

PROJECT EVALUATION SUMMARY (PES) - PART I

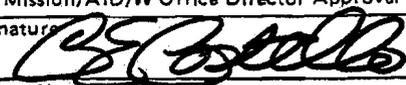
1. PROJECT TITLE FAMILY PLANNING	2. PROJECT NUMBER 615-0161	3. MISSION/AID/W OFFICE KENYA
	4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) <u>615-82-05</u> <input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING		7. PERIOD COVERED BY EVALUATION	
A. First PRO-AG or Equivalent FY <u>75</u>	B. Final Obligation Expected FY <u>79</u>	C. Final Input Delivery FY <u>82</u>	A. Total	\$ <u>5,047,000</u>	From (month/yr.)	<u>8/77</u>
			B. U.S.	\$ <u>2,303,000</u>	To (month/yr.)	<u>12/81</u>
					Date of Evaluation Review	

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICE RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Preparation of Project Assistance Completion Report	Silberstein	6/30/82
Deobligation of residual project funds	Robinson	6/30/82

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT		
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan, e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____	A. <input type="checkbox"/> Continue Project Without Change		
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	<input type="checkbox"/> Other (Specify) _____	B. <input type="checkbox"/> Change Project Design and/or		
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C		<input type="checkbox"/> Change Implementation Plan		
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P		C. <input type="checkbox"/> Discontinue Project		

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)	12. Mission/AID/W Office Director Approval
SPENCER M. SILBERSTEIN Population Officer	Signature: 
	Typed Name: _____
	Date: <u>3-2-82</u>

PROJECT EVALUATION SUMMARY (PES) -PART III

13. Summary:

USAID, six other international donors, and the Government of Kenya participated in an integrated maternal child health/family planning (MCH/FP) program. Although the program was scheduled to operate for five years during the period 1974-79, there have been substantial delays in the implementation of project 615-0161, necessitating extension of the PACD until 12/31/81. The major components of the multi-donor program are:

- (a) introduction of full-time maternal and child health/family planning (MCH/FP) services in 400 GOK health facilities, (b) extension of MCH/FP services through 17 mobile teams to an additional 190 facilities, (c) establishment of 8 enrolled community nurse (ECN) training schools and 30 health centers, (d) training 600 ECNs in FP, (e) training and deploying 800 family health field educators (FHFE), a new cadre of field workers, (f) enhancement of health education materials production capacity, and (g) establishment of a new organizational unit, the National Family Welfare Center (NFWC) to plan and support FP activities within the MOH. Although many quantitative targets were achieved, the purpose and goal of the project were not achieved. Recruitment of FP acceptors was substantially below target and the population growth rate has increased rather than declining.

14. Evaluation Methodology

At the request of the Government of Kenya, an External Mid-Term Review Mission, composed of representatives of the World Bank, United Nations, Sweden

and AID, visited Kenya in March, 1977. The World Bank issued the External Mid-Term Review Mission's Report (Report No. 1713-KE) on August 18, 1977. The findings and recommendations were reported in an earlier USAID/Kenya PES. A final multi-donor external review was scheduled to take place in late 1979 under the leadership of the United Nations. However, arrangements for the evaluation were postponed because of the illness of the then Kenya-based United Nations Fund for Population Activities representative. The multi-donor external review has not taken place, largely because both the MOH and a majority of the donor agencies felt that few new lessons would be learned. The consensus reached was that the MOH and donor agencies would evaluate past performance during a Joint Appraisal of the GOK's Integrated Rural Health and Family Planning Program. The Joint Appraisal involving six donor agencies and the MOH took place during October and November, 1980. The draft Appraisal Report was issued on March 18, 1981. The World Bank, after consulting with donor agencies including USAID/Kenya, issued its Project Performance Audit Report and Project Completion Report on April 28, 1981. USAID/Kenya has also assessed progress in meeting project objectives and identified project issues through the Mission's Quarterly Reviews. This PES has been developed by USAID/Kenya staff utilizing information from internal review documents and the above reports. This is the final evaluation scheduled for this terminating project.

15. External Factors

The USAID Project Paper identified two major constraints limiting the effective delivery of family planning services in Kenya. These two constraints are lack of trained manpower, especially in the paramedical and information and education areas, and MOH management deficiencies. However, the project designers seemingly ignored two other constraints which ultimately affected achievement of the project goal and purpose. The other constraints are inadequate GOK

commitment to family planning and limited popular demand for smaller families.

Indeed the Project Paper states, "There is high level political commitment on the part of the GOK to move ahead as rapidly as possible to implement a national family planning program." This high-level commitment failed to materialize during the period of project implementation. The World Bank Project Performance Audit Report states, "An evaluation of the successes and failures of the First Population Project requires an interpretation of the relative weight given to its two major components, MCH and FP. From initial conception of the project through preparation, appraisal and implementation, the major stockholders..... held widely differing levels of commitment to the two parts. A successful process of design would have required that the differing levels of commitment be understood and accurately perceived by each of the stakeholders and that a means be found that would satisfy the proposed stake each had in the project outcome. Many of the problems of design and implementation can be traced to the inappropriateness of the fit between project strategy and structure and the relative commitment of the stakeholders to the two major components. As early as October 1967 the GOK demonstrated its relative lack of commitment to family planning by disbanding the interministerial Family Planning Council and relegating control of the Government's family planning effort to the MOH.... From the earliest days of project conception in 1969, the Kenyan Government made it clear that its primary interest was rural health and that it would only consider family planning as part of a maternal and child health program.... It was also clear that the Kenyan population, especially the 75% living outside of the urban areas, was not in favor of family planning."

16. Inputs

This multi-donor project was intended to be implemented between July 1, 1974 and June 30, 1979. The final/obligation was made on December 14, 1978, and
USAID

AID LOP funding is \$2.3 million. The following inputs were provided by

USAID:

- 1) Technical assistance (\$194,000)
- 2) Participant training (\$802,000)
- 3) Commodities (\$729,000)
- 4) Salary supplements (\$572,000)

Funding for participant training was the largest USAID project input.

Although the participant training proffered appears appropriate in terms of quantity and quality, there were problems in the selection process. The MOH was unable to identify qualified candidates on a timely basis and the output of trained MOH staff was affected.

The provision of commodities was a significant implementation problem. USAID Project Managers ordered commodities on a timely basis, but a number of lengthy delays have occurred due to: (a) frequent breakdown in communication between USAID, AID/W and the procurement agent, Afro-American Purchasing Center (AAPC), (b) non-availability of commodities from U.S. sources and necessity to obtain numerous waivers not originally anticipated by project designers and (c) very slow procurement by the procurement agent.

USAID agreed to reimburse the MOH for salary payments to certain categories of MOH personnel. Two other donor agencies also provided similar assistance. The MOH was to have hired additional personnel for the National Family Welfare Center, the Health Education Unit and rural health facilities, but did not submit the required reimbursement vouchers on a timely basis. Although there is no evidence to suggest that delays in reimbursement affected project outputs, the delays resulted in extremely slow expenditure of funds earmarked for salary reimbursement. Ultimately, reimbursement claims were presented immediately prior to the expiration of the PACD.

17. Outputs

The Project Paper specified the following project outputs:

	<u>Projected</u>
Community Nurses on the job	417
Family Health Field Educators on the job	817
Supervisory/Professionals employed	92
NFWC Administrative Unit employed	19
Health Education Unit employed	99
Health Education Unit FP activities as % of total effort	50%

950 enrolled/community nurses received in-service FP training, but many of those trained were deployed where their training could not be utilized. On the average only one out of every 2.5 nurses trained in FP was posted to a MCH/FP Service Delivery Point (SDP). There were 364 SDPs established by the MOH and staffed by a enrolled/community nurse. Though Family Health Field Educators were trained in sufficient numbers, 750 vs. a target of 817, they were inadequately supervised and supported. During 1978 FHFES managed to recruit less than 18 new FP acceptors on average during the year. The output of 92 supervisory professionals was not accomplished because the MOH decided to abolish the cadres of Family Health Field Officers and Nurse Trainers/ Supervisors (NT/S). Clinical Officers, who are in charge of rural health centers, never received training in FP. Supervision was left in the hands of 46 provincial and district matrons who were overburdened with other duties. More than 19 employees were employed at the National Family Welfare Center's Administrative and Planning Unit, but the unit gave only limited support because the key posts of Administrative Officer, Executive Officer and Accountant were vacant through much of the project period. Although the Health Education

Unit expanded its staff substantially, the HEU was not able to retain skilled audio-visual production personnel. Delays in utilization of a new HEU building and in provision of audio-visual equipment also adversely affected materials production. Finally, HEW FP activities never approached 50% of the HEU's total effort because of other higher priority needs of the MOH.

18. Purpose

The original purpose of this project was to create a national framework capable of recruiting 640,000 new family planning acceptors over the five-year period ending June 30, 1979, and significant additional acceptors in succeeding years. The 640,000 new acceptor target was reduced to 450,000 as a result of the Mid-Term Review. However, only 310,000 acceptors were actually recruited. Progress Towards End of Project Status (EOPS) Conditions has been uneven.

1. Family Planning services were to be available on a full-time basis at 400 SDPs which would each recruit 300 new FP acceptors yearly.

Although 364 SDPs were operating, most SDPS fell far short of recruiting 300 new FP acceptors during the final year of the project. Although two FHFES were generally assigned to a SDP, they did not provide FP community outreach as envisioned by the project designers. Additional recruitment for this cadre has been frozen pending revision of FHFES duties.

2. 17 Mobile Units were to provide FP services on a part-time basis to 190 additional service points and recruit 150 new acceptors yearly. The 17 were operating but were ineffective in recruiting new FP acceptors largely because vehicles and staff were often diverted to other health activities. The MOH has decided to phase out the mobile units.

3. An effective system of community nurse and FHFES supervision was never established at the district and provincial levels because the NT/S and FHFOS cadres of supervisors were abolished by the MOH. Lack of

effective field supervision continues to be a major constraint.

4. Although a National Family Welfare Center (NFWC) is operational within the MOH, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out its mandate, the spearheading of the National Family Planning Program. There is not a full-time, relatively independent Director, and the principal responsibility for directing NFWC activities fell to the Deputy Directors, who were changed three times during the life of the project and themselves received little support. Key professional staff resigned or transferred as donor salary support was phased out according to project design. The NFWC currently has little institutional capacity to carry out its mandate.

5. Although the Health Education Unit of the MOH received substantial inputs (new building, audio-visual production materials and increased staff), it has never attempted to mount a comprehensive FP Information and Education (I&E) Program and has utilized those inputs for other forms of health education.

6. The number of FP acceptors increased to 310,000 instead of 640,000.

The Project Paper's assumption for achieving the project purpose was that sufficient demand for FP services already exists or will be generated by educational activities under the project to attain the 640,000 new acceptors. In light of widespread popular attitudes favoring high fertility as revealed by the Kenya Fertility Survey and the meager FP I&E activities implemented under the project, the assumption appears wildly unrealistic in retrospect. It is difficult however, to attribute the lack of project success solely to lack of demand for FP services. The MOH's management deficiencies and lack of commitment to FP resulted in inadequate quality and quantity of FP information and services.

Both supply and demand constraints probably caused low acceptance of FP by the Kenyan public.

19. Goal

The goal of this multi-donor assisted Government of Kenya five-year family planning program is a reduction in the annual rate of natural increase from an estimated 3.3 percent in 1974 to 3.0 percent in 1979, leading to continued reductions over the succeeding 20 years, which would bring the growth rate down to 2.8 percent by 1999. Although it is still possible to achieve the goal of a 2.8 percent growth rate by 1999, the project did not materially contribute to the reduction of the growth rate from 3.3 percent to 3.0 percent during the project period. Evidence from the National Demographic Survey, the Kenya Fertility Survey and the 1979 Population Census indicates that the growth rate has risen to 3.8-4.0 percent rather than declining. The number of births averted through project activities was too low to have any appreciable demographic effect at the goal level. The assumption that the birth rate would be reduced faster than the death rate proved to be unrealistic.

If the project had attained its purpose, it would have contributed to substantial progress toward the goal. Because the project progress has been so unsatisfactory in terms of increasing FP acceptance, there has been no progress toward the goal. Other projects and external factors have likewise failed to contribute to goal attainment. In our view, the purpose goal linkage remains valid. The project designers erred in thinking that donor inputs would ultimately lead to achievement of the project purpose. The input-output and output-purpose linkages were unrealistic because they failed to adequately recognize and deal with the significant external constraints. These constraints include: lack of political support for FP, inadequate commitment to FP within the MOH, fundamental

organizational weaknesses within the MOH and socio-economic/cultural support for large families.

20. Beneficiaries

The 310,000 Kenyans who accepted FP services together with their families were the primary beneficiaries of this AID project. The Project Paper estimated that these would be 640,000 new FP acceptors. The Project Paper provided no detailed analysis of the intended beneficiary group, but indicated that reduced rates of population growth resulting from FP acceptance would have a beneficial socio-economic impact on Kenya in terms of employment, social services and per capita income. It is difficult to estimate the births averted by the recruitment of 310,000 FP acceptors as continuation rates are not known precisely. Moreover, there is evidence to suggest that adoption of modern methods of contraception often served as a substitute for traditional methods of child spacing such as abstinence and prolonged lactation. The demographic impact of the project was relatively negligible.

Several factors may have contributed to the increased fertility observed during the project period: improved health, reduced lactational amenorrhea and declines in the practice of polygamy. Death rates were not expected to decline appreciably during the period, but improved health services and socio-economic development led to a reduction in the death rate from about 17 in 1974 to about 14 in 1978.

Although project activities did not have their anticipated impact on fertility, the impact on maternal and child health was encouraging. During 1977 there was a 30% increase over 1976 in the number of clients requesting MCH services at clinics. About 440,000 first visits and 850,000 revisits for antenatal services, and 465,000 first visits and 1,050,000 revisits for child welfare

services were carried out in 1977. A majority of pregnant women (about 65%) and a smaller but growing portion of children are utilizing MCH services. Although it is difficult to prove causality, there were substantial declines in infant mortality during the project period. Analysis of the 1969 Census and 1977/78 Kenya Fertility Survey indicates that infant mortality declined from 119 in 1969 to 87 in 1977.

21. Unplanned Effects

There was only one major unplanned effect. The multi-donor integrated MCH/FP Program to which this USAID project contributed was designed to improve the health of mothers and children as well as to reduce fertility. However the project designers did not anticipate that the success of the MCH activities would temporarily exacerbate the population growth rate problem by stimulating fertility (through reduction of fecundity impairments) and depressing mortality (through reduction of infant and child mortality). Nor did the project designers realize that demand for MCH services would far exceed that for FP services. As a result, the rate of population increased from 3.3% to almost 4% rather than declining to 3%.

22. Lessons Learned

The 1974-79 MCH/FP Program was quite successful in the following areas: a) construction of health facilities and training schools, b) training of paramedicals and c) expansion of MCH services in rural Kenya. The impact on the health of Kenyan women and children was positive.

The project was not successful in terms of recruiting FP acceptors or reducing the rate of population growth. In retrospect, one can conclude that the conditions necessary for a successful FP program were not present and that donor assumptions about FP in Kenya were unrealistic.

A number of important lessons were learned that will influence the design of follow-on activities funded by USAID. Firstly, the GOK MCH/FP Program concentrated heavily on the supply side of family planning, although available evidence clearly suggests that the main constraint to the reduction of fertility levels in Kenya is the almost universal desire for large families. Thus a greater emphasis on activities designed to change family size norms and attitudes about FP is clearly indicated.

Secondly, it is clear that donor agencies supporting the GOK MCH/FP Program overestimated the level of GOK commitment to reduction of the rate of population growth and provision of FP information and services. Lack of GOK commitment seriously affected the establishment and operation of the National Family Welfare Center. It is important that designers of future FP projects in Kenya realistically appraise Kenyan commitment to project objectives and build realistic assumptions into the project design. A greater emphasis on activities designed to foster clearer understanding of POP/FP issues on the part of leadership groups is clearly indicated.

Thirdly, the GOK MCH/FP Program relied excessively on the MOH as the sole vehicle to achieve its objectives. There was no serious attempt by either the GOK or donor agencies to involve other Government agencies or the private sector in the attainment of the MCH/FP Program's objectives. Such a broad, multi-sectoral involvement is important for the achievement of fertility reduction objectives which requires wide community cooperation and political support. Follow-on activities should involve the establishment and institutionalization of mechanisms to encourage and coordinate the implementation POP/FP activities by Government and private sector agencies.