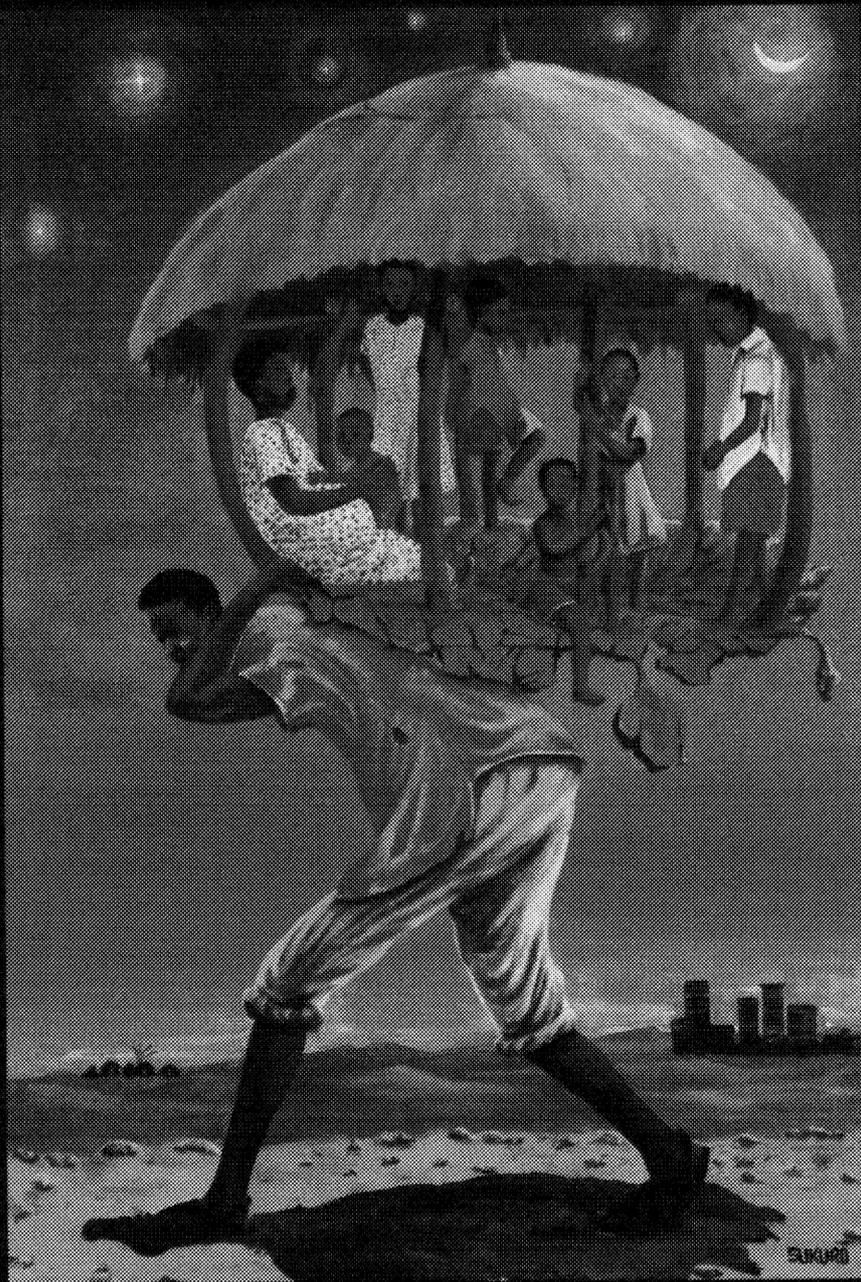


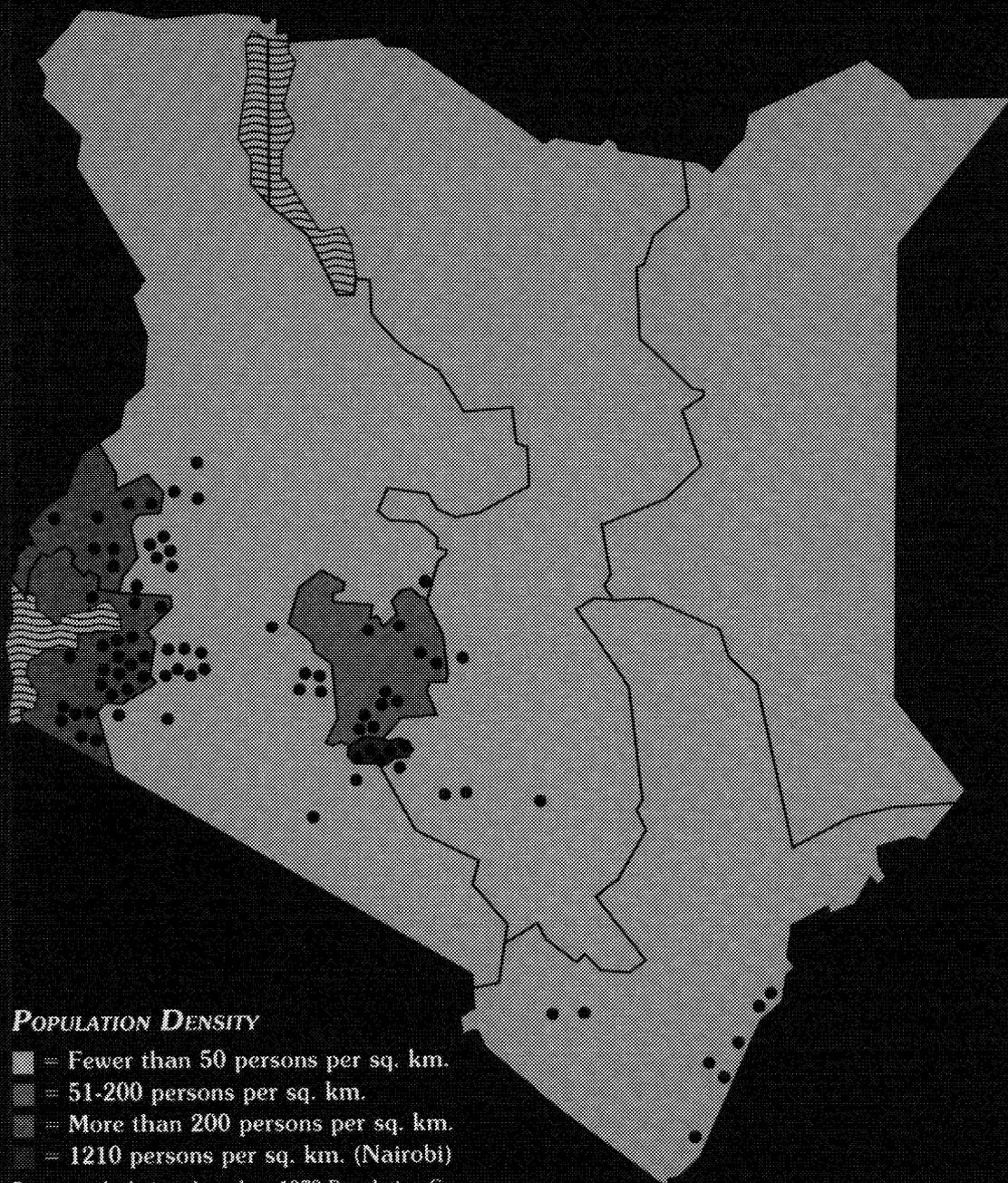
NEW PATHS TO FAMILY PLANNING



*THE
FAMILY PLANNING
PRIVATE SECTOR
PROGRAMME
OF KENYA*

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FPPS PROJECTS AND FAMILY PLANNING SERVICE DELIVERY SITES



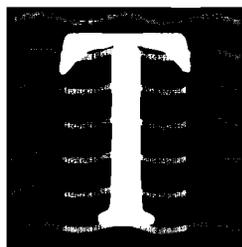
POPULATION DENSITY

- = Fewer than 50 persons per sq. km.
- = 51-200 persons per sq. km.
- = More than 200 persons per sq. km.
- = 1210 persons per sq. km. (Nairobi)

Density calculations based on 1979 Population Census

THE FAMILY PLANNING PRIVATE SECTOR PROGRAMME OF KENYA

INTRODUCTION



he world now generally agrees that rapid population growth can slow improvements in the health and economic well-being of its peoples. The successful delivery of family planning information and services, however, remains a challenge and calls for many approaches. In Kenya, the Family Planning Private Sector Programme (FPPS) uses a relatively unexplored approach: it works through private channels—companies, plantations, factories, private health clinics, parastatals and other non-governmental organizations. FPPS is an important complement to the Kenyan Government's own family planning programme, assisting the Kenyan private sector to carry out family planning programmes for its workers.

NEW PATHS TO FAMILY PLANNING

BACKGROUND

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Kenya in recent years has experienced one of the world's fastest rates of population growth, about 4 percent annually. The Government of Kenya recently launched a programme to increase the "awareness of the wananchi (citizenry) about the relationship between the growth of population on the one hand and economic progress on the other." But as Vice President Mwai Kibaki has noted, Kenya has before it the "mighty task of bridging the gap between awareness and practice." Since its beginning in 1984, FPPS has been a major component of a national plan of action.

FPPS's approach is a logical one: to assist Kenya's private sector, one of the most vigorous and socially responsible in Africa, to add family planning services to the health services already provided to its workers and dependents. In the process, FPPS seeks to upgrade organizations' health clinic facilities and extend services out to workers' communities. The project was originally charged with introducing family planning services into 30 non-governmental organizations and attracting 30,000 new family planning acceptors.

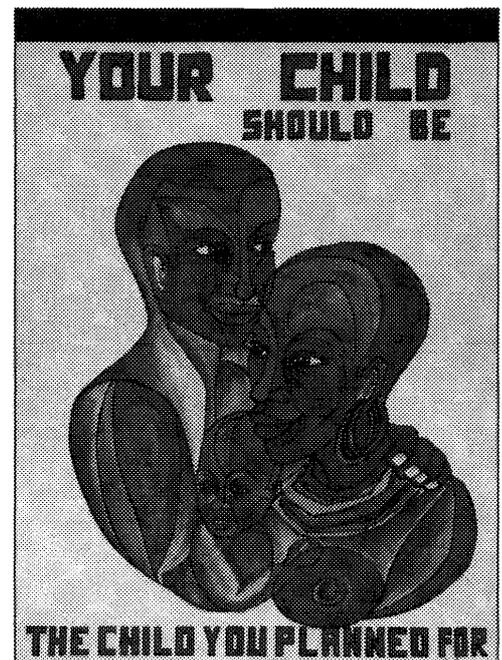
STRATEGY

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At the outset, FPPS contacted a wide variety of non-governmental organizations to identify the prime candidates for family planning subprojects. A prerequisite was that the subproject site already have a government-registered health clinic.

Kenya's well organized agricultural sector produces various large export crops—tea, coffee, sugar, sisal, pineapples, flowers—that utilize and concentrate large numbers of workers on estates and their environs. Estate workers are generally provided with housing, schools, health facilities and other social services. The nation's developing industrial base also consists of various factories that have large work forces served by the company clinic. FPPS's strategy, then, was first to show these estates and companies that their social and economic interests would be served by adopting strong family planning programmes.

2 In the second phase, health clinic staff were trained and programmes designed to carry out subprojects in the work place. Finally, the workers





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BOX 1:

PANAFRICAN PAPER MILLS

"We asked 'when,' not 'why,'" recounts Mr. Arjun Rijhwani, the Executive Director of Panafrikan Paper Mills. The reasons for accepting FPPS's assistance in making family planning services available at the company's residential estate in Webuye were self-evident to Mr. Rijhwani: the company could offer its workers a social service, save money and align itself with the Kenyan Government's family planning policies.

With 17,000 workers, mostly men, located in the densely populated Western province of the nation, Panafrikan Paper Mills found large families a drain on many of its workers, albeit indirectly. If the workers' wives have a succession of babies, the men often need salary advances to pay for it all. Financial worries, overcrowded housing conditions and sick family members combine to undermine a man's work habits. Too many babies too soon easily can affect the health of a woman and add to the company's mandated obligation to provide health care for a worker, his wife and four children.

According to Mr. Rijhwani, family planning pays dividends for Panafrikan Paper Mills: smaller families result in a higher per capita standard of living and more productive workers; absenteeism is reduced; the programme is tax deductible and cuts the company's health-care costs, mostly in maternity benefits. Further, the expense of adding family planning to the clinic services was small.

In most months, the company exceeds its targeted number of new acceptors. It has added two nurses trained by AMREF, built a new wing on the clinic to offer family planning services with privacy, and established worker committees to motivate families. Panafrikan Paper Mills has "graduated" from the FPPS programme and serves as a model of enlightened self-interest.

were educated about the economic and health benefits of smaller families, and provided with appropriate information, contraceptives and follow-up services. According to the schedule, FPPS support is phased out of the individual projects after two years to let the companies run and finance their own programmes on a permanent basis.

The first companies to be recruited include such places as Nzoia Sugar Company (serving 36,000 workers and dependents), Kenya Canners (18,000), Kenya Cashewnut (11,750), Brooke Bond (93,000 at three sites), and Kenya Tea Growers (122,000). Why did these companies want to work with FPPS? In addition to their commitment to social responsibility, those companies which rely on female workers (for example, tea pickers) could see the direct benefits of family planning. Fewer pregnancies mean fewer women on maternity leave—an economic benefit to the company. Firms that employ mainly male workers perceived less direct, but still significant, economic benefits—fewer dependents to provide services for and less family pressure on the workers. Many companies have labour agreements which include clauses limiting company benefits coverage to only one wife and four children per worker. For these companies the economic benefit of FPPS was even more indirect but nonetheless substantial. (See Box 1.)

FPPS has also worked with hospitals in the Protestant Church Medical Association (PCMA)—serving a population of 300,000—and other self-help/private health clinics to assist them to improve their family planning activities. These committed organizations have strong links to their communities, and by including them, FPPS is tapping the energy of another vital element of the private sector. Indeed, church hospitals provide some 40 percent of health care services in Kenya. FPPS is now adding the University of Nairobi and teacher-training colleges to its roster of subprojects.

IMPLEMENTATION



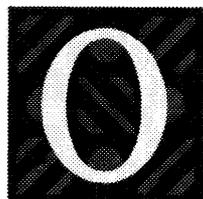
When a company applies for a subproject, it is judged on three main points: the presence of a government-approved health clinic or dispensary at the project site, a long-term commitment to add family planning to its other health services, and its potential for reaching a significant number of people of childbearing age not now involved in family planning.

A shortage of personnel trained in family planning was initially identified as a major obstacle. The African Medical and Research Foundation

(AMREF), therefore, collaborated with FPPS to train more than 200 nurses, midwives, clinical officers and other health providers. During the nine-week training course, FPPS often provides funds for substitute staff so clinic operations will not be interrupted. The training programme allows FPPS to enhance the skills of the existing clinic staff so they can successfully provide continuing family planning services, recruit new acceptors and follow up with health and information services. FPPS can also provide funds for the subproject to employ additional staff to ensure full-time family planning service delivery on the condition that the sub-contractor assume the staff salary at the end of the two-year funding period.

By employing the same staff within the established health care system, family planning is added with little fanfare to clinic services, thereby guaranteeing privacy for men and women seeking services. Education and information for workers and their families are gradually expanded in each subproject's clinic. In fact, several FPPS subprojects now also include community-based programmes, where they reach out to potential clients who feel constrained by time or attitude from coming directly to the clinic. (See Box 2.)

COMMUNICATING THE MESSAGE



Once a few key companies took the lead, convincing other companies of the benefits of implementing a family planning programme was relatively easy. Corporate officials could see the potential savings from reduced maternity leaves, lower absenteeism, fewer dispensary visits by mothers and decreased costs for medical care and education of children. Further, the FPPS programme adhered to the high priority the Kenyan government placed on family planning and demonstrated the private sector's social responsibility.

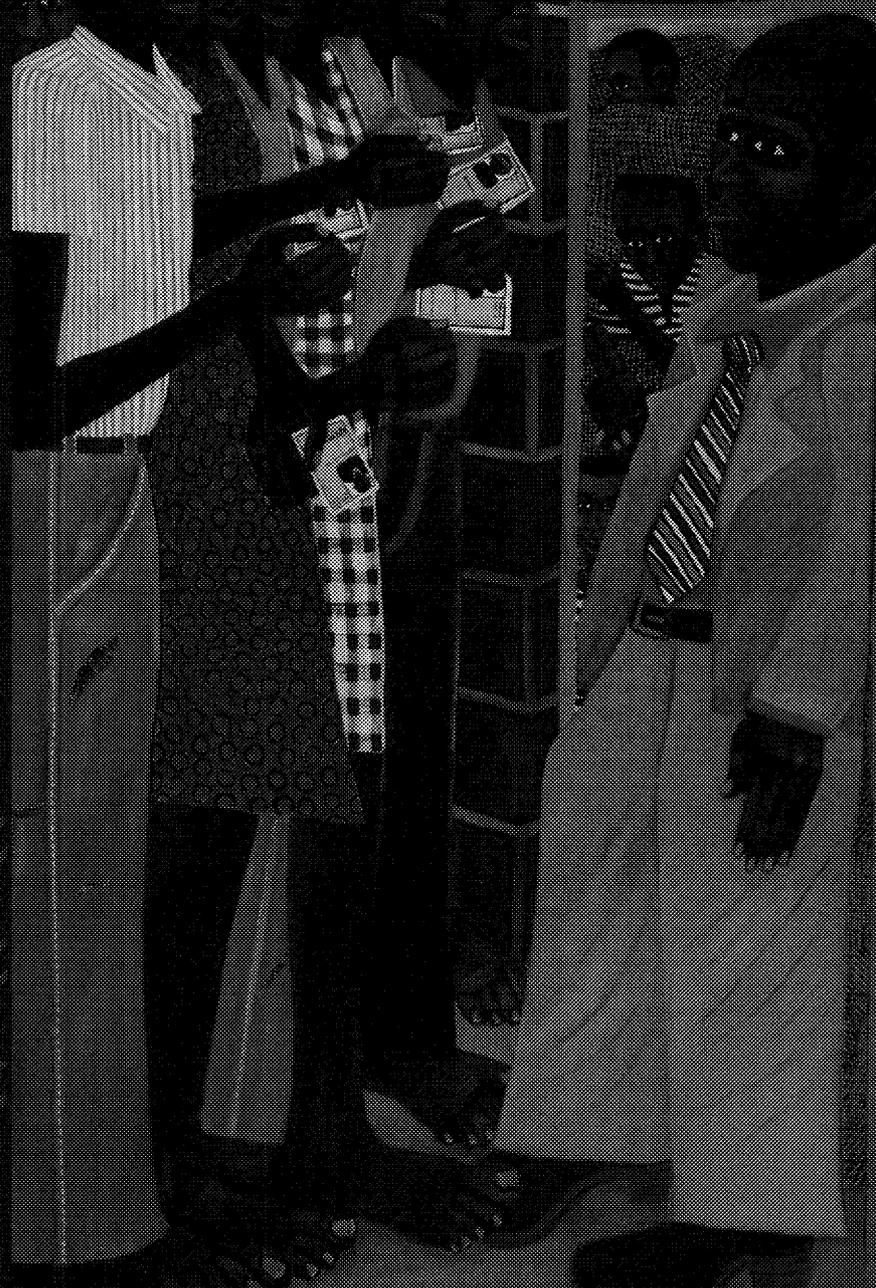
But the attitudes and social environment of workers were manifestly more complex. A 1985 baseline survey of employees revealed high illiteracy among women; only 32 percent of the women had ever used modern contraceptive methods despite relatively low family incomes for supporting children; and women on average stated a desire for four children, compared to the men's expressed desire for five. The different attitudes of women and men were highlighted by a response from 77 percent of the women that the husband's objection to family planning

BOX 2:

SUPPLIES, LOGISTICS AND STATISTICS

- *FPPS has also upgraded clinic equipment and supplies so that highest quality family planning services can be provided.*
- *Although originally intending to rely on government central stores to provide contraceptives to the subprojects, the FPPS staff decided to assist in contraceptive supply to guarantee efficiency and timeliness.*
- *FPPS's detailed record-keeping system not only ensures good contraceptive logistics, but also allows it to measure progress against targeted goals. The record system is ingeniously designed both to provide clients with appointment reminder slips in a discreet way, and to allow clinic staff to follow up on "defaulters"—clients who failed to keep appointments. This helps subprojects meet one of their obligations to FPPS—to maintain a 60 percent continuation rate for family planning acceptors.*

HAKUNA KAZ





BOX 3:

OPERATIONS RESEARCH

Since its inception, FPPS has carried out a series of studies designed to monitor, evaluate and modify its activities. Project staff are aware that in order to provide the best services possible, they need to understand both the needs of their sub-project companies and what kinds of people will be using their clinics. In addition to the 1985 baseline survey (with a follow-up survey planned), FPPS has so far conducted two additional studies, "The Cost Impact of Family Planning in Private and Non-governmental Organizations," and "The Relationship between Incomes and Attitudes towards Family Size and Family Planning." Among the findings are:

- 85 percent of workers approve of family planning and 68 percent expressed a willingness to visit a family planning clinic. However, only 18 percent had done so in the past.
- Birthspacing is not only healthy for mothers and children but can save companies money. Research has shown that companies with FPPS subprojects have saved from KS 274 to KS 348 per child per year.
- Pregnant mothers' prenatal clinic visits cost companies an average of KS 110 per pregnancy.
- The reduced demand for maternity leave can save companies from KS 850 to KS 4534 per postponed pregnancy.

was the major reason why married women didn't contracept, while 85 percent of the husbands claimed that they were willing to support their wives in the practice of family planning. Any communication campaign would have to take these findings into account. (See Box 3.)

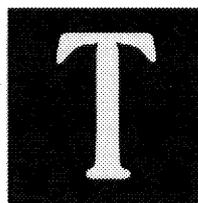
In addition, reaching the clients through the FPPS system called for explaining the benefits of family planning in images and language that were clear and colloquial. Two activities typify FPPS's dedication to communication in the idiom of the people:

1) **Posters and Calendars.** Some of East Africa's best artists were commissioned to prepare posters on population and development issues. The artists' images and concepts were carefully pre-tested to assess their effectiveness. In view of the relatively high rate of illiteracy among the workers, FPPS found that ideas had to be conveyed simply in terms that fit the realities of the clients' lives. Abstractions were, in a word, out. The result has been a combination of fine poster art and compelling messages. The illustrations in this booklet were drawn from this pool.

2) **Folk Media.** In common with much of the world, Kenyans have traditionally articulated the values of their society through songs, dances, poems, drama and proverbs. FPPS, with the assistance of Kenyan anthropologists, tapped into this system of popular communication. FPPS and the individual companies organized and oriented local committees, developed basic messages on nutrition and family planning, formed troupes and put on performances for their communities.

Folk media has proved a smashing success. The workers greatly enjoy putting on the performances and draw large audiences, particularly in rural areas where entertainment is in short supply. In the process, the virtues of family planning are disseminated and reinforced. (See Box 4.)

RESULTS



There are many measures by which FPPS's success can be judged. The programme fills an obvious niche in Kenya's overall family planning efforts because of the major role played by the private sector both in the Kenyan economy and in the delivery of health services. In fact, FPPS is considered to be so important that the Kenyan government requested that the project be extended until 1989, two years beyond its original completion date. The project now has a new total target of 50 subprojects and 50,000 family planning acceptors. Beyond its importance in Kenya,

FPPS has been judged a success by rigorous international standards and used in part as a model for a major international project.¹

FPPS has fulfilled its original goal for acceptors and has witnessed steady increases in the distribution of contraceptives. For condoms, in particular, the distribution has grown exponentially. (See Table 1.) While some subprojects have not approached their new acceptor goals, most have done so, and, in fact, many subprojects have greatly exceeded their goals. Further, all the companies whose initial two years with FPPS have ended—"graduate" subprojects—have continued, with their own resources, to provide and even expand family planning services for their workers and dependents. The graduates do continue to maintain some links with FPPS, namely access to contraceptive supplies, posters and other educational material as well as provision of statistical data on their programmes.

CONCLUSION

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amily planning can work in Kenya, the present high growth rate notwithstanding. The Kenyan government actively supports family planning, many

women want smaller families and the nation is endowed with many institutions with direct access to the people. The key, then, is to establish authentic lines of communication and make contraceptives and health care available at the work site and in the community. The private sector has proved a pioneering vehicle for shaping a better future for Kenya.

BOX 4:

FOLK MEDIA AT BROOKE BOND IN KERICHO

"Dear and loving parents, we eat food to live, grow, and stay healthy and energetic for work and play..."

So chanted a group of brightly uniformed children against the glorious backdrop of the verdant, rolling hills of Brooke Bond's vast tea estates near Kericho in July 1987. The audience, drawn from the estate's 15,000 workers and 25,000 family members, alternately listened intently and laughingly applauded as the children used verse, acting, props and dancing to pass on solid information on the importance of a good diet. These children were part of a long list of performers spending the day entertaining and educating their neighbors and co-workers.

Their messages—good nutrition, health and family planning—were novel. But the styles of presentation—rhythmic spoken verse, stories to pass on group wisdom, poetry, skits and role playing, dancing and songs—are drawn from traditional Kenyan culture. FPPS, in conjunction with its subprojects and consulting anthropologists, has worked out a system of using folk media to reach workers and their families with basic messages. Local troupe leaders are identified and coached as they themselves write the poems, songs and skits. FPPS staff play supporting roles as they teach and revise the messages and hone their delivery. The results are polished and entertaining. These popular presentations have now become a central educational tool of the private sector programme.

The on-site presentations draw crowds, do not depend on literacy, and involve the performers as well as the spectators. The Ford Foundation in New York was so impressed by the system that it has donated money for nationwide folk media festivals.

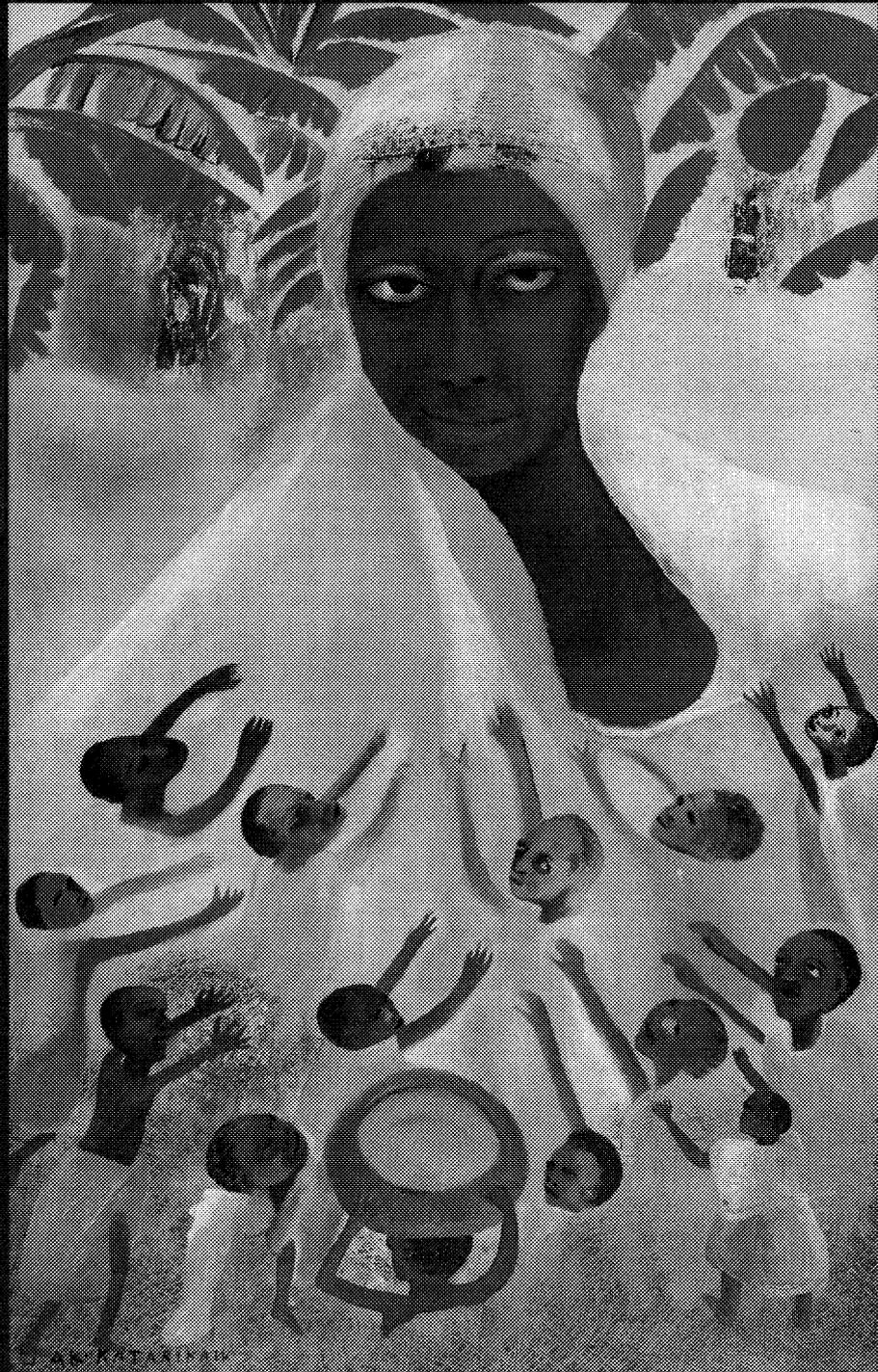


TABLE 1:

FPPS CONTRACEPTIVE DISTRIBUTION, JULY 1985, 1986, 1987

	July 1985	July 1986	July 1987
Birth Control Pills ¹ (cycles distributed)	1,542	2,798	4,845
Condoms ² (number distributed)	2,625	45,771	124,741
Tubal Ligations ³	71	121	159
Foaming Tablets ⁴ (number distributed)	3,020	45,560	81,280
Injectables ⁵	233	835	2,132
IUCDs ⁶	131	106	195

¹ One cycle of pills is good for one month of contraceptive protection.

² Each condom is used only once and couples are assumed to use about 100 condoms per year.

³ Tubal ligation (female sterilization) is a permanent method of contraception.

⁴ Foaming tablets are distributed in tubes of 20. One tablet is used at the time of sexual intercourse and couples are assumed to use about 100 per year.

⁵ Each dose of injectable contraception lasts approximately three months. Injectables are provided by UNFPA or other non-USAID sources.

⁶ IUCDs offer contraceptive protection as long as they are in place, on average about two years.

**FPPS SUBPROJECTS IN
ORDER OF ESTABLISHMENT**

MIWANI SUGAR	NANYUKI COTTAGE
PANPAPER	CHANGAMWE
KENYA CANNERS	E.A. INDUSTRIES
NZOIA SUGAR	SIRIBA TEACHERS
KENYA FLUORSPAR	UNIVERSITY OF NRB
KENYA CASHEWNUTS	SDA II
PCMA KAIMOSI	PCMA II—
PCMA KENDU BAY	MASENO
PCMA KIKUYU	MUNDOLI
PCMA KIMA	MWIHILA
PCMA LUGULU	OLOOSEOS
KANGARU CLINIC	PLATEUA
B.B. NAIVASHA	ST. LUKES
CHEMELIL SUGAR	KHASOKA
B.B. MABROUKIE	LITEIN
B.B. KERICHO	TUMUTUMU
AFRICAN HIGHLANDS	CRESCENT—
ELGEYO SAW MILLS	JAMIA
CANAAN MEDICAL	BIAFRA
VOI SISAL	KIBERA
SULMAC SISAL	PANGANI
KENYA BREWERIES	PUMWANI
OSERIAN FLOWER	MALINDI MAT. HOME
MUMIAS SUGAR	ELDORET NURSING HOME
SDA I	GETEMBE NURSING HOME
BAT KENYA	OKANGA—
SOUTH NYANZA	MOMBASA
KTGA NANDI HILLS	UKUNDA
KTGA SOTIK	NAKURU NURSING HOME
KTGA KERICHO	KARIMA HEALTH CENTRE

The art in this booklet was created by the following African artists commissioned by FPPS as part of a programme to effectively communicate family planning messages:

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Cover, Sukuro Etale; page 2, Emmy Kintu; page 3, Ancent Soi; page 4, Jak Katarikawe; page 7, Ancent Soi; page 8, Sukuro Etale; page 11, Jak Katarikawe.

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*Family Planning Private Sector Programme, a JSI Programme coordinated
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For further information, contact:

FPPS

Longonot Place, Kijabe Street

P.O. Box 46042

Nairobi, Kenya

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