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EVALUATION OF THE
FPPS PROJECT
(FAMILY PLANNING PRIVATE SECTOR)

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LIST OF ACRONYMS

A.I.D.	AGENCY FOR INTERNATIONAL DEVELOPMENT
AMREF	AFRICAN MEDICAL AND RESEARCH FOUNDATION
AVSC	ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION
CBD	COMMUNITY BASED DISTRIBUTION
CHAK	CHRISTIAN HEALTH ASSOCIATION OF KENYA
Crescent	
CYP	COUPLES YEARS OF PROTECTION
FP	FAMILY PLANNING
FPAK	FAMILY PLANNING ASSOCIATION OF KENYA
FPPS	FAMILY PLANNING IN THE PRIVATE SECTOR
JSI	JOHN SNOW RESEARCH AND TRAINING INCORPORATED
KDHS	KENYA DEMOGRAPHIC AND HEALTH SURVEY
LOE	LEVEL OF EFFORT
LOP	LIFE OF PROJECT
MOH	MINISTRY OF HEALTH
MOL	MINISTRY OF LABOR
MOU	MEMORANDUM OF UNDERSTANDING
NCPD	NATIONAL COUNCIL FOR POPULATION & DEVELOPMENT
NGO	NON-GOVERNMENTAL ORGANIZATION
PACD	PROJECT ASSISTANCE COMPLETION DATE
PSFP	PRIVATE SECTOR FAMILY PLANNING
PVO	PRIVATE VOLUNTARY ORGANIZATION
SDA	SEVENTH DAY ADVENTIST
TAC	TECHNICAL ADVISORY COMMITTEE
TFR	TOTAL FERTILITY RATE
TTI	TEACHER TRAINING INSTITUTION
USAID/K	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT/KENYA
USAID/PH	USAID - OFFICE OF POPULATION AND HEALTH
VSC	VOLUNTARY SURGICAL CONTRACEPTION

Acknowledgement

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I. INTRODUCTION

A. PURPOSE OF EVALUATION

The purpose of the FPPS (Family Planning Private Sector) project evaluation are to evaluate overall project impact, assess progress to date, assess the sustainability of subprojects, verify the extent of unmet need for family planning in the private sector; and make recommendations for transition of FPPS functions.

B. PROJECT BACKGROUND

The purpose of the Private Sector Family Planning project (Family Planning in the Private Sector [FPPS]) is to introduce and/or strengthen family planning services within existing clinic-based health programs of private firms and institutions. This is a rational approach to family planning service delivery in Kenya because these private "entities" deliver services to a significant number of employees and dependents. A.I.D. project development took place during 1983. Following a full and open competition, John Snow Research and Training Incorporated won a four year \$4.5 million Cooperative Agreement grant and began work in Kenya in January 1984. The specific objective was to establish thirty (30) subprojects of approximately two years duration each, after which the firms would continue family planning service delivery without external support (with exception of contraceptives supplied by the MOH). The project was amended in 1986 and 1988. The present LOP total is \$8.59 million with a PACD of September 30, 1991. Anticipated (revised) outcomes of the effort are: 1) 85,000 new users of FP services; 2) 60 private institutions operating new and/or improved FP programs; 3) 80,000 couple years of protection achieved over the LOP; 4) commitment of private organizations to maintain FP services upon termination of FPPS project assistance; and, 5) a Kenyan private sector organization established to carry out private sector coordination function as needed.

The FPPS project operates in Kenya under a Memorandum of Understanding (MOU) with the Government of Kenya (GOK), endorsed by the Ministry of Finance (MOF) and Ministry of Health (MOH). The latter ministry provided secretariat support to Kenya's NCPD, a council of twenty-six (26) senior persons from eight ministries and major health-related NGOs. The NCPD has appointed a Technical Advisory Committee (TAC) to establish FPPS project policy guidance, case/subproject approval, and evaluation support.

A mid-term evaluation of the FPPS project was conducted in 1986. It was concluded that the project was successful in delivering Family Planning (FP) services through existing private sector facilities, thus demonstrating private sector firms can and will contribute to the national program. A major recommendation of that evaluation was to extend the FPPS project. In July 1986 the

project was extended for 24 months. Its Life of Project increased to \$6.5 million. In August 1988 the project was amended once again to add \$1.9 million and to extend the PACD through September 30, 1991 with the amended outcomes as listed above. Thus, from its original design and level of effort, the project has expanded significantly (almost doubling) in terms of outputs, timeframe and expected achievements. This history may be considered a testimony to USAID/Kenya's vision of the project, the private sector's willingness to seriously consider the provision of FP services, and the GOK's endorsement of the complementary approach to the delivery of FP services nationwide.

Programmatically, the present evaluation is timely because the 1989 National Demographic and Health Survey has established that childbearing patterns have at last begun to change. Fertility has fallen, and contraceptive practice has risen. Broad-based actions taken now (inclusive of private sector initiatives) may be very important, since the readiness of the public is clear. A familiar axiom in family planning relates to the age structure of the population; i.e. there is a built in time penalty: anything not done now will be more difficult to do later, due to population momentum.

II. METHODOLOGY

The team based the content of this evaluation upon four sources of information: the extensive documentation provided by the FPPS staff (see Annex VIII for the list of documents), extensive discussions with FPPS staff, briefings by the senior staff of key agencies (NCPD, MOH, FPAK, USAID), and field visits to approximately twenty percent of the sub-projects (recipients) of FPPS funding, in which we interviewed administrative and medical staff and inspected their facilities, equipment, and records (see Appendix for the list of sites visited)

III. END OF PROJECT STATUS (EOPS)

A. OVERVIEW

Generally speaking the FPPS project is on track in meeting its proposed objectives and goal. Table 1 presents the project's EOPS in terms of "Outcomes Anticipated" and "Outcomes Observed". Overall the project has performed well with 90% of the subproject target achieved (54/60); 103% of the delivery site objective achieved (154/150); and 158% of the anticipated training accomplished (828/525). Table 1 provides comment on the actual impact of these (and other) accomplishments, beyond their impressive numerical totals.

IV. FINDINGS

A. PROJECT ACCOMPLISHMENTS

TABLE 1: END OF PROJECT STATUS (EOPS) INDICATORS
 ANTICIPATED AND OBSERVED (44/60 MONTHS)

EOP ANTICIPATED	EOP OBSERVED	COMMENT
APPROXIMATELY 85,000 CLIENTS USING FAMILY PLANNING SERVICES IN PRIVATE SECTOR FACILITIES	THUS FAR APPROXIMATELY 88,300 KENYANS ARE USING FPPS SUBPROJECT CONTRACEPTIVES	PROBABLY THE OBSERVED FIGURES ARE AN UNDERCOUNT BECAUSE DISTRIBUTION UNDER THE CBD SYSTEM IS NOT FULLY
SIXTY (60) INSTITUTIONS OPERATING NEW AND/OR IMPROVED FAMILY PLANNING ACTIVITIES	FIFTY-FOUR INSTITUTIONS OBSERVED WITH SIX SUBPROJECT ACTIVITIES PLANNED BY PACD	ALL STILL FUNCTIONING & H DEMONSTRABLE FP ACTIVITIES
RESOURCES OF PARTICIPATING ORGANIZATIONS ADEQUATE TO MAINTAIN PROGRAMS	LARGER ORGANIZATIONS ARE SUSTAINING ACTIVITIES; SMALLER ORGANIZATIONS LESS SO	SPECIFIC DROPS IN IEC, CBD, IEC TRAINING OBSERVED IN MANY INSTITUTIONS; CLINICAL SERVICES MAINTAINED
INCREASED CAPACITY AND COMMITMENT OF PRIVATE SECTOR ORGANIZATIONS TO MAINTAIN AND EXPAND FP SERVICE DELIVERY UPON W/HDRAWL OF EXTERNAL ASSISTANCE	AS ABOVE	SMALLER ORGANIZATIONS MAY NOT BE ABLE TO CONTINUE AFTER FPPS SUPPORT WITHDRAWN

TABLE 1: EOPS ANTICIPATED AND OBSERVED (CONTINUED)

EOP ANTICIPATED	EOP OBSERVED	COMMENT
<p>INVOLVEMENT/ENCOURAGEMENT OF OTHER PRIVATE SECTOR ORGANIZATIONS (NOT ASSISTED BY THIS PROJECT) HAVE ADDED FP SERVICES TO THEIR GENERAL HEALTH SERVICES</p>	<p>NOT OBSERVED</p>	<p>THIS MAY BE AN AREA FOR FUTURE ANALYSIS DURING THE TIME REMAINING IN THE PRESENT PROJECT - A FOLLOW-ON PROJECT MIGHT ADDRESS THIS ISSUE IN MORE DETAIL</p>
<p>FAMILY PLANNING TRAINING FOR 525 SERVICE DELIVERERS (COMMUNITY NURSES, MIDWIVES, CLINICAL OFFICERS, OTHERS</p>	<p>IT IS ESTIMATED THAT 828 MID-LEVEL WORKERS WERE TRAINED IN FAMILY PLANNING SERVICE DELIVERY</p>	<p>THE OBSERVED FIGURE WAS ABOVE TARGET BECAUSE 374 NURSES / CLINICAL OFFICERS WERE TRAINED BY AMREF BEFORE THE PROBLEMS WITH TRAINING DEVELOPED - FURTHERMORE, THE ESTIMATE OF TRAINING CAPABILITY IN THE ORIGINAL DESIGN WAS LOW</p>
<p>IMPROVED FAMILY PLANNING TRAINING METHODOLOGY DEVELOPED, TESTED AND IMPLEMENTED</p>	<p>FPPS SUBMITTED A LESS COSTLY TRAINING PROPOSAL FOR CLINICAL TRAINING WHICH WAS REJECTED BY THE TAC</p>	<p>FPPS SHOULD IMPROVE THE TRAINING PROPOSAL AND RESUBMIT IT TO THE TAC NLT THE END OF CY 1990</p>

EOPS INDICATORS ANTICIPATED AND OBSERVED (CONTINUED)

EOP ANTICIPATED	EOP OBSERVED	COMMENT
<p>OPERATIONS RESEARCH ACTIVITIES CONDUCTED ON SEVEN (7) PERTINENT FAMILY PLANNING/PRIVATE SECTOR TOPICS; RESULTS COMPILED, ANALYZED AND REPORTED</p>	<p>SIX OPERATIONS RESEARCH PROJECTS COMPLETED</p>	<p>PROJECTS ARE OF VARIED QUALITY - FPPS, RESEARCHERS, AND AID NEED TO RETHINK PRIORITY RESEARCH TOPICS AND FUTURE OR DIRECTIONS</p>
<p>FPPS RESULTS EVALUATED AND DISSEMINATED THROUGH AND ESTABLISHED DATA COLLECTION AND INFORMATION SYSTEM - TWO NATIONAL WORKSHOPS ON DATA MANAGEMENT AND EVALUATION CONDUCTED DURING THE PROJECT PERIOD</p>	<p>WORKSHOPS NOT CONDUCTED, RESULTS OF DATA COLLECTION NEITHER PUBLISHED NOR DISSEMINATED TO SUBPROJECT SITES AND OTHER INTERESTED PARTIES</p>	<p>AN IMPORTANT NEED STILL EXISTS TO ANALYZE AND DISSEMINATE EXISTING DATA/INFORMATION - THIS SHOULD BE A PRIORITY FOR FPPS MANAGEMENT AND BE DONE PRIOR TO THE PACD</p>

A.1 General Project Performance

Historically, the FPPS project entered uncharted territory in 1983 in trying to add family planning services and education to the health units of private organizations. During the period it has met its objectives and has developed a central staff of considerable competence. Reasonably smooth relationships have developed with the NCPD, the MOH, and USAID, as well as with FPAK, AVSC, and others organizations concerned with promoting effective family planning in Kenya

A.2 Project Accomplishments

A.2a Couple Years of Protection

Table 1 and Figures 1 and 2 represent tabular and graphic displays of Couple-Years of Protection (CYPs) for FPPS-assisted projects. The data indicate that from 1985 through 1989 there has been a general increase in the CYP for each method of contraception, with the possible exception of foams. Curiously, CYPs for condom use presented the greatest rate of change and the highest CYP. This high rate is likely due to the use of condoms for AIDS prevention and possibly the male-skewed user population in FPPS-assisted subprojects. Table 1 indicates that a total of 264,589 couple-years of protection was provided in FPPS-assisted subprojects. Respective rates for CYP were: condoms, tubal ligations, injectables, orals, IUDs and foaming tablets. The impressive results reflected in the CYPs indicates that FPPS-assistance encouraged user acceptance; the increase over time indicates that progress towards sustainability is likely being made. Figure 2 illustrates that condoms gained increased acceptance in 1987-1988 and demand escalated significantly in 1989. Demand for tubal ligations appears "bell-shaped" with a peak in 1988. Orals appear to be increasing steadily in FPPS-assisted projects as do injectables.

A.2.b Cost Per Couple-Year of Protection

Table 2 and Figure 3, present information on cost per CYP by institution by year. As expected relatively, high costs were incurred during the project startup period in all institutions. NGOs appeared to have the lowest startup costs with nursing homes a relatively distant second (\$11.35 and \$21.70 respectively). Parastatals had high costs in 1985 (\$30.78), but decreased drastically to \$1.52 in 1989. All organizations' costs rapidly dropped after the first year of implementation and with continued trends through 1989. Mean CYP costs for institutions between 1985 and 1989 ranged from \$5.21 to \$10.59 (educational institutions and community-based delivery are excluded because data are only available from 1987). Average CYP costs declined from \$23.23 in 1985 to \$1.72 in 1990 with an average of \$12.52 for all FPPS-assisted institutions. These averages must be taken with caution due to a high 1987 value for Community Based

TABLE 1: COUPLE-YEAR OF PROTECTION (CYP)
BY FPPS-ASSISTED FAMILY PLANNING
PROJECTS BY METHOD AND YEAR

CONTRACEPTIVE METHOD	1985	1986	1987	1988	1989	1990	TOTAL
ORALS	725	1755	3329	6754	10500	11243	34306
CONDOMS	317	3018	9816	18738	26578	30734	89201
TUBALIGATIONS	2856	7101	13818	16226	15260	13169	68430
FOAMING TABLETS	208	1893	3629	3485	2321	2309	14045
INJECTIBLES	190	1195	3773	7281	10137	13278	35854
IUDs	1588	3484	3387	5004	5253	4307	23023
TOTAL	5884	18446	37952	57488	70049	75040	264859

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COUPLE-YEARS PROTECTION (CONTRACEPTIVE METHODS)

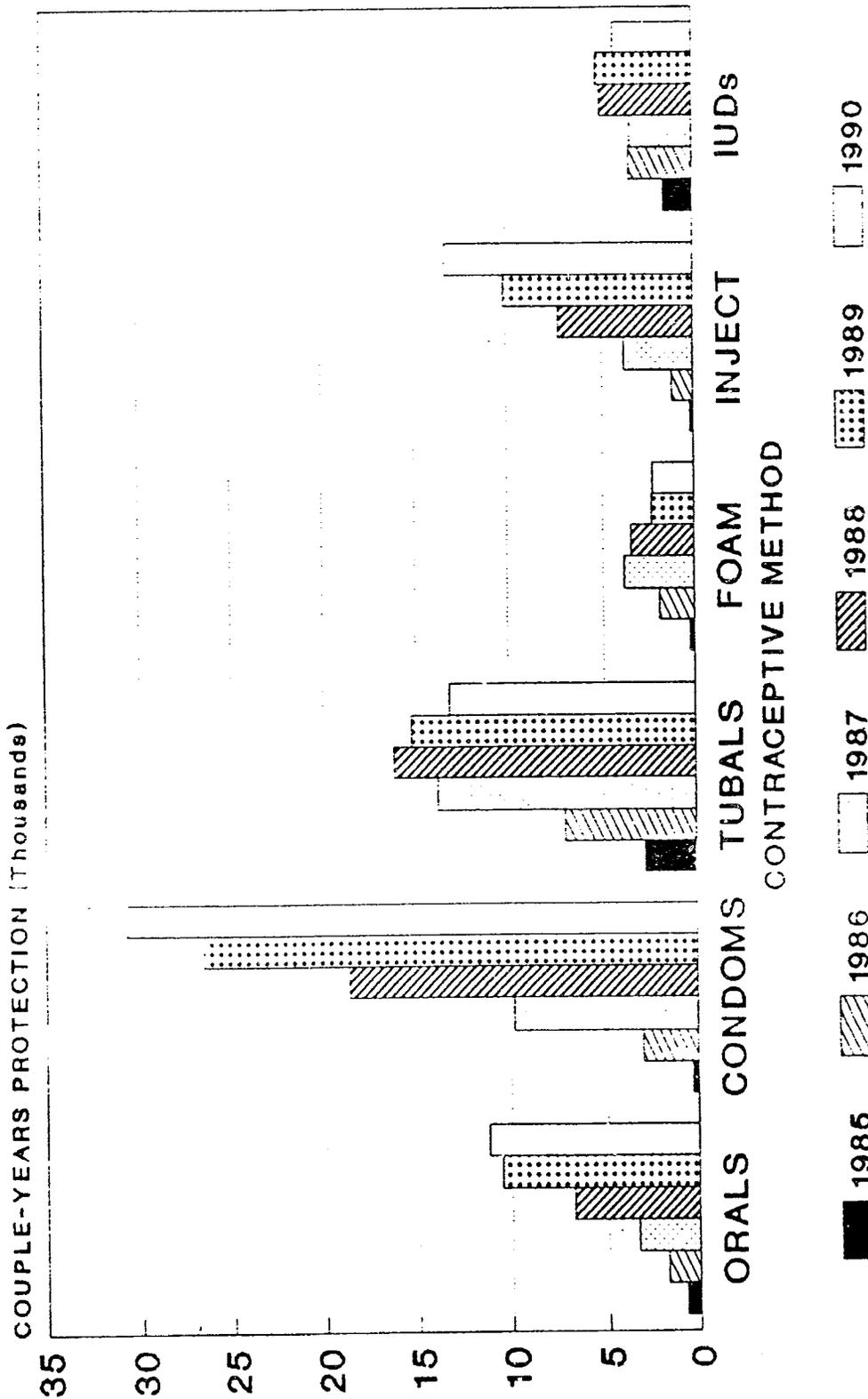


FIGURE 1

Information Supplied by FPPS/EKystal

COUPLES-YEARS PROTECTION (CONTRACEPTIVE METHODS)

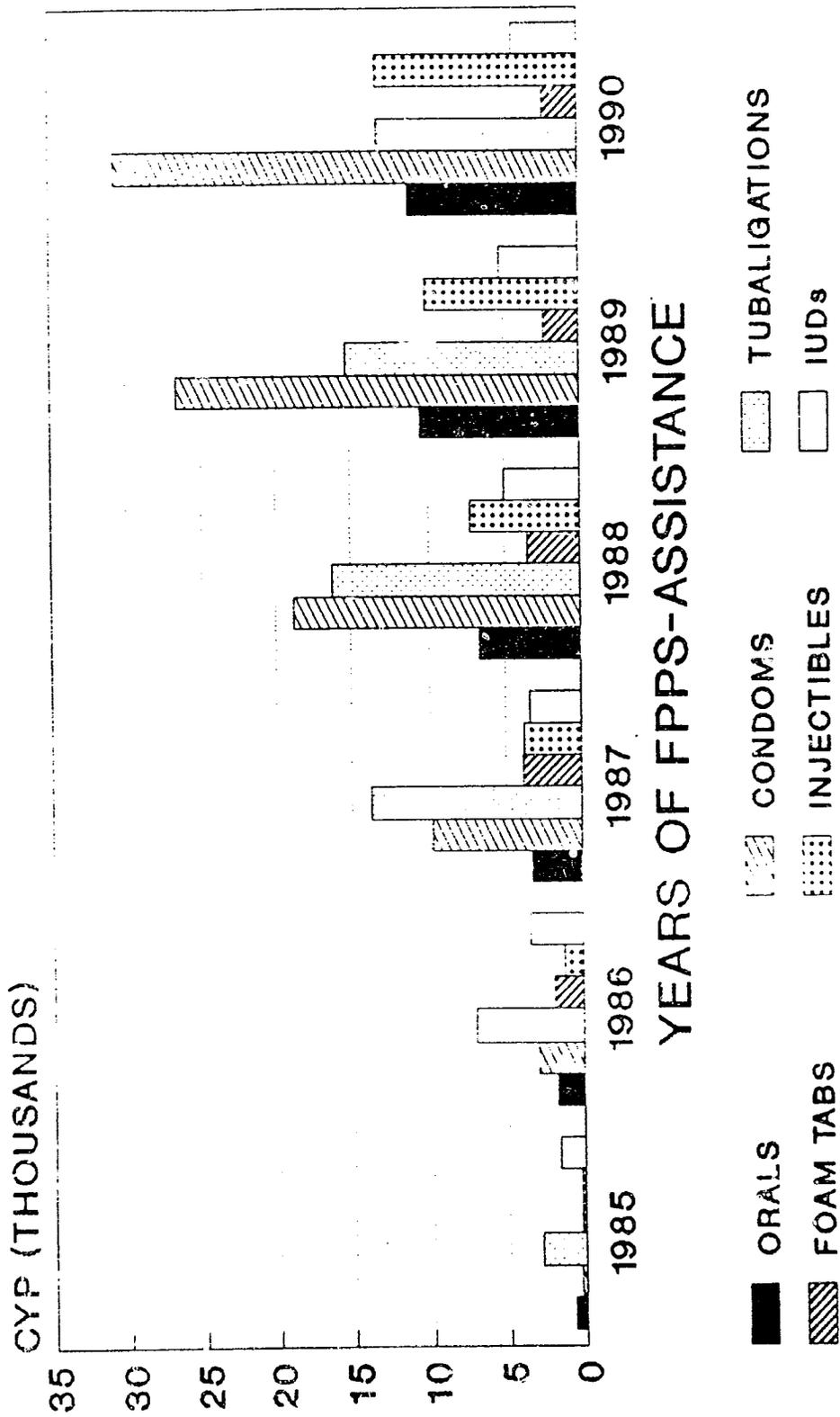


FIGURE 2

Information Supplied by FPPS/EKystal

TABLE COST (\$USD) PER ONE COUPLE-YEAR PROTECTION IN
 FPPS LISTED FP PROJECTS BY INSTITUTION AND YEAR

INSTITUTION	YEAR						MEAN
	1985	1986	1987	1988	1989	1990	
PRIVATE SECTOR COMPANIES	29.09	11.39	12.39	5.43	3.70	1.52	10.59
PARASTATALS	30.78	9.96	6.70	1.17	0.09	0.02	8.12
NON GOVERNMENT RELIGIOUS ORGANIZATIONS	11.35	6.39	3.91	4.39	3.13	2.09	5.21
PRIVATE DOCTORS AND NURSING HOMES	21.70	9.09	11.52	7.74	5.87	3.22	9.86
EDUCATIONAL INSTITUTIONS	NA	NA	6.22	2.39	2.09	0.13	1.81
COMMUNITY-BASED DELIVERY	NA	NA	211.78	16.00	6.00	3.52	39.55
MEAN	23.23	9.21	42.09	6.19	3.48	1.75	12.52

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COSTS OF COUPLE-YEAR PROTECTION (FPPS-ASSISTED PROJECTS)

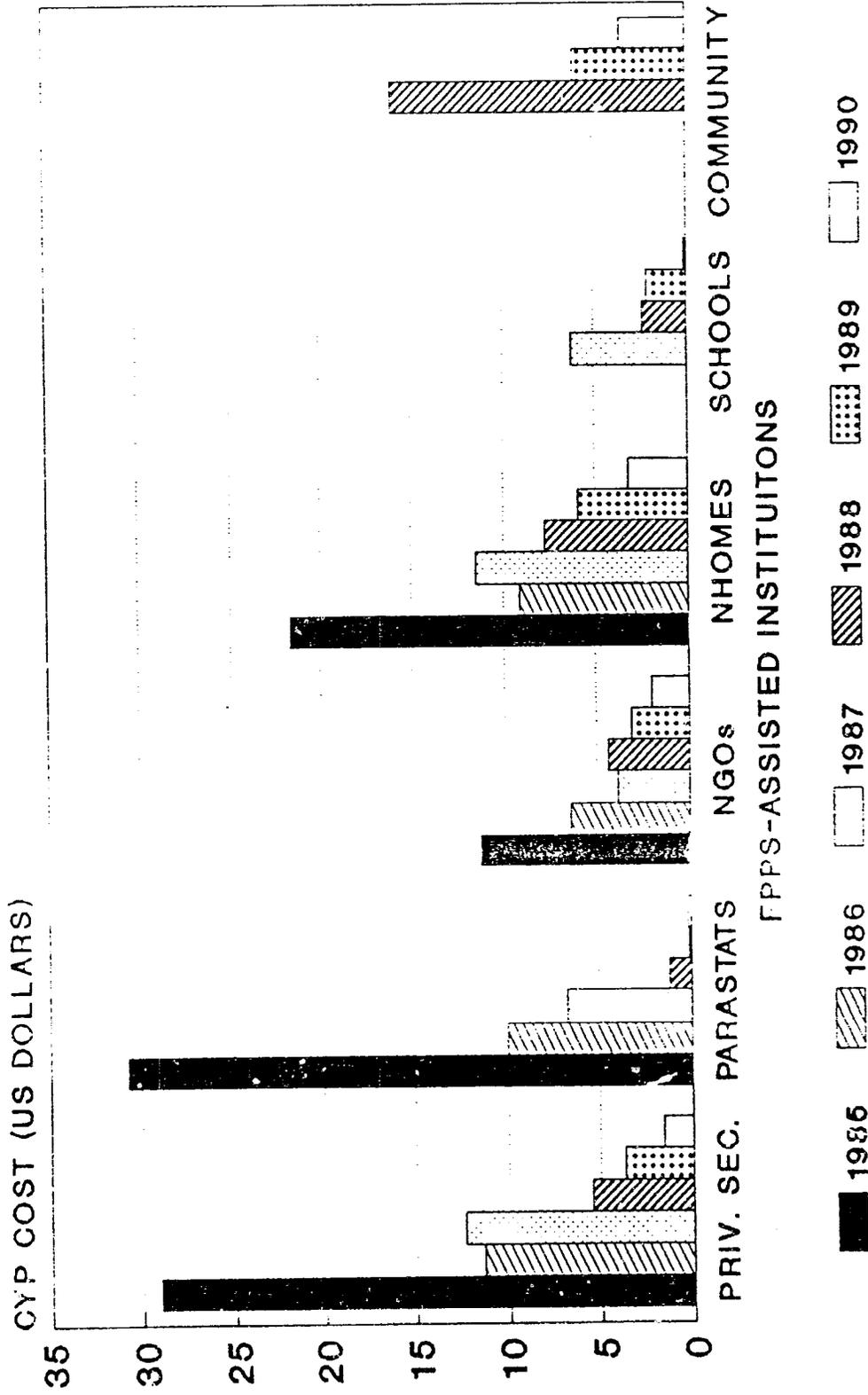


FIGURE 3

Information Supplied by FPPS/EKystal

Distribution (CBD) (\$211.78) and unweighted calculations for educational institutions and CBD systems. It is promising that costs appear to be steadily decreasing in all institutional delivery systems. Whether this trend is sustainable without FPPS support remains to be seen.

A.3 Program Sustainability

Strictly speaking, the original concept of sustainability has not been tested. While FPPS funding has generally ceased at the two-year point for each organization, other, external assistance has not. Thus, contraceptive supply, training, information, education and communication (IEC), and technical assistance have selectively continued. Often this has occurred because FPPS has found ways to obtain partial continued support for its subproject organizations. The kinds and amounts have varied somewhat, partly according to type of organization. The activities which tend to drop away as FPPS support diminishes are IEC, service outreach, CBD, and IEC training. This is because the subprojects do not commit resources to IEC activities. FPPS has supported IEC activities for the duration of the project. Thus, when the subgrant is completed, clinical staff support is sustained, but IEC efforts fall off. Even though the importance of IEC is well documented, subprojects hold clinical costs as clear priority. From interviews during the field visits, it was evident that subprojects depended on FPPS for contraceptives, IEC and training. If support for these activities abruptly stopped, attention to these activities would also stop, and hard-won momentum lost. Indeed, small nursing homes and private religious organizations have been asking FPPS for continued support because of their limited funding. Thus, a rigid "2 year" cutoff period may be unreasonable given the demonstrated need and the risk of losing momentum. The team felt that the timeframe for project assistance should remain flexible, based on the progress of an organization and the ability of the organization to carry on the spectrum of activities endorsed by FPPS (see Table 2). Religious organizations usually have fewer resources than the private companies, and thus often need greater (and longer) funding assistance. Notably, religious groups produce about half of all new acceptors and current users in the entire program.

A.4 Perceptions of Private Management

In discussions with representatives of private companies, perceived cost savings accrued were discussed. Areas mentioned included: reduced amount of maternity leave; lowered absenteeism; and less medical expenses for child care.

A.5 Sustainability of Service

As indicated in Table 3, forty-four of the 54 sub-projects ever begun have passed the two-year point, and all of these still continue to provide family planning services and to send in their monthly reports. Staff from the forty-four organizations

continue to attend the periodic monitoring meetings held in regional centers. To a remarkable extent the relationships begun have endured, and the service programs created or augmented have continued. Figure 4 indicates that CYP by institution is also increasing steadily with NGOs and private sector firms leading the way. It is important to note that for many of the organizations FPPS support has stopped or is about to cease, yet CYP continues to grow. Although subproject-specific data are not presented, it is fair to conclude that positive trends are occurring in FPPS-assisted projects and that some degree of FP service delivery will be sustained.

A.6 Cost Effectiveness

In broad terms, the direct expenditures have totaled about one million dollars per year, or six million dollars to date. It is estimated that the FPPS effort has produced an aggregate of 238,000 couple years of protection. Thus, the average CYP is approximately \$25 dollars (\$6m/238k) if all costs are considered. On a cost per person basis, the program (approximately \$1.0 million per year) is carrying approximately 69,000 persons annually on current contraceptive practice which amounts to an average of \$14.5 dollars per person per year. However, it is reasonable to state that the investments have bought much more in terms of client and public education, strengthened infrastructures, and legitimization of family planning through several types of private sector organizations. Additional "payoffs" include funds stimulated from the private sector itself, as a means of cost-sharing, and of enlarging the total resources devoted to the family planning effort. By working through existing structures, and drawing in investments by its own recipients, the project has (in effect) brought in new monies.

A.7 FPPS as a Catalyst for Contraceptive Use

An additional achievement is the contraceptive practice FPPS has stimulated outside its own supply line. The team observed that clients not directly associated with FPPS service outlets have been motivated to start family planning practices on their own through the various (project-supported) educational activities. Others have started practice through a sub-project, but later switched to another service delivery source. Furthermore, on an organizational basis, it is fairly clear that many or most of the organizations would not have started up projects on their own, or done as much as they have done, without the FPPS stimulus and assistance. Although notable, this accomplishment should be viewed with caution because it is difficult to attribute all new users to specific project activities.

A.8 Monitoring and Disseminating FPPS Results

A system is in place that meets the principal requirements established in the project agreement. This system allows for: 1)

TABLE 3: PROJECT MONITORING:
SUBPROJECT STATUS

PROJECTS ONGOING AND STILL IN FIRST TWO YEARS	PROJECT WITH TWO YEARS COMPLETE BUT CONTINUING TO RECEIVE EXTERNAL FUNDS	PROJECTS WITH TWO YEARS COMPLETE BUT WITHOUT FUNDING
KARIOBANGI NURSING HOME GOLDSMITH SEEDS MOI UNIVERSITY MUMISA SUGAR COMPANY KENYA TELECOMMUNICATIONS NYAWITA NURSING HOME	NAKURU NURSING HOME CHRISTIAN COMM. HEALTH CENTER (1&2) KARIMA COMM. HEALTH CENTER SOUTH NYANZA SUGAR COMPANY NANUKI COTTAGE HOSPITAL MAGADI SODA COMPANY SIRIBA TEACHERS COLLEGE UNIVERSITY OF NAIROBI HOME HILL CENTER KAGUMO TEACHERS COLLEGE KTGA (NANDI) KANGARU MATERNITY HOSPITAL I VOI/CHANGAMWE KTGA (KERICHO) SEVENTH DAY ADVENT (1&2) NAIVASHA NORTH LAKE	BATA-LIMURU GETEMBE NURSING HOME KENYA PORTS AUTHORITY CRESCENT MEDICAL AID EAST AFRICAN PORTLAND CEMENT B.A.T. KENYA CANAAAN MEDICAL SERVICES KENYA CANNERS VOI SISAL ESTATES KENYA FLOURSPAR OSERIAN DEVELOPMENT COMPANY NZOIA SUGAR COMPANY MACHAKOS TEACHERS COLLEGE KENYA BREWERIES ELGEYO SAW MILLS EAST AFRICAN INDUSTRIES CHEMELIL SUGAR COMPANY KENYA CASHEWNUTS MALINDI NURSING HOME KTGA (SOTIK) BROOKE BOND KERICHO PANAFRICAN PAPER (I) AFRICAN HIGHLANDS BROOKE BOND MABROUKIE BROOKE BOND KIBWEZI KTGA (KARIRANA) SULMAC NAIVASHA ELDORET NURSING HOME

CYP BY INSTITUTION (FPPS-SUPPORTED INSTITUTIONS)

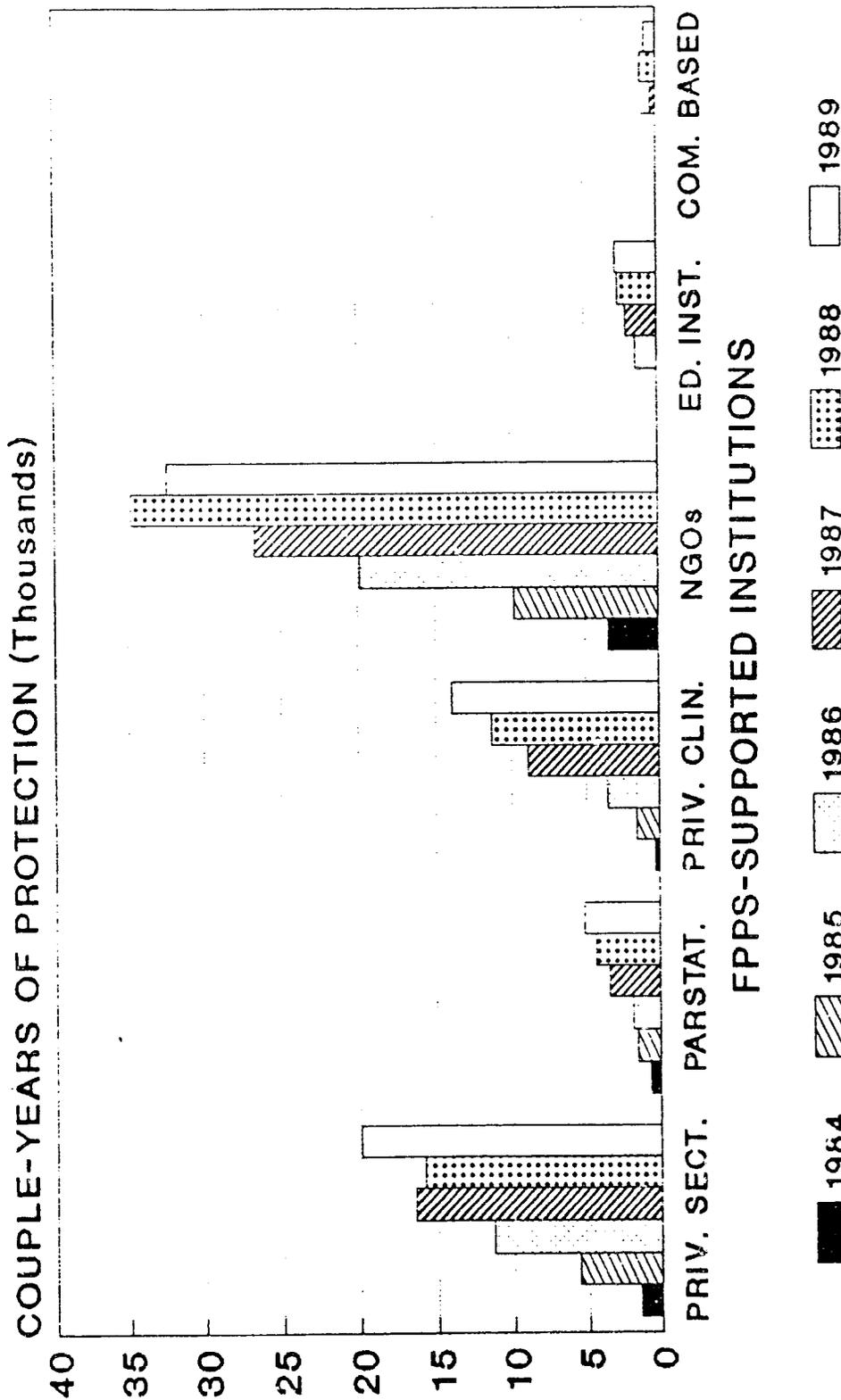


FIGURE 4

DATA SUPPLIED BY EKRYSTALL

a basic clinical record; 2) follow-up slips for both client and clinic; 3) counts of new acceptors of clinical methods (with a conservative definition of who a "new" acceptor is); 4) the volume of all contraceptive supplies given to clients whether in the clinic or the field; and, 5) a flow of information to the FPPS office that permits the calculation by month and organization of current users, CYP, new acceptors, and percent of the new acceptor target achieved. This system appears to be free of any significant incentive for over-reporting, and compliance with it is good as indicated by the percent of organizations reporting promptly (including those no longer being funded). The system is amenable to computerization, and this is underway. A more detailed CYP calculation (beyond a "general user figure") should be added to the routine reports and to the computerized output.

A.9 FPPS Project Management

The present staff appear generally appropriate in number and in balance of technical expertise. Besides the Director and part-time Deputy Director (shared with the Enterprise project) there is a Program Administrator and an Accountant. Professional program staff include a medical coordinator, two communication specialists, and a clinical specialist. Formal job descriptions are not used, and as a consequence there is room for some clarification of staff responsibilities. Adjustments in staff responsibilities are currently underway based on a new management plan which assigns each sub-project to a particular staff member. This action should clarify the oversight responsibilities of specific staff members and help insure that no sub-project is neglected. Each staff member has approximately eight sub-projects to monitor. The addition of a full time accountant in 1988 has helped to address the heavy volume of financial documentation. Staff seem genuinely committed to their work (notwithstanding the extensive travel requirements). This is evidenced by a negligible turnover during the entire life of the program.

A.10 Unmet Need

A thoroughly systematic analysis of unmet need has not yet been accomplished (although USAID has outlined one and has requested it be undertaken. Such an analysis would comprise information on the number of parastadals in Kenya, their distribution by size, number of employees by sex; the number and size of the nursing and maternity homes in Kenya; and other related elements for each major category of interest in the private sector. Data of particular import would concern the type of health facilities which exist on the premises and the client volume. Furthermore, maintaining the active involvement of religious organizations represents a critical issue and should be adequately addressed in an unmet needs survey. The analysis would provide a clearer picture of the future potential of family planning in the private sector.

Even though a systematic analysis of unmet need has yet to be undertaken, there is already substantial evidence of significant unmet need for family planning services in the private sector. The team is aware of a number of outstanding request for family planning assistance to which the FPPS project has been unable to respond due to time and funding constraints. Such requests include: six large commercial firms, four large parastatals, 13 private hospitals/clinics (often referred to as nursing or maternity homes), and five non-governmental organizations. There are also 22 teacher training institutions/colleges in the country of which the FPPS project is only supporting two. Innovative opportunities exist for the private clinics or hospitals in small towns to serve medium sized commercial firms which do not possess a clinical facility on-site.

There is also a continued need for technical assistance in the areas of contraceptive supply, management systems and training. Expanded support is also needed for information and outreach activities, particularly community based distribution of contraceptives in subprojects which serve large disperse populations.

Refer to Annex I for additional data on unmet need.

A.11 Clinical Training

The clinical training course is standardized by the MOH for nine weeks and is given to nurses and clinical officers for family planning and service provision. FPPS has provided personnel from its sub-projects through an arrangement with the African Medical and Research Foundation (AMREF), but although this training has been of good quality it has been attended by difficulties and has been costly. A two-week refresher course has been given periodically, but this has been discontinued temporarily due to differences between AMREF and FPPS. Field visits revealed an urgent need for a prompt solution to the training hiatus. New nurses, hired to add to staff or to replace turnover, stand in need of the nine-week course. Other nurses are overdue for the refresher course. The present plan, in recognition of the urgent need and the absence of an alternative, is to send some nurses to the AMREF nine-week course, despite the very high cost. However, FPPS has already developed a plan to implement a Clinical Training Course with its own personnel.

A.12 Role of VSC

VSC has been added to some FPPS sub-projects since 1989, and 8 teams of physicians and nurses have been trained. However, so far only 2 counselors have been trained due to lack of space in the FPAK training program. Continued attention is needed to rectify this lag.

A.13 IEC and CBD Training

Training is handled entirely by FPPS. It is given to sub-project coordinators, field educators, and CBD workers. Effective IEC and field education are two of the most important determinants of sub-project success, and both are dependent upon good training. When funding stops, at or about the two-year point, continuing education is vulnerable. It has become clear that continued contact with trainers and refresher training do much to keep outreach workers technically competent and motivated. In addition, some sub-projects wish to expand their outreach work, and thus will need training assistance.

A.14 Publications

The experience of this project should be recorded in one or more publications with wide circulation in Africa, and preferably throughout the developing world. Large resources and much effort have gone toward testing the potential of the private sector, with highly significant findings. This experience is buried in internal memoranda, unpublished documents, and annual reports, none of which put a full scientific assessment before an international audience. The important results here should not be lost. They should be preserved for the future, and they should be communicated effectively to country programs and agencies throughout the developing world. A project of this magnitude and pioneering character, with strong affirmative results, should not go six years without fully reporting its experience through referred journals in the family planning field. Time should be allotted for FPPS staff to further analyze and publish data generated from this project. Perhaps external TA can be used to assist in the preparation of manuscripts.

A.15 Operations Research

Operations research (OR), can potentially guide management decisions toward steady program improvements. If attempted in-house at FPPS however, it would require a new staff position and would then rest upon a single, as yet unknown, individual, and this is probably not advisable. Moreover the target of seven operations research projects has been fulfilled (although with uneven quality). In the future (follow-on) it would be worthwhile to limit OR and consider some relevant research topics. For example: the cost-effectiveness analyses were well done, but others such as the follow-up for fertility survey were superficial in their analysis. Future activities should be linked to local researchers based in local institutions. However, an effective relationship must be developed between FPPS and indigenous institutions which includes a genuine commitment to FPPS needs, and an orientation that is operational rather than academic.

A.16 Case Studies

A set of case studies was undertaken, to look in detail at the achievements and characteristics of a sample of sub-projects. The following elements of subproject success were identified.

1. Active support by top management.
2. Support of spill-over effects (i.e. provision of family planning services to non-employees and to the surrounding community).
3. Promotional activities through IEC channels (film shows, staged drama, traditional dances, poetry, lectures).
4. Enhanced community support, obtained by good relations with local dignitaries, e.g. priests, chiefs, women leaders, youth leaders. (It is important to operate the sub-project as complementary to, not competitive with, those of other individuals and/or organizations.)
5. Maintained logistical support to field educators (transport, supplies, adequate salaries).
6. Efficiency in provision of services (short waiting times, reliable contraceptive supplies, easy physical access to clinic or worker).
7. Staff motivation (staff selected from the nearby community, good training, perceive themselves as integral to the agency rather than an appendage to it).
8. Involvement of the men in family planning, through IEC and outreach work.

These eight determinants of sub-project success emerge from careful case studies and deserve close attention in field visits and administrative reviews.

A.17 Organization of FPPS

In interviews with Kenyan personnel we have been told that while a further shift toward local Kenyan responsibility for the FPPS project is assumed, it need not be immediate or total. With this the team agrees. Already the staff is entirely Kenyan nationals except for the current Director's position. While recognizing the need to move in this direction, the existing arrangement of cooperation with an international agency has proved beneficial. JSI has clearly served to set the FPPS project in motion and has sustained it over the past six and one-half years. It has recruited key staff, has structured the financial management, expedited important equipment acquisition, and arranged or directly provided much technical assistance. JSI (Boston) has also handled complex relationships with USAID as the prime funding agency. It has a well-established infrastructure that has been of assistance in a variety of ways over the years.

A major strength of the project has been its ability to manage and coordinate subproject activities. Continuity is vital (given that about 10% to 13% of all modern method use in Kenya flows through the present arrangement, and that the precedents for family planning continue in several parts of the private sector). Thus, the team recommends continuation of FPPS's present administrative structure intact.

If a future project (with full and open competition) is bid, this should include a collaborative arrangement with a US-based firm. This would free the local agency from some burdensome parts of the administrative and fiscal relationship while allowing freedom of action in the planning and implementation of the project/program itself. This arrangement preserves the advantages of the international linkage(s) and still places autonomy in local hands. The team believes that this (rearrangement) deserves consideration, since it retains the advantages of a standing international relationship, includes primarily Kenyan staffing in decision making, and lets the local organization seek supplementary funding and projects.

A.18 Potential Directions

Six guidelines may be considered for the continuation of existing services and further expansion of present activities. These guidelines are based on a FPPS internal assessment and are presented below.

- o **Nursing/Maternity Home Focus** - The nursing homes see a clientele that contains a high percentage of eligible couples, and the maternity homes afford a classic opportunity for postpartum provision of information and services.
- o **Teacher Training Institutions (TTI) Focus** - These institutions have a need for expanded contraceptive services, but as importantly, good IEC programs in TTIs will affect advice given to the next generation.
- o **Consider a "Two-Step" Model** - FPPS has carried family planning into institutions that possess health facilities -- a single step. Attractive opportunities exist for some of these institutions to go one more step to serve organizations with no health facilities of their own. An example is the Machakos trial, in which a private clinic is providing family planning to outer locations. Another is the potential at a facility like the Eldoret Nursing Home, which has a well-equipped clinic and is located in the midst of numerous very large factories. It is already in touch with them, and with proper outreach could have a major impact on these populations of workers in the childbearing ages. A future project should systematically pursue Two-Step opportunities.

- o **Emphasize Extension Activities** - The team observed an uneven pattern of extension work, out beyond the participating clinics. There is some CBD, some outlying dispensaries, some home visiting, etc., but the potential is far greater than what exists to date. Some clinics are under-used, which while regrettable means that they can handle the additional clients that increased outreach would produce. Every effort should be made to expand subproject outreach in the future.

- o **Religious Network Focus** - Appropriate technical and financial assistance should be given to the three major religious networks associated with the FPPS project. CHAK, SDA, and Crescent together provide over half of all contraceptive users in the entire program, and over 70 percent of the VSC cases. Although CHAK and SDA are complex organizations, they are vital to the volume of services given by FPPS, and they give highly significant religious endorsement to family planning.

- o **Monitoring of Subproject Organizational Performance** - Subprojects that perform poorly over a long period should be discontinued, to lighten the administrative load and to improve cost-efficiency. Subprojects that can carry more of their own supply procurement through the District Hospital, or, that can do more of their own transport, IEC, etc., should be pressed to do so. The process of cautious "weaning" should be a persistent one, to move recipients toward self-sufficiency and free up resources for other places. This applies also to categories of recipients; for example the group of major private companies may be largely exhausted, with considerable movement toward self-sufficiency. This however is clearly not true of the religious organizations.

B. PROJECT SHORTFALLS/PROBLEMS

B.1 Contraceptive Supply Coordinated with the MOH System

A contraceptive supply system for access by the private sector is in place, but it is not functionally efficient yet. The operative word is "efficient," and that may be too favorable an adjective as yet. Our impression is that the FPPS has done its part as best it could, relying on its well-regarded MIS system and direct communications with grantees to know their supply needs. The primary constraint has been one common to the larger context of supply, i.e. coordination with the Ministry of Health's national system upon which nearly all agencies rely. This in turn rests partly upon the implementation of the new contraceptive logistics MIS that the Ministry has installed and which should be operational nationwide by September 1990.

B.2 Logistics and Supply

A major concern relates to the regular supply of contraceptives from the MOH to FPPS-supported organizations. Although this is a routine problem in the implementation of many projects, it is particularly worrisome in this case since private sector initiatives rely on improved service delivery, of which supply is a major part. However, the project developed a parallel system to get supplies from the MOH and to the service delivery points. The major problem has been the dearth of adequate supplies on a continuous basis. This situation has been improving recently.

B.3 Training

FPPS and AMREF have experienced problems in the conduct of the nine week course for mid-level managers. Although FPPS developed a proposal for taking its own initiative for the conduct of the training, it was not reviewed by the TAC. Specific problems with the AMREF liaison revolved around cost, billing and other administrative issues.

B.4 Unmet Needs

At the time of this evaluation, an in depth review of the dimension(s) of unmet need would have been valuable. Although USAID/K requested FPPS to conduct an in-house assessment of unmet need, apparently more information than FPPS delivered is/was required. Thus, a need remains to conduct an in-depth analysis of unmet need. The team suggests that USAID/K design and monitor the conduct of that assessment.

B.5 Subproject Reimbursement

Problems have arisen for reimbursement of subproject accounts by FPPS due to delays in voucher submission and incorrect accounting procedures. Arrangements for procurement on a reimbursement basis is problematic. Money is difficult to track and subproject accounts often experience delayed payments. The project should closely examine the reimbursement system and derive methods to improve the system in order to avoid hard feelings between subproject management and FPPS.

B.6 Assessment of Program Impact

Difficulties in assessing program impact concerned: 1) defining a specific population of users; 2) problems with baseline data and the availability of a quantifiable denominator for the population; and, 3) problems with KAP surveys done in 1984 and 1988 which were not compatible and thus limited in their utility. In order to facilitate the assessment of program impact, sound design and planning for KAP and other OR activities should take into account future comparisons, baseline data and denominator/coverage estimates in order to promote a more

meaningful follow-up. Regrettably, it is difficult to ascertain if FPPS activities have made a lasting contribution to sustaining contraceptive delivery through public/private sector cooperation.

V. CONCLUSIONS

Project Performance - The project's overall record of accomplishment is an unusually good one, and in this we echo a similar conclusion in the 1986 Evaluation Report.

Encouragement of Private Sector Themes - Continued assistance is needed, but with a persistent effort toward greater cost-sharing programs, and toward an independent commitment to their family planning activities. Themes to stress include: 1) cost savings to institutions produced by fewer pregnancies; 2) possible income generation (through fees) within the nursing home system; and, 3) service motivation within non-profit organizations. In each case family planning activities advance the organizations' own performance goals, in addition to improving the welfare of their employees.

Program Directions - The team strongly favors the root strategy of adding family planning to private infrastructures that are already in place. We believe that the blend of techniques and forms of assistance that FPPS has developed should continue.

Contraceptive Supply - Assistance with contraceptive supply for many sub-grantees will be needed for some time to come, while the national MOH system moves toward improvement. Nothing is more vital to effective program implementation or to client satisfaction, than reliable contraceptive supply. The current "mixed" plan for FPPS implementation should continue, i.e. devoting special efforts to central supply lines, while relying upon local district supplies wherever those can flow consistently.

Level of Full-Time Staff - The present staffing level appears to be appropriate for the current workload.

Religious Organizations - The ongoing work by the three religious organizations (CHAK, SDA, CRESCENT) provides about half of all contraceptive practice in the program. Unlike many of the private companies, these three can hardly sustain the full financial load of their family planning activities. Unmet need will unfortunately increase unless these services continue.

Clinical Training Course - In the longer term, the team concludes that FPPS is fully capable of arranging a separate nine-week course and should be allowed to do so.

VSC Service - VSC is an important and growing service in the FPPS program.

Training - The team agrees that FPPS provides good quality (IEC) training.

VI. RECOMMENDATIONS

Project Continuation - The success of the project to date, combined with the continued demand by private sector organizations for project financed services, leads the team to recommend an extension and expansion of project activities. The team recommends that the USAID/K consider extending the project to meet the additional unmet need.

Job Descriptions - Consideration should be given to developing a set of formal job descriptions. A new plan of assigning each subproject to a particular staff member should be re-assessed periodically. USAID/K should participate in the review of the job descriptions as appropriate.

Unmet Needs Survey - An appropriate investigation should be undertaken promptly to gain insights into the design of a possible follow-on project.

Attention to Religious Organizations - Consideration should be given to a line of funding beyond the two year cut-off to address the special circumstances of religious organizations.

Clinical Training Course - The revised 9 week Clinical Training Course should be resubmitted to the TAC, with stronger arguments than previously given, including a detailed statement of the need and the considerable cost savings.

Role of VSC - To the full extent possible VSC should be incorporated as a standard part of FPPS activities.

Training - FPPS must address the ongoing needs for refresher training. It should rapidly respond to opportunities to train new sub-project staff for expanded outreach and provide follow-up as appropriate.

Publications - Technical reports should be prepared promptly for appropriate, peer-reviewed family planning journals. (We say "promptly" because the preparation and submission of a manuscript, with the refereeing lag, can easily consume the next 16 months.)

Operations Research - FPPS should enter into operations studies only with caution, if time permits, and only if local professionals and institutions can be recruited to

address operations questions. Given the remaining timeframe for the PACD, it is doubtful that any meaningful operations research can be pursued within the next 16 months.

Case Studies - The eight case study determinants of project success should be considered as objectives in subproject design and as factors to assess the progress of subprojects.

FPPS Organization - The role and responsibilities of the prime and subcontractors should be reassessed and addressed in detail in the design of any follow-on initiative to FPPS.

Role of Child Survival - The role of child survival in FPPS activities should be reviewed in a new design and if appropriate incorporated with more emphasis in a planned follow-on project.

VII. LESSONS LEARNED

Integrated Subproject Success - Projects which provided integrated care appeared to succeed better than those with solely family planning interventions. Future design should explore options for service delivery integration to maintain interest and encourage sustainability.

IEC Subcommittees - These committees were formed from local populations which thus served as a local mechanism to promote FP messages. Subprojects with IEC Subcommittees appeared to do better than those without, arguing for future consideration in a follow-on.

Mode of Contraceptive Distribution - Promoting contraceptives through senior managers appears less effective. Contraceptive distribution should be passed down to subunit heads who appear less threatening and thus will encourage increased contraceptive use.

Management Information System Development - MIS is a valuable tool in terms of reporting technical and administrative information. Data analysis/presentation is an important factor in project implementation and significant attention should continue in this important area.

Supply and Logistics - In order to insure commodity availability and distribution, attention must be paid to the supply and logistics systems of the private and public sector. This is a critical area for project success. Future efforts must focus on improving the supply and logistics of commodities.

NGO Linkage - Linkage to NGOs and the Ministry of Labour's (MOL) IEC project should be considered. NGOs can act as demand generators, and, strengthening of the MOL's IEC project will promote contraceptive use in both the public and private sectors.

Subproject "Weaning" Strategies - Subprojects should be "weaned" as appropriate - a flexible timeframe for review (for example 24 months after project initiation) should be considered. This would avoid abrupt loss of support and possibly interest, and provide the subprojects with time to adjust to, and plan for activities without FPPS support.

Differential Approach to Support for Subprojects - In order to increase efficiency, future efforts may wish to promote a "graded" approach to subprojects, based on the character of the organizations. For example, large organizations might require one set of special investments and smaller organizations might require a different set of investments. This may improve efficiency over the long-term and lead to more sustainable efforts.

Initial Unmet Needs Survey - An analytical, objective assessment of unmet need should be conducted well-before the initiation of a follow-on design to ascertain specific objectives. The projected outputs/achievements of the present project may have been too low. In the future, a more rigorous appraisal of outcome and impact should be instituted.

ANNEX I

- SYNOPSIS OF FPPS DOCUMENT -

PRESENT STATUS AND FUTURE DIRECTIONS OF THE FPPS

UNMET NEED

The following comments represent an outlined synopsis of the FPPS document entitled: **Present Status and Future Directions of the FPPS.**

1. The present flow of requests in the private sector includes 24 institutions that have requested assistance: 6 large commercial firms, 4 government parastatals, 13 private maternity homes, and 5 NGOs. These 24, if funded, would add over 40 percent to the 1983-1991 program. Additional requests have been received from small organizations; these are part of the unmet need, and they may benefit from a program variation that would assist them in groups, through a Two-Step Method using a "magnet" clinic (see below).
2. A letter and questionnaire sent to 2524 organizations on various lists for the private sector elicited 55 interested responses, after nine deletions for agencies already funded. Of the 55, 42 have clinics, and though most have too few employees to be funded they again indicate unmet need that might be served through groups along the Machakos model. Again, if funded these would represent a substantial percentage enlargement of the current program.
3. In four large cities, 27 possible CBD sites have been identified which could be served through clinics and nursing homes already funded by FPPS.
4. FPPS is in touch with, and has aided in various ways, approximately 63 non-project organizations that have clearly demonstrated their interest in family planning. The presence of substantial potential in the private sector seems clear, in terms of present needs and in terms of future increases. This is corroborated by the FPPS evidence above and by our own impressions.

ANNEX II

FAMILY PLANNING SERVICES IN KENYA

DEMOGRAPHIC BACKGROUND AND POTENTIAL DEMAND

Results from the 1989 Kenyan Demographic and Health Survey (KDHS) show that the transition to lower fertility levels has begun and they also indicate that the trend may accelerate in the future.

The total fertility rate (TFR) has dropped sharply during the past five years, from 7.7 to 6.7. The degree to which the observed decline in fertility is translated into a fall in the population growth rate by altering the underlying age structure can be examined through the 1989 census. However, the crude birth rate has probably declined from about 52 to about 46 births per 1000 population. With an estimated crude death rate of 10 per 1000, the current natural increase is about 36 per 1000. This gives an estimated population growth rate of 3.6% per annum.

Kenya's total fertility rate is still high compared to Botswana (5.0) and Zimbabwe (5.7). However, significant fertility differentials exist among Kenyan women, associated with area of residence and level of education. For example, Nairobi has a TFR of only 4.6 while in Western Province it is still above 8. Urban women have 4.8 children while rural women have just over 7. Fertility also differs according to education. Women with no education have an average of 7.2 children while those with secondary or higher education have almost 5.0.

The potential demand for family planning services is evidenced by the proportion of women who want no more children. In the 1989 national survey, half of married women reported that they do not want any more children, a considerably higher figure than in any other Sub-Saharan country. It is 33 percent in Botswana and Zimbabwe, 25 percent in Togo, 24 percent in Burundi, 23 percent in Ghana, 19 percent in Uganda and Senegal, and 17 percent in Mali and Liberia. In Kenya the proportion varies widely by province, with two out of three women in Central Province wanting to stop childbearing, compared to just over one in four in Coast Province.

Future demand for fertility control is foreshadowed by the 1989 finding of an average ideal family size of 4.4 children, compared to a total fertility rate of 6.7. Moreover, ideal family size fell from 5.8 in 1984 to 4.4 in 1989. A further indicator of future fertility decline is that over half of the births in the 12 months before the survey were reported to have been either unwanted (11 percent) or mistimed (42 percent).

Using detailed information in the 1989 survey it is possible to estimate unmet need for family planning. For this we separate

(1) the expressed need for spacing the next child (i.e. non-pregnant, fecund, nonusers who want to delay their next birth by two or more years, and pregnant or amenorrheic women whose last birth was mistimed), from (2) need for limiting childbearing (i.e. non-pregnant, fecund, nonusers who want no more children, and pregnant or amenorrheic women whose last birth was unwanted).

These estimates imply that over one-third (36 percent) of married women are in need of family planning: 22 percent for spacing purposes and 14 percent for limiting. The KDHS survey data imply that the already sizeable proportion of married women using surgical contraception (4.7 percent) could potentially be quadrupled if the unmet need for limiting were to be raised by the 14 percent to a total of 19. Overall, the contraceptive prevalence rate should be 63 percent if the potential unmet need (36 percent) were to be met and added to the 27 percent who currently practice family planning..

Unmet need can be addressed through improved family planning information, education, and communication (IEC), to accompany the family planning services that are now available or will become so. According to the 1989 KDHS, 86 percent of women who know a contraceptive method live within 60 minutes of a family planning service delivery point, although of course not all service points offer a full method mix as yet.

COURA PLANES PROTECTION (CWP) REQUESTS BY F.F.P.S. - ASSISTIVE FAMILY PLANNING PROJECTS BY INSTITUTIONAL TYPE, YEAR (from 1st JULY 1984 to 30th JUNE 1990) AND COUNTERCEPTIVE METHOD

METHODS	PRIVATE SECTOR COMPANIES										PRIVATE CLINICS AND DOCTORS										NON-GOVERNMENT RELIGIOUS ORGANIZATION										GOVERNMENT INSTITUTIONS										COMMUNITY-BASED CLINICS										ALL F.P.P.S. ASSISTIVE PROJECTS																			
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993										
ORALS	137	152	145	130	120	110	100	90	80	70	110	120	130	140	150	160	170	180	190	200	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190
CONDOMS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
TUBAL LIGATIONS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
INTRACONCEPTALS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
ALL METHODS	157	177	165	155	150	145	140	135	130	125	170	185	200	215	230	245	260	275	290	305	210	225	240	255	270	285	300	315	330	345	360	375	390	405	420	435	450	465	480	495	510	525	540	555	570	585	600	615	630	645	660	675	690	705	720	735	750	765	780	795										

AC ABOVE PERCENTAGE

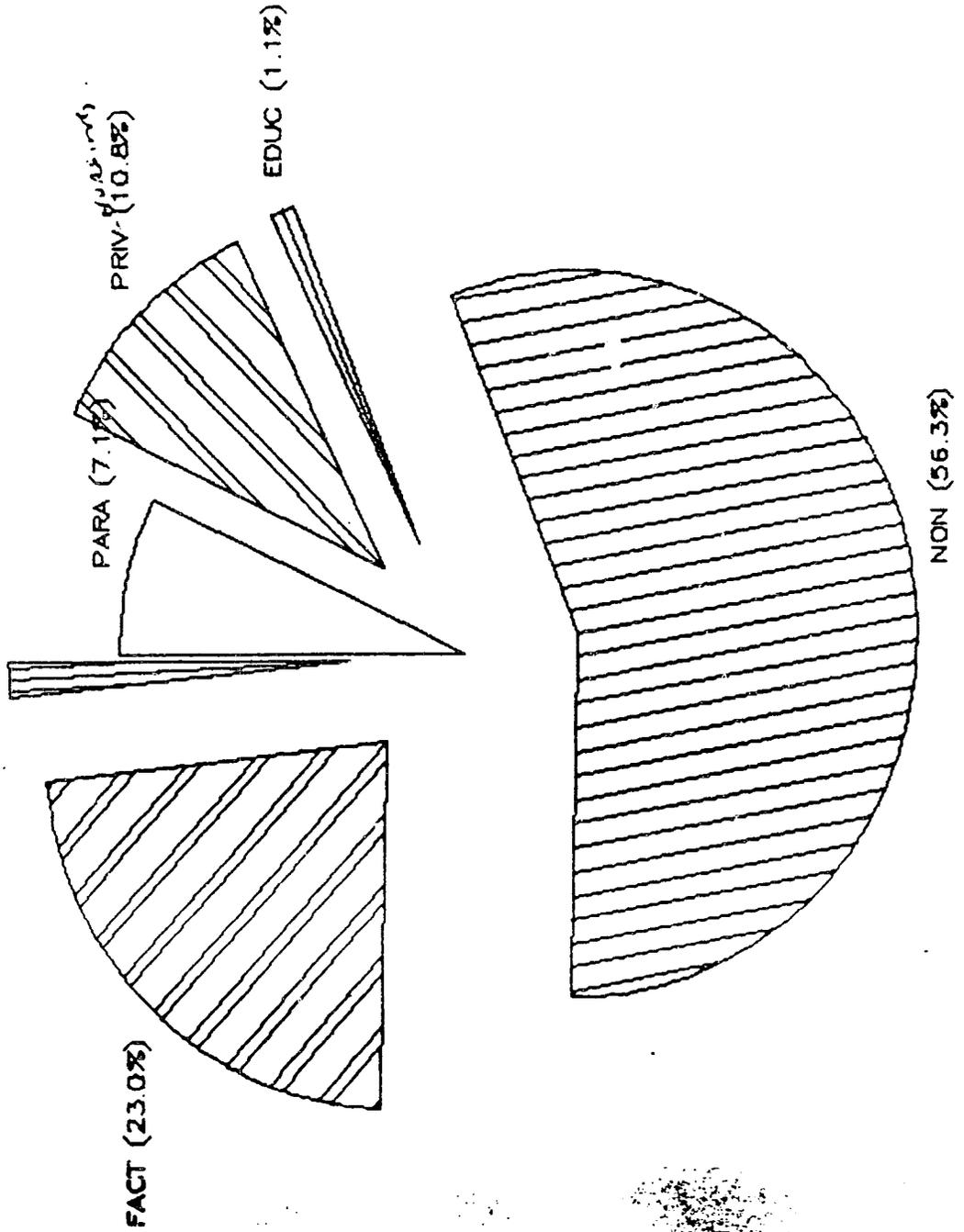
METHODS	PRIVATE SECTOR COMPANIES										PRIVATE CLINICS AND DOCTORS										NON-GOVERNMENT RELIGIOUS ORGANIZATION										GOVERNMENT INSTITUTIONS										COMMUNITY-BASED CLINICS										ALL F.P.P.S. ASSISTIVE PROJECTS																			
	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993										
ORALS	137	152	145	130	120	110	100	90	80	70	110	120	130	140	150	160	170	180	190	200	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190	100	110	120	130	140	150	160	170	180	190
CONDOMS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
TUBAL LIGATIONS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
INTRACONCEPTALS	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305										
ALL METHODS	157	177	165	155	150	145	140	135	130	125	170	185	200	215	230	245	260	275	290	305	210	225	240	255	270	285	300	315	330	345	360	375	390	405	420	435	450	465	480	495	510	525	540	555	570	585	600	615	630	645	660	675	690	705	720	735	750	765	780	795										

COST PER ONE COUPLE-YEARS PROTECTION IN F.P.R.S - ASSISTED
FAMILY-PLANNING PROJECTS BY INSTITUTIONAL TYPE AND
BY YEAR - JUNE 1984 - JUNE 1990 (in K. Shillings) (dollar)

TYPE OF INSTITUTION	YEAR					
	1984/5	1985/6	1986/7	1987/8	1988/9	1989/90
PRIVATE SECTOR COMPANIES	K. Sh. 6491 \$ 29,009	262 11.39	205 12.39	125 5.43	85 2.70	35 1.52
PARASTATALS	K. Sh. 7108 \$ 30.73	229 9.96	154 6.70	22 1.17	2 0.09	4 0.12
NON-GOVERNMENT RELIGIOUS ORGANIZATION	K. Sh. 261 \$ 11.35	147 6.39	90 3.91	101 4.39	72 3.13	48 2.09
PRIVATE DOCTOR/CENTR NURSING HOMES	K. Sh. 499 \$ 21.70	209 9.09	265 11.52	178 7.74	135 5.82	74 3.22
EDUCATIONAL INSTITUTIONS	K. Sh. —	—	143 6.22	55 2.39	40 2.09	3 0.13
COMMUNITY-BASED	K. Sh. —	—	4221 211.72	368 16.00	138 6.00	81 3.52

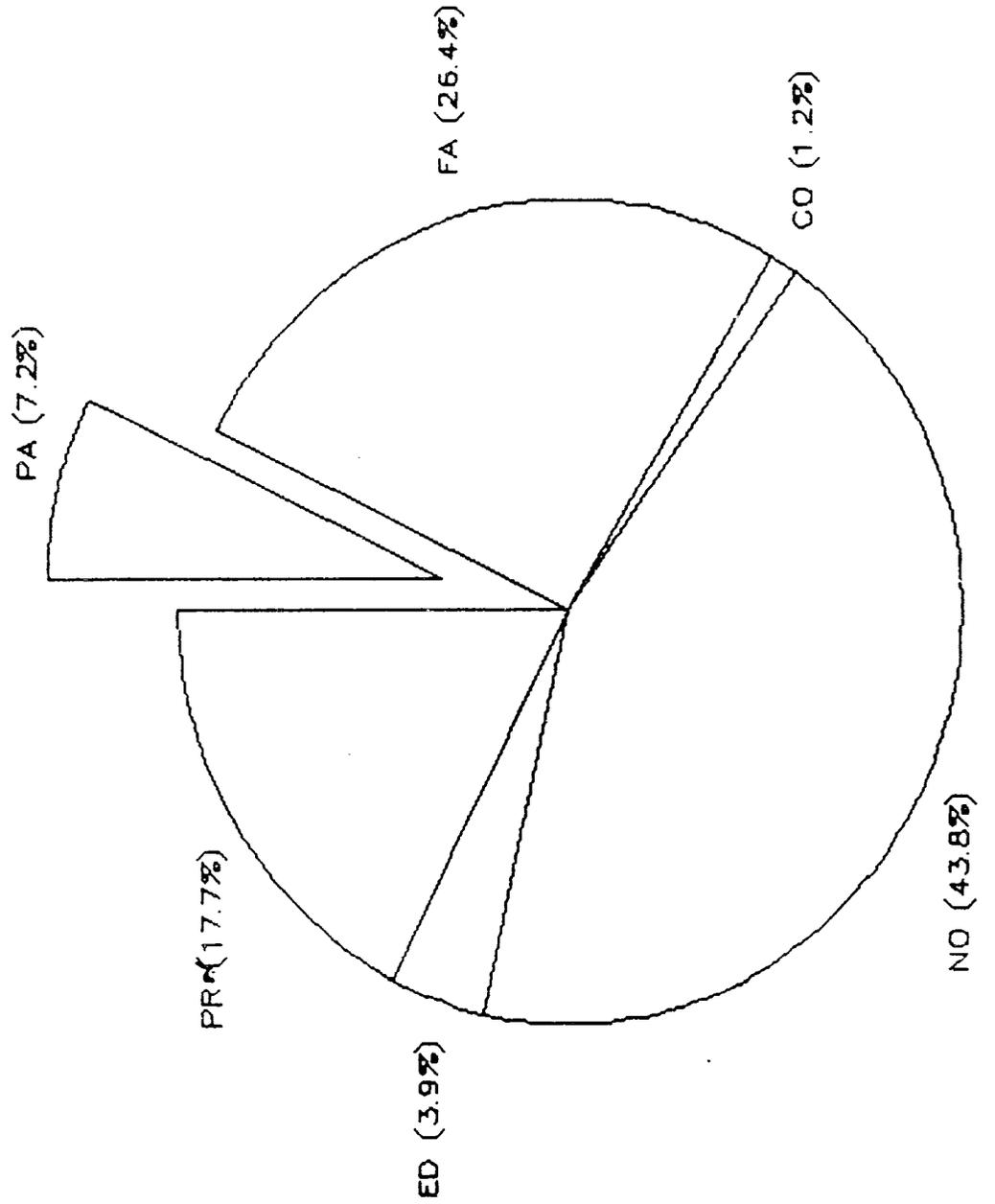
PROPORTION OF NEW ACCEPTORS RECRUITED

BY VARIOUS ORGANS. PERIOD(7/84-12/89)
COMM (1.6%)



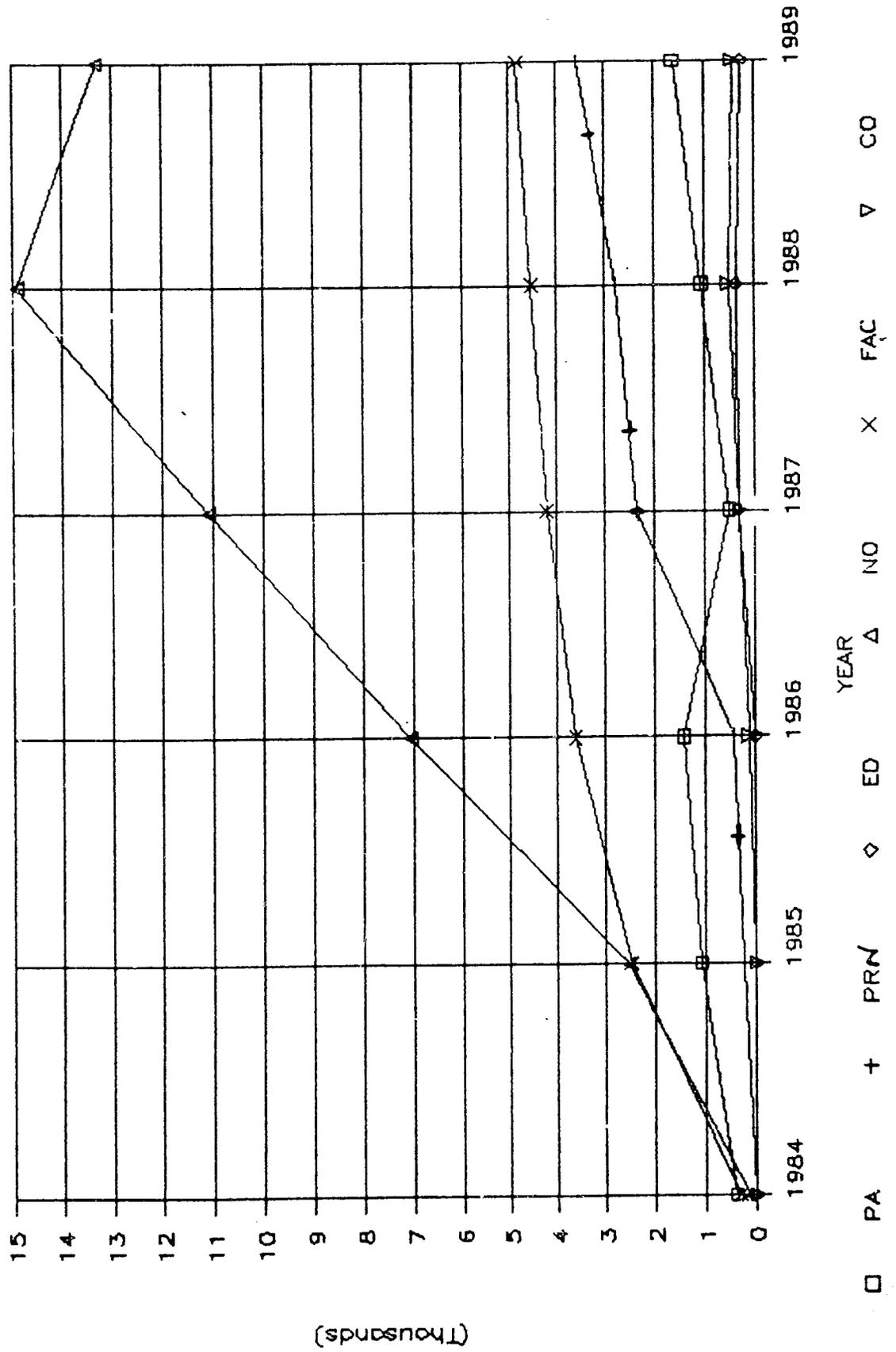
CONTRIBUTION TO CURRENT USERS BY

VARIOUS ORGANIZATIONS



22

TRENDS IN NEW ACCEPTORS



5

ANNEX III

ANALYSIS OF NEW ACCEPTORS AND CURRENT USERS BY SOURCE AND TIME TRENDS

From July 1984 through December 1989, a total of 87,150 new acceptors were recruited by 53 sub-projects of FPPS. Over half (56%) were recruited through the three NGOs (CHAK, SDA, and Crescent). All of these have been operational for at least three years and have 58 sites. CHAK accounts for 29%, SDA for 25%, and Crescent for 3%.

Thus about half of the activity in the overall program has come from the three religious organizations. As noted elsewhere, the implication is that they should be part of the future program, and that their needs for continuous financial support should be viewed sympathetically.

Private sector companies are the second leading recruiter of new acceptors, as well as of current users. They account for 23% of all new acceptors. Over half of the companies have been in the program for over 60 months, and they contain a large number of operating sites.

Community and educational institutions are relatively few, and have recruited only 2.7% of new acceptors. On the other hand they are relatively new, having participated in the program for a shorter period than some of the other institutions.

Private nursing homes are promising. In the rather short period of their participation they have recruited 11% of all new acceptors, more than the parastadals during their longer period.

The time trend chart shows that the three religious organizations have been consistent in their domination of recruitment. They have risen steadily, to a high maximum in 1988. Part of their rise reflects the addition of more sites in CHAK and SDA when their Phase II began.

The private nursing homes and the private companies (factories etc.) have continued to rise mildly during recent years in their recruitment of new acceptors.

The above remarks pertain to the three charts that immediately follow. After those, a number of additional charts are included which trace detailed time trends for current users, by method. The final two charts present new acceptor trends.

ANNEX IV

SUPPLEMENTAL FUNDING FOR IEC AND CBD ACTIVITIES

The original scope of the FPPS Project did not specifically target IEC & CBD activities. Experience with the initial subprojects quickly demonstrated that strengthening community outreach and involvement was a common need across all types of organizations and this was crucial to subprojects in order to effectively serve their target populations. Thus, FPPS added technical assistance in IEC as one of its primary areas of activity. Later a CBD component was added. These related program components have turned out to be a very successful area of activity with far ranging impact.

The impact of IEC activities, (films, murals, folk media festivals), is visible in terms of increased awareness and enhanced discussion in the community. The impact of IEC and CBD activity has also been immediately measurable at many subprojects by the number of new acceptors referred to clinics and the number of couple years of protection provided. The results of operations research on cost effectiveness and sustainability of subprojects also demonstrated the important relationship between IEC, CBD, field education activities and family planning utilization.

In spite of the recognized importance of IEC activities, one Issue affecting the future sustainability of subprojects is the fact that they have not typically committed resources to IEC activities. Research indicates that FPPS tends to support the IEC activities and field education functions, not host organizations. In contrast, the majority of the subproject costs go to support staff. Thus, subprojects that have completed their grant periods tend to have fewer field educators and spend less on IEC activities in terms of percentage of the budget for FP/MCH.

Project coordinators have also expressed their concern with respect to the future source of funding and support for IEC activities. For example, sites have stated in interviews and meetings that they are capable of covering clinic personnel costs, but that they would like the support for an outreach worker, or IEC transportation costs, or IEC special events. It is not coincidental that managers cite the importance of IEC efforts in influencing clinic activity. Regrettably, IEC outreach also seems to be the first to go unfunded when FPPS assistance ends. The important role of FPPS in supporting community outreach and motivation activities is clear, as is the importance of these activities for maintaining or expanding clinic utilization. Continued training, Technical assistance and materials support in these areas will be very important for future maintenance and growth of service delivery in FPPS subprojects. It may be appropriate to consider a supplemental

grant program to support special activities in this area for project that have completed their grant period. The program would specifically support activities which the subprojects define or propose through applications to FPPS within the parameters of IEC and outreach. The programme should not necessarily be limited to those that require a direct subsidy however, but could be open to all FPPS subprojects for supporting one-time activities such as folk media events. In any case, the level of support available, the number and type of projects that could be supported, and the criteria for the program's activities could all be outlined in advance to the subprojects. Such a program could also provide an additional mechanism for continuation of the important linkage that now exists between FPPS and its subprojects for motivation and assistance toward family planning service delivery. It is important to ensure relevance of messages, and create a nucleus of concerned individuals who are likely to perpetuate the activities beyond the period of FPPS support. At this stage in the development and maturation of the FPPS subprojects, a supplemental grant program to sustain IEC activities should be considered.

ANNEX VI

FIELD SITES AND ORGANIZATIONS VISITED

Week 1

Monday 14th May

- 9.00 - 11.00 - Introduction to FPPS team.
Presentation by FPPS team of history,
background, and status of project.
- 1.00 - Briefing by USAID
- Review & discussion of documents

Tuesday 15th May - Meeting with key organizations & people

- 8.30 - Mrs. Mukolwe (FPAK)
CHAK
- 10.00 - Meetings with individual members of
FPPS Team
- Dr. Matheka Mwololo -MCO
Nester Theuri
Daudi Nturibi

Wednesday 16 May - Meeting with individual members of
FPPS team (continued)

- Meeting with Key Organizations & people
(continued)
- 9.00 - Millicent Odera
- 10.00 - SDA
- 11.30 - Dr. Eraj. TAC member
- 2.30 - Dr. Ndirangu, Director NCPD
(W/ Eric Krystall)
- 3.30 - Crescent Medical Aid (NGO) ; site
visit to dropped (w/ Eric)

Thursday 17th May - Meetings continue
Document review and discussions
continue.

9.00 a.m - Phoebe Omondi

9.45 a.m. - Mary Ibutu/ Joan Robertson

Times to be - Division of Family Health
arranged Dr. Ng'ethe

Friday 18 May - Meeting continue as required
site visit to Nairobi area
Projects.

9.00 a.m - Machakos (Private) - Dr. Mwololo

3.00 p.m. - Kariobangi (Private) - Eric Krystall
fees for service

WEEK II - Tentative Schedule of Site Visit to
selected projects outside Nairobi.

Monday 21 May (Stay in Kisumu)

9.00 a.m * Sulmac Naivasha (Private) - Daudi &
Mwololo

2.00 p.m - KTGA Kericho (African Highland) - " "
(Private)

5.00 p.m - Nyamwita Maternity Home (Private) - " "

KISUMU

Tuesday 22 May (Stay in Webuye)

9.00 a.m - Siriba Teachers College - Kisumu - Daudi &
Mwololo

11.30 a.m - Mumias Sugar (Private) - Webuye - " "

2.30 p.m * Nzoia Sugar (Parastatals)- Webuye - " "

Wednesday 23 May

8.00 a.m - Panpaper (Private) - Eldoret - Daudi &
Mwololo

- 10.00 a.m - Eldore Nursing Home - Daudi & Mwololo
- 12.00 a.m - Kaptagat (Private, Extension
of Panpaper) - Daudi Mwololo
- 2.00 p.m. - Return to Nairobi - Daudi Mwololo

Thursday 24th May

- 9.30 - CHAK KIKUYU
- 11.30 - Discussions and briefing with FPPS
staff re: site visits
Begin report writing

Friday 25th May Continue report writing other data collection
and interviews as required

WEEK III

Monday 28th & Tuesday 29th May - Continue report writing

Wednesday 30th May - Presentation and Discussion of
findings with TAC, USAID,
&FPPS

Thursday 31st May - Finalize draft report

ANNEX VII

SELECTED DATA PREPARED BY MESSRS. OBUNGU AND KRYSTALL

ANNEX VIII

DOCUMENTS REVIEWED

FPPS Quarterly report Sept 1989

FPPS Progress Report 1988

FPPS Present status and future directions of FPPS Programme May 1990

FPPS Sustainability and cost effectiveness of FPPS subprojects - January 1990 report-submitted to FPPS by T. Kibua, J. Stewart S. Njiru, A. Gitari.

FPPS External Evaluation report Feb/March 1986 (J. Mati, J. Ssenyonga, P. Maccannon, J. Huge.

FPPS Project File: Cost impact of Family Planning Programmes in Private and Non-Governmental organizations.

FPPS Project File: Family Planning Private Sector Focus group interviews preliminary report on selected companies in Kenya.

FPPS Status Report January 1986

FPPS Project File: Influence of Wage Income and non-Benefits on Employees Attitudes towards family size and Family Planning practice

FPPS Project file: Baseline survey on Fertility - Related factors and Family Planning Practices Nov. 1986

FPPS Project File: Follow up to the Baseline survey

FPPS Subproject Monthly Reports

FPPS Family Planning Impact Evaluation of the FPPS Programme (Changes in Contraceptive Prevalence rates between 1984 and 1988) by E. Mburugu May 1990

Minutes of the National Council for Population and Development (NCPD) Technical Advisory Committee (TAC) meetings.

NCPD: The Kenya Demographic and Health survey - 1989.

USAID/Government of Kenya Memorandum of understanding September 1983

USAID/Kenya Co-operative Agreement No. 615-0223 A-00-3066-00 Amendment No. 5

ANNEX IX

SITE VISITS TO SUBPROJECTS

Machakos Medical Clinic - Machakos
Kariobangi North Family Planning and Nursing Home - Nairobi
Sulmac Flower Estate - Naivasha
African Highlands Produce - Kericho
Nyauta Maternity Nursing Home - Kisumu
Siriba Teachers College - Kisumu
Mumias Sugar Company Limited - Webuye
Panafrikan Paper Mills Ltd - Webuye
Kaptagat - (Extension of Panapaper)
Eldoret Nursing Home - Eldoret

Organizations and Individuals Visited

Family Planning Private Sector (FPPS)

Dr. Eric Krystall
Dr. Millicent Odera
Mrs Joan Robertson
Dr. Matheka Mwololo
Mrs Nester Theuri
Mr. Daude Nturibi
Ms. Mary Ibutu
Ms. Phoebe Omondi

USAID - Dr. David Oot

Family Planning Association of Kenya (FPAK) - Dr. Oyoo

Christian Health Association of Kenya (CHAK)

Seventh Day Adventist (SDA)

National Council for Population and Development - Dr. Ndirangu

Technical Advisory Committee - Dr. Yusuf Eraj

Crescent Medical Aid

Ministry of Health -

Division of Family Health - Dr. Ngethe