
40. Second training class graduates certified	GOK	7/21/84
41. Second subproject SDPs registered	GOK	7/30/84
42. Commodities, forms delivered to SDPs	TAT	8/1/84
43. Third round subproject grants negotiated, signed	TAT	8/1/84
44. Subproject commodities ordered	TAT	8/1/84
45. Baseline data collection begins	TAT	8/7/84

Year II

46. Advisory Panel meets	GOK	8/15/84
47. Third training cycle begins	TAT	9/4/84

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
48. Fourth round subprojects submitted AID	TAT	10/1/84
49. Fourth round approved	USAID	10/10/84
50. Contraceptive needs additional SDPs provided MOH	TAT	11/1/84
51. Commodities arrive	TAT	11/1/84
52. Third training class graduates certified	GOK	11/24/84
53. Third subproject SDPs registered	GOK	11/30/84
54. Commodities; forms delivered SDPs	TAT	12/1/84
55. Plans for first conference initiated	TAT	12/1/84
56. Contraceptive order provided to MOH	TAT	12/1/84
57. Fourth round subproject grants negotiated, signed	TAT	12/1/84
58. Baseline data collection begins	TAT	12/8/84
59. Fourth training cycle begins	TAT	1/3/85
60. Advisory Panel meets	GOK	2/15/85
61. Contraceptive needs additional SDPs provided to MOH	TAT	3/1/85
62. Fourth training class graduates certified	GOK	3/23/85
63. Fourth subproject SDPs registered	GOK	3/31/85
64. Commodities, forms delivered SDPs	TAT	4/1/85
65. Fifth training class begins	TAT	4/30/85
66. Scope of work for first project evaluation	SAID	7/15/85.
67. Fifth training class graduates certified	GOK	7/20/85
68. First Kenya conference to exchange information begins	TAT	8/13/85

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
<u>Year III</u>		
69. Advisory Panel meets	GOK	8/15/85
70. Preparation for first project evaluation begins	TAT/USAID	9/1/85
71. Sixth training class begins	TAT	9/3/85
72. First project evaluation conducted	USAID	10/15/85
73. Sixth training class graduates certified	GOK	11/23/85
74. Contraceptive order provided to MOH	TAT	12/1/85
75. Seventh training class begins	TAT	1/2/86
76. Advisory Panel meets	GOK	2/15/86
77. Seventh training class graduates certified	GOK	3/22/86
78. Plans second Kenya conference begin	TAT	4/1/86
89. Eighth training class begins	TAT	5/5/86
80. Scope of work for final evaluation prepared	USAID/TAT	7/1/86
81. Eighth training class graduates certified	GOK	7/22/86
<u>Year IV</u>		
82. Advisory Panel meets	GOK	8/15/86
83. Plans any expected publication begin	ECIPIENT	9/1/86
84. Contraceptive order provided to MOH	TAT	12/1/86
85. Final evaluation begins	USAID	2/1/87
86. Advisory Panel meets	GOK	2/15/87
87. Final evaluation ends	USAID	3/1/87
88. Last subproject commodity order placed	TAT	3/31/87
89. Second Kenya conference on private sector family planning begins	TAT	5/1/87

<u>Event</u>	<u>Responsibility</u>	<u>Date</u>
90. Final order commodities arrive and distributed	TAT	6/1/87
91. Advisory Panel meets	GOK	7/15/87
92. Last contraceptive order provided to MOH	TAT	7/31/87
93. TAT submits final report and departs	TAT	8/15/87

ANNEX H

PROJECT COMMODITY LIS
(IN 000'S)

A. Vehicles

	<u>\$</u>	<u>Kshs.</u>
4 Minivans right hand drive, VW Kombi or equivalent	<u>47.0</u>	<u>-</u>
<u>Subtotal</u>	47.0	-

B. Office Equipment

3 'Executive' desks, metal @ Kshs. 4000	-	1.2
3 Executive chairs	-	0.9
1 Secretary desk	-	4.5
1 Secretary chair	-	1.3
8 In and out boxes	-	1.6
2 IBM selectrics or equivalent @ \$900	1.8	-
1 Typewriter stand	-	1.7
1 Conference table (12 place)	-	6.0
19 Side chairs @ Kshs. 400	-	7.6
4 Side chairs @ Kshs. 1900	-	7.6
3 Work tables @ Kshs. 1600	-	4.8
2 Side tables @ Kshs. 1000	-	2.0
5 Waste receptacles @ Kshs. 250	-	1.2
3 Bookcases (2 shelves) @ Kshs.	-	3.8
3 4-drawer file cabinets @ Kshs. 4,800	-	14.4
5 sets of drapes	-	13.0
2 Flip chart easles @ \$150	10.3	-
1 Office and photocopy supply cabinet with lock	-	3.9

H-2

1 Photocopy machine (Xerox 3107 or equiv.)	6.6	-
2 Blackboards @ Kshs. 500	-	1.0
1 Desk calculator	0.2	-
3 Pocket calculators @ 20	0.1	-
1 Apple 11-e (or equivalent) unit	6.1	-
Apple 11-e computer with 64K RAM C \$1300		
Disk with controller and cable @ 540		
Zenith green phosphor monitor @ 120		
Epson MA-120 printer @ 770		
R.F. Modulator @ \$65		
Microsoft premium softcard 11-e @ \$420		
Sorcim Supercalc @ 200		
Micropro three-pack @ \$570		
Ashton-Tate Dbase 11 @ \$580		
Ecostat Micostat Software @ \$310		
Apple plot software @ \$ 70		
30 Replacement ribbons @ 450		
Ten boxes, 10 each floppy disks @ \$400		
Apple super serial card @ \$180		
Assembly, testing, repacking @ \$120		
1 Uninterruptable power source	1.5	-
Miscellaneous office supplies for four years (typing paper, duplicating paper, pencil sharpners, scotch tape, scissors, staplers, file folders, petty cash box, etc.)	8.0	16.0
Airshipment @ 50%	12.3	-
<u>Subtotal</u>	\$ 36.9	Ksh. 92.5 ^{1/}

1/ Estimated costs of local equipment from K.J. Office Supplies Ltd., Reinsurance Plaza, Tel. 339098 subject to discount.

C. ILLUSTRATIVE COMMODITY "STANDARD" LIST (PER CLINIC)

1. IUD insertion kit @ 100	0.2	Kshs.
2. Sphygmomonometer, Stethoscope	0.1	-
3. Angled Lamp	0.1	-
4. Sterilizer	0.2	-
5. Pelvic Models	0.2	-
6. Salter Scale or similar	0.1	-
7. Adult Scale	0.1	-
8. Disposable Gloves 1500 pairs	0.5	-
9. Hand-held Calculators @ 20	0.04	-
10. Desk	-	3.0
11. 3 chairs @ 325	-	1.0
12. Exam Couch	-	3.9
13. Table (small stand)	-	0.7
14. Drape & Stand	-	1.0
15. File Cabinet	-	2.5
16. Stationery, wastebaskets, office supplies	-	4.5
For projected 50 subprojects =	\$ 1.5	Kshs. 16.6
	\$ 75.0	Kshs. 830
Additionally, upto 6 minilap kits may be needed @ \$250	1.5	-
Shipping and transport @ 50%	38.2	@ 20% 166
<u>Subtotal</u>	<u>\$114.7</u>	<u>Kshs. 966.0</u>
Total	\$200.2	Kshs.1058.5

HEALTH INSTITUTIONS

IN

KENYA

1982

GAZETTE NOTICE No. 3211

**THE MEDICAL PRACTITIONERS AND DENTISTS ACT
(Cap. 253)**

APPROVED INSTITUTIONS

IN EXERCISE of the powers conferred by paragraph (ii) of the proviso to section 22 of the Medical Practitioners and Dentists Act, the Director of Medical Services declares the institutions named in the Schedule to this notice to be approved institutions for the purposes of that section.

SCHEDULE

I--Nairobi Area

1. GOVERNMENT HOSPITALS

Kenyatta National Hospital.
Infectious Diseases Hospital.
Mathari Hospital (Nairobi).
Orthopaedic Unit (Kenyatta National Hospital, Kabete).
Forces Memorial Hospital.
Kantiti Prison Hospital.

2. NAIROBI CITY COUNCIL HOSPITALS/MATERNITY UNITS

Bahati Maternity Unit.
Pumwani Maternity Hospital.
Eastleigh Maternity Unit.
Langata Maternity Unit.
Westlands Maternity Unit.
Makadara Maternity Unit.
Ngara Maternity Unit.
Kahawa Maternity Unit.

3. NON-GOVERNMENT HOSPITALS

Nairobi Hospital.
H.H. The Aga Khan Hospital.
Gertrude's Garden Children Hospital.
M.P. Shah Hospital, Parklands.
Ideal Nursing Home.
Park Road Nursing Home/Out-patient Clinic.
Radiant Health Centre.
Alfa Maternity Hospital.
Avenue Nursing Home.
Masaba Nursing Home, Nairobi.
City Nursing Home.
Eastleigh Maternity Home.
Westlands Cottage Hospital.

4. MISSION HOSPITALS

Riruta (Nyina wa Mumbi) Maternity Home.
Mater Misericordiae Hospital.
Jamua Maternity, Jericho.

5. MISSION DISPENSARIES/MOBILE CLINICS

Bahati Dispensary.
Caledonia Dispensary.
Makadara Catholic Dispensary.
Riruta Catholic Dispensary.
Kariobangi Catholic Dispensary.
Kibera Catholic Dispensary.
S.D.A. Liverpool Road Dispensary, Kenyatta Avenue.
Edelvale Dispensary.
Westlands Dispensary.
Kahawa Dispensary.

6. GOVERNMENT HEALTH CENTRES AND DISPENSARIES

Loco Dispensary.
Railways Headquarters Dispensary.
N.Y.S. Holding Unit Dispensary.
Mathari Police Line Dispensary.
Police Depot Dispensary.
Kabete Technical and Trade Dispensary.
Kabete Approved School Dispensary.
Starehe Boys Centre Dispensary.
State House Dispensary.
Muguga Dispensary.
Mbagathi Dispensary, Postal Training School.
G.S.U. Training Wing Dispensary, Embakasi.
G.S.U. "A" Coy Mobile Dispensary.
G.S.U. "B" Coy Mobile Dispensary.
G.S.U. "C" Coy Mobile Dispensary.
G.S.U. "D" Coy Mobile Dispensary.
G.S.U. "E" Coy Mobile Dispensary.
G.S.U. "F" Coy Mobile Dispensary.

G.S.U. "G" Coy Mobile Dispensary.
G.S.U. "H" Coy Mobile Dispensary.
G.S.U. Headquarters, Thika Road Dispensary.
G.S.U. Ruiru Camp Dispensary.
Embakasi K.A.F. Dispensary.
M.O.W. Supplies Branch Dispensary.
Prison Staff Training College Dispensary.
Nairobi Remand and Allocation Prison Dispensary.
Provincial Engineer, M.O.W. Dispensary.
Langata Barracks M.I.R. Dispensary.
M.I.R. Dispensary, Ulinzi House.
Langata Women's Prison Dispensary.
Kahawa Garrison M.I.R. Dispensary.
Kenya Air Force Eastleigh Medical Centre.
Dagoretti Approved Dispensary.
Gitathuru Approved School Dispensary.
Kabete Juveniles Remand Home Dispensary.
Kenyatta University College Dispensary.
University of Nairobi Health Services.
Jomo Kenyatta International Airport Dispensary.
Railway Training School Dispensary.
Kenya Airways Dispensary, Embakasi.
Utalii College Dispensary.

7. NAIROBI CITY COUNCIL HEALTH CENTRES, DISPENSARIES AND CHILD WELFARE CLINICS

Karuru Health Centre.
Waitthaka Health Centre.
Riruta Health Centre.
Karen Health Centre.
Kangemi Health Centre.
Kariobangi Health Centre.
Bahati Health Centre.
Eastleigh Health Centre.
Langata Health Centre.
Westlands Health Centre.
Makadara Health Centre.
Ngara Health Centre.
Kahawa Health Centre.
Rhodes Avenue Dispensary.
Pumwani Health Sub-Centre.
Embakasi Dispensary.
Kaloleni Health Sub-Centre.
Kasarani Health Sub-Centre.
Lower Kabete Health Sub-Centre.
Ngong Road Health Sub-Centre.
Ofafa Jericho Health Sub-Centre.
Chest and T.B. Clinic, Rhodes Avenue.
Special Treatment (Staff Clinic).
Pumwani Clinic (Staff Clinic).
Family Welfare and Planning Clinic.

8. COMPANIES

Philips (K) Ltd., Factory Dispensary.
B.A.T. Factory Dispensary.
B.A.T. Shauri Moyo Village Dispensary.
K.B.S. Dispensary, Eastleigh.
K.M.C. Dispensary, Athi River.
Metal Box Factory Dispensary.
C.M.C. Dispensary, Chepkoio Road.
Portland Cement Athi River Dispensary.
E.A. Industries Factory Street Dispensary.
Kenya Breweries (Ruaraka) Factory Dispensary.
Kenya Breweries (City Factory) Dispensary.
Cadbury Schweppes Dispensary.
Firestone Factory Dispensary.
E.A.P. & L. Staff Clinic.
N.A.S. Caterer's Dispensary, Embakasi.
Car & General Dispensary.
General Motors (K) Limited, Dispensary.
Associated Battery Dispensary.
Coca-Cola Company Dispensary.

9. NAIROBI CITY COUNCIL CHILD WELFARE CLINICS

Kariokor.
Shauri Moyo.
Kaloleni.
Mbotela.
Bahati.
M.O.W. (Ministry of Works).
Charles New Road.
Hono Crescent.
Jerusalem.
Eastleigh.
Ngara.

SCHEDULE—(Contd.)

- Pangani.
Highridge.
Pumwani.
Police Lines.
Sandford Road.
Woodley.
Maringo.
Makadara.
Makongeni.
Jinnah Avenue.
Post and Telecommunications.
Eastleigh Lines.
K.A.P.
Ofafa.
Edelvale.
Embakasi.
Bohra Road.
State House.
Nairobi South.
Muthurwa.
Prison.
Ruaraka.
Bahati.
Langara.
Eastleigh.
Makadara.
Kahawa.
Westlands.
- 10 PRIVATE CLINICS
- Dinshaw Byramjee Clinic.
Siri Guru Sikh (Ranigharia) Dispensary.
The Social Service League Dispensary.
Jamia Red Crescent Clinic.
- II—Central Province
- GOVERNMENT HOSPITALS
- Central Province General Hospital, Nyeri.
Kiambu District Hospital.
Thika Hospital.
Tigoni Hospital.
Gatundu Hospital.
Kerugoya District Hospital.
Murang'a District Hospital.
Murirania's Hospital.
Ol Kalou District Hospital.
Nyeri Prison Hospital.
Nyuhururu District Hospital.
Mt. Kenya Hospital, Nyeri.
Karatina Hospital.
2. MISSION HOSPITALS
- Kijahe Mission Hospital.
Kikuyu Mission Hospital.
Tumutumu Mission Hospital.
Mweiga Maternity Clinic.
St. Anne Maternity, Kiganjo.
Mathari Hospital, Nyeri.
North Kinangop Hospital, Nyandarua.
Karuri Maternity Hospital and Nursing Home.
Gaichaniru Hospital, Murang'a.
Thika Maternity Hospital.
Kagwe Maternity Hospital.
Kalimoni Maternity Home, Kiambu.
Nazareth Hospital.
Kiriaine Hospital.
Mwea Cottage Hospital.
Icagaki Maternity Hospital.
Karira Hospital.
Belle Vue Maternity Hospital, Mweiga.
Baricho Maternity Home.
Kianyakya Maternity Home.
Mangu Maternity Home.
Keritta Maternity Home.
Immaculate Heart of Mary Hospital, Kilimambogo.
Kilimambogo Hospital.
- PRIVATE
- Muthiga Medical Centre.
Kikuyu Nursing Home.
Saba Saba Maternity Home.
Limuru Nursing Home.
Thika Nursing Home.

4. HEALTH CENTRES AND DISPENSARIES

(a) Kiambu:

Government

- Karuri National Ref. Health Centre.
Githunguri Health Centre.
Limuru Health Centre.
Wangigi Health Centre.
Lari Rural Demonstration Health Centre.
Ngorongo Health Centre.
Ruiru Health Centre.
Kagwe Sub-Health Centre.
Karatu Health Centre.
Igeganiu Rural Demonstration Health Centre.
Munyu Rural Demonstration Health Centre.
Ngeva Health Centre.
Nge'nda Health Centre.
Cianda Dispensary.
Anmer Dispensary.
Kagua Dispensary.
Jacaranda Estate Dispensary.
G.K. Prison Dispensary (Kiambu).
G.K. Prison Dispensary (Thika).
Kigumo Dispensary.
Uplands Forest Dispensary.
Keritta Forest Dispensary.
Kieni Forest Dispensary.
Kinale Forest Dispensary.
Kamae Forest Dispensary.
Gichuru Dispensary.
Muguga (E.A.F.R.O.) Dispensary.
Nduudu Dispensary.
Ragia Forest Dispensary.
Karia Dispensary.
Mangu High School Dispensary.
Thika High School Dispensary.
Thika Blind School Dispensary.
Joy Town Cripples Dispensary.
Gatitu Dispensary.
Keringa Dispensary.
Nderu Dispensary.
Miguta Dispensary.
Rioki Dispensary.
Kagwi Dispensary.
Lusigetty Health Centre.

Mission

- Thigio Dispensary.
Kambui Dispensary.
Mangu Dispensary.
Tinganga Dispensary.
Ngarariga Dispensary.
Kiriko Dispensary.
Keritta Dispensary.
Kagwi Dispensary.
Karinga Dispensary.
Rioki Dispensary.
Nduudu Health Centre.

Company

- Muchana Estate Dispensary.
Ruora Estate Dispensary.
Oaklands Estate Dispensary.
Kibubuti Estate Dispensary.
Mabrokie Estate Dispensary.
E.A. Bag & Cordage Dispensary.
Nyara Tea Estate Dispensary, Limuru.
Kentmere Estate Dispensary.
Karirana Estate Dispensary.
Bata Shoe Dispensary.
Ngariga Dispensary.
Uplands Bacon Factory Dispensary.
Juja Farm Dispensary.
Thika Green Leaf Threshing Plant Dispensary (U.A.T.).

(b) Kirinyaga:

Government

- Sagana Rural Demonstration Health Centre.
Kianyakya Health Centre.
Kimbimbi Health Centre.
Baricho Health Centre.
Kibiriro Dispensary.

SCHEDULE—(Contd.)

<p>Kiaraguna Health Sub-Centre. Kangaita Health Sub-Centre. Gathambi Dispensary. Mutira (Kagumo) Dispensary. Kamurandi Dispensary. Kiamutuga Health Sub-Centre. Difathus Health Sub-Centre. Nega's Dispensary. Kabare Dispensary. Mwea G.K. Prison Dispensary. Mutithi Dispensary. Kiambu-ini Dispensary. Gatuguru Dispensary. Kamweli Forest Dispensary. Wanumu Approved School Dispensary. Gathigirini Dispensary. Kandonga Dispensary. Nguka Dispensary. Kianjege Health Sub-Centre. Kiangombe Dispensary. Gatwe Dispensary. Kiungai Dispensary. Kutus Dispensary. Thiba Dispensary.</p> <p><i>Mission</i></p> <p>Kerugoya Dispensary (Catholic). Gatumbi Dispensary (S.D.A.). Sagana Mission Dispensary.</p> <p><i>Private</i></p> <p>Katulus P. Maternity Home. Kagumo P. Maternity Home.</p> <p><i>Company</i></p> <p>Kangaita Tea Authority Dispensary.</p> <p>(c) Nyandarua:</p> <p><i>Government</i></p> <p>Milangine Health Centre. Maina and Mwangi Health Centre. Subukua Health Centre. Njabini Dispensary. Ndaragwa Dispensary. Shamata Dispensary. Pesi Dispensary. Manunga Dispensary. Mawingo Dispensary (O.d). North Kinangop Dispensary (Engineer). Ol Bolosat Forest Department Dispensary. Geta Forest Dispensary. Mutarakwa Forest Dispensary. New Mawingo Dispensary. Turasha Dispensary. Ngorika Dispensary. Silibweti Dispensary. G.K. Prison Dispensary, Nyahururu. North Marmunet Dispensary. Murungaro Dispensary. Mutarakwa Dispensary. Ndeni Dispensary. Leshaupondo Dispensary. Wanjohi Health Centre. Uruku Dispensary. Kurungatha Health Centre. Ngano.</p> <p><i>Mission</i></p> <p>Thomson's Falls Dispensary. Nyahururu Catholic Disp. and Maternity Clinic.</p> <p>(d) Nyeri:</p> <p><i>Government</i></p> <p>Ngorano Rural Demonstration Health Centre. Mukurweini Health Centre. Othaya Health Centre. Wamagana Health Centre. Endarasha Rural Demonstration Health Centre. Warazo Rural Demonstration Health Centre. Naromoru Dispensary. Gatuguru Dispensary.</p>	<p>Aguthi Dispensary. Mihuti Dispensary. Gumba Dispensary. Kiganjo Dispensary. Island Farms Dispensary. Kiangongo Forest Dispensary. Kabage Forest Dispensary. Ndathi Forest Dispensary. Kahurura Forest Dispensary. Gathuru Forest Dispensary. Ragati Forest Dispensary. Kiganjo Police College Dispensary. Ihururu Dispensary. Gichini Dispensary. Gichichi Sub-Health Centre. Amboni Dispensary. Bellevue Dispensary. Ndamaini Dispensary. Nyeri Primary School Dispensary. Kinunga Health Centre. Caltex Children's Home (Ruring'u). Nyeri Town Municipal Health Centre. Nyeri G.K. Prison. Kamoko Dispensary. Nyeri High School Dispensary. Wandumbi Dispensary. Zaina Dispensary. Kamwenja T.T.C. Dispensary. Othaya App. School Dispensary. Chehe Forest Dispensary. Gatui Dispensary. Nairobi Forest Dispensary. Thangathi Dispensary. Hombe Forest Dispensary. Karaba Dispensary. Njoki Dispensary. Ichamara Dispensary. Kagumo High School Dispensary. Kagumo Teachers College Dispensary. Nyeri Technical School Dispensary.</p> <p><i>Mission</i></p> <p>Gikondi Dispensary & Maternity Home. Kaheti Dispensary & Maternity Home. Karima Dispensary. Mweiga Maternity Home. Ngandu Dispensary. Bellevue Dispensary. Naromoru Dispensary.</p> <p><i>Private</i></p> <p>Mariini Maternity Home.</p> <p>(e) Murang'a:</p> <p><i>Government</i></p> <p>Mumgwa Rural Health Training Centre. Makuyu Rural Health Demonstration Centre. Kangema Rural Health Demonstration Centre. Kigumo Health Centre. Kandara Health Centre. Kirogo Health Centre. Gatura Health Centre. Saba Saba Health Sub-Centre. Iruri Dispensary. Kiria Dispensary. Kiunyu Dispensary. Kihoya Dispensary. Kambirwa Dispensary. Ngurueini Dispensary. Tuthu Dispensary. Gatara Dispensary. Gituuru Dispensary. Kirwara Dispensary. Kiriani Dispensary. Kanyenyaini Dispensary. Kamahuha Dispensary. Muthithi Dispensary. Kangari Dispensary. Kariua Dispensary. Kigoro Dispensary. Kiruara Dispensary. Githunguri Dispensary. Murang'a G.K. Prison Dispensary. Nyakiauga Dispensary.</p>
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SCHEDULE—(Contd.)

Maragwa Ridge Dispensary.
Ithanga Dispensary.
Ichichi Dispensary.
Kigetuni Dispensary.
Gatara Forest Dispensary.
Kinakia Forest Dispensary.
Kiamara Dispensary.
Kinyangi Dispensary.
Kairo Dispensary.
Gakurwe Sub-Health Centre.
Gitugi Dispensary.
Wanjengi Dispensary.
Kihumbuni Dispensary.
Mitumbiri Dispensary.
Gatheru Dispensary.

Mission

Githumu Dispensary.
Gatanga Dispensary.
Mugoi Dispensary.
Muriira Dispensary.
Kianguyi Dispensary.
Gaturi Dispensary.
Ruchu Dispensary.
Murang'a Dispensary.
Nyangunyi Dispensary.
Muthithi Dispensary.
Ichagaki Dispensary.
Kiito Dispensary.

Company

Kenya Canners Dispensary.

III—Eastern Province

GOVERNMENT HOSPITALS

Eastern Province General Hospital, Machakos.
Embu District Hospital.
Isiolo District Hospital.
Kitui District Hospital.
Kangundo District Hospital.
Makindu Hospital.
Makueni Hospital.
Marsabit District Hospital.
Moyale District Hospital.
Meru District Hospital.
Ishara Cottage Hospital.
Athi River G.K. Prison Hospital.
Chuka Hospital.

MISSION HOSPITALS

Mulango Mission Hospital.
Chogoria Mission Hospital.
Masa Mission Hospital.
Chuka (St. Joseph's) Mission Dispensary.
Kilungu Mission Hospital.
Kimungao Mission Hospital.
Kyenjira Mission Hospital.
Muthale Mission Hospital.
Mutomo Mission Hospital.
Nkubu Mission Hospital.
Tigania Mission Hospital.
St. Anne's Egou Maternity Hospital, Meru.
Laisamis Mission Hospital.
Kiirwa Maternity Hospital.
Franciscan Convent, Kangundo.
Sololo Dispensary.
Kikoko Mission Hospital.

PRIVATE HOSPITALS

Milimani Maternity Nursing Home, Meru.
Machakos Nursing Home.
Kibirichia Maternity Home.

HEALTH CENTRES AND DISPENSARIES

Machakos:

Government

Matuu Demonstration Health Centre.
Masii Health Centre.
Mbooni Health Centre.
Sultan Hamud Health Centre.
Ngwata Health Centre.

Athi River Health Centre.
Kilwa Health Sub-Centre.
Nunguni Health Sub-Centre.
Donyo Sabuk Health Sub-Centre.
Mwala Demonstration Health Sub-Centre.
Kakuyuni Dispensary.
Kithyoko Dispensary.
Thindu Dispensary.
Muthyambua Dispensary.
Kibauni (or Katulani) Dispensary.
Miu Dispensary.
Mutungulu Dispensary.
Kaani Dispensary.
Kilala Dispensary.
Tawa Demonstration Health Centre.
Naiu Dispensary.
Okla Dispensary.
Opete Dispensary.
Kasikeu Dispensary.
Kalama Dispensary.
Kisau Dispensary.
Mua Hills Dispensary.
Ekarakara Dispensary.
Ndalani Dispensary.
Kitise Dispensary.
Kikumini Dispensary.
Mwanyani Dispensary.
Mhumi Dispensary.
Wananyu Dispensary.
Kithimani Dispensary.
Masinga Dispensary.
Matiliku Dispensary.
Yatta N.Y.S. Dispensary.
Masii N.Y.S. Dispensary.
Mavindini Dispensary.
Mitaboni Health Centre.
Kalulini Dispensary.
Kaviani Dispensary.
Muthetheni Dispensary.
Kwa-Kavisi Dispensary.
Kyambeke Dispensary.
Kinyatta Dispensary.
Mbitini Dispensary (Sisters of Mercy).
Kibwezi Health Centre (AMREF).

Mission

Sisters of Mercy Dispensary (Mbooni).
Grace Baptist Dispensary (Muto Andei).
Kilungu Dispensary.
Mulala Dispensary.
Mukaa Dispensary.
Kiteta Dispensary.
Mbitini Dispensary.
Makueni Dispensary.
Kianzabe Dispensary.
Kabaa Dispensary.
Makindu Catholic Disp. and Maternity Clinic.
Muthetheni Dispensary.
Kibwezi Dispensary.

Company

D.C.K. Farms Dispensary.

(b) Kitui:

Government

Migwani Health Centre.
Ikutha Health Centre.
Tsekuru Health Centre.
Mutio Health Centre.
Yatta Health Centre.
Nuu Health Centre.
Nguni Health Centre.
Katulani Health Centre.
Mui Dispensary.
Endau Dispensary.
Kauwi Dispensary.
Usueni Dispensary.
Tharaka Dispensary.
Katsa Dispensary.
Mivukoni Dispensary.
Ngomeni Dispensary.
Enziu Dispensary.
Kanziku Dispensary.
Mutha Dispensary.

SCHEDULE—(Contd.)

Voo Dispensary.
 Kitui Road N.Y.S. Dispensary.
 Inyuu (or Zombe) Dispensary.
 G.K. Prison Kyuso Dispensary.
 Miamhani Dispensary.
 Waita Dispensary.
 Miamhani Dispensary.
 Matinyani Dispensary.
 Kyatane Dispensary.
 Mbitini Dispensary.
 Nzaluni Dispensary.

Mission

Ikanga Dispensary.
 Mulungo Dispensary.
 Mutune Dispensary.
 Kimangao Dispensary.
 Mutitu Dispensary.
 Nuu Catholic Dispensary and Maternity Clinic.

(c) Embu:

Government

Karimmo Rural Health Centre
 Siakago Demonstration Centre.
 Runyenjes Health Centre.
 Gategi Dispensary.
 Kiamjokoma Dispensary.
 Kanja Dispensary.
 Ena Dispensary.
 Nambure Dispensary.
 Githniu Dispensary.
 Kwika Dispensary.
 Kiambere Dispensary.
 Mufu Dispensary.
 Riakanau Dispensary.
 Karaba Dispensary.
 Karitiri Dispensary.
 Kathanjuri Dispensary.
 Githegi Dispensary.
 Kairuri Dispensary.
 Kigumo Dispensary.
 Ngandure Dispensary.

Mission

Siakago Dispensary.
 Iriamorai Dispensary.
 Kithungururu Church Dispensary.
 Nguvio Mission Dispensary.
 Kavote Dispensary.
 Kanyunthura Dispensary.
 Kimununga Dispensary.
 Gwakaethe Dispensary.

(d) Meru:

Government

Ruini Rural Health Training Centre.
 Githongo Health Centre.
 Marimani Health Centre.
 Chiokarige Health Centre.
 Mpukoni Health Centre.
 Timau Health Centre.
 Mithene Health Centre.
 Laare Health Centre.
 Mikumbune Health Centre.
 Naani Dispensary.
 Kirua Dispensary.
 Giika Dispensary.
 Kajuki Dispensary.
 Kamanyaki Dispensary.
 Kiomyu Dispensary.
 Kaongo Dispensary.
 Kathangacine Dispensary.
 Kibugua Dispensary.
 Kuncne Dispensary.
 Mikinduri Dispensary.
 Mitunguu Dispensary.
 Mituati Dispensary.
 Muthambi Dispensary.
 Muthara Dispensary.
 Nkondi Dispensary.
 Ontulili Dispensary.
 Thimaogiri Dispensary.
 Uruku Dispensary.

Uruku G.K. Prison Dispensary.
 Kangeta Dispensary.
 Maguti Dispensary.
 Kiini "Muthenge" Dispensary.
 Kanyakine Dispensary.
 Gatimbi Dispensary.
 Mukui Dispensary.
 Wachoru Dispensary.
 Meru National Park Dispensary.
 Machanga Dispensary.

Mission

Ithimbari Dispensary.
 Gatuntine Dispensary.
 Kinoru Dispensary.
 Ngeru Dispensary.
 Weru Dispensary.
 Iriga Dispensary.
 Kigumo Dispensary.
 Mukuni Dispensary.
 Kiini Dispensary.
 Kierenii Dispensary.
 Ikumbo Dispensary.
 Kieni (Kirindini) Dispensary.
 Karimba Dispensary.
 Kaunua Dispensary.
 Kariani Dispensary.
 Kathigu Dispensary.
 Kajampau Dispensary.
 Kooru Dispensary.
 Amungeti Dispensary.
 Kirua Dispensary.
 Nkabune Dispensary.
 Mikinduri Dispensary.
 Ruiru Dispensary.
 Igoji Dispensary.
 Eigandene Dispensary.
 Gitoro Dispensary.
 Nyukine Dispensary.
 Gatunga Dispensary.
 Michii Dispensary.
 Matiri Dispensary.
 Karijaji Dispensary.
 Angiri Dispensary.
 Mujuwa Dispensary.
 Timau Dispensary.
 Tigania Dispensary.
 Mekinduri Dispensary.
 Mbarange Dispensary.
 Mworoga Dispensary.
 Muguna Nutr. Home.
 Muthambi Dispensary.
 Kariakoino Dispensary.
 Tuuru Dispensary.
 Tuuru Disabled Child Home.
 Cheera Dispensary.
 Mucimukuru Dispensary.
 Riji Dispensary.

Company

Mucimikuru Tea Estate Dispensary.

(e) Marsabit/Moyale:

Government

Ileret Dispensary.

Mission

Laglogu Dispensary.
 North Horr Dispensary.
 Loiyungalani Dispensary.
 Maikona Dispensary.
 Ngurunit Dispensary.
 Korgi Mission Dispensary.
 Korr Mission Dispensary.
 Kalacha Dispensary.
 Gatab Mission Dispensary.
 Marsabit Catholic Disp. and Maternity

(f) Isiolo:

Government

Garba Tulla Health Centre.
 Merti Health Centre.
 Mudo-Gashe Dispensary.
 Kina Dispensary.
 Sericho Dispensary.

SCHEDULE—(Contd.)

- Dulera Dispensary.
Irisaburu Dispensary.
Mau Kadeka Dispensary.
- Mission**
- Isiolo Dispensary.
Odu Nyiro Dispensary.
Anti-Poaching Dispensary.
- IV—North-Eastern Province**
- GOVERNMENT HOSPITALS**
- Provincial General Hospital, Garissa.
Mandera District Hospital.
Wajir District Hospital.
2. **HEALTH CENTRES AND DISPENSARIES**
- (a) **Garissa:**
- Government**
- Mudo-Gashe Health Centre.
Masalani Health Centre.
Liboi Health Centre.
Dadaab Health Sub-Centre.
Hulughu Health Sub-Centre.
Garissa M.C.H. Clinic.
Belambala Dispensary.
Bura Dispensary.
Ijara Dispensary.
Masababu Dispensary.
Garissa Army Camp Dispensary.
- (b) **Wajir:**
- Government**
- Buna Health Centre.
Bute Health Centre.
Terhaj Health Sub-Centre.
Habaswein Health Sub-Centre.
Gurar Dispensary.
Girifu Dispensary.
El-Ben Dispensary.
El-Das Dispensary.
Wajir Bar Dispensary.
Wajir Army Camp Dispensary.
- (c) **Mandera:**
- Government**
- Rhamu Health Centre.
El Wak Health Centre.
Takaha Health Centre.
Arabia Dispensary.
Benisa Dispensary.
Mandera Army Camp Dispensary.
- V—Coast Province**
1. **GOVERNMENT HOSPITALS**
- Coast Provincial General Hospital, Mombasa.
Kilifi District Hospital.
Malindi Sub-District Hospital.
Msambweni District Hospital.
Kwale Hospital.
Lamu District Hospital.
Port Reitz Chest Hospital.
Lady Grigg Maternity Hospital.
Wesu District Hospital.
Taveta Hospital.
Voi Hospital.
Hala District Hospital.
Kipini Hospital.
Shimo-la-Tewa G.K. Prison Hospital.
Kinango Hospital.
Manyani G.K. Prison Hospital.
Ngao Hospital.
2. **MISSION HOSPITAL**
- St. Luke Kaloleni Mission Hospital.
3. **NON-GOVERNMENT HOSPITALS**
- Mombasa Hospital, Mombasa.
Pandya Memorial Clinic.
Aga Khan Hospital.
4. **COMPANY HOSPITAL**
- Kenya Sugar Company Limited Hospital, Ramisi.
5. **PRIVATE HOSPITALS**
- Dr. Vibhakar's Maternity Hospital.
Changamwe Nursing Home.
6. **HEALTH CENTRES AND DISPENSARIES**
- (a) **Mombasa:**
- Government**
- Moi Airport S/H/C.
Shanzu T.T. College Dispensary.
Shimo-la-Tewa G.K. Prison Dispensary.
Mtongwe M.I.R. Dispensary (Kenya Navy).
Kilimuni Port Dispensary.
Mtongwe N.Y.S. Dispensary.
Mombasa G.K. Prison Dispensary.
State House Dispensary.
Shimo-la-Tewa Dispensary.
Nyali Barracks M.I.R. Dispensary.
- Municipality**
- Mwembe Tayari Health Centre.
Makupa Health Centre.
Magongo Health Centre.
Majengo Health Centre.
Likoni Health Centre.
Kwa Jomvu Health Sub-Centre.
Utunge Health Sub-Centre.
Kongowea Health Sub-Centre.
Shikaadabu Health Sub-Centre.
Mtongwe Health Sub-Centre.
Kwa Jomvu Kuu Health Sub-Centre.
Mvita Clinic.
Mwembe Tayari Staff Clinic.
Senior Staff Clinic.
M.O.W. Dispensary Shimanzi.
Mwainguja Dispensary.
Mwakirunge Dispensary.
Old Town Daderbhooy Dispensary.
- Mission**
- Trubwani Consolata Sisters Dispensary.
- Company**
- Bamburi Portland Cement Dispensary.
Changamwe Oil Refinery Dispensary.
Kenya Shell Dispensary, Mombasa.
Cargo Handling Dispensary.
Kenya Breweries Dispensary.
K.M.C. Dispensary, Mombasa.
Shimanzi Railways Dispensary.
African Marine Eng. Dispensary.
Kipevu Dispensary.
Kenya Port Authority Clinic.
- Private**
- Saifee Foundation Clinic.
Mkomani Harambee Clinic.
Visa Oshwal Dispensary.
Mrs. Alshabal Haji Aboo Dispensary.
- (b) **Kwale:**
- Government**
- Tiwi Rural Health Training Centre.
Shimba Hills Health Centre.
Kikaneni Health Centre.
Ngombeni Dispensary.
Kichakasimba Dispensary.
Waa Dispensary.
Matuga Dispensary.
Tiwi Dispensary.
Diani Dispensary.
Muhaka Dispensary.
Lungalunga Dispensary.
Vanga Dispensary.
Kilimanogodo Dispensary.
Lutsaagazi Dispensary.
Munyenzani Dispensary.

SCHEDULE—(Contd.)

Shimoni Dispensary.
Mwangulu Dispensary.
Ndavaya Dispensary.
Mkongani Dispensary.
Kibandaongo Dispensary.
Mwanda Dispensary.
Sumburu Dispensary.
Mazeras Dispensary.
Lukupe Dispensary.
Makani Harambee Dispensary.
Hofu Dispensary.
Taru Dispensary.

Mission

Kichaka Simba Dispensary.
Siella Miris Dispensary.

(c) Kilifi:

Government

Mariakani Demonstration Health Centre.
Rabai Demonstration Health Centre.
Vipingo Rural Demonstration Health Centre.
Jihana Health Centre.
Konibeni Health Centre.
Bamba Health Centre.
Garashi Health Centre.
Takaungu Dispensary.
Gongoni (Junju) Dispensary.
Shimo-la-Tewa Dispensary.
Jaribuni Dispensary.
Chonyi Dispensary.
Mgamboni Dispensary.
Ribe Dispensary.
Bwagamoyo Dispensary.
Gotani Dispensary.
Lenga Dispensary.
Junju/Gongoni Dispensary.
Tsangatsi Dispensary.
Ganze Dispensary.
Vitengeni Dispensary.
Muryachakwe Dispensary.
Chakama Dispensary.
Kakoeni Dispensary.
Kakuyuni Dispensary.
Gede Dispensary.
Mamburi Dispensary.
Marikibuni Dispensary.
Gongoni (Muliindi) Dispensary.
Marafa Dispensary.
Adu Dispensary.
Baricho Dispensary.
Daganira Dispensary.
Sosoni Dispensary.
Garenyi Dispensary.

Mission

Wena Catholic Dispensary.
Giriama Catholic Dispensary.
Chonyi Dispensary.

Company

Kenya Cashewnuts Dispensary.
Kilifi Plantation Dispensary.
Vipingo Estate Dispensary.
Malindi Maternity Home.

Private

Kikambala Maternity Clinic.
Malindi Maternity Clinic.

(d) Lamu:

Government

Faza Health Centre.
Witu Health Centre.
Lake Kenyatta Health Centre.
Kiunga Dispensary.
Mkunumbi Dispensary.
Matondoni Dispensary.
Siu Dispensary.
Nduu Dispensary.
Kisingitini Dispensary.

Mission

Lake Kenyatta Mobile Clinic.

(e) Tuna River:

Government

Garsen Health Centre.
Chewani Dispensary.
Makere Dispensary.
Wayu Dispensary.
Punwani Dispensary.
Majengo Dispensary.
Wenje Dispensary.
Mnaziini Dispensary.
Semikaro Dispensary.
Bura Dispensary.
Marembo Dispensary.
Bura N.Y.S. Dispensary.
Odu Dispensary.
Bura N.Y.S. Dispensary.
Kipini Prison Dispensary.
Wema Dispensary.
Ozi Dispensary.
Chwele Dispensary.
Mbatambala Dispensary.
Nanghi Dispensary.
Tarazo Secondary School Dispensary.
Motozo Health Centre.

Mission

Wema Dispensary.

Taita/Taveta:

Government

Mwatate Demonstration Health Centre.
Mwakilau Health Centre.
Mpizinyi Health Centre.
Nyache Health Centre.
Mbale Health Centre.
Rukanga Health Centre.
Kasigau Dispensary.
Kimorigo Dispensary.
Murigua Dispensary.
Mwanda Dispensary.
Mgange Dispensary.
Wundanyi Dispensary.
Shelemba Dispensary.
Msau Dispensary.
Manyani G.K. Prison Dispensary.
Mwambirwa or Rong'e Dispensary.
Ndomo Dispensary.
Sagalla Dispensary.
Ghazi Dispensary.
Bura Dispensary.

Mission

Bura Catholic Dispensary.
Taveta Catholic Dispensary.
Eldoro Catholic Dispensary.

Company

Taveta Sisal Estate Dispensary.
Mwatate Sisal Estate Dispensary.
Kamboyo Dispensary (N. Park, Voi).
Jipe Sisal Estate Dispensary.
Ziwani Sisal Estate Dispensary.
Mugono Rading Dispensary.
Taita Hills Lodge Dispensary.
Salt Lick Lodge Dispensary.

VI—Rift Valley Province

GOVERNMENT HOSPITALS

Provincial General Hospital, Nakuru.
Kabarnet District Hospital.
Molo Hospital.
Naivasha Hospital.
Kajiado District Hospital.
Kericho District Hospital.
Kapkatet Sub-District Hospital.
Londiani Hospital.
Nanyuki District Hospital.
Narok District Hospital.
Ichundura Dispensary.
Mokowe G.S.U. Dispensary.
Hindi G.K. Prison Dispensary.
Maralal District Hospital.
Lodwar District Hospital.
Lokitaung' Sub-District Hospital.

SCHEDULE—(Contd.)

- Tambach District Hospital.
Kapsabet District Hospital.
Nandi Hills Hospital.
Kitale District Hospital.
Eldoret District Hospital.
Kapenguria District Hospital.
Nakuru Prison Hospital.
Mathari Mental (Extension) Hospital, Gilgil.
Loitokitok Hospital.
2. MISSION HOSPITALS
Leticia Mission Hospital.
Tenwek Mission Hospital.
Kapsowar Mission Hospital.
Lolori Mission Hospital.
Plateau Reformed Church Hospital, Eldoret.
Itubojoi Mission Hospital.
Kaplonu Mission Hospital.
Kilgoris Mission Hospital.
Ortuni Mission Hospital.
Lorogumu Mission Hospital.
Kakuma Hospital.
Wamba Hospital.
Mercy Hospital, Eldama Ravine.
Rombo Hospital.
Kaihoi Hospital.
Lumbwa Mission Cottage Hospital.
3. NON-GOVERNMENT HOSPITALS
Nakuru War Memorial Hospital.
Uasin Gishu Hospital.
Mount Elgon Hospital.
Nanyuki Cottage Hospital.
Menengai Nursing Home.
Egerton College Cottage Hospital.
Eldoret Nursing Home.
Wangu Maternity Home.
4. COMPANY HOSPITALS
Kenya Tea Company Limited Hospital, Kericho.
African Highlands Produce Limited Hospital.
Magadi Soda Company Limited Hospital.
5. NAKURU MUNICIPALITY
Langalanga Health Centre.
Nakuru West Dispensary.
Bondeni Maternity Home.
Lanet Dispensary.
6. HEALTH CENTRES AND DISPENSARIES
- (a) Nakuru:
Government
Gilgil Demonstration Health Centre.
Bahati Demonstration Health Centre.
Elburgon Health Centre.
Njoro Health Centre.
Rongai Health Centre.
Subukia Health Centre.
Solai Health Centre.
Dundori Health Centre.
Olenguruoni Health Sub-Centre.
Mau Narok Health Sub-Centre.
Maiella Health Sub-Centre.
Molo South Dispensary.
Lower Solai Dispensary.
Bahati D. Forest Dispensary.
Kabati Dispensary.
Gilgil N.Y.S. Dispensary.
Lanet M.I.R. Dispensary.
Nakuru Barracks M.I.R. Dispensary.
Gilgil Barracks M.I.R. Dispensary.
Nanyuki K.A.F. Dispensary.
Kenyatta Barracks M.I.R. Dispensary.
Elburgon Forest Dispensary.
Mariashoni Forest Dispensary.
Baraget Forest Dispensary.
Kiptunga Forest Dispensary.
Nessuit Forest Dispensary.
Likia Forest Dispensary.
Teret Forest Dispensary.
Bondeni Dispensary.
Ndoinet Forest Dispensary.
Kerisoi Forest Dispensary.
Emburu Dispensary.
- Rocko Dispensary.
Naivasha Max. Prison Dispensary.
Naivasha Open Prison Dispensary.
Naivasha N.Y.S. (Women) Dispensary.
Rugongo Forest Dispensary.
Siruru Dispensary.
Kabarak High School Dispensary.
Moi Barracks M.I.R. Dispensary.
- (b) Baringo:
Government
Eldama Ravine Health Centre.
Marigat Health Centre.
Nginyang' Health Centre.
Mogotio Health Centre.
Kampi ya Samaki Health Centre.
Tanuilbei Dispensary.
Kapulelwa Dispensary.
Kapticny Dispensary.
Seretwala Dispensary.
Torongo Dispensary.
Sirwa Dispensary.
Kiptagich Dispensary.
Tengus Dispensary.
Kolobea Dispensary.
Lobei Dispensary.
Maji Moto Dispensary.
Emining Dispensary.
Kabartoojo Dispensary.
Kapluk Dispensary.
Bartabwa Dispensary.
Bartolimo Dispensary.
Poi Dispensary.
Kisanadan Dispensary.
Narasha Dispensary.
Essageri Forest Dispensary.
Maji Mazuri Forest Dispensary.
Sabuda Forest Dispensary.
Sabor Dispensary.
Kipcheritica Dispensary.
Salawa Dispensary.
Talai Dispensary.
Sargat Dispensary.
Koturwo Dispensary.
- Mission*
Eldama Ravine Dispensary.
Kapedo Dispensary.
Kapsaram Dispensary and M. Clinic.
- (c) Samburu:
Government
Baragol Health Centre.
Wamba Health Centre.
Seroleni Dispensary.
Sirata Oirobi Dispensary.
Suguta Marmar Dispensary.
Barsaloi Dispensary.
- Mission*
Maralal Dispensary.
Archer's Post Dispensary.
Gatab Dispensary.
South Horr Dispensary.
Maragoi Catholic Dispensary and M. Clinic.
Wamba Dispensary.
- Private*
Samburu Lodge Dispensary.
- (d) Kericho:
Government
Kipkoros Health Centre.
Sosiot Health Centre.
Sigor Health Centre.
Ndaani Health Centre.
Roret Health Centre.
Lumbwa Health Centre.
Kaitui Dispensary.
Kerison Dispensary.
Sungunyiet Dispensary.
Chepkemel Dispensary.
Itare Forest Dispensary.
Kericho G.K. Prison Dispensary.
Kipsonoi Dispensary.
Sougunyot Dispensary.

SCHOOLS—(Contd.)

Kapkitai Dispensary.
 Kabianga Dispensary.
 Kaparok Dispensary.
 Kiptere Dispensary.
 Chebungang Dispensary.
 Mogogosiek Dispensary.
 Suik Dispensary.
 Merigi Dispensary.
 Lungaa Dispensary.
 Gungor Dispensary.
 Kipkelion Dispensary.
 Kenegut Dispensary.
 Chepar Dispensary.
 Solita Dispensary.
 Kipsitet Dispensary.
 Tebeonia Dispensary.
 Cheptalal Dispensary.
 Tarakwa Dispensary.
 Chemamer Dispensary.
 Chebunyo Dispensary.
 Siognitot Dispensary.
 Gele Gele Dispensary.
 Bomet Dispensary.
 Chebutge Dispensary.
 Fort Ternan Dispensary.
 Sambret Dispensary.
 Kericho Forest Dispensary.
 Ainamoi Dispensary.
 Makutano Forest Dispensary.
 Surget Forest Dispensary.
 Malagat Forest Dispensary.
 Merisot Forest Dispensary.
 Olykya Dispensary.

Mission

Kabuson Dispensary.
 Thessalia Dispensary.
 Keheheti Dispensary.
 Tinga Farm Dispensary.
 Kipchimechim Maternity.
 St. Francis H.C. (Kipkelion).

Company

Kiptenden Estate Dispensary.
 Arrocket Dispensary.
 Monieri Dispensary.
 Tillet Dispensary.
 Dimbil Dispensary.
 Chomogonday Dispensary.
 Majengo Dispensary.
 Snot Dispensary.
 Cheppuithen Dispensary.
 Engineering Department Dispensary.
 Mariny Dispensary.
 Kitamber Dispensary.
 Kapkoros Dispensary.
 Changana Dispensary.
 Cheppolben Dispensary.
 Chemamul Dispensary.
 Chemasingi Dispensary.
 Kumulot Dispensary.
 T.R.I. Dispensary.
 Ngoina Dispensary.
 Jamji Dispensary.
 Kilio Dispensary.
 Koilwas Dispensary.
 Kimari Dispensary.
 Koruma Dispensary.
 Kapwen Dispensary.
 Tagahi Dispensary.
 Chewun Dispensary.
 Kerenga Estate Dispensary.
 Kapndege Dispensary.
 Karenga Factory Dispensary.
 Kericho Estate Dispensary.
 Marsabet Dispensary.
 Mbiri Dispensary.
 Chelima Dispensary.
 Kapkotechi Dispensary.
 Kapkatangor Dispensary.
 Brooke Bond Central Packing Factory Dispensary.
 Chagaa Dispensary.
 Chebowwa Dispensary.
 G. M. Dispensary.

Kusimotwa Tea Estate Dispensary.
 Kalsugu Limited Dispensary.
 Solik Tea Estate Dispensary.
 Changoi Limited Dispensary.
 Kapterwa Tea Estate Dispensary.
 Kipkebe Tea Estate Dispensary.
 Terajira Dispensary.

(e) Narok:

Government

Nairagie Ngare Health Centre.
 Oluhinga Sub-Health Centre.
 Narau-ura Sub-Health Centre.
 Kilgoris Health Centre.
 Lulgorien Sub-Health Centre.
 Enosein Dispensary.
 Emarti Dispensary.
 Olckurto Health Centre.
 Mosiro Dispensary.
 Ololpironito Dispensary.
 Olckoro Dispensary.
 Ennabelbel Dispensary.
 Sakutiek Dispensary.
 Enosubukia Dispensary.
 Ongata Barikoi Dispensary.
 Lemek Dispensary.
 Aitong Dispensary.
 Keekorok Lodge Dispensary.
 Naiturr/Ajii's Dispensary.
 Inta-ekera Dispensary.
 Ikerin Mission Dispensary.
 Morijo Lita Dispensary.
 Ngarkori Dispensary.
 Euso-Nyiro Dispensary.
 Ngararo Dispensary.
 Emarti Dispensary.
 Olangata Osaen Dispensary.
 Poroko Mission Dispensary.
 Naikarra Mission Dispensary.
 Lemek Mission Dispensary.
 Engetia Dispensary.
 Edasigira Dispensary.
 Maji Moto Mission Dispensary.
 Seyabei Mission Dispensary.
 G.K. Prison Dispensary.
 Megwara Dispensary.
 Kojonga Dispensary.
 Mara-Serena Dispensary (Private).
 Olirikirirai Mission Dispensary.

(f) Uasin Gishu:

Government

Turbo Demonstration Health Centre.
 Burnt Forest Demonstration Health Centre.
 Kipkabus Health Sub-Centre.
 Soy Health Sub-Centre.
 Moiben Health Sub-Centre.
 Timboroa Forest Dispensary.
 Kapsabet Forest Dispensary.
 Cengalo Forest Dispensary.
 Sabor Forest Dispensary.
 Penon Forest Dispensary.
 Kapagat Forest Dispensary.
 Kipkabus Forest Dispensary.
 Cherengoni Forest Dispensary.
 Railways Dispensary, Eldoret.
 Nabkoi Forest Dispensary.
 Kiptogot Forest Dispensary.
 Kimothon Forest Dispensary.
 Moi's Bridge Dispensary.
 Kapagat Dispensary.
 Matunda Dispensary.
 Lorenges Dispensary.
 Kipkurere Forest Dispensary.
 Ngeria G.K. Prison Dispensary.
 Eldoret G.K. Prison Dispensary.
 Hill School Dispensary.

Mission

Ainabkoi West Health Centre.
 Leasos Dispensary.
 Ndalat Dispensary.
 Rurigi Dispensary.

SCHEDULE—(Contd.)

Sergoit Dispensary.
Cheburwi Dispensary.
Kaigat Dispensary.
Turbo Dispensary.
Timborou Dispensary.
Kiminini Dispensary.
Moi's Bridge Health Sub-Centre.
Kapigat Dispensary.
Matunda Dispensary.
Kapkoi Health Centre.

Municipality

Eldoret West Health Centre.

(g) Nandi:

Government

Musoriot Rural Health Training Centre.
Kabylet Health Centre.
Kilibwoni Health Centre.
Kapumo Health Centre.
Kapkolei Dispensary.
Chemase Dispensary.
Maraba Dispensary.
Kemeloi Dispensary.
Chempierwai Dispensary.
Kaptangani Dispensary.
Kipsisiya Dispensary.
Soba River (Songhor) Dispensary.
Chepsoite Dispensary.
Kipsoite Dispensary.
Kaptangani Dispensary.

Mission

Chepiet Dispensary.
Kapsabet Dispensary.
Miteitei Dispensary.

Private

Kapimotwa Dispensary.
Kaimosi Tea Estate Dispensary.
Kapsubweiwa Dispensary.
Kipkoinot Dispensary.
Kaphorua Dispensary.
Kaphomo Dispensary.
Konsagat Dispensary.
Sira Dispensary.
Chemoni Dispensary.
Nandi Tea Estate Dispensary.

(h) Elgeyo-Mara/Lwet:

Government

Iten Health Centre.
Tut Health Centre.
Chipkoria Health Centre.
Chehororwa Health Sub-Centre.
Kamwasi Health Sub-Centre.
Karonciti Health Sub-Centre.
Chebiemit Dispensary.
Kaparakwa Dispensary.
Muskut Dispensary.
Masekedwa Dispensary.

Company

Fluospar Mine Dispensary.
Elgeyo Saw Mills Dispensary.

Mission

Cheongoch Health Centre.
Aror Health Centre.
Mulgil Dispensary.
Kapalama Dispensary.
Kapeherop Dispensary.
Chebulba Dispensary.
Chesi Dispensary.
Liter Dispensary.
Kehetwa Dispensary.
Koromaiti Health Sub-Centre.

(i) West Pokot:

Government

Sigor Health Centre.
Kaibichich Health Centre.
Kacheliba Health Centre.
Ployo Dispensary.
Kapenguria G.K. Prison Dispensary.

Mission

Lomut Dispensary.
Chepararia Dispensary c/o Ortum.
Kapetya Dispensary.

(j) Laikipia:

Government

Dol Dol Health Centre.
Rumuruti Health Centre.
Ngarua Health Centre.
Uinande Health Centre.
North Marmaret Forest Dispensary.
Ontulili Forest Dispensary.
South Marmaret Dispensary.
Sharmarek Dispensary.
Citundaga Forest Dispensary.
Nanyuki Barracks Medical Reception Station.
Engineering Battalion M.I.R. Dispensary.
Nanyuki Forest Dispensary.
Keaya Air Force M.I.R. Dispensary, Nanyuki.

Mission

Mary Immaculate Dispensary, Nanyuki.

Company

Keaya Textile Industry Dispensary.

(k) Trans Nzou:

Government

Elgon Dispensary.
Endchess Sub-Health Centre.
Saboti Health Sub-Centre.
Kwanza Health Centre.
Nzota Health Sub-Centre.
Chepchoina Dispensary.
Kaptoga Dispensary.
Kiptogot Dispensary.

Kitale Municipality

Tom Mboya Clinic.
Kitosa Majunga Dispensary.

Mission

Segeu Dispensary.
Mary Immaculate Dispensary.
Tartar Dispensary.
Suam Dispensary.
North Mt. Elgon Dispensary.
Kiminini Dispensary and Maternity Clinic.
Kulongula Cath. Disp. and Maternity Clinic.
Kucheliba Cath. Disp. and Maternity Clinic.
Farm Settlement Health Education Unit.

(l) Kajiado:

Government

Ngong Health Centre.
Bissil Health Centre.
Mashuuru Health Centre.
Mile Forty-Six Health Centre.
Namanga Health Centre.
Rombo Health Centre.
Elangata Wuas Health Sub-Centre.
Meto Dispensary.
Isenya Dispensary.
Shiainhole (Oloita) Dispensary.
Zebra Dispensary.
Lengisim Dispensary.
Olkeremation Dispensary.
Amboteli Dispensary.
Olgului Dispensary.
Ewaso Dispensary.
Oltepesi Dispensary.
Athi River Health Sub-Centre.

Mission

Kiserian Health Centre.
Iloosos Health Centre.
Enkorika Dispensary.
Ongata Rongai Dispensary.
Mbitikani Dispensary.
O. Tukeni Dispensary.
Rombo Health Centre.
Fatima Dispensary.

SCHEDULE—(Contd.)

Company

Kenya Marble Quarry Dispensary.

(ii) Turkana:**Government**Kaitulo Health Centre.
Turkwell Irrigation Scheme Dispensary.
Lopure Dispensary.**Mission**Lourenak Health Centre.
Kaputir Health Centre.
Kataboi Health Centre.
Lorugumu Health Centre.
Kapenjo Health Centre.
Lorugumu Dispensary.
Kalokio Health Centre.
Ile Dispensary.
Lokichoggio Dispensary.
Loylog Dispensary.
Oropoi Dispensary.
Larenga Dispensary.
Nanani Dispensary.
Mukutano Dispensary.
Kerio Dispensary.
Loiya Dispensary.
Gelinak Dispensary.
Kieruk Dispensary.
Machukui Dispensary.
Kodenyang Dispensary.
Kali Dispensary.
Namudaka Dispensary.
Todenyang Dispensary.
Loitanit Dispensary.
Kalobeyei Dispensary.
Lonkankai Dispensary.
Lokodule Dispensary.
Nadapal Dispensary.
Lochangamanalak Dispensary.
Juluk Dispensary.
Kaaling Dispensary.
Nachekwi Dispensary.
Kengolokerion Dispensary.**VII—Nyanza Province****1. GOVERNMENT HOSPITALS**New Nyanza Provincial General Hospital, Kisumu.
Old Nyanza Provincial General Hospital, Kisumu.
Victoria Amenity Hospital.
Kisumu Prison Hospital, Kodiaga.
Kisii District Hospital.
Homa Bay District Hospital.
Siaya District Hospital.
Nyamira Sub-District Hospital.**2. MISSION HOSPITALS**Kendu Bay Mission Hospital.
Maseno Mission Hospital.
Asurubi Mission Hospital.
Nyabondo Mission Hospital.
Lwak Mission Hospital.
Rang'ala Mission Hospital.
Tabaka Mission Hospital.
Sengera Maternity Hospital.
Mbuga Hospital.
Sega Mission Hospital.
Mirogi Hospital.
Rapogi Hospital.
Isibania Maternity Hospital.
Ulanda Maternity Hospital.
Rakwaro Maternity Hospital.
Matungaa Maternity Hospital.
Ombo Maternity Hospital.
Komotobo Maternity Hospital.
Nyamagwa Hospital.**NON-GOVERNMENT HOSPITAL**

Aga Khan Dispensary and Maternity Hospital.

COMPANY HOSPITAL

Miwani Nursing Home.

5. PRIVATE HOSPITALSLake Nursing Home.
Kisii Nursing Home.
Koru Nursing Home.
Christa Marianne Nursing Home, Kisii.
Nyangweso Maternity Home.
Siraga Maternity Home.
Ruloo Maternity Home.
Nyawita Maternity Home.
Getembe Nursing Home.**6. HEALTH CENTRES AND DISPENSARIES****(a) Municipality of Kisumu:****Government**Railway Dispensary.
Kisumu Technical School Dispensary.
Kibus G.K. Prison Dispensary.**Municipality**Kajulu Dispensary.
Lumumba Health Centre.
Chiza Mobile Dispensary.
Mosque Dispensary.
Ober Kamoua Dispensary.
Airport Dispensary.
Town Hall Dispensary.
Ojola Dispensary.**Private**Guru Nanak Dispensary.
Ramgharia Sikh Dispensary.**(ii) Kisumu:****Government**Muhoroni R.H. Demonstration Centre.
Muhoroni R.H. Demonstration Centre.
Ahero Health Centre.
Nyahera Health Centre.
Sigoti Health Sub-Centre.
Masogo Health Sub-Centre.
Raboor Dispensary.
Sondu Dispensary.
Nyangande Dispensary.
Kibigori Dispensary.
Siriba Dispensary.
Pap Onditi Health Sub-Centre.
Tamu Dispensary.
Kombewa Rural Health D. Centre
Chemelil Dispensary.
Kibus G.K. Prison Dispensary.
Nyamarimba Dispensary.
Nyangoma Dispensary.
Manyanda Dispensary.
Kibus Blind School Dispensary.
Kusa Dispensary.
Minara Dispensary.**Mission**Aluor Health Centre.
Chemelil F.G.C. of K. Dispensary.
Koru Catholic Dispensary.**Company**Chemelil Sugar Mills Dispensary.
Muhoroni E.A. Sugar Company Dispensary.**(c) Siaya District:****Government**Yala Demonstration Health Centre.
Bondo Health Centre.
Ukwala Health Centre.
Madiany Health Centre.
Tingare Dispensary.
Nyawara Health Sub-Centre.
Ndere Dispensary.
Marenyo Dispensary.
Alala Dispensary.
Udigu Dispensary.
Ong'ielo Dispensary.
Rwambwa Dispensary.
Got Agulu Dispensary.

SCHEDULE—(Contd.)

Antira Dispensary.
Sigomere Dispensary.
Boro Dispensary.
Uyawi Dispensary.
Malanga Dispensary.
Munyanda Dispensary.
Uranga Dispensary.
Rabar Dispensary.
Naya Dispensary.
Kera Dispensary.
Got Matar Dispensary.
Madiany Health Centre.

Mission

Nyamagwa Health Centre.
Sega Dispensary and Nursing Home.
Nyang'oma Dispensary.
Nyumbare Hill Dispensary.
Ngi'ya Dispensary.
Aluur Dispensary.

(d) Kisii:

Government

Marani Demonstration Health Centre.
Ndugu Demonstration Health Centre.
Ogembo Health Centre.
Keumbu Health Centre.
Ibena Health Centre.
Keroka Health Centre.
Manga Health Sub-Centre.
Nyumache Health Sub-Centre.
Chepngombe Dispensary.
Nyangema Dispensary.
Kenyanya Dispensary.
Tinga Dispensary.
Magombo Dispensary.
Nyamaya Dispensary.
Magwagwa Dispensary.
Ekerenyo Dispensary.
Riana Dispensary.
Kegogi Dispensary.
Isoge Dispensary.
Iranda Dispensary.
Etogo Dispensary.
Rantasha Dispensary.
Iyabe Dispensary.
Itego Dispensary.
Isani Dispensary.
Masimba Dispensary.
Raganga Dispensary.
Kisii C.K. Prison Dispensary.
Kiunokama Dispensary.
Ritumbur Dispensary.
Busiigo Dispensary.
Migengi Dispensary.
Sieka Dispensary.
Mageni Dispensary.
Nyamusi Dispensary.
Etono Dispensary.
Egena Dispensary.
Kiogoro Dispensary.

Mission

Iterio Health Centre.
Matongo Health Centre.
Rangenyo Health Centre.
Magenche Health Centre.
Moniaku Health Centre.
Kanyanya Dispensary and Maternity Home.
Riokindo Dispensary.
Gesusu Dispensary.
Rutumbe Health Sub-Centre.
Ritumbe Health Sub-Centre.
Nyasiogo Health Sub-Centre.

(e) South Nyanza:

Government

Sindo Demonstration Health Centre.
Isibanzi D. Health Centre.
Oyugis Health Centre.
Migori Health Centre.
Homa Lime Health Centre.
Kehanchu Health Centre.

Macalder Health Centre.
Awendo Health Centre.
Nduhiwa Health Centre.
Mbita Health Centre.
Kabondo Health Centre.
Karungu Health Centre.
Kamugambo (Rongo) Health Centre.
Mariwa Health Centre.
Ndiru Health Sub-Centre.
Rinya Health Centre.
Tom Mbuya Health Centre.
Mohuru Health Sub-Centre.
Sena (Mfangano) Health Centre.
Gwasi (Magunga) Dispensary.
Kadem Dispensary.
Kendu Bay Dispensary.
Marindi Dispensary.
Mfangano Dispensary.
Mirul Dispensary.
Moluru Dispensary.
Ntimaru Dispensary.
Pala Dispensary.
Rangwe Dispensary.
Taranganya Dispensary.
Uriri Dispensary.
Wagwe Dispensary.
Ogungo Dispensary.
National Youth Service (Lambwe) Dispensary.
Ongo Dispensary.
Atemo Dispensary.
Oluso Dispensary.
Kuja Dispensary.
Nyandango Dispensary.
Bware Dispensary.
Ober Dispensary.
Masaba Dispensary.
Kegonga Dispensary.
Rugumbe Dispensary.
Kandiego Dispensary.
Ndiwa Dispensary.
Adiedu Dispensary.
Oyami Dispensary.
Nyakuru Dispensary.
Got Oyaro Dispensary.

Mission

Tongo Health Centre.
Kaswanga (Mennonites) Health Centre.
Mawego Health Centre.
Rusinga Health Centre.
Kamaganibo Dispensary (Saye).
Ranen Dispensary.
Migori Dispensary.
Rukwuro Maternity.
Karuwa Dispensary.
Verna Maternity.
Mbita R.H.U. and Maternity Clinic.
Kadem Dispensary.
Uluada Health Centre.
Rapogi Mission Dispensary.
Boborera Mission Dispensary (Kuria).
Homa Bay Nutrition Rehabilitation Centre.

Company

South Nyanza Sugar Co. Clinic.

VIII—Western Province

1. GOVERNMENT HOSPITALS

Western Province General Hospital, Kakamega.
Bungoma District Hospital.
Alupe Leprosy Hospital.
Busia District Hospital.
Port Victoria Sub-Hospital.

2. MISSION HOSPITALS

Kima Mission Hospital.
Lugulu Mission Hospital.
Kaimosi Mission Hospital.
Mwhinda Mission Hospital.
Amukura Mission Hospital.
Butula Mission Hospital.
Eregi Mission Hospital.
Misikhu Mission Hospital.

SCHEDULE—(Contd.)

Mukumu Mission Hospital.
Mumias Mission Hospital.
Nangina Mission Hospital.
Maseno Mission Hospital.

3. HEALTH CENTRES AND DISPENSARIES

(a) Bungonia:

Government

Cwele Health Centre.
Dumala Health Centre.
Sirisia Health Centre.
Kinilili Health Centre.
Webuye Health Centre.
Kapsakwony Health Centre.
Mochimero Health Centre.
Ndalu Health Centre.
Kimalwa Health Centre.
Chekutuma Health Sub-Centre.
Malakisi Health Sub-Centre.
Kabuchai Dispensary.
Naitiri Dispensary.
Cheptaisi Dispensary.
Karima Dispensary.
Bungonia G.K. Prison Dispensary.
Ikokoli Dispensary.

Mission

Khasoko Mission Health Centre.
Kibabii Dispensary.
Kaptana Mission Dispensary.
Chesanisi Dispensary.
Kinilili Dispensary.
Muyekwe Dispensary.
Chwele Dispensary.
Dunyangu Health Centre.

Company

Nzoi Sugar Company Medical Clinic.
Pan Paper Co. Dispensary, Webuye.

(b) Kakamega:

Government

Mbale Rural Health Training Centre,
Igubu Health Centre.
Lyanaginga Health Sub-Centre.
Sabatia Health Centre.
Hansisi Health Centre.
Vihiga Health Centre.
Ebsuratsi Health Centre.
Khwisero Health Centre.
Butere Health Centre.
Matungu Health Centre.
Navakholo Health Centre.
Malava Health Centre.
Banja Health Centre.
Heho Health Centre.
Kilingili Health Centre.
Emuhaya Health Centre.
Lumakanda Health Centre.
Shama Khubu Health Centre.
Mautuma Health Centre.
Mabusii Health Centre.
Likhuyani Health Sub-Centre.
Tigoi Health Centre.
Bukura Health Centre.
Ipali Health Sub-Centre.
Turbo Forest Dispensary.
Kakamega G.K. Prison Dispensary.
Kakamega Forest Dispensary.
Shukusa G.K. Prison Dispensary.
Turbo N.Y.S. Dispensary.
Mumias Dispensary.

Mission

Dunyangu Health Centre.
Idudumi Health Sub-Centre.
Namasoli Maternity Home.
Ingotse Dispensary.
Enanga Dispensary.
Shianda Dispensary.
Tiriki Dispensary.
Vihiga Mission Dispensary.
Malindi Dispensary.
Sirwa Mission Dispensary.

Company

Mumias Sugar Co. Dispensary

Private

Shianda Dispensary.
Inaya Maternity Home.

(c) Busia:

Government

Kocholia Health Centre.
Nambale Health Centre.
Khuinyangu Health Centre.
Amukura Health Sub-Centre.
Sio Port Health Sub-Centre.
Nangina Dispensary.
Lukolis Dispensary.
Rukala Dispensary.
Angurai Health Centre.
Maduwa Dispensary.
Mukhobola Dispensary.
Nambuku Dispensary.

Mission

Kolanya A.I.M. Dispensary.

Gazette Notice No. 1216 of 16th April, 1981 is cancelled.

Dated the 30th July, 1982.

W. K. KOINANGE,
Director of Medical Service

GAZETTE NOTICE No. 3212

THE LAND ACQUISITION ACT

(Cap. 295)

NOTICE OF WITHDRAWAL

IN PURSUANCE of section 23 (1) of the Land Acquisition Act, I give notice that the Government withdraws from the acquisition in respect of the following land subject to hereinafter mentioned Gazette Notices:

SCHEDULE

L.R. No.	Locality	Area in Hectares
12248 (part)	Naivasha	8.82 (approx.)

Plans of the affected land may be inspected during office hours at the office of the Commissioner of Lands, Kencom House, Nairobi. Gazette Notice Nos. 2905 and 2906 of 31st October, 1979.

Dated the 19th October, 1982.

J. R. NJENGA,
Commissioner of Lands.

The health care staff profess an interest in providing family planning services, but lack the resources and training to do so. The nearest source of family planning is 5 kilometers away at Kilifi for those who can get to these headquarters, but considerably further away for those who live in the outlying areas. Over half of the employees are women.

Of the 2000 employees, presuming a five percent new contraceptive acceptance rate during the two year subproject, it should be possible to recruit and serve one hundred new acceptors.

D. INPUTS BY (THE GRANTEE)

1. Technical Assistance:

(The Grantee) provide up to two person weeks of technical assistance in such areas as records keeping and information management, contraceptive - logistics, planning, clinic management, evaluation etc.

2. Training:

(The Grantee) will provide funds for two months of motivational and clinical training for each of two enrolled nurses, as well as two months of such training for the clinical officer.

3. Supplies and Equipment

(The Grantee) will provide funds for supplies, office equipment, hand calculators and contraceptive-related equipment including an examining couch, IUD insertion kits, baby scales, etc.

4. Travel Allowance

(The Grantee) will provide a fixed - rate distance reimbursement of shs.3.0 per kilometer for family planning related travel.

E. INPUTS BY KENYA CASHEWNUTS LIMITED

The company will provide 80 sq.ft. of designated space for family planning in a new addition to be added to the present dispensary. It will make a vehicle available as needed for family planning and will be credited for depreciation for such vehicles as well as for depreciation on health/m.c.h. equipment.

F. INPUTS BY MINISTRY OF HEALTH

Contraceptive supplies for 100 new acceptors.

G. ADMINISTRATIVE ARRANGEMENTS

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award with Kenya Cashewnuts along the lines suggested herein. A Grant Award document will describe the terms and conditions of the Award. Final awarding of the Grant Award is conditional upon USAID approval, in consultation with the Government of Kenya.

H. EVALUATION:

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with requirements for evaluation established by (The Grantee).

FINANCIAL BUDGET

(IN 000'S)

SUB-GRANTEE: KENYA CASHEWNUTS LIMITED

S O U R C E USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX <u>1/</u>	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel				11.2						11.2
2. Technical Assistance <u>2/</u>	(4)								(4)	
3. Training		110.4								110.4
4. Supplies, Equipment	1.7	20.0							1.7	20.0
5. Travel Support.		12.5								12.5
6. Designated Space				12.0						12.0
7. Equipment Depreciation				30.0						30.0
8. Contraceptives						20.8				20.8
9. Other										
TOTAL		142.9		53.2		20.8				216.9
(\$ EQUIVALENT)	1.7	(11.0)		(4.1)		(1.6)			1.7	(16.7)

1/ U.S.\$ 1.00 = 13.00 K.SHS.2/ Expressed in person - months

Total cost expressed in U.S.\$ = \$ 18.4

USAID share = \$ 12.7, or 69%

All others share = \$5.7, or 31%

J-5

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: KENYA CASHEWNUTS LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX 1/	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel				11.2						11.2
2. Technical Assistance 2/	(.5)								(.5)	
3. Training		110.4								110.4
4. Supplies, Equipment	1.7	20.0							1.7	20.0
5. Travel Support:		12.5								12.5
6. Designated Space				12.0						12.0
7. Equipment Depreciation				30.0						30.0
8. Contraceptives						20.8				20.8
9. Other										
TOTAL		142.9		53.2		20.8				216.9
(\$ EQUIVALENT)	1.7	(11.0)		(4.1)		(1.6)			1.7	(16.7)

1/ U.S.\$ 1.00 = 13.00 K.SHS.

2/ Expressed in person - months

Total cost expressed in U.S.\$ = \$ 18.4

USAID share = \$ 12.7, or 69%

All others share = \$5.7, or 31%

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PROPOSED SUB-PROJECT DESCRIPTION AND BUDGET

2. DURATION: Start _____
 Finish _____

TITLE: Vipingo Sisal Family Planning

SUB-GRANTEE AGENT: Vipingo Estate Limited

AUTHORISED OFFICIAL: Karl Thür

TITLE: General Manager

MAILING ADDRESS: Vipingo Estate Limited

P. O. Vipingo Via Mombasa

Tel. Vipingo 4

A. Summary

The Vipingo Estate Limited will introduce and provide a wide range of clinical and non-clinical family planning services in its two clinics at Vipingo. At least 110 new acceptors of family planning will be recruited and served during the project. At the end of the project, the Vipingo Estate Limited will maintain the level of achievement reached during the project without further assistance from the Grantee.

B. Objectives

1. To introduce and maintain a wide variety of family planning services at the Vipingo Estates Limited.
2. To serve a minimum of 110 additional acceptors of family planning services.
3. To develop a capacity by the Vipingo Estates Limited to maintain or expand the level of family planning services achieved under the project without additional inputs from (The Grantee) after project termination.
4. To manage the sub-project with practices consistent with those of the Vipingo Estates Limited and (The Grantee).

C. Background

The Vipingo Estates Limited is a subsidiary of a company which began sisal operations in Tanzania in 1921. The Kenya plant was established in 1929. In recent years, the Estate has branched out into the production of cattle and mangoes, as well as sisal. The Estates are located in Coastal Province near Kilifi, along highway B.8. The Estate employs about 1,200, of which about 200 are women. Two thirds of the labour force live within five miles of the factory. The health facilities consist of two buildings (clinic and a maternity) at the headquarters, and a smaller dispensary perhaps 10 Kilometers north of the factory. These are managed by a male enrolled nurse, nurse-midwife, and dresser, respectively. The nearest family planning services are at the District hospital at Kilifi, but distance and transport are restrictive. The manager is very supportive of adding family planning to the health services in order to minimize

time loss and education costs. The midwife and enrolled nurse both seem anxious to add family planning. They have had previous work experience, but no formal training. Estimating 200 women, and 1000 men employees with an average of two wives each, an estimated 2200 women might be reached. Assuming 5 percent new acceptors during the two year subproject, about 110 new acceptors should be recruited.

D. Inputs by (The Grantee)

1. Technical Assistance

(The Grantee) will provide up to two person - weeks of technical assistance in such areas as baseline surveys, record management, medical/contraceptive supply management, supervisory techniques, planning, etc.

2. Training

(The Grantee) will arrange and fund family planning motivation and clinical training for the enrolled nurses and midwives; two months each.

3. Supplies and Equipment

(The Grantee) will provide funds for office equipment and supplies, and contraceptive related equipment such as an examination table, sterilize, rubber gloves, I.U.D. insertion kits, supply table, pelvic models etc.

4. Travel Expenses

A fixed rate distance reimbursement will be provided at the rate of K.shs.3/- per kilometer for family planning related travel.

E. Inputs by Vipingo Estates Limited

Designated office and family planning space. Attribution of the general Manager's time for 5 percent. Motor vehicle and maternal child health equipment depreciation.

F. Inputs by the Government of Kenya

Orals, condoms, foaming tablets and other contraceptive - related materials for 110 new acceptors.

G. Administrative Arrangements

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award along the lines suggested herein. The Grant Award document will describe terms and conditions of the Award. Final awarding of the Grant Award is conditional upon USAID'S approval, in consultation with the Government of Kenya.

H. Evaluation

Evaluation and reporting requirement will be developed by (The Grantee), and Grant Award recipients are required to comply with the requirements established by (The Grantee).

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: VIPINGO ESTATES LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		M O H		OTHER		TOTAL	
	FX <u>1/</u>	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel	-	-		45.0						45.0
2. Technical Assistance <u>2/</u>	(0.5)								(0.5)	
3. Training		73.6								73.6
4. Supplies, Equipment	1.7	20.0							1.7	20.0
5. Travel Support		9.4								9.4
6. Designated Space				12.0						12.0
7. Equipment Depreciation				30.0						30.0
8. Contraceptives						11.0				11.0
9. Other										
TOTAL	1.7	103.0		87.0		11.0				201.0
(\$ EQUIVALENT)		(\$7.9)		(6.7)		(0.9)			1.7	(15.5)

1/ U.S.S 1.00 = 13.00 K.S.H.S.

Total cost expressed in U.S. Dollar = \$17.2.

2/ Expressed in person - months

USAID Share = \$9.6 or 56%

All Other = \$7.6 or 44%

PROPOSED SUBPROJECT DESCRIPTION AND BUDGET

3. DURATION: START _____
FINISH _____

TITLE: EXPANSION OF FAMILY PLANNING SERVICES

SUB-GRANTEE AGENT: MIWANI SUGAR MILLS LIMITED

AUTHORIZED OFFICIAL: R. J. RAITHATHA

TITLE: DIRECTOR

MAILING ADDRESS: MIWANI SUGAR MILLS LIMITED
P. O. MIWANI
TELEPHONE 035-2716 OR 17

A. SUMMARY

Miwani Sugar Mills operates an extensive, quality health facility which serves its 2000 employees and their families plus patients from a large surrounding area. The hospital is staffed full time by about 35 health professionals. Family planning is included as part of a wide range of services but has been of relatively low priority. Top management and the company OB-GYNs strongly support upgrading this service and feel low or no cost supplies (non employees pay for contraceptives which Miwani purchases commercially) will greatly increase demand. They estimate 250 new acceptors during the first year. Equipment needs are modest and training inputs welcomed; a guaranteed supply of free contraceptives will be the cornerstone for continued high level support for sustaining, expanded family planning services. Space, MCH/FP related equipment and staff time committed by the company plus the value of GOK donated contraceptives will substantially exceed the 25% contribution requirement.

B. OBJECTIVES

1. To expand family planning services presently provided by the Miwani Sugar Mills health care facilities and to provide contraceptives free of charge.
2. To at least double the present new acceptors to 250 in the first year and to 400 in year two.
3. To develop a capacity to maintain the level of family planning services achieved under the project without additional inputs from (The Grantee) after project termination.
4. To manage the Subproject with practices consistent with those of the company and with the (Grantee)

C. BACKGROUND

Miwani Sugar Mills Limited, established in 1922, was taken over in 1948 by an English, Ugandan based company. The Company appears to be well managed. Mr. Raichatha, the director, has been with the company 20 years. In response to telephone contact on the morning of April 6, 1983, the director readily agreed to meet with the team that afternoon. After the nature of the project was described, he expressed keen interest in upgrading family planning services given by his company. He then provided basic information on the company and present health services.

Miwani Sugar Company employs 2,000 people full time; about 30 are women holding secretarial or clerical jobs. Employees receive housing, and facilities for schools, staffed by GOK teachers, are provided for their children. An estimated 3,000 workers' wives (polygamy is common in the area) and unspecified number of children live on the Miwani Estate. The Company encourages and helps support athletic and social clubs, such as Lions International. Quality health care is a major company benefit. Medical services (and apparently drugs) are free of charge to employees and their families. The company maintains an exceptional 200 bed hospital with a small operating room, outpatient clinic, and well stocked drug dispensary on the factory compound. Cases requiring major surgery are referred to hospitals in Kisumu. The Miwani health facility also serves patients from outside the company. An estimated 25,000 people, including workers and their families, within a surrounding 25 kilometer area regularly receive care. In addition, the facility draws people from as far as 200 and more kilometers because of its excellent reputation for care and adequate drug supply. Patients from outside the company pay for drugs (at cost), hospital rooms (K.shs.90/- for ward and 1,500/- for semi-private), and some selected, more complex outpatient services. MCH care is an important part of everyday services. There are about 50 deliveries a month, prenatal, postnatal and infertility care are well established, and an average of 20 family planning patients (one half new acceptors) are seen each month. The company purchases contraceptives from local commercial suppliers and charges patients at-cost prices for supplies. Presently, OCs are K.sh.20 - 50 per cycle, Depo Provera K.shs.60 per injection, and Copper IUCDs K.shs.165 (a Kisumu private physician reportedly charges K.shs.500/-); tubal ligation, however, is done free and average two per month. The company doctors feel their family planning acceptors would more than double if contraceptives were substantially cheaper. One of the physicians, a young Obstetrician gynecologist is very interested in family planning, was trained and active in such programs in India, and recently organized a family planning seminar for the company's Lions Club. He reported there were about 100 new acceptors as a result.

The hospital facility is staffed full-time as follows:

- 4 doctors (2 OB-GYs)
- 10 KRN's (4 midwife trained)
- 20 EN and CNs
- 1 pharmacist
- 1 stores/equipment manager.

⌋ The hospital serves the other two sugar mills in the region, Muhoroni, and Chemilil.

Spacious new wings to the hospital, office space, waiting area and drug dispensary have just been completed.

D. INPUTS BY GRANTEE:

- a. Personnel - none
- b. Technical Assistant - Project planning and project required record keeping, community outreach, etc.
- c. Training - upgrade family planning techniques for selected EN and CN and refresher courses for KRN's (total 15 nurses).
- d. Travel expenses - for supplies surveys, outreach and other project related travel.
- e. Equipment and supplies.

- IUD insertion kits	4
- Pelvic models	2
- Examining tables	3
- Desk	1
- Chairs	3
- File cabinet	1
- Sterilizer	1
- Rubber gloves	1500
- Laperascope or mini laperascope kits	2
- Auto clave	1
- Lamp with stand	1
- Additional surgical equipment	to be determined.

E. INPUTS BY MIWANI SUGAR MILLS

- Designated office space for two staff
- Back-up administrative support
- Physician services
- Operating theatre for female sterilization
- Designated space for family planning services
- Staff for training, service provision
- MCH related health equipment
- Participation in baseline surveys and records keeping.

F. INPUTS BY GOK

Orals, condoms, foaming tablets, diaphragms, IUCDs and other contraceptive related materials.

G. ADMINISTRATIVE ARRANGEMENTS

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award along the lines suggested herein. A Grant Award

document will describe the terms and conditions of the Award. Final awarding of the Grand Award is conditional upon USAID's approval in consultation with the Government of Kenya.

H. EVALUATION

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with requirements established by (The Grantee).

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INDICATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: MIWANI SUGAR MILLS LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX 1/	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		48		372						420
2. Technical Assistance <u>2/</u>	($\frac{1}{2}$)								($\frac{1}{2}$)	
3. Training		537								537
4. Supplies, Equipment	3.6	40							3.6	40
5. Travel Support.		36								36
6. Designated Space				72						72
7. Equipment Depreciation				60						60
8. Contraceptives						65				65
9. Other										0
TOTAL	3.6	661		504		65				1230
(\$ EQUIVALENT)	-	(50.8)		(38.8)		(5)			3.6	(94.6)

1/ U.S.\$ 1.00 = 13.00 K.SHS.

2/ Expressed in person - months

Total Cost in \$U.S. = \$98.2

USAID Share \$54.4 = 55.4%

All Other \$43.8 = 44.6%

PROPOSED SUBPROJECT DESCRIPTION AND BUDGET

4. DURATION: START _____
FINISH _____

TITLE: Augmentation of FP/MCH Services

SUB-GRANTEE AGENT: Protestant Church Medical Association (PCMA)

AUTHORIZED OFFICIAL: Dr. Geoffrey Irvine

TITLE: Medical Coordinator

MAILING ADDRESS: Dr. Geoffrey Irvine
Protestant Church Medical Association
1st Avenue, Eastleigh,
P. O. Box 17106,
Nairobi (Tel.64432).

A. SUMMARY:

The PCMA will introduce or augment the delivery of a wide range of clinical and non-clinical family planning services in ten (10) of its network of 51 clinics and 15 hospitals.

Each of the 10 sites, serving an average of 6000 population each, will recruit and serve at least one hundred (100) new acceptors of family planning. At the completion of the subproject, the 10 sites will maintain the level of achievement reached during the subproject without further assistance from (The Grantee).

B. OBJECTIVES:

1. To introduce or augment MCH/FP service delivery in ten (10) PCMA affiliated hospitals or dispensaries now providing no or inadequate F.P. services.
2. To serve a minimum of at least one hundred (100) additional acceptors of family planning services at each of the 10 service delivery points.
3. To develop a capacity by PCMA to maintain the level of family planning services achieved under the project without additional inputs from (The Grantee) after project termination.
4. To manage the Subproject with practices consistent with the PCMA and with the (Grantee).

C. BACKGROUND:

The PCMA is an affiliation of most of the Protestant medical providers in Kenya, and currently is composed of 15 hospitals and 51 clinics/dispensaries under separate management. The PCMA managerially has been very weak (Contribution by AND FUTURE POTENTIAL OF THE PCMA in the Delivery of Health Services in Kenya, Dr. Gordon W. Brown, CORAT, 3 December, 1982), a situation which should change markedly 1 June, 1983 when Dr. Geoffrey Irvine (now with Chogoria Hospital)

becomes full time medical Director in an expanded PCMA Management capacity made possible by funds from the multidonor "Integrated Rural Health and Family Planning Project." In addition to improving management capability, that Project will upgrade 18 PCMA service delivery points. Many other of the PCMA dispensaries have indicated willingness to provide family planning services, but lack the trained staff, supplies and equipment to do so. This subgrant will enable PCMA to introduce or augment F.P. services in 10 of the facilities not being assisted by the multidonor Project. It is the intent of this activity to provide PCMA with staff, funds, supplies, equipment and technical assistance to enable these ten as yet unidentified sites to become service delivery points efficiently providing modern family planning services.

D. Inputs by (The Grantee)

1. To PCMA

a. Personnel - A Project Director and secretary will be provided to PCMA for the grant period. It is anticipated that at the end of the Project, the ten sites will be self sufficient, and the need for these personnel will cease, unless PCMA continues funding the positions to establish additional service delivery points.

b. Technical Assistance

(The Grantee) will provide PCMA up to 4 man months of Technical Assistance in such areas as medical/contraceptive supply management, information management, supervisory techniques, planning, community outreach, etc.

c. Training

(The Grantee) will arrange and fund family planning motivation and clinical training for two persons from each facility for two months each (40 person months). Additionally, funds will be provided for three- three day conferences to be held in Nairobi or elsewhere for clinical and/or managerial short courses and information exchange among the subproject personnel and other interested parties.

d. Supplies and Equipment

(The Grantee) will provide funds for office supplies, postage, telephone, office equipment, desks, chairs, wastepaper baskets, file cabinets, an electric typewriter, flip charts, etc) and desk calculators.

e. Travel Expenses

A fixed rated mileage reimbursement will be provided at the rate of shs.3/- per kilometer, and a per diem of shs.300/- per day to permit the project director to visit each site at least once monthly for administrative, supervisory and data coordination purposes.

2. To each of 10 sub units

a. Prior to implementation, the ten subproject sites will be identified and a needs assessment made by PCMA from among facilities not being assisted by the Integrated Rural Health and Family Planning Project. A Grant Award will be prepared by the Grantees' Technical Assistance Team, and approval sought from USAID. The following supplies and equipment list is illustrative only.

a. Hand held calculators with batteries,	2 per unit
b. IUD inserting kits	2 " "
c. Pelvic models	1 " "
d. Examining table	1 " "
e. Desk	1 " "
f. Chairs	3 " "
g. File cabinet	1 " "
h. Sterilizer	1 " "
i. Rubber gloves	1500 " "

3. To Hospital

In the event one or more hospitals are selected as service delivery points, needs likely will be more extensive, and in addition to items similar to above, may require additional surgical equipment, minilap kits, etc.

E. INPUTS BY PCMA

- Designated office space for two staff
- Duplicating machine depreciation
- Back-up administrative support
- Motor vehicles depreciation

F. INPUTS BY MCH

Orals, condoms, foaming tablets, diaphragms and other contraceptive related materials for 10 units.

G. INPUTS BY SERVICE SITES

- Designated space for family planning services
- Provide staff for training, service provision
- MCH related health equipment, i.e.
 - Sphygmometers
 - Laboratory access
 - Stethoscopes
 - Baby Scales
- Participation in baseline surveys and records keeping.

H. ADMINISTRATIVE ARRANGEMENTS

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award with PCMA along the lines suggested herein. A Grant Award document will describe the terms and conditions of the award. PCMA will select the 10 service points with its constituent members. Final awarding of the Grant Award is conditional upon USAID approval, in consultation with the Government of Kenya.

I. EVALUATION

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with requirements established by (The Grantee).

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: Protestant Church Medical Association

SOURCE	GRANTEE		SUB-GRANTEE		G O K		OTHER		TOTAL	
	FX 1/	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		352.8		22.5				450.0		825.3
2. Technical Assistance 2/	(4)								(4)	
3. Training		851.0								851.0
4. Supplies, Equipment	25.2	220.0							25.2	220.0
5. Travel Support		21.0								21.0
6. Designated Space				24.0				6.0		30.0
7. Equipment Depreciation				30.0				300.0		330.0
8. Contraceptives						104.0				104.0
9. Other										
TOTAL	25.2	1444.8		76.5		104.0		756.0		2381.3
(\$ EQUIVALENT)		(111.1)		(\$5.9)		(0.8)		(\$58.2)	25.2	(183.3)

1/ U.S.S 1.00 = 13.00 K.S.H.S.

2/ Expressed in person - months

Total Cost, expressed in U.S. Dollar = \$208.4

USAID Share = \$ 136.3 or 65.4%

All others = \$ 72.1 or 34.6%

PROPOSED SUBPROJECT DESCRIPTION AND BUDGET

5. DURATION: START _____
 FINISH _____

TITLE: Associated Sugar Company Limited Family Planning

SUB-GRANTEE AGENT: Associated Sugar Company Limited

AUTHORIZED OFFICIAL: Ramanahai M. Patel

TITLE: Director

MAILING ADDRESS: Associated Sugar Company Limited,
 P. O. Box 90134,
 MOMBASA.

TEL: MSAEWENI 3 AND 11
 MOMBASA 23703
 313045

A. Summary

The Associated Sugar Company Limited, will introduce and provide a wide range of clinical and non-clinical family planning services in its hospital/clinic and throughout the sugar plantation at Ramisi. At least 225 new acceptors of family planning will be recruited and served during the project. At the end of the project, the Associated Sugar Company Limited will maintain the level of achievement reached during the project without further assistance from (The Grantee).

B. Objectives

1. To introduce and maintain a wide variety of family planning services at the Associated Sugar Company Limited plantation and factory at Ramisi.
2. To serve a minimum of 225 additional acceptors of family planning services.
3. To develop a capacity by the Associated Sugar Company Limited to Maintain or expand the level of family planning services achieved under the project without additional inputs from (The Grantee) after project termination.
4. To manage the subproject with practices consistent with those of the Associated Sugar Company Limited and (The Grantee).

C. Background

The Associated Sugar Company Limited is a privately held plantation and processing plant headquartered at Ramisi, Coastal Province, Kenya. The complex extends 10 miles south and 12 miles north from the headquarters/factory, paralleling high A.14 south of Mombasa near the Tanzania border. The complex employs about 1500 men and 1200 women, mostly permanent employees (many Luo tribesmen migrated from Western Kenya), and provides free medical care to them, their dependants, and to additional peoples from the surrounding area when needed. The hospital/clinic occupies a series of three 2 - 4 room buildings in the headquarters area. The Medical Director,

Dr. S.A.C. Raja, has been resident five years. Previously, he worked actively in family planning in Madras, India, and received an award for performing 6000-7000 vasectomies in a 2 - 3 year period there. 15 "dressers", and 7 other employees provide daily curative medical services at 7 small dispensaries scattered throughout the complex. Many of the health workers have been employed up to 20 years, but none are graded. Dr. Raja's participation in family planning at Ramisi has been to cooperate with the irregular visits by the Family Health Field Workers from Msambweni district hospital, and to provide advisory services infrequently to employees/dependants. The Director and the Doctor both seem keen to provide family planning services, but have been hampered by lack of resources due to the depression of international sugar prices in recent years.

This project will provide one added staff (enrolled community nurse), training, limited equipment and supplies, and transportation expenses to enable the company to provide easy access to family planning services throughout the plantation, as the nearest source of family planning services currently is at Msambweni hospital, about 15 kilometers from Rimisi.

D. Inputs by (The Grantee)

1. Personnel - an enrolled community nurse will be funded for the two year project duration.

2. Technical Assistance

(The Grantee) will provide up to one man month of technical assistance in such areas as baseline data gathering and information management, medical/contraceptive supply management, supervisory techniques, planning, community outreach, etc.

3. Training

(The Grantee) will arrange and fund family planning motivation and clinical training for the enrolled community nurse, and perhaps lesser amounts (up to one week each) for 2 - 3 ungraded personnel, if it can be shown such training will benefit materially the activity.

4. Supplies and Equipment

(The Grantee) will provide funds for office supplies, office equipment (desk, chair, wastepaper basket, fire cabinet, flip charts, etc), and two hand held calculators. Additionally, contraceptive related equipment will be provided, such as an examination table, sterilizers, rubber gloves, IUD insertion kits, supply table, pelvic models, sphygmometer, baby scales, etc.

5. Travel Expenses

A fixed rate mileage reimbursement will be provided at the rate of shs.3/- per kilometer, as well as a per diem for the medical director should he be requested by (The Grantee) to attend project-related conferences.

E. Inputs by Associated Sugar Company Limited

Designated office and examining room space for one new staff.
Utilization of the medical director for 10 per cent of his time.
Back up administrative and secretarial support. Motor vehicle depreciation.

F. Inputs by the GOX

Orals, condoms, foaming tablets, diaphragms, and other contraceptive related materials for 225 new acceptors.

G. Administrative Arrangements

After USAID selects a technical assistance grantee, that firm will negotiate a Grant Award along the lines suggested herein. The Grant Award Document will describe terms and conditions of the award. Final awarding of the Grant Award is conditional upon USAID's approval, in consultation with the Government of Kenya.

H. Evaluation

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with the requirements established by (The Grantee).

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: ASSOCIATED SUGAR COMPANY LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX 1/	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		84.0		45.0						129.0
2. Technical Assistance 2/	(1)								(1)	
3. Training		46.9								46.9
4. Supplies, Equipment	1.7	20.0							1.7	20.0
5. Travel Support		31.2								31.2
6. Designated Space				45.0						45.0
7. Equipment Depreciation				30.0						30.0
8. Contraceptives						23.4				23.4
9. Other										
TOTAL	1.7	182.1		120.0		23.4				325.5
(\$ EQUIVALENT)		(\$14.9)		(\$9.2)		(1.8)			1.7	(25.0)

1/ U.S.\$ 1.00 = 13.00 K.S.H.S.

2/ Expressed in person - months

Total cost, expressed in U.S. Dollars = \$26.7

USAID cost = \$15.7 or 58.8%

All Others cost = \$11.0 or 41.2%

PROPOSED SUBPROJECT DESCRIPTION AND BUDGET

6. DURATION: START _____
FINISH _____

TITLE: KENYA CANNERS LIMITED, FAMILY PLANNING

SUB-GRANTEE AGENT: KENYA CANNERS LIMITED

AUTHORIZED OFFICIAL: MR. WALLACE MANTU

TITLE: PERSONNEL AND INDUSTRIAL RELATIONS MANAGER

MAILING ADDRESS: MR. WALLACE MANTU
KENYA CANNERS LIMITED
P. O. BOX 147
THIKA TEL. THIKA 21601
21600

A. SUMMARY

The subproject will enable Kenya Cannners Limited to add a wide variety of family planning services to its factory dispensary and to the four smaller dispensaries throughout its pineapple - coffee plantation near Thika. During the two year life of the sub-project, Kenya Cannners Limited will recruit and serve 300 additional users of modern family planning services. At the end of the sub-project, Kenya Cannners will maintain the level of achievement reached during the sub-project, without further assistance from (The Grantee).

B. OBJECTIVES

1. To introduce modern family planning service delivery in the five dispensaries of the Kenya Cannners Limited.
2. To recruit and serve at least three hundred (300) additional accpetors of family planning services.
3. To develop a capacity by Kenya Cannners Limited to maintain or exceed the level of achievement reached during the sub-project, without additional inputs from (The Grantee). termination.
4. To manage the sub-project with practices consistent with management practices of Kenya Cannners Limited and (The Grantee).

C. BACKGROUND

The Kenya Cannners Limited is the largest American related (Del Monte) employer in Kenya, employing about 6000. Its headquarters and main plantation are at Thika, about 55 kilcmeters north of Nairobi. The Planta-tion contains 14,000 acres planted in pineapple, and 11,000 planted in coffee.

Curative medical services are provided at a factory dispensary by a clinical officer, who receives supervision one hour daily by a part time contract physician. Four other dispensaries are spaced along a 30 kilometer road extending from the headquarters, and are staffed by an aggregate of 6 enrolled nurses and 4 ungraded nurses. (There are no clerical personnel in these latter facilities). These four dispensaries are under the medical supervision of a second contract physician, Dr. Wamitha Kirika (Box 1450, Thika, Office telephone 21124; home 22677). Dr. Kirika is a pediatrician with public health training and has a long and active interest in family planning including surgical contraception. Her practice is a general one. Her offices, about 10 kilometers away, are in the same building as that of Dr. J. McAllan, a pioneer in family planning in Kenya, and nurse Lydia Muchara, who is practising as a nurse practitioner specialising in family planning clinical service delivery.

Delmonte workers now seeking family planning services must take off work, pay shs.30 round trip to Thika, and visit either the MOH hospital (long queues) or relatively expensive private facilities.

The company at one time provided family planning services under the auspices of a social worker. After her departure, however, her replacement apparently did not share this interest, and the services 'disappeared.' Management is keen to introduce family planning in order to reduce time loss, and Dr. Kirika, who will be the general medical supervisor, is fully supportive.

Of the 6000 employees, 4000 (half women) work on the plantation, and 2000 (1420 women) at the plant. Assuming a five percent new acceptance of family planning services in these 6000 employees, approximately 300 new acceptors should be added during the two year sub-project.

D. INPUTS BY (THE GRANTEE)

1. Personnel

(The Grantee) will provide a record keeping officer to help develop an efficient method of record keeping. After the sub-project ends, this function may no longer be needed. Alternatively, Kenya Cannery may extend his/her employment.

2. Technical Assistance

(The Grantee) will provide Kenya Cannery Limited with up to three person months of technical assistance in such areas as medical and contraceptive logistics, clinic management, supervisory techniques, baseline data gathering, information management, evaluation, planning, etc.

3. Training

(The Grantee) will arrange and fund family planning motivation and clinical training for two months each for each of the six existing enrolled nurses, and for four additional enrolled nurses if hired (as planned) by the company. Such training will assure that there will be a motivated and trained person at all times at each of the five facilities. Additionally, two months similar training will be provided by the clinical officer.

4. Supplies and Equipment

(The Grantee) will provide funds for office equipment and furniture (including file cabinets), flip charts, and contraceptive related supplies and equipment, including IUD insertion kits, rubber gloves, examining couches, pelvic models, pregnancy testing kits, etc. Additionally, should Dr. Kirika obtain refresher training as planned, a minilap kit shall be provided for her clinic use.

E. INPUTS BY THE KENYA CANNERS LIMITED

1. Personnel

Medical supervision by the medical consultant throughout the life of project. Add services of 4 enrolled nurses, who will spend one fourth of time with family planning.

2. Travel Support

Provide transportation to clinics for services and logistic purposes. 150 km/week.

3. Designated Space

Provide a total of 100 square feet for family planning service delivery.

4. Equipment Depreciation

Provide general mch equipment and vehicles.

F. INPUTS BY GOVERNMENT OF KENYA

Sufficient contraceptives for 300 additional users.

G. ADMINISTRATIVE ARRANGEMENTS

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award with the Kenya Cannners Limited along the lines suggested herein. A Grant Award document will describe the terms and conditions of the Award. Final awarding of the Grant Award is conditional upon USAID's approval, in consultation with the Government of Kenya.

H. EVALUATION

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with requirements established by (The Grantee).

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: KENYA CANNERS LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX <u>1/</u>	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		96.0		106.0						202.0
2. Technical Assistance <u>2/</u>	(3)								(3)	
3. Training		393.8								393.8
4. Supplies, Equipment	5.7	40.0							5.7	40.0
5. Travel Support				15.6						15.6
6. Designated Space				15.0						15.0
7. Equipment Depreciation				30.0						30.0
8. Contraceptives										
9. Other						30.0				30.0
TOTAL		529.8		166.6		30.0				726.4
(\$ EQUIVALENT)	5.7	(40.8)		(12.8)		(2.3)			5.7	(55.9)

1/ U.S.\$ 1.00 = 13.00 K.SHS.2/ Expressed in person - months

Total costs expressed in U.S.\$ = \$62.6

USAID share \$46.5 = 75.5%

All Other shares \$15.1 = 24.5%

PROPOSED SUBPROJECT DESCRIPTION AND BUDGET

7. DURATION: START _____
FINISH _____

TITLE: UPGRADE PRESENT AND EXPAND ELIGIBILITY :
FAMILY PLANNING SERVICES

SUB-GRANTEE: NZOIA SUGAR COMPANY LIMITED

AUTHORISED OFFICIAL: MR. RICHARD ONGECHE ONYANGO

TITLE: GENERAL MANAGER

MAILING ADDRESS: NZOIA SUGAR COMPANY LIMITED
P. O. BOX 285
BUNGOMA
TEL.81, 129
TELEX 31096 NZUCO.

A. SUMMARY:

Nzoia Sugar Company Limited provides basic health care in a facility on the company compound. It is staffed full time by a doctor, two clinic officers and four nurses. Family planning (OCS) is included as part of health service to 3000 permanent and 3000 casual workers and their families but receives lesser attention partly because:

- 1) the company purchases OCs from the commercial trade, and
- 2) company policy requires a small service fee for health care for workers' wives and children (K.sh.5/- and K.sh.2/- respectively).

The General Manager, a board member of the FPAK, and doctor enthusiastically support upgrading family planning service delivery. An estimated 1000 new acceptors from workers' families (and perhaps another 225 from 6000 area farm families if company client service policies change) can be recruited based on informal family planning acceptor and other data provided by the company. Personnel, equipment needs and costs for training are relatively low although substantial technical assistance for family planning clinic management may be needed. Nzoia's management appears receptive to assistance and participation as long as company profitability potential is not jeopardized. A continuing and steady supply of free contraceptives is critical to commitment to maintain any level of service resulting from the two year subproject. Space and staff time contributed by Nzoia plus value of contraceptives donated by the GOK will equal about half the total subproject costs.

B. OBJECTIVES:

1. To upgrade FP service delivery to full-time company employees, and to expand to casual labourers (and possibly to local cane farmers).
2. To serve a minimum of at least 900-1000 additional acceptors of family planning services from company employee families (and possibly another 225 farm families).

3. To develop a capacity to maintain the level of family planning services achieved under the project without additional inputs from (The Grantee) after project termination.
4. To manage the Subproject with practices consistent with Nzoia Sugar Company and with the (Grantee).

C. BACKGROUND:

Nzoia Sugar Company Limited, a government parastatal incorporated in 1975, became operational in Western Province late in 1978. The Company is 97.5% GOK and local Kenyan and 2.5% French (Fives-Cail Babcock) owned. Management is under the direction of a government appointed director while some technical assistance is provided by a French subcontractor. Forty percent of the cane processed by the plant is grown on company owned land, and 60% is purchased from local farmers who are assisted by the company with ploughing, obtaining seed, farming techniques, and crop transport. Farmers also are advised on other cash crop and livestock production. The local population benefits from water, sewage, electricity and other services brought to the area as a result of the company's establishment. The company is justifiably proud of the health services available to company employees and their families. The General Manager was very responsive to participating in the overall project and saw substantial need for upgrading family planning services. He is a member of the FPAK board of Directors.

Nzoia employs about 3000 permanent and another 3000 "casual" labourers. Full-time workers either are housed on the estate (300 company-owned units) or receive housing and transport allowance. Approximately 250 are managers and supervisors; only 30 or so women are employed, most as secretaries. The remaining 2,500 or so full-time workers are unionized while casual workers are not. The union has negotiated with company management to provide medical care free for members and at a modest fee for their families; wives, e.g. pay K.shs.5/- and each child K.shs.2/- per visit to the company health facility. Since polygamous marriages are common in the area (reportedly many husbands have 2 or 3 wives), multiple wives and their offspring pay higher fees. Family planning services are offered on a limited scale: of the 250 patients (150 of which are women) seen weekly, about 10 come for family planning and only OCs (occasionally Depo Provera) are provided. Three Schering formulations and Wyeth's Nordette are purchased from commercial distributors at trade prices. (The General Manager reported that K.shs.1.2 million had been spent for such contraceptive supplies in the past). Requests for sterilization are referred to the District Hospital at Bungoma or to private physicians. The hospital also sends an MCH team to the company once a month for MCH/FP education. Both the General Manager and the company physician, Dr. A. J. Muyumbu, stated company commitment to family planning services would be strengthened by a ready supply of both a range and free supply of methods. They saw no problem in serving both

permanent and casual workers but preferred to test any new system resulting from a subproject agreement before committing the company to providing service delivery to the 6000 farm families who grow and supply cane. The total number of workers' wives is estimated at 9,000 (conservatively assuming 1.5 wives per worker). If new acceptors can be generated at 5% per annum level, there is a potential for 900-1000 acceptors. Should company policy in year 2 include farm families, half that number (2.5% acceptors) would add an additional 225, or about 1,200 total acceptors from a potential 13,500 women connected in some way to the factory.

The health facility employs the following staff:

- 1 full-time doctor
- 2 clinic officers
- 1 KRN
- 1 EN
- 2 CN

The facility is targeted for expansion as soon as possible, and space for family planning services easily should be available according to the doctor and General Manager.

D. Inputs (by Grantee)

- a. Personnel - one full-time MCH/FP trained nurse and one helper for general assistance and clean-up.
- b. Technical assistance - project planning, Family Planning clinic management, record keeping, inventory and supplies management, motivational techniques and community outreach, financial management.
- c. Training - full curriculum in family planning for present EN and one or both CNS.
- d. Travel expenses - for supplies, surveys, outreach and other project related travel.
- e. Equipment and supplies.

- Sterilizer	1
- Angled lamp	1
- Adult Scale	1
- Hand held calculators with batteries	2
- IUD insertion kits	2
- Pelvic models	1
- Examining table	1
- Drape and Stand	1
- Desk	1
- Chairs	3
- File Cabinet	1
- Sterilizer	1
- Rubber gloves	1500
- Additional equipment	to be determined.

E. Inputs by Nzoia

- Designated Office space
- Back-up administrative support
- Motor vehicles depreciation
- Designated space for family planning services
- Staff for training, service provision
- MCH related health equipment, e.g.
 - Sphygmometers
 - Laboratory access
 - Stethoscopes
 - Baby Scales

Participation in baseline surveys and records keeping.

F. Administrative Arrangements

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award along the lines suggested herein. A Grant Award document will describe the terms and conditions of the Award. Final awarding of the Grant Award is conditional upon USAID's approval in consultation with the Government of Kenya.

G. Inputs by MCR

Orals, condoms, foaming tablets, IUCDs, diaphragms and other contraceptive related materials.

H. Evaluation

Evaluation requirements will be developed by (The Grantee), and Grant Award recipients are required to comply with requirements established by (The Grantee).

ILLUSTRATIVE BUDGET

(IN 000'S)

SUB-GRANTEE: NZOLA SUGAR COMPANY LIMITED

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX <u>1/</u>	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		236		297						533.0
2. Technical Assistance <u>2/</u>	(1)								(1)	
3. Training		110.4								110.4
4. Supplies, Equipment	1.6	19.2							1.6	19.2
5. Travel Support		72.0								72.0
6. Designated Space				40.5						40.5
7. Equipment Depreciation				30.0						30.0
8. Contraceptives						202.5				202.5
9. Other										0
TOTAL		437.6		367.5		202.5				1007.6
(S EQUIVALENT)		(33.7)		(28.3)		(15.6)			(1.6)	(77.5)

1/ U.S.\$ 1.00 = 13.00 K.SHS.

Total Cost in U.S.S = 77.5

2/ Expressed in person - months

USAID Share = 45%

All Other = 55%

B. OBJECTIVES:

1. To introduce family planning service delivery through five (5) and, by 1984, seven (7) mobile units operated by LEDA in five districts of Nyanza and Western Provinces.
2. To serve a minimum of 5,250 new acceptors of family planning.
3. To develop a capacity by LEDA to maintain the level of family planning services achieved under the project without additional inputs by (the contractor) after project implementation.
4. To manage the subproject with practices consistent with LEDA and the (contractor to be selected by AID).

C. LEDA, a parastatal development agent, operates in the two heavily populated (7.5 million) provinces of Nyanza and Western. Their activities cover a wide range of development projects including MCH but no family planning services. LEDA attempts to communicate to target populations the synergistic relationships among development concerns and activities. Administration, however, is divided into four departments, and each department has separate divisions responsible for discrete areas of activity (see Attachment A). The Public Health Division is one of eight divisions within the Operations Department, which oversees technical field activities under the LEDA mandate. The Public Health Specialist, Dr. J. G. C. Amolo, is responsible for all environmental health, preventive programs, entomology, and research; LEDA presently is searching for staff to head each area under his direction.

Current LEDA activities focus on five of the seven districts within Nyanza and Western Provinces - South Nyanza, Siaya, Kisumu, Bungoma and Busia - with a total population of about 6 million. Two other districts, Kakamega and Kisii, even more densely populated, soon will be included in the service area. (see Attachments B). MCH Care, conceptually integrated with other LEDA programs, is delivered through five Land Rover Mobile Units. A donation of two more by the CDC is anticipated later this year. Each mobile unit is assigned to a district and has a regular monthly round of designated stops. The maximal plan calls for a schedule of stops which will bring services to all at no greater than 2 kilometers walking distance. Two field teams, each comprised of a Ministry of Health community nurse and a records keeper, are attached to each unit. After one year of operation, this delivery system attracts ever increasing numbers as more and more people become aware of the schedule and services provided. Presently emphasis is on immunizations for children (e.g. DPT) and tetanus injections for pregnant women.

Dr. Amolo already has planned to incorporate family planning into the Ministry of Health mobile delivery system, and he is very interested in participating in the project. He sees great potential for promoting and for satisfying latest demand for family planning among the women who already utilize the mobile delivery system.

Based on a plan Dr. Amolo had been developing to stimulate demand for family planning and to resupply contraceptives between monthly mobile unit stops, he suggests selecting a cadre of about 200 local married couples (perhaps 6 per village) who would act as volunteer family planning workers to counsel and resupply contraceptives. This cadre plus routine, regularized contacts by the mobile vans would, he feels, provide an attractive family planning system for huge numbers of couples.

An estimated 70,000 - 80,000 women currently seek MCH services in the five districts. (This estimate is supported by extrapolation from 9,933 actual child immunizations done in two districts over a 4 month period: $9,933 \times 3 = 29,799$ annual $\times 2.5$ or 5 districts = 75,000.) Dr. Amolo, in fact, indicates a potential for ultimate access to 700,000 - 800,000 women (60% of the fertile women in Nyanza and Western Provinces) with MCH units. Even with a modest estimate of reaching 5% of women currently utilizing MCH services in the five districts over a two year subproject period, 3,750 new acceptors can be added through the LBAD; if all seven districts are reached, 5% represents 5,250 new acceptors ($30,000 \times 3.5 = 105,000 \times 5\%$). Dr. Amolo suggests 30% of MCH clients will seek family planning services, thus yielding potential acceptor figures of 22,500 in five districts or 31,500 in seven.

D. INPUTS (BY CONTRACTOR TO BE SELECTED BY USAID)

- a. Personnel - 1 trained, full-time nurse and one administrative assistant plus, perhaps, a volunteers coordinator.
- b. Technical assistance - assistance with financial, clinic and supplies management, record keeping, motivational techniques, volunteer teaching, etc.
- c. Training - full curriculum in family planning for present Ministry of Health deployed community nurses, training as needed for present record keepers, and training a possible volunteers coordinator.

d. Supplies and equipment

"Examining room" tent for each unit	5 - 7
Vehicle for field supervision	1
Teaching material package for volunteers	3
Hand held calculators with batteries	2 per unit
IUD inserting kits	2 " "
Pelvic models	1 " "
Examining table	1 " "
Desk	1 " "
Chairs	3 " "
File cabinet	1 " "
Sterilizer	1 " "
Rubber gloves	1500 " "

- e. Travel expenses - for supervisory activities, mobile unit site inspections, client surveys, and training/coordination of possible village volunteer cadres.

INPUTS BY LEDA

- transport of tents, equipment and supplies on mobile units
- designated office space for staff in Kisumu headquarters
- medical services of mobile unit teams and time for training
- back-up administrative support
- mobile unit and equipment depreciation
- staff for training in project record keeping

F. INPUTS BY MINISTRY OF HEALTH

- orals, condoms, foaming tablets, diaphragms, IUCDs and other contraceptive related materials for 5 - 7 mobile units
- community nurses for training

G. ADMINISTRATIVE ARRANGEMENTS

After USAID selects a technical assistance Grantee, that firm will negotiate a Grant Award with LEDA along the lines suggested herein. A Grant Award document will describe the terms and conditions of the award. Final awarding of the Grant Award is conditional upon USAID approval in consultation with the Government of Kenya.

H. EVALUATION

Evaluation requirements will be developed by the (The Grantee), and Grant award recipients are required to comply with requirements established by (The Grantee).

ADMINISTRATIVE BUDGET

(IN 000'S)

SUBGRANTEE: LBDA

SOURCE USE	GRANTEE		SUBGRANTEE		G O K		OTHER		TOTAL	
	FX 1/	LC	FX	LC	FX	LC	FX	LC	FX	LC
1. Personnel		300		507						807.0
2. Technical Assistance 2/	(2)								(2)	
3. Training		668.1								668.1
4. Supplies, Equipment	11.3	277.9							11.3	277.9
5. Travel Support.		280								280.0
6. Designated Space				476						476.0
7. Equipment Depreciation				210						210.0
8. Contraceptives						525				525.0
9. Other										
TOTAL	11.3	152.6		1193		525				3244
(S EQUIVALENT)		117.4		91.8		40.4			11.3	260.9

1/ U.S.\$ 1.00 = 13.00 K.S.H.S.

2/ Expressed in person - months

Total cost in \$U.S. = 260.9

USAID Share = 49%

All other = 51%

Annex K

INVENTORY OF POTENTIAL SUBPROJECTS

This inventory prepared by the Project Paper design team contains brief descriptions of promising subproject activities, as well as lists of firms and the names of representatives of the firms contacted. The material in this Annex is included as prepared by the design team. The inventory is organized in two sections: the most promising potential subprojects and other possible subprojects. Most of the information on which the descriptions are based is derived from interviews with representatives of the various firms and from the Private Sector Family Planning Project questionnaire which interested firms were asked to complete. The consultant team also wrote up information on other project possibilities, including health facilities not requiring assistance, unlikely subproject possibilities, useful contacts, made by team visits telephone contacts, and additional organizations and companies not yet contacted. The attachments referred to in the descriptions are on file in the Health, Nutrition and Population Division of USAID/Kenya.

I. MOST PROMISING POTENTIAL SUBPROJECTSA. SUBGRANTEE AGENT: Rift Valley Textile Mills Ltd. (Rivatex)CONTACT: Mr. Bore, Chief Executive or
Major Langat, Adm. ManagerAddress Box 2236

Eldoret

Telephone 2910, 2916, 31900DESCRIPTION:

Rivatex (a shortened form of Rift Valley Textiles) has been operating just outside of Eldoret since 1976. It is a private company manufacturing bolts of textiles for use primarily in Kenya. The company employs 1415 person, 30 of whom are women, who work in three 8 hour shifts a day, except on Sundays. The company maintains a dispensary on the factory compound which is open 24 hours, six days a week. All employees receive free care and drugs for minor illness and injury. More serious cases are sent to the District Hospital in Eldoret: the company pays hospital costs which it then recovers from the National Hospital Insurance Fund (NHIF). Apparently all employees are covered by NHIF (participation in this government plan is compulsory for all persons earning KShs.1,000/- or more per month), and recovery is on a sliding scale basis. No dispensary services are provided for employees' families; fees, however, are paid to the District Hospital if the family is covered in the employees' NHIF plan. The Administrative Manager, who was the first contact, suggested he would check with the NHIF to see if they covered family planning service. If so, any company with a similar plan could recover costs associated with such new dispensary services. NHIF policy on family planning delivery should be investigated by the TA Team.

The dispensary employs the part-time services of a doctor (1 hour each morning and afternoon), three Clinic Officers and one Enrolled Nurse Midwife. He suggested one full-time qualified nurse would satisfy additional manpower needs for dispensary based family planning service delivery. If the concept was accepted, he saw problem neither in allowing space and time of present clinic staff nor in allowing workers' families access to the dispensary. The next step, he felt, was to bring the idea before representatives of Rivatex's workers union. He

asked, however, that we return the following morning when both Doctor Lodhia and the Chief Executive, Mr. Bore, would be present for further discussion.

The meeting next morning was somewhat less positive. It appears company management wished more time to consider future implications before making a commitment. A copy of the PSFPP questionnaire was left with Major Langat. Meetings were held on April 4 and 5, 1983.

INPUTS:

Needed by grantee include 1 new full-time, trained, qualified nurse; training of clinical officers and the ENM. The level of assistance and training for project required operations research and management and record keeping will have to be determined; generally the company seems to be well managed. Equipment and supply needs probably will be the more or less standard package developed for the eight Proposed Subprojects. Project travel related expenses should be minor. Contraceptive need will depend on projected acceptors developed by the company and the TA Team.

Provided by the grantee include personnel time (clinical and some management), space in the three room dispensary, and some vehicle and equipment depreciation.

B. **SUBGRANTEE AGENT:** East African Tanning Extract Company Ltd. (EATEC)
CONTACT: Mr. Van Kaufman, General Manager
 Mr. Charles N. Mukanda, Company Secretary
Address P.O. Box 190
 Eldoret, Kenya
Telephone 31311-5
Telex 35048

DESCRIPTION:

EATEC operates 40,000 acres divided among three estates near Eldoret, Nandi and Soy. Eldoret is the company headquarters and site of the primary estate. The company is an agrobusiness with several products: tannin from company tree groves; quinine from other trees; fencing post; poles for East African Power and Lighting Co.; grains (maize and wheat); livestock (cattle and sheep), mushrooms (both grow and canned for domestic and export markets). It has 2,500 employees on the three estates, one-fourth of whom are women. A number of amenities are provided to workers. Among these are free housing, five primary schools (another is being built), a nursery school at the Eldoret operation, and free medical services to all employees and their families. Senior staff are treated at company expense by a private physician in Eldoret, and other employees receive care and drugs from one of three EATEC operated health facilities. The largest and best equipped is a dispensary in Eldoret under the full-time charge of a clinic officer. The other two estates each have a first aid post staffed by a person trained and certified by the St. Johns Ambulance to provide first aid.

The Company Secretary was very receptive to a meeting on short notice, expressed keen interest in participating in the PSFPP, and stated that the General Manager has been encouraging him to incorporate family planning service as part of medical care provided to employees. He was disappointed that we could not stay a few days to meet with the General Manager when he returned from a trip. Mr. Mukanda expected to be in Nairobi the following week, however, and, after speaking with Mr. Van Kaufman, planned to contact USAID while in Nairobi. (Ms. Helen Soos left

her business card and a copy of the PSFPP questionnaire.) The meeting was held at EATEC on April 4, 1983.

INPUTS:

Specific needs were not identified, but the need for training of present personnel, basic family planning equipment and supplies, some travel related expenses and, of course, contraceptives are presumed necessary. One additional medical person trained to handle basic family planning and resupply services as well as related administration probably will be needed at least half-time. Company inputs will have to be defined with EATEC management.

C. SUBGRANTEE AGENT: Panafrican Paper Mills (E.A.) Ltd.
 CONTACT: A. D. Mundhra, General Manager
 D. L. Nenawati, Chief Accountant or
 Shem A. Ombuya, Personnel Manager

Address P.O. Box 535

Webuye, Western Province

Telephone Webuye 16 or 17, Eldoret 31597 or 31599

Cable Papermills

Telex 35584

DESCRIPTION:

Panafrican Paper Mills has been in operation since 1974. The company is owned by Orient Paper Mills (India), the International Finance Corporation, and 33% by the Government of Kenya. The company employs 1,400, only a handful of whom are women. Amenities include housing for 800 employees; a large number of employees are residents of the area and walk to the mill. The management estimated at least 600 company housed employees have their families living with them, some with two or more wives, for a total of 800 resident wives. At least another 200 employees living in the area have one or more wives. Panafrican Paper also provides free medical care to employees and their families; but by agreement with the company union, they give free care to a wife and up to four children. Basic care is provided at the dispensary on the factory compound. Family planning services were incorporated as part of health care in 1980. The company pays transport costs to nearby hospitals for serious illness or need for surgery. There are District Hospitals in Bungoma (35 kilometers), Kakamega (46 kilometers), and a mission hospital at Lugulu (9 kilometers). Other nearby facilities include MCH Health Centers and Dispensaries and three private doctors. The dispensary is staffed by two ENs, one E/M, and two Clinical Officers. A doctor, M. K. Z. Khan, is scheduled from 7.30 - 8.30 (Dr. Khan reported he usually stays one and a half to two hours). About 250 patients are seen each day, about 150 of whom are women. There are not many family planning acceptors, but consensus among staff at the meeting identified the cost of oral

contraceptives as a major deterrent. Nevertheless, 5-10 cycles are distributed daily. OCs are bought on the open market and provided to acceptors at cost; condoms and spermicides are obtained from the Bungoma District Hospital. IUCDs are not inserted by the Panafrican Paper dispensary, and IUCD clients are sent to one of the above hospitals. Peluce Omboto, an enthusiastic supporter of family planning and chief nurse, also provides family planning education. She has been trained to insert IUCDs but stated she needed a refresher course.

All company representatives at the meeting were very supportive of upgrading the family planning program and participating in the PSFPP. The General Manager, who arrived at the end of the meeting, however, was adamant that Depo Provera not be included as a method because of its controversial nature. There was unanimous support for receiving free supplies of all other methods and for training and refresher courses for present nursing staff. The meeting was held on April 6, 1983.

INPUTS:

Suggested by the grantee included a full-time trained person who could provide service delivery as well as motivate in the community, and basic equipment for a clinic room (examining couch, sterilizer, blood pressure "machine", and disposable gloves). Other equipment and supplies as well as administrative and training needs should be discussed between the TA Team and Panafrican Paper. The company, however, appears to be well managed.

Those inputs provided by the grantee include a new room which can be built on to the dispensary (about two months is required), time from present medical staff, vehicle and equipment depreciation.

D. SUBGRANTEE AGENT: Kisumu Cotton Mills Ltd. (Kicomi)
 CONTACT: James Odaga, General Manager
Address P.O. Box 47
 Kisumu
Telephone 41200
Telex 31132

DESCRIPTION:

Kicomi is a long established textile company which recently has experienced difficult times. This major Kisumu employer (1,500 with 60-70 women workers) unfortunately was in receivership when the visit was made on April 6, 1983. The General Manager, Mr. Odaga, nevertheless, was supportive of the PSFPP, said he would have been willing to hire a part-time nurse, and was very interested in having the incoming management continue discussions about implementing a family planning delivery service at Kicomi. He strongly urged the Consulting Team members who visited him to immediately write a letter for the company records confirming the conversation. The Standard carried a news item on April 23 announcing that new management is to be appointed May 1 by the shareholders comprised of the Industrial Development Bank (I.D.B.), the Industrial and Commercial Development Corporation (I.C.D.C.), the Development Finance Corporation of Kenya (D.F.C.K.), and the Commercial Development Corporation (C.D.C.). The new company will be known as Kicomi (83) Ltd. Presumably, the new company will continue to offer health services to its employees. They have a clinic operated by a Medical Assistant and three local doctors who routinely take referrals. The company pays all physicians' charges for its employees. Company practice has been to not pay for the care of employees, but it is worth checking about any new policies which may be established under the incoming company management.

INPUTS:

Project needs and company inputs will have to be discussed with new persons after May 1, 1983.

E. SUBGRANTEE AGENT: Seventh Day Adventists (SDA)
CONTACT: C. Kraft, MD, Health Director
Address East African Union
Seventh Day Adventist Church
P.O. Box 42276
Nairobi
Telephone 566022, 566025

DESCRIPTION:

When contacted in April, 1983, the health services of the Seventh Day Adventist Church in Kenya were undergoing reorganization which would place them administratively under a single medical director, instead of under the jurisdiction of the various field organizations. Kenya is divided geographically into five fields by the SDA. Health facilities are comprised of a hospital at Kendu Bay, 20 clinics outside Nairobi, one clinic in Nairobi, and the Nairobi SDA Health Service. The multidonor Integrated Rural Health and Family Planning Project reportedly will upgrade three of the clinics to provide full family planning and maternal-child-health services.

Once the health services are reorganized (planned for May, 1983), Dr. Kraft and Mr. Solomon Wolde-Eudreus (Seventh Day Adventist World Services Director for the East African Region) have indicated a keen interest in preparing a proposal involving introduction of family planning services in a number of clinics not assisted by the World Bank, as well as a possible community based project in Nairobi.

INPUTS:

Needed by the Grantee likely would consist of training for clinic personnel, some office and medical (family planning related) equipment, and transportation allowance.

Provided by the Grantee would include personnel, administrative, clinical and supervisory time, designated space, and vehicular/equipment depreciation.

ATTACHMENT:

Listing of SDA facilities and personnel

200

II. Possible Subprojects

This category lists instances where meetings were held but which need further discussion before possibilities for a subproject can be fully assessed. In some cases, the potential is very good, but contact by the Consulting Team was premature for one or more reasons (e.g., health facilities were in the planning stage). In others, the key person/persons to contact should be sought out for a meeting and full discussions. In still others, a small health facility operated by one or two persons or a company employing relatively few persons may not justify development of a full scale subproject with the heavy inputs of management, evaluation, and administrative requirements scheduled for both the TA Team and the subproject grantee. In such cases, perhaps a mechanism simply to supply free contraceptives from the MCH may be more appropriate.

200

A. SUBGRANTEE AGENT: Kenya Tea Growers Association or
Subprojects with individual, large tea estates
CONTACT: Frederick Soi, Executive Director
Mr. H. Salwengter, Chairman
Address Box 320
Kericho
Telephone

DESCRIPTION:

The Kenya Tea Growers Association, established in 1930, represents 47 tea growers in four estate areas surrounding Kericho, Limuru, Nandi Hills, and Sotik. The main office, located next to the post office in Kericho, is managed by the KTGA Executive Director. The association elects a chairman and vice chairman as well as an executive committee. The Chairman and Executive Director are the key contacts for all the tea estates. Branch associations, with the same pattern of elected officials, are located in Limuru, Nandi Hills and Sotik. Members of the KTGA collectively employ many thousands of workers. The 8 or so largest, e.g. have over 35,000 employed. Labour needs tend to be seasonal, however, and many workers leave for employment elsewhere or go to their home areas during the five "slow" months of January through May. Still, year round work is available for thousands, and many workers are permanently settled in tea estate housing. The largest concentrations are on the following estates:

Brooke Bond, Nick Patterson, Director and Musa Sang, Co-Director.

Kericho, Telephone 146 (15,000 employees)

African Highlands, Mr. Rabley, Director and W. Tancy, Associate Director.

Kericho, Telephone 155 (10,000 employees)

George Williamson Africa Ltd. (or Changoi), H. Salwengter, Manager.

Kericho, Telephone 7041 (1,500 employees)

Sotik, C. G. Gibbon, General Manager.

Sotik, Telephone 63 (2,000 employees)

Nandi Tea Estate, J. R. Cairns, General Manager.

Nandi Hills, Telephone 8 (1,000 employees)

Mau Forest, S. F. Sangol, General Manager,

Kericho, Telephone 20028 (400 employees)

Eastern Produce, Ken Archer, Manager Chemoni and estates agent for smaller growers. Nandi Hills, Telephone 11, 20 or 34 (4,000 total employees)

DESCRIPTION:

Apparently all the major and many of the smaller estates provide free medical care for employees through an estate health facility. These range from Brooke Bond's medical complex consisting of a fairly large, well staffed hospital (two doctors, a head matron, 4 ENs and medical assistants), two medical centers at Limuru and Koroma, 27 drug dispensaries each serving about 800-1000, and one mobile MCH unit, all of which serve 70,000 people associated in some way with the Brooke Bond estate, all the way to a small, individual grower's dispensary for a few hundred workers. Emphasis is on curative services, and some provide only first aid. The Brooke Bond Hospital offers family planning services - OCs, IUCDs and tubal ligation - and monthly sees an estimated 30 continuous users and four new acceptors. OC users are expected to report for a check-up every 3 months. The mobile unit resupplies OC cycles and refers potential clients to the hospital. Supplies are collected from the MCH hospital at Nakuru. When the number of family planning acceptors is compared to the estimated 300 female patients seen at the hospital each week and the total 2,700 served weekly at all the health facilities, it is reasonable to conclude that family planning is not a high priority service. The Co-Director of Brooke Bond (the Director was on holiday), nevertheless, expressed interest in the PSFPP and arranged for the Consulting Team to visit the hospital.

Other than Brooke Bond, the Team was not able to see the managers of any other estates. This was partly circumstantial: The General Manager of African Highlands was ill, local telephone lines were torn up by road construction crews, and time was limited to one day in the Kericho area. After several attempts to make

appointments led back to the KTGA, we felt contact through this group and advance appointment or scheduling several days in the area were preferred. The Chairman of the KTGA, who was the first to suggest we ask Mr. Soi to try to arrange an afternoon meeting, nevertheless, invited us to drive the 22 or so miles to Changoi for a visit. (It was not possible to get a second call through because telephone lines were broken). The suggested meeting with members of the KTGA Executive Committee could not be arranged on short notice, and Mr. Soi said he would put discussion of the proposed PSFPP on the agenda for the next KTGA meeting. A copy of the PSFPP questionnaire was left with Mr. Soi on April 8, the day of the Team's stop in Kericho.

B. SUBGRANTEE AGENT: Aga Khan Medical Center

CONTACT: Dr. Aziz Mohamed (Kisumu)
Dr. Nizar Verjee (Nairobi)

Address P.O. Box 530
Kisumu

Telephone 40372 (Kisumu)
339560 or 22384 (Nairobi)

DESCRIPTION:

The Aga Khan Medical Center in Kisumu caters to a more affluent client. Expansion from a 20 to a 47 bed facility with double the outpatient capacity (presently serves 8,000 - 9,000 annually) will be completed soon. All services are on a fee basis. Family Planning is provided as part of comprehensive MCH care; OCs, IUCDs, sterilization and infertility analysis are included. This modern, expensive facility is not a good candidate for the PSFPP. The Aga Khan Medical Center is in the final stage, however, of planning a major primary health care program in two areas near Kisumu.

The new service, targeted to begin in 1984, will be funded by the Aga Khan Foundation, CARE/Canada, and the Ford Foundation. In cooperation with the MCH Provincial Health authorities, the program will focus on basic health care, health education, endemic and common disease and accident prevention, nutrition education and MCH. Family planning, as part of the MCH program, will provide OCs and maybe IUCDs. Training of community health workers is another program emphasis. The two areas scheduled for implementation are quite different: Kajulu, 15 km outside Kisumu, is highly urban while North Nyakach, 40 km Southeast, is very rural. About 60,000 people reside in the target areas. Apparently the entire program will be well funded and managed. All services will be free, and data computerized to yield maximal and rapid feedback. Since present plans call for relatively small emphasis on family planning, the representative of the Aga Khan Foundation (Dr. Verjee) and the program administrator (Dr. Mohamed) are very receptive to discussing additional inputs from the PSFPP. Meetings were held with Dr. Verjee on March 30 and with Dr. Mohamed on April 7, 1983. Dr. Verjee was notified that agreement was

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reached with Dr. Mohamed to reopen discussions once their new project was underway later this year.

ATTACHMENT: Aga Khan Medical Center, Kisumu

C. SUBGRANTEE AGENT: Maendeleo Ya Wanawake (MYW)
CONTACT: Jennifer Mukolwe, Chief Administrator
Address P.O. Box 44412
Nairobi
Telephone 27033 or 22095

DESCRIPTION:

This possible project is part of a larger community health pilot project in a heavily populated area of Kakamega District. The health facility nearest to Shiraha, the target area, is 18 miles away in Kakamega. MYW hopes the full CSD project can be funded through one or more sources. While the project is oriented toward all people in the community, MYW suggests focusing on local men, who already appear committed to family planning, to motivate neighbors and supply condoms and spermicides (see attached proposal). Advice and back-up medical services are available from a retired clinic officer and a Kenya Registered Nurse whose home is in the community. MYW expects that experience gained in several female oriented CSD projects it is presently initiating will be valuable for further development of this male oriented project.

ATTACHMENT: Community Based Family Planning Education and Service Delivery Pilot Project.

D. SUB-GRANTEE: Raymond Woollen Mills (K) Ltd.
 CONTACT: R. K. Kedia, General Manager
Address Box 735
 Eldoret
Telephone 31811, 31817

DESCRIPTION:

Raymond began its operation in Eldoret in 1969. The company produces quality woollen and polyester goods in both bolts and finished clothing. The market is basically Kenyan. The General Manager describes his company as quasi-government since it is partly owned by Raymond Mills, Bombay, and a government corporation. The company employs 2,000 workers, 450 of whom are women. The General Manager recognizes frequent maternity leave as a big production problem (5% - 8% are on such leave at any one time). Management's solution is to fill former female identified jobs with male workers when women leave the mill. Apparently, women traditionally are considered more manually dexterous and better at some jobs. The solution to substitute men is not considered an ideal but rather a practical one because of substantial labor losses resulting from government laws requiring two months maternity leave and restricting women to work during daylight hours.

The company does not provide health facilities at present although recently it has been considering such a benefit. There are two nearby hospitals as well as an FPAK clinic, and many employees are covered by the NHIF. The General Manager felt a company health facility, while expensive, would be an impressive benefit, and one which "once started you can't stop." During the conversation he seemed to be intrigued by the idea of somehow offering planning services to his employees. He appeared to shift somewhat from his original opinion that there were no benefits to his company in such a program to considering how a family planning program might help the company retain more women for those jobs which they perform better than men. He did not hesitate to agree that such a program would benefit women workers but pointed out his company, after all, was business oriented; and future costs of continuing the service were an important consideration.

After a lengthy, frank discussion, he suggested we send some ideas (or format) as a "starting ground" for further talks. The meeting was held on April 5, 1983.

- E. SUB-GRANTEE AGENT: Ken-Knit (Kenya) Ltd.
 CONTACT: B. Z. Shah, General Manager
Address P.O. Box 142
 Eldoret
Telephone 31287 or 88
Telex 35012

This company also produces woolen goods; it employs 500 men and 200 women on a permanent basis. There is a long range plan to provide benefits such as housing and health care. Although Mr. Shah thought many of his women employees already practised family planning, he was interested in reopening discussion in the near future, especially if the company instituted health care benefits. He, in fact, mentioned he was thinking of services by a Dr. Lodhia in Eldoret. Ken-Knit was visited on April 5, 1983.

- F. SUB-GRANTEE AGENT: Kasuku Garments Factory Ltd.
 CONTACT: Morris O. Kasuku, Chairman/Director
Address P.O. Box 1837
 Kisumu
Telephone 41500 or 3342

This small business was started by Mr. Kasuku in 1980. After many years working as a tailor for other companies, this entrepreneur struck out on his own after arranging contracts to sew uniforms. He now has several large contracts to make uniforms for military and police units. About 100 people (31 women) are employed by Kasuku. He has not been able to yet provide any benefits to workers, but complained about time taken away from work for treatment of even minor illnesses. It can take all day to receive treatment at a Kisumu health facility; and, he reasoned, workers would be willing to go to a company clinic for fast services. He was receptive to the idea of a family planning component for he saw this as means to help start the company clinic he had been

thinking about. He suggested he would be willing to built a clinic room, stock it with antibiotics and other medicines, as well as furniture if the project could provide a bed, cabinet, some equipment and contraceptives. He felt payment for the services of a trained nurse could be shared; i.e., the project would pay her first year's salary, and he would provide 50% in the second year. The meeting was held on April 7, 1983.

G. SUB-GRANTEE AGENT: Mumias Sugar Co. Ltd.
CONTACT: R. Gladsford, General Manager
Address Private Bag
 Mumias
Telephone 46 - 50

This large, privately owned combined plantation and factory is the major employer in the area. It has 4,800 full time and 5,000 part time workers. Only very few are women, and these are mostly the company's secretaries. Mumias Sugar owns 3,500 worker's houses but provides health care only to the 300 or so managers and supervisors and their families. They are served by a full time physician, Dr. James Makayoto (formerly with the FWC and MCH family planning program), one nurse and two assistants. Workers and their families go to Matungu Government Health Clinic or St. Mary's Catholic Hospital in Mumias. The former provides family planning services, while the latter recently eliminated the service because the new Bishop to the area opposes family planning. The General Manager and doctor both felt family planning services were needed in the area and would be a good thing for their workers. Each, however, had his own objection to company participation in the project. Dr. Makayoto believed the government would insist on an expensive, comprehensive MCH program, which the company basically would have to provide; while Mr. Gladsford stated the Sugar Industry Board, an association of private and parastatal companies, last December had established a policy not to provide any workers health services. He seemed surprised to hear that Nzoia Sugar already had clinical health services, but he noted they often set independent policies. The General Manager conceded that the Kenya Union of Plantation Workers was

pressing for family planning care and felt it was only a matter of time before the management of plantation complexes would give in. He recognized the expense of MCH care and certainly preferred not to include it in a company health package since "once a benefit is started, it can't be cancelled". Both men, were leary of opening a health facility on the factory compound as they envisioned thousand of women and children flocking in daily for care. Mr. Gladsford indicated that if and when Mumias initiated health care, he would be pleased to discuss the project at further length. The meeting was held on April 6, 1983.

H. SUB-GRANTEE AGENT: Nairobi City Council

CONTACT: Dr. Achola, Medical Officer for Health

Nairobi City Council Government was suspended in April 1983, and the Chief Medical Officer was on enforced leave, so no contact was made. This seems like an excellent possibility for the future, however. Several persons indicated the City Council health facilities could upgrade family planning services, and that many nurses would wish to cooperate if superiors were more supportive and nurses were better trained.

I. SUB-GRANTEE AGENT: Anna M. Muthoni

CONTACT: Same

Address Wareng Maternal and Child Welfare Clinic

P.O. Box 3053

Eldoret

Telephone 31411

Ms. Muthoni single-handedly has operated a small clinic in Eldoret for a number of years. She is an Enrolled Midwife who received her training in 1949 but who has extensive practical experience. Her clients come mainly for anti and prenatal care. She serves fewer family planning clients, and she attributes this to proximity to the FPAK clinic (on the same block) and to her high fees because she buys contraceptives from a commercial supplier. Her charges are as follows: KShs.39/- Depo Provera; 25/- OC cycle; 75/- Lippes Loop C or D insertion. Ms. Muthoni felt she could attract many more clients

if she has access to free supplies. She averages about 50 clients a year.

J. SUB-GRANTEE AGENT: Lydia Muthara
 CONTACT: above
Address Box 1478
 Thika
Telephone 21873

Mrs. Muthara has been active in family planning for many years. She worked for the FPAK most recently and opened her own clinic in a small, private hospital in Thika this past summer. She receives free supplies from Pathfinder (OCs, condoms, and Lippes Loops) and also buys CuT, Cu7, Depo Provera and diaphragms commercially. Although she obtained supplies from the MOH once, she was chided for charging a fee, and probably will not get any supplies again. She feels that her clients appreciate the services she provides and are willing to pay her modest fees. Records for the first months of 1983 bear this out; she had 167 new acceptors and 300 or so returning clients. About 40% of her clients preferred the IUCD, with OCs as the next most popular method.

Mrs. Muthara is a pioneer in private sector services. She hopes to build a large MCH facility in Embu someday which will provide quality services. If her ambition is realized, this project could provide substantial assistance; until the facility is built, however, perhaps she could be supported in a modest way through the project.

K. SUB-GRANTEE AGENT: Kenya Breweries
 CONTACT: Dr. James S. Nesbitt
Address P.O. Box 44231
 Nairobi
Telephone 331192

Kenya Breweries operates three breweries. The main one, outside Nairobi at Ruaraka, has about 4,000 employees, mostly men. Mombasa brewery has about 1,000 employees and Kisumu about 600. The Ruaraka Brewery has a health facility. The company's physician, Dr. J. Nesbitt, expressed interest in the project.

Annex L

SUBPROJECT SELECTION AND MANAGEMENT GUIDELINES

This Annex contains the following materials:

1. Instructions and Criteria for Subproject Selection;
2. Cover Letter and Subgrant Application;
3. Terms and Conditions of Grant Award;
4. Standard Provisions for Non U.S. Non Governmental grantees and Non U.S. Non Governmental Subgrantees.

INSTRUCTIONS FOR USING CRITERIA FOR SUBPROJECT SELECTION

The Criteria are grouped in five categories. A maximum number of points is established for each category so that a total of 100 points is possible.

	<u>Category</u>	<u>Maximum points Possible</u>
A.	Type of Organization	10
B.	Number of persons of childbearing age potentially reached	10
C.	Existing services delivered	10
D.	Organizational considerations	40
E.	Other factors	30
	Total	<u>100</u>

Evaluators of subproject proposals should proceed by entering the appropriate response to the best of his judgment in each category. Note: Footnotes may be entered to explain points awarded.

The criteria favor private-for-profit organizations over other types of organizations, greater numbers of recipients over lesser numbers, facilities which currently offer no family planning services over those which do, organizations with existing interest and administrative capabilities over those lacking these, and other factors which are self-explanatory.

Since Grant Awards will be competitive, 'minimal' qualifications will be established only after time by USAID and the Technical Assistance Team.

While these criteria should be used comparative ratings, the demonstration intent of the overall project must be kept in mind. Accordingly, the project should include: as great a variety of organizations as possible; target populations of various sizes and characteristics; and various mixes of service delivery.

CRITERIA FOR SUBPROJECT SELECTION

POSSIBLE POINTS

10
8
6
5
4

(10)

A. TYPE OF ORGANIZATION

1. Private-for-profit company
2. Parastatal organization
3. Professional, woman's or similar group
4. Private voluntary organization
5. Other

Subtotal _____

B. NUMBER OF PERSONS OF CHILDBEARING AGE POTENTIALLY REACHED

10
8
6
4
3
2

(10)

1. Over - 5000
2. 2500 - 4999
3. 1000 - 2499
4. 500 - 999
5. 100 - 499
6. Less than 100

Subtotal _____

EXISTING HEALTH/FP SERVICES DELIVERED

10
8

(10)

- 1: Health Services without Family Planning
2. Some Family Planning as part of health services.

Subtotal _____

POSSIBLE POINTS

10
4
3
2
2
8
6
3
8
—
(40)

D. ORGANIZATIONAL CONSIDERATIONS

1. Top level commitment to family planning and Project objectives
2. Willingness to comply with grant conditions.
3. Medical provider interest
4. Organizational reputation
5. Previous project track record
6. Estimated administrative capability:
 - a) without assistance;
 - b) with assistance
7. Estimated fiscal management capability
8. Ability to meet 25% requirement.

Subtotal _____

E. OTHER FACTORS

2
5
5
2
5
3
8
4
0
—
(30)

1. Relationship to known demand generation
2. Attempt to reach or involve men
3. Attempt to reach or involve adolescents
4. Lack of easy accessibility to other resources
5. Estimate of sustainability capacity
6. Nearest other FP services more than 6 Km.
7. Relative estimated cost-effectiveness
 - a) Above average of other subprojects
 - b) Average
 - c) Below Average

Subtotal _____

Total Points _____

(SUBPROJECT COVER LETTER TO ACCOMPANY
S&B GRANT APPLICATION)

PRIVATE SECTOR FAMILY PLANNING PROJECT

(NAME)

(TITLE)

(AGENCY/COMPANY/ORGANIZATION)

(CITY)

Dear _____:

We have learned of your interest in adding family planning services to your existing health services, or in expanding the types of coverage of natural and other family planning services currently being offered. To assist us in determining whether we will be able to provide your agency/company/organization with financial and/or other types of support, we request that you answer the questions contained in the enclosed grant application. If necessary, use additional sheets of paper.

Once the completed application has been received and reviewed in our office, a member of staff will contact appropriate officials of your agency/company/organization and indicate further actions to be taken.

We appreciate your cooperation and look forward to being of assistance.

Sincerely,

Enclosure: Private Sector FP Project
Grant Application

PRIVATE SECTOR FAMILY PLANNING PROJECT

A. The Project

The objective of the project, managed by (Implementing Agency), is to increase the range of options available to potential Kenyan female and male users of Family Planning services by expanding Family Planning services delivery in the private sector. 'Private' may be described as referring to institutions and facilities whose operations are not wholly financed by the Central Government. Under the Project, grants may be made to private-for-profit organization, Private and voluntary groups, and other non-governmental groups (e.g. Parastatals) to increase provision of Family Planning services to their employees (and/or dependants), beneficiaries or clients.

B. The Grants

This application for a grant may be for a period of up to two years. As the grants are competitive, your diligence in completing this application will increase your chances of an award. (Implementing Agency) is willing to assist you in preparing the application. Grants of money or materials may be requested to add Family Planning services to existing health services being provided, or to expand types of coverage of natural and other Family Planning services being offered. The application may request, inter alia, funds to provide training, supervision, staffing, equipment or supplies, but only if evidence is provided that your organization can sustain the level of services achieved under the grant once the grant has ended. Application for funds to provide construction will not be considered. Decisions on grant awards will be made by (Implementing Agency), whose decision is final. Should an award be granted, you must follow any conditions agreed to at the time of the award.

C. Organizational Information

1. Organization requesting Assistance

s	Address	_____
f		_____
e	Telephone No.	_____
	Name of Person to contact	_____
	Title	_____

2. Health Facility(s) to which grant will apply, if different from above _____
Address _____
Telephone No. _____

3. Does the facility or organization now offer health servicesYes...No.
Describe _____

4. Does the facility or organization now offer Family Planning services?
.....Yes.....No.

5. What are the names and distances of the closest facilities offering Family Planning services?
Name _____ Distance _____
Name _____ Distance _____

6. What official or informal affiliations does your organization have with other organizations/institutions/agencies?

7. How many people are employed by your organization? Men _____
Women _____

8. Are health services provided by your organization to dependants of your employees? _____ Yes _____ No.
If yes, to Wives? _____ Husbands? _____ Children? _____

9. Are charges made for health services? If so, describe _____

10. Have you received or applied for assistance for Family Planning services from organizations or sources outside your organization/firm/agency? _____
If so, please describe source and type of assistance received/applied for.

11. Have you received and managed outside assistance for activities other than Family Planning? Please describe _____

D. Proposed Program Information

1. What specific Family Planning services do you propose to provide?
(Examples are clinical services such as oral contraceptives; diaphragms I.U.D.'s, injections, sterilization; non-clinical services such as foams; jellies; condoms, foaming tablets; instruction in natural family planning; community outreach services.)

2. How many new acceptors of Family Planning services do you plan to reach during the grant period? _____

3. What resources do you already have that can be utilized to provide the proposed services?

- a) Personnel
- b) Equipment
- c) Supplies
- d) Administrative support
- e) Transportation
- f) Access to additional budgetary resources

4. What additional resources are required to provide the proposed services?

a) Additional staff? If yes, how many, and what duties will they perform? _____

b) Training for existing staff? _____ If so, for whom, type, expected duration, and possible location of training _____

c) Equipment and supplies? (example are file cabinets, examining couches, tables, baby cradles/scales, chairs, flip charts, hand calculators, stationery, postage etc.). If so, list types and quantities. _____

d) Contraceptive materials? (If you have a current source of supply, please describe source of various materials, adequacy of supply, costs involved) _____

e) If additional contraceptive related medical equipment is needed, please list types and quantities. _____

5. What is the estimated size of the population aged 15 and above to be offered Family Planning services? _____ What is the source of this estimate? _____

What percentage are estimated to be within 6 Km. of your facility _____

6. How is it proposed to maintain or expand level of service achieved during the grant once the grant expires? Please be as specific as possible.

TERMS AND CONDITIONS OF GRANT AWARD

By signing the Grant Award Letter, you agree to abide with the following terms and conditions:

1. A Progress and Financial Report must be submitted every three months in the format specified by (Implementing Agency). The first report is due _____ and subsequent reports every three months thereafter. The reports will be mailed or delivered to:-

The final report will be submitted no more than 30 days after the project funding period.

2. Grant Award Management

- A. A separate bank account must be established to receive and distribute funds provided by this Grant Award.
- B. Upon receipt of your signed acceptance of the Grant Award (Implementing Agency) will provide the project with an initial advance payment equal to the estimated expenditures of the three months.

Thereafter, upon submission of satisfactory Progress and Financial Reports (Implementing Agency) will reimburse your project-related special account for allowable expenditures every three months to the original level of the advance, up to, but not exceeding, the total amount specified in the project budget.

In no case may you exceed the Grant budget total.

- C. Any unexpended funds, not needed to satisfy liabilities incurred during the approved funding period shall be refunded to (Implementing Agency).
- D. Funds or materials provided by (Implementing Agency) must be used only for those activities described in the Grant Award. (Implementing Agency) retains ownership of all material provided or funded by (Implementing Agency) until completion or expiration of this Grant, at which time it shall be disposed of in a manner determined by (Implementing

- E. Changes in approved objectives and/or budget must be authorized by (Implementing Agency) through a written Grant modification to the original Grant Award, except that you may, without exceeding the total amount of your Grant, increase budget categories up to a maximum of ten percent (10%) for any individual category without prior written authorization by (Implementing Agency). Increases exceeding ten percent (10%) require justification, indication of what budget category(s) will be reduced to offset the requested increase, and prior written authorization from (Implementing Agency).
- F. The final determination of expenditures allowable in accordance with the approved Project Budget and Terms and conditions of Grant Award is made by USAID. In order to avoid disallowances, which means refunds to (Implementing Agency), your project should adhere rigidly to the approved budget and Terms and Conditions.
- G. All procurement using funds provided by (Implementing Agency) will be undertaken using procedures approved by (Implementing Agency).
1. In general, items available of local manufacture may be purchased after satisfactory evidence of soliciting competitive bids.
 2. Equipment and supplies not of Kenya origin generally must be procured from U.S. source and origin unless a waiver is granted by (Implementing Agency).
 3. Unless specified in the Grant Award (or subsequent modifications), (Implementing Agency) funds may not be used:
 - a. to purchase vehicles
 - b. for entertainment
 - c. for subcontracts.
3. Non-Liability
(Implementing Agency) does not assume liability with respect to any claims for damages arising out of work supported by this Grant Award.

TERMS AND CONDITIONS OF GRANT AWARD

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1. In general, items available of local manufacture may be purchased after satisfactory evidence of soliciting competitive bids.
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 3. Unless specified in the Grant Award (or subsequent modifications), (Implementing Agency) funds may not be used:
 - a. to purchase vehicles
 - b. for entertainment
 - c. for subcontracts.
3. Non-Liability
(Implementing Agency) does not assume liability with respect to any claims for damages arising out of work supported by this Grant Award.

4. Program Regulations

A. Voluntary Nature of Activities

The purpose of this Grant is to expand the availability and accessibility of voluntary family planning services.

Under no circumstances are the funds and/or property provided and/or financed under this Grant Award to be used to support activities that coerce or tend to coerce persons to accept family planning services. Your agency must ensure that such funds and/or property are not used to coerce any individuals to practice methods of family planning in conflict with their moral, philosophical or religious beliefs.

It is essential that your agency conduct its project activities in a manner which safeguards the rights, health and welfare of all individuals in the program.

B. Prohibition on Abortion-Related Activities

No funds or property available under this Grant Award will be used to finance, support or be attributed to the following family planning and population assistance activities:

1. Procurement or distribution of equipment for the purpose of inducing abortions as a method of family planning;
2. Procurement or distribution of Menstrual Regulation (MR) Kits;
3. Special fees or incentives to women to coerce or motivate them to have abortions as a method of family planning;
4. Payments to persons to perform abortions or MR procedures, or to solicit persons to undergo abortions or MR procedures; and
5. Information, education, training or communication programs that seek to promote abortion as a method of family planning.

These restrictions do not prohibit support for the performance of uterin evacuation, including MR, for other medical, diagnostic and curative purposes.

C. Allowable Activities

Funds and property made available under this Grant Award may be used only for specific allowable activities described in your Project Document.

Allowable activities are defined as follows:-

- a) Provision of contraceptive commodities, services and devices including, but not limited to, oral contraceptives, condoms, female sterilization, vasectomy, IUD insertion, diaphragms, jellies, foams, etc.
- b) Provision of family planning training for physicians, paramedical personnel, family planning information agents and contraceptive distribution agents, and other personnel as necessary to implement family planning information and/or service activities. These training activities shall not include training for, or the conduct of, abortion as a non-therapeutic procedure.
- c) Provision of family planning information, motivation and counselling when related directly to services provision.
- d) Collection and analysis of family planning service statistics and/or demographic data.
- e) Pregnancy testing.
- f) Treatment of health disorders relating to fertility, including the treatment of incomplete abortions, abortions medically necessary to save the physical health or life of the patient, and other health problems discovered or revealed in the course of providing family planning services.

5. Audit Regulations

At any time prior to the final payment under this Grant (Implementing Agency) AID (Agency for International Development) or their representatives may audit and/or inspect the project. This may include, among other things, an examination of books, records, and documents which relate to management and accounting procedures, financial transactions and commodities received from (Implementing Agency).

(Implementing Agency) routinely requests audits of the projects it funds at the end of each project funding period.

Your agency must keep all invoices, vouchers, supporting documents and timesheets, if required, relating to expenditures of Grant Award funds and property for at least three (3) years following the end of the Award for audit purposes.

6. Termination

(Implementing Agency) may terminate this Grant by means of a written notification.

Upon receipt of such notification your agency must take immediate action to minimize all expenditures and obligations financed by this Grant, and, cancel

unpaid obligations whenever possible. No further (Implementing Agency) payments shall be made to your agency after the effective date of termination unless prior payments were insufficient to cover the project's obligations prior to termination.

Within thirty (30) days after the effective date of termination, your agency must repay to (Implementing Agency) all unexpended Grant funds not otherwise obligated by a legally binding transaction applicable and/or financed property as directed by (Implementing Agency).

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APPENDIX 4D

STANDARD PROVISIONS
FOR

NON-U.S., NONGOVERNMENTAL GRANTEES AND NON-U.S.,
NONGOVERNMENTAL SUBGRANTEES
(Both educational institutions and nonprofit organizations
other than educational institutions)

A. The following Standard Provisions are mandatory for use in all grants, cooperative agreements, and subgrants with non-U.S., nongovernmental organizations:

1. ALLOWABLE COSTS AND CONTRIBUTIONS (NONPROFIT ORGANIZATIONS - OTHER THAN EDUCATIONAL INSTITUTIONS)

Use Standard Provision 1 of APP 4C.

2. ALLOWABLE COSTS AND CONTRIBUTIONS (EDUCATIONAL INSTITUTIONS)

Use Standard Provision 2 of APP 4C.

3. ACCOUNTING, AUDIT AND RECORDS

Use Standard Provision 3 of APP 4C, however, delete the reference to paragraph 1M of Handbook 13.

4. REFUNDS

Use Standard Provision 4 of APP 4C.

5. REVISION OF FINANCIAL PLANS

Use Standard Provision 9 of APP 4C.

6. TERMINATION

Use Standard Provision 23 of APP 4C.

7. DISPUTES

Use Standard Provision 33 of APP 4C.

B. The following Standard Provisions are required to be used when applicable. Applicability statements are contained in the parenthetical statement preceding the Standard Provision as set forth in Appendix 4C and supplementary statements below. When a Standard Provision is determined to be applicable in accordance with the applicability statement, the use of such Standard Provision is mandatory unless a deviation has been approved in accordance with Paragraph 1E of Chapter 1 of this Handbook.

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B.

1. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

Use Standard Provision 5 of APP 4C; however, delete the applicability statement and insert the following therefor:

* * * * *

(This provision is applicable to non-U.S. Grantees and non-U.S. Subgrantees when any portion of the program being supported is to be undertaken in the United States.)

* * * * *

2. NEGOTIATED OVERHEAD RATES -- PREDETERMINED

Use Standard Provision 6 of APP 4C.

3. NEGOTIATED OVERHEAD RATES -- NONPROFIT ORGANIZATIONS -- OTHER THAN EDUCATIONAL INSTITUTIONS

Use Standard Provision 7 of APP 4C.

4. NEGOTIATED OVERHEAD RATES -- EDUCATIONAL INSTITUTIONS

Use Standard Provision 8 of APP 4C.

Standard Provisions 6, 7 and 8 (i.e., B.2, B.3 and B.4 above) are to be used only when the Grantee proposes reimbursement of indirect costs and the Grantee's accounting system provides for the allocation of indirect costs.

5. PAYMENT -- PERIODIC ADVANCE

(This provision is applicable when (1) the requirements of paragraph 1.0.6 of Chapter 4 of this Handbook have been met, and (2) the Grantee has the ability to maintain procedures that will minimize the time elapsing between the transfer of funds and the disbursement thereof, and (3) the Grantee's financial management system meets the standards for fund control and accountability required under the standard provision of this agreement entitled "Accounting, Audit and Records.")

a. Each month (or quarter, if the Grantee is on a quarterly basis) after the initial cash advance, the Grantee shall submit to the AID Controller voucher form SF 1034 (original) and SF 1034-A (three copies); "Public Voucher for Purchases and Services Other Than Personal."

b. Each voucher shall be identified by the appropriate grant or cooperative agreement number and shall be accompanied by an original and three copies of a report in the following format:

FEDERAL CASH ADVANCE STATUS REPORT
(Report Control No. W-245)

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A. Period covered by this report: Period covered by the next report

FROM (Month, day, year) _____ FROM (month, day, year) _____
 TO (" " ") _____ TO (" " ") _____

B. Cash Advance Use and Needs

1. Cash advance on hand at the beginning of this reporting period.....\$ _____
2. U.S. Treasury check advance(s) received during this reporting period..... \$ _____
3. Interest earned on cash advance during this reporting period.....\$ _____
4. GROSS cash advance available during this reporting period (Lines 1, 2, & 3)..... \$ _____
5. LESS, interest remitted to AID during this reporting period..... \$ _____
6. NET cash advance available during this reporting period (Line 4 minus Line 5)..... \$ _____
7. Total disbursements during this reporting period, including subadvances (see footnote 1)..... \$ _____
8. Amount of cash advances available at the end of this reporting period (Line 6 minus Line 7).... \$ _____
9. Projected disbursements, including subadvances, for the next reporting period (see footnote 2)..... \$ _____
10. Additional cash advance requested for the next reporting period (Line 9 minus Line 8)..... \$ _____
11. Total interest earned on cash advance from the start of the Grant or Cooperative Agreement to the end of this reporting period, but not remitted to AID.....\$ _____
12. Total cash advances to subgrantees, if any, as of the end of this reporting period..... \$ _____

FOOTNOTES:

1. The Grantee shall submit a cumulative detailed report of disbursements by BUDGET line item quarterly; the monthly cash advance status report does not require a detailed report of disbursements.
2. The Grantee shall attach to this summary a detailed projection by BUDGET line item, of its anticipated needs for the next reporting period.

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C. Certification

The undersigned hereby certifies: (1) that the report in paragraph B.9 above represents the best estimates of funds needed for the disbursements to be incurred over the period described, (2) that appropriate refund or credit to the Grant will be made in the event of disallowance in accordance with the terms of the Grant, (3) that appropriate refund or credit to the Grant will be made in the event funds are not expended and that any interest accrued on the funds made available herein will be refunded to AID.

BY _____

DATE _____

TITLE _____

c. AID funds shall not be commingled with other Grantee owned or controlled funds. The Grantee shall deposit all AID cash advances in a separate bank account and shall make all disbursements for goods and services from this account.

6. PAYMENT--REIMBURSEMENT

(This provision is applicable to grants for construction, or to grants which do not provide for a periodic advance.)

(a) Each month the Grantee shall submit to the AID Controller an original and 3 copies of SF 1034, "Public Voucher for Purchases and Services Other Than Personal"; each voucher shall be identified by the grant or cooperative agreement number and shall state the total amount of costs incurred for which reimbursement is being requested.

(b) In addition to the SF 1034, each nonconstruction voucher shall be supported by an original and 2 copies of SF 270, "Request for Advance or Reimbursement," and each construction voucher shall be supported by an original and 2 copies of SF 271, "Outlay Report and Request for Reimbursement for Construction Programs."

(c) Each quarterly voucher (or each third monthly voucher) shall also be supported by an original and 2 copies of a SF 269, "Financial Status Report." The SF 269 shall be submitted within 30 days after the end of the reporting quarter and may be submitted separately from the SF 1034(s).

7. TRAVEL AND TRANSPORTATION

Use Standard Provision 13 of APP 4C (The requirements of SP 13(c) are applicable to travel within the cooperating country.)

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8. OCEAN SHIPMENT OF GOODS

Use Standard Provision 14 of APP 4C.

9. PROCUREMENT OF GOODS AND SERVICES UNDER \$250,000

Use Standard Provision 15 of APP 4C, however, delete paragraph (e) in its entirety and substitute the following therefor:

* * * * *

(e) The Grantee's Procurement System

(1) The Grantee may use its own procurement policies and procedures provided they conform to the geographic source and order of preference requirements of this provision and paragraphs 1U.3.a., b., and c. of Chapter 1, AID Handbook 13.

(2) If the Grantee's procurement policies and procedures have been reviewed against the procurement requirements of paragraph 1U.3.a., b., and c. and have been approved by AID or another Federal department or agency, the Grantee shall furnish the Grant Officer a copy of such approval; otherwise the Grantee's procurement policies and procedures shall conform to those specified in paragraph 1U.3.a., b., and c. of Chapter 1, AID Handbook 13.

* * * * *

10. PROCUREMENT OF GOODS AND SERVICES OVER \$250,000

Use Standard Provision 16 of APP 4C, however, delete paragraph (k) in its entirety and substitute the following therefor:

(k) The Grantee's Procurement System

(1) The Grantee may use its own procurement policies and procedures provided they conform to the geographic source and nationality requirements of this provision and paragraphs 1U.3.a., b., and c. of Chapter 1, AID Handbook 13.

(2) If the Grantee's procurement policies and procedures have been reviewed against the procurement requirements of paragraphs 1U.3.a., b., and c. and have been approved by AID or another Federal department or agency, the Grantee shall furnish the Grant Officer a copy of such approval; otherwise the Grantee's procurement policies and procedures shall conform to those specified in paragraph 1U.3.a., b., and c. of Chapter 1, AID Handbook 13.

11. LOCAL COST FINANCING WITH U.S. DOLLARS

Use Standard Provision 17 of APP 4C.

12. GOVERNMENT FURNISHED EXCESS PERSONAL PROPERTY

Use Standard Provision 18 of APP 4C.

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13. TITLE TO AND USE OF PROPERTY (GRANTEE TITLE)

Use Standard Provision 19 of APP 4C.

14. TITLE TO AND CARE OF PROPERTY (U.S. GOVERNMENT TITLE)

Use Standard Provision 20 of APP 4C.

15. TITLE TO AND CARE OF PROPERTY (COOPERATING COUNTRY TITLE)

Use Standard Provision 21 of APP 4C.

16. VOLUNTARY PARTICIPATION

Use Standard Provision 24 of APP 4C.

17. PROHIBITION ON ABORTION - RELATED ACTIVITIES

Use Standard Provision 25 of APP 4C.

18. VOLUNTARY PARTICIPATION REQUIREMENTS FOR STERILIZATION PROGRAMS

Use Standard Provision 26 of APP 4C.

19. PUBLICATIONS

Use Standard Provision 27 of APP 4C.

20. PATENTS

Use Standard Provision 28 of APP 4C.

21. REGULATIONS GOVERNING EMPLOYEES OUTSIDE THE UNITED STATES

Use Standard Provision 29 of APP 4C. (This provision applies only to the Grantee's employees working outside their country of residence.)

22. SUBORDINATE AGREEMENTS

Use Standard Provision 30 of APP 4C.

23. PARTICIPANT TRAINING

Use Standard Provision 34 of APP 4C.

24. HEALTH AND ACCIDENT COVERAGE FOR PARTICIPANT TRAINEES

Use Standard Provision 35 of APP 4C.

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C. The following clauses, while not required by law or regulation to be applicable to grants and cooperative agreements with non-U.S. organizations, should be included:

1. U.S. OFFICIALS NOT TO BENEFIT

Use Standard Provision 37 of APP 4C.

2. COVENANT AGAINST CONTINGENT FEES

Use Standard Provision 38 of APP 4C.

3. NONLIABILITY

Use Standard Provision 39 of APP 4C.

4. AMENDMENT

Use Standard Provision 40 of APP 4C.

5. THE GRANT

Use Standard Provision 41 of APP 4C.

6. NOTICES

Use Standard Provision 42 of APP 4C.

D. The requirements for selecting Grantees and processing grants and cooperative agreements which are set forth in Chapter 4, paragraphs 4F through 4G for grants, and Chapter 5 for cooperative agreements are applicable to grants, cooperative agreements, and subgrants to non-U.S., nongovernmental institutions.

E. Deviations

(See paragraph 1E, Chapter 1 of this Handbook)

ANNEX M

GUIDELINES FOR TECHNICAL ASSISTANCE TEAM SCOPE OF WORK

In the process of design of this project, the Project Paper Design Team prepared a detailed description of the kinds of tasks which will likely face the Recipient, as well as requirements for logistical support and reporting, and specific requirements in relation to the members of a hypothetical implementation team. The description prepared by the design team is included herein to illustrate the kind of implementation tasks envisioned for the implementation team.

1. Tasks of the Recipient's Long Term In-Country Team

The major task of the Recipient's team will be to cooperate with the United States Agency for International Development (USAID/Kenya) in the design, implementation, and evaluation of specific activities intended to initiate or expand private sector (e.g. private-for-profit companies, parastatals, private and voluntary organizations, women's and professional groups) delivery of family planning services. The team will also have independent reporting and other document preparation responsibilities to USAID/Kenya. The team will have the overall responsibility for ensuring that all policies, procedures and practices necessary for the effective expansion of project-related family planning services delivery by the private sector are in place and operational. Major institutional capabilities which are to be developed include establishment of:

- a. a new training methodology for Ministry of Health approved family planning motivation and clinical training;
- b. a contraceptive supply and management system for the private sector, and
- c. a reporting system to enable the Government of Kenya to be informed regularly of private sector family planning activities.

The team will develop discrete private sector family planning service delivery subprojects with potential subgrantees; request USAID approval for implementation; negotiate subgrant awards with proposed subgrantees; and assist the subgrantees in implementation, including necessary arrangements for training, technical assistance, contraceptive supply management, monitoring, reporting and evaluation. The team will propose to USAID discrete operational research activities to be undertaken in conjunction with the subprojects, and, if approved by USAID, conduct such research and report

results. The team will have responsibility and funding for limited off-shore and local equipment and supplies procurement, distribution and monitoring. It is anticipated that the following items will be procured: vehicles, clinical equipment/supplies and office equipment/supplies. The team will arrange and conduct national seminars/conferences to disseminate findings and lessons learned in the activity, and to increase participation by a wider number and variety of private sector organizations. Specific responsibilities will include; in cooperation with USAID/Kenya, :

- Identify, design, implement, monitor and report on approximately 30-35 private sector organization demonstration family planning service delivery subprojects, each of about two-years duration.
- Assist subprojects by identifying needs for recruiting and supervising appropriate technical assistance.
- Make arrangements for motivational and clinical training, assure compliance with Government of Kenya family planning educational requirements, and assist in securing GOK certification of graduates.
- Assist subprojects to secure a wide range of contraceptives through the Ministry of Health contraceptive supply system, and to meet Ministry of Health supply requirements, including documentation and reporting. In the event that it should be determined that this system does not work satisfactorily, recommend to USAID alternative supply arrangements acceptable to Government. (Contraceptive procurement will not be undertaken without express permission of USAID.)
- Propose, design, implement and report on 4 or 5 operational research activities which may impact on quality of services delivered upon expansion of family planning delivery by the private sector, and/or upon more effective family planning practice.
- Conduct national level seminars/conferences designed to exchange information, disseminate project results, and stimulate increased family planning service delivery by the private sector.

- Identify and procure those commodities (equipment and supplies), either locally or in the United States, needed for operations and subproject implementation.
- Provide USAID with reports as described in Paragraph 3 below, and such other project related documentation as required.

2. Logistical Support

USAID will not be responsible for providing logistical support. Cost applications should include provision for housing, utilities, educational allowances, home leave, night guard services, international travel, shipping or storage of household effects, and other matters as appropriate for long term technicians.

In all cases where applicable, allowable costs will be determined according to USAID standard provisions. Expatriate long term technicians will be allowed initially to import personal effects and one privately owned vehicle (or purchase of same in Kenya) duty free if shipped within three months after arrival at post.

Office space in Nairobi, office equipment, furniture, expendable supplies, and necessary subproject related non-contraceptive commodities will be funded under the Agreement. Upon signing the Cooperative Agreement, the Recipient will make arrangements to purchase and ship from the U.S. necessary items not locally available in Kenya. USAID intends to process waivers for the purchase of two right hand drive project vehicles for the Recipient. Procurement maintenance and operation of these vehicles will be the responsibility of the Recipient. It is anticipated by agreement of USAID and the Government of Kenya Kenya, that the following exemptions from duties, taxes and similar charges will be afforded:.

A. Exempt from customs duty and sales tax, goods and equipment imported or purchased prior to clearance through customs for the purpose of the Project.

B. Exempt personnel of the Contractor (other than citizens or residents of Kenya), who are in Kenya solely for the purpose of executing the project, from paying customs duty and sales tax on new or used household and personal effects, including one motor

vehicle, imported or purchased prior to clearance through customs within the first three months of their first arrival in Kenya, or for such further period as the Treasury may approve in writing. Provided that in all other respects the customs and sales tax laws and regulations for the time being in effect shall remain applicable. Provided further that in the event of such goods being sold or disposed in Kenya other than to a person or organization similarly privileged, customs duty and sales tax shall then be payable thereon in accordance with the appropriate rates.

C. Exempt from all direct tax and national social security contributions on income or any other emoluments received, the personnel of the Cooperative Agreement (other than citizens or residents of Kenya) who are in Kenya solely for the purpose of executing the project on behalf of USAID.

Terms of-employment for Kenyan nationals will be consistant with the laws of Kenya and commercial practices in Kenya.

3. Reporting

It is anticipated that the Recipient's team will work in close cooperation with USAID's Project Officer

The Recipient will provide semi-annually, five copies of written reports to the USAID Mission, Kenya. Such reports will be presented in a format agreed upon in the course of the development of the Recipient's work program. A final comprehensive report will be delivered in two copies to USAID at least two weeks prior to the team's departure from Kenya

4. Projected Team Composition

The preliminary project design envisions the need for three long term technicians, a secretary, two driver-messengers, and approximately twelve person months of short-term consultants. A summary of the design team's discussion of requirements for an implementation team is included below.

The long-term technicians are:

- . Senior Family Planning Management Specialist
- . Evaluation/Research Specialist,
- . Administration and Procurement Specialist.

It is considered preferable that at least the Evaluation/Research Specialist be Kenyan. Qualifications and experience required, working relationships and specific duties of each individual team member are set forth below.

1. Senior Family Planning Management Specialist
(Anticipated four-year assignment in Kenya)

a. Qualifications

The incumbent will possess an MPH in health or family planning administration, MPA, or equivalent degree, with substantial field experience in an international setting. The incumbent should have a broad understanding of health system organization, programming, planning, management, and family planning or primary health care delivery systems. Must be willing to travel extensively and frequently throughout Kenya.

b. Experience Requirements

The incumbent should have a minimum of ten years experience beyond the completion of formal study, of which at least five years is successful experience working in developing countries, preferably in Africa, in a responsible position related to family planning, health care, or development management. Experience with private-for-profit companies is desirable. The incumbent must have demonstrated leadership capabilities through the management of field activities in the health or family planning areas. He or she must also have demonstrated the ability to be sensitive to political constraints within a developing country context. The person must be experienced in working with host country and other private sector (including business) personnel, and government agencies and in working cooperatively with technical assistance personnel from outside and within host country agencies. Knowledge of and experience with AID regulations would be an asset.

c. Duties and Responsibilities

Duties and responsibilities of the Senior Family Planning Management Specialist include the following:

- (1) Serve as team leader with responsibility for the overall direction and coordination of Project activities.
- (2) Work cooperatively with USAID in the technical design and implementation of project components.
- (3) Assume major responsibility for the oversight of project documentation and reports, operational research planning and USAID project-related documents.
- (4) Work with the Evaluation/Research Specialist, the Administration and Procurement Specialist, and USAID in the development of a work program for the project as well as assisting in final drafting and review of individual work programs and consultants' scopes of work.
- (5) Serve as the principal representative of the Recipient and work with the Administration and Procurement Specialist in administering the procurement, deployment, and utilization of all commodities acquired for purposes of implementing the project and maintaining records of funds expended.
- (6) Assist in coordinating project activities with other USAID-funded projects in Kenya as appropriate.
- (7) Work with the other two members of the team in the identification, development, securing of USAID approval, implementing, monitoring, evaluating and reporting on subprojects, including training and commodity supply related thereto.

- (8) Work with the Evaluation/Research and Administration and Procurement Specialists in arranging to provide all motivational and clinical training related to the project. This includes securing MOH approval, monitoring and securing evaluation of training.
- (9) In collaboration with the Administration and Procurement Specialist, keep USAID apprised of the adequacy of the contraceptive supply system, and, if deficient, make recommendation to USAID for improvement or for an acceptable alternative system(s).
- (10) Work with USAID in suggesting to the Government of Kenya improvements in organizational relationships or procedures which will improve the coordination of the Government of Kenya with private sector family planning service providers.
- (11) Coordinate with USAID to ensure that a reporting system is in place whereby the Government of Kenya is fully informed of project-related utilization of family planning services.
- (12) Work with the Evaluation/Research Specialist and expert consultants in developing data gathering instruments and in applying techniques that produce information required for administration, planning, and evaluation of various subproject activities.
- (13) Gain approval from USAID for the conduct of 4 or 5 operational research activities and in conjunction with the Evaluation/Research Specialist, arrange for implementation, monitoring, evaluation, and reporting on results.
- (14) In cooperation with USAID, arrange and develop mechanism for dissemination of project results.

- (15) Provide technical assistance in management to various subproject demonstration activities.
- (16) Assure that he/she, or at least one of the other team members has working familiarity with a micro-computer.

2. Evaluation/Research Specialist
(anticipated four-year assignment in Kenya)

a. Qualifications

The incumbent will possess a Master's level or higher degree in the social or biological sciences, with successful experience in research and evaluation of field activities, preferably in the health or family planning areas. The incumbent should have a substantial understanding of family planning service delivery, the training of paraprofessional health manpower, and methodologies for evaluating delivery systems. He/she must be willing to travel extensively and frequently throughout Kenya. Preferably the incumbent will have an understanding of Kenyan local cultures and proficiency in one or more local languages.

b. Experience Requirements

The incumbent should have a minimum of eight years' experience beyond the completion of education study. The position requires at least four years' experience working in developmental activities, preferably health-family planning related in Africa, preferably in Kenya. Experience should include major responsibility for operational research and evaluation in the social or biological sciences. A full understanding of the Kenyan health and family planning educational system is required and the incumbent should be aware of and understand educational and training methodologies involved in the preparation of

health-related Kenyan paraprofessionals (e.g. enrolled community nurses, clinical officers). He/she should be able to design, implement, and report on operational research activities and an internal project evaluation plan.

c. Duties and Responsibilities

Duties and responsibilities of the Evaluation/Research Specialist include:

- (1) Assist the Senior Family Planning Management Specialist in the preparation of project documentation, reports, and and special analytical studies.
- (2) Work with the Senior Family Planning Management Specialist and the Administration and Procurement Specialist in the development of an overall work program for the project and draft scopes of work for technical consultants.
- (3) In collaboration with USAID and the other team members, design, arrange implementation, monitor, and report on results of evaluation procedures for project and subproject activities. Prepare scopes of work for any technical assistance required.
- (4) Work with the Senior Family Planning Management Specialist and consultants in the design, implementation, evaluation and reporting of operations research activities related to project activities.
- (5) Provide technical assistance in evaluation, operational research and training to various subproject demonstration activities.
- (6) In cooperation with the Senior Family Planning Management Specialist, develop mechanisms for reporting and disseminating results of project activities, including evaluation and research findings in order to exchange information and to further stimulate the private sector to provide family planning services.

- (7) Maintain active liaison with universities, governmental agencies, private sector entities, private and voluntary organizations and others involved in operational research and family planning related training, for purposes of information exchange, coordination and possible cooperation.
- (8) Assist the Senior Family Planning Management in the identification, development, implementation, monitoring, evaluation and reporting on subprojects funded by the Cooperative Agreement.

3. Administration and Procurement Specialist
(anticipated four-year assignment in Kenya)

a. Qualifications and Experience Requirements

No specific academic level is specified for the incumbent; rather, a documented successful work experience involving office and field administration, with procurement experience is the key requirement. Experience in the private sector is desirable. Ideally this would include at least two years' successful experience in developing countries and familiarity with U.S. Government regulations. He/she would be required to travel frequently throughout Kenya.

b. Duties and Responsibilities

The incumbent will participate in the development of individual work plans and subproject activities. In addition to having primary responsibility for all project matters related to procurement, he will provide day to day administration and supervision of the team's office. Duties and responsibilities of the Administration and Procurement Specialist include:

- (1) Establishing, with USAID, clear guidelines on procurement of office and other project-related equipment and supplies from U.S. and Kenyan source and origin (unless otherwise agreed to in writing by USAID); initiate procurement; monitor pipelines, delivery and end-use; and, establish and maintain a record and reporting system for project-related commodities.
- (2) Closely monitor the adequacy of the Government of Kenya contraceptive supply and management system as it relates to timely contraceptive supply.
- (3) Work cooperatively with the Senior Family Planning Management Specialist and Evaluation/Research Specialist in the identification, design, implementation, evaluation and reporting of demonstration subproject activities.
- (4) In collaboration with the team leader, establish and implement office administrative procedures which permit maximum team efficiency.
- (5) Provide day to day management and supervision of the office, including scheduling of transport for team members and consultants, making conference arrangements, assuring that reporting requirements are met, and maintaining management and fiscal records.
- (6) Provide technical assistance in administration and medical logistics to the various subprojects.
- (7) Work with the Research/Evaluation Specialist in identifying procedures and protocols required to evaluate the subprojects.

Annex N

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

GENERAL CRITERIA FOR COUNTRY
ELIGIBILITY

The responses contained in the Structural Adjustment Program Grant (615-0213) Program Assistance Approval Document approved on June 24, 1983, remain valid.

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only:
B.1. applies to all projects funded with Development Assistance Funds,
B.2. applies to projects funded with Development Assistance loans, and
B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY
CHECKLIST UP
TO DATE? HAS
STANDARD ITEM
CHECKLIST BEEN
REVIEWED FOR
THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act
Sec. 523; FAA Sec. 634A;
Sec. 653(b); Second CR FY 83,
Sec. 101(b)(1).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;

(b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million)

over that amount)?

(c) If the proposed assistance is a new country program or will exceed or cause the total assistance level for the country to exceed assistance amounts provided to such country in FY 82, has a notification been provided to Congress?

(d) If the proposed assistance is from the \$85 million in ESF funds transferred to AID under the Second CR for FY 83 for "economic development assistance projects", has the notification required by Sec. 101(b)(1) of the Second CR for FY 83 been made?

a) This project was included in the FY 84 Congressional Presentation pages 171-172. A Congressional Notification was sent to Congress on the 15-day waiting period expires on --without Congressional objection

b) Yes

c) FY 83 assistance is above FY 1982 level. Congress has been notified as stated above.

d) N/A

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be

(a) engineering, financial or other plans necessary to carry out the assistance and
 (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

N/A

N/A

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?
4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

N/A

N/A

N/A

N/A

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
- This project is specifically designed to foster private initiative in the provision of family planning and related health services. Such initiatives may include those undertaken by cooperatives.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
- Grant-funded technical and management assistance will draw on U.S. private sector enterprise, and to a limited extent commodities related to family planning and health service delivery.
9. FAA Sec. 612(b), 636(h); FY 1982 Appropriation Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.
- Private institutions participating in subproject activities will contribute 17% (\$1000) of total project costs. The GOK will contribute 8% (\$500). There are no US owned foreign currencies available for this project.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?
- NO
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?
- Yes

12. FY 1982 Appropriation

Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16?. Does the project or program take into consideration the problem of the destruction of tropical forests?

This activity meets the criteria for Categorical Exclusion in accordance with Section 216.2 of Agency's procedures as approved by Africa Bureau Environmental Officer.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

15. FAA Sec. 128; Second CR FY 83, Sec. 101(b)(2). Has an attempt been made to finance productive facilities, goods, and services which will expeditiously and directly benefit those living in absolute poverty under the standards adopted by the World Bank?

Yes, through support of subproject activities which provide family planning and related services to the poor.

B.

FUNDING CRITERIA FOR PROJECT1. Development Assistance
Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

- a) This project is directed towards encouraging and assisting Kenya families and individuals to space births and limit family size in accordance with their own wishes and socio-economic needs using available, appropriate contraceptive methods.
- b) This project will include provision of technical assistance in management and related areas to private institutions to improve their capacity for family planning service delivery.
- c) Institutional and community self-initiated activities supported by the project will serve to increase involvement of individuals families, organizations and enterprises in improving their well being.
- d) The prime beneficiaries of the project are women; they will also constitute most of the service delivery personnel.
- e) N/A

Section 104: this is a population/family planning activity

Yes, the use of grants and technical assistance to private and voluntary institutions which enables the "piggy backing" family planning service delivery is a highly efficient means of promoting nationwide coverage.

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes, the Government of Kenya will contribute 8% (\$500,000) and private participating institutions will contribute 17% (\$1000,000).

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

N/A

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes, especially as it improves the capacity of private and voluntary organizations to provide family planning and related health services on a self-sustaining basis.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in government processes essential to self-government.

The project is designed to generate participation by supporting activities which will promote and enable voluntary adoption of family planning practices. Training of service delivery personnel is a component of the project, as is involvement with development of institutions including the National Council on Population and Development.

2. Development Assistance Project
Criteria (Loans only)

a. FAA Sec. 122(b).

Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.

N/A

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N/A

c. ISDCA of 1981, Sec. 724 (c) and (d). If for

Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)?

N/A

d. Second CR FY 83, Sec. 134.

If the recipient country has an annual per capita gross national product greater than \$795 but less than \$1,285, will the loan be repayable within 25 years following the date on which funds are initially made available? If it has an annual per capita GNP greater than or equal to \$1,285, within 20 years?

N/A

**3. Economic Support Fund
Project Criteria**

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

N/A

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to non-proliferation objectives?

N/A

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N/A

e. Second CR FY 83, Sec. 101(b)(1). If ESF funds to be utilized are part of the \$85 million transferred to AID under the Second CR for FY 83 for "economic development assistance projects", will such funds be used for such projects and not for non-development activities including balance of payments support, commodity imports, sector loans, and program loans?

N/A

5C(c) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?
2. FAA Sec. 604(a). Will all commodity procurement financed be from the United States except as otherwise determined by the President or under delegation from him?
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or

N/A

Kenya does not discriminate against U.S. marine companies.

product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one or these areas?

NO

6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates?

N/A

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the

Yes

fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U. S. carriers be used to the extent such service is available?

Yes

9. FY 1982 Appropriation Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services to be used?

N/A

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)?

N/A

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

N/A

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A

3. FAA Sec. 620(b). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the communist-bloc countries?

Yes

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1982 Appropriation Act Sec. 525: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

Yes

b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property?

Yes

c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

Yes

d. FAA Sec. 662. For CIA activities?

Yes

e. FAA Sec. 636(1). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?

Yes

f. FY 1982 Appropriation Act, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?

Yes

g. FY 1982 Appropriation Act, Sec. 505. To pay U.N. assessments, arrearages for dues?

Yes

h. FY 1982 Appropriation Act, Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)?

Yes

i. FY 1982 Appropriation Act, Sec. 510. To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?

Yes

j. FY 1982 Appropriation Act, Sec. 511. Will assistance be provided for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

Yes

k. FY 1982 Appropriation Act, Sec. 515. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

Yes

APPROVED

ANNEX O

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

Project Country: Kenya

Project Title and Number: Private Sector Family Planning

Funding: FY (s) '83 \$ 4.5 million

IEE/CE Prepared by: Satish Shah

Environmental Action Recommended:

Positive Determination _____
Negative Determination _____

OR

Categorical Exclusion _____

This activity meets the criteria for Categorical Exclusion in accordance with Section 216.2 and is excluded from further review because:

According to Section 216.2 of Agency's procedures stated in EECPE Part 216, an Initial Environmental Examination, Environmental Assessment and Environmental Impact Statement are not required for programs involving nutrition, health care or population and family planning services if they do not include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.). The AID Grant does not include any activities which could directly affect the environment.

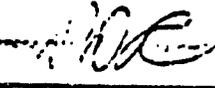
Action Requested by: _____ Date: _____
(Mission Director)

Concurrence: GEORGE R. THOMPSON
(Bureau Environmental Officer)

APPROVED 

DISAPPROVED

DATE JAN 28 1983

Clearance: GC/AFR  Date 31 Jan 83

Annex P

SOURCE/ORIGIN WAIVER

WAIVER NO: KEN-W-83-005

WAIVER EFFECTIVE DATE:

ACTION MEMORANDUM TO THE DIRECTOR, USAID/KENYA

From: Edward Greeley, Acting Chief, Projects Division

Subject: Private Sector Family Planning - 615-0223

Date: June 20, 1983

PROBLEM: A procurement source and origin waiver from Geographic Code 000 (U.S. only) to Geographic Code 935 (Special Free World) and a waiver of section 636(i) of the Foreign Assistance Act of 1961, as amended are requested to finance the purchase of four right hand drive vehicles for project use.

Cooperating Country	-	Kenya
Authorizing Document	-	Cooperative Agreement
Project	-	Private Sector Family Planning (615-0223)
Nature of Funding	-	Grant
Description of Commodity	-	4 right hand drive vehicles mini-vans or equivalent
Approximate Value	-	\$47,000
Probable Origin	-	United Kingdom, Germany, Japan or Kenya
Probable Source	-	United Kingdom, Germany or Kenya

DISCUSSION

Section 636 (i) of the Foreign Assistance Act of 1961, as amended, prohibits AID from financing motor vehicles unless such vehicles are manufactured in the United States. Section 636 (i) does provide, however, that "... where special circumstances exist, the President is authorized to waive the provisions of this section in justification.

AID is funding a Recipient under a Cooperative Agreement which will implement the proposed project through a Technical Assistance Team. The Team of three specialists will be responsible for identifying, developing, implementing and evaluating an estimated 35 discrete subprojects countrywide. Examples of the types of projects to be funded, in Eastern, Central and Western Kenya are included in the Project Paper. Additionally, the Team will implement five operational research activities and will conduct several workshops around the country. Efficient and effective implementation of project activities will require constant travel by the Technical Assistance Team, and also of the institutions which take responsibility for supporting subproject activities in a number of different organizations associated with them. For example, the Protestant Church Medical Association will fund and support ten different member institutions. The Lake Basin Regional Development Authority will operate family planning service delivery in several districts in Western Kenya.

A number of the participating institutions are located in areas remote from Nairobi and removed from a capability to maintain and repair vehicles. Timely efficient travel is the essence of this project of subprojects.

Handbook 1 Supplement B Chapter 5 section 5, B, 4a(2) provides that when a commodity is not available from countries in the authorized Geographic Code, a source/origin waiver may be granted. Four right hand drive mini-vans required specifically for the project and which can be maintained in Kenya are not available from the U.S. or Code 941 countries.

Delegation of Authority No. 140 (Revised) provides Mission Directors the Authority to waive and grant special exemptions in accordance with Chapter 5 Supplement B of Handbook 1, of source, origin or nationality requirements up to \$50,000 for the purchase of vehicles.

RECOMMENDATION

For the above reasons, it is recommended that you:

- 1) Approve a vehicle procurement source/origin waiver from AID Geographic Code 000 to Code 935;
- 2) Conclude that special circumstances exist which justify a waiver of the provisions of Section 636(i) of the Foreign Assistance Act as amended;

3) Certify that exclusion of procurement from Free World Countries other than the Cooperating Country and countries included in Code 941 would seriously impede the attainment of U.S. foreign policy objectives and the objectives of the foreign assistance program.

Approved: CEHewitt

Disapproved: _____

Date: 3 August 1983

Drafted: PRJ:NGreeley:am:6/17/83 NG
 Clearance: HNP:REritanak RE
 PRJ:SPShah (draft)
 RFMC:LMartin LM
 REDSO/RLA:EDragon ED
 REDSO/RSA:DCowles DC