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STAFF APPRAISAL REPORT

KENYA

FOURTH POPULATION PROJECT

MARCH 9, 1990

Population and Human Resources Division
Eastern Africa Department

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KENYA: FOURTH POPULATION PROJECT

CURRENCY EQUIVALENTS[a/]

Currency Unit	=	Kenya Shilling (KSh)
KSh 20	=	Kenya Pound (KL) 1
US$ 1.00	=	KSh 21.78 (Feb. 15, 1990)
US$ 1.00	=	SDR 1.33[b/]

METRIC EQUIVALENTS

1 meter (m)	=	3.28 feet
1 square meter (sq.m)	=	10.76 square feet
1 kilometer (km)	=	0.62 miles
1 square kilometer (sq.km)	=	0.386 square miles

GOVERNMENT FISCAL YEAR

July 1 = June 30

a/ Since August 1985 the Kenya shilling has been pegged to a basket of currencies. The rate vis-a-vis the US dollar fluctuates. A rate of US$1.00 = KSh 22 has been used in appraising this project.

b/ As of February 16, 1990.

This Report is based on the findings of an appraisal mission which visited Kenya in November 1989 and consisted of Dr. V. Jagdish, Ms. J. Armstrong (Bank Staff), and Messrs/Mmes. N. Binkin, A. Hudgins, K. Ichoya, B. Jacobson, and P.C. Mohan (Consultants). Mr. Peter Godwin represented ODA on the mission. Mr. Dennis Mahar, Chief AF2PH participated in the last week of the mission.

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Abbreviations

CBD	Community Based Distribution
CPR	Contraceptive Prevalence Rate
CMASK	Crescent Medical Aid Society of Kenya
DFH	Division of Family Health, Ministry of Health
DPFPC	District Population and Family Planning Committee
DPO	District Population Officer
ECN	Enrolled Community Nurse
FINNIDA	Finnish International Development Agency
FP	Family Planning
FPAK	Family Planning Association of Kenya
GDP	Gross Domestic Product
GNP	Gross National Product
GOK	Government of Kenya
ICB	International Competitive Bidding
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IRHFP	Integrated Rural Health and Family Planning
IUD	Intra-uterine Device
KAP	Knowledge, Attitude and Practice
KCPS	Kenya Contraceptive Prevalence Survey
KCS	Kenya Catholic Secretariat
KDHS	Kenya Demographic and Health Survey
KFS	Kenya Fertility Survey
KNH	Kenyatta National Hospital
KRCN	Kenya Registered Community Nurse
LCB	Local Competitive Bidding
LIB	Limited International Bidding
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MSCU	Medical Supplies Coordinating Unit
MOH	Ministry of Health
MOHANH	Ministry of Home Affairs and National Heritage
MTTAT	Ministry of Technical Training and Applied Technology
NCPD	National Council for Population and Development
NGO	Non-Government Organization
NORAD	Norwegian Development Agency
ODA	Overseas Development Administration
SDA	Seventh Day Adventist
SDP	Service Delivery Point
SDR	Special Drawing Right
SIDA	Swedish International Development Agency
SOE	Statement of Expenditure
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VFT	Vaginal Foaming Tablets
VSC	Voluntary Surgical Contraception

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KENYA: FOURTH POPULATION PROJECT

Definitions

Term	Definition
Age Specific Fertility Rate:	Number of live births to women in a given age group per 1,000 woman in the same age group, in a given year.
Contraceptive Prevalence Rate:	The percentage of married women of reproductive age who are using (or whose husbands are using) any form of contraception.
Crude Birth Rate:	The number of births per 1,000 population in a given year.
Crude Death Rate:	The number of deaths per 1,000 population in a given year.
Dependency Ratio:	The ratio of the economically dependent part of the population to the productive part, arbitrarily defined as the ratio of the young (those under 15 years of age) plus the elderly (those 65 years of age and over) to the population in the "working ages" (those 15 to 64 years of age).
Infant Mortality Rate:	The number of deaths of infants under one year old in a given year per 1,000 live births in that year.
Life Expectancy at Birth:	The average number of years a newborn would live if current age-specific mortality rate trends prevailing at the time of birth were to continue.
Net Reproduction Rate:	The average number of daughters that would be born to a woman (or group of women) if during her lifetime she were to conform to the age specific fertility and mortality rates of a given year. A net reproduction rate of 1.00 means that each generation of mothers is having exactly enough daughters to replace itself in the population.

Rate of Natural Increase:	The rate at which a population is increasing (or decreasing) in a given year due to surplus (or deficit) of births over deaths expressed as a percentage of the base population.
Rate of Population Growth:	The rate at which a population is increasing (or decreasing) in a given year due to natural increase and net migration, expressed as a percentage of the base population.
Total Fertility Rate:	The average number of children that would be born alive to a woman (or group of women) during her lifetime if during her child-bearing years she were to bear children at each age in accord with prevailing age-specific fertility rates.

KENYA: FOURTH POPULATION PROJECT

Basic Data[a/]

Area	569,249 sq.km
Population (1989)	23.3 million
Rural	18.1 million
Urban	5.2 million
Population Growth Rate	3.6%
Population Density	40 persons/km^2
Crude Birth Rate	46.3/1000 births
Crude Death Rate	10.4/1000 deaths
Infant Mortality Rate	68/1000 births
Total Fertility Rate[b/]	6.7 children per woman
Contraceptive Prevalence Rate[b/] (1989; all methods)	27%
GNP per capita (1988)	US$360

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a/ Population and demographic indicators, except where noted, are World Bank estimates.

b/ Data are taken from the Kenya Demographic and Health Survey (KDHS), 1989, (the Tocal Fertility Rate (TFR) is the average rate for the five year period preceeding the survey).

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MAP IBRD No. 21992

KENYA: FOURTH POPULATION PROJECT

Credit and Project Summary

Borrower: Government of Kenya

Amount: SDR 26.3 million (US$35.0 million equivalent)

Beneficiary: National Council for Population and Development (NCPD), Ministry of Home Affairs and National Heritage; and Ministry of Health (MOH)

Project Objectives:

The proposed project has three main objectives: (a) to further increase the availability, accessibility, and quality of family planning services provided by the Government and Non-Government Organizations (NGOs); (b) to further strengthen the demand for family planning services through expansion of Information, Education and Communication (IEC) programs to additional government ministries and NGOs; and (c) to further strengthen the capacity of the NCPD to plan and monitor the expanding national population program.

Project Description: The project would increase the availability, accessibility and quality of family planning services provided by Government and NGOs by provision of adequate supplies of contraceptives to cope with increasing demand and through the improvement and strengthening of the logistics system for contraceptives. The project will also support the establishment of a surveillance system for clinical contraception. Regarding demand, the project will further expand the coverage of information and education activities by strengthening mass media and publicity campaigns and continuing to encourage the integration of IEC activities with other governmental and non-governmental development programs. The project would also continue to strengthen the NCPD and to expand district level population programs.

<u>Risks:</u>

As with the earlier population projects in Kenya, the main risks of this project relate to the administrative, managerial and financial capabilities in the Division of Family Health of the MOH and the ability of the NCPD to coordinate and manage an expanding multi-sectoral program. NCPD staffing has steadily increased over the past few years and a staff development plan is being implemented. The NCPD is becoming more effective in managing an expanding population program and is expected to continue to do so. With support for management strengthening, and closer supervision by senior MOH management the Division of Family Health is expected to become more effective.

Project Data: **KENYA: FOURTH POPULATION PROJECT**

A. Estimated Costs:

	US$ million		
	Local	Foreign	Total
1. Contraceptive Supply and Surveillance	2.0	11.8	13.8
2. Promotion of Family Planning Services	4.9	4.1	9.0
3. National Council for Population Development	5.4	7.1	12.[illegible]
4. Research and Evaluation	1.5	--	1.5
Total Base Cost	13.8	23.1	36.9
Total Contingencies	1.8	2.6	4.4
Total Project Cost	15.6	25.7	41.3

B. Financing Plan:

	Local	Foreign	Total
Government of Kenya	3.3	0.8	4.1
USAID	--	2.2	2.2
IDA	12.3	22.7	35.0
Total Project	15.6	25.7	41.3

C. Estimated Credit Disbursements:

IDA Fiscal Year (US$ million)

	FY91	FY92	FY93	FY94	FY95	FY96	FY97
Annual	2.0	3.4	4.9	6.3	7.3	6.0	5.1
Cummulative	2.0	5.4	10.3	16.6	23.9	29.9	35.0

D. Economic Rate of Return: Not Applicable

E. Map: IBRD No. 21992

I. POPULATION SECTOR STATUS AND ISSUES

Introduction

1.01 Over the past few months a number of positive developments in Kenya's population program have become apparent. Results of a Demographic and Health Survey conducted earlier this year show that there has been a significant increase in the contraceptive prevalence rate. Contraceptive usage has risen by 50% in the past five years. About 27% of married women are currently using some method of contraception. Nearly two-thirds of these are modern methods. These trends have translated into an estimated fertility decline from 7.7 children per woman in 1984 to 6.7 at present.

1.02 The results of the demographic and health survey are very good news for Kenya which has experienced increasing population growth rates since Independence. This rapid population growth has placed enormous strains on the country's education system, labor market and natural environment, thus acting as a serious constraint to national economic and social development. And while it is unlikely that the dramatic decline in the total fertility rate will be immediately translated into a precipitous fall in the population growth rate, nonetheless it is crucial to maintain the recently gained momentum in Kenya's population program.

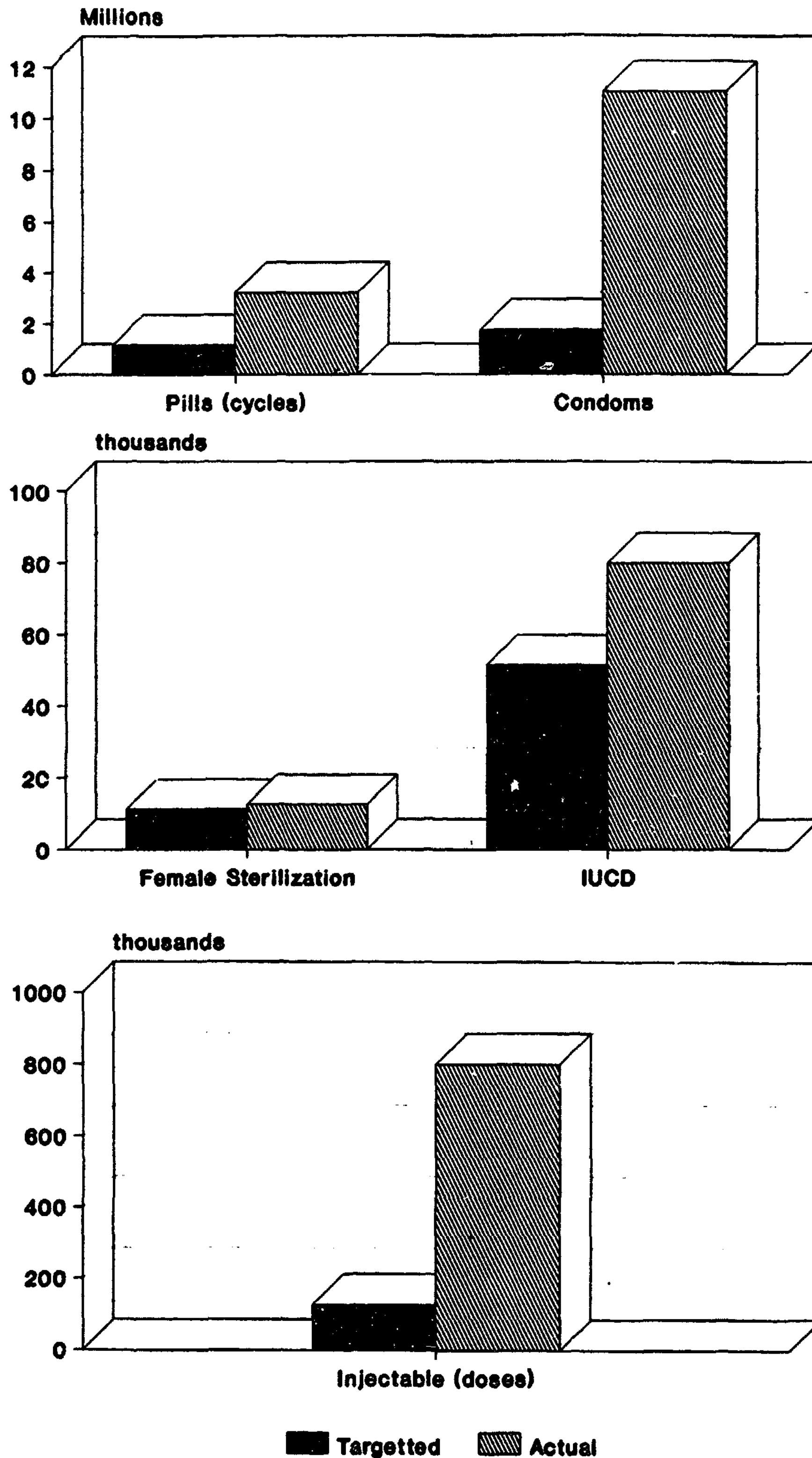
1.03 As a result of the acceleration in demand, all of the family planning targets set at the time of approval of the Third Population Project have been surpassed. (See Figure 1) The demand for all types of contraceptives has increased dramatically: actual use of condoms in 1988 was nearly ten times the estimated target; demand for injectables, estimated to be 127,000 doses, was 800,000 doses; and, use of pills was more than twice the target figure. Such growth in the use of contraception shows no immediate sign of slowing. After years of inactivity and little progress, Kenya's population program appears to have finally taken off.

1.04 A number of factors help to explain the recent progress of Kenya's population program. Undoubtedly the most important of these has been the strong and sustained commitment at the highest levels of Government, particularly the Office of the President, to addressing the causes and consequences of rapid population growth. This high-visibility support has made a major contribution to changing traditional attitudes of Kenyans toward population and family planning.

1.05 Considerable improvements have also been made on the supply side. Learning from experience accumulated over more than two decades, public and private (especially NGO) delivery systems have been vastly expanded. The National Council for Population and Development (NCPD), the agency responsible for overall coordination of Kenya's population program, has at the same time been substantially strengthened both administratively and financially. A final ingredient of success for the program has been strong donor support, including NORAD, ODA, SIDA, UNFPA, USAID plus three IDA credits totalling around US$45 million.

FIGURE 1

Contraceptive Methods
Targets and Actual, 1988



1.06 The Kenyan population program is now at a critical juncture. Although the recent achievements are encouraging, there is a serious risk that further progress will be jeopardized by shortage of contraceptive supplies and weak demand in provinces with low contraceptive prevalence rates. Furthermore, there is evidence from Asian population programs that contraceptive prevalence tends to reach a plateau of about 25-30% unless new incentives are introduced, such a women's income generating activities which have resulted in further substantial fertility decline. Under no circumstances can Kenya afford a break in contraceptive supplies, notably injectables. It is under these circumstances that the current population project is proposed. The project, quickly following the Third Population Project. fills gaps that are mainly attributable to the recent positive developments in the program.

1.07 The following paragraphs deal in greater depth with the demographic situation, population policy and past experience with population programs, sectoral issues, IDA's role and the rationale for the proposed project.

A. Demographic Status

Recent Developments

1.08 Fertility decline. The most significant result of the recently released Kenya Demographic and Health Survey (KDHS) is the dramatic reduction in the total fertility rate (TFR) during the past five years from 7.7 to 6.7. (See Figure 2) The reported drop in the fertility rate has been observed throughout the country (see Annex 1, Table 1). Yet despite this achievement, important fertility differentials still exist among Kenyan women associated with area of residence and level of education. For example, Nairobi has a TFR of only 4.6 while in Western Province the TFR is still above 8. Women in urban areas tend to have 4.8 children with rural women having just over 7 children. Similarly, fertility differs according to education levels achieved by women: those with no education had an average 7.2 children compared to women with secondary or higher having almost 5.

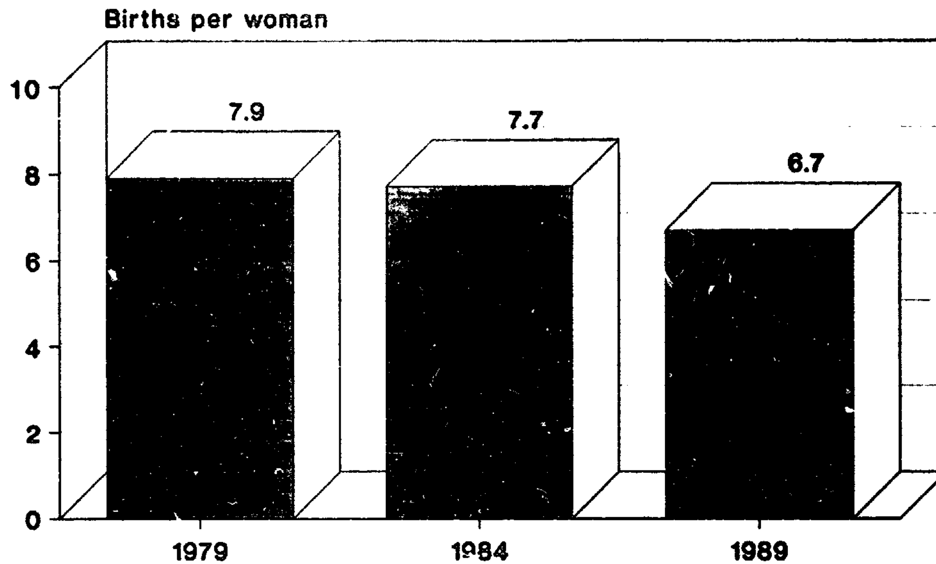
1.09 Contributory factors. Accounting for the reported fertility decline is a complex task and detailed analysis of the KDHS remains to be done. Historically, however, factors which have contributed to the drop in fertility have been increased use of contraceptives (a so-called "proximate" cause) and socio-economic determinants such as increased age at marriage and women's educational status. The results of the KDHS have indeed shown the dramatic rise in the contraceptive prevalence rate (CPR), which increased by 50% during the past five years. And, while reported use of all methods rose, there was a shift toward more modern methods. (See Figure 3) As with the TFR, there are substantial variations at the provincial level despite reported increases country-wide. (See Annex 1, Table 2) The KDHS data also show that even though Kenyan women tend to marry young, the age at first marriage has increased. The proportion of women who marry before age 15 has declined from 25% of women now aged 40-44 to only 4% of women aged 15-19. (See Annex 1, Table 3) Educational levels

attained by women have also risen over time. The proportion of women aged 15-49 with no education declined from 44% in 1977/78 to 25% in 1989.

1.10 Other factors. There is need for further research to isolate the determinants of Kenya's apparent fertility decline. However, preliminary analysis of the KDHS indicate that one possible factor explaining falling fertility in the Kenyan case is the relative cost of children. Children are becoming increasingly "expensive" as families are paying for items such as school uniforms, books and making contributions to harambee funds for schools. The Government's recent introduction of user charges for health services (other than preventive care for children) will also contribute to the share of household income going towards investment in school-aged children.

1.11 Fertility and population growth. The degree to which the observed decline in fertility becomes translated into a fall in the population growth rate by altering the underlying age structure is only ascertainable by a full population census. Although the results of the 1989 Census for Kenya have not been released, it is unlikely that a noticeable fall in the population growth rate will be observed immediately given the underlying age structure of the population. Kenya's population will continue to grow rapidly despite the drop in the TFR because of the growing percentage of women entering their childbearing years. In other words, although the number of children per woman is falling, there will be more women of reproductive age in absolute terms. (See Annex 1, Table 4)

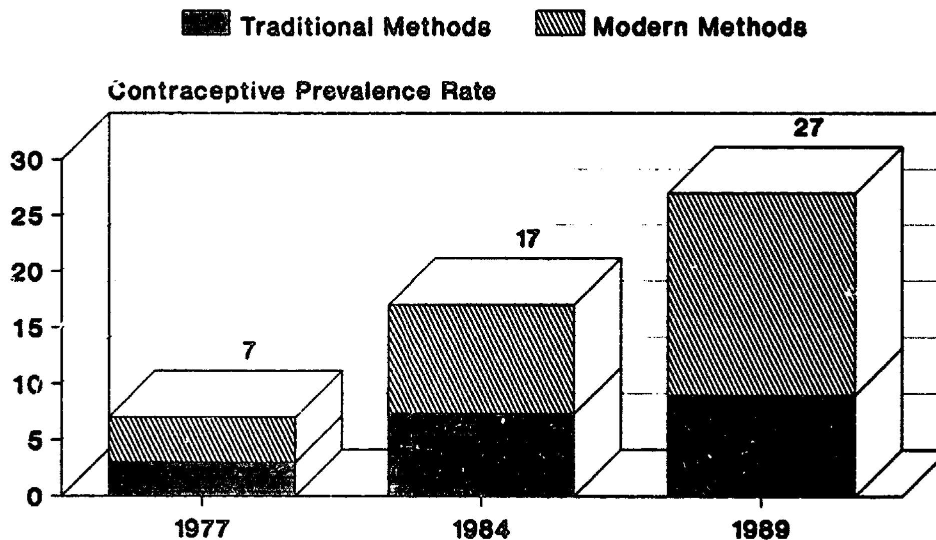
FIGURE 2
TOTAL FERTILITY RATE



Source: KDHS, 1989

For Women Aged 15 - 49

FIGURE 3
CURRENT CONTRACEPTIVE USE 1/



Sources: KFS 1977, KCPS 1984, KDHS 1989

1/ Married Women of Reproductive Age

1.12 Consequences. The consequences of rapid population growth are evident. Kenya's population will continue to be young. Based on projections from the 1979 Census, over half of Kenya's people are under the age of 15 and will remain so until the year 2000. (See Annex 1, Table 4) The youthfulness of the population has a direct bearing on the ability of the education system to accommodate larger cohorts entering schools. In the near term, it is unlikely that the size of the school-age population will diminish, despite falling fertility. Similarly, the ability of the economy to absorb increasing numbers of entrants into the labor force is also strained. Any decrease in fertility levels today will have little or no moderating impact on the growth of the labor force during the present century.

1.13 Despite the limited effect of the drop in fertility in the short-term, two points are worth stressing. First, that the drop in fertility is a very positive development rate in the African context and may well herald the demographic transition to low growth, accompanied by both low birth and death rates. Furthermore, had the current decline in fertility not occurred, the negative consequences of a rapidly growing population would have been exacerbated. Second, there is still much more that can be done in the short-term to push fertility even lower. The KDHS has highlighted two areas in particular where immediate efforts are warranted, and form the basis for the proposed project: a need for an increased and uninterrupted supply of contraceptives; and, an expansion of IEC activities in regions where TFRs remain high and CPRs are low.

B. Population Policy and Programs

1.14 Voluntary efforts to provide family planning through information, education and communication (IEC) and services began in the early 1950s. These pioneering efforts led to the establishment of the Family Planning Association of Kenya (FPAK) in 1961. In 1967 the Government of Kenya (GOK), recognizing the potential severe impediment to economic and social development implied by rapid population growth, planned and implemented Sub-Saharan Africa's first national Family Planning program.

1.15 In 1984 the Government established as policy 1/ the reduction of population growth by achieving a sustained decrease in fertility. The goals of the policy are to: encourage Kenyans to have small families; motivate males to adopt and practice family planning; reduce infant and child mortality; improve the status of women; and, provide the population with appropriate family planning education and contraceptive services. The policy includes the promotion of population information activities, in general, and in particular family life education in schools and population awareness through the mass media. Regarding other services, the Government stresses that it will only support services

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1/ Population Policy Guidelines, Sessional Paper No. 4, 1984.

that are non-coercive. Induced abortion is strictly illegal. Voluntary sterilization requires written consent of the patient.

1.16 To achieve these goals, the Government has launched a broad effort on the part of ministries, NGOs and community leaders to guide, organize and integrate population and development programs. Particular attention is to be paid to the role of schools. In noting changing traditional norms, the need for population and family life education is stressed.

NCPD and its Evolving Role

1.17 To coordinate the population activities of the ministries, NGOs and the private sector, the Government created in 1982 the NCPD in the Office of the Vice President and Ministry of Home Affairs and National Heritage. The Council initially coordinated the Government's IEC Program. In 1984, however, it was assigned a broader mandate which included: the development and promotion of a population policy; the design of IEC, research and service programs; and the monitoring and evaluation of population program activities. In 1986, the NCPD's responsibilities were revised to include the coordination of population activities at the district level. The NCPD's Secretariat is divided into four divisions: the Planning, Research and Evaluation Division; the Finance and Administrative Division; the Programs Division; and the IEC Division. The Secretariat is charged with oversight of all projects approved by the Council and implemented by NGOs and Government ministries.

1.18 The NCPD has funded population IEC activities in various NGOs including: the Family Planning Association of Kenya (FPAK), the National Council of Churches of Kenya (NCCK), Maendaleo Ya Wanawake (MYWO), the Christian Health Association of Kenya (CHAK), the Salvation Army, the YMCA, the Kenya National Union of Teachers (KNUT), and the Family Life Counselling Association of Kenya. In addition to supporting NGOs for IEC activities, the Third Population Project is funding FP clinics for the FPAK and upgrading 20 dispensaries for CHAK.

1.19 The NCPD has also encouraged the dissemination of population/FP information by Government ministries. The Office of the President is responsible for the organization and conduct of population-education seminars for chiefs and assistant chiefs, while the Ministry of Information and Broadcasting has been contracted to produce radio and television soap operas aimed at increasing the general acceptance of family planning.

1.20 In 1986 the Office of the President issued "Guidelines for District Population and Family Planning Committees" to ensure that population and family planning activities were integrated with district development efforts. The impact of rapid population growth rates on local services is now strongly emphasized. District Population and Family Planning Committees (DPFPCs) are being established in all districts. These committees, composed of representatives of government ministries, the district administration and locally active NGOs have as their secretary the District Population Officer (DPO). The DPO is answerable to the District Commissioner and functionally to the NCPD. DPFPCs are expected to

encourage local populations to accept small family norms; set local family planning acceptor targets and promote the reduction of fertility; promote programs to reduce infant and child mortality; and oversee activities involving family life and population education. DPFPCs will also review district level population programs. The success of this program to decentralize the administration of population activities depends on the ability of the NCPD to establish strong district offices and to provide them with appropriate supervision and support. To ensure the success of this effort, the functions of the population committees and officers must be carefully programmed. The district focus program is being implemented in a phased manner with fourteen districts already chosen for Phase I through the Third Population Project, with all DPOs in place. The Second National Leaders' Conference gave great weight to the district program and recommended rapid placement of DPOs and the establishment of district population offices in all districts.

Ministry of Health

1.21 Governmental efforts to provide family planning services began in 1967 when Sub-Saharan Africa's first national Family Planning (FP) program was launched. The program, designed to limit the size of families and to provide clients with modern methods of child spacing, was characterized by the integration of maternal and child health (MCH) services with family planning. The 1969 Census showed that despite launching of FP activities the rate of population growth had actually increased. The Government then gave the MOH responsibility for implementation of a five-year MCH/FP program. This program too failed to meet its FP goals. The MOH was severely constrained by lack of trained staff, inadequate facilities, poor management and a lack of commitment to deliver FP services. In retrospect it was determined that there had been too much reliance on one single agency (MOH) to provide FP services. Through the Integrated Rural Health and Family Planning Project and more recently through the Third Population Project a series of steps are being taken to strengthen the role of the MOH in FP service delivery.

1.22 The Division of Family Health in the MOH is charged with the responsibility of planning and implementing the FP program. It has, in the past, suffered from weak leadership, poor management and an inability to communicate with other MOH units and the NCPD. The past year has seen a considerable improvement in the Division's status. First, a Senior Deputy Director of Medical Services has been appointed its Director. Secondly, additional staff have been appointed to the FP program. This has resulted in considerable improvements in communication with other MOH units and the NCPD. Despite this promising trend much needs to be done to further improve the management of the Division of Family Health. Unit and job descriptions have not been prepared and this has resulted in a lack of clear responsibilities for program management. A condition of effectiveness is that the MOH submit an organization structure for the Division of Family Health for review and comment by IDA and a plan for its implementation (para. 7.01(a)).

Other Ministries

1.23 Several other ministries and departments receive support for the integration of population IEC activities within their on-going programs. The Ministry of Agriculture and Livestock Development has been supported in its efforts to train extension personnel to incorporate population and family planning information in their advice to farmers. In a similar fashion, funds have been provided to the Department of Social Services for the training of field staff and to the Department of Adult Education for the training of teachers and the development of population teaching materials for adult education classes. In addition, the program provides direct support to the MOH Health Education Unit for the development and dissemination of educational materials relating to health and family planning.

NGO Activities

1.24 NGOs have played a critical role in the development of Kenya's population program. During the early years of the program NGOs were primarily involved in demand creation activities. By 1988 their roles evolved to include service delivery. The recent KDHS shows that NGOs and other non-government providers account for almost 30% of services delivered. Government support for NGOs has been strong. The NCPD makes grants to NGOs to undertake population activities. Continued support from NCPD is contingent on the performance of the NGO concerned. Problems arise between the NCPD and NGOs, though significantly less than in the past, primarily because of the questions of release of funds and accountability. The issue of sustainability of NGO activities is becoming important since virtually all support for NGOs is coming from external sources. A study of sustainability of NGO activities is being undertaken through the Third Population Project.

C. Sectoral Issues

1.25 Due to strong and consistent political support and intensive IEC activities, the KDHS has reported a major increase in the use of contraceptives over the last five years. Furthermore, based on questions regarding ideal family size and the desirability of more children, there is evidence of untapped demand for contraceptives and that the CPR can be pushed even higher. Ideal family size has declined from 6.3 to 4.4, or by almost two children between 1984 and 1989. And, the percentage of mothers who "don't want more children" increased over the same five years from 31.5% to nearly 50%. (See Annex 1, Table 5). More women know about family planning methods--90% of women interviewed in the KDHS knew of at least one method of contraception, and nearly the same percentage also approved of family planning. In certain provinces like Coast, Western, Nyanza and Northeastern, however, CPR levels are still low. In such areas, the challenge is to develop province-specific IEC programs to raise awareness and thus increase CPR. While the rise in the CPR from 17% to 27% in the space of five years is impressive, Kenya's population strategy must

be carefully designed to avoid plateauing of the CPR. 2/ On the demand-generation side, there is evidence to suggest that the promotion of women's income-generating activities results in marked fertility decline. (see para. 2.24 below). Development of new activities such as this are necessary to avoid plateauing.

1.26 On the supply-side, the availability and accessibility of contraceptives is crucial to sustaining the CPR and encouraging new acceptors. Of particular importance is the growing role of injectable contraceptives. Despite earlier uncertainty and controversy injectable contraceptives are now widely accepted by most international and national family planning authorities as a highly effective and safe form of contraceptive (see Annex 6). The role of NGOs in providing family planning services has been a substantial supplement to MOH outlets. Taken together, there are over 850 family planning service delivery points throughout Kenya. Communication and coordination between the Ministry of Health and NGOs is key to developing an effective logistic and distribution system. It is necessary to have in place a system that ensures that there are ample supplies of contraceptives and one that can respond to changing demand.

D. Role of the Bank

1.27 IDA involvement in the Kenyan family planning program has evolved over the past twenty years and reflects changes in prevailing government policy. Initially, IDA support for population activities was channelled solely through the Ministry of Health, with family planning services delivered through MOH facilities. The First Population Project (Cr. 468-KE for US$12 million) began in 1974 and worked to strengthen the provision of health services, particularly at the primary level.

1.28 The second IDA lending operation which began in 1982 was the Integrated Rural Health and Family Planning Project (Cr. 1238-KE for SDR 20.5 million). The objectives of this project were to create demand for family planning services and expand access to family planning in rural areas, while continuing to reduce mortality and morbidity. As the population program matured it became evident that the project was not meeting changing needs. The project was redesigned and amended in 1985 to strengthen FP services in urban areas and district hospitals where there was large unmet demand. Implementation has recently picked up. The NCPD component is complete and the MOH components are likely to be completed by June 1990.

2/ Plateauing is defined as the flattening out of the CPR after regular continued annual increases. Traditionally, population programs in Asia have seen CPRs level off initially at around 35%, because of saturation of unmet demand and limitations of existing programmatic and managerial approaches. They have finally levelled off between 65-70% with the introduction of new and innovative approaches.

1.29 The Third Population Project (Cr. 1904-KE for SDR 9 million) which began in 1989 entailed a change in IDA strategy in Kenya. For the first time population issues were appraised separately from health and a free standing population project was designed. And while the focus of lending narrowed, the scope of agents involved broadened. The approach became multi-sectoral and other government ministries and NGOs played an active role in both the generation of demand for and delivery of family planning services. The demand for services continued to be promoted through IEC activities. At the same time, the project supports the raising of the availability, accessibility, and quality of family planning services, now provided by government and NGOs. In addition, the project supports the strengthening of the NCPD's capacity to plan, program, coordinate and monitor this multi-sector population program. (See also Staff Appraisal Report: Kenya Third Population Project, No. 7053-KE)

1.30 Implementation of the Third Project has now begun. However in the time since the Project was designed, the KDHS has identified several emerging gaps in the Kenya population program. Specifically, the KDHS revealed that demand for contraceptives was not only higher than figures used for appraisal, but likely to continue to increase. As a result, the requirements for contraceptive supplies estimated during the appraisal of the Third Population Project have been far surpassed (see para. 1.03). The Survey also pointed out that there are specific regions of the country (Western and Coast Provinces) where CPRs are very low and require targeted IEC activities. Hence, the broad objectives of the proposed Project will be to fill these newly identified gaps as well as to address the longer-term issue of CPR plateauing.

E. Other Donors

1.31 Kenya's population program has been strongly supported by external donors from the very beginning. UNFPA has been playing a key role in donor coordination and has developed mechanisms for regular consultations between donors and the Government. USAID has been the largest bilateral donor in the population sector. It is involved in virtually all aspects of Kenya's population program. NORAD, ODA, and SIDA have also been strongly supporting the population program. It is expected that these donors will continue to play a key role in the development and implementation of the multi-sectoral population program. In addition, FINNIDA has recently indicated its interest in supporting population activities in Kenya.

II. THE PROJECT

A. Objectives and Design

2.01 The objectives of the proposed project are to: (a) further increase the availability, accessibility, and quality of family planning services provided by the Government and NGOs; (b) further strengthen the demand for family planning services through expansion of IEC programs to additional government ministries and NGOs; and (c) further strengthen the capacity of the NCPD to plan and monitor the expanding national population program. These objectives will be achieved by mobilizing and coordinating the resources of both government and NGOs and through close collaboration with donor assisted on-going population projects, particularly the IDA-assisted Third Population Project. Demand generation activities would be undertaken by NGOs in those areas where the 1989 KDHS shows low contraceptive prevalence rates thereby complementing NGO activities being implemented through the Third Population Project. To address the issue of plateauing, the project also supports women's income generating and IEC activities which are expected to result in substantial fertility decline in the medium and long term. The project also supports male motivation programs on a pilot basis. On the issue of supply, the project will ensure a steady supply of contraceptives to meet growing demand while continuing to expand family planning services through NGOs.

2.02 To achieve these objectives the project would:

(a) provide adequate supplies of contraceptives for both Government and NGO services to cope with increasing demand;

(b) introduce Norplant as a contraceptive method in the population program;

(c) improve and strengthen the logistics system for contraceptives, including a separate one for NGOs;

(d) establish a clinical contraception surveillance system including support for research on contraception;

(e) develop women's and men's activities (income generation with Family Planning, IEC and contraceptive distribution);

(f) introduce Family Planning, IEC and services through NGOs in districts with low contraceptive prevalence rates;

(g) strengthen the NCPD through expansion of district level population programs and provision of a national headquarters; and

(h) develop a national IEC strategy and an implementation plan.

B. Summary Project Description

2.03 The project is designed for implementation over a four-year period starting July 1, 1990. It consists of the following four major components, each subdivided into a number of sub-components:

(a) Increasing availability and accessibility of contraceptives (US$13.8 million): 3/

(i) Contraceptive supplies. Provision of vaginal tablets and injectable contraceptives;

(ii) Norplant. Introduction of Norplant (a subdermal implant) as a method of contraception in the population program through provision of training, technical assistance and supplies;

(iii) Logistics System for Contraceptives. Strengthen the existing MOH logistics system to provide contraceptives for MOH facilities through upgrading of warehousing, provision of vehicles, technical assistance and training; and

(iv) Surveillance of Clinical Contraception. Establish systems to monitor the side effects of clinical contraception through technical assistance, training and monitoring.

(b) Promotion of Family Planning Services (US$9.0 million):

(i) Ministry of Health. Construction and equipping of six voluntary surgical contraception units in Nairobi; equipment for provision of family planning services in 300 MOH health facilities;

(ii) Introduction of Surgical Contraception services through the private sector. Provision of equipment and supplies, qualified medical personnel and renting of facilities for a private clinic in Nyeri to introduce male and female surgical contraception services;

(iii) Income generation activities for Women's and Men's Groups. Introduction of income generating activities, family planning, IEC and contraceptive distribution to women's and men's groups through provision of technical assistance, training and development of small scale projects;

3/ Costs excluding contingencies.

(iv) Family Planning, IEC and Services through NGOs:
Family Planning Association of Kenya. Development of IEC programs in Western and Coast provinces;
Kenya Catholic Secretariat. Upgrading 40 clinics to provide integrated MCH and natural family planning services; and development of IEC programs in Western Province;
Seventh Day Adventists. Upgrading 10 clinics to provide MCH/FP services, construction and equipping of two voluntary surgical contraception unit in Nyanza province together with IEC programs;
Crescent Medical Aid Society of Kenya. Expansion of MCH/FP services in eight peri-urban areas of Nairobi, upgrading and equipping of one voluntary surgical contraception unit and for the development of IEC programs in those areas;
Northeastern Province. Development of IEC programs in Northeastern province.

(c) Strengthening the National Council for Population and Development (US$12.5 million):

(i) NCPD Headquarters. Construction and equipping of a national headquarters building for NCPD and for the FPAK;

(ii) District Focus. Establishment and construction of 14 additional District Population Offices, including office equipment, furniture, vehicles, technical assistance and training;

(iii) Long-term Manpower Development. Development for a manpower development plan for NCPD staff, and for a coordination of staff development and training activities throughout the population program;

(iv) IEC activities. Development of a national IEC strategy and implementation plan, including mass media activities.

(d) Research (US$1.5 million):

(i) Support for research on reproduction through the Institute of Primate Research;

(ii) A feasibility study for the local manufacture of injectable contraceptives (DMPA) and oral contraceptives; and

(iii) Technical assistance, supplies and research costs for operations' research including evaluation of the first phase of the district population program and KAP studies.

C. Detailed Project Description

(a) Increasing availability and accessibility of contraceptives - Contraceptive Supplies

2.04 Over the past 18 months there has been a steady increase in the demand for FP services which shows no signs of slowing down. The use of injectable contraceptives has increased from 300,000 doses in 1986 to about 915,000 in 1989. Pill usage has increased from 1.2 million cycles in 1986 to 3.2 million cycles at present. Condom usage has increased from about 2 million pieces in 1986 to nearly 11 million pieces at present. The number of surgical contraception procedures has also dramatically risen from less than 100 in 1982 to over 15,000 in 1989.

2.05 Demand for contraceptives is continuing to grow rapidly. There are currently no reserve stocks and shortages of supplies particularly oral pills (Microgynon), condoms, and injectable contraceptives (Depo-Provera) have occurred in the recent past. Needs for commodities for all formal population programs in Kenya have been estimated. These estimates are based on partial distribution data and verified with the recent KDHS data. The table below gives the requirements for commodities from 1990 to 1994 and includes an 18 month reserve stock to be build up by the end of 1990. Details of contraceptive commodity needs are provided in Working Paper I which is available in the project file.

Table 1 - KENYA - Estimates of Contraceptive Usage 1990-1994

	1990[1]	1991	1992	1993	1994
Oral Pills (millions)	8.4	4.3	4.9	5.3	5.9
Condoms (millions)	14.4	12.3	13.5	14.8	16.3
IUCDs (thousands)	105.6	72.6	79.0	87.0	96.0
Vaginal Foaming Tablets (millions)	5.2	2.8	3.1	3.4	3.7
Injectables (DMPA) (millions)	2.4	1.2	1.3	1.3	1.4

[1] Includes reserve stock of 18 months.

2.06 The project would support the procurement of all injectable contraceptives and vaginal foaming tablets. USAID will finance all IUCD and condom requirements outside the project. SIDA has financed oral contraceptives and will continue to do so but will reduce the number to four of the most popular brands. This will eliminate storage of less demanded brands. SIDA financing of oral contraceptives is being undertaken through on-going bilateral agreements.

Norplant

2.07 Norplant was developed by the Population Council of New York. It is an effective, long-lasting, reversible contraceptive that provides protection for five years. Six thin, flexible capsules made of a soft rubber-like material and filled with a synthetic progestin are inserted just under the skin of a woman's arm in a minor surgical procedure. Protection is provided within hours of insertion, but a woman returns rapidly to normal fertility when the implants are removed. In accordance with Population Council recommendations, Norplant should be fully introduced into a country only after the method has been approved by the country's regulatory agency and health care providers have been trained in counselling, insertion and removal. Furthermore, it is advised that the method should be offered only when there is a broad choice of other available methods and where sufficient family planning infrastructure exists to support the method.

2.08 The Kenyan experience with Norplant dates back to 1985 when Kenya was selected as one of the countries involved in a larger program of the Population Council to introduce Norplant worldwide. These trials included provision of proper training for physicians in insertion and removal and in client counselling. Since late 1985 selected staff in the Department of Obstetrics and Gynecology at the University of Nairobi have been trained. In 1986 pre-introduction trials began in four rural clinics in Machakos district. One of the objectives of selecting rural clinics was the opportunity to design and test the requirements necessary to take this clinic-based method to a rural area while maintaining aseptic standards. A report examining the first year of the trial suggested that the Norplant system is a highly effective and acceptable method among Kenyan women. There were no pregnancies and no serious or unanticipated adverse experiences. As found in other international trials, the main disadvantage of the method is its effect of producing irregularity in women's menstrual cycles. The study also showed that the method could be delivered in rural areas without infection during insertion provided that attention is paid to provision of sterilized materials and aseptic procedures. The trial has now been extended to an additional site, the Kenyatta National Hospital (KNH), which will provide further opportunities to train more doctors and nurses in the provision of the Norplant method as well as to place the introduction in an urban setting. In 1989 Kenya became the first African country to grant regulatory approval to Norplant.

2.09 The project would support the phased introduction of Norplant as a method of contraception in the Kenya Population Program through technical assistance, training, educational materials and the implants.

Logistics System for Contraceptives

2.10 The MOH's logistics system is used for the distribution of contraceptives throughout the country. The logistics system comprises a central warehouse, 42 district stores and about 1,000 outlets. Contraceptive storage and handling is managed by the Medical Supplies Coordinating Unit (MSCU) at the Central level. At present there is no

clear cut responsibility within the MSCU for family planning logistics. A family planning sub-unit within MSCU has been recommended. The second tier of the logistics system are the 42 district medical stores, located in the district hospitals. The third tier comprises the Service Delivery Points (SDPs) in the districts. Usually nurses from the SDPs visit the district medical stores to collect their supplies. In addition, there are also two regional depots in Kisumu and Mombasa. Rather than function as a separate tier of the logistics system these have served as supplementary storage facilities supplying only a part of the needs of the districts in their immediate vicinity. Through the Essential Drugs Program, however, steps are underway to rectify this situation and a total of five sub-depots, in addition to the central warehouse in Nairobi, are being established.

2.11 The logistics system has had a number of problems and there have been numerous occasions of stock-outs of some commodities and over-supply of others. Transportation of contraceptive commodities to district medical stores is often constrained by lack of space and by a lower priority assigned to them than other medical supplies. Since transport from the MSCU is not available on a timely basis, districts often send their own transport to Nairobi only to find that the needed supplies they cannot collect since the necessary paperwork has not been completed. Similarly, the system of nurses from SDPs visiting their district medical stores to collect supplies on an ad hoc basis has resulted in a relatively haphazard resupply including stock-outs and oversupply of different commodities. Also, lack of information regarding numbers and mix of contraceptives dispersed to clients has led to inappropriate procurement of contraceptives nationally.

2.12 Over the past two years there have been considerable efforts in improving the logistics system. With USAID financed technical assistance, a Logistics Management Information System (LMIS) has been implemented. This system began in October 1988 in 12 pilot districts and was expanded to 9 additional districts in November 1989. The LMIS provides information on supply status in SDPs and districts and has already resulted in a decreased number of stock-outs from the pilot districts. USAID has also provided funds for transporting supplies from the MSCU to the districts thereby considerably improving the logistics system.

2.13 The project will continue the process of improving the logistics system through strengthened logistics management at the MOH, improved transportation of contraceptives and improvements of local logistics operations. To improve logistics management at the MOH the project would support both long and short-term technical assistance. A long-term advisor would be appointed to the Division of Family Health. The project would also provide funds for short-term technical assistance. A condition of effectiveness of the credit would be that the Government would appoint a Logistics Management Advisor in the Division of Family Health, whose qualifications and experience would be satisfactory to IDA. (para. 7.01(b)).

2.14 To improve transportation of contraceptives to the districts the project would provide two lorries and one smaller delivery vehicle to the Division of Family Health. The project would strengthen local logistics

operations by renovating and upgrading district medical stores and by providing storage cabinets at the SDPs. The project would also provide funds for limited hiring of vehicles at the district and SDP levels.

2.15 NGOs account for almost 30% of the FP services provided in the country. NGO programs are currently supplied with contraceptives through a variety of mechanisms. Larger NGOs like the FPAK have their own warehouse and often supply smaller NGOs. However, many NGOs have problems in obtaining contraceptives on a steady and reliable basis. A more coordinated approach is required to develop an effective system to supply NGOs with contraceptives. During the life of the project the Division of Family Health would be responsible for NGO contraceptive supply. A longer term objective is to develop a separate system for NGOs. The Logistics Management Advisor in the Division of Family Health would design procedures by which NGOs could receive contraceptives regularly. The project would also support the provision of one lorry and two pickups to the Division of Family Health in order to ensure NGO supplies. NGO area stores would also be renovated and upgraded to provide adequate storage facilities for contraceptives. Details of the Logistics System are provided in Working Paper I which is available in the Project File.

Surveillance of Clinical Contraception

2.16 At present, there are few systems in place in Kenya to assure that contraceptive methods are being used appropriately and safely. As family planning acceptance increases and additional methods are made available, it is important to monitor the appropriate and safe use of these methods. This need for monitoring applies to all methods but has particular relevance for the use of injectables, implants, and permanent methods because of concern about their safety. The objectives of this sub-component are to: improve contraceptive safety by assuring that women are correctly counselled about appropriate methods; ensure that procedures are carried out safely to minimize short and long-term complications; counsel women thoroughly so that they can identify any danger signs; train family planning providers and supporting health staff to recognize and manage complications; and, establish a system of surveillance that will enable identification of family planning clients with complications.

2.17 These objectives will be realized by: (a) family planning training for service providers, particularly supervisory staff of SDPs (clinical officers); (b) publication of circular updating knowledge of family planning workers; (c) development of training modules emphasizing appropriate contraceptive counselling according to each woman's medical and reproductive history; (d) publication of contraceptive related research performed in Kenya for distribution to family planning providers and appropriate physicians; (e) small scale studies to investigate potential safety problems and correct misconceptions about individual methods; (f) appropriate training procedures for Norplant introduction; and (g) establishment of a surveillance system looking at complications of contraceptive use. Overall responsibility for this subcomponent rests with the Divsion of Family Health. Implementation of individual items would be

contracted out to institutions named below, subject to on-time performance and quality standards.

2.18 The surveillance sub-component would be implemented through the Division of Family Health, Department of Obstetrics and Gynecology, University of Nairobi, and FPAK. Overall coordination of the surveillance system would be the responsibility of the Reproductive Health Committee of the NCPD.

2.19 Training of clinical officers in family planning will be under the overall direction of the Division of Family Health. Eighty-four clinical officers will be trained annually. The project will support incremental salaries, office supplies, one vehicle, educational materials and training costs. As USAID is funding a number of training activities outside the project, this activity will be implemented in close collaboration with USAID. Publications of circular updating knowledge of family planning workers will be the responsibility of the Department of Obstetrics and Gynecology, University of Nairobi. A Quarterly Circular on family planning topics will be issued. The project will support the employment of an editor and two clerical assistants, desk top computer and printer and the printing and mailing costs of the circular. Training modules emphasizing appropriate contraceptive counselling would be developed by the Department of Obstetrics and Gynecology with assistance from the Division of Family Health and the FPAK. The project would support the production and mailing of two special issues of the Journal of Obstetrics and Gynecology of East and Central Africa on contraceptive safety matters. Funds to undertake small scale studies (US$1000 per study and five studies per year) to investigate potential safety problems and correct misconceptions about individual methods would be provided through the Department of Obstetrics and Gynecology. Approval of protocols would be the responsibility of the Reproductive Health Committee of the NCPD. The project would also support production of IEC materials for clients on danger signs associated with individual methods, IEC materials for service providers, and KAP studies.

2.20 Although it would be ultimately ideal to have all service providers in the country participate in a surveillance system, it is more feasible to start with a sentinel site surveillance of about 100 service provider sites representative of urban and rural, large and small, and MOH and NGO sites. Such surveillance is best conducted by those groups responsible for the actual provision of care, since in addition to providing overall figures on complications, the data can be highly useful in providing feedback to providers that will improve the quality of care. Coordination of these activities will come from the Department of Obstetrics and Gynecology, University of Nairobi with the active participation of the Division of Family Health for MOH facilities and the FPAK for NGO facilities. The project will support the recruitment of four surveillance coordinators, a half-time senior medical officer, two vehicles, two computers and printers, support staff, printing expenses and operating expenses. The project will also provide funds (US$20,000 over the four-year period) for investigation of unusual clusters of complications or special studies of excess rates of complications due to any given method. Details of the activities proposed under this sub-

component are presented in Working Paper II which is available in the Project File.

(b) Promotion of Family Planning Services

Ministry of Health

2.21 There has been a steady increase in the numbers of voluntary surgical contraception procedures undertaken in Kenya recently and demand for these services continues to grow. Through the Integrated Rural Health and Family Planning Project, seven Voluntary Surgical Contraception (VSC) units at district hospitals have been completed and three more will be ready shortly. An additional twelve such units are scheduled to be built under the Third Population Project. Work on seven of these has already commenced. In Nairobi, the Pumwani Hospital has been providing surgical contraception services. It too, is being upgraded through the Third Population Project. However, the demand for surgical contraception in Nairobi is heavy and the existing facilities are unable to cope. The project would therefore support the construction of six VSC units in the Nairobi area. Equipment lists used for earlier VSC units are considered appropriate and will be used for the proposed VSC units.

2.22 Earlier Bank projects financed the equipping of all of Kenya's SDPs for provision of FP services. Increased demand, breakages and losses over the past five years have resulted in shortages of FP equipment in most SDPs. Through the Third Population Project FP equipment for 100 facilities in 14 districts is being provided. The project will support the procurement of FP equipment for the remaining SDPs throughout Kenya.

Surgical Contraception through the Private Sector

2.23 The potential role of the private sector in the provision of surgical contraception services has not been fully exploited despite the fact that VSC services were begun in 1976 at a private clinic. VSC services have been predominantly tubectomies. Men have not accepted permanent methods in general. The project would support a private clinic in Nyeri, Central Province to undertake a pilot project to encourage vasectomies although tubectomies would not be excluded. Already this clinic has undertaken pioneering work in introducing vasectomies in Kenya. The opportunity exists to encourage vasectomies in Kenya. The project would support the salaries of clinic staff, transport costs, office supplies and medical supplies. The NCPD would make a grant to the private clinic, as it does with NGOs. All monitoring and reporting requirements of NCPD would be followed as is the case with NGOs.

Women's Income Generating Activities

2.24 Although the CPR is likely to continue to rise in the short term as a result of the steady demand for FP services, it is likely that there will be a plateauing of acceptors in the not too distant future. Traditionally, programs in South Asia have initially plateaued around 32-35% and have resulted in the development of new and innovative approaches

to population control. IDA projects in South Asia have supported mother's clubs, women's cooperatives and other income generating activities for women with a view to raising the socio-economic status of women and making them receptive to the small family norm. It was found that about 25% and 38% of participants in the mother's clubs and women's cooperatives respectively, had accepted family planning. A UN study in Bangladesh revealed that there had been a fertility reduction of 48% among members of mother's clubs. With technical assistance from USAID and other donors a number of NGOs have developed experience in establishing income generating projects including those for women's groups. The project will support the introduction of income generating activities, FP IEC and contraceptive distribution to women's and men's groups through provision of technical assistance, training and support for small scale projects. Criteria for the selection and design of these small scale projects are as follows:

(i) contain a significant population component;
(ii) available only to well-established groups;
(iii) income-generating capacity;
(iv) of relatively small size; and
(v) do not need significant technical support.

2.25 For the women's and men's income generation sub-component a condition of disbursement would be the submission to IDA of an acceptable implementation plan by June 30, 1990 for the first year (para. 7.02(a)).

Family Planning IEC, and Services through NGOs.

2.26 The 1989 KDHS has identified areas with low CPRs (Nyanza, Coast, Western and Northeastern Provinces). In those provinces it is planned to intensify FP, IEC activities to increase the demand for services through NGOs working in them. The proposed activities of this sub-component are closely related to NGO activities being implemented through the Third Population Project and will fill recently identified gaps as a result of growing demand.

2.27 Family Planning Association of Kenya. The objectives of this sub-component are to expand and strengthen FPAK's IEC activities in Coast and Western Provinces. The IEC strategy includes mass media and training workshops/seminars. Mass media activities include cultural festivals, poster production and distribution, booklet and flip chart production. Training workshops/seminars include staff orientation seminars, community leader's seminars and Village Group Sensitization seminars. These training activities will be intense and are expected to reach 4,000 village groups in the four-year period. To implement these activities the project will support the purchase of two vehicles, two video cameras, two TV monitors and two 16mm projectors and screens. Similar activities shall also be developed by an appropriate NGO in Northeastern province.

2.28 Kenya Catholic Secretariat (KCS). IEC activities undertaken by the Kenya Catholic Secretariat will also focus on Western Province. The KCS will develop and produce posters on Natural Family Planning. These will be used by Natural Family Planning teachers to give promotional/awareness talks to different Christian communities. During the

four-year period about 50,000 persons will be covered. Other IEC activities include production of flip charts, shamba cloths (these are cloth posters used at village levels to pictorially depict themes and are predominantly used in Bungoma district) depicting Natural Family Planning themes, t-shirts, teaching manuals, production of books and seminars for married couples, Natural Family Planning teachers and youth. The project will support the purchase of bicycles, audio-visual aids and IEC materials. In addition to IEC activities in Western Province, the 40 KCS dispensaries scattered throughout the country will be upgraded. These facilities will provide primary health care, MCH services and natural family planning services.

2.29 Seventh Day Adventists (SDA). IEC activities undertaken by the SDA will focus on Nyanza Province. The IEC strategy includes mass media and training activities and in country study tours. The SAD will develop and print posters on FP themes in Kisii, Luo and Swahili. Other IEC activities include production of flip charts, t-shirts, khangas, booklets and CBD manuals. Seven anatomic models for training and demonstrations will be obtained. Training activities include seminars for pastors, literacy evangelists, local church representatives, traditional birth attendants, community health worker supervisors, community health workers, dorcas ladies (church volunteers) and enrolled community nurses. The project also supports the strengthening of family planning services in SDA run health facilities. Ten dispensaries will be upgraded and renovated. In addition, two VSC units will be constructed and equipped in South Nyanza and Kisii.

2.30 Crescent Medical Aid Society of Kenya (CMASK). IEC activities and family planning services are provided in peri-urban Nairobi by the CMASK. Existing facilities are dilapidated, yet demand for services is very strong. The project will support the construction of a VSC facility in the Nairobi area replacing the existing facilities. In addition, the project will support IEC activities in eight peri-urban areas of Nairobi. These include posters, pamphlets, flip charts and training activities for community health workers and client counselling. The project shall provide one vehicle, office equipment and a video recorder and TV. Details of the IEC activities under this component are contained in Working Paper III and details of the civil works are contained in Working Paper IV, both of which are available in the project file.

(c) Strengthening the National Council for Population and Development (NCPD) Headquarters

2.31 Funds had been allocated in the Third Population Project to construct, furnish and equip a permanent headquarters for the NCPD. Due to the unexpected demand for injectable contraceptives, however, these funds were diverted for their procurement. At the same time, the NCPD's space requirements have increased due to establishment of new staff positions. Also, the NCPD has agreed to provide the FPAK with permanent office space. The revised requirements will be financed through the project.

District Focus

2.32 As part of the Government's District Focus Policy, District Population and Family Planning committees are being formed in a phased manner. Through the Third Population Project, 14 district population offices are being established. Funds have been provided for the construction and equipping of population offices and for training. The second National Leaders Conference, held in September 1989, endorsed the district approach to population programming and this has resulted in considerable pressure from districts to expand the program nationwide. However, before an expansion can take place the initial program needs to be fully operational and an evaluation carried out to enable necessary changes to be made in the strategy. The project will support the expansion of the district population program to an additional 14 districts of Baringo, Kiambu, Kitui, Kilifi, Kisumu, Kwale, Lamu, Nyandarua, Elgeyo-Marakwet, Embu, Nakuru, Busia, Nandi and Kajiado (see map) upon evaluation of the first phase. A condition of disbursement for this sub-component would be the submission to IDA of an evaluation of the first phase of the district population program and agreement with IDA on changes required for implementation of the next phase. (Para. 7.02(b)).

Long-Term Manpower Development

2.33 Funds have been provided by UNFPA, USAID, ODA and previous IDA assisted projects for the development of manpower for the population program. The majority of the NCPD's staff are recent graduates and are expected to benefit from the on-going manpower development activities. As the population program continues to expand it is necessary to ensure that NCPD staff have access to higher level training. The NCPD will be required to prepare a long-term manpower development plan and to identify resources available from other donors. The project provides funds for implementation of the long-term manpower development plan.

IEC Strategy

2.34 IEC activities, until recently, have been undertaken primarily by NGOs. The NCPD has not developed a comprehensive national IEC strategy. This drawback has now been recognized and the NCPD is developing a national IEC strategy and implementation plan. A condition of disbursement for this subcomponent is that the NCPD would submit a national IEC strategy and implementation plan satisfactory to IDA (para. 7.02(c)).

(d) Research

Institute of Primate Research

2.35 The Institute of Primate Research is part of the National Museums of Kenya. It undertakes bio-medical research in the areas of conservation/ecology, infectious diseases/parasitology and reproductive biology. The Institute has been supported by a number of international donors/agencies including the WHO, National Institute ot Health, the European Community, Rockefeller Foundation, Edna McConnell Clark Foundation

and the Pasteur Institute. As some of the earlier grants are now coming to an end, the Institute needs resources to continue its research activities.

2.36 In the field of fertility regulation the Institute of Primate Research is involved in the following major areas of research: evaluation of traditional methods of family planning; development of new, safe and effective methods of fertility regulation (emphasis on sperm-based contraceptive vaccine); testing of existing methods of fertility regulation; and information dissemination. The project will support research projects in reproductive biology. A sum of US$1 million is provided during the life of the project. During negotiations assurances were obtained that by June 30, 1991 the NCPD would submit research proposals to IDA for review and approval (para. 7.03(c)).

Feasibility Studies

2.37 With the growing demand for FP services the need for a steady supply of contraceptives is critical. Over the long-term the Government is expected to finance its contraceptive requirements. The project provides funds for undertaking feasibility studies for the local manufacture of oral contraceptives and injectables (DMPA). These studies will examine the technical, economic and financial feasibility of local manufacture particularly through the private sector.

Operations' Research

2.38 Funds for undertaking population research have been provided by UNFPA and USAID. The project provides technical assistance, training and other research costs for undertaking operations research activities including the evaluation of the first phase of the district population program and KAP studies. Research activities will be closely coordinated with USAID and UNFPA.

III. PROJECT COST AND FINANCING

A. Costs

3.01 Total costs of the proposed project are estimated at KSh907.9 million (US$41.3 million equivalent). Base costs are calculated at US$36.9 million equivalent (89%) and contingencies at US$4.4 million equivalent (11%). Foreign exchange costs account for US$25.7 million or 62% of total project costs. Taxes and duties have been excluded in calculating the project cost. Project costs by expenditure category are summarized in Table 2 below, and details are provided in Annex 2. Civil works account for 24% of base costs; furniture, equipment, vehicles, supplies and materials for 23%; contraceptive supplies 25%; monitoring and research activities 5%; technical assistance and overseas training 6%; training 10%; and incremental recurrent costs (salaries and allowances, building, equipment and vehicle operation and maintenance) 7%.

3.02 Project costs have been estimated using February 1990 prices. Civil works costs have been estimated on the basis of the value of current Ministry of Works contracts for comparable buildings. Furniture and equipment lists are available and were reviewed by IDA. Project costs also include provision for a total of 25 vehicles, at a unit cost of about US$22,000 (on CIF basis); 125 months of overseas training; 132 months of long-term foreign/local consultants and 21 months of short-term consultants. Incremental salaries, local training costs and operational and maintenance expenses are based on current Government and NGO scales and rates respectively.

3.03 The total project costs include US$4.4 million equivalent for contingencies. Physical contingencies have been included at 10% for civil works and 5% for vehicles, equipment, furniture, materials/supplies and furniture maintenance and amount to US$1.3 million equivalent (4% of base costs). The following price contingencies have been included: (i) on foreign exchange expenditures, 4.9% in the first six years of the project and 3.7% in 1996; and (ii) on local cost expenditures, 7.5% in 1990; and 5.5% every year thereafter. Price contingencies account for US$3.0 million equivalent or 8% of base costs.

3.04 The foreign exchange component of US$25.7 million equivalent is based on estimates of 65% for civil works; 100% for vehicles and equipment; 40% for materials/supplies; 100% for contraceptive supplies; 30% for furniture; and 100% for overseas training and study tours. The incremental recurrent costs mainly cover equipment and building maintenance, and vehicle operation and maintenance.

3.05 Project costs by functional component are shown in Table 3. Contraceptive supplies and logistics system would absorb 37% of base costs; strengthening the NCPD 34%; promotion of family planning 24%; and research 4%.

Table 2: PROJECT COSTS BY EXPENDITURE CATEGORY

Summary Accounts Cost Summary

	KSH			US$			% Foreign Exchange	% Total Base Costs
	Local	Foreign	Total	Local	Foreign	Total		
I. INVESTMENT COSTS								
A. CIVIL WORKS	68456500.0	125804377.0	194260877.0	3123165.2	5800164.0	8923329.2	64.8	24.2
B. VEHICLES	0.0	16208160.8	16208160.8	0.0	744518.2	744518.2	100.0	2.0
C. FURNITURE	10440500.0	4427721.1	14868221.1	478077.9	204890.5	682968.4	29.8	1.8
D. MATERIALS	58157490.0	38366319.9	96523809.9	2660279.6	1773519.7	4433799.3	39.7	12.0
E. EQUIPMENT	0.0	54757298.3	54757298.3	0.0	2515264.0	2515264.0	100.0	6.8
F. CONTRACEPTIVE SUPPLIES	0.0	202691069.3	202691069.3	0.0	9310568.2	9310568.2	100.0	25.2
G. TECHNICAL ASSISTANCE	3320000.0	42451500.0	45771500.0	152508.4	1950000.0	2102508.4	92.7	5.7
H. EVALUATION, MONITORING	37242800.0	0.0	37242800.0	1710739.5	0.0	1710739.5	0.0	4.6
I. OVERSEAS TRAINING	0.0	5442500.0	5442500.0	0.0	250000.0	250000.0	100.0	0.7
J. TRAINING	82687410.0	0.0	82687410.0	3798227.4	0.0	3798227.4	0.0	10.3
Total INVESTMENT COSTS	260304700.0	490148944.5	750453644.5	11922993.0	22548924.5	34471917.5	65.3	93.4
II. RECURRENT COSTS								
A. SALARIES	28997280.0	0.0	28997280.0	1331993.5	0.0	1331993.5	0.0	3.6
B. ALLOWANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
C. PER DIEM	6105795.0	0.0	6105795.0	280468.3	0.0	280468.3	0.0	0.8
D. UTILITIES/SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
E. VEHICLE OPERATION/MAINT	5278000.0	9699524.5	14977524.5	240796.2	447193.0	687989.2	64.8	1.9
F. EQUIPMENT MAINTENANCE	1097600.0	2017089.5	3114689.5	50075.4	92997.2	143072.6	64.8	0.4
G. BUILDING MAINTENANCE	136800.0	7124.7	143924.7	6280.6	330.6	6611.1	5.0	0.0
H. FURNITURE MAINTENANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total RECURRENT COSTS	41615475.0	11723738.7	53339213.7	1909604.0	540520.7	2450124.7	22.0	6.6
Total BASELINE COSTS	301920175.0	501872683.2	803792858.2	13832597.0	23089445.2	36922042.2	0.0	100.0
Physical Contingencies	10275549.5	18268412.6	28543962.1	472005.0	839155.4	1311160.4	64.0	3.6
Price Contingencies	30184733.4	45438341.6	75623075.0	1258146.1	1779555.7	3037701.7	58.6	9.2
Total PROJECTS COSTS	342380457.9	565579437.5	907959895.4	15562748.1	25708156.2	41270904.3	62.3	111.8

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Table 3: PROJECT COSTS BY FUNCTIONAL COMPONENT

Project Cost Summary

	KSH			US$			% Foreign Exchange	% Total Base Costs
	Local	Foreign	Total	Local	Foreign	Total		
A. CONTRACEPTIVE SUPPLY								
1. DIV OF FAMILY HEALTH	31938275.0	251790335.6	283728610.6	1466079.4	10648234.4	12114313.8	87.9	32.8
2. DEPT OF OBSTETRICS & GYN	6098300.0	1082277.0	7180577.0	279947.0	48972.5	328919.5	14.8	0.9
3. FPAK	3078420.0	1793233.4	4871653.4	141045.7	82732.5	223778.2	36.9	0.6
4. NORPLANT	2314000.0	22875236.2	25189236.2	115352.1	1041709.8	1157061.8	90.0	3.1
Sub-Total	43428995.0	267822082.2	300950077.2	2002424.2	11821649.2	13824073.4	85.5	37.4
B. FAMILY PLANNING PROMOTION								
1. FPAK IEC	23621000.0	4756942.0	28377942.0	1084050.8	219473.6	1303524.4	16.8	3.5
2. CATHOLIC SECRETARIAT	10693600.0	15591494.5	26285094.5	497458.0	709033.2	1206491.1	58.8	3.3
3. CRESCENT MEDICAL ASSOC	10013300.0	5501520.0	15514820.0	459151.8	258116.4	717268.2	35.9	1.9
4. SEVENTH DAY ADVENTISTS	14922800.0	10780604.3	25703404.3	678199.0	501481.0	1180580.0	42.5	3.2
5. WOMEN'S ACTIVITIES	35840000.0	30042600.0	65882600.0	1633121.7	1383993.6	3017115.3	45.7	8.2
6. VASECTOMY CLINIC	1121480.0	427285.7	1548765.7	51449.1	19693.1	71142.2	27.6	0.2
7. MINISTRY OF HEALTH (DFH)	10710000.0	22453584.9	33163584.9	488688.9	1034672.8	1523361.7	67.7	4.1
Sub-Total	106811980.0	89544232.4	196356212.4	4893129.3	4126448.6	9019578.0	45.7	24.4
C. NCPD								
1. INSTIT'L DEVT	46410000.0	85288922.7	131698922.7	2118546.1	3931014.0	6049560.1	64.8	16.4
2. DISTRICT FOCUS	42481200.0	27700345.9	70181545.9	1948384.4	1275389.0	3223773.4	39.5	8.7
3. LONGTERM MANPOWER DEVT	0.0	5442500.0	5442500.0	0.0	250000.0	250000.0	100.0	0.7
4. IEC	29040000.0	36573600.0	65613600.0	1329001.4	1684944.4	3013945.8	55.7	8.2
Sub-Total	117931200.0	155005368.6	272936568.6	5395931.9	7141347.3	12537279.2	57.0	34.0
D. RESEARCH AND EVALUATION	33550000.0	0.0	33550000.0	1541111.6	0.0	1541111.6	0.0	4.2
Total BASELINE COSTS	301920175.0	501872683.2	803792858.2	13832597.0	23089445.2	36922042.2	62.5	100.0
Physical Contingencies	10275549.5	18268412.6	28543962.1	472005.0	839155.4	1311160.4	64.0	3.6
Price Contingencies	30184733.4	45438341.6	75623075.0	1258146.1	1779555.7	3037701.7	58.6	8.2
Total PROJECTS COSTS	342380457.9	565579437.5	907959895.4	15562748.1	25708156.2	41270904.3	62.3	111.8

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B. Financing

3.06 Of the total project costs of US$41.3 million, the Government's contribution would be US$4.1 million (10%), which would cover 3% of investment costs and 100% of the recurrent costs. The remainder of investment costs would all be financed from external sources. Table 4 presents project costs by financing source. USAID is providing US$2.2 million for contraceptive supplies, technical assistance and VSC equipment. An IDA credit up to US$35.0 million is proposed.

TABLE 4: PROPOSED PROJECT FINANCING
(US$ million)

Expenditure Categories	Total Base Costs	GOK	USAID	IDA	Percentage IDA
Civil Works	8.9	1.0		7.9	88.7
Vehicles	0.7			0.7	100.0
Furniture	0.7	0.2		0.5	71.4
Materials/Supplies	4.4			4.4	100.0
Equipment	2.5		0.2	2.3	92.0
Contraceptive Supplies	9.3		1.2	8.1	87.1
Technical Assistance	2.1		0.8	1.3	61.9
Monitoring, Research, Evaluation	1.7			1.7	100.0
Local Training	3.8			3.8	100.0
Overseas Training	0.3			0.3	100.0
Recurrent Costs	2.4	2.4			0.0
Total Base Costs	36.9	3.6	2.2	31.1	84.2
Total Contingencies	4.4	0.5		3.9	88.6
Total Project Costs	41.3	4.1	2.2	35.0	84.7

Financial Viability

3.07 The financial viability of the proposed project and of the population sector overall in the short-term is secured through continued donor contributions (either bilaterally or cofinancing through IDA projects) and by Government of Kenya assurances from the Office of the Vice President and Ministry of Finance for counterpart funds. However, given the long-term fertility goals of the Kenyan population program and the implications for contraceptive supplies, consideration of the financial sustainability of the population sector in a medium- to long-term framework is warranted.

3.08 As the population program matures--infrastructure becomes developed, IEC activities reach saturation--an increasing proportion of costs will fall on recurrent expenditures. The largest bulk of non-salary recurrent costs will be for contraceptive supplies. Annex 1, Tables 6-10 presents three scenarios for different contraceptive usage and their estimated contraceptive prevalence rates projected to the year 2000. On the restrictive assumption that the MOH's gross recurrent budget allocation does not increase significantly in real terms 4/, and using the base case scenario for projected contraceptive needs, the total cost for modern temporary contraception MOH supplies in 1994 would account for 2.5% of the budget if the government were to finance all supplies. Excluding salaries, the share would rise to 4%. Although the figures are rough calculations, they offer an order of magnitude which the population program will have to address when considering long-term financing issues.

3.09 The Kenyan population program has several long-term options. Funds have been provided under the Third Population Project to undertake a study to examine alternative financing mechanisms for expanding NGO family planning programs. The proposed project will support a feasibility study for the local manufacture of injectables (Depo-Provera) and oral contraceptives. Consideration should also be given to the government financing a larger portion of recurrent costs, including salaries. An agreement with SIDA has already been reached that the Government begin financing the procurement of oral pills amounting to KSh 5 million in 1992/93 and KSh 10 million in 1993/94.

4/ This is a plausible assumption given expectations of increased revenue generated under the Government's user charge scheme and overall austerity of GOK budget allocations. The above figures are with reference to central government expenditures and thus the assumption does not necessarily imply that total expenditures for the health care remain relatively flat.

C. Procurement

TABLE 5: PROCUREMENT
(US$ million)

	Procurement method					
	ICB	LIB	LCB	Other	N.A.	Total Cost
Civil Works	6.1		4.4			10.5
	(5.4)		(4.1)			(9.5)
Vehicles	.8					.8
	(.8)					(.8)
Equipment/Furniture	3.2		.3	.2		3.6
	(3.1)		(.1)			(3.2)
Materials/Supplies			4.4	.4		4.8
			(4.4)	(.4)		(4.8)
Contraceptive Supplies	1.0	7.8		1.4		10.2
	(1.0)	(7.8)		(.2)		(9.0)
Technical Assistance				2.3		2.3
				(1.5)		(1.5)
Monitoring, Research/ Evaluation					1.8	1.8
					(1.8)	(1.8)
Local Training					4.1	4.1
					(4.1)	(4.1)
Overseas Training					.3	.3
					(.3)	(.3)
Salaries/Allowance/ Per Diem					1.9	1.9
					(-)	(-)
Vehicle Op./Maintenance					.8	.8
					(-)	(-)
Equipment Maintenance					.2	.2
					(-)	(-)
Building Maintenance					.07	.07
					(-)	(-)
TOTAL	11.0	7.8	9.1	4.3	9.2	41.3
	(10.3)	(7.8)	(8.6)	(2.1)	(6.2)	(35.0)

Numbers in parentheses are the respective amounts to be financed by IDA.

3.10 Procurement arrangements are summarized in Table 5. USAID financed procurement would be undertaken by USAID in accordance with its procurement procedures. IDA financed procurement would be undertaken as follows. The civil works contract for the NCPD headquarters building at Nairobi, estimated at about US$6.1 million would be awarded following International Competitive Bidding (ICB) procedures. ICB contracts will be subject to prequalification. Local firms bidding for construction contracts under ICB would receive a preference of 7.5%. Other extension of civil works aggregating to US$4.4 million, including 9 voluntary surgical contraception units, 48 clinic upgrading KCS and SDA and 14 district population offices are too small and scattered to attract international bidding. These contracts estimated to cost less than US$200,000 equivalent per contract will be awarded following competitive bidding advertised locally. However, interested foreign contractors, would not be precluded from participation. The local procurement procedures were reviewed by IDA earlier and are consistent with the requirements except for preference for local firms. This issue will be resolved at negotiations. The first LCB document will be reviewed by IDA before its release to bidders.

3.11 Furniture and equipment would be grouped, to the extent practicable, into contracts valued at US$100,000 or more and procured through ICB. Furniture and equipment estimated to cost less than US$100,000 but more than $20,000 per contract, up to an aggregate amount not to exceed US$300,000, would be procured through LCB. For locally manufactured goods procured through ICB a preference of 15% of duties whichever is less would be applicable provided the value added in such goods is more than 20% of the ex-factory cost. Vehicles would be procured as a package through ICB. Vaginal tablets will be procured through ICB. The requirement for injectable contraceptives (DMPA) is highly specific. DMPA, in the required form, is made by very few manufacturers. It will therefore, be procured through Limited International Bidding (LIB) and the list of firms from which solicitations can be made will be approved by IDA. It is estimated that US$7.8 million worth of DMPA will be procured through LIB during the project period. Norplant manufactured exclusively for the Population Council will be procured through the Population Council. Contracts for materials and supplies are too small and diverse to attract ICB. Materials and supplies estimated to cost less than US$50,000 per contract, up to an aggregate amount not to exceed US$1 million, would be procured through LCB. Miscellaneous items of materials and supplies estimated to cost less than US$20,000 per contract, up to an aggregate amount of US$400,000, would be procured through prudent shopping with at least three price quotations. The threshold limit for prior review by IDA is set at US$100,000 per tender. It is expected that 27% of total project costs would be procured through ICB, 19% through LIB, 22% through LCB, and 10% through other means.

3.12 For all IDA-financed consultants employed for this project, selection procedures, qualifications, experience and terms and conditions of employment would be satisfactory to IDA, and in accordance with the "Guidelines for the Use of Consultants by World Bank Borrowers and the World Bank as an Executing Agency" (August 1981).

D. Disbursements

3.13 Disbursements from the proposed IDA credit will be on the basis of: (a) 80% of total expenditures on civil works; (b) 100% of foreign expenditures and 70% of local expenditures on goods, equipment, supplies and vehicles; (c) 100% of expenditures for training, consultant services research, and foreign and local technical assistance. For the women's and men's income generating activities sub-component 80% of expenditures will be eligible for reimbursement. For the NCPD's IEC sub-component, 100% of foreign expenditures and 70% of local expenditures will be eligible for reimbursement. Withdrawal applications for expenditures for civil works, supplies and materials under contracts or purchase orders of less than US$20,000 would be submitted against statements of expenditure (SOE) except for the women's and men's income generating activities sub-component where all expenditures would be against SOEs; supporting documentation would be retained in the implementing agencies for review by Bank supervision missions and for annual audits. All other disbursements would be fully documented. It is anticipated that the credit would be fully disbursed by June 30, 1997. An indicative schedule of disbursements is shown in Annex 3. This schedule is based on the standard disbursement profile for Kenya, plus realistic estimates of disbursements of contraceptive supplies.

E. Accounts and Audit

3.14 Project funds would be maintained in a separate account and would be channeled from the Ministry of Finance to the NCPD and would be administered by the Under Secretary (Finance) Ministry of Home Affairs. Project financial records would be maintained by the Under Secretary (Finance) in the Ministry of Home Affairs. The Project would be subject to normal government accounting and auditing procedures, which are considered satisfactory to IDA. During negotiations assurances were obtained that: audits of project accounts and SOEs by the Auditor General would be carried out; that all audited accounts would be made available to IDA within nine months of the close of each GOK fiscal year (para. 7.03(a)).

IV. PROJECT IMPLEMENTATION

A. Status of Project Preparation

4.01 The project was prepared by the NCPD in collaboration with the MOH, FPAK, KCS, SDA and CMASK. Sessional Paper No. 4, 1984, the Third Population Project and the KDHS provided the framework for project development. Site plans and sketch drawings for the NCPD building and the district population buildings have been reviewed by IDA. Working drawings, bills of quantity and tender documents for all contracts are expected to be finalized and submitted to IDA for review about three months after project effectiveness. Furniture and equipment lists for the NCPD headquarters building will be submitted to IDA for review and approval within three months of project effectiveness. Furniture and equipment lists for VSCs and health centers have been previously reviewed by IDA and are satisfactory. During negotiations assurances were obtained that subsequent draft annual work plans including adequate budgetary allocations, satisfactory to IDA, would be submitted by the NCPD, by March 31 annually (para. 7.03(b)).

B. Organization and Management

4.02 As with the Third Population Project, the Permanent Secretary, Ministry of Home Affairs and National Heritage would have overall responsibility for coordination of the project. The Director of NCPD would have day-to-day responsibility for coordination, supervision, and implementation of the NCPD component and for monitoring activities undertaken by other government and non-government agencies. In each such agency, a project coordinator has been identified. All project coordinators would work closely with the NCPD. A project coordinating committee chaired by the Director of NCPD, comprising the coordinators of all project components and senior NCPD staff established for the Third Population Project would be modified and also coordinate the proposed project. The coordinating committee would meet every quarter to review project implementation. The NCPD secretariat would be responsible for maintaining minutes of every meeting, initiating follow up actions and for preparing progress reports.

4.03 The Director, NCPD would be responsible for the civil works program. Since the NCPD does not have the staff for production of architectural drawings and for coordination of the quantity surveying, mechanical, electrical and civil engineering inputs of design work, use would be made of consultant firms. The Ministry of Works would assist NCPD in the selecting and briefing of consultant firms and in monitoring the civil works program.

4.04 Procurement of furniture, equipment and supplies, and recruitment of consultants for all project components would be undertaken by the respective agencies. NCPD, which has developed the capability to

undertake procurement efficiently, would provide guidance and support as necessary.

4.05 Responsibility for implementation of the component on increasing availability and accessibility of contraceptives would rest with the Director, Division of Family Health, MOH. Responsibility for implementation of each sub-component undertaken under the Promotion of Family Planning component would rest with the respective government ministry or NGO. The Director, Division of Family Health would be responsible for the MOH sub-component. Responsibility for the NGO sub-components would be as follows: FPAK: Executive Director; KCS: Deputy Director; Seventh Day Adventist: Medical Director; CMSAK: Project Director. Responsibility for implementation of each sub-component undertaken under NCPD component would rest with the applicable section of the NCPD. The section head (Programs) would supervise the district focus sub-component and the IEC head would supervise the IEC sub-component. Long-term training and construction of the NCPD building would be supervised by the Director. The Research component would be supervised by the section head of the Research and Evaluation Division.

C. Monitoring, Reporting and Evaluation

4.06 The Director, NCPD would have responsibility for monitoring the progress of implementation of all project components. He would prepare quarterly progress reports, and would highlight major issues needing resolution. These reports would be approved by the project coordinating committee (para. 4.02) before submission to IDA and other donors. Regular coordination meetings of the donor agencies would be held in Nairobi. As a basis for monitoring, annual implementation plans are being prepared for the Third Population Project and will include activities of the proposed project. In addition a mid-term review of the Third Population Project is planned no later than December 31, 1990 and will assist in monitoring the project.

4.07 Progress of the project would be monitored through process and impact indicators. Process indicators include: procurement of contraceptives on timely basis, number of service providers trained to introduce Norplant, number of implants per year, expansion of Logistics Management Information System to cover all project districts, publications of circular for FP workers on contraceptive safety issues, and numbers of clinical officers trained in FP. For IEC activities carried out by NCPD and NGOs, indicators to be monitored will be the production of posters, booklets and other materials by types and numbers. For district focus activities, monitoring criteria include the number of districts in which population activities are begun annually, as well as the number and types of seminars held each year. Finally, for service delivery activities the numbers of new acceptors by type of method will be reviewed.

4.08 In terms of impact, the project's goals are to achieve a TFR of 6.0 and a CPR of 35% by 1995, representing nearly 25% decline in fertility since 1984. Annex 1, Tables 6-9 show three scenarios for projected

contraceptive use to the year 2000. All scenarios assume that the numbers of married women of reproductive age (15-49) continues to grow by 4% per year. The scenarios differ in assumptions concerning market penetration. The base case scenario growth rate of 10% implies an increase in the CPR due to changes in the use of modern temporary methods of about 1% per year, in line with recent increases in prevalence. The high and low cases imply a change in the CPR of approximately 1.5% and 0.5% respectively.

4.09 In addition to the studies and surveys being undertaken through the Third Population Project, regular surveys are planned every two years to monitor CPR. Annual work plans will be produced based on a component-by-component review of progress in the preceding year. A mid-term review of the project would be carried out by December 31, 1992 (para. 7.03(a)).

V. ENVIRONMENTAL ASPECTS

5.01 Although the adverse environmental effects of a large, rapidly growing and youthful population are likely to continue in the short-term, increased CPR and declining fertility will have a positive impact on the environment over the long-term. By reducing the rate of population growth, pressure on natural resources is expected to ease. The project will therefore, have a direct positive impact on the environment.

VI. PROJECT BENEFITS, JUSTIFICATION AND RISKS

A. Benefits and Justification

6.01 The proposed project continues to build on efforts begun under previous IDA lending operations, including towards institution building, strengthening of the NCPD, and expansion of NGO population programs. The project is designed much along the same lines as the previous project but fills crucial gaps resulting from an acceleration of program adoption that were not anticipated during the appraisal of the Third Population Project. In addition, the project lays the groundwork for addressing longer-term sustainability issues, relating to further expansion of contraceptive prevalence levels and the future financing of the program.

6.02 The project is expected to improve the effectiveness of the population program and expand its coverage. The 14 districts selected under the Third Population Project covered about 65% of the population. The establishment of 14 additional district population offices supported by this project would account for another 25% of Kenya's population.

6.03 The NCPD's role in coordinating the mobilization of Kenya's population program is key and efforts to strengthen the Council and its Secretariat will benefit the program. The provision of funds for a

contraceptive logistic system will facilitate the MOH's and NGOs' delivery of family planning services without any break in supplies. The introduction of a surveillance system, including a counselling component, will ensure that couples choose a family planning method that best suits their need and that any complications will be properly monitored.

6.04 Population IEC activities through selected NGOs are expected to benefit people living in areas with low CPRs and high infant mortality rates, particularly in Western and Coast provinces.

B. Risks

6.05 This project faces similar risks as those in the Third Population Project, and steps taken under the previous project to reduce these risks will be mutually beneficial to this project. The capacity of the MOH's Division of Family Health (DFH) to administer the family planning program continues to be weak. More coordination at working levels between the DFH, other MOH units, NGOs, as well as the NCPD is required.

6.06 A second risk emanates from the ability of the NCPD to coordinate and manage an increasingly complex population program. Symptoms of this possible weakness are the slow implementation of the district program and the lack of an overall IEC strategy despite ongoing individual IEC activities. In part, these difficulties may be due to the relative inexperience of the staff. It is expected, however, that the recent appointment of a new Director along with funds for long-term high-level manpower development provided under the proposed project will pre-empt this risk.

VII. ASSURANCES AND RECOMMENDATION

7.01 The following would be conditions of effectiveness:

(a) the MOH would submit an organizational structure for the Division of Family Health for review and comment by IDA and a plan for its implementation (para. 1.22);

(b) the Government would appoint a Logistics Management Advisor in the Division of Family Health, whose qualifications and experience would be satisfactory to IDA (para. 2.13); and

7.02 The following would be conditions of disbursement:

(a) for the women's income generation sub-component an implementation plan, acceptable to IDA, for the first year of the project by June 30, 1990 (para. 2.25);

(b) for the district focus sub-component the NCPD would submit to IDA an evaluation of the first phase of the district population program and agreement with IDA on changes required for implementation of the next phase (para. 2.32); and,

(c) for the IEC sub-component, the NCPD would submit to IDA a nationwide IEC strategy and a plan for its implementation (para. 2.34).

7.03 Other covenants would be:

(a) audits of project accounts and SOEs by the Auditor General would be carried out; that all audited accounts would be made available to IDA within nine months of the close of each GOK fiscal year (para. 3.14).

(b) draft annual work plans, including budgetary allocations, satisfactory to IDA would be submitted by the NCPD, by March 31 annually (para. 4.01) and a mid-term review by December 31, 1992 (para. 4.09).

(c) for the Institute of Primate Research sub-component, the submission of research proposals for review and approval by IDA by June 30, 1991 (para. 2.36).

7.04 Subject to the above provisions, the proposed project would constitute a suitable basis for an IDA credit of SDR 26.3 million (US$35.0 million equivalent) to the Government of Kenya.

ANNEX 1

LIST OF TABLES

1. Total Fertility Rates, Selected Years
2. Contraceptive Prevalence Rates, 1984 and 1989
3. Age at First Marriage, 1989
4. Population Projections, Selected Age Groups and Years
5. Selected Determinants of Family Planning, 1984 and 1989
6. Projected Contraceptive Prevalence Rates, Selected Scenarios
7. Projected Contraceptive Usage, Base Case Scenario
8. Projected Contraceptive Usage, High Case Scenario
9. Projected Contraceptive Usage, Low Case Scenario
10. Estimated Contraceptive Costs, by Scenario

ANNEX 1

Table 1

KENYA

Total Fertility Rates
Selected Years

Province	KFS 1977-78	KCPS 1984	KDHS 1989
Nairobi	6.1	5.6	4.6
Central	8.6	7.8	6.0
Coast	7.2	6.7	5.5
Eastern	8.2	8.0	7.0
Nyanza	8.0	8.2	7.1
Rift Valley	8.8	8.6	7.0
Western	8.2	6.3	8.1
Residence			
Urban a/	6.8	5.3	4.8
Rural	8.4	8.1	7.1
Education			
No Education	8.8	8.5	7.2
Some Primary b/	9.0	9.0	7.5
Primary Complete b/	8.1	7.9	6.5
Secondary +	7.3	5.4	4.9
Total	7.9	7.7	6.7

Source: Table 4.14 KCPS for 1977/78 and 1984;
Table 3.5 KDHS for 1989.

a/ For 1977 and 1984, urban areas exclude Nairobi and Mombasa.

b/ For 1977/78 and 1984, educational categories are "1-4 Years" and "5-8 Years" for "Some Primary" and "Secondary Complete" respectively.

ANNEX 1

Table 2

KENYA

Contraceptive Prevalence Rates
Married Women of Reproductive Age
1984 and 1989

Province	All Methods 1984	All Methods 1989	Modern Method 1984	Modern Method 1989	Traditional 1984	Traditional 1989
Nairobi	28.3	33.5	22.9	27.9	5.4	5.6
Central	34.1	39.5	20.7	30.8	13.5	8.7
Coast	10.5	18.1	6.8	14.8	3.7	3.3
Eastern	26.3	40.2	14.2	19.5	12.1	20.8
Nyanza	8.6	13.8	5.5	10.2	3.0	3.5
Rift Valley	15.1	29.6	5.4	18.1	9.6	11.5
Western	4.6	13.7	3.5	10.0	1.1	3.7
Total	17.0	26.9	9.7	17.9	7.3	9.0

Sources: 1984: KCPS, Table 7.13
1989: KDHS, Table 4.7

ANNEX 1

Table 3

KENYA

PERCENT DISTRIBUTION OF WOMEN BY AGE AT FIRST MARRIAGE, ACCORDING TO CURRENT AGE, 1989

Current age	Never married	Age at first marriage <15	15-17	18-19	20-21	22-24	25+	Total
15-19	79.8	3.5	11.8	4.9	0.0	0.0	0.0	100.0
20-24	31.8	5.6	25.9	20.3	12.0	4.4	0.0	100.0
25-29	10.7	15.7	27.5	22.0	11.3	8.5	4.2	100.0
30-34	5.4	23.0	27.7	17.2	13.6	8.5	4.7	100.0
35-39	3.2	20.1	31.3	20.0	12.4	7.1	5.9	100.0
40-44	1.5	25.0	30.3	19.7	11.9	7.1	4.4	100.0
45-49	2.4	17.7	28.0	20.5	13.4	10.1	7.9	100.0
Total	26.0	13.8	24.7	16.9	9.7	5.8	3.1	100.0

Source: KDHS, Table 2.4

Table 4

KENYA

POPULATION PROJECTIONS a/ SELECTED AGE GROUPS AS PERCENTAGE OF TOTAL POPULATION

	1985	1990	1995	2000
Female				
<15	26.1	26.3	25.6	24.9
15-49	20.4	20.3	21.1	21.8
50+	3.8	3.6	3.5	3.5
Male				
<15	26.2	26.6	26.0	25.2
15-49	19.7	19.7	20.6	21.4
50+	3.8	3.5	3.2	3.2
Total				
<15	52.3	52.9	51.6	50.1
Dependency ratio b/	121.1	122.8	116.0	109.0

---

a/ World Bank estimates based on the 1979 Kenya Census and assuming net reproduction rate (NRR, see definitions) of 1 by 2050.

ANNEX 1

Table 5

KENYA

SELECTED DETERMINANTS OF FAMILY PLANNING
1984, 1989

Variable	Kenya	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western
Ideal Family Size a/								
1984	6.3	4.3	5.4	6.1	5.4	5.9	6.5	6.0
1989	4.4	3.6	3.8	5.6	4.2	4.6	4.7	4.9
Don't Want More b/								
1984	31.5	32.6	41.2	20.4	43.6	24.2	29.0	34.1
1989	49.4	43.7	67.3	28.0	59.7	41.7	49.7	43.2
Knowledge of at least 1 method b/								
1984	84.0	84.5	90.0	80.2	88.0	87.5	69.5	68.7
1989	91.3	94.8	95.8	92.3	92.7	93.3	84.6	90.6
Female Approval of Family Planning b/								
1984	76.2	79.7	85.7	75.4	73.6	79.3	74.7	69.9
1989	88.2	92.1	92.0	77.7	91.0	93.8	81.1	87.7

Sources: KDHS, 1989
KCPS, 1984

a/ All women of reproductive age.
b/ Percentage of currently MWRA.

ANNEX I

TABLE 6

CONTRACEPTIVE PREVALENCE RATES
VARIOUS SCENARIOS
Selected Years

	KFS 1977/78	KCPS 1984	KDHS 1989	BASE CASE a/ 1990	BASE CASE a/ 1995	BASE CASE a/ 2000	HIGH CASE b/ 1990	HIGH CASE b/ 1995	HIGH CASE b/ 2000	LOW CASE c/ 1990	LOW CASE c/ 1995	LOW CASE c/ 2000
TOTAL CPR	7	17	27	28	33	38	29	36	43	28	30	32
MODERN METHODS	4	10	18	19	24	29	20	27	34	19	21	23
Temporary Methods	3	7	13	14	19	24	15	22	29	14	16	18
Surgical Methods	1	3	5	5	5	5	5	5	5	5	5	5
TRADITIONAL	3	7	9	9	9	9	9	9	9	9	9	9

a. Assumes growth in modern temporary methods of 10% per year, of which 4% growth of MWRA and 6% growth of market penetration.
b. Assumes growth in modern temporary methods of 14% per year, of which 4% growth of MWRA and 10% growth of market penetration.
c. Assumes growth in modern temporary methods of 7% per year, of which 4% growth of MWRA and 3% growth of market penetration.

ANNEX 1

Table 7

KENYA
CONTRACEPTIVE USAGE
Base Case Scenario a/
Selected Years

CONTRACEPTIVES (in '000) b/	1994	1995	1996	1997	1998	1999	2000
Orals							
Microgynon	3,943	4,337	4,771	5,248	5,773	6,350	6,985
Eugynon	811	892	981	1,079	1,187	1,306	1,437
Neogynon	450	495	545	599	659	725	797
Microlut	693	762	839	922	1,015	1,116	1,228
Condoms	16,323	17,955	19,751	21,726	23,899	26,288	28,917
IUDs	96	106	116	128	141	155	170
VFTs	3,703	4,073	4,481	4,929	5,422	5,964	6,560
Injectables	1,442	1,586	1,745	1,919	2,111	2,322	2,555
NORPLANT	5	5	5	5	5	5	5

a. Assumes growth in all contraceptives listed above except NORPLANT of 10% per year, of which 4% growth of MWRA and 6% growth of market penetration.
b. Assumes no change in contraceptive mix over the period.

ANNEX 1

Table 8

KENYA
CONTRACEPTIVE USAGE
High Case Scenario a/
Selected Years

	1994	1995	1996	1997	1998	1999	2000
CONTRACEPTIVES (in '000) b/							
Orals							
Microgynon	3,943	4,495	5,124	5,842	6,660	7,592	8,655
Eugynon	811	925	1,054	1,202	1,370	1,562	1,780
Neogynon	450	513	585	667	760	866	988
Microlut	693	790	901	1,027	1,170	1,334	1,521
Condoms	16,323	18,608	21,213	24,183	27,569	31,429	35,829
IUDs	96	109	125	142	162	185	211
VFTs	3,703	4,221	4,812	5,486	6,254	7,130	8,128
Injectables	1,442	1,644	1,874	2,136	2,435	2,776	3,165
NORPLANT	5	5	5	5	5	5	5

a. Assumes a 14% per year increase in all contraceptives listed above except NORPLANT, of which 4% increase in MWRA and 10% increase in market penetration.
b. Assumes no change in contraceptive mix over the period.

ANNEX 1

Table 9

KENYA
CONTRACEPTIVE USAGE
Low Case Scenario a/
Selected Years

	1994	1995	1996	1997	1998	1999	2000
CONTRACEPTIVES (in '000) b/							
Orals							
Microgynon	3,943	4,219	4,514	4,830	5,168	5,530	5,917
Eugynon	811	868	929	994	1,063	1,137	1,217
Neogynon	450	482	515	551	590	631	675
Microlut	693	742	793	849	908	972	1,040
Condoms	16,323	17,466	18,688	19,996	21,396	22,894	24,496
IUDs	96	103	110	118	126	135	144
VFTs	3,703	3,962	4,240	4,536	4,854	5,194	5,557
Injectables	1,442	1,543	1,651	1,767	1,890	2,022	2,164
NORPLANT	5	5	5	5	5	5	5

a. Assumes a 7% per year increase in all contraceptives listed above except NORPLANT, of which 4% increase in MWRA and 3% increase in market penetration.

b. Assumes no change in contraceptive mix over the period.

ANNEX 1

Table 10

KENYA
CONTRACEPTIVE COSTS a/
By Scenarios
Selected Years
(in millions, 1989 KSH)

	1994	1995	1996	1997	1998	1999	2000
BASE CASE SCENARIO b/							
TOTAL Costs	88.5	97.1	106.6	117.1	128.6	141.3	155.2
of which:							
Injectables	31.7	34.9	38.4	42.2	46.4	51.1	56.2
HIGH CASE SCENARIO c/							
TOTAL Costs	88.5	100.6	114.4	130.1	148.0	168.5	191.8
of which:							
Injectables	31.7	36.2	41.2	47.0	53.6	61.1	69.6
LOW CASE SCENARIO d/							
TOTAL Costs	88.5	94.5	101.0	107.9	115.3	123.3	131.8
of which:							
Injectables	31.7	33.9	36.3	38.9	41.6	44.5	47.6

a. Figures based on 1989 costs and expressed in millions of 1989 KSH. Also assumes no change in contraceptive mix over the period.
b. Assumes growth in all temporary modern methods of contraception except NORPLANT of 10% per year of which 4% growth of MWRA and 6% growth of market penetration.
c. Assumes growth in all temporary modern methods of contraception except NORPLANT of 14% per year of which 4% increase in MWRA and 10% increase in market penetration.
d. Assumes growth in all temporary modern methods of contraception except NORPLANT of 7% per year of which 4% increase in MWRA and 3% increase in market penetration.

ANNEX 2

List of Detailed Cost Tables

1. Costs Including Contingencies, by Functional Component, by Year

2. Costs Excluding Contingencies, by Functional Component, by Year

3. Summary Account, by Functional Component, by Expenditure Category

KENYA
FOURTH POPULATION PROJECT
Projects Components by Year

ANNEX 2
Table 1 Page 1

Totals Including Contingencies
KSH

	1990	1991	1992	1993	1994	1995	1996	Total
A. CONTRACEPTIVE SUPPLY								
1. DIV OF FAMILY HEALTH	98140981.0	60333249.2	63968622.5	68953874.9	435819.4	458989.6	482449.3	292873964.9
2. DEPT OF OBSTETRICS & GYN	1918200.8	1395718.1	1333906.9	1568397.0	740100.8	780741.9	823539.2	8560013.7
3. FPAK	3228466.2	680391.9	732982.7	772501.9	0.0	0.0	0.0	5409242.7
4. NORPLANT	7272793.9	6370903.1	6403747.2	8096468.9	0.0	0.0	0.0	28143911.1
Sub-Total	110555330.9	68879162.8	72438859.4	79391240.6	1175920.1	1239730.5	1305988.5	334787032.4
B. FAMILY PLANNING PROMOTION								
1. FPAK IEC	8233332.4	7908773.8	9403770.9	6841293.2	0.0	0.0	0.0	32487170.4
2. CATHOLIC SECRETARIAT	8540181.7	7376849.0	7757598.1	8158278.5	0.0	0.0	0.0	31832687.4
3. CRESCENT MEDICAL ASSOC	8308889.8	5233192.4	1362105.8	1436603.0	491831.1	518881.8	547420.3	17893924.2
4. SEVENTH DAY ADVENTISTS	19801875.6	6555078.0	1889478.8	630660.5	0.0	0.0	0.0	28877090.8
5. WOMEN'S ACTIVITIES	70718773.9	0.0	0.0	0.0	0.0	0.0	0.0	70718773.9
6. VASECTOMY CLINIC	564893.5	371442.4	407505.1	429499.3	0.0	0.0	0.0	1773340.4
7. MINISTRY OF HEALTH (DFH)	37592695.2	0.0	0.0	0.0	0.0	0.0	0.0	37592695.2
Sub-Total	153755822.2	27535183.6	20820459.7	17496334.6	491831.1	518881.8	547420.3	221155682.3
C. NCPD								
1. INSTIT'L DEVT	31176994.4	63329744.8	64136080.3	0.0	0.0	0.0	0.0	158642819.5
2. DISTRICT FOCUS	41140985.2	8219377.9	5970070.2	6290060.4	6252366.1	6587870.8	6931545.5	81392255.5
3. LONGTERM MANPOWER DEVT	1408893.7	1478352.2	1551235.0	1627710.9	0.0	0.0	0.0	6066191.8
4. IEC	71059812.4	0.0	0.0	0.0	0.0	0.0	0.0	71059812.4
Sub-Total	144786685.8	73027474.9	71657385.5	7917771.3	6252366.1	6587870.8	6931545.5	317161079.2
D. RESEARCH AND EVALUATION	34548750.0	0.0	0.0	307351.4	0.0	0.0	0.0	34856101.4
Total PROJECTS COSTS	443646588.9	169281770.8	164917503.5	105112697.9	7920117.3	8346482.6	8784954.3	907959895.4

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Table 1 Page 2

KENYA
FOURTH POPULATION PROJECT
Projects Components by Year

Totals Including Contingencies
US$

	1990	1991	1992	1993	1994	1995	1996	Total
A. CONTRACEPTIVE SUPPLY								
1. DIV OF FAMILY HEALTH	4460048.2	2787829.5	2907710.1	3134287.0	19810.0	20888.1	21929.5	13303357.5
2. DEPT OF OBSTETRICS & GYN	67101.4	68441.7	69804.9	71290.8	33640.9	35488.3	37438.6	383081.5
3. FPAK	146521.2	30022.4	33317.4	35113.7	0.0	0.0	0.0	245874.7
4. NORPLANT	330581.5	286588.5	281079.4	363021.2	0.0	0.0	0.0	1270268.7
Sub-Total	5025242.3	3121780.1	3292711.8	3603692.8	53450.9	56351.4	59368.1	16217592.4
B. FAMILY PLANNING PROMOTION								
1. FPAK IEC	374242.4	363126.1	427444.1	310987.9	0.0	0.0	0.0	1475780.5
2. CATHOLIC SECRETARIAT	388180.2	335302.2	352616.1	370830.8	0.0	0.0	0.0	1446940.3
3. CRESCENT MEDICAL ASSOC	377449.6	237872.4	61618.9	65900.1	22356.0	23585.5	24882.7	813280.2
4. SEVENTH DAY ADVENTISTS	900085.3	297858.0	85865.4	28688.4	0.0	0.0	0.0	1312596.0
5. WOMEN'S ACTIVITIES	3214489.7	0.0	0.0	0.0	0.0	0.0	0.0	3214489.7
6. VASECTOMY CLINIC	25677.0	16993.7	18523.0	19622.7	0.0	0.0	0.0	80606.4
7. MINISTRY OF HEALTH (DFH)	1708758.9	0.0	0.0	0.0	0.0	0.0	0.0	1708758.9
Sub-Total	6988891.9	1251142.4	946384.5	795287.9	22356.0	23585.5	24882.7	10052531.0
C. NCPD								
1. INSTIT'L DEVT	1417188.1	2878624.8	2915276.4	0.0	0.0	0.0	0.0	7211087.2
2. DISTRICT FOCUS	1870043.9	373808.1	271888.8	285911.8	284198.5	299448.6	315070.2	3699648.0
3. LONGTERM MANPOWER DEVT	64040.8	67197.8	70510.7	73986.9	0.0	0.0	0.0	275736.0
4. IEC	3229991.5	0.0	0.0	0.0	0.0	0.0	0.0	3229991.5
Sub-Total	6581212.1	3319430.7	3257153.9	359898.7	284198.5	299448.6	315070.2	14416412.7
D. RESEARCH AND EVALUATION	1570387.7	0.0	0.0	13970.5	0.0	0.0	0.0	1584358.2
Total PROJECTS COSTS	20165744.0	7692353.2	7496250.2	4777849.9	360006.3	379385.6	399316.1	41270904.3

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ANNEX 2
Table 2 Page 1

KENYA
FOURTH POPULATION PROJECT
KSH

Project Components by Year

	Base Costs							Total	
	1990	1991	1992	1993	1994	1995	1996	KSH	US$
A. CONTRACEPTIVE SUPPLY									
1. DIV OF FAMILY HEALTH	94255323.5	55038461.3	55938940.2	57426322.9	329617.6	329617.6	329617.6	263729610.6	12114313.6
2. DEPT OF OBSTETRICS & GYN	1809509.1	1248787.5	1182984.0	1262862.1	570804.9	570804.9	570804.9	7180677.0	328919.5
3. FPAK	2904849.1	618458.2	630408.0	630403.0	0.0	0.0	0.0	4871653.4	223778.3
4. NORPLANT	7008981.6	5842437.3	5588718.4	6747400.9	0.0	0.0	0.0	25189838.2	1157081.6
Sub-total	108055873.3	62797154.0	63298938.6	66038789.0	910522.5	910522.5	910522.5	300950077.2	13824073.4
B. FAMILY PLANNING PROMOTION									
1. FPAK IEC	7808183.5	7108158.2	7851758.2	5514847.1	0.0	0.0	0.0	28277942.9	1298934.4
2. CATHOLIC SECRETARIAT	7685704.8	6209798.6	6209798.6	6209798.6	0.0	0.0	0.0	26265084.5	1208481.1
3. CRESCENT MEDICAL ASSOC	7878220.5	4478895.8	1162551.8	1162551.8	379200.0	379200.0	379200.0	15614820.0	717263.2
4. SEVENTH DAY ADVENTISTS	18080075.9	5901153.0	1806195.5	512980.0	0.0	0.0	0.0	25708404.3	1180980.0
5. WOMEN'S ACTIVITIES	65682900.0	0.0	0.0	0.0	0.0	0.0	0.0	65682900.0	3017115.3
6. VASECTOMY CLINIC	520670.8	330781.7	344086.6	344086.6	0.0	0.0	0.0	1548765.7	71142.2
7. MINISTRY OF HEALTH (DFH)	33168584.9	0.0	0.0	0.0	0.0	0.0	0.0	33168584.9	1523561.7
Sub-total	140572040.4	23828783.2	17277986.6	13744842.1	379200.0	379200.0	379200.0	196356212.4	9019578.0
C. NCPD									
1. INSTIT'L DEVT	27352053.2	52979589.1	51066500.5	0.0	0.0	0.0	0.0	131698922.7	6049560.1
2. DISTRICT FOCUS	37870988.8	7361839.5	5137061.4	5137061.4	4858232.3	4858232.3	4858232.3	70181545.9	3223773.4
3. LONGTERM MANPOWER DEVT	1360625.0	1360625.0	1360625.0	1360625.0	0.0	0.0	0.0	5442500.0	250000.0
4. IEC	65613600.0	0.0	0.0	0.0	0.0	0.0	0.0	65613600.0	3013945.6
Sub-total	132297865.0	61402033.6	58164186.8	6497686.4	4858232.3	4858232.3	4858232.3	272936568.6	12537279.2
D. RESEARCH AND EVALUATION	33300000.0	0.0	0.0	250000.0	0.0	0.0	0.0	33550000.0	1541111.6
Total BASELINE COSTS	412225878.7	147922950.9	138740947.0	86538317.4	6147954.7	6147954.7	6147954.7	603792858.2	36922042.2
Physical Contingencies	15370675.5	7118717.8	4802080.6	656088.1	0.0	0.0	0.0	28548562.1	1311160.4
Price Contingencies	15549814.7	14295102.1	21273775.9	17898892.3	1772162.6	2198527.9	2636900.5	75623075.0	3037701.7
Total PROJECT COSTS	443046369.9	169331770.8	164817503.5	105112897.9	7920117.3	8346482.6	8784854.3	907959895.4	41270904.3
Taxes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Foreign Exchange	257673249.4	114775287.6	111754453.7	76279846.1	1621254.9	1701182.6	1774162.9	565578487.5	25708156.2

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ANNEX 2

Table 3 Page 1

KENYA
FOURTH POPULATION PROJECT
Summary Account by Project Component
KSH

	DIV OF FAMILY HEALTH	DEPT OF OBSTETRICS & GYN	FPAK	NORPLANT	FPAK IEC	CATHOLIC SECRETARIAT	CRESCENT MEDICAL ASSOC	SEVENTH DAY ADVENTISTS	WOMEN'S ACTIVITIES	VASECTOMY CLINIC	MINISTRY OF HEALTH (OFM)
I. INVESTMENT COSTS											
A. CIVIL WORKS	8277878.0	0.0	0.0	0.0	0.0	20082781.8	4042842.5	14004184.1	0.0	0.0	29200213.8
B. VEHICLES	6170211.7	0.0	484772.7	0.0	969645.5	142484.5	969645.5	484772.7	0.0	0.0	0.0
C. FURNITURE	1088880.0	0.0	0.0	0.0	0.0	1188238.4	858870.8	333949.3	0.0	0.0	598118.2
D. MATERIALS	103686.1	1468862.7	1092880.8	1106388.2	8333000.5	1284583.8	2816178.8	868840.5	34606100.0	613842.2	0 0
E. EQUIPMENT	488149.1	485400.0	187908.1	0.0	455190.9	1878480.2	787867.3	878747.7	16327600.0	197909.1	3366253.1
F. CONTRACEPTIVE SUPPLIES	107871181.8	0.0	0.0	4818878.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
G. TECHNICAL ASSISTANCE	21770000.0	20000.0	0.0	17418000.0	0.0	0.0	0.0	0.0	8300000.0	0.0	0.0
H. EVALUATION, MONITORING	0.0	842800.0	0.0	. 0.0	0.0	0.0	0.0	0.0	1650000.0	0.0	0 0
I. OVERSEAS TRAINING	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
J. TRAINING	21280400.0	10000.0	0.0	1848000.0	18800200.0	2188800.0	6840000.0	8188310.0	9800000.0	0.0	0.0
Total INVESTMENT COSTS	252008842.2	2872082.7	2888872.7	25180288.2	28577042.9	28265094.5	15814820.0	25703404.3	65682600.0	711761.3	33163584.9
II. RECURRENT COSTS											
A. SALARIES	1527800.0	4218000.0	1863200.0	0.0	0.0	0.0	0.0	0.0	0.0	633280.0	0 0
B. ALLOWANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0 0
C. PER DIEM	6714878.0	0.0	458420.0	0.0	0.0	0.0	0.0	0.0	0.0	132000.0	0.0
D. UTILITIES/SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
E. VEHICLE OPERATION/MAINT	4808488.1	0.0	688880.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
F. EQUIPMENT MAINTENANCE	68824.3	68824.3	27808.7	0.0	0.0	0.0	0.0	0.0	0.0	27809.7	0.0
G. BUILDING MAINTENANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	143924.7	0.0
H. FURNITURE MAINTENANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total RECURRENT COSTS	11719088.4	4288834.3	2488080.8	0.0	0.0	0.0	0.0	0.0	0.0	837014.5	0.0
Total BASELINE COSTS	263728810.6	7160677.0	4871053.4	25189238.2	28377942.9	28288084.5	15814820.0	25703404.3	65682800.0	1540766.7	33161584 9
Physical Contingencies	718231.5	84882.6	119278.6	65207.9	488887.1	2208711.3	850858.1	1528818.9	2541830.0	35687.6	3118189.9
Price Contingencies	28228022.9	1804474.0	418310.7	2890407.0	3600340.3	3280881.5	1622248.1	1648087.6	2494548.9	188987.1	1310920 4
Total PROJECT COSTS	292873864.9	8680018.7	5408242.7	28148911.1	32487170.4	31832887.4	17888924.2	28877080.8	70718773.9	1773340.4	37592696.2
Taxes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Foreign Exchange	258145268.6	1208183.2	1887889.7	25188424.1	5445438.4	18881822.2	6385408.1	12484804.8	32883792.7	483186.6	25391696 2

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KENYA
FOURTH POPULATION PROJECT
Summary Account by Project Component
KSH

	INSTIT'L DEVT	DISTRICT FOCUS	LONGTERM MANPOWER DEVT	IEC	RESEARCH AND EVALUATION	Total	Physical Contingencies		Price Contingencies	
							%	Amount	%	Amount
I. INVESTMENT COSTS										
A. CIVIL WORKS	111437550.0	12236280.0	0.0	0.0	0.0	194280877.0	10.0	19428087.7	8.9	17361945.6
B. VEHICLES	0.0	6926818.2	0.0	0.0	0.0	16208160.0	5.0	810408.0	4.0	650417.0
C. FURNITURE	10168009.1	1116487.8	0.0	0.0	0.0	14868221.1	5.0	743411.1	14.0	2084755.3
D. MATERIALS	0.0	1116316.4	0.0	42720600.0	0.0	96523809.8	5.0	4826190.5	6.2	6000407.4
E. EQUIPMENT	10093883.6	3879018.2	0.0	16327500.0	0.0	54757298.8	5.0	2737864.8	6.1	3330829.2
F. CONTRACEPTIVE SUPPLIES	0.0	0.0	0.0	0.0	0.0	202691069.8	0.0	0.0	10.4	21047437.4
G. TECHNICAL ASSISTANCE	0.0	0.0	0.0	4265500.0	0.0	45771500.0	0.0	0.0	10.3	4730926.9
H. EVALUATION, MONITORING	0.0	1100000.0	0.0	0.0	33550000.0	37242800.0	0.0	0.0	4.1	1540008.4
I. OVERSEAS TRAINING	0.0	0.0	6442500.0	0.0	0.0	6442500.0	0.0	0.0	11.5	623691.8
J. TRAINING	0.0	9800000.0	0.0	3300000.0	0.0	82687410.0	0.0	0.0	10.1	8390954.8
Total INVESTMENT COSTS	131698922.7	36173920.0	6442500.0	65613600.0	33550000.0	750453644.5	3.8	28543962.1	8.6	64761372.7
II. RECURRENT COSTS										
A. SALARIES	0.0	21884200.0	0.0	0.0	0.0	28997280.0	0.0	0.0	22.6	6557594.6
B. ALLOWANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
C. PER DIEM	0.0	0.0	0.0	0.0	0.0	6105705.0	0.0	0.0	13.2	805954.6
D. UTILITIES/SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
E. VEHICLE OPERATION/MAINT	0.0	9733404.5	0.0	0.0	0.0	14977524.5	0.0	0.0	18.8	2809873.0
F. EQUIPMENT MAINTENANCE	0.0	2920021.4	0.0	0.0	0.0	3114689.5	0.0	0.0	21.5	669105.7
G. BUILDING MAINTENANCE	0.0	0.0	0.0	0.0	0.0	143924.7	0.0	0.0	13.3	19174.4
H. FURNITURE MAINTENANCE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total RECURRENT COSTS	0.0	34007625.9	0.0	0.0	0.0	53339218.7	0.0	0.0	20.4	10861702.3
Total BASELINE COSTS	131698922.7	70181545.9	6442500.0	65613600.0	33550000.0	803792858.2	3.6	28543962.1	9.4	75623075.0
Physical Contingencies	12158823.6	1075510.0	0.0	2952405.0	0.0	28543962.1				
Price Contingencies	14787078.1	9335199.6	623691.8	2493807.4	1306101.4	75623075.0	2.8	2105330.5		
Total PROJECT COSTS	158642819.5	81392255.5	6066191.8	71059812.4	34856101.4	907959896.4	3.4	30649292.6	9.3	75623075.0
Taxes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Foreign Exchange	102164171.6	31570682.5	6066191.8	39525549.9	0.0	565579487.4	3.5	19839601.2		

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ANNEX 3

KENYA: FOURTH POPULATION PROJECT

ESTIMATED SCHEDULE OF DISBURSEMENTS
(US$'000)

IDA Fiscal Year & Quarter Ending	Disbursement During Quarter	Accumulated Disbursement	Accumulated % Disbursement
FY91			
Sept. 30, 1990	500	500	1.4
Dec. 31, 1990	500	1000	2.9
March 31, 1991	500	1500	4.3
June 30, 1991	500	2000	5.7
FY92			
Sept. 30, 1991	700	2700	7.7
Dec. 31, 1991	700	3399	9.7
March 31, 1992	983	4382	12.5
June 30, 1992	983	5364	15.3
FY93			
Sept. 30, 1992	1174	6538	18.7
Dec. 31, 1992	1174	7712	22.0
March 31, 1993	1316	9028	25.8
June 30, 1993	1316	10343	29.6
FY94			
Sept. 30, 1993	1624	11967	34.2
Dec. 31, 1993	1624	13590	38.8
March 31, 1994	1482	15072	43.1
June 30, 1994	1482	16554	47.3
FY95			
Sept. 30, 1994	2148	18702	53.4
Dec. 31, 1994	2148	20850	59.6
March 31, 1995	1557	22407	64.0
June 30, 1995	1557	23963	68.5

ANNEX 8

KENYA: FOURTH POPULATION PROJECT

ESTIMATED SCHEDULE OF DISBURSEMENTS
(US$'000)

IDA Fiscal Year & Quarter Ending	Disbursement During Quarter	Accumulated Disbursement	Accumulated % Disbursement
FY96			
Sept. 30, 1995	1557	25520	72.9
Dec. 31, 1995	1557	27076	77.4
March 31, 1996	1415	28491	81.4
June 30, 1996	1415	29906	85.4
FY97			
Sept. 30, 1996	1415	31321	89.5
Dec. 31, 1996	1415	32736	93.5
March 31, 1997	1132	33868	96.8
June 30, 1997	1132	35000	100.0

Note: The standard disbursement profile for Kenya was applied to an amount of US$ 28.3 million. Estimated disbursements of the remaining US$ 6.7 million for injectables were then added to the standard profile amount.

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ANNEX 5

Relevant IDA Projects

Credit Name	Number	Amount	Effective Date
First Population Project	CR 468-KE	US$12 million	1974
Integrated Rural Health and Family Planning Project	CR 1238-KE	SDR 20.5 million	2/83
Third Population Project	CR 1904-KE	SDR 9 million	2/89

INJECTABLE CONTRACEPTION

1. Injectable contraception has been in use from the early 1960's and at present is in increasing demand in many developing countries. Of those in common use, the best known and the most researched are Depo-Provera (DMPA for short) and Noristerat (NET-EN for short). DMPA has been in use since the 1970's and NET-EN since 1980. They contain synthetic hormones similar in action to the natural female hormone progesterone.

2. Though injectables have the highest effectiveness rate of any reversible contraceptive and have been shown to have far fewer life threatening complications than any of the other systemic contraceptives, they have nevertheless been subjected to an international controversy exceeding that surrounding any other method of contraception. The controversy falls under two headings -

A. the scientific
B. the political and ethical

A. The Scientific Controversy

When the manufacturers of DMPA applied for USFDA license to manufacture and distribute the drug in the United States, they were turned down. The basis of the denial was that DMPA could not be considered as entirely safe since there was a potential of its causing cancer in women and foetal malformation if given early in pregnancy. This derived from the finding that DMPA, at many times the dose to be used by women, when given to beagle bitches, led to the development of breast tumors in the beagles. The WHO's Toxicology Review Panel, the International Medical Advisory Panel of IPPF and many respected human reproductive scientists went through the evidence and came to the conclusion that the facts did not warrant withholding the licensing of the drug. It was also pointed out that the beagle was a poor model for the study of these particular hormones since they metabolized them differently from humans. Several studies on human beings were cited showing the effectiveness and the safety of Depo-Provera. The FDA's own Advisory Committee on Obstetrics and Gynecology and the one on Biometrics and Epidemiologic Methodology advised that the drug be approved because scientifically it had proved to be effective and safe. It had proved not to have many adverse side effects and it did not show any long term effect on any infants whose mothers had used DMPA. Similar findings were available at a later time for NET-EN. Despite all this, the USFDA refused to license the drug and so USAID could not supply it.

The FDA admitted that refusal to license the drug was based on: (a) risk benefit ratios for U.S. women; and (b) the availability of adequate alternatives in the U.S. Neither of these points really impugned the safety or effectiveness of the drug. Several European countries also took a hard look at the findings and most of them have licensed the drug for use.

B. The Political and Ethical Controversy

The fact that the drug once given stays in the body for three months has been used as a point against it by womens' groups. These groups contend that such a drug ensured that women had no control. Injectables have been at the center of some legal "battles" in treating individuals against their will. The ethics of using a drug in LDCs not approved for use in the country in which it was developed has posed a problem for some. At present, almost all injectables in use in LDCs are produced in Europe where they are licensed. They are used in the U.K., West Germany, Scandinavia and Canada.

Injectables in Use

4. One injection lasts two to three months. DMPA is effective for three months but if a user fails to return for re-injection on time, the chances are that she would not risk pregnancy provided she came back within the next two weeks. NET-EN, on the other hand, has to be given, at least in the first year, at 8-weekly intervals. Some studies have shown that after the first six months to one year, the drug can be given at three-monthly intervals the same way as DMPA. Both these drugs have side effects which some women do not like. They interfere with the regular menstrual cycle and, in some cases, the cycles do not occur at all. This may cause alarm among users as to whether they are pregnant or they may be pregnant and not know it. Another problem is irregular or spotty bleeding which makes injectables a difficult method for women whose religion or culture forbids their performing some household chores when they are menstruating. Unlike the combined oral pills, injectables have so far not been linked with any of the more serious and potentially fatal thromboembolic phenomena or cardiovascular accidents, such as strokes or heart attacks.

5. In the developing countries, DMPA has been studied most extensively in Thailand. DMPA has been used extensively in Mexico, Kenya, Zimbabwe, Ghana, Nigeria and Tanzania. It is in high demand by women who find it more suitable to their conditions and the protection of their privacy.

Side Effects and Complications

6. As stated, there are no lethal complications known for women using injectables, in fact, they are less likely to have strokes and similar illnesses than women on the pill. The injectables also have one advantage in that they do not decrease the supply of milk to the infant and some studies reported they increased it. They are therefore good for nursing mothers. There has been a question, however, as to whether the transfer of tiny amounts of the hormone to the infant can have any possible consequences on it in the future. This remains to be finally determined although some studies indicate that no such ill-effects are probable.

7. The one serious side effect of the injectable is excessive endometrial bleeding which occurs in a few women. However, if this occurs, estrogen therapy or a couple of cycles of an oral contraceptive can treat it. Any woman who bleeds excessively while on Depo-Provera or NET-EN needs to have careful examination to exclude more serious pathologies such as cancer of the cervix or other parts of the womb.

Return to Fertility

8. One of the most important questions asked about injectables is whether or not they cause infertility in a proportion of women. The evidence is that in most women, return to fertility after withdrawal of an injectable follows a pattern similar to that with the pill but slower. In some cases, there is a delay. Compared to the pill, the delay on a population basis is no more than six months. There is no evidence that the injectables cause permanent infertility.

Injectables in National Programs

9. To use injectables effectively in a national family planning program, certain conditions have to be met. First, there should be a clear decision that they will not be the only or even the main contraceptives to be used; that there will be what we call "a cafeteria of methods" available for the population to choose. By a cafeteria of methods, we do not necessarily mean making available every type of pill or every type of injectable that is available. There should be groups of methods. There should be pills, injectables, surgical means, and the conventional methods such as spermicide and condoms and there should be training for periodic abstinence. Next, it is important to ensure the regular availability of

all of these methods. Third, counselling and full explanation to clients must be ensured. It is not enough simply to show a person several methods and how to use each one. The advantages and disadvantages of each of the methods and the type of problems to be expected should be made known. Next, there should be a back-up system ranging from village midwives right up to hospital care which will be available for those patients or clients who run into side effects or any serious trouble. It is not enough to tell clients that troubles will be a mild headache or slight nausea. Even a mild headache or a slight nausea may be interfering with an individual's activities and thoughts; therefore there should be a provision made for such problems to be attended to very quickly and correctly. Trained staff from health centers, hospitals, and so on, should all be available to assist.

10. When dealing with the injectables in particular, asepsis needs to be maintained at all times. Because of the AIDS epidemic, programs should ensure that needles and syringes used for injections are sterilized between one patient and another. Where possible, disposable units should be used. It must be stressed here that there have been no reports linking injectables with AIDS. The advise is good preventive practice as advocated for immunization programs. A follow-up program, together with research component which ensures that supplies are used properly, that complications and side effects are identified, documented and treated, and that scientific evaluation of what is happening is faithfully undertaken, must be mandatory within all national family planning programs.

11. Who is the most suitable candidate for injectables? It is particularly suitable for women living in conditions where personal hygiene is difficult and where water supply is undependable. It has proved particularly useful for women with sickle cell disease. It is a good method for women who cannot use the pill or in whom IUDs have failed. Women with complications which can be assigned to the estrogen content of the pill, such as high blood pressure, are better off on an injectable. It is also more suitable for women who are likely to forget dates and appointments. In addition, it is more suitable than the combined pill for women breastfeeding.

12. Finally, it must be stressed that this method is very popular because it is very safe, effective and convenient. There are no valid scientific reasons for not using injectables in national programs and every reason to do so. The method is approved by the WHO and the IPPF - two agencies with a truly international perspective on health and safety issues in the field of family planning.

IBRD 21992

KENYA
DISTRICT POPULATION PROGRAMS

SUDAN
ETHIOPIA
UGANDA
SOMALIA
TANZANIA

RIFT VALLEY
EASTERN
NORTH EASTERN
WESTERN
NYANZA
CENTRAL
NAIROBI
COAST

TURKANA
MANDERA
WAJIR
WEST POKOT
TRANS NZOIA
ELGEYO MARAKWET
SAMBURU
ISIOLO
BARINGO
BUNGOMA
UASIN GISHU
BUSIA
KAKAMEGA
NANDI
LAIKIPIA
MERU
SIAYA
KISUMU
NAKURU
NYANDARUA
NYERI
KIRINYAGA
EMBU
GARISSA
KERICHO
SOUTH NYANZA
KISII
MURANGA
KIAMBU
NAROK
KITUI
TANA RIVER
MACHAKOS
KAJIADO
LAMU
KILIFI
TAITA
MOMBASA
KWALE

Lake Turkana
Lake Victoria
Bor R.
Tana R.
Athi R.
Galana R.
Indian Ocean

Population IV Districts
Population III Districts
Province Capitals
National Capital
Rivers
District Boundaries
Province Boundaries
International Boundaries

0 50 100 150 200 Kilometers
0 50 100 Miles

December 1989