

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET	1. TRANSACTION CODE <input type="checkbox"/> A = ADD <input type="checkbox"/> C = CHANGE <input type="checkbox"/> D = DELETE	88418 AMENDMENT NUMBER	DOCUMENT CODE 3
2. COUNTRY/ENTITY Kenya	3. PROJECT NUMBER 615-0264		
4. BUREAU/OFFICE Africa/USAID/Kenya	5. PROJECT TITLE (maximum 40 characters) AIDS Population & Health Integrated Assistance		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) 09/30/2000	7. ESTIMATED DATE OF OBLIGATION (Under 'B', below, enter 1, 2, 3, or 4) A. Initial FY 95 B. Quarter 4 C. Final FY		

8. COSTS (\$000 OR EQUIVALENT \$1 = X)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. LC	D. TOTAL	E. FX	F. LC	G. TOTAL
AID Appropriated Total						
(Grant)	4.600		4.600	28.500		28.500
(Loan)						
Other U.S.						
Host Country					9.000	9.000
Other Donor(s)						
TOTAL	4.600		4.600	9.000		37.500

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATION TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1 Grant	2 Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA				-0-	-0-	4,600		28,500	
(2)									
(3)									
(4)									
TOTALS						4,600		28,500	

10. SECONDARY SPECIAL CODES (maximum 6 codes of 3 positions each)	11. SECONDARY PURPOSE CODE
12. SPECIAL CONCEPTS CODES (maximum 7 codes of 4 positions each)	
A. Code	
B. Amount	

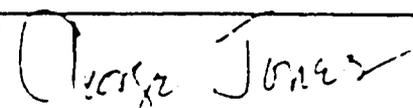
13. PROJECT PURPOSE (maximum 480 characters)
 Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.

14. SCHEDULED EVALUATIONS	15. SOURCE/ORIGIN OF GOODS AND SERVICES
Interim: 02/99 01/00 Final	<input type="checkbox"/> 000 <input type="checkbox"/> 941 <input type="checkbox"/> Local <input checked="" type="checkbox"/> 935

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

The method of implementation and financing in the Project Paper has been reviewed and approved by the Mission Controller.


 Cacile Adams, Controller

17. APPROVED BY	Signature:  Title: Mission Director	Date Signed: 8/4/95	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
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ACTION MEMORANDUM FOR THE USAID/KENYA MISSION DIRECTOR**FROM:** ~~Steff~~ Steff Meyer, Chief, Office of Projects**SUBJECT:** AIDS, Population and Health Integrated Assistance Project (615-0264) - Project Approval**DATE:** -4 AUG 1995**Action:**

Pursuant to Sections 104 and 496 of the Foreign Assistance Act of 1961, as amended, your approval is requested for a grant in the amount of \$28,515,000 in Development Fund for Africa (DFA) bilateral funds to the Government of Kenya (GOK) for the AIDS, Population and Health Integrated Assistance Project (APHIA). It is planned that \$4,600,000 in bilateral funds will be obligated in FY95. You are also requested to approve i) the subject Project Paper, ii) the Project Authorization and iii) the Project Grant Agreement. The Project Assistance Completion Date (PACD) is September 30, 2000.

Background and Description:

The new USAID Project is entitled, "AIDS, Population and Health Integrated Assistance." When pronounced, the Project's acronym APHIA -- sounds like the Kiswahili word for health, afya. The Project is designed to consolidate, focus and rationalize all USAID support to the Population and Health sector in Kenya. APHIA will employ a two-pronged strategy to address the immediate and compelling needs of millions of Kenyan women and men for the skills, knowledge and services necessary to prevent unintended pregnancies, unwanted abortions and HIV/AIDS, and build Kenya's capacity to sustain services and meet future needs with local resources. APHIA will provide technical assistance, training and limited commodities over a five-year period (1995 - 2000). The Project is consistent with: 1) USAID/K Goal: Promote sustainable, broad-based economic growth; 2) the Sub-Goal: Stabilize population growth and protect health; and 3) the APHIA Strategic Objective: Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.

The total Project cost of an estimated \$69,000,000, is comprised of \$28,515,000 in bilateral funds from the Development Fund for Africa (DFA), and \$31,485,000 in AID/W Global Bureau field support. The value of in-kind counterpart contributions from the GOK, Private Voluntary Organizations (PVOs), and Non-Governmental Organizations (NGOs) is estimated to be \$9,000,000. In addition, there will be an estimated \$16,759,000 in core support from the

Global Bureau for population, health and nutrition activities of global or regional significance to be implemented in Kenya. The table below summarizes USAID/Kenya bilateral and counterpart contributions.

Budget Item/Amount (\$000)

	USAID	COUNTER- PART	TOTAL
1. NATIONAL SERVICE DELIVERY SUPPORT	2,750	861	3,611
2. PRIVATE SECTOR SERVICE DELIVERY	5,300	1,656*	6,956
3. HEALTH CARE FINANCING AND SUSTAINABILITY	16,815	6,181	22,996
4. DISTRICT FOCUS	700	302	1,002
5. MANAGEMENT AND COORDINATION	2,950	----	2,950
GRAND TOTAL	28,515	9,000	37,515

*Applicable only to Kenyan NGO Grantees.

Project Expected Results:

The following results will be necessary to attain the Strategic Objective by the year 2000:

1. Access to and the use of integrated family planning and HIV/AIDS/STD services will be increased through change, improved planning and communication, improved service quality, and an expansion in the supply of services.
2. The MOH will have the independent capacity to develop, monitor, and update national implementation plans for family planning and HIV/AIDS/STD prevention and use them to coordinate and budget local and external resources.
3. The national population and family planning IEC program will be institutionalized and broadened to include selected messages related to HIV/AIDS/STD, and maternal, reproductive, and child health; the national family planning logistics program will have incorporated commodities related

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to HIV/AIDS/STD prevention, notably drugs; and, national training programs which focus on family planning will be institutionalized and integrate HIV/AIDS/STD and other aspects of reproductive health.

4. Kenyan organizations in the USAID-supported private sector network will have broadened the range of services offered to clients beyond family planning to include HIV/AIDS/STD prevention and other reproductive health services, and will have increased total Couple Years of Protection (CYPs) annually from 400,000 to 850,000.
5. The Family Planning Association of Kenya (FPAK), the Christian Health Association of Kenya (CHAK), and Chogoria Hospital will have made significant progress towards sustainability through improved management and the pursuit of strategies such as fees for service and the establishment of endowment funds.
6. The Population Services International (PSI)-implemented national condom social marketing project will: 1) have increased sales from 6 to 10 million annually (8 percent of the condoms distributed nationally); 2) have made the transition to a Kenyan NGO or company (or been incorporated into an existing Kenyan NGO or company); 3) possess the independent capacity to manage a national social marketing program; and 4) have made significant progress towards financial independence.
7. The John Snow, Inc. (JSI)-implemented Private Sector Family Planning Project will have made the transition to a Kenyan NGO or company with the independent capacity to plan strategically; solicit, raise, and account for funds; provide technical assistance (TA) and training; and develop, monitor and evaluate sub-grants to the private sector to establish, expand and improve health services.
8. District Health Management Teams and Boards (DHMTs and DHMBs) will have assumed primary responsibility for many essential cost-sharing management functions.
9. Cost sharing revenue will have increased to at least \$9 million annually -- from 25 percent to 50 percent of potential.
10. A Vaccine Independence Initiative (VII) and a Contraceptive Independence Initiative (CII) will have been launched to build self-reliance in the procurement of key public health commodities.

11. The technical, resource, management and coordination requirements necessary to reduce the risk of HIV/AIDS transmission at the district or sub-district level will have been documented and disseminated.
12. The technical, resource, management and coordination requirements necessary to reduce malaria transmission at the district or sub-district level will have been documented and disseminated.
13. There will be systematic use of WHO and UNICEF algorithms designed to ensure appropriate immunizations and improve recognition and treatment of major childhood illnesses at first-level health facilities.

Analyses and other requirements: The Project Paper demonstrates that the Project is technically, economically, and socially sound, and administratively feasible. The technical design and cost estimates are reasonable and adequately planned, thereby satisfying the requirements of Section 611 (a) of the Foreign Assistance Act of 1961, as amended. The timing and funding of Project activities are appropriately scheduled and the implementation plan is realistic and establishes a reasonable time frame for carrying out the Project. Adequate provision has been made for evaluation and audit. The Project is environmentally sound (the Bureau Environmental Officer approved a Categorical Exclusion for the Project on March 3, 1995).

Conditions and Covenants:

USAID is proposing the following major covenants and conditions precedent. A complete listing of the conditions and covenants is contained in the Project Agreement:

1. Conditions Precedent to First Disbursement. Except as USAID may otherwise agree in writing, prior to any disbursement under the Grant, or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee shall furnish or have furnished to USAID, in form and substance satisfactory to USAID a written statement setting forth the names and titles of persons holding or acting in the Office of the Grantee and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the Grantee, together with a specimen signature of each such person certified as to its authenticity.

2. Special Covenants

(a) Support to U.S. Contractors and Cooperating Agencies. The Grantee agrees to exempt U.S. Contractors and Cooperating Agencies funded by USAID and charged with the implementation of APHIA, from all customs duties and sales taxes, and to exempt from income tax and National Social Security contributions, all income or other emoluments received by non-Kenyan technical staff contracted under this activity. The Grantee also agrees to approve work permits for non-Kenyan technical staff employed for this activity.

(b) Health Care Financing and Sustainability. The Grantee agrees provide evidence that new District Health Management Boards have been gazetted by September 1, 1995 and that the Ministry of Health will issue a ministerial circular, not later than November 1, 1995, to clearly re-define the role and responsibilities of the Boards regarding the implementation of cost sharing and the broader district-wide health and family planning activities.

(c) Import of Program Commodities. The Grantee agrees to publish in the GOK Gazette, and to retain in force through the life of the Project, language specifying that Project-funded contraceptives will enter Kenya free of all duty and taxes.

(d) Information, Education, and Communication. The Grantee agrees to reorganize, by January 1997, the Ministry of Health, Division of Health Education to strengthen the Division's capacity to organize, coordinate, and support field-based Health Education Officers, services providers, community leaders, and community volunteers in expanding health information, education, and communications materials and activities. IEC material production by Private Sector sources will be at the discretion of the Grantor.

(e) Focus Districts. The Grantee agrees to approve the district focus areas proposed by USAID by September 1995, and will facilitate, as appropriate, USAID's collaboration with personnel from DHMTs, DHMBs and government service delivery sites.

Waivers:

Implementation of the Project does not require any foreseeable waivers.

Responsible AID Officer:

The Chief of the Office of Population and Health will be responsible for the Project, with assistance from a Deputy Chief and eight Project-funded staff.

Project Review Action:

The Executive Committee Project Review (ECPR) reviewed the Project Paper on May 23, 1995, and recommended the approval of the Project subject to: 1) clarification of the relationship between APHIA's Strategic Objective and Mission's goal/other Strategic Objectives; 2) inclusion of a detailed outline for a 5-year Implementation and Evaluation Plan and; 3) discussion of the relationship between APHIA and the GRAI. These revisions and changes plus others not listed here, have been incorporated into the Project Paper. A copy of issues raised and their resolutions is attached.

The New Activity Description (NAD) was approved by the Mission on June 17, 1994. USAID/K was delegated the authority to approve this project in 94 STATE 086675. The budget allowance has been received (STATE 77498 & 72145) and the Congressional Notification (CN) for initial obligation of \$ 4,600,0000 was sent to Congress on June 28, 1995. Obligation may be incurred after expiration of the CN on 1995.

Authority:

Delegation of Authority 551 Section 4A(1) provides you the authority to authorize a Project if the Project: does not exceed \$50 million in life of Project funding; does not present significant policy issues; does not require waivers which can only be granted by the Assistant Administrator for Africa or the Administrator; and does not have a Project life in excess of 10 years.

Recommendation:

That you approve the AIDS, Population, and Health Integrated Assistance (APHIA) Project by approving this Action Memorandum and signing the Project Data Sheet, and that you authorize the Grant by signing the attached Project Authorization.

Approved: George Jones

Disapproved: _____

Date: 8/4/95

Attachments:

1. Project Paper and Project Facesheet
2. Project Authorization
3. 94 STATE 086676, Delegation of Authority Cable
4. Issues Paper dated May 24, 1995
5. State 77498 & 72145 Budget Allowance Cable

Drafted: OPH:MHoward

Clearance: _____ Date _____

PH:GNewton [Signature] Date 7/12/95

PRJ:SRgama [Signature] Date 7/12/95

PRCG:CBwire [Signature] Date 7/13/95

ONT:CADams [Signature] Date 7/11/95

RLA:Tfillinger [Signature] Date 7/7/95

D/DIR:KToh [Signature] Date 8/4/95

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PROJECT AUTHORIZATION

NAME OF COUNTRY: Kenya
NAME OF PROJECT: AIDS, Population and Health Integrated Assistance (APHIA)
PROJECT NO: 615-0264

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS, Population and Health Integrated Assistance Project for Kenya involving planned obligations not to exceed Twenty-eight million, five hundred fifteen thousand United States dollars (\$28,515,000) in bilateral Development Fund for Africa (DFA) grant funds over a five-and-a-half year period from the date of authorization, subject to the availability of funds in accordance with the USAID OYB/Allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is five years and six months from the date of initial obligation.

2. The Project consists of assistance to the Government of Kenya and selected Non-governmental Organizations to develop, strengthen, expand and sustain integrated family planning and related health programs in Kenya. The purpose of the Project is to reduce fertility and risk of HIV/AIDS transmission through sustained and integrated health/family planning service delivery.

3. Project Agreement. The Project Agreement, which may be negotiated and executed by the officers to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority, shall be subject to the following terms and covenants and major conditions, together with such other terms and conditions as USAID may deem appropriate.

3.1 Source and Origin of Commodities, Nationality of Services.

Except as USAID may otherwise agree in writing:

(a) Commodities financed by USAID under the Project shall have their source and origin in countries included in USAID Geographic Code 935. All reasonable efforts will be used to maximize U.S. procurement whenever practicable. Air travel and transportation to and from the U.S. shall be upon certified U.S. flag carriers.

(b) Except for ocean shipping, the suppliers of commodities or services financed by USAID under the Project shall have countries included in USAID Geographic Code 935 as their place of nationality.

(c) Ocean shipping financed by USAID under the Project shall be financed only on flag vessels of the countries included in USAID Geographic Code 935 and Kenya subject to the 50/50 shipping requirements under the Cargo Preference Act and the regulations promulgated thereunder.

George Jones

Mission Director

8/4/95

Date

Project No. 615-0264

Clearances:

OPH:GNewton	<u>[Signature]</u>	Date	<u>7-12-95</u>
PRJ:SMeyer	<u>[Signature]</u>	Date	<u>3/12/95</u>
PROG:CBwire	<u>LO LHR</u>	Date	<u>7/13/95</u>
AGENT:CAAdams	<u>[Signature]</u>	Date	<u>7/21/95</u>
RLA:Tfillinger	<u>[Signature]</u>	Date	<u>7/17/95</u>
D/DIR:KToh	<u>LDC for LT</u>	Date	<u>8/4/95</u>

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USAID
PROGRAM DOCUMENT
for
AIDS, POPULATION & HEALTH INTEGRATED ASSISTANCE
(APHIA)
to
KENYA

26 JUNE 1995

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Annexes

- A Kenya Population and Health Sector Assessment**
- B Matrix Summary of Donor Support to the PH Sector**
- C Key Constraints to Effective Sustainable Solutions**
- D USAID Strategy for the Kenya Health and Population Program 1995-2000**
- E Contraceptive Procurement**
- F Policy and Planning**
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- N Logical Framework and Objective Tree**
- O Initial Environmental Examination**
- P Letter of Request**
- Q Statutory Checklist**
- R Social and Gender Analysis**
- S Technical Analysis**
- T Economic Analysis**
- U Financial Plan and Implementation Table**
- V APHIA Bibliography**

References

1. Joint Sector Assessment and Strategy for Health, Population and AIDS in Kenya, April 1995
2. Inventory of Donor Assistance to the Population and Health Sector in Kenya, April 1995
3. Kenya's Health Policy Framework, November 1994
4. Summary of APHIA Design Workshop, January 1995
5. Kenya Demographic and Health Survey-II, 1993
6. Family Planning Financial Resource Requirements (1993-2010), March 1995
7. USAID Guidelines for Strategic Planning, February 1995
8. FAMPLAN Model - Family Planning Projections for Strategic Planning, USAID, August 1994

I. Executive Summary

A. Introduction

Kenya's progress in the population and health (PH) sector has been laudable and Kenya is increasingly being seen as a model for countries in the region as they develop their own strategies to cope with population, HIV/AIDS and health care financing challenges. For a quarter century, USAID has been a reliable provider of technical, financial, and commodity assistance to the Kenyan family planning program. At \$22 million in expenditures in FY 1994, the population program in Kenya was by far the Agency's largest in Sub-Saharan Africa. For ten years, USAID has assisted the Government of Kenya (GOK) to design and implement a forward-looking financing strategy to improve and expand health services and lessen reliance on external and public support.

The document which follows describes a new phase of USAID support to the PH sector in Kenya, a phase which will be markedly different. The new program's size and scope have been shaped by a number of factors -- politics and economics in Kenya and the United States; the reorganization of USAID; the success of the program to date; and assumptions regarding USAID's comparative advantages and other donors' planned support. The new program scales-down and begins to phase-out USAID support to the PH sector. It emphasizes donor coordination, institutionalization, and sustainability to help ensure that essential public health services will continue as USAID assistance diminishes -- as it inevitably must.

B. Progress to Date

American taxpayers' support for family planning and health -- carefully programmed and monitored by USAID -- has made a major difference in the lives of Kenyan women, men and children.

1. **Population and Family Planning:** USAID has supported Kenya's family planning program since 1972 and since the mid-1980's has been the lead donor providing an average of \$15 million annually through bilateral and central projects. Kenya's family planning program has benefited from the full breadth and scope of USAID technical family planning in policy; quality assurance; logistics; training; information, education and communication (IEC); research; management; clinical contraception; and community-based service delivery. USAID financial and technical assistance has contributed to an increase in the modern method contraceptive prevalence rate among all women of reproductive age from 9 percent in 1984 to 21 percent in 1990-1993; a decrease in the fertility rate from one of the highest in the world, 8.1 in 1977-1978, to one of the lowest in sub-Saharan Africa, 5.35 in 1990-1993; and a decrease in the population growth rate from 4.1 in 1980-1985 to just under 3.0 in 1994. USAID support has helped usher-in and expedite Kenya's demographic transition with its many benefits -- improved maternal and child health, expanded educational and economic opportunities for women; and economic growth greater than population growth. Had

population growth rates prevailing in the early 1980's persisted. Kenya's population could have been 120 million in 2025 rather than 49 million.

2. HIV/AIDS: Since 1989, USAID has been a lead donor to Kenya's national HIV/AIDS prevention program providing an average of \$2.8 million annually for a private sector condom social marketing project, a public sector condom program, and the FHI/AIDS CAP project. Many components are in place for a potentially effective prevention program. Attitudes and behaviors conducive to HIV/AIDS prevention are developing. Condom use is on the increase. However, HIV continues to spread, increasing from a 3.5 percent prevalence among adults in 1990 to 5.7 percent in 1993. There are glimmers of hope that the epidemic can be slowed. According to the 1993 Kenya Demographic and Health Survey (KDHS), 99 percent of women and men were aware of AIDS, and 66 percent of men and 50 percent of women believed themselves to be at risk. There is evidence that sexual and reproductive attitudes and behavior are changing -- age at marriage and age at first intercourse have increased; condom use among married men increased from three percent in 1989 to seven percent in 1993 and ever use among men has increased from 17 to 27 percent over the same period. An estimated 110,000 HIV infections (i.e. deaths) have been averted through 1993 by increased condom use.

3. Health Care Financing: Since 1989, USAID has been the main donor to Kenya's national health care financing program providing an average of over \$2 million annually. At present, a national cost-sharing program is in place which generated over \$12 million between 1990 and June 1995 -- over \$1.0 million of which went to improve and expand district-level primary health care in GOK FY 1994/95. Under the project, sub-Saharan Africa's first private sector managed care (i.e. HMOs) programs are being developed to improve the coverage, efficiency and equity of health care and family planning. The project is facilitating a dynamic regional interaction under which eight African countries are learning from Kenya's experience as they embark on their own cost-sharing programs to improve health care and lessen reliance on external assistance.

4. Current Portfolio Ending: The current USAID/Kenya 1990-1995 Country Program Strategic Plan (CPSP) and the bilateral projects through which USAID provides assistance for family planning, HIV/AIDS prevention and health care financing, end in 1995. Consequently, in early 1994, USAID began to plan a new strategy and program of assistance to address priority needs in the population and health sector beyond 1995.

B. The Chronology of the New Program Design

In April 1994, USAID Kenya was given Delegation of Authority to design a \$50 million five-year consolidated bilateral Population and Health project; in June 1994, a New Activity Description (NAD) was approved; between June 1994 and January 1995, planning and analyses on which to base the design were completed; from 23 January 1995 to 17 February 1995, a design team completed a detailed outline for a \$100 million (\$50 million in DFA and \$50 million in Global Bureau field support) sectoral program under new Global Bureau joint

country programming precepts; between 17 February 1995 and 10 April 1995, planning and coordination tasks fundamental to the design were completed including the first joint Japanese/USAID PH sector assessment and strategy, a comprehensive inventory of assistance from 20 donors to the PH sector in Kenya, and discussions with the GOK/MOH and key Cooperating Agencies (CAs); in late April 1995, a draft program document dated 21 April 1995 was sent for review to approximately fifty people in Kenya and USAID/W; on 12 May 1995, a second draft was completed incorporating reviewers' input; on 23 May 1995, based on a 12 May 1995 draft APHLA program document, the program was approved at a USAID/Kenya ECPR; on 30 May 1995, the Office of Population and Health (O/PH) learned of a change in Africa Bureau policies requiring field support to be included within Kenya's country level; on 7 June 1995, the decision was made to recast the \$100 million APHLA program using a \$60 million Life of Project (LOP) funding level; and on 19 June 1995, a revised APHLA Program document was completed.

C. The New Program

1. **Program Title and Duration:** The new USAID program is entitled, "AIDS, Population and Health Integrated Assistance." The program's acronym -- APHLA -- is pronounced like the Kiswahili word for health, *afya*. The program has a five-year life beginning in September 1995 and ending in September 2000.
2. **What's New About the New Program ?**
 - APHLA was designed by the USAID/Kenya O/PH with an unusual degree of participation by USAID/Washington, REDSO and Kenyan partners. The 20-person GOK/USAID design team was guided by a 32-person public/private sector Kenyan advisory committee and informed by the views of over 200 Kenyans. Representatives from four GOK ministries and nine donor organizations participated in the design and staff from the Japanese Embassy and JICA were de-facto team members. Mechanisms have been established to ensure participation continues throughout program implementation. Sustainability was one of the key concerns expressed by Kenyan partners.
 - APHLA represents an unprecedented degree of strategic unification and focusing. APHLA establishes the framework for consolidating, focusing, and rationalizing all USAID support to the PH sector in Kenya -- bilateral, global, and regional -- under one unified Agency strategy, action plan, and budget and on a single Strategic Objective. An effort was made in the design to follow emerging Agency guidance on Joint Country Programming and reengineering.
 - APHLA may be the last major program of USAID assistance to the PH sector in Kenya. USAID resources for Kenya have been reduced significantly since 1991 due to Kenya's halting progress on democratization and governance (D.G). However, through FY 1994, USAID protected and maintained "historic" levels of support to the

PH sector (the USAID-funded population program in Kenya was the Agency's largest in sub-Saharan Africa in FY 1994 with over \$22 million in expenditures). Future USAID funding levels for Kenya are uncertain. As of this writing, all indications point to additional and significant cuts. The APHLA program was therefore scaled-down significantly and designed as if it could be the last major program of USAID assistance to the sector. Under APHLA we begin an orderly and responsible phase-out of USAID support to the sector, and attempt to ensure that the U.S. taxpayers' substantial investment to date is not squandered.

- **APHLA includes an exceptional degree of attention to sustainability. In view of declining and ultimately finite USAID resources, APHLA focuses on a number of strategies to ensure essential health and family planning services -- long subsidized by USAID and other donors -- will continue into the next century. Strategies include stimulating the growth of private sector health services, expanding cost-sharing, establishing endowments for key NGOs, establishing revolving funds for key public health commodities, and enhanced donor coordination.**
- **APHLA represents a new level of programmatic consolidation within the PH sector. Under a single mechanism -- APHLA -- USAID will attempt to coordinate, plan, implement, monitor and evaluate all Agency assistance to the PH sector in Kenya. At present, USAID assistance to the sector is administered through four bilateral projects, a "priority country" program with FHI/AIDSCAP, and over twenty different additional PHN activities funded by the three USAID/W Bureaus -- Global, AFR and BHR.**
- **APHLA is linked synergistically to the new USAID/Kenya micro-enterprise development project (MICRO-PED). Efforts will be made to utilize MICRO-PED resources and expertise to assist key Kenyan health and population NGOs achieve sustainability goals and to expedite the growth of alternative health insurance schemes.**
- **APHLA integrates HIV/AIDS/STD services into FP/MCH programs. One of the central USAID strategies to slow the spread of HIV is to integrate selected HIV/AIDS/STD prevention services with existing family planning/MCH programs and existing service delivery support functions (e.g. logistics, IEC, training). USAID believes this strategy is justified on ethical grounds, is responsive to clients' needs and is cost-effective. With two years of experience, USAID and the Cooperating Agency (CA) community in Kenya are leading the way in the region in planning and implementing integrated services.**
- **APHLA targets resources on the most needy. Wide disparities exist in Kenya in health and fertility status. To reduce disparities, USAID resources will be targeted geographically to help the neediest.**

- **The APHIA design was based on an unprecedented degree of donor coordination, particularly with the Government of Japan.** A comprehensive inventory of assistance from twenty donors was completed in part to confirm that contraceptive, condom and STD drug requirements will be met. The APHIA design was the first to be done in cooperation with the Japanese Government (GOJ) under the Global Issues Initiative for Population/HIV/AIDS (GII). The cooperation resulted in the identification of a set of synergistic activities for potential funding by the GOJ which will be complementary to APHIA and enhance impact.
- **USAID/Kenya O/PH and APHIA have important regional roles.** In APHIA, USAID acknowledges, delineates and plans for the bilateral Mission's important regional role in the management of Global and Africa Bureau activities implemented in Kenya which have significance beyond Kenya's borders, and in the diffusion of family planning, health and health care financing lessons learned in Kenya throughout the region. O/PH is poised to play a role in the Greater Horn of Africa Initiative (GHAI) when and if called upon.

3. Resources Available:

- **USAID:** APHIA is budgeted at \$60 million in USAID funding over five years (FY 1995 - FY 1999), \$28.515 million in USAID/Kenya bilateral funding (Development Fund for Africa - DFA), and \$31.485 million in Global Bureau field support (Development Assistance - DA).
- **Kenyan Counterpart Support:** In addition, there will be an estimated \$9.623 million in counterpart contributions from the GOK, Private Voluntary Organizations (PVOs), and Non-Governmental Organizations (NGOs).
- **Japanese Government:** Under the Government of Japan (GoJ) Global Issues Initiative for Population/HIV/AIDS (GII) there will be parallel funding for activities complementary to APHIA identified under the joint USAID/GoJ PH sector assessment and strategy. At this writing (June 1995), the GoJ is in the project formulation phase.
- **USAID/Washington Global Core:** In addition, there will be an estimated \$16.8 million in core support from the Global Bureau for PHN research, technical leadership, and new initiatives of global or regional significance implemented in Kenya.

4. **Strategic Objective:** The USAID PH strategy and APHIA program will focus on the achievement of the Strategic Objective of *reducing fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*, which will in turn contribute to the USAID Sub-Goal of stabilizing population growth and protecting human health, which will in turn contribute to the overall USAID Goal of promoting sustainable, broad-based economic growth. The selection of the Strategic Objective was

based on USAID policy, findings of the PH sector assessment and the participatory APHLA design process.

The sustainability component of the Strategic Objective is of preeminent importance. USAID will maximize investment in strategies and programs which build Kenya's capacity to sustain health and family planning services and meet *future* needs with local resources, thereby reducing reliance on foreign aid. At the same time, USAID will continue to meet the immediate and compelling needs of millions of Kenyan women and men through support of services to prevent unintended pregnancies, unwanted abortions, HIV/AIDS, and child and maternal illness and death.

- 5. The three top priority public health problems facing Kenya are: (a) unsustainable population growth and fertility higher than desired; (b) an uncontrolled and worsening AIDS epidemic; and (c) stalled progress on child survival. Assisting Kenya to protect her children from preventable morbidity, mortality and orphanhood; and assisting Kenyan women to protect themselves from unintended pregnancies, unwanted abortions, STIs, and AIDS, is justified on humanitarian grounds -- it is simply the right thing to do.**
- 6. Key constraints to solving these problems include: (a) demand for family planning is greater than the supply of services; (b) a coordinated and comprehensive HIV/AIDS prevention program with demonstrated impact on HIV transmission among a significant sub-population has not yet been implemented in Kenya; (c) a dearth of cost-effective solutions to the worsening malaria problem; (d) the persistence of significant geographic disparities in health and fertility status; (e) barriers to young adults' access to information and services to protect themselves from unwanted pregnancies and STD/HIV; (f) inadequate and declining GOK per capita health resources, particularly for preventive health services; (g) a high degree of dependence upon external assistance to meet PH needs and inadequate attention to sustainability; (h) less than optimal coordination of external resources; and (i) the existence of serious procurement and accountability problems which impede the GOK's effective use of external resources.**
- 7. There are feasible solutions to many of these constraints and problems: (a) to meet unmet demand for family planning, continue and expand current service delivery programs and strategies; (b) to prevent HIV, expand cost-effective strategies such as condom programs and the integration of HIV/AIDS/STD services into family planning/MCH programs; and (c) to improve sustainability, continue and expand current health care financing cost-sharing strategies and programs.**
- 8. USAID, due to our comparative advantages among donors, is well-positioned to help Kenya solve population, AIDS, and sustainability problems. USAID has a 23-year history of assistance to family planning service delivery in Kenya; the ability**

to channel and program substantial funding to the private sector; a seven-year history as the lead donor working with the GOK on its national health care financing/cost-sharing program; and strong in-country technical and implementation capability backed-up by an unparalleled array of technical resources accessible through USAID/W.

9. Key assumptions underlying the USAID Strategic Plan include: the GOK will implement policies articulated in the 1994 Health Policy Framework; the relationship between the GOK and donors will stabilize and there will not be additional significant cuts in external support over the next five years; and donor support for population and health activities and key public health commodities (e.g. contraceptives, condoms, STD drugs) will be generally consistent with plans outlined in the 1995 donor inventory.

10. APHLA Program Components

- Component 1. National Service Delivery Support: Assistance to centrally-coordinated public sector entities to institutionalize and sustain essential support services to public and private sector providers nationwide (e.g. logistics, training, IEC).
- Component 2. Private Sector Service Delivery: Assistance to private sector organizations to provide integrated services. (Note: these organizations rely on public sector service delivery support (Component 1)).
- Component 3. Health Care Financing and Sustainability: Assistance to public and private sector organizations to sustain services with local resources over the long-term.
- Component 4. District Focus: Assistance to public and private sector organizations to provide services to the most needy populations and to develop and demonstrate innovative service delivery models for replication on a broader scale.

11. Key Results by the Year 2000 Necessary to Achieve Strategic Objective

- a. Access to and the use of integrated family planning and HIV/AIDS/STD services will be increased through policy change, improved planning and coordination, improved service quality and an expansion in the supply of services.
- b. The MOH will have the independent capacity to develop, monitor and update national implementation plans for family planning and HIV/AIDS/STD prevention and use them to coordinate and budget local and external resources.
- c. The national population and family planning IEC program will be broadened and institutionalized to include selected messages related to HIV/AIDS/STD, and

maternal, reproductive and child health; the national family planning logistics program will have incorporated commodities related to HIV/AIDS/STD prevention, notably drugs; and, national training programs which focus on family planning will be institutionalized and integrate HIV/AIDS/STD and other aspects of reproductive health.

- d. Kenyan organizations in the USAID-supported private sector network will have broadened, carefully and incrementally, the range of services offered to clients beyond family planning to include HIV/AIDS/STD prevention and other reproductive health services; and will have increased total Couple Years of Protection (CYPs) annually from 400,000 to 850,000.**
- e. The Family Planning Association of Kenya (FPAK), the Christian Health Association of Kenya (CHAK), and Chogoria Hospital, will have made significant sustainability progress through improved management and the implementation of strategies such as fees-for-service and the establishment of endowment funds.**
- f. The PSI-implemented national condom social marketing program will have increased sales from 6 to 10 million annually (8 percent of the condoms distributed nationally); will have made the transition to a Kenyan NGO or company (or will have been incorporated into an existing Kenyan NGO or company); will possess the independent capacity to manage a national social marketing program; and will have made significant progress towards financial independence.**
- g. The JSI-implemented Private Sector Family Planning Project will have made the transition to a Kenyan NGO or company with the independent capacity to plan strategically; solicit, raise, and account for funds; provide technical assistance (TA) and training; and develop, monitor and evaluate sub-grants to the private sector to establish, expand and improve health services.**
- h. District Health Management Teams and Boards (DHMTs and DHMBs) will have assumed primary responsibility for many essential cost-sharing management functions.**
- i. Cost-sharing revenue will increase to at least \$9 million annually -- from 25 percent to 50 percent of potential.**
- j. A Vaccine Independence Initiative (VII) and a Contraceptive Independence Initiative (CII) will have been launched to build self-reliance in the procurement of key public health commodities.**
- k. The technical, resource, management and coordination requirements necessary to reduce the risk of HIV/AIDS transmission at the district or sub-district level will have been documented and disseminated.**

- l. The technical, resource, management and coordination requirements necessary to reduce malaria transmission at the district or sub-district level will have been documented and disseminated.**
- m. There will be systematic use of WHO and UNICEF algorithms designed to ensure appropriate immunizations and improve recognition and treatment of major childhood illnesses at first-level health facilities.**

12. Implementation, Management and Coordination

- **Office of Population and Health (O/PH) role and functions:** O/PH will focus on seven key functions central to the achievement of the Kenya Strategic Objective and the implementation of the APHLA program: strategic planning; policy dialogue; technical assistance; coordination; reporting, monitoring and evaluation; the oversight of global and regional activities; and the dissemination of lessons learned in Kenya throughout the region.
- **Overall implementation strategy:** To achieve optimal performance of these functions, USAID is consolidating its PH portfolio, merging many separate projects into a single sectoral program; simplifying and streamlining program implementation; rationalizing CAs' roles and responsibilities; and devolving as much day-to-day implementation responsibility to contractors and CAs as possible.
- **Staffing:** To perform these functions and assume primary responsibility for the achievement of results, the following USAID/K O/PH staff will be supported with DFA, DA/Ex-G and Global core funds: five Personal Services Contractors (PSCs); one Technical Advisor in AIDS and Child Survival (TAACS); one Child Survival Fellow; and two International Population Fellows.
- **Implementation and Financing:** Achievement of results and the USAID PH Strategic Objective will rely upon a number of implementation and financing methods including: Hand Book 13 grants to three Kenyan NGOs; annual field support agreements with Cooperating Agencies and Global Bureau-managed projects (19 in FY 1995); buy-ins to the AIDS Technical Support Project; OYB transfers for Central Contraceptive Procurement, the Vaccine Independence Initiative and, in FY 95, FHI/AIDSCAP; an Institutional Contract for the implementation of most of Component Three; two Cooperative Agreements (JSI/PSFP II through FY 1997 and PSI/CSM); Personal Services Contracts; and Purchase Orders. Note: For NGO endowments and the Contraceptive Independence Initiative, implementation mechanisms and methods of financing are not yet finalized.

While the APHLA program will provide significant support to address public sector needs, no USAID funds will be channelled through the Government of Kenya.

Coordination: There are four main formal mechanisms for coordination: (1) an APHIA Coordination and Implementation Group (ACIG) chaired by O/PH and comprised of representatives from organizations with major oversight, coordination and implementation roles and responsibilities under APHIA including the GOK, other donors, Cooperating Agencies, and contractors; (2) the USAID/W Kenya Joint Programming Team (KJPT); (3) the bi-monthly PH donor/GOK coordination group; and (4) the USAID/CAs "Kenya Integration Group" (established in mid-1993 to plan for and manage the AIDS/FP integration process).

10. APHIA Program Document

The APHIA program document which follows is based on ideas, information and guidance contained in 22 annexes and eight key references. The document consists of seven sections: this executive summary; an overview of the PH sector in Kenya; the identification of priority PH problems and their implications for health and sustainable development; a summary of key constraints to solutions; a strategic plan for the PH sector; a plan of action to implement the strategy; and a management and coordination strategy to implement the plan of action.

II. Overview of the Population and Health Sector in Kenya

The purpose of this section is to offer an overview of the population and health sector in Kenya and the context in which the APHIA program is to be implemented.

This overview is based primarily on Annex A, "Kenya Population and Health Sector Assessment;" Reference 1, the April 1995 "Government of Japan and USAID Joint Sector Assessment and Strategy for Health, Population and AIDS in Kenya; and Reference 2 "The 1995 Inventory of Donor Assistance to the Population and Health Sector.

A. Demographic Background

Total Population and Population Growth Rate: At Independence in 1963 there were 8.7 million Kenyans. Today, the total population of Kenya is estimated to be 26.2 million, and growing at just under 3.0 percent per annum.¹ In addition, Kenya hosts at least 230,000 refugees.

Geographic Distribution and Density: The proportion of the population living in urban areas has increased from 5.1 percent in 1948 to 19 percent in 1995. Population density increased from 19 persons per square kilometer in 1969 to 37 in 1989. There are eight provinces and 48 districts in Kenya. Provinces with the best land and rainfall (Central,

Nyanza and Western) have high population densities per square kilometer of arable land (337, 280 and 343 respectively).

Age Distribution: Over 50 percent of Kenya's population is less than 15 years of age.

Ethnic Composition: There are 43 ethno-linguistic groups in Kenya. The major groups are Kikuyu, Luo, Luhya, Kamba, Kalenjin, Mijikenda, Meru, Embu and Kisii.

B. Health Policies

General Health Sector: Sessional Paper No. 1 of 1966 included Kenya's first broad national health policy statement which guaranteed universal free health care for all citizens and emphasized development of health care infrastructure (hospitals, clinics and dispensaries particularly in rural areas). In 1978, the MOH introduced a new policy emphasis on primary health care with the adoption of the Alma Ata principles. By the mid-1980s, financing of national health care emerged as a major policy concern culminating in 1990 with the introduction of health cost-sharing and other alternative health financing schemes.

In November 1994, the MOH issued "Kenya's Health Policy Framework" (Reference 3). The Health Policy Framework is the most comprehensive health policy statement yet produced by the GOK and provides the parameters for general health sector policy development and planning over the next ten years.

Population and Family Planning: Kenya has had an official policy on population and family planning since 1969. The National Council for Population and Development (NCPD) was established by Sessional Paper No. 4 of 1984. In 1995, the MOH plans to revise the "Guidelines for Family Planning Providers" to officially remove many barriers to access. In October 1995, a new sessional paper on population is expected to be issued. On balance, a very favorable and supportive population and family planning policy environment has prevailed in Kenya.

HIV/AIDS: HIV/AIDS policy is under development. At present, GOK policy is articulated mainly in the 1994-1996 National Development Plan in which a chapter is devoted to HIV/AIDS. The current Medium Term Plan for HIV/AIDS prevention also serves in part as a policy document. The GOK is in the process of drafting Kenya's first Sessional Paper on AIDS which will serve as the official AIDS policy.

C. Health Resources

1. Financial Resources:

Public Sector: GOK expenditures on health have increased over the years in absolute terms. In real terms, however, the trend has been one of decline. In 1980, \$1, per capita expenditures on health were US\$ 9.50 but fell to US\$ 4.50 in 1991/92.

Similarly, the MOH share of overall GOK recurrent expenditures declined from 9.5 percent in 1980/81 to 8.5 percent in 1991/92 and is expected to further decline to 7.6 percent in 1994/95.

Private Sector: Relative to the public sector, less is known about resource levels and trends in the private sector largely due to the diversity and autonomy of private providers.

The majority of for-profit health provider resources come from user-fees. Non-profit organizations' resources come from donors, private sources, the GOK (e.g. direct cash transfers, training, secondment of staff, and duty exemptions for donated medical equipment and supplies) and some fees.

External Resources: Donor contributions account for approximately 80 percent of the MOH development budget, 30 percent of which is used as recurrent budget support for items such as essential drugs, contraceptives and vaccines.

There are 21 main donors to the population and health sector, five provide substantial support (over \$20 million for respective project cycles). Cumulative donor resources amount to over \$500 million (including projects on-going since 1985 and projected to end in the year 2000). Total donor support for family planning between 1995-2000 is projected to be \$160 million; for HIV/AIDS/STD prevention, over \$75 million; and for child survival services, over \$45 million. See Annex B for a summary of donor support and Reference 2 for the unabridged version.

2. *Health Facilities*

Overall, there are approximately 3,500 health care facilities, 150 administrative facilities; and 24 Medical Training College (MTC) centers.

Public Sector: The GOK accounts for almost 60 percent of health facilities and 52 percent of all beds and cots.

Private Sector: As of October 1994, there were 1,446 private health facilities; 47 percent in the mission sector; 51 percent in the private for-profit sector; and the remaining 1.7 percent run by the Family Planning Association of Kenya (FPAK). The mission sector is the largest non-governmental provider of curative care.

Distribution: There are 14 health facilities for every 100,000 Kenyans (one facility per 7,150 people). There is a slightly higher concentration of health facilities per capita in urban areas than in rural areas.

3. *Human Resources*

There are approximately 80,000 people employed in the health sector, 46 percent of whom are administrative, maintenance or subordinate staff.

There are approximately 10,000 Community Based Health Workers and Community Based Distributors, approximately 6,000 of whom are in the public sector.

Public Sector: The GOK employs approximately 70 percent of all health sector personnel. The MOH has an estimated 44,000 employees who staff approximately 2,000 health facilities and offices.

Private Sector: The private sector accounts for 30 percent of all health personnel. Private non-profit health facilities also benefit from staff seconded from the MOH, from parent organizations, and from the services of volunteers.

Distribution: The distribution of key health personnel between rural and urban areas and among the provinces shows substantial differences. For example, less than 20 percent of the Kenyan population live in urban areas, but 55 percent of key health personnel work there.

D. Knowledge, Access to and Utilization of Health Services

1. *Family Planning*

The 1993 KDHS indicates that 97 percent of Kenyan women and 99 percent of men know a modern method of contraception. Overall, 89 percent of married women who know a contraceptive method approve of family planning. Nearly two-thirds of women indicated that their husbands approve of family planning. While knowledge of female methods is high among men and women, both groups have relatively little knowledge of vasectomy (56 percent awareness among men, 46 percent among women).

Half of currently married women live within five kilometers of a health facility that provides family planning services. Forty-five percent of women live within five kilometers of a health center or dispensary offering family planning services while only 11 percent live within five kilometers of a hospital offering these services. Approximately 60 percent of women live within one hour's travel time to a source of family planning and 37 percent live within 30 minutes of an outlet. Travel time to services is not a major barrier to contraceptive use among Kenyan women.

The modern method contraceptive prevalence rate among all women of reproductive age increased from 9 percent in 1984 to 21 percent in 1990-1993.

2. *HIV/AIDS/STDs*

While significant misconceptions persist, basic knowledge of HIV transmission and prevention is virtually universal in Kenya. According to the 1993 KDHS, 99 percent of women and men were aware of AIDS, and 66 percent of men and 50 percent of women believed themselves to be at risk. There is evidence that sexual and reproductive attitudes and behavior are changing – age at marriage and age at first intercourse have increased; condom use among married men increased from three percent in 1989 to seven percent in 1993 and ever use among men has increased from 17 to 27 percent over the same period.

3. *Child Health Services*

- *Antenatal care:* Utilization of antenatal care is high; over half of women deliver with the assistance of medical professionals.
- *Immunization:* 79 percent of children aged 12-23 months are fully vaccinated; three percent have received no vaccinations; and, 71 percent received all recommended vaccinations during the first year of life.
- *ORS:* Of children with diarrhea, 21 percent were given ORS; 49 percent received a homemade rehydration solution; 47 percent were taken to a health facility; and 10 percent received no treatment.

4. *Maternal Health Services*

Data from the 1993 KDHS indicates that half of women in Kenya live within five kilometers of a facility that offers antenatal services. Forty-three percent of women live within five kilometers of a health center or dispensary with antenatal services while only 12 percent live within five kilometers of a hospital offering these services. With respect to delivery care, 32 percent of currently married women live within five kilometers of a facility – hospitals, health centers and dispensaries – that offers this care. Twenty-two percent live within five kilometers of a health center that provides delivery care while 12 percent live within five kilometers of a hospital providing delivery assistance. It is important to note that nearly one-third of women live in communities where the health center/dispensary does not provide delivery care.

Fifty-five percent of women nationally deliver their babies at home. Thirty-three percent of all women are assisted during labor and delivery by a trained traditional birth attendant (TBA), while 35 percent of women are assisted by an untrained person during delivery and ten percent deliver alone.

E. Fertility and Health Status

1. Fertility

The total fertility rate declined from one of the highest in the world, 8.1 in 1977-1978, to one of the lowest in sub-Saharan Africa, 5.35 in 1990-1993.

2. Children's Health

Mortality: The infant mortality rate (IMR) has fallen from 124/1000 in 1960 to 61/1000 in 1993 and the under-5 mortality rate has declined from 150/1000 in the early 1980s to 90/1000 in 1993. Reductions in infant and under-five mortality stalled in the mid-1980s. Mortality due to AIDS will likely worsen the outlook. There are marked differences in infant mortality by province – the IMR in Nyanza is 128/1000 versus 31/1000 in Central Province.

Infant deaths continue to be highly concentrated during the early neonatal period (birth through three days); those typically caused by prematurity, complications of pregnancy and delivery and congenital defects. Survival chances among infants one to twelve months old and children one through five years old have deteriorated. Continued high levels of morbidity and mortality resulting from common childhood illnesses including diarrhea, malaria and acute respiratory infection are probable causes of the plateauing in mortality rates. These illnesses are underlined by high rates of acute chronic malnutrition.

Malnutrition: One in three children under five was short for his/her age (stunted) which reflects chronic undernutrition. Twelve percent of children were severely stunted and six percent were wasted. Calorie supply per capita for Kenya in 1989 was 130 calories below the recommended level.

Malaria: Children under five years of age are particularly vulnerable to malaria as they have yet to acquire immunity to malarial infection. While it is difficult to trace the precise proportion of child deaths due to malarial infection, there is a correlation between high mortality rates and malaria infection rates within areas of Kenya. This points to malaria not only as a direct contributor to child death but a leading contributor to malnutrition, anemia and susceptibility to other infections. Western and Nyanza provinces have the highest levels of under-five mortality as well as the highest reported levels of malaria-related fever. Children with fever in these provinces are least likely to be taken to a health care provider or facility.

3. Fertility Behavior and Child Survival

Fertility behaviors play a clear role in the health and survival of infants and children in Kenya. A recent analysis of 1993 KDHS data indicates that common high-risk fertility behaviors such as young maternal age may account for an estimated five percent of under-

five deaths. Taken together, high-risk fertility behaviors account for an estimated 14 percent of all under-five deaths. At present 61 percent of future births in Kenya, can be classified as high risk because of the mother's age, high parity or too short birth interval. The latter condition which is common in several parts of Kenya, is particularly dangerous for children born less than 24 months after the preceding births. These short-birth interval babies have a 50 percent greater chance of dying than babies born 36 or more months apart. Thus, increasing birth intervals to 24 months or more could have a significant impact on reducing under-five mortality.

As evidenced from 1993 KDHS results, an infant is four times as likely to be born after an interval as short as 7 to 17 months if the preceding birth died than if the preceding birth lived. Analysis of the 1989 KDHS results show that these differences in birth intervals are in part determined by replacement and insurance effects, i.e. couples are seeking either to directly replace a child lost or purposefully bear more children than ultimately desired based on the experience of child mortality in the community. These patterns reflect the early resumption of sexual intercourse, shorter duration of breastfeeding and minimal use of contraceptives.

4. Maternal Health

Mortality and morbidity: The 1994 maternal mortality rate is estimated to have been 530 per 10,000 women of reproductive age. Nyanza accounts for 23.6 percent; Western 23 percent and Eastern 21 percent of overall maternal mortality. Most maternal deaths occur among women aged 15-29 years and 53 percent of maternal deaths are among women who are not practicing family planning; 45 percent of maternal deaths are related to hemorrhage (both ante-partum and post-partum hemorrhages) and sepsis especially during the post-partum period. Maternal deaths have a negative impact on the survival status of the index child.

Female Genital Mutilation (FGM): While the official policy of the Kenyan Government discourages female circumcision and the number of girls exposed to FGM is thought to be declining, many girls are still being subjected to the practice. In a recent survey of four districts, 89.6 percent of the women aged 14 years and above were circumcised. There is a variation in incidence and type of FGM but what is clear is that it is widely administered under unhygienic conditions and more than 60 percent of those interviewed expect to circumcise their own children usually between the ages of 10 and 14.

Abortion: The incidence of abortion in Kenya is thought to be high. In 1993, there were an estimated 75,000 Kenyan women who induced abortion, and roughly 500 abortion related deaths. Abortion complications are the leading cause of admission to emergency gynecological wards at Kenyatta National Hospital and district hospitals. One-third of admissions are teenagers; most of the remaining admissions were women between 20 and 25 years of age.

5. HIV/AIDS

There were 52,000 cumulative AIDS cases reported by October 1994 out of an estimated 150,000 actual cases; by 1993, HIV sero-prevalence among adults was thought to be 5.7 percent (11-12 percent urban and 4-5 percent rural) which means an estimated 730,000 adults and 30,000 children were infected.

6. Life Expectancy

Life expectancy at birth in Kenya is 60 years (the sub-Sahara Africa average is 52 years). Further improvements in life expectancy will likely be jeopardized by an uncontrolled AIDS epidemic.

III. Priority Problems in Population and Health

The purpose of this section is to summarize priority population and health problems and their implications for Kenya's future development.

A. Unsustainable population growth and fertility higher than desired

1. National level:

While Kenya's population growth rate (PGR) has started to decline, even at 3.0 percent it is too high in relation to projected economic growth. If the PGR remains constant, the population will double in a little over 21 years. At 3.0 percent growth, the Kenyan economy will be hard pressed to improve the standard of living for future generations.

The GOK, recognizing the problem of higher than desired population growth, plans to reduce the population growth rate to 2.5 percent by the year 2000.² If the GOK goal of 2.5 percent is not met and the population growth rate remains a constant 3.0 percent, in the year 2020 there will be:

- 8.2 million more Kenyans to feed, educate and employ – a total population of 49.6 million versus 41.4 million;
- 71 more Kenyans per 100 hectares of arable land – 427 versus 356;
- a 24 percent decline in the GOK's health expenditure per capita;

²See Ministry of health, National Implementation Plan, in draft, Nairobi, January 1995.

- 3.3 million more students to educate – 10.6 million versus 7.3 million;
- the need for \$238 million in additional funding for education – \$807 million versus \$569 million;
- 49 grandchildren for the average Kenyan couple (age 65) versus 20, a difference of 29 direct descendants.

2. *Individual and family level:*

The 1993 KDHS found that for 1990-1993, Kenya's total fertility rate (TFR) was 5.35 while the desired family size was 3.7 children. If desired fertility is not attained, the implications for individuals and families include:

- a woman's right to control her fertility is denied;
- unintended pregnancies and unwanted abortions will increase as will related maternal morbidity and mortality;
- child mortality will increase as children have a greater probability of dying if they are born to mothers who are especially young or old, if they are born after a short birth interval, or if they are of a high birth order; and
- not all children will receive the support and education necessary to achieve their full potential.

B. The AIDS Epidemic

The burden of an uncontrolled AIDS epidemic on the health and economic well-being of Kenya will be severe throughout the decade in terms of illness, treatment costs, and the loss of labor from Kenya's most productive age groups.

If adult HIV prevalence increases from the current 5.7 percent to 9 percent by the year 2005 (an optimistic scenario), then the number of infected people in the population would increase to 1.6 million by the year 2000 and to 1.9 million by the year 2005. The number of new AIDS cases resulting from these infections would increase to over 230,000 annually by the year 2000. The cumulative number of AIDS deaths would increase from about 100,000 today to 1 million by 2000 to over 2 million by 2005.

1. *Health Status:* Within the next decade HIV/AIDS is likely to become Kenya's most serious health problem.

- *Morbidity:* HIV positive persons will suffer numerous episodes of illness both before and after they develop full-blown AIDS including diarrhea.

tuberculosis, skin problems and pneumonia. The annual, additional case load for tuberculosis associated with AIDS will exceed 90,000 by the year 2005. In addition, people infected with HIV and other STDs may have more severe STD symptoms and a higher rate of HIV infectivity.

Mortality: The impact will be most severe among adults (aged 15–49 years) and children under age five. AIDS will more than double the annual number of deaths among young adults from 133,000 in 1994 to 220,000 a year by 2000 and 280,000 a year by 2005. The annual number of children's deaths due to AIDS is projected to range between 40,000 and 50,000 through the year 2005.

2. *Health Services:* As of August 1993, it was estimated that 40 percent of all hospital beds were occupied by patients with HIV-related infections, with some hospitals reporting that they cannot accept any more AIDS in-patients. Furthermore, the opportunity cost of not treating other patients is a significant problem, as is the reduced level of quality of care because scarce resources are being devoted to AIDS. The total cost of caring for HIV/AIDS patients alone in the year 2000 could equal the entire MOH recurrent budget of 1993-94.

3. *The Economy:*

Macroeconomic: By the year 2005, simulations show that uncontrolled, the AIDS epidemic could retard growth in Kenya's Gross Domestic Product. Per capita income may be reduced by nine percent – primarily due to a decline in savings associated with increased AIDS related health expenditures and a subsequent decline in formal sector employment.³

Sectoral: Essential sectors of the Kenyan economy will be adversely affected by the loss of skilled labor, particularly health professionals, banking and insurance, mining, transportation, manufacturing and the military. In addition, farms could face seasonal labor shortages as rural prevalence rates rise.

4. *Demographic:* While AIDS will likely have a significant impact on population size, the population growth rate would still be 1.7 percent per year in the year 2005 under the worst case AIDS scenario.

³ Hancock, et al., 'The Macroeconomic Impact of HIV/AIDS' in Socio-Economic Impact and Policy Implications of AIDS in Kenya, Chapter 6, Family Health International/AIDSCAP, publication scheduled for August 1995.

C. Child Survival

Child survival trends are disquieting. After slow but steady declines, infant and child mortality rates leveled-off in the mid-1980s, and all indications suggest that the AIDS epidemic will make a continuation of the downward trend exceedingly difficult. Unchecked, AIDS will likely *increase* both infant and child mortality rates between 1995 and 2005. Most deaths will occur in the first two years of life from perinatal transmission. By the year 2025, under-five mortality is expected to increase by 62 percent over the 1990 level.⁴

Continued high fertility and high levels of unmet need for contraceptives among women of reproductive age may further contribute to the stagnation in child survival trends. In 1993, high-risk fertility behaviors accounted for an estimated 14 percent of all under-five deaths in Kenya.

The number of children orphaned by AIDS is projected to increase to 600,000 by the year 2000 and to one million by the year 2005. Traditionally the extended family has cared for orphans, but families and communities will be increasingly unable to cope with the vast numbers of AIDS orphans. Many of these children will likely suffer higher morbidity and mortality.

Malaria-related morbidity and mortality rates will likely continue to increase in Kenya as the parasite becomes increasingly resistant to treatment.

IV. Key Constraints to Effective, Sustainable Solutions

The purpose of this section is to summarize key constraints which impede the resolution of priority population and health problems. This summary is based mainly on Annex C.

Policy: restrictions on family planning services to vulnerable groups, particularly youth and unmarried persons; and, formidable challenges related to the implementation of new fundamentally sound health policies.

Family planning: insufficient supply of services; uneven distribution of services; insufficient programmatic focus on males; limited information regarding adolescent pregnancy and abortion; lack of national IEC strategy and weak coordination; and uncertain contraceptive funding and supplies.

HIV/AIDS/STD prevention: unsteady supply of HIV/STD diagnostic kits; insufficient supply of STD drugs; GOK commitment tepid but warming; misconceptions regarding condoms and AIDS causation; large percentage of STDs unrecognized in asymptomatic

⁴Projection of Under Five Mortality Rates, UNICEF Report, April 1993.

women; paucity of trained personnel in STD diagnosis; lack of effective, affordable female-controlled methods of protection.

Child survival: stock-outs of antibiotics and other pharmaceuticals; low levels of maternal education; increasing poverty of women; poor child spacing and high maternal mortality; immunization drop-outs; inaccurate diagnosis and improper treatment of childhood diseases.

Maternal health: facilities often lack appropriate lifesaving equipment; excessive time and distance to health facilities when emergency medical intervention required; and traditional birth attendant (TBA), midwife and community training inadequate for recognition of high risk pregnancies and labor complications.

Organization and management of health care: centralized management; accountability problems; verticality of public and private sector services; weak district level coordination; and weak supervision and health information system.

Utilization of health services: women's relatively low status and related problems of limited educational and economic opportunities; declining quality of some public health services and impact on client satisfaction; persistent myths and misinformation regarding disease prevention and causation and family planning; religious and socio-cultural beliefs.

Resource constraints: decline in MOH per capita allocations; majority of recurrent budget devoted to personnel; deficits in the numbers of professional staff; staff productivity problems; uneven distribution of health resources; lack of private sector access to capital and credit; taxes on imported drugs and equipment; user-fees not always resulting in improved service quality, leading to reduced utilization and revenue; and declining external resources due to donor conditionality.

V. USAID Strategic Plan for the Population and Health Sector in Kenya, 1995-2000

A. Introduction

This summary of the USAID strategic plan for assisting the population and health sector in Kenya from 1995-2000 is based mainly upon the January-February 1995 participatory APHIA design (see Reference 4 for a summary of design workshop proceedings); the April 1995 "Japanese/USAID Joint Sector Assessment" (Reference 1); the April 1995 USAID-funded "Inventory of Donor Assistance to the PH Sector in Kenya" (Reference 2); the September 1993 "Kenyan Demographic and Health Survey (KDHS)" (Reference 5), and Annex D. The plan is guided mainly by three policy and planning documents: the November 1994 GOK "Health Policy Framework," the February 1995 USAID "Guidelines for Strategic Plans," and the March 29, 1995 "Strategic Plan for the Global Bureau's Center for Population, Health and Nutrition.

The plan is shaped by the following considerations:

1. **Assisting Kenya to protect her children from preventable morbidity, mortality and orphanhood; and assisting Kenyan women to protect themselves from unintended pregnancies, unwanted abortions, STIs, and AIDS, is justified on humanitarian grounds – it is simply the right thing to do;**
2. **USAID resources are declining and finite, making significant progress on sustainability imperative;**
3. **USAID's comparative advantages among donors in Kenya include a 23-year history of assistance to family planning service delivery; the ability to channel and program substantial funding to the private sector; a seven-year history as the lead donor working with the GOK on its national health care financing/cost-sharing program; strong in-country technical and implementation capability backed-up by an unparalleled array of technical resources accessible through USAID/W;**
4. **USAID's challenge is to strike the right balance between two competing priorities one, short-term with "people-level" impact measurable and attributable to USAID during the program period; and the other, long-term, with the focus on sustaining impact in the future:**
 - a. **... to meet the immediate and compelling needs of millions of Kenyan women and men for the skills, knowledge and access to services necessary to prevent unintended pregnancies, unwanted abortions, HIV/AIDS, and preventable child and maternal illness and death;**
 - b. **... and, to build Kenya's capacity to sustain family planning and health services to meet future needs with local resources, reducing incrementally Kenya's reliance on foreign aid.**

B. Key assumptions

Key assumptions underlying the USAID Strategic Plan include: the GOK will implement policies articulated in the 1994 Health Policy Framework; the relationship between the GOK and donors will stabilize and there will not be additional significant cuts in external support over the next five years; and donor support for population and health activities and key public health commodities (e.g. contraceptives, condoms, STD drugs) will be generally consistent with plans outlined in the 1995 donor inventory (Reference 2).

C. Conceptual Framework

- 1. USAID Goal: Promote sustainable, broad-based economic growth.**
- 2. USAID Sub-Goal: Stabilize population growth and protect health.**
- 3. USAID PH Sectoral Strategic Objective: Reduce fertility and reduce the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.**

APHIA represents the Agency's total effort in the sector, therefore, the APHIA program purpose statement and the Strategic Objective in the USAID/Kenya Strategic Plan are the same.

- 4. Relationship between Goal (Promote sustainable, broad-based economic growth) and Sub-Goal (Stabilize population growth and protect health).**

Continued reductions in Kenya's PGR will facilitate broad-based economic growth and poverty alleviation in Kenya mainly by reducing unemployment, increasing per capita investments in education and health, and increasing income per capita. Without reductions in the PGR, 492,000 new jobs will need to be created annually by the year 2000. The main underlying cause of a serious degradation of Kenya's natural resources is the rapid growth of population. Stabilizing population growth will lessen this degradation and help Kenya maximize the attendant economic benefits.

- 5. Relationship between Sub-Goal (stabilize population growth and protect health) and Strategic Objective (reduce fertility and reduce the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services).**

a. Total Fertility Rate (TFR) and the Population Growth Rate (PGR)

Of the three components that directly influence population change -- migration, mortality and fertility -- fertility is the major determinant of the current decline in the population growth rate in Kenya.⁵

b. The Total Fertility Rate (TFR) and Contraceptive Prevalence Rate (CPR)

The main proximate determinants of the fertility decline in Kenya are postpartum infecundability and the use of contraception. Contraceptive use between 1977 and 1993 accounted for 62 percent of the aggregate fertility decline. Other determinants

⁵Muganzi and Takona; "Fertility Decline and Demand for Family Planning in Kenya"; DHS/MACRO Inc.; April 1994; pg 13.

such as age at marriage, abortion, and sterility influence the TFR, but contraceptive use had the greatest impact on population dynamics in Kenya.

Socioeconomic Factors Influencing CPR and TFR

Driving the dramatic increase in contraceptive use is the demand for family planning services. While exceedingly difficult and costly to tease-out with any degree of certainty, it is fair to say that gradual improvements in Kenya's socioeconomic development over the long-term have led to incremental improvements in women's status, improved child survival, and increased demand for educational and economic opportunities, the basic underlying forces fueling interest in family planning.

TFR and Health

Pregnancy-related complications continue to cause serious illness and premature death among women and their children – 74 percent of currently married Kenyan women age 15–49 are within one or more of the high-risk birth categories and high-risk births accounted for an estimated 14 percent of all deaths among children under-five. Unintended pregnancies also increase the incidence of abortion and related morbidity and mortality and, through perinatal HIV transmission, increase the number of children with AIDS.

HIV/AIDS and Health

Uncontrolled, AIDS will become the primary cause of death among Kenyans in their productive and reproductive prime, and will reduce overall life expectancy. In addition to AIDS' direct impact on health, AIDS undermines health in other ways: opportunistic infections, notably tuberculosis, are on the increase; morbidity and mortality among non-HIV infected AIDS orphans is likely to increase; and the quality and quantity of health services will suffer as an already taut public health budget is further stretched to care for people with AIDS.

D. Four Objectives

The Strategic Plan is comprised of four basic objectives:

- Reduce fertility.
- Reduce the risk of HIV/AIDS transmission.
- Sustain reductions in fertility and HIV/AIDS transmission beyond the year 2000.
- Support related policies and programs upon which sustained reductions in fertility and HIV/AIDS transmission rely.

1. Reduce fertility: To reduce fertility, USAID will focus support on increasing and sustaining access to and the supply of family planning services. USAID will also continue to support activities intended to further strengthen demand and improve the quality of services.

a. Increase access to and the supply of modern methods of contraception: Assumptions underlying this strategy include: there are at present high levels of unwanted fertility and unintended pregnancy, consequently, there is significant current unmet need for contraception; the need for family planning will increase substantially in the future due to Kenya's demography (a young population); and expressed need for contraception is a reliable predictor of subsequent use. Therefore, the relative priority is to further expand the supply of information and quality services.

(i) Current Demand for Contraceptive Services: The 1993 KDHS found that the level of unwanted fertility remains high in Kenya -- one in six recent births was unwanted and one in three mistimed. The 1993 KDHS found that 52 percent of married Kenyan women did not want any more children and 26 percent want another child, but not within the next two years. Thus, potential demand for family planning is 70 percent. Of this number, 33 percent are actually using modern contraception, leaving an unmet need of 37 percent. The survey found that Kenya's fertility rate would be substantially lower were unintended pregnancies averted.

USAID will focus resources where the needs for family planning services are greatest as indicated by the KDHS: e.g. the 15-19 year old cohort; women of high parity; women with lower levels of education, or no education; and women residing in provinces with the greatest need (e.g. Western).

National-level survey data on the needs of the 2.5 million women who are not married are scant, but the needs of this group to be protected from unintended pregnancy and sexually transmitted diseases are assumed to be substantial.

(ii) Future Demand for Contraceptive Services: The GOK is committed to meeting the needs and increasing contraceptive prevalence among *all* women of reproductive age from 25.9 percent in 1993, to 43.3 percent by 2000, and to 62.1 percent by 2010. The number of modern method users will increase from 1.2 million in 1993, to 2.9 million in 2000, and 5.9 million in 2010 (Reference 6).

(iii) The Cost of Meeting Contraceptive Needs: Between 1995 and 2005 expenditures on family planning are projected to increase significantly due to an increase in the number of reproductive age women and an increase in the overall contraceptive prevalence rate. Total GOK and donor expenditures on family planning services provided by the public and NGO sectors in 1993 were estimated to have been \$23.1 million, of which donors contributed 90.5 percent and the GOK 9.5 percent. USAID was the main source of support, accounting for \$12.01 million or 52 percent

of total expenditures. The next most prominent source of support was ODA which accounted for 14.3 percent of expenditures.

The annual cost of family planning services is projected to increase to \$43.4 million in 2000, and \$72.4 million in 2010. To meet increasing costs, the MOH plans to increase funding from \$2.2 million (9.5 percent of total program costs) in 1993, to \$6.5 million (15 percent) in 2000, to \$18.7 million (32.3 percent) in 2005. However, an increase in GOK funding will not be enough to meet the future costs of program expansion. In 2000 there will be a \$38 million shortfall (\$44.5 million versus \$6.5 million).

In addition to providing direct financial support, USAID will help the GOK reduce this shortfall through several strategies: advocacy, technical assistance and coordination with other donors to generate additional donor support for family planning and with the GOK to further increase public funding for family planning; the selective introduction of user fees; and, improving the efficiency of services.

(iv) **The Cost of Contraceptive Commodities:** The cost of contraceptive commodities is expected to increase from \$2.9 million in 1993 (12.4 percent of total program costs), to \$7.6 million in 2000, to \$16.8 million in 2010.

Contraceptive commodities are funded by a consortium of donors -- FINIDA, IPPF, ODA, SIDA, UNFPA, USAID and the World Bank. ODA funds the procurement of injectables and condoms; SIDA, oral contraceptive pills; UNFPA, condoms, injectables and Norplant; USAID will fund condoms for public sector distribution through 1995 (ODA will fund condoms for APHIA's social marketing component) and IUDs; while IPPF, UNFPA, and USAID/AVSC will fund implants.

An exhaustive analysis of future contraceptive requirements relative to funding was undertaken for this design (See Annex E). In sum, there is cause for concern. Funding gaps and commodity shortfalls are imminent. USAID will pursue several strategies to avert shortfalls: continue to coordinate with the GOK and other donors to accurately forecast requirements and costs and to develop financing strategies and plans; coordinate with donors and the GOK to advocate initiatives designed to lessen Kenya's dependence on external funding of contraceptives; and, continue to support the National Implementation Plan process as a mechanism to pursue the strategies above.

(v) **The National Implementation Plan (NIP) for Family Planning:** In 1994, with technical assistance from USAID/FPMD, the MOH started the process of developing the first-ever National Implementation Plan (NIP) for Family Planning, 1995-2000. The NIP will include a vision for the family planning program for the year 2000, key strategic directions, agencies responsible for implementation, capacity-building needs, and resource requirements.

- b. **Increase demand for contraceptive services:** The GOK envisions revitalizing and placing a new "stamp of approval" on public health Information, Education and Communication (IEC) with an enhanced role and increased visibility from the MOH. A major mass media campaign which will emphasize family planning, MCH, and reproductive health is planned during the next 1-2 years. APHIA will assist the GOK/MOH consolidate and focus national IEC messages to increase knowledge and demand for services.
 - c. **Maximize Quality of Contraceptive Services:** USAID will ensure quality is maintained while services are expanded by supporting proven tools such as COPE (Client Oriented Provider Efficient) and In-Reach and by devoting significant attention to key service delivery support functions upon which quality depends such as training, logistics and supervision.
2. **Reduce the Risk of HIV/AIDS transmission:** Underlying this strategy is the conviction that with continued support, the rapid increase in HIV sero-prevalence in Kenya can be slowed significantly over the next 5 to 10 years. This conviction is based on the fact that:
- ... five years of public information and education programs have resulted in AIDS knowledge being virtually universal and many believe themselves to be at personal risk;
 - ... twenty-five years of family planning experience in Kenya has shown that reproductive and sexual behavior can change significantly and with relative speed;
 - ... in addition to the rapid increase in contraceptive use, there is evidence of broad social and sexual behavior change, notably the increasing acceptability and use of the condom to prevent HIV/AIDS/STDs;
 - ... and, a considerable amount of programmatic experience has been accrued which shows that HIV/AIDS/STD services and information can be delivered effectively in a variety of settings.

Under APHIA, USAID's approach will be to scale-up proven interventions and test promising approaches. Based on experience to date and an analysis of other donor programs and plans, USAID's HIV/AIDS prevention strategy is to:

- Accelerate the integration of HIV/AIDS/STD prevention activities into the existing nationwide USAID-funded FP/MCH service delivery network and into centrally-coordinated service delivery support functions (e.g. logistics, IEC and training), with a particular emphasis on improving the diagnosis, treatment and prevention of sexually transmitted diseases (STDs),

- **Accelerate condom use primarily by expanding the social marketing of condoms in the private sector;**
- **Reduce the sexual transmission of HIV through reducing high-risk sexual behavior using behavior change communications (BCC) targeting women in integrated health delivery settings, adolescents, and men and women in the work place;**
- **Plan and implement a comprehensive HIV/AIDS/STD prevention program at the district level to demonstrate the interventions, coordination and resources required to make a significant impact on the AIDS epidemic, measurable and attributable to the program.**

3. Sustain reductions in fertility and HIV transmission beyond the year 2000

Sustainability is the *leitmotif* of USAID investments in the health and population sector in Kenya from 1995 to the year 2000. The emphasis on sustainability responds to concerns expressed by Kenyan colleagues during the design process; is grounded squarely in the new GOK health policy reform strategy; and is indicated by the political climate in Kenya and the U.S..

Beyond lip service: Five strategies will be pursued to achieve sustainability goals by the year 2000:

- **Decentralize, improve and expand the national cost-sharing/fee-for-service program;**
- **Improve the cost-efficiency of family planning, HIV/AIDS, and related reproductive health services, in part, through integration;**
- **Graduate selected Kenyan population and health NGOs from USAID technical and financial support and assist them to achieve programmatic, technical and financial self-sufficiency;**
- **Graduate the Ministry of Health from USAID technical and financial support for key centrally-coordinated support functions on which Family Planning and HIV/AIDS services rely (e.g. logistics; training; and IEC) and assist the MOH to institutionalize the independent capacity to manage these support functions over the long term;**
- **Support key GOK policies and reforms intended to improve efficiency, impact and sustainability throughout the health sector such as privatization and decentralization.**

4. Support *related* policies and programs which contribute to the achievement of sustained reductions in fertility and HIV transmission

Achievement of the PH Strategic Objective depends upon active USAID engagement in the following areas:

- **Child Survival:** USAID's main direct contribution to child survival will continue to be made through increasing the use of contraception and reducing HIV transmission. As noted, these two interventions contribute significantly to reductions in child mortality and morbidity. In addition, USAID will support the establishment of a Vaccine Independence Initiative (VII), and will support child survival services in selected districts where children's needs are greatest. These activities will include training health workers in the use of WHO and UNICEF Integrated Case Management algorithms for diagnosis and treatment of the sick child; field tests and other interventions in malaria prevention and case management; and, maternal health services which will directly impact child health.

Through policy dialogue and donor coordination, USAID will work to ensure the continuation and improvement of other programs of fundamental importance to child survival for which other donors have the lead role such as KEPI, CDD and ARI.

- **Girls' and Women's Education:** The 1993 KDHS reiterates the link between education and contraceptive use and fertility. Through policy dialogue and donor coordination, USAID will actively support public, private and donor efforts to increase educational opportunities for girls and women.
- **Employment and Income:** Employment in the formal sector and income are believed to be important determinants of fertility status and reproductive health in Kenya. Through policy dialogue and donor coordination, USAID will actively support public, private and donor efforts to increase employment opportunities for women.
- **Women's rights and status:** Reproductive health is inextricably linked to women's status and rights. Through advocacy, policy dialogue and donor coordination, USAID will support initiatives to improve women's status and expand women's rights.

VI. Plan of Action

The purpose of this section is to summarize how USAID will implement the strategy outlined in Section V above through the following four components:

- **Component 1: National Service Delivery Support**

Assistance to centrally-coordinated public sector entities to institutionalize essential support services to public and private sector providers nationwide.

- **Component 2: Private Sector Service Delivery**

Assistance to private sector organizations to provide services; these organizations rely on public sector service delivery support (Component 1).

- **Component 3: Health Care Financing and Sustainability**

Assistance to public and private sector organizations to sustain services with local resources over the long-term.

- **Component 4: District Focus**

Assistance to public and private sector organizations to provide services to the most needy populations and to develop and demonstrate service delivery models for replication on a broader scale (the program's re-engineering lab).

For component details see Annexes F through M. At the end of this section is a summary of potential complementary support from the Government of Japan for selected components. Annex G is the FY 1995 Memorandum of Understanding (MOU) between USAID/Kenya and the Global Bureau for \$11.5 million defining roles for each of the 20 CAs working in Kenya in FY 1995 and illustrative Field Support Resources (FSR) levels.

A. Component 1: National Service Delivery Support

Background: Kenya's public health delivery system is relatively "young," having evolved over the 32 years since independence. The system is still formative and requires strengthening, particularly the centrally-coordinated support functions upon which public and private sector health providers are critically dependent. Over the past ten years USAID has contributed substantially to the strengthening of selected support functions mainly as they relate to family planning.

Out of necessity, the national family planning program is evolving to address broader reproductive health needs including the need to avoid HIV/AIDS STD; the contraceptive needs of a broader clientele; and to further improve the quality and sustainability of services.

Over the next five years, USAID will assist the GOK to develop and institutionalize the following centrally-coordinated support systems to meet evolving needs: policy; planning and coordination; IEC; logistics; training; quality assurance and supervision; and research, evaluation and monitoring.

1. Policy

a. Background

The GOK's Health Policy Framework is a sound and progressive statement of health policy. The main challenge faced by the GOK is to implement these policies. As an established and major presence in the sector, USAID is well positioned to assist the GOK with this formidable challenge. Specific policy tasks with which USAID may assist include:

- Clarifying policy to reduce implicit restrictions on services to vulnerable groups, particularly youth and unmarried persons;
- Establishing authorizations and structures to facilitate decentralized financing, planning and coordination of health services;
- Formulating and enforcing compliance with guidelines related to the local management of cost-sharing revenues;
- Procuring waivers for fees for public health messages on publicly owned radio and television;
- Obtaining blanket waivers on import and value-added taxes for donor-funded reproductive health commodities (including contraceptives and STD treatment drugs);
- Establishing and enforcing district guidelines and practices for priority movement of essential drugs, STD drugs, and contraceptive commodities;
- Establishing decentralized provincial and district authorities to determine in-service training schedules and selection of training candidates;
- Establishing break-even fee structures for use in Rural Health Training Centers (RHTCs);
- Developing additional guidelines and enforcing regulations for certification of private for-profit service providers.

USAID's historical role as a lead donor in the population and health sector has provided many ad hoc opportunities for USAID to facilitate Government policy formulation through research and policy dialogue. Under APHIA, USAID facilitation of health policy

development will become a more strategic and formalized function within the O/PH office. Staff will be mainly concerned with policy dialogue where adequate policy has been established, but where systems and management approaches do not allow the policy to be effectively implemented, and where lack of policy effectively denies certain vulnerable groups access to services.

b. Results and Sustainability Status by the Year 2000

- National health policies affecting access to quality services will become further liberalized as a result of more informed dialogue and broadened participation of public and private individuals and interest groups;
- Policy analysis will show increased consistency among policy as expressed in the Health Policy Framework, regulatory guidance, and implementation of policies on a national basis;
- Women's and special interest groups will have strengthened capacity to influence national health policies.

c. Funding and Implementation

- DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above.
- DA/EX-G/Field Support: The ACCESS Project (CEDPA) to support key women's groups (e.g. Maendeleo, Women Parliamentarians, alumni) with advocacy and networking; the RAPID and POLICY Projects; and the AIDS Technical Support Project (ATSP) to assist with policy analysis and development, training and technical assistance.

USAID/Kenya O/PH will rely upon advocacy and technical assistance from USAID/K management and Program Office for progress on selected policy and regulatory changes noted above.

2. Program Planning and Coordination

a. Background

USAID has played a lead role in the development of planning and coordination capacity in the health sector. In 1979, USAID provided technical assistance to the MOH to help strengthen capacity to identify and rationalize service delivery priorities; to articulate requirements to donors; to improve equity in the allocation of health resources (shifting emphasis from curative to preventive health care); and to lay the groundwork for the formation of Provincial and District Health Management Teams. In 1981, USAID

established the five-year Health Planning and Information Project (HPIP) to help institutionalize provincial and district management structures and strengthen Health Information Systems. The Information and Planning Systems (IPS) Project was undertaken from 1987-1992 to further strengthen the national Health Information System and strengthen District Health Management Team planning and action.

Much was achieved in the early phases of USAID assistance. Rudimentary structures for decentralized planning and management were institutionalized; the national health information system has continued to evolve computerized management of the massive array of national aggregate data; and, an environment conducive to systematic planning has been established in the health sector in Kenya.

Concurrently, the GOK became increasingly concerned about their ability to finance and sustain health services. Early attempts at establishing decentralized district planning and management had served to highlight resource deficiencies. During the mid-1980s, USAID assisted with a series of health care costing and financing studies which reinforced the need to generate income for the health sector. By 1990, USAID had shifted emphasis from general support to strengthen planning and coordination capacity to specific support for health care financing and sustainability through the Health Care Financing (HCF) Project.

USAID shifted support away from the national Health Information System to specialized analyses and tools intended to better inform national planning and decision-making such as the 1989 and 1993 KDHS's and DemProj, AIM, FamPlan and iwgAIDS. USAID has also assisted with several major national planning exercises such as the "National Family Planning Implementation Plan" and the "Five-year Implementation Plan for Financing Health Care in Kenya."

Remaining constraints to further improvements in planning and coordination include:

- Unclear role and functions of the Provincial Health Management Teams within the context of "district focus;"
- Decentralized planning and coordination functions have become increasingly complex with the introduction of District Health Boards, Population Committees, and District Population Officers;
- Decentralized coordination is constrained by lack of resources, weak supervision and accountability problems.

As in the past, USAID will continue to play a significant role in strengthening planning and coordination structures and functions in the health sector. However, under APHIA the focal point of this assistance will substantially shift from the national to district and implementing levels, with concentration on facilitating national policies with potentials for impacting

district level management, and support for development of prototype planning and coordination systems.

b. Results and Sustainability Status by the Year 2000

- **Selected organizations (candidates include NCPD, MOH/NACPS, University of Nairobi, selected DHMBs) will have the independent capacity to regularly utilize state-of-the-art forecasting and projection tools and techniques such as DemProj, FamPlan, AIM, iwgAIDS and the Target-Cost Model, to update and modify program and implementation plans and focus resource allocation.**
- **The MOH will have the independent capacity to develop, monitor and periodically update a national implementation plan for family planning (NIP/FP) and a national implementation plan for HIV/AIDS/STD prevention (NIP/AIDS) and use them to estimate, coordinate and budget local and external resources.**
- **Prototype planning and coordination structures will be established and functioning in selected districts.**

c. Implementation and Funding

- **DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above.**
- **DA/EX-G/Field Support: The RAPID IV and the new POLICY Project; Demographic and Health Surveys (DHS); the Family Planning Management Development (FPMD) Project (FY 1995 only); and the Evaluation Project (FY 1995 only).**

3. Information, Education and Communication (IEC)

a. Background

While fertility rates have fallen in Kenya, a sizeable gap persists for many between actual and desired fertility. While knowledge of family planning methods is virtually universal, continued efforts are needed to strengthen the demand for smaller families. Moreover, there is growing awareness, as reflected in trends in the national health care system, of inter-relationships between family planning and many other health concerns. The risk of HIV/AIDS demands safer sexual practices; a message that must be equally well communicated to the same sexually active population at risk of unintended pregnancies.

A 1990 analysis identified the need to target priority audiences and evaluate the effectiveness of IEC activities. Working with NCPD and FPAK, JHU/PCS has helped establish a national IEC Working Group comprised of key NGOs; develop a national reference training curriculum for training of community based distributors (CBDs); develop national "Client-

Provider materials to improve the quality of clinic-based face-to-face interactions and information exchange between providers and clients; and launch a major national IEC campaign promoting the "Haki Yako" ("Your right!") family planning theme.

While progress has been made, challenges remain. Both the public and private sectors are rapidly moving beyond basic maternal and child health and family planning to include other relatively complex reproductive health services (e.g. safe motherhood and STD prevention). The scope of IEC will need to be broadened and become more integrated. The GOK believes that the MOH should play a more direct role in broadening the reproductive health theme through national campaigns.

Historically, the MOH has not performed well as a producer of IEC materials. The MOH envisions its future IEC role as management and coordination at a policy level, while contracting for technical services. The MOH plans to reorganize its Health Education Division such that its main function will become mobilization and supervision of a network of approximately 350 Health Education Officers, and a large pool of community level health workers. Over the next five years, USAID will support the MOH to implement new IEC strategies.

IEC approaches under APHIA will be substantially modified from past approaches. The scope of efforts will be broadened and directed away from discrete technical activities, the production of IEC materials, and IEC campaigns. Greater emphasis will be placed on institution-building and sustainability activities necessary for the development of a coherent national IEC program such as: strengthening mechanisms and structures for development of a national IEC strategy and coordinated implementation; providing technical assistance and services to planners and implementors to develop effective IEC messages and campaigns keyed to audiences identified as strategically important such as couples having an unmet need for family planning, people at risk of HIV/AIDS/STD infection, and youth; and, assisting a Kenyan institution to develop the capacity to become a lead technical resource to planners and implementors in the research, design, production, implementation and evaluation of IEC programs.

b. Results and Sustainability Status by the Year 2000

- The MOH will have independent capacity to develop and revise periodically a coherent, integrated national IEC strategy and implementation plan; and will be functioning successfully as national IEC program coordinator;**
- HIV/AIDS/STD prevention and selected messages regarding maternal, reproductive, and child health will be integrated into population and family planning IEC plans and programs;**

- **IEC will be targeted more effectively to the most vulnerable and needy – e.g. those with unmet need for family planning; at risk of HIV/AIDS/STD infection; and adolescents;**
- **A private sector Kenyan organization(s) will have independent capacity to provide technical expertise in the design, testing, production and evaluation of IEC programs;**
- **The MOH will have the independent capacity to contract IEC materials production to the private sector.**

c. Implementation and Funding

- **DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above.**
- **DA/EX-G/Field Support: Population Communications Services (PCS).**

4. Logistics

a. Background

Public sector health care in Kenya is plagued by chronic shortages of essential drugs, medical supplies and contraceptive commodities. Shortages are due mainly to problems in public sector tendering and weaknesses in the management information system which make the accurate forecasting of national requirements difficult. This situation prompted the MOH, with assistance from USAID, to create a parallel national contraceptive commodities logistics system in 1991. Since then, the USAID-funded Family Planning Logistics Management Project (FPLM) has assisted the MOH establish a Reproductive Health Logistics Unit (RHLU) which now facilitates national supply forecasting, ordering, delivery, warehousing and distribution to meet national contraceptive supply requirements. At present, contraceptive supplies are maintained at a 90-95 percent adequacy level at the national, zonal and district stores, and a 70-90 percent adequacy level at Service Delivery Points.

In spite of the RHLU's achievements to date, two main deficiencies in the current contraceptive logistics system persist: NGOs sometimes experience difficulties in accessing commodities at the district and sub-district levels from Government outlets; NGOs lag behind in timely reporting to the RHLU; and, the RHLU has limited capacity to get commodities from the district level to SDPs. The RHLU will be under increasing pressure to handle large quantities of STD drugs slated to arrive in country.

Logistics systems to manage reproductive health commodities are in place, but GOK resources to procure and finance these commodities are limited. Contraceptives are financed exclusively by donors. The MOH has had serious difficulties procuring some donor-financed commodities. Forecasts show that to meet the demand for family planning services Kenya

will need to double contraceptive supplies. Donors are not able to cover increased commodities costs. Due to budgetary constraints USAID must reduce the level of financing for contraceptive commodities. USAID is phasing-out support for condom procurement in FY 1995 but will continue to broker GOK and donor efforts to ensure that condom supply levels for both free distribution and social marketing are adequate. USAID plans to continue to provide limited quantities of Intrauterine Devices (Copper T 380A).

APHIA will continue to assist and institutionalize technical capacity in the RHLU, with emphasis on placement of senior-level management in the Unit, further technical staff training, and strengthening of management systems. In addition, three areas will receive special attention: technical assistance to the RHLU to establish procedures for incorporation of STD equipment/supplies and drugs into the contraceptives logistics system; assistance to the RHLU in assessing district requirements, identifying additional essential inputs, and conducting district management workshops to improve district transport and logistics coordination; and, assistance to NGOs to improve logistics coordination with the RHLU.

b. Results and Sustainability Status by the Year 2000

- The RHLU will be fully integrated into the GOK/MOH's logistics system, regularizing the warehousing and distribution of family planning commodities and STD drugs;
- All SDPs will routinely maintain 90 percent of contraceptive and STD drug stock requirements;
- All private sector providers will be fully integrated into the national reproductive health logistics system and be routinely receiving supplies from the RHLU.

c. Implementation and Funding

- DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above; and for the Central Contraceptive Procurement (CCP) program for condom and IUD procurement.
- DA/EX-G/Field Support: The Family Planning Logistics Management (FPLM) Project and the RAPID IV Project (in the area of forecasting).

5. Training

a. Background

Systematic in-service training programs were introduced by the MOH in the early 1970s to ensure that health workers' knowledge and skills were kept current. To facilitate this effort, six Rural Health Training Centers (RHTCs) were opened in 1977-78 as "centers of

excellence providing residential accommodations for forty in-service trainees and a full-service 20-bed clinic to serve the community and offer a practical learning setting for trainees (in 1995 another RHTC will be turned over to the GOK by FINIDA bringing the national total to seven).

After a good start, a proliferation of donor-driven in-service training programs caused RHTCs to become under-utilized hotel/conference facilities in various stages of disrepair rather than centers of excellence. The MOH Division of Family Health (DFH) Training Program stopped using the RHTCs in 1982 and with USAID assistance the DFH set up 12 decentralized training "centers" in selected districts with permanent trainers, office space at health facilities and has used local hotels for accommodation and classrooms.

A 1990 USAID-funded evaluation of the national Family Planning In-service Training Program recommended streamlining DFH training logistics and improving training quality. In response, USAID placed a Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) resident technical advisor in the DFH. Accomplishments include the development of a competency-based, six-week family planning certificate course; an introductory family planning course for nurses working at the dispensary level; and a training information system that prioritizes the selection of trainees on the basis of geographical staffing needs. No improvements have been made in the logistical arrangements for family planning training.

Over the next five years USAID will assist the MOH to improve training logistics; to consolidate and integrate reproductive health training (family planning, HIV/AIDS/STD, maternal health and safe motherhood); and improve the efficiency and cost-effectiveness of MOH in-service training programs.

USAID and JHPIEGO will continue to provide technical and operational support to the DFH Family Planning Training Program, with an additional scope of responsibilities. JHPIEGO will coordinate with AVSC which will continue expansion of permanent and long-term methods in MOH and NGO facilities, including improving supervisory approaches and quality of care. JHPIEGO will play a lead role in facilitating and coordinating new approaches to in-service training which will include integration, to the extent possible, of maternal/reproductive health, child health, family planning, and HIV/STD prevention. In the area of child health training, JHPIEGO will coordinate technical assistance from health CAs such as BASICS and Mothercare to the MOH in moving away from vertical training (e.g., ARI, CDD, malaria case management, etc.), favoring use of the WHO/UNICEF algorithm for integrated case management of the sick child. JHPIEGO will also ensure that all instructional approaches introduced at the national level will be reflected in interventions to be undertaken in the District Focus Component of APHIA.

Consistent with APHIA's integration strategy, JHPIEGO will assist in revitalizing the MOH RHTC network (or a suitable alternative network of existing facilities such as the Medical Training Colleges), which originally played an important strategic and functional role in the

development of integrated preventive and promotive health care in Kenya. JHPIEGO assistance will include coordination of the physical rehabilitation of the RHTCs as well as institutionalization of both technical and managerial capacity to make RHTCs cost-effective and self-sustaining. In addition to the wide variety of integrated courses that may be offered by the rehabilitated RHTCs, these facilities will also provide much needed permanent accommodation for the DFH (integrated) Family Planning Training Program. UNFPA is currently supporting the operations of eight of the twelve DTCs now being used by the Family Planning Training Program, but UNFPA is in agreement with steps to revitalize the RHTC network, and has pledged full support for this effort.

JHPIEGO, in cooperation with UNFPA, will assist the MOH in establishing a centrally-managed office (to be designated by the Ministry), which will manage the RHTC network in collaboration with MOH provincial administration.

b. Results and Sustainability Status by the Year 2000

- Pre-service teaching institutions will have added integrated reproductive health training to their teaching curricula;
- The Division of Nursing (DoN), DFH, and the University of Nairobi Department of Ob/Gyn will be coordinating activities related to in-service training of doctors, nurses and clinical officers in integrated family planning/reproductive health;
- The MOH will have developed a national integrated in-service training manpower information and planning system administered at provincial and district levels in consultation with the Division of Nursing;
- The network of seven RHTCs (or a suitable alternative network of existing facilities), will have been converted to permanent residential facilities for integrated reproductive health training and replace the 12 decentralized training "centers" currently operated by the DFH. RHTCs will have developed and implemented cost recovery plans for financial self-sufficiency targeted to attract and service priority markets for training accommodations; and
- The DFH and DoN will have jointly established a formal structure and regular activities for district and sub-district level supervision of integrated family planning/reproductive health activities.

c. Implementation and Funding

- DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above; and for condom and IUD procurement;
- DA/EX-G/Field Support: JHPIEGO, AVSC and PRIME (in FY 1995 only).

6. Quality Assurance and Supervision

a. Background

Throughout most of the 1980s, the main priority in family planning service delivery in Kenya was to develop facilities and train personnel. Quality of care emerged as a concern in the late 1980's, in part due to a Situation Analysis conducted by the Population Council. The analysis found Kenya's family planning program was performing moderately well and identified specific weaknesses in service quality. Several initiatives to improve quality ensued spearheaded by INTRAH, Pathfinder, CEDPA, JHPIEGO and AVSC.

AVSC is helping to develop a network of MOH quality assurance supervisors concerned mainly with permanent and long term methods but with the potential to broaden their focus to include other reproductive health services. AVSC has made substantial progress introducing COPE (Client Oriented Provider Efficient) and "In-Reach" in several NGOs (new approaches to supervision which emphasize self-assessment and on-site training).

Quality assurance in clinical contraception is particularly critical. With AVSC assistance, Kenya has established an excellent track record. Continued vigilance is necessary to ensure the highest standards of clinical contraceptive services are maintained. The MOH plans to expand access to permanent and long-term (PLT) methods.

USAID has devoted most attention to two prerequisites to quality -- ensuring the presence of trained staff and required supplies and equipment at SDPs -- and less attention to ensuring adequate supervision which has emerged as a serious deficiency in the national health care delivery system.

The main remaining constraints to improving quality are weak supervisory responsibilities at the provincial level; a substantial amount of supervision is attempted from central technical support offices (e.g. the DFH training unit) direct to district and sub-district operations, making coverage spotty; the span-of-control from the District Public Health level downward is impossible to manage (as high as 1:250 in some districts); the MOH does not have supervisory personnel available to fulfill its supervisory support responsibilities to NGO implementors; and supervision is mainly carried out by the traditional observation/checklist approach which is largely ineffective in re-enforcing skills or improving workers' performance. The MOH National Family Planning Implementation Plan to be released in 1995 will document these constraints and call for urgent corrective action.

Over the next five years, in addition to continued assistance for logistics and training, USAID will help strengthen supervision of family planning, MCH and reproductive health services.

In addition to continued assistance to strengthen logistics and training, USAID will support efforts to strengthen supervision of family planning, MCH, and reproductive health services.

Quality assurance in clinical contraception (TLs, Vasectomy, IUDs and Norplant) is particularly critical, not only because these procedures must be carefully done to avoid complications, but also because they are connected in the public's mind with safety of all family planning methods. With AVSC assistance over the past 10 years, Kenya has an excellent track record. Continued vigilance is necessary to ensure that high standards of clinical contraceptive services are maintained. The MOH has set priority on expansion of PLT method services, and targeted substantially increases in PLT acceptance rates. USAID will continue support for both the expansion and quality assurance of clinical contraceptive methods.

b. Results and Sustainability Status by the Year 2000

- The MOH will have defined and implemented a national supervisory structure for all levels of service delivery;
- Strengthened methods of supervision will be widely implemented at both public and private service sites;
- A 1999-2000 Situation Analysis will show measurable improvements in quality of public and private reproductive health services.

c. Implementation and Funding

- DFA/bilateral funding: USAID/Kenya O/PH staff to assume primary responsibility for achieving the results listed above;
- DA/EX-G/Field Support: AVSC;
- Global Bureau Core Funding: AVSC to develop, test, disseminate, and replicate innovations in FP service delivery, particularly quality assurance and supervision, in the region.

7. Research, Evaluation, and Monitoring (REM)

a. Background

USAID assistance for REM includes the 1977 Kenya Fertility Survey; the 1984 Contraceptive Prevalence Survey; and the 1989 and 1993 Demographic and Health Surveys. USAID has invested heavily in clinical and programmatic family planning research. From 1988 to 1993, Family Health International (FHI) assisted the University of Nairobi to strengthen the Department of Obstetrics and Gynecology to conduct reproductive health

research and to develop leadership in reproductive health research in Kenya and the region. In addition, since the establishment of Population Council's AFR/OP Project in 1988, a large volume of operations research studies have been conducted in Kenya. See Annex F for a listing of past and on-going USAID-funded research.

Over the next five years, USAID will continue to offer support for practical REM activities related to priority policy, program planning and financing issues such as: establishing and monitoring HIV sero-prevalence rates among the rural population; evaluating the impact of condom use on HIV transmission; ascertaining the efficacy of counseling and testing in reducing HIV transmission; the prevalence and prevention of female genital mutilation (FGM); the prevalence and prevention of abortion; the effectiveness and affordability of methods women can control to prevent HIV/AIDS, including viricides and the female condom; evaluating the impacts of integrating HIV/AIDS/STD services into existing FP/MCH programs; determining the interactions between HIV and contraception and between HIV and malaria; determining the efficacy of impregnated bednets in reducing malaria morbidity/mortality in areas of high transmission; the development of indicators to monitor policy reform; the feasibility of establishing "Independence Initiatives" for vaccines, condoms, essential drugs, contraceptives; the feasibility of charging for family planning and STD services.

In the past, USAID has been a major contributor to research in Kenya related to priority policy, program planning, and financing issues. However, under APHIA, research will be more strategically focussed upon those areas which support other APHIA program objectives. Particular attention will be given to such research issues as: the relationships between contraception and risk of HIV infection, and operations research geared to strengthening service delivery modalities such as service integration -- both of which are newly emerging issues in the sector.

b. Results and Sustainability Status by the Year 2000.

- Priority research will be completed and results used to inform policy and improve access to and the quality, cost-effectiveness and sustainability of services;
- A KDHS-III will be implemented and results utilized to improve program effectiveness and impact;
- A national HIV surveillance system will be functioning and informing program planning.

c. Implementation and Funding

- DFA bilateral funding: USAID Kenya OPH staff to assume primary responsibility for achieving the results listed above;

- **DA/EX-G/Field Support: FHI and the Population Council under the Africa OR Project and the Program Grant;**
- **Global Bureau Core Funding: FHI and the Population Council to conduct population, family planning and health research which addresses USAID Global, regional, and Kenya priority issues.**

B. Component 2: Private Sector Service Delivery

1. Background

A notable feature of USAID support to the PH sector in Kenya has been a sustained focus on the private sector – for example, USAID has supported the Family Planning Association of Kenya (FPAK) and the Christian Health Association of Kenya (CHAK) for nearly 15 years; USAID with JSI launched the first sub-Saharan family planning program exclusively focused on the private commercial sector in 1984; and USAID with PSI launched Kenya's first private sector social marketing program in 1990.

USAID currently supports a nationwide network of private family planning and health service providers. The network is funded with bilateral resources through three Handbook 13 (HB-13) grants to Kenyan NGO's; a cooperative grant agreement with JSI for PSFP-II; a cooperative grant agreement with PSI for Social Marketing; and a blend of bilateral and Field Support Resources to Pathfinder and CEDPA who fund eight Kenyan NGOs, the Nairobi City Commission and three university-based projects.

The USAID-funded private sector network involves 60 organizations with over 4,000 service delivery points and accounts for approximately 7.3 percent of all family planning services nationally. In addition, on average, 800,000 TRUST brand condoms per month are sold through 6,000 retail outlets.

In addition to a significant service delivery role, the private sector has played an important role as innovator testing new service delivery strategies such as the community based distribution of oral contraceptives and condoms; Norplant minilaparotomy with local anesthesia; and no-scalpel vasectomy.

Pathfinder International, resident in Kenya for over twenty years, currently provides sub-grants to Maendeleo ya Wanawake for CBD services in seven districts; Mkomani Clinic Society in Mombasa for CBD and clinical family planning; Church of the Province of Kenya (CPK) community based services in Western Kenya; Universities Project for peer and staff counselling; high-risk clinic at KNH; the Nairobi City Commission; and the private practitioners work with the Kenya Medical Association (KMA).

CEDPA, resident in Kenya since 1993, currently provides sub-grants to Maendeleo for CBD services in three districts; outreach services for FPAK in Taita Taveta; FLPS and Kabiro Kawangware clinics; and women's networking activities among CEDPA alumni.

FPPS is a key private sector activity under the USAID PH strategy. FPPS and its sub-projects will target beneficiaries/organizations within the private-for-profit sector, expanding service integration and shifting private companies to commercial sales of condoms where feasible.

In the 1994 Health Policy Framework the GOK provides strong support for expanding the private health sector. APHIA will support this expansion to increase access to high quality family planning services; extend the coverage and impact of HIV/AIDS prevention; and sustain services over the long term as external support is phased out.

2. Results and Sustainability Status by the Year 2000

a. Service Delivery:

- Total CYPs will increase from 400,000 to 850,000 representing growth from 32 percent to 38 percent of the services provided nationally;
- Services will be broadened to include prevention of STDs, particularly HIV. Between 60 and 70 private hospitals and health centers will provide screening and appropriate treatment for STDs, 4,000 community outreach workers will be able to correctly counsel and refer clients for clinical family planning and STD treatment;
- Condoms sold through commercial outlets will increase to nearly ten million annually and represent eight percent of the condoms distributed nationally;

b. Sustainability:

- FPAK will achieve full programmatic sustainability and partial financial sustainability through fees for service and income derived from establishing an endowment fund;
- Chogoria will graduate from USAID financial support and achieve financial self-sustainability through a structured fee-for-service scheme and a one-time endowment of local currency;
- CHAK will institutionalize the independent capacity to manage sub-grants; expand and improve TA and training to member organizations; and three member organizations will achieve 70 percent financial self-sustainability;
- The PSI-implemented national social marketing program will have made the transition to a Kenyan NGO or company (or will have been incorporated into an existing

Kenyan NGO or company); will possess the independent capacity to manage a national social marketing program; and will have made significant progress towards financial independence.

The JSI-implemented Private Sector Family Planning Project will have made the transition to a Kenyan NGO or company with the independent capacity to plan strategically; solicit, raise and account for funds; provide TA and training; and develop, monitor and evaluate sub-grants to the private sector to establish, expand and improve health services.

3. Implementation and Funding

a. DFA/Bilateral

Bilateral funding for USAID/Kenya O/PH staff to manage and coordinate financial and technical resources to achieve the results noted above and for:

- **PSFP-II Project (615-0254):** The USAID Cooperative Agreement with JSI for the PSFP II Project ends in October 1998 and bilateral funds -- outside the context of APHIA -- have been allocated for FY 1995, 1996, and 1997 as planned. FY 1997 will be the last year of USAID support to PSFP;
- **Social Marketing (615-0251):** The USAID Cooperative Agreement with PSI for the social marketing project ends in December 1995. USAID intends to provide bilateral support in FY 1996 and 1997 for a follow-on Cooperative Grant Agreement with PSI, an American PVO, to continue the activity through on/about December 1997;
- **Family Planning Association of Kenya (FPAK):** Bilateral funding in FY 1995 and 1996 to improve the quality of and expand integrated services;
- **Christian Health Association of Kenya (CHAK):** Bilateral funding in FY 1995 and 1996 to improve the quality of and expand integrated services;
- **P.C.E.A. Chogoria Hospital:** Bilateral funding in FY 1995 and 1996 to work with the population in Tharaka-Nithi District and Meru District to provide affordable and accessible health care including family planning services.

b. DA/EX-G Field Support

- **Pathfinder International:** To support integrated services delivered by private and parastatal providers (e.g. Maendeleo ya Wanawake, the Church of the Province of Kenya (CPK), Mkomani, Crescent Medical Aid (CMA), the Seventh Day Adventist Church, universities and high-risk clinical services at key hospitals),

- **ACCESS/CEDPA:** To support integrated services delivered by private sector providers (e.g. FLPS and Kabiro Kawangware);
- c. **Global Bureau Core Funding:** Pathfinder International to develop, test, disseminate and replicate innovations in the delivery of integrated family planning and health services in the region.

C. Component 3: Health Care Financing and Sustainability

1. Background

Since 1989, USAID has worked collaboratively with the Ministry of Health (MOH) and Kenyatta National Hospital (KNH) to implement the Kenya Health Care Financing (KHCF) Project. The Program was designed to develop cost-sharing programs of user-fees (with a waiver system to ensure access to care by the poor) and insurance reimbursements to improve the availability and quality of health and family planning services, and to achieve a shift in public financing for health care in favor of primary and preventive care (P/PHC) services. KHCF incorporates a complementary mix of technical assistance to support the design and implementation of the cost sharing program, and Non-Project Assistance (NPA) to support broader policy reforms required to support the above objectives.

As a result of the above assistance and GOK support for the program, Kenya's national cost sharing program has generated over \$9 million in funding for the public health sector, and is expected to raise over \$4.5 million in GOK fiscal year 1994/95. These resources are used for a wide range of purposes from capital improvements of facilities to controlling infectious disease outbreaks.

Despite the impressive gains made under the KHCF program, it is increasingly clear that Kenya's public health sector faces a serious and worsening budgetary crisis. In addition to the need for increased financial resources, major improvements in managing existing financial resources are required to more effectively use all health and family planning resources available to the sector.

The MOH has made commendable strides in identifying management and accountability problems within the health sector and proposing strategies to tackle these obstacles. The Health Policy Framework sets an ambitious agenda which, it is generally acknowledged, will require technical and financial inputs beyond those available within the MOH.

Based on its experience with the GOK in jointly designing, implementing and evaluating Kenya's first major health reform program, USAID possesses a strong comparative advantage in assisting the MOH effect national level health policy reform. Policy reforms central to the KHCF Program, namely achieving a shift in GOK funding away from curative care to P PHC, and increasing overall revenue to the health sector through cost sharing and greater efficiency, have now been elevated to a broader overall MOH strategy as key to

MOH reform. USAID will support the same two above overall objectives under Component Three of APHIA.

Due to the unavailability of NPA resources under APHIA, however, the means towards achieving the first of the above two objectives will differ from those of the KHCF Program. APHIA will support progress towards this objective of shifting public sector resources in favor of P/PHC services by: (1) increasing availability of curative care in the private sector by developing alternative financing and management arrangements; and (2) increasing private sector responsibility for curative and preventive care through improved NGO and mission sector efficiency in health and family planning service delivery.

Activities identified in Component 3 build upon TA provided under the KHCF Program, and in most cases, were identified by the GOK as steps required to meet MOH policy objectives. The current cost sharing program will not provide adequate resources to resolve the severe budgetary crisis facing the health sector today. The centralized management of the cost-sharing program -- once critical to ensuring consistency in the process of defining, field testing and implementing cost-sharing policies and systems developed under the KHCF Program--is now associated with declining accountability in reporting and using cost-sharing revenue. Component Three will, therefore, assist the MOH decentralize several key functions institutionalized at the HCF Secretariat with assistance under the KHCF Project, such as training, supervision, and revenue and expenditure reporting, as a critical step towards ensuring the continued viability of the national cost-sharing system. APHIA's Component Three will also support the MOH to identify and develop new means in the private sector towards generating additional financial resources for health and family planning service delivery.

Effectively decentralizing Kenya's national cost sharing program, supporting overall MOH reform, developing alternative social financing mechanisms, and supporting the controlled growth and increased efficiency of private sector providers are natural outgrowths of the country's health care financing reform efforts and may prove vital to its future viability and effectiveness.

APHIA assistance to support the above objectives was designed based on lessons learned and the effective working relationship developed between USAID, a USAID-funded resident TA team, and the MOH under the KHCF Program, and will assist the MOH address four major obstacles:

- Inadequate recurrent support for and poor quality of GOK health and family planning service delivery;**
- Centralized management and implementation of cost sharing;**
- Inadequate social financing mechanisms; and**
- Need for improved NGO management capacity and sustainability.**

2. Results and Sustainability Status by the Year 2000

The four major objectives of USAID assistance to Kenya's health care financing program are to:

- Expand and institutionalize Kenya's national cost-sharing program through phased decentralization and increased effectiveness of the program;
- Expand private health financing programs;
- Develop NGO self-sufficiency in health and family planning service delivery; and
- Improve Kenya's self-reliance in key public health commodities.

Component Three thus includes a complementary mix of support similar to that under the KHCF Project, and new areas of focus, as well – both reflective of the natural growth and maturation of Kenya's health care financing program.

A resident technical assistance institutional contractor will be charged with implementing activities designed to support the above objectives. Progress made in achieving the above objectives will directly contribute to the successful implementation of the MOH health reform agenda spelled out in the Health Policy Framework and the Five Year Health Care Financing Implementation Plan.

a. Expand and Institutionalize Cost-Sharing

Increased efficiency in implementing the cost-sharing program, and the decentralization of responsibility for supervision, training and evaluation of the program to the provincial and district levels will result in:

- The increased efficiency in collecting cost-sharing revenue from 25 percent to 50 percent of potential;
- An increase in cost sharing revenue to the equivalent of at least 30 percent of the MOH non-wage recurrent budget.

b. Expand Private Financing and Management Mechanisms

Support for promising financing and management mechanisms in the health sector identified under the KHCF Project will result in:

- Three (3) operational managed care schemes in selected health and family planning NGOs;
- Completion of one (1) feasibility study for establishing a pre-paid health insurance scheme with one major cooperative society;

- **Market and actuarial analyses for the creation of three (3) insurance risk pools* for smaller employers;**
- **Two (2) service contracts or internal market mechanisms for the alternative management of targeted services for selected GOK health facilities.**

c. Develop NGO Service Delivery Capacity and Sustainability

The objective behind improving NGO self-sufficiency is two-fold:

- **To reduce the burden on the public sector for meeting Kenya's health and family planning needs through increased involvement of the private sector in providing quality health and family planning services; and**
- **To reduce the health and family planning NGOs' dependence on donor assistance.**

Assistance to health and family planning NGOs under this component is designed to build upon relationships developed over twenty years of USAID support for improved family planning service delivery capacity. Whereas USAID assistance to NGOs has focused largely on increasing their capacity to provide quality health and family planning services, APHIA assistance will more explicitly support NGOs' programmatic and financial strengthening in an effort to ensure their future viability to meet the on-going health and family planning needs of Kenya with lessened reliance on external support.

Several individual facilities and NGO networks will be selected to receive some or all of the following assistance based on nine key criteria. The following criteria will be applied to select those NGOs most likely to effectively utilize TA provided and most likely to succeed independent of donor assistance: a) established relationship with USAID; b) afford broad client coverage; c) demonstrate strong actual or potential capacity for integrated service delivery; d) demonstrate a commitment to meeting the health and family planning needs of the underserved; e) offer a mix of both facility- and community-based service delivery; f) exhibit an interest in implementing and/or revising fees for service and alternative mechanisms for financing commodities and personnel; g) have existing functional financial systems; h) possess a captive market; i) and demonstrate the willingness to address quality of care issues.

APHIA support devoted to achieving the above objectives will assist three (3) major family planning service delivery NGOs attain a level of 70 percent financial self-sustainability by the year 2000 through the following targets:

- **Ten (10) facilities will have fully-functioning financial management systems in place, encompassing the capacity to conduct cost-efficiency, marketing and client satisfaction analyses;**
- **Two (2) NGOs will have fully-functioning national level marketing strategies and in-house marketing units;**
- **Four (4) NGOs will have contraceptive social marketing programs in place.**

d. Increase Self-reliance in Key Public Health Commodities

- **The GOK will have established a Vaccine Independence Initiative (VII) and a Contraceptive Independence Initiative (CII) which will serve to lessen Kenya's reliance on external funding for these essential public health commodities.**

This approach to supporting increased MOH capacity to ensure reliable supply of key public commodities represents a major departure from previous USAID-supported assistance towards this end.

3. Implementation and Funding

- a. DFA/Bilateral funding for an Institutional Contractor (IC) to achieve the results outlined above (see Annex M for detail); NGO endowments, the capitalization of vaccine and contraceptive independence initiatives; and a U.S. PSC to supervise the contractor and assume overall responsibility for the achievement of results. (Note: funding for a PSC to manage the District focus component is included in the IC).**
- b. DA/EX-G/Field Support to PROFIT to complete NGO capacity assessments and to provide initial capital for expansion of NGO for-profit services; and HFS to define, support and evaluate activities related to the decentralization of selected HCF Secretariat functions to the district level.**
- c. Global Bureau Core Funds: HFS to assist with the development, evaluation and dissemination of managed care, cooperative prepaid schemes, and enhanced traditional indemnity plans in the region.**

D. Component 4: District Focus

1. Background

There are significant geographic differences in the use of family planning and health services and in health and fertility status. There are also significant questions regarding the design of cost-effective, integrated approaches to solving old public health problems such as malaria and newer problems such as HIV/AIDS. The purpose of the district focus component is twofold:

- ... to strategically concentrate USAID health and population resources in selected districts where the needs and potential for impact are greatest;
- ... and, to develop and test promising new programmatic and management approaches to priority public health problems for replication on a broader scale.

Background analyses have identified Nyanza, Western and Coast provinces as areas with poorest health status and greatest levels of unmet need. These provinces have the:

- highest levels of fertility;
- lowest use of family planning (CPR) and highest unmet demand for family planning services;
- greatest risk factors for child illnesses;
- poorest coverage with basic treatment;
- highest levels of childhood morbidity and mortality; and
- highest HIVsero-prevalence levels.

Using the above criteria and those which follow, districts within these provinces will be selected for USAID support in consultation with the GOK and other donors:

- feasibility of improving management and financial operations as indicated by adequate potential for cost sharing;

and, opportunities to collaborate and build upon prior USAID, U.S. government and other donor investments in infrastructure and capacity building such as CDC and USAID/Africa Bureau HHRAA project activities in Western Kenya.

2. Results and Sustainability Status by the Year 2000

a. Overall

- Geographic differences in the use of health and family planning services and in health and fertility status will have been lessened.

b. HIV/AIDS/STDs

- The technical, resource, management and coordination requirements necessary to achieve measurable impact on HIV transmission attributable to the project will have been documented and disseminated;
- HIV sentinel surveillance sites will be regularly and accurately reporting seroprevalence; data will be used at the district level to inform policy, generate resources and improve the efficacy of programs;
- The efficacy of behavior change communications (BCC) undertaken with targeted groups will have been fully documented;
- HIV counselling and testing services will have been piloted;
- The social marketing project will have implemented comprehensive, intensive condom sales and IEC programs in selected districts; and USAID-supported grantees will be selling TRUST condoms.

c. Integrated Case Management (ICM) of the Sick Child

In selected public and private sites, the district focus will assure implementation and evaluation of an integrated package of services to ensure the quality and efficiency of curative and preventive care for sick children with the following results:

- There will be systematic, appropriate use of WHO and UNICEF algorithms designed to ensure appropriate treatment of children presenting to first level health facilities;
- Field tests of impregnated bednets and other interventions in malaria prevention and case management will have been undertaken;
- Health workers will receive improved supervisory support to provide higher quality child health services.

d. Reproductive Health Services

Activities implemented in selected sites under the district focus will maximize access to and improve quality of integrated reproductive health services including family planning, HIV/AIDS/STDs and maternal health activities. Results will include:

- Family planning service delivery will be focused on the use of permanent and long term methods, where appropriate, and on improved targeting and service to adolescents and men;

- Family planning staff at all levels will have enhanced capacity to provide integrated reproductive health services;
- Health personnel will have strengthened capacity to deliver maternal health services and to recognize high risk pregnancies, high risk labor and delivery, and the need for referral.

e. MOH Management Decentralization

The district focus will assist the GOK to implement and evaluate its policies and plans to decentralize key operational functions to the provincial and district level management.

Anticipated results are:

- Provincial level supervisory and quality of care oversight will be incorporated into a decentralized management approach;
- DHMTs and DHMBs will have assumed primary responsibility for a wide range of cost-sharing related activities, including reporting, monitoring, evaluating and supervising cost-sharing at the district level, using a district management approach suitable for replication throughout Kenya.

f. Financing and Sustainability

The district focus activities will strengthen community channels to create health awareness and demand for services, provide high quality, integrated services and mobilize community resources for sustainable development. Anticipated results include:

- DHMTs and DHMBs will control and use cost sharing funds appropriately;
- DHMT and DHMB management capacities will be improved in areas such as quality assurance, personnel management and retention, planning and budgeting;
- Community initiated pharmacies will have improved capacity to effectively use the revenue generated from collection of fees and communities will have improved capacity to undertake social marketing and other income generating projects.

3. Implementation and Funding

APHIA's District Focus Component represents the first time USAID resources will be targeted in specific geographic areas where needs for strengthened health, family planning and reproductive health services are greatest. In the aggregate, this Component will demonstrate impact and program synergies through development of comprehensive district-specific programs of APHIA interventions including HIV/AIDS, STD prevention, integrated management of the sick child, reproductive health services, MOH management

decentralization and financing and sustainability. The component will be implemented using the following funding mechanisms:

- a. DFA/Bilateral:** Support for salary, benefits, logistics and housing for a district-based Kenyan component manager will be included in the Health Care Financing and Sustainability Institutional Contract; assistance from the AIDS Technical Support Project to implement HIV/AIDS activities in focus district(s).
- b. DA/EX-G Field Support:** In 1995, field support will be used from the Basic Support for Institutionalizing Child Survival (BASICS) project and the Environmental Health Project to initiate integrated case management and malaria activities in the districts. Several cooperating agencies currently working in Kenya may, as appropriate, be asked to focus specific activities in the selected districts, including Family Planning Services (Pathfinder), Access to Family Planning through Women Managers (CEDPA), Population Communication Services/Population Information Program, and Training in Reproductive Health (JHPIEGO). The Resources for Awareness of Population Impacts on Development (RAPID IV) as well as the Evaluating Family Planning Program Impact Project will undertake district level activities during the course of the project, particularly in the area of HIV/AIDS modeling and training of district level policy makers. The AIDS Technical Support Project will support HIV/AIDS and STD prevention interventions. Technical assistance for the DHMTs and DHMBs will be funded by field support through the Health Financing and Sustainability Project.
- c. Global Core:** Global core funding to develop, test, disseminate and replicate innovative approaches of regional interest in the areas of HIV/AIDS/STD prevention, integrated case management, reproductive health services, management decentralization and financing and sustainability. Primary implementation roles will be undertaken by Basic Support for Institutionalizing Child Survival (BASICS), Breastfeeding and Maternal and Neonatal Health (Mothercare), the AIDS Technical Support Project, the Environmental Health Project and Centers for Disease Control. Other implementors will include the Program for Voluntary and Safe Contraception (AVSC) and Pathfinder which will undertake selected pilot activities, as appropriate, in the focus district(s). Finally, ACCESS will undertake an HIV/AIDS Counselling and Testing Pilot in connection with existing service delivery sites. Other activities may be implemented with funding from BHR/PVC such as Child Survival or Matching Grants, and the Greater Horn of Africa Initiative.

E. Strategy for Collaboration with the Japanese Government

The purpose of this section is to summarize potential Japanese Government support for PH activities complementary to those funded by USAID

The Government of Japan (GoJ) and the United States have embarked on a program to coordinate development assistance under the U.S.-Japan Common Agenda on Global Perspectives and the Government of Japan's Global Issues Initiative on Population and AIDS (GII). Kenya is one of the countries selected for the implementation of this initiative. As a result, the Japanese International Cooperation Agency (JICA) and USAID/Kenya collaborated from December 1994 - April 1995 to produce "The Joint Sector Assessment and Strategy on Health, Population and AIDS In Kenya" (Reference: 1).

Building upon the results of the Joint Sector Assessment, JICA and USAID/Kenya are cooperating to identify and plan mutually reinforcing projects and programs in the population and health sector in Kenya. The Joint Strategy entails collaboration in program planning, design and evaluation of population and health projects. Implementation will be through projects managed independently by Japan's ODA agencies and USAID. The GoJ and USAID will establish mechanisms to share the results of respective efforts and will collaborate on project monitoring and evaluation.

The findings of the Joint Sector Assessment suggest that the following broad needs are critical to building Kenya's capacity to sustain health and family planning services over the long-term:

- strengthen the capacity of the public sector to plan, design, implement and evaluate appropriate family planning and health services;
- strengthen the capacity of the private sector to plan, design, implement and evaluate appropriate family planning and health services; and
- strengthen the sustainability of family planning and health services.

APHIA provides a framework for the development of these joint activities, emphasizing sustainable approaches in the PH sector. Potential parallel GoJ support for each APHIA component is summarized below.

1. National Service Delivery Support

- **Policy:** The GoJ and USAID will work together to promote issues of mutual concern and interest.
- **Logistics:** The GoJ will consider the possibility of providing project-type assistance or an individual JICA expert to strengthen the logistics management system and grant aid for the construction of warehouses in some districts and the supply of small trucks and vehicles to distribute contraceptives, drugs and medical supplies.
- **IEC:** JICA has an ongoing IEC project in population and AIDS in Kenya. Under the Joint Strategy, JICA and USAID may collaborate in a needs assessment to prepare a plan for the dissemination of high quality materials

that currently exist and for the development and testing of electronic and print materials.

- **Training:** Both USAID and GoJ training activities will address the need to strengthen management as well as technical capacity within the population and health sector. Curricula and other training materials may be jointly developed, tested and evaluated, as appropriate. JICA may also provide grant aid to rehabilitate some of the Rural Health Training Centers.
- **Research, Evaluation and Monitoring:** The GoJ and USAID will closely monitor and evaluate the activities and projects funded under the Joint Strategy. Through KEMRI JICA is considering expanding their technical assistance to include clinical research in HIV/AIDS. Collaboration on the design of this new research activity will provide an opportunity to ensure complementarity with USAID's on-going research interests.

2. Private Sector Service Delivery

In 1994, based on consultations with USAID, the Japanese Embassy awarded six grants totalling \$210,000 to Kenyan health and family planning NGOs under their Small Scale Grants Assistance Program (SSGA). The grants were primarily for the procurement of STD drugs, HIV testing kits, health center equipment and minor renovations to facilities. The GoJ plans to continue and expand this program, now called Grant Assistance for Grass Roots Projects (GAGRP), and it will continue to present a mechanism by which the GoJ and USAID can collaborate to assist Kenyan NGOs to integrate HIV/AIDS/STDs within existing family planning programs. In addition, the GoJ will consider providing GAGRP monies to USAID-supported NGOs for small scale construction/renovation to promote long-term self-sufficiency.

3. District Focus

Complementary activities being considered by the Japanese include: a) the provision of HIV test kits to support APHIA's testing and counselling services; b) clinical research in HIV/AIDS through KEMRI in selected district sites; c) provision of condoms for HIV/AIDS prevention; d) provision of safe motherhood equipment for district hospitals; e) training of trainers for the promotion of lactation management at the district level and f) the placement of one or more Japan Overseas Cooperation Volunteers (JOCV) in a USAID-supported NGO to provide assistance in developing capacity building skills, i.e. management and training.

VII. Coordination and Management

A. Overall Strategy

The USAID/Kenya Office of Population and Health (O/PH) will focus on six key functions central to the achievement of the Agency's PH Strategic Objective and to the successful implementation of the APHIA action plan above:

- 1. Strategic Planning:** The launching of a consolidated sectoral program; a heightened emphasis on results and sustainability; the many donors active in the sector; and the fragmentation and specialization of USAID implementation mechanisms combine to make strategic planning increasingly important. A key O/PH function is to marshal and orchestrate USAID's many specialized inputs within the context of the Big Picture and the Overall Sectoral Strategy.
- 2. Policy Dialogue:** The success and sustainability of family planning and HIV/AIDS programs in Kenya relies to a large extent on reforms in the health sector. USAID must of necessity continue to work outside our parochial focus on family planning and HIV/AIDS and remain actively engaged in the broad policy dialogue which shapes the context in which these programs are implemented and the infrastructure on which they depend.
- 3. Technical Assistance:** The breadth and depth of USAID's collective technical and implementation capability is unparalleled. USAID will fully exploit this capability and offer technical assistance for family planning, HIV/AIDS prevention, Health Care Financing/Sustainability and other related areas in which USAID has capability and comparative advantage.
- 4. Coordination:** APHIA is a consolidated Agency-wide effort under which bilateral and central activities are interdependent. Coordination between the Mission and USAID/W is imperative for success.

There are 19 CA partners and contractors with specialized implementation roles under APHIA. Coordination between USAID and CAs and among CAs is imperative for success. There are 21 donors active in the PH sector in Kenya. While coordination among donors and between donors and the GOK is improving, further improvement is imperative for success.

Under the Common Agenda/Global Issues Initiative, the Japanese Government worked with USAID on a joint PH sector assessment and a strategy for collaboration. As a result, the Japanese Government plans to offer assistance which is parallel to several APHIA components. Continued coordination with the Japanese will be imperative if plans are to be transformed into complementary projects.

5. **Reporting, Monitoring and Evaluation of Results:** USAID resources are being focused, coordinated, and concentrated to maximize results. O/PH will monitor, report and evaluate results primarily through the API.
6. **Disseminating Lessons Learned:** Countries in the region are currently grappling with public health service delivery and financing problems to which Kenya has found answers. O/PH can play a timely role facilitating the dissemination of lessons learned in Kenya throughout the region.

To achieve optimal performance of these functions, USAID is consolidating its PH portfolio, merging many separate projects into one sectoral program; simplifying and streamlining program implementation; rationalizing CAs' roles and responsibilities; and devolving as much day-to-day implementation responsibility to contractors and CAs as possible.

B. Strategic Planning

USAID/Kenya O/PH will be responsible for the following ongoing and specific strategic planning responsibilities:

1. Coordinate with Global PHN, AFR, and BHR to ensure all USAID PH resources and activities -- bilateral/DFR, Global Bureau field support, Global Bureau core funding, AFR Bureau HHRAA Project, and other types and pots of money -- are consistent with and directly contribute to the implementation of the 1995-2000 USAID Kenya Strategic Plan (SP) and the attainment of the authorized Strategic Objective;
2. Monitor implementation of the PH component in the 1995-2000 SP annually in connection with the API process (September/October);
3. Update and modify as needed the PH component of the 1995-2000 SP;
4. By May 1999, complete all necessary PH technical analytic input for the 2000-2005 update of the USAID PH Strategic Plan for Kenya in collaboration with Global PHN.

C. APHIA Program Planning and Coordination Process

1. By 30 June 1995, establish a coordination and implementation group comprised of representatives from organizations with major implementation responsibilities under APHIA and key donors. The APHIA Coordination and Implementation Group (ACIG), chaired by USAID/K O/PH, will include representatives from Cooperating Agencies, contractors, the GOK, donor agencies, USAID/Kenya, and, when possible, the Kenya Country Coordinator and/or Alternate from the USAID/W Global Bureau Kenya Joint Programming Team (KJPT). The ACIG mandate will include: to define and clarify implementation roles and responsibilities; to coordinate planning and budgeting; to avoid duplication of effort; to resolve implementation problems and

constraints; to ensure comparative advantages are exploited; to develop and implement a reporting, monitoring, and evaluation plan; etc.

By 31 August 1995, the ACIG will finalize detailed coordination and implementation plans for the first phase of the project.

The ACIG will continue and build-upon the highly successful Advisory Committees formed to guide the APHLA design.

- 2. By 14 July 1995, review and finalize with USAID/W the following draft terms of reference for the Kenya Country Coordinator and the Kenya Joint Programming Team (KJPT) during the era of APHLA. The KJPT role, responsibilities and functions will include:**
 - a. Reengineering: Assist USAID/K O/PH to anticipate, plan for and implement reengineering as it relates to APHLA.**
 - b. Programming and budgeting: collaborate with USAID/K O/PH to develop annual plans and budgets for CAs and field support resources; manage the USAID/W review and approval of "Written Agreements in Support of Global Field Support."**
 - c. Reporting, Monitoring and Evaluation: monitor implementation plans; review semi-annual APHLA Project Implementation Reports (PIRs); and annual Assessments of Program Impact (API); participate in the ACIG and periodic APHLA program and sectoral reviews.**
 - d. Donor coordination: working with the USAID/W donor coordination offices and/or direct with donor agencies -- ensure optimal coordination between USAID and other donor programs; resolve any coordination problems; represent the interests of USAID and APHLA at reviews of other donor strategies and projects.**
 - e. USAID/W Coordination: ensure USAID/Kenya participates fully in the development of Global and AFR-funded PHN research and analytical (R&A) agenda; ensure USAID/Kenya reviews/approves all such R&A activities proposed for implementation in Kenya; minimize the number of USAID/W-funded "outlier" activities imposed on USAID/K which do not address the Strategic Objective and are outside the context of APHLA.**
 - f. Information, Education and Advocacy: represent the Kenya PH program at relevant USAID/W meetings, to the press, other donors, Congress; collect, update and disseminate Kenya PH success stories, etc.; control and rationalize USAID/W information requests of USAID/K O/PH.**

3. USAID/Kenya O/PH will continue to oversee and participate in the work of the "Kenya Integration Group" established in mid-1993 to plan for and manage the integration of HIV/AIDS/STD services into existing FP/MCH programs. USAID will work with the Group to ensure it plays a central role under APHIA.

D. APHIA Program Implementation and Evaluation Plan

The APHIA Coordination and Implementation Group (ACIG) will develop detailed plans for program implementation and reporting, monitoring and evaluation (RME). At the core of the RME strategy is the annual Assessment of Program Impact (API) and a third Kenya Demographic and Health Survey (KDHS) to monitor and evaluate the status of Strategic Objective attainment. All implementing organizations will be required to synchronize reporting to ensure congruence with the API cycle. The RME plan will include periodic evaluations of components, strategies (e.g. counseling and testing), Cooperating Agencies and contractors. In addition, USAID/K O/PH will work with the USAID/K Controller to establish a rigorous audit program throughout the life of the project.

The ACIG will meet to discuss and flesh-out the following implementation and RME outline:

<u>Action</u>	<u>Date</u>	<u>Responsibility</u>
FY 94-95		
APHIA Coordination & Implementation Group (ACIG) Established	06/30/95	PH
Program Grant Agree't Signed	07/07/95	GOK/USAID
Terms of Reference for KJPT Finalized	07/14/95	PH;G/HPN
CAs roles under APHIA Finalized	07/15/95	PH/CA's
RFP Issued for Component 3	07/21/95	REDSO/PROC
APHIA Authorized/Obligated NLT	07/26/95	DIR
HB-13 Grant Final Evaluation Completed	07/31/95	PH/NCPD/NGOs
PSC Contracts Finalized	08/11/95	EXO
Three follow-on HB-13 Grants to Kenyan NGOs Awarded	08/15/95	PH
Annual KJPT Working Group Meeting	08/15/95	PH/GOK/NGOs
ACIG Coordination and Implementation Plans Finalized	08/31/95	PH
Coordination Plan, Implementation Schedule and Budget Prepared for District Focus Activity	09/95	PH
FPPS:Kenya Registered as Kenyan NGO	09.95	FPPS
District Selection Finalized	10/01/95	PH

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FY 95/96

FY 95 API Finalized	10/95	PH:PROG
FSR levels for FY96	11/95	PH;G/HPN
Finalized with G/HPN		
PIO/T for CSM Coop Agree't Completed	12/1/95	REDSO/PROC
Semiannual O/PH-implementing		
agency meeting	01/96	PH/PROJ
Contract Awarded/Finalized for		
Component 3	NLT 3/96	REDSO/PROC
Project Officer for Component 3		
Arrives at Post	04/96	PH/REDSO/PROC
MSH KHCF Project TA Contract		
Closed	05/96	PH/MSH
KHCF Project Close Out	06/96	PH;PROJ
District Focus Component Manager		
Arrives at Post	06/96	EXO/PH
		REDSO/PROC
Annual KJPT Working Group Meeting	08/96	PH/GOK/NGOs
Six-Month District Focus Workplan		
Finalized for FSR contractors, etc.	09/96	PH;G/HPN
Grantee sustainability assessments		
Completed; new grantee Program		O/PH;Inst'l
Descriptions developed	NLT Sept '96	Contractor

FY 96/97

ACIG Meeting	10/96	
PH/CAs/GOK/donors		
Annual KJPT Working Group Meeting	11/96	PH/GOK/NGOs
Semiannual O/PH-implementing	01/97	PH/PROJ
agency mtg		
PSFP II Final Evaluation	04/97	PH;TBD
KDHS III Fieldwork	06-08/97	Macro Int'l
National VII Launched	07/97	GOK/USAID/UNICEF
AIDSCAP Final Evaluation	07/97	PH/FHI/TBD
Annual KJPT Working Group Meeting	08/97	PH/GOK/NGOs
APHIA Component Mid-Term Eval(s)	05-08/97	PH;TBD

FY 97/98

ACIG Meeting	10/97	PH/CAs/GOK/donors
CSM Final Evaluation	10.97	PH.TBD
Annual KJPT Working Group Meeting	11/97	PH/GOK/NGOs

CSM funding begins from an alt donor	12/97	PH/CSM/donor
Semiannual O/PH-implementing	01/98	PH/PROJ
agency meeting		
KDHS III Dissemination	03/98	NCPD/Macro National CII
Launched	07/98	
GOK/USAID/UNICEF		
PVO Status of CSM/PSI Program		
Determined	08/98	PH:PSI
Chogoria-Apollo Pre-Paid		
Insurance Scheme Fully Functional	09/98	Chogoria

FY 98/99

ACIG Meeting	10/98	PH/CAs/GOK/donors
Annual KJPT Working Group Meeting	11/98	PH/GOK/NGOs
Semiannual O/PH-implementing	01/99	PH/PROJ
agency meeting		
Seven RHTCs will have become		
residential integrated reproductive		
health training facilities	06/99	MOH
RHLU fully integrated into		
GOK/MOH logistics system	07/99	USAID/MOH
Annual KJPT Working Group Meeting	08/99	PH/GOK/NGOs
Chogoria will graduate from		
USAID financial support	09/99	Chogoria

FY 99/2000

ACIG Meeting	10/99	PH/CAs/GOK/donors
Annual KJPT Working Group Meeting	11/99	PH/GOK/NGOs
Semiannual O/PH-implementing	01/2000	PH/PROJ
agency mtg		
1999-2000 Situation Analysis Conducted	01-02/2000	PH/TBD
PVO/Private Sector Status of CSM		
Program Finalized	04/2000	PSI/PVO
PH SAPIR (10/99 - 3/2000)	04/99	USAID/K
CSM Final Evaluation	07/2000	PH/PSI/PVO/TBD
APHIA Component Final Evaluation(s)	05 - 07/2000	PH/TBD
Close-Out Action begun by O/PH	08/2000	PH/REDSO/PROC
Project PACD	09/31/2000	

In addition to the above activities, O/PH will participate annually in the following processes to ensure routine monitoring and evaluation of APHIA:

- (1) Annual Budget Submission (ABS)/Action Plan - May/June**
- (2) Coordinate with G/HPN, AFR and BHR to review resource availability vis-a-vis APHIA funding requirements**
- (3) Assessment of Program Impact (API) - Sept/Oct**
- (4) SAPIRs - April and October**

E. APHIA Program Coordination

1. USAID/Kenya and the Government of Kenya (GOK): There are two formal coordination mechanisms between the GOK Ministry of Health and USAID/Kenya:

- a. The USAID APHIA Coordination and Implementation Group (ACIG);
- b. The bi-monthly PH donors group which the MOH attends routinely and is chaired by donors on a rotating basis.

2. USAID/Kenya and USAID/W Global PHN: Coordination and communications between USAID/Kenya O/PH and USAID/W Global Bureau PHN is principally with the USAID/W Global PHN Kenya Country Specialist. The main coordination task relates to the integration of Global Bureau central and USAID/Kenya bilateral activities under our common strategy. The task involves the development, review and approval of annual written agreements outlining field support requirements; the implementation of field support; and the reporting, evaluation and monitoring of field support.

A suggested timetable for the coordination process follows:

- a. October: Discussions begin between USAID/K and USAID/W Global PHN regarding Field Support Levels for the new fiscal year.
- b. December: Levels of Field and Bilateral support are finalized; recorded in a Memorandum; and sent from the USAID/Kenya Mission Director to the Global Bureau, Center for Population/Health and Nutrition. USAID/Kenya will put together the Congressional Presentation (CP) for the next two fiscal years.
- c. January: Semi-annual meeting between Mission and all implementing agencies. Review of progress to date and confirmation of budget levels and activities for remainder of fiscal year.

- d. **March:** USAID/W Global Bureau in conjunction with the Africa Bureau reviews the draw down on Field Support funds. USAID/W determines whether or not to re-program Field Support funds in consultation with the Mission. Mission collects information for semi-annual Project Implementation Reports (PIRs).
 - e. **June:** Semi-annual meeting between Mission and all implementing agencies. Review progress to date and implementation and financing plans for the upcoming fiscal year. USAID/Kenya prepares Action Plan (formerly ABS) for the fiscal year two years hence.
 - f. **September:** Mission prepares the annual Assessment of Program Impact (API) with information from Cooperating Agencies and contractors and collects information for the semi-annual Project Implementation Reports (PIRs).
3. **USAID/Kenya and USAID/W Africa Bureau/Sustainable Development/Human Resource and Democracy Division (AFR/SD/HRD):** USAID/Kenya O/PH and AFR/SD -- in consultation with REDSO/ESA PH -- will jointly develop and agree on that portion of the AFR regional PHN R&A/OR agenda to be implemented in Kenya; agree on respective roles and responsibilities of USAID/Kenya, REDSO/ESA and USAID/W AFR in the planning, review and approval, implementation, monitoring and utilization of R&A activities in Kenya; incorporate AFR-funded R&A activities into the USAID/Kenya O/PH work plan and anticipate implications for workload and staffing requirements.
4. **USAID/Kenya and USAID/W Bureau for Humanitarian Response (BHR)**
- a. **Office of Private and Voluntary Cooperation (PVC):** In collaboration with the BHR, issue jointly-agreed criteria to be used to review proposals for USAID/W BHR Child Survival and Matching Grant Program funding in Kenya.

Application of the criteria will ensure that Agency resources programmed through the BHR will be coordinated with bilateral, AFR and Global resources to directly address the approved USAID PH Strategic Objective in Kenya.
 - b. **Office of US Foreign Disaster Assistance OFDA:** With support from the USAID/Kenya Disaster Response Assistance Group (DRAG), and with the respective responsibilities of OFDA and USAID/K clearly demarcated, O/PH will assume "technical" project management and monitoring responsibilities for OFDA-funded projects which exclusively or primarily involve the provision of health and family planning services.

5. **USAID/Kenya and REDSO/ESA PHN:** There are a number of REDSO/ESA PH initiatives directly relevant to the work of USAID/Kenya O/PH and a number of REDSO initiatives which depend upon USAID/Kenya's cooperation. Based on consultations with REDSO/ESA, by 31 October 1995, USAID will have drafted a plan for USAID/Kenya O/PH and REDSO/ESA PH collaboration.
6. **USAID/Kenya O/PH and other USAID/Kenya Offices and Projects:** At the Strategic Plan and Program Logframe level, USAID/Kenya projects and the strategic objectives they address are synergistic and interdependent. USAID will pursue a "no-missed-opportunities" approach to maximize synergy at the programmatic operational level. For example, efforts will be made to offer credit and business management assistance provided under the new USAID Micro-PED Project to Kenyan "PH" NGOs. Financial sustainability is of central concern under APHLA.
7. **USAID/Kenya and other Donors:** USAID will continue to regard donor coordination as of paramount importance and key to the achievement of sustainability and accountability goals. USAID will continue to attach priority to coordination with the Japanese Government under the Global Issues Initiative/Common Agenda.

The main O/PH roles and responsibilities regarding donor coordination are:

- a. **USAID/Kenya and the Japanese Government:** USAID will work to implement the strategy for collaboration articulated in Chapter 10 of the April 1995 "Joint Japanese/USAID PH Sector Assessment" document. Specifically, O/PH will reach an understanding by 31 August 1995 with the Japanese Government which articulates the nature of continued coordination (1995-2000) between USAID and the Japanese Government under the Global Issues Initiative/Common Agenda. USAID has been invited by the GoJ to participate in GOJ project design and formulation missions beginning in May 1995.

Communication and coordination on the Kenya Common Agenda will continue to be with the Global Bureau's Common Agenda Coordinator and the USAID Officer based at the American Embassy in Tokyo in-charge of development cooperation.

- b. **USAID/Kenya and the Kenya Population and Health Donors' Group:** USAID was one of the founding members of a reorganized, consolidated, action-oriented PH donors group which began in January 1994 under a new terms of reference (drafted by USAID). The group is functioning well and has notched-up a couple tangible achievements. USAID will continue to participate actively in the group and through it will pursue the following objectives:

- **Ensure the implementation of planned donor-funded activities and procurements on which USAID APHIA program impact depends; focusing on the planning and timely implementation of a financing strategy to meet Kenya's needs for key public health commodities such as contraceptives, condoms, vaccines and essential drugs;**
- **Work towards consensus among donors on a common set of PH sector policy priorities and, if necessary, conditionalities;**
- **Identify and attempt to resolve over arching, cross-donor, cross-program, policy, implementation, financing and sustainability issues;**
- **Rationalize donor support and avoid duplication of effort;**
- **Provide the MOH a single, convenient forum for centralized and efficient communication between donors and the MOH;**
- **Work with the GOK and MOH to resolve MOH accountability and corruption problems;**
- **Collaborate on project design missions and evaluations;**
- **Establish a Vaccine Independence Initiative (VII) and establish a Contraceptive Independence Initiative (CII).**

When and if WHO's hospitality should end, USAID is prepared to assume the costs of secretariat services for the PH donors group and is also prepared to support the costs of periodically updating the inventory of donor assistance to the PH sector, most recently updated by USAID in April 1995 on behalf of the donors and the GOK.

- c. **USAID/Kenya and the World Bank:** Due to the potential magnitude of World Bank assistance to the sector and the closeness and complementarity of our respective programs, USAID will continue to attach high priority to coordinating with the World Bank. As time and staffing allow, USAID will continue to participate as full-time team members on World Bank PH missions (assuming we continue to be invited).
- d. **USAID/Kenya and USAID/W Bureau for Policy and Program Coordination (PPC)/Office of Donor Coordination (DC):** The U.S. Government (USG) is a major source of funding to five key multilateral donors in the PH sector in Kenya who fund programs parallel to those of USAID namely, UNICEF, UNFPA, the World Bank, WHO and IPPF. In an ideal world, the USG would have leverage to coordinate all U.S. taxpayer

support to the sector to ensure maximum impact. In the real world, coordination with multilateral donors can be difficult and time-consuming. Yet, as external resources decline, rationalizing and coordinating donor support becomes increasingly important. There are a variety of constraints to improved USAID/Kenya multilateral coordination – staffing; lack of a mandate; lack of access to information; and the degree to which some multilateral donors are centralized.

USAID/Kenya intends to more fully utilize the resources and leverage we assume are available at USAID/W (PPC/DC; Global), to improve coordination and influence the shape and scope of PH programs parallel to those of USAID upon which the success of USAID programs depend. USAID/Kenya will use our in-depth, local knowledge to report to USAID/W on the use of USG/USAID-funds channeled through UN agencies and multilateral organizations; the extent to which these organizations coordinate with USAID; and the effectiveness and impact of PH programs.

F. USAID/Kenya's Regional Role

Because of its central location in the Horn of Africa, Kenya is directly affected by, and shares many common concerns with, the Greater Horn of Africa Initiative (GHAI), particularly as relates to addressing the urgent health needs of refugees, internally displaced persons and drought victims. Kenya also shares with its near-neighbors more general concerns for development of stable and affordable national health care systems. Because of recent progress, Kenya has valuable experiences and expertise to share with regional partners.

USAID/Kenya has supported Kenya's regional role through the coordination of Global and AFR Bureau-funded research and analyses, and in the dissemination of lessons learned in Kenya throughout the region. Under APHIA, the bilateral mission's regional role will be acknowledged, formalized and expanded. USAID/Kenya will facilitate the dissemination and application of lessons learned in Kenya to a broader regional audience. The utilization of lessons learned in the following priority public health areas may benefit Kenya's neighbors -- family planning service delivery; cost-sharing and privatization; and donor coordination, particularly USAID's collaboration with the Japanese Government under the Common Agenda/Global Issues Initiative.

Experience soon to be gained in a number of areas may have utility beyond Kenya's borders -- the integration of HIV/AIDS activities into FP/MCH programs; the effort to determine what is required in terms of technical interventions, resources, and coordination to mount an effective HIV/AIDS prevention program; efficacy of impregnated bednets in areas of high malaria transmission; and integrated case management of the sick child.

USAID expects to build upon regional USAID efforts, including the REDSO/ESA BASICS Health Network Partnerships Support and the Africa Bureau's Health and Human Resources Analysis for Africa (HHRAA) Project, in implementing and evaluating several activities under Component 3.

The Regional Health Network has been in place since FY 94-95 and has, to date, actively focused on promoting technical and general information exchange regarding health care financing and family planning and HIV/AIDS in the region. As of April 1995, the USAID/Kenya HCF Project MSH TA team and the MOH HCF Secretariat have shared Kenya's experience with Ethiopia, Uganda, Tanzania, Malawi and Senegal as these countries plan to cope with challenge of financing health care.

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1. ON MARCH 17 A PROJECT COMMITTEE WAS CONVENED TO DISCUSS USAID/KENYA'S REQUEST FOR DELEGATION OF AUTHORITY TO APPROVE THE SUBJECT PID AND PP IN THE FIELD. MISSION WAS PRAISED FOR ITS POSITIVE ACCOMPLISHMENTS AND ITS EFFECTIVE LEVERAGE IN THE AREA OF POPULATION AND HEALTH PROGRAM IN KENYA. AFTER EXTENSIVE DISCUSSION ON THE PROPOSED PROJECT, THE PROJECT COMMITTEE RECOMMENDED DELEGATION OF AUTHORITY TO THE FIELD TO APPROVE THE PID AND PP FOR THIS PROJECT NOT TO EXCEED DOLS 5.53 MILLION FOR FIVE YEARS.

2. THE COMMITTEE, HOWEVER, RAISED SEVERAL TECHNICAL CONCERNS WHICH MISSION SHOULD CONSIDER AS IT DESIGNS THE PID/PP. THESE CONCERNS ARE DISCUSSED BELOW.

3. THE PROJECT COMMITTEE EXPRESSED CONCERN ABOUT THE MAGNITUDE OF THE PROJECT AND SUBSTANTIAL INVESTMENT IN THE PROJECT OVER THE LONG TERM.

4. THE PROPOSED PROJECT INCLUDES TWO MAJOR NEW COMPONENTS: HIV/AIDS AND STD PREVENTION AND MALARIA CONTROL AND TREATMENT. APR/ARTS POINTED OUT THAT THESE TWO COMPONENTS WILL INVOLVE POTENTIALLY GROUND BREAKING AND UNTESTED APPROACHES. FOR EXAMPLE, THE EXPERIENCE TO DATE WITH INTEGRATING FAMILY PLANNING WITH HIV/AIDS AND STD PREVENTION IS ONLY BEGINNING TO UNFOLD AND THE RESULTS ARE INCONCLUSIVE. IN AFRICA AND ELSEWHERE, THE EXPERIENCE IS VERY NEW AND FEW RULES OF THUMB EXIST TO GUIDE MAJOR NEW EFFORTS. FOR THIS REGARD, APR/ARTS IS AVAILABLE TO PROVIDE WHAT ASSISTANCE AND KNOWLEDGE IT HAS ON GLOBAL EXPERIENCE TO DATE AS MAY BE APPLICABLE TO KENYA AT THE TIME WHEN A PID OR EQUIVALENT IS PREPARED.

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5. NO ONE DISAGREES THAT MALARIA IS A MAJOR CAUSE OF MORTALITY AND MORBIDITY IN KENYA. HOWEVER, THERE IS NO DOMINANT CONSENSUS ON HOW TO PREVENT OR TREAT IT IN A PUBLIC HEALTH SENSE, I.E. ACHIEVING MAXIMUM COVERAGE AT REASONABLE EFFECTIVENESS AND COST. THE AGENCY AND THE AFRICA BUREAU HAVE NO APPROVED POLICY ON MALARIA WHICH IN LARGE PART IS A RESULT OF THIS LACK OF CONSENSUS AND PARALLEL CONCERN ABOUT EFFECTIVENESS AND COST IMPLICATIONS. AT THIS TIME, HOWEVER, USAID STAFF ARE WORKING WITH WHO ON FORMULATING A MALARIA STRATEGY AND THE EXPERIENCE ACQUIRED IN THAT SHOULD BE APPLIED TO CONSTRUCTING AN APPROPRIATE AND EFFECTIVE MALARIA PROJECT.

6. THE NEWLY CREATED GLOBAL BUREAU WILL BE PROMINENT IN POPULATION AND HEALTH STRATEGIES, PROGRAMMING, AND PROVISION OF TECHNICAL ASSISTANCE. FOR YOUR INFORMATION, AT A RECENT GLOBAL BUREAU MEETING, ADMINISTRATOR ATWOOD ANNOUNCED THAT ONE OF THE MANDATES OF THE NEW "G" BUREAU WAS TO PROVIDE TECHNICAL SUPPORT, DIRECTION, OR THROUGH COOPERATING AGENCIES, TO ASSIST THE REST OF USAID IN THE DESIGN AND IMPLEMENTATION OF FIELD ACTIVITIES. IF THE BUREAU CAN BE OF ANY ASSISTANCE PARTICULARLY WITH RESPECT TO PROVIDING TECHNICAL EXPERTISE FROM WASHINGTON, PLEASE LET US KNOW. WE WOULD ALSO LIKE FURTHER MISSION CONSIDERATION OF LIFE OF PROJECT FUNDING AND DURATION, AND TO HEAR YOUR VIEWS ON THE OPTIONS VIS-A-VIS A PHASED, LOWER BUDGET INITIATIVE. THIS WOULD APPEAR THE MORE APPROPRIATE GIVEN THE TECHNICAL CONSIDERATIONS RELATED TO QUOTE STATE OF THE ARTS UNQUOTE EXPRESSED IN PARAS 4 AND 5 ABOVE. PLEASE ADVISE.

7. AA/APR HEREBY DELEGATES AUTHORITY TO THE MISSION DIRECTOR, USAID/KENYA, OR TO THE PERSON ACTING IN THAT CAPACITY, TO APPROVE THE PID AND THE PROJECT PAPER FOR THE SUBJECT PROJECT, IN AN AMOUNT NOT TO EXCEED DOLS. 50 MILLION. THIS AD HOC DOA SHALL BE EXERCISED IN ACCORDANCE WITH ALL THE TERMS AND CONDITIONS OF DOA 551, EXCEPT FOR

THE DOLLAR AMOUNT LIMITATIONS.

TALBOTT

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MINUTES OF ECPR MEETING FOR APHIA PROJECT

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Date: May 24, 1995
From: Stephen Ragama, Office of Projects
Subject: AIDS Propulation Health Integrated Assistance
Project No. 615-0264
Ref: ECPR meeting of May 23, 1995

1. Project Purpose/Strategy:

The purpose/strategy statement should be more focussed. The last part of strategy/objective statement 'through sustainable, integrated FP' should be deleted as it will be problematic to develop sustainable and integrated indicators. How will the two 'sustainability and integration be measured?

Outcome: O/PH feels that sustainability is too important for the program that it must be placed at the strategy objective level.

The project logframe has addressed the issues on measuring sustainability (page 7 of 9). NGOs are expected to graduate and be self-reliant at certain levels of the program. The project will also assist in increasing the district level capacity to build in sustainability.

The expected result in the PP is very well articulated, however it is not clear on how we move from where we are to the expected results. This should be explained.

Outcome: There is a work plan included in the PP, however this section will be further developed to include all the proposed actions for the entire project life e.g. specific dates for planned evaluation, a monitoring plan, audits etc. OPH will hold discussions with each of the implementing agencies and reach an agreement with them on specific activities to be included in the work plan and budget which will form part of the agreement between USAID and the implementor.

As a follow on to the issue, there was a discussion on the need to integrate other health activities/diseases in the program e.g. Child survival, malaria are clearly laid out in the project

paper, however, other serious diseases are not provided for but are generally covered in the project logframe and has indicators to measure the impact of these health activities. It was concluded that these other health issues will be more clearly spelt out in the PP text.

2. Components:

One major component proposed in the PP is the Private Sector service delivery component. Why can't this component be integrated to the current Private Sector Family Planning II project or vice versa.

Response: The PSFP II Project will be integrated into APHIA as a HB 13 grant by 1997, however, the issue of mortgage/pipeline between the PSFP II and the Private Sector component of APHIA will be further analyzed to minimize any chance of double counting or overlap of activities in the projects.

The proposed project seems to have integrated all the current PH portfolio into one program. Given the current Mission budget constraint, and the past Mission investment in those activities, weren't there any or some of those activities that we can either graduate out of USAID assistance or drop to enable mission target a few activities with highest returns?

Outcome: There are activities that have been graduated i.e Community Based Services has been graduated and procurement of commodities shifted to other donors. Chogoria hospital is expected to graduate soon and the budget is phasing out. FPAK will receive an endowment that should assist them to graduate from USAID funding.

The project has also incorporate other new activities/approaches i.e the district level support, program integration etc , and increased emphasis on sustainability

3. Funding:

Given 1) the uncertainties about Mission OYB levels and 2) projects' high dependency on other donor supplied commodities, how would APHIA respond if the projected levels of funding from both mission and G bureau and expected donor supplied commodities did not come through?

Outcome: Discussions on the issue of funding and uncertainties about mission OYB was postponed. It will be discussed at a later meeting specifically set to discuss the broader mission OYB allocation.

On high dependency on other donor supplied commodities, OPH first reckons that it can not do everything in the sector but to collaborate with other donors, secondly, OPH has reached a situation where its dialogue with other donors now makes a difference, and lastly it is hoped that the GOK will gradually and eventually take over the supply of these commodities.

Sustainable provision of some of these commodities is also covered through the Condoms Independence Initiative and the Vaccine Independent Initiative.

Counterpart contributions does not meet the 25% requirement. Are there budgets/input from GOK to support its contribution?

Outcome: This has already been revised. However, there is no guidelines on whether calculation of counterpart contribution should be based on total project cost inclusive of central funds or whether the 25% counterpart contribution only applies to the AID bilateral funds provided for the project. Controller's Office will check this and advise.

Financial plan section is incomplete i.e no USAID management or OE expenses costed.

Outcome: OE expenses under the project will be included in the PP. The current Financial Plan will also be further worked on to present several options in response to the expected constraints in OYB levels.

4. Sustainability:

Very few local organizations are being proposed as the direct implementing entity of the project activities. Why is this so? How will the project activities be carried out once APHIA phases out?

The CAs assistance will be predominantly focussed at strengthening the capacity of local NGOs in the sector. All the CAs currently targeted are aware of the institutional capacity building.

Whereas it is important to have targets dates, how realistic is it to assume that by the year 2000, all the assisted organizations will have become self reliant and USAID assistance for the sector is no longer required?

Outcome: APHIA is designed as a program planned for inevitable phase-out of USAID assistance and focus primarily on sustainability. CPH is confident of achieving this sustainability because most of the organizations targeted for the assistance are the same organizations PH has worked with for several years and now what APHIA will do is to help them build capabilities for sustainable provision of services they are providing.

4/4/71

UNCLAS AID ADM

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ACTION: AID-1
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~~PROG/CONT~~ Project 615-024

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Action taken None
No action necessary 4/5/95
(Initials) (Date)

AID ADM

E.O. 12356: N/A

TAGS:

SUBJECT: GSS5 ALLOWANCE - NAIRCB:

1. APPROPRIATION 725/61014, BUDGET PLAN CODE GSS5-95-21615-KG13 INCREASED BY DOLLARS 2,200,000 FOR PROJECT 615-0249, KENYA EXPORT DEVELOPMENT SUPPORT (PA). NOTE: THIS AMENDMENT ALSO ~~CORRECTS BPC~~ ~~FOR PROJECT~~ FROM FAMILY PLANNING SERVICES & SUPPORT II, ~~POPULATION HEALTH INTEGRATED ASSISTANCE~~ - PREVIOUSLY ALLOWED UNDER AMENDMENT 02. TOTAL ALLOWED TO DATE UNDER THIS BPC IS DOLLARS 14,350,000.

2. ADVICE OF BUDGET ALLOWANCE FOLLOWS.

CHRISTOPHER
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**INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION**

PROJECT COUNTRY: Kenya

PROJECT TITLE: Assistance to the Population Health Sector/615-0264

PROJECT FUNDING: 50,000,000

IEE/CE PREPARED BY: Gary Newton, USAID/Kenya

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination:	
Negative Determination:	
Categorical Exclusion :	XX

SUMMARY OF FINDINGS:

Pursuant to 22 CFR Section 216.2(c)(2)(viii) of USAID's Environmental Procedures, "Projects involving nutrition, health care of population and family planning services" are "categorically excluded" from the Agency's environmental review requirements except to the extent that they are designed to include activities directly affecting the environment. This project proposes no construction or other activities which might directly affect the environment. Accordingly, it is recommended that this project receive a Categorical Exclusion as its Environmental Threshold Decision.

MISSION CONFERENCE: John R. Westley
Mission Director

Date: _____

CLEARANCES: Eric R. Loken, REO: _____ ; AVance, RLA: _____

[Signature]
Bureau Environmental Officer
APR/ARTS/PAWA

Date: 3/3/95

GC/AFR: *[Signature]*

Date: 3/3/95

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Kenya
PROJECT TITLE/NUMBER: Assistance to the Population Health Sector/615-0264

PROJECT FUNDING: 50,000,000

IEE/CE PREPARED BY: Gary Newton, USAID/Kenya

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination: _____
Negative Determination: _____
Categorical Exclusion : XX

SUMMARY OF FINDINGS:

Pursuant to 22 CFR Section 216.2(c)(2)(viii) of USAID's Environmental Procedures, "Projects involving nutrition, health care or population and family planning services" are "categorically excluded" from the Agency's environmental review requirements except to the extent that they are designed to include activities directly affecting the environment. This project proposes no construction or other activities which might directly affect the environment. Accordingly, it is recommended that this project receive a Categorical Exclusion as its Environmental Threshold Decision.

MISSION CONCURRENCE: John R. Westley Date: 6/7/94
John R. Westley
Mission Director

CLEARANCES: Eric R. Loken, REO: ERL; ^{SPage} ~~AVance~~, RLA: SP

Bureau Environmental Officer,
AFR/ARTS/FARA Date: _____

GC/AFR: _____ Date: _____

INITIAL ENVIRONMENTAL EXAMINATION (IEE)

Assistance to the Population Health Sector in Kenya

I. Project Description

The purpose of the Assistance to the Population Health Sector (APHS) Project is to continue to build upon the success of the Family Planning Services and Support Project (FPSS, 1985-1993) in assisting the Government of Kenya (GOK) to improve the effectiveness of service delivery programs for family planning and, in addition, to address the growing HIV/AIDS epidemic. Achievement of these objectives contributes directly to USAID/Kenya's goal of promoting sustainable, broad-based economic growth.

This project consists of three major components, including: support for the public sector, non-governmental organizations and a small component to assist the commercial, for-profit sector to develop support systems for the delivery of high quality family planning services and HIV/AIDS prevention activities. This will be accomplished through the provision of technical assistance, training and commodity support under each of these three sectoral components.

II. Recommended Environmental Threshold Decision

Pursuant to 22 CFR Section 216.2(c)(2)(viii) of USAID's Environmental Procedures, "projects involving nutrition, health care or population and family planning services" are "categorically excluded" from the Agency's environmental review requirements except to the extent that they are designed to include activities directly affecting the environment. This project proposes no construction or other activities which might directly affect the environment. Accordingly, it is recommended that this project receive a Categorical Exclusion as its Environmental Threshold Decision.

To ensure that concerns are properly addressed regarding possible environmental contamination and/or inadvertent transmission of highly contagious diseases, e.g., HIV/AIDS, associated with certain aspects of planned project activities, this Categorical Exclusion is recommended subject to the following conditions:

1. That environmentally sound and safe sanitary practices will be adhered to in the disposal of all medical wastes generated through the testing, treatment and/or prevention of any/all such highly contagious diseases; and\

2. That all adult education programs designed to prevent the spread of such diseases include appropriate training on sanitary disposal practices for potential sources of contamination and/or infection. e.g. condoms.

Drafted: PH/REO:GLEinen/ELcken:lm:06/03/94
Clearance: PH/PRJ:SPagama/SMeyer___

U:\USAID\USAID.PED\DOCS\MAD\EX-ANNEX.B

Project 615-0254



MINISTRY OF HEALTH

OFFICIAL FILE

Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 717077
When replying please quote

OFFICE OF THE PERMANENT SECRETARY
AFYA HOUSE
CATHEDRAL ROAD
P.O. Box 30018
NAIROBI



REF No. IB/11/2/1

Date 27th March, 1995

Mr. George Jones, Mission Director
USAID Mission to Kenya
Post Office Box 30261
NAIROBI.

Dr. Mr. Jones,

USAID co-operation with the Ministry of Health in promoting health, family planning, and health care financing programs has been instrumental in bringing about declines in the fertility rate and improvements in the health status of Kenyans.

However, in spite of these achievements, it is widely recognized that our growing population and increasing demands for health care, brought on in part by the HIV/AIDS epidemic, outstrip the ability of the Government to provide effective service without external assistance.

Cognizant of the interests of the United States Government to stabilize population growth and protect human health, the Government of Kenya requests assistance to undertake a five year program which will reduce fertility and risk of HIV/AIDS transmission through sustained and integrated health/family planning service delivery.

Based on preliminary analysis and discussions, the Ministry estimates the need for US\$50 million in bi-lateral grant assistance supported by an expected additional \$50 million in central assistance from USAID/Washington. The Ministry of Health and participating Non-Governmental Organizations will contribute at least US\$16.67 millions as a required 25 percent in-kind counterpart contribution.

The Ministry of Health appreciates the past assistance and looks forward to continued collaboration.

Sincerely,

Dei
D.L. MAKHANU
AG. PERMANENT SECRETARY

ACTION COPY

Action taken _____
No action necessary _____

9.5 / 2308

615-0254	ACTION OFFICE	INFO	DIR	REDSO	REPIC	PHUDO	ISQA	RIGI	PRCO	PRJ	PBO	PH	AGR	COMT	BYO	PER	CSO	LINE	PLAS	COREC	MP	CHRON