KENYA POPULATION PROJECT (CREDIT 468-KE)
DRAFTS

Project File
Mr Holsen

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Mervyn L. Weiner, Director-General, OE

DATE June 15, 1981

FROM: Shiv S. Kapur, Director, OED

SUBJECT: Project Performance Audit Report on Kenya First Population Project (Credit 468-KE)

6/18

I am attaching for your approval the Performance Audit Report on Kenya First Population Project, supported by Credit 468-KE of 1974. Comments received from Eastern Africa Region and Central Projects Staff have been taken into consideration.

→ SK

Attachment

W
6/17

cc: Mr. Ernest Stern, SVPOP
Mr. Warren C. Baum, CPSVP
Mr. Willi A. Wapenhans, EANVP
Mr. Heribert Golsong, VPG

How will this project be classified in next year's review: failed ? (That would not reflect success on input side); success ? (that would not reflect failure on goals).

See P. 9

{ A frank & well-presented PPAR }

COMMENTS RECEIVED

DGO 6/18

CPS

Region

LEG

SVPOP

The World Bank

PPAR UNIT COST SHEET

PROJECT: KENYA FIRST POPULATION PROJECT
(Credit 468-KE)

		Man-Days
PREPARED BY:	William Smith and	28
	S.E. Migot-Adholla	28
APPROVED BY:	John M. Malone	7

TOTAL OED COST:

Staff	1 week
Consultants	8 weeks
TOTAL	9 weeks

DATE: June 10, 1981

PCR Assessment: Excellent, but cautious in treating "political" issues, such as lack of GOK commitment.

THE WORLD BANK

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

June 15, 1981

Operations Evaluation Department

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

TABLE OF CONTENTS

ABBREVIATIONS

CN	Community Nurse
CNTS	Community Nurse Training School
CO	Clinical Officer
EN/CN	Enrolled Nurse/Community Nurse
FHFO	Family Health Field Officer
FP	Family Planning
FPAK	Family Planning Association of Kenya
GOK	Government of Kenya
HEO	Health Education Officer
HEU	Health Education Unit
I & E	Information and Education
MCH	Maternal and Child Health
MOEPD	Ministry of Economic Planning and Development
MOH	Ministry of Health
MOW	Ministry of Works
NFWC	National Family Welfare Center
NT/S	Nurse Tutor/Supervisor
PSRI	Population Studies and Research Institute
RHC	Rural Health Center
RHDC	Rural Health Development Center
RHF	Rural Health Facility

GLOSSARY

Crude Birth Rate:	Number of live births per year per 1,000 population.
Crude Death Rate:	Number of deaths per year per 1,000 population.
Rate of Natural Increase:	Difference between crude birth and crude death rates; usually expressed as a percentage.
Rate of Population Growth:	Rate of natural increase adjusted for (net) migration, and expressed as a percentage of the total population in a given year.
Infant Mortality Rate:	Annual number of deaths of infants under 1 year per 1,000 live births during the same year.
Total Fertility Rate:	The average number of children that would be born per woman if she were to live to the end of her child-bearing years, and bear children according to a given set of age-specific fertility rates. The Total Fertility Rate often serves as an estimate of the average number of children per family.
Life Expectancy:	Average number of years expected to be lived by children born in the same year if mortality rates for each age/sex group remain the same in the future.
Contraceptive Prevalence Rate:	Percentage of married women of reproductive age group (15-49 years) using some method of contraception at a given point in time.

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT (CREDIT 468-KE)

PREFACE

This report presents the performance audit of the First Population Project in Kenya, for which a Credit of US$12.0 million was approved on March 19, 1974. The credit was fully disbursed on December 31, 1979.

The audit report comprises: (a) a Project Performance Audit Memorandum (PPAM) prepared by the Operations Evaluation Department (OED); and (b) a Project Completion Report (PCR) dated January 1981, prepared by the Population Health and Nutrition Department (PHN). The PCR incorporates the findings of a mission which visited Kenya in April 1980 for the preparation of the second Rural Health and Family Planning Project, as well as the collection of data for the PCR on the first project.

An OED mission visited Kenya in February 1981. The mission held discussions with officials of the Ministries of Health and Finance and Planning, as well as representatives of IPPF, SIDA, UNDP/UNFPA and USAID, and visited a number of rural health facilities in three different provinces. The audit memorandum is based on the findings of that mission and a study of the PCR; the Appraisal Report (No. 266a-KE dated February 20, 1974); the Credit Agreement (No. 468-KE dated April 1, 1974); and the report of the mid-term review (No. 1713-KE, datd August 18, 1977). Correspondence with the Borrower and the other donors and internal Bank memoranda and reports contained in the project files have also been reviewed, and Bank staff and other individuals associated with the project have been interviewed.

The audit finds that the PCR covers the project's main features and lessons adequately; however, the PPAM elaborates further on the underlying organization and management issues affecting project strategy, design, implementation and lesson-learning, matters which are relevant not only to this project and its successor but to other projects in socially-oriented development sectors.

A copy of the draft report was sent to the Government, DANIDA, SIDA, USAID and UNFPA for comments on April 24, 1981.

The valuable assistance provided by the Government of Kenya, SIDA, UNDP/UNFPA and USAID and their staff met during the preparation of this report is gratefully acknowledged.

PROJECT PERFORMANCE AUDIT BASIC DATA SHEET

KENYA FIRST POPULATION PROJECT (CREDIT 468-KE)

KEY PROJECT DATA

Item	Appraisal Estimate	Actual or Current Estimate
Total Project Cost (US$ million)	15.4	17.9
Overrun (%)		16.0%
Credit Amount (US$ million)		12.0
Disbursed		100.0%
Dates for Completion of Physical Components		
National Family Welfare Center	03/77	03/78
Community Nurse Training Schools	12/77	09/79
Rural Health Demonstration Centers	03/77	03/80

OTHER PROJECT DATA

Item	Original Plan	Revision	Actual or Current Estimate
First Mention in Files		-	-
Government's Application		-	-
Negotiations		-	-
Board Approval	03/19/74	-	-
Loan Agreement Date	04/01/74	-	-
Effectiveness Date	07/31/74	-	-
Closing Date	06/30/78	06/30/79	12/31/79
Borrower	Government of Kenya		
Executing Agency	Ministry of Health		
Fiscal Year of Borrower	July 1 - June 30		
Follow-on Project	2nd Population/Health Project		Appraisal 10/80

MISSION DATA

Item	Month/ Year	No. of Days	No. of Persons	Staff Days	Interval Between Missions (Months)
Reconnaisance	05/71				
Identification					
Preparation					
Preappraisal					
Appraisal	11/12/72	30	8		
Total					
Supervision I	06/74	7	2		
Supervision II	10/74	5	2		4
Supervision III	03/75	10	3		5
Supervision IV	06/75	7	2		3
Supervision V	11/75	12	3		5
Supervision VI	03/76	6	3		4
Supervision VII	09/76	11	4		6
Supervision VIII	04/77	20	4		7
Supervision IX	10/77	7	1		6
Supervision X	04/78	14	5		6
Supervision XI	07/78	17	3		3
Supervision XII	12/78	10	3		5
Supervision XIII	03/79	10	1	10	3
Supervision XIV	08/79	19	5	95	5
Supervision XV	12/79	12	1	12	4

COUNTRY EXCHANGE RATES

Name of Currency	Kenyan Shilling (K.Sh.)	
Appraisal Year Average	Exchange Rate: US$1	= 6.9 K.Sh.
Completion Year Average (November 1979)/a	US$1	= 7.4 K.Sh.

/a In October 1975, the Kenya Shilling was devalued and pegged to the SDR 1 = K.Sh. 9.66, and the rate vis-a-vis the US dollar has fluctuated since that time.

PROJECT PERFORMANCE AUDIT MEMORANDUM

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

HIGHLIGHTS

The goals of the project were to reduce the population growth rate from 3.3 to 3% and improve the health of mothers and children. The specific components called for (i) the introduction of full-time maternal and child health/family planning (MCH/FP) services in about 400 government facilities, (ii) an extension of those services through the use of 17 mobile teams to some 190 facilities, (iii) the establishment of eight nurse training schools and 30 rural health centers, (iv) training supervisors, family health educators and field workers, (v) provision of increased capacity within the Ministry of Health to produce health education materials and (vi) the establishment of a new organizational unit to plan and support the activities of the program.

In general, the quantitative targets of the program were achieved but major problems were experienced in providing organizational support and effective integration of family planning activities with MCH activities.

The primary objective of the project was not achieved. The population growth rate rose to 3.9% rather than declining to 3% and the number of acceptors of family planning services was 310,000 as opposed to the goal of 600,000. The maternal and child health program, however, performed more satisfactorily than the family planning component.

The following points may be of special interest:

- Government gave priority to rural health and considered family planning only as part of a maternal and child health program (PPAM paras. 7-11);
- the plan has been largely prepared by expatriate advisors in the Ministry of Finance and Planning and has not been extensively reviewed within the Ministry of Health (PPAM paras. 12-13);
- the new project organizational unit was never provided with the staff required to fulfill its function (PPAM para. 25); and
- weakness in evaluation and research left the project with an inadequate internal system for learning where its strategies, structure and operating systems needed to be revised (PPAM para. 28).

PROJECT PERFORMANCE AUDIT MEMORANDUM

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

I. SUMMARY

1. From late 1969 to 1973 the Bank participated in negotiations with the Government of Kenya (GOK) and seven international donors to develop a five-year program (1974-79) for family planning that would be integrated with maternal and child health care. The goals of the program were to reduce the population growth rate from 3.3 to 3% and improve the health of mothers and children. The strategy developed was to remedy what was perceived as the principal constraint, lack of trained paramedical staff. The specific components of the plan called for: (a) the introduction of full-time maternal and child health/family planning (MCH/FP) services in over 400 government health facilities; (b) an extension of those services through the use of 17 mobile teams to some 190 facilities without staff trained in FP; (c) the establishment of eight enrolled community nurse (ECN) training schools and 30 associated rural health centers; (d) training, and establishing a new class of supervisors for, 600 ECN's; (e) introduction and training of a new class of field workers, family health field educators (FHFE's) and their supervisors; (f) provision of increased capacity within the Ministry of Health (MOH) to produce health education materials; and (g) the establishment of a new organizational unit the National Family Welfare Centre (NFWC), to plan and support the activities of the MCH/FP program.

2. The total cost of the plan was estimated at $38.8 million. It was to be financed in part (32%) by the GOK and in part by seven donors: IDA, UNFPA, SIDA, USAID, DANIDA, the Federal Republic of Germany, and ODA. The IDA credit of $12 million financed mainly the physical infrastructure.

3. In general the quantitative targets of the program were achieved. By the end of 1979, 90% of the service delivery points had been established. The mobile teams were severely delayed in operation and not deployed till 1978. The target for nurse training was increased from 600 to 1,000, and 950 actually received the FP training, but, many of those trained were deployed where their training could not be utilized.

4. Major problems were experienced in providing organizational support and effective integration of family planning activities with MCH activities. The NFWC was never provided with the staff required to fulfill its function. Though FHFE's were trained in sufficient numbers, 750 versus a planned 800, they were inadequately supervised and supported, and their performance was poor relative to the provision of clinical MCH services. A new building provided for the Health Education Unit (HEU) was completed by mid 1977 but not occupied till late 1979. The Information and Education (I&E) activities of

the NFWC were not well managed. The planned resources were merged with those of the HEU and diverted to more general purposes. Some progress was made in I&E activities in 1979.

5. Evaluation and Research provided some useful statistics and reports but failed to provide the monitoring and evaluation function necessary for management and redesign of the program. The establishment of the Population and Research Center at the University of Nairobi to provide demographic research in support of the program did not achieve its objectives and had little impact on implementation of the project.

6. The primary objective of the project was not achieved. The population growth rate rose to a startling 3.9% rather than declining to the 3.0% hoped for. The number of acceptors of family planning services was 310,000 as opposed to the revised goal of 450,000, which had already been reduced from 600,000. The project was not designed in a way that adequate information was available to explain the shortfalls, thus valuable opportunities for learning were lost. The MCH component performed much more satisfactorily than the FP component; between 65-75% of pregnant women were being reached by the program by the end of 1979. The success of the program, however, was inhibited by bottlenecks in training due to the takeover of an IDA-financed nurse-trainees' dormitory at the NFWC by medical students, severely limiting the number of in-service FP training opportunities; by the failure of the drug supply system to keep rural health facilities stocked; and by the diversion of project-financed transport to more general services.

II. COMMITMENT TO PROJECT PURPOSES

7. An evaluation of the successes and failures of the First Population Project requires an interpretation of the relative weight given to its two major components, MCH and FP. From initial conception of the project through preparation, appraisal and implementation, the major stakeholders (the donors, the Ministry of Finance and Planning (MOF&P), the MOH, NGO's, provincial and district staff, politicians, and the intended beneficiaries) held widely differing levels of commitment to the two parts. A successful process of design would have required that the differing levels of commitment be understood and accurately perceived by each of the stakeholders and that a means be found that would satisfy the proposed stake each had in the project outcomes. Many of the problems of design and implementation can be traced to the inappropriateness of the fit between project strategy and structure and the relative commitment of the stakeholders to the two major components.

8. As early as October 1967 the GOK demonstrated its relative lack of commitment to family planning by disbanding the interministerial Family Planning Council and relegating control of the Government's family planning effort to the MOH. At that time the primary commitment to family planning came from the private sector. The Family Planning Association of Kenya (FPAK)

had such a strong commitment that the government could not successfully compete with it in hiring the best qualified Kenyans to run its own programs. The international donors were also strongly committed to FP and provided the country with its major source of expertise. So strong was the donors' commitment that some felt they created undesirable competition in their effort to assist the Government.

9. From the earliest days of project conception in 1969, the Kenyan Government made it clear that its primary interest was rural health and that it would only consider family planning as part of a maternal and child health program. The MOF&P took the early lead in negotiating with the Bank and at that time saw more clearly the economic necessity of family planning than did the other ministries. It was also clear that the Kenyan population, especially the 90% living outside of the urban areas, was not in favor of family planning. A 1968 survey covering the six largest tribes revealed a high ideal family size of six children, only slightly less than the 6.8 actually achieved. The survey did, however, also indicate a positive correlation between improvements in education and improved living standards and interest in family planning.

10. The theme of population and its critical relationship to economic growth was stressed strongly in Mr. McNamara's September 1968 address to the Board of Governors. The address was followed by the establishment of the Population Projects Department within CPS in the Fall of 1969. The new department was under considerable pressure to produce projects. By the time of preparation of the Kenya project, it had assembled a staff of approximately 10 professionals, most of whom were unfamiliar with Bank procedures. They faced additional difficulties of dealing with a "soft" sector and found dialogue with Bank economists frustrating. Their organizational position in CPS also weakened them in their relationship with the Regions. The department had worked on several projects; however, these were not regarded as making the kind of impact envisaged by the Bank. In preparing the Kenya project, the first large multi-donor project and the first population project ever in sub-Saharan Africa, the staff were under tremendous pressure to produce a "bankable project".

11. During preparation the differences of priority attached to the two components became more evident as specific proposals for project design began to take shape. The Bank supported the GOK's position, giving priority to the MCH component. The UNFPA and USAID objected that the emerging strategy, with its massive assistance for construction of rural health facilities and training schools, would slow down the implementation of family planning activities and provide only modest returns in terms of reducing the rate of population increase at very high cost. The difference of viewpoint helped fuel a struggle between the UNFPA and the Bank for the prime coordinating role relative to the other donors. The role was ultimately assigned to the World Bank. The difference, however, probably influenced the Bank's choice of tactics for completing the appraisal report. It declined to mount a joint appraisal by all the donors because:

"past experience has shown that the technical quality of reports has suffered from having various agencies who tend to press for their agencies' interests rather than the technical quality....The mission will be comprised of impartial experts and will have a low profile given existing political sensitivities."1/

III. THE CHOICE OF STRATEGY AND STRUCTURE

12. The choice of project strategy was influenced by the process and outcome of the struggle to determine the relative priority of the MCH and FP components. As the struggle continued up to the time of the appraisal mission, a factor of time pressure was added to the negotiations. A five-year family planning program provided the vehicle for the discussions of strategy. The plan was sponsored by the MOF&P and the MOH. It was cross-sectoral in nature and included an integrated plan for the development of manpower for a range of rural health services. The plan had been largely prepared by expatriate advisors in the MOF&P and had not been extensively reviewed within the MOH in the context of the overall development of health services in Kenya.

13. The Bank mission reviewed the plan as part of its appraisal mission in December 1972. The problem the mission faced was to design a strategy that would reconcile the MCH services and construction of facilities favored by the MOH with its own mandate as the Population Projects Department and the family planning mandates of the key contributors. The strategy it chose was to concentrate on removing what was then perceived as the key constraint to improved MCH/FP services: the shortage of trained paramedical staff. It concentrated more on the supply of services than on stimulating demand. Its key elements were: staffing 450 service points, recruiting new acceptors, establishing an organizational center to spearhead a national program and providing it with functional support, increasing information and education activities and providing research and evaluation.

14. The GOK was disappointed with the proposal because it only provided enough physical facilities to keep pace with the rate of training provided by the program itself. The WHO criticized the plan for its lack of emphasis on rural health services and its excessive concern with population growth reduction. The UNFPA felt that it did not sufficiently reflect and build on many of the related health activities already ongoing in the country. The program was too expensive and was really a health program "masquerading" as a population project. The USAID felt that the program lacked appropriate emphasis on the organizational and management constraints within the MOH that would be likely to hamper the implementation of the project.

1/ Internal Bank memorandum, September 27, 1972. Underlining added by the audit.

15. Pressed for time, the Bank felt that it would be impossible to develop or study any radically different approaches without delaying the appraisal. It incorporated what suggestions were feasible and agreed with the GOK to proceed with the modified appraisal report, if necessary, without the support of the dissident donors.

16. The difficulties experienced in developing a common strategy were equally manifest in the choice of organizational form to implement the project. Up until 1970 family planning activities and rural health services had been conducted under the decentralized control of the County Councils. At the time of project preparation the MOH had still not developed, institutionally, an ability to handle large projects that demanded centralized control. The centerpiece of the proposed organizational strategy was the creation of a unit within the MOH that would spear-head the formulation and implementation of the family planning component of the project. It was initially referred to as the National Family Planning Center, but under the influence of political sensitivity and the integrated MCH/FP strategy became the National Family Welfare Center. It was to be housed in the new Kenyatta National Medical Center and, in addition to an administrative unit, would accommodate four functional support units: Clinical Services, Information and Education, Training, and Evaluation and Research. Physical facilities would include a dormitory for FP trainees, a family planning clinic and a Health Education Unit (AEU) for production of family planning educational materials.

17. It was hoped that the special status imparted to the NFWC through external project funding would enable it to overcome the major barriers facing implementation of such a program within the MOH, shortage of skilled managerial staff and procedural constraints. The Director of Medical Services in the MOH would oversee the program and head an Advisory Working Committee to formulate policy and coordinate with participating agencies. Three advisory sub-committees would provide the working committee with program support in the areas of training, research and information. The NFWC would also closely coordinate its activities with a Project Construction Unit established within the MOH and with the new HEU. Details of how this coordination would be achieved were left unspecified. What is clear is that the NFWC's primary role was to support the family planning activities of the integrated MCH/FP strategy. The evaluation and research were to provide the fundamental intelligence for FP training and provision of clinical FP services and information and education were to support service delivery by generating a climate of opinion favorable to family planning and to provide prospective users with operationally relevant information on the services and how to use them. The construction component would primarily serve the interests of general rural health and MCH.

18. The organizational linkage between the intelligence and training resources provided by the NFWC and the physical and human nursing resources provided by the MOH was the offices of the provincial and district medical staff (see Chart I). Unfortunately the staff had not been very much involved in the project design process and by inclination did not tend to give family

planning activities a high priority. The nurses' organization was most closely integrated with the project's purpose through the training and supervision of community nurses. The initial plan called for the 46 registered public health nurses trained as Provincial and District Nurse Trainer/Supervisors (NT/S) to report to the head of the Clinical Services Division in the NFWC. The Chief Nursing Officer (CNO), reflecting the general political mood of the country, was not favorably disposed to give family planning activities a high priority in relation to general nursing duties, nor was she favorably disposed to the degree of power sharing suggested by the proposed organizational arrangements. Her opposition eventually resulted in the disappearance of NT/S's as a separate cadre (they were merged with the District and Provincial Public Health Nurses).

19. A parallel organization was planned to supervise the family planning field workers, a Provincial Family Health Officer as a counterpart to the Provincial Nursing Officer and a District Field Officer equivalent to the District Nurse Trainer. The proposed compensation for these positions and for the new category of FHFE, had been based on that paid by the FPAK. Unfortunately this created a disparity with nurses' salaries and added to the difficulties of the family planning specialists.

20. The organizational strategy for family planning, in summary, relied on strong vertical integration through the provincial and district medical offices and strong lateral coordination with the nursing organization and the HEU, with interministerial coordination provided by the committees. It failed to supply linkages to external sources of support for family planning activities, e.g. the MOF&P and the NGO's. Its design relied heavily on the MOH where the commitment to family planning was not very strong.

IV. IMPLEMENTATION

21. Staffing. The organizational strategy depended on the NFWC to rapidly accelerate the normal rate of FP activity within the MOH in order to move the project forward. The Credit Agreement called for appointment of all key staff within 90 days of project start-up. Six months after start-up, however, none of the four division heads of the NFWC had been appointed. During the life of the project the NFWC never had a full-time Director nor full-time head of the I&E division. No Kenyan head was ever found to run the research and evaluation unit, which was run by a relatively junior UNFPA advisor. There was considerable delay in appointing a program advisor. The GOK preferred a Kenyan, but none could be found with the necessary experience of running a family planning program. The most serious effect on the project came from the lack of a full-time, relatively independent director. As a result, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out the role envisaged, and the principal task of directing NFWC activities fell to the deputy directors, who were changed three times during the life of the project and themselves received little support.

22. The current (February 1981) state of staffing is reflected in Chart II. There is no operating clinical division. The public health nurse who was supposed to be assigned to assist the head of the division was never transferred from the office of the CNO in the MOH to the NFWC. The physician who headed the division was transferred due to illness and never replaced. There are no heads for any of the other three functional support areas, and the administrative unit has no professional staff.

23. Support Functions. The second part of the strategy required the NFWC to develop the intelligence and support systems necessary for the training and service activities of the clinical group. Unlike the provision of physical facilities, which requires a relatively simple implementation strategy, the provision of intelligence and support activities required a relatively sophisticated adaptive strategy. Little was known about fertility determinants in the Kenyan context, or about methods to use in the different local contexts to persuade Kenyans to adopt family planning practices. For planning purposes models drawn from the Asian context had been employed. Both targets and choice of strategy were based on assumptions that required testing. Major revisions in strategy and tactics should have been expected and planned for. The GOK was not in favor of a pilot project approach, but little attention was given to developing a variety of implementation strategies to foster and accelerate the amount of required learning. For example, the need for information about fertility determinants was identified, and a Population Study and Research Center was established in the University of Nairobi to carry out relevant studies. Due to internal difficulties within the University, however, the studies did not materialize during the life of the project, and no serious alternatives were developed to obtain this essential information.

24. The evaluation and research unit, though operating without a head, managed to produce a number of useful studies and sets of statistics. It did not provide the management information system envisaged in planning. The project was left without the information necessary to test the assumptions on the basis of which it was designed, and the insights necessary to revise its strategies, structure and operating systems.

25. The I&E division and the HEU throughout the life of the project were never able to adequately differentiate their roles. The I&E division thus never developed a strategy backed by an action plan that was implemented. Mid-way through the project the Bank, in particular, gave very detailed assistance to the I&E division in drawing up a plan of action, but it was never followed through. The two major successes of I&E were not even envisaged in the original design. The division, with considerable help from the Institute of Adult Education, undertook the training of the family planning field workers, a role originally envisaged for the training division. It also mounted a series of seminars to communicate to, and motivate, the provincial and district medical and clinical officers. Evidence indicates that these seminars were successful in gaining acceptance of the concept of integrating MCA and FP activities but not necessarily in gaining the active support and cooperation of the medical officers for the FP component. This is probably

best evidenced by the officers' lack of support in freeing transportation allocated to the FP program for use by field supervisors. The HEU, sharing the same manager as the I&E division, suffered from similar problems. 50% of its resources were meant to be devoted to producing materials for the program; however, general health priorities tended to supercede those of FP.

26. The training division found it impractical to carry out its original mandate to provide all short and long term basic and in-service training. The responsibility had to be shared with several other divisions of NFWC and other organizations. The confusion of priorities attached to the MCH and FP components had its effect also in the training of field workers. The trainers were originally unclear about the kind of worker they wanted to produce, how much MCH versus FP. It took till 1977 for the trainers to develop their own clarity based on feedback from early intakes. In spite of the difficulties of role clarity and lack of informational support the result of the training can be seen as one of the highlights of the project. This is particularly true of the training of NT/S's, whose numbers exceeded those estimated by a considerable margin. The success of this training effort has been hampered by the failure of the Director of the NFWC to negotiate an agreement with the CNO on deployment of FP-trained nurses. Many are posted to units which do not make use of their training. Similarly the failure of the NFWC director or the Ministry of Health to intervene to restore the project-financed dormitory facilities to the in-service FP trainees at the NFWC after their unlawful takeover by medical students has caused a serious bottleneck in the flow of training recruits, due to the difficulty of finding alternative accommodation in hotels, etc. At the end of the project, in service training of clinical officers, essential to the effective supervision of field workers, had not yet begun.

27. Clinical services. The strategy of combining MCH/FP at service delivery points has worked well. The quantity of service provided has approximated planned levels but the quality is hampered by lack of supervision, failure of the material supply system, and lack of transport. The CNO never relinquished control of the NT/S's to the clinical services division, nor did the public health nurse chosen to assist the head of the division ever transfer to an office in NFWC. In general the impact of the FP component at the service delivery points has been much less than that of the MCH component. Although 42% of all married women had heard of family planning services, less than 6% actually visited one in the surveyed period (12 months), while 65-75% of all pregnant women were being reached by the MCH program.

V. MANAGEMENT INFORMATION

28. Weaknesses in the evaluation and research division left the project with an inadequate internal system for learning where its strategies, structure and operating systems needed to be revised. The provision of such information was, by default, left to an external mechanism, the supervision

missions of the donors, and in particular the mid-term review. As few GOK or MOH officials were involved directly in either the supervision or mid-term review, the donors were left with the same problem they faced in initiating the original design process - how to translate their learning into actions that had the genuine commitment of the relevant Kenyan officials. The lack of an effective internal learning system caused the donors as a result of the mid-term review to miscalculate the strength of the program. At the time of the review the program was going as well as it had ever been. The program advisor was in place and had developed an effective team including an effective deputy director and several other key staff in the NFWC. However, the basic problems of commitment had not been solved. The evaluation team foresaw an increase in influence for the NFWC. This failed to materialize. The program advisor left and was not replaced; the deputy director was transferred along with the other key staff. To correct the fundamental problems would have taken strong intervention from outside of the MOH. The Ministry of Finance and Planning had no active role in the project. The international donors, if well coordinated, might have been able to bring about such an intervention, but their position had been weakened by the internecine struggle over project priorities. As the second project is being appraised, the same fundamental problems remain: how to design a project that has the genuine commitment and support of the most influential officials of the Ministry of Health; how to develop a learning process within the MOH that will enable it to increase its capacity to manage its own staff and resources more effectively. Considerable learning from the first project has been incorporated in the design of the second. This time the other donors have been involved in a joint appraisal, allowing the diversity of their knowledge and experience to enrich the design process. Greater emphasis has been placed on management of the external environment of the project by involving more ministries and private organizations in the project. There has been a wider participation of MOH officials in the gathering of information, if not in the decision-making process, which has involved mainly senior-level MOH managers in Nairobi.

29. Information and education activities, designed to stimulate demand for FP services, have been given much greater emphasis in the second project, and a stronger differentiation has been made between MCH and FP activities and their organization. The need for more powerful support for family planning activities has been recognized by the proposal of a National Council on Population Development. The Council would be placed in the President's Office and would include members of participating ministries and NGOs. It would have budget approval powers over I&E spending.

30. Three of the organization issues raised in the first project still appear to require more attention in the design of the second, however: (i) clarity of the role of the NFWC and reasons for the continuing lack of support for its activities, (ii) the lack of commitment and support for FP program activities from key officials of the MOH, and (iii) the management capacity of the MOH to implement the much larger planned program. The Population, Health and Nutrition Projects Department does not agree with this particular finding of the audit, but believes that enough attention has been given to these issues in the appraisal of the second project. OED does not share in this belief.

The Audit

The Bank's Role

31. The technical assistance role of the Bank in the design of the project was well appreciated both by the GOK and other donors. Its role on supervision missions was regarded as very professional and considerate. A less obvious function the Bank performed was that of a third party to facilitate negotiations during design, implementation and evaluation between the GOK and the other donors. This role was particularly important due to the multi-purpose, multi-donor nature of the project. The Bank performed this role best during the early stages of identification and preparation and during the mid-term evaluation. It performed it less well during the appraisal process. Apparently, norms of technical efficiency and internal Bank time pressures to produce a significant population project influenced Bank staff to press for rapid agreement and firm decision making inconsistent with the long term uncertain nature of the family planning components of the project. The primary effect was for undue emphasis to be placed on the technical, quantifiable elements of the project and too little on the institutional objective: i.e., developing a process of commitment, adaptive planning and learning.

VI. CONCLUSIONS

32. Most of the problems of project design and implementation can be traced to the differing levels of commitment on the part of the major stakeholders to the two project components, MCH and FP. Developing a consensus on project priorities took so long that the Bank felt pressured to move ahead with a project design that had not adequately involved the nursing organization, the provincial and district staff, other ministries, NGOs and possibly the other international donors themselves.

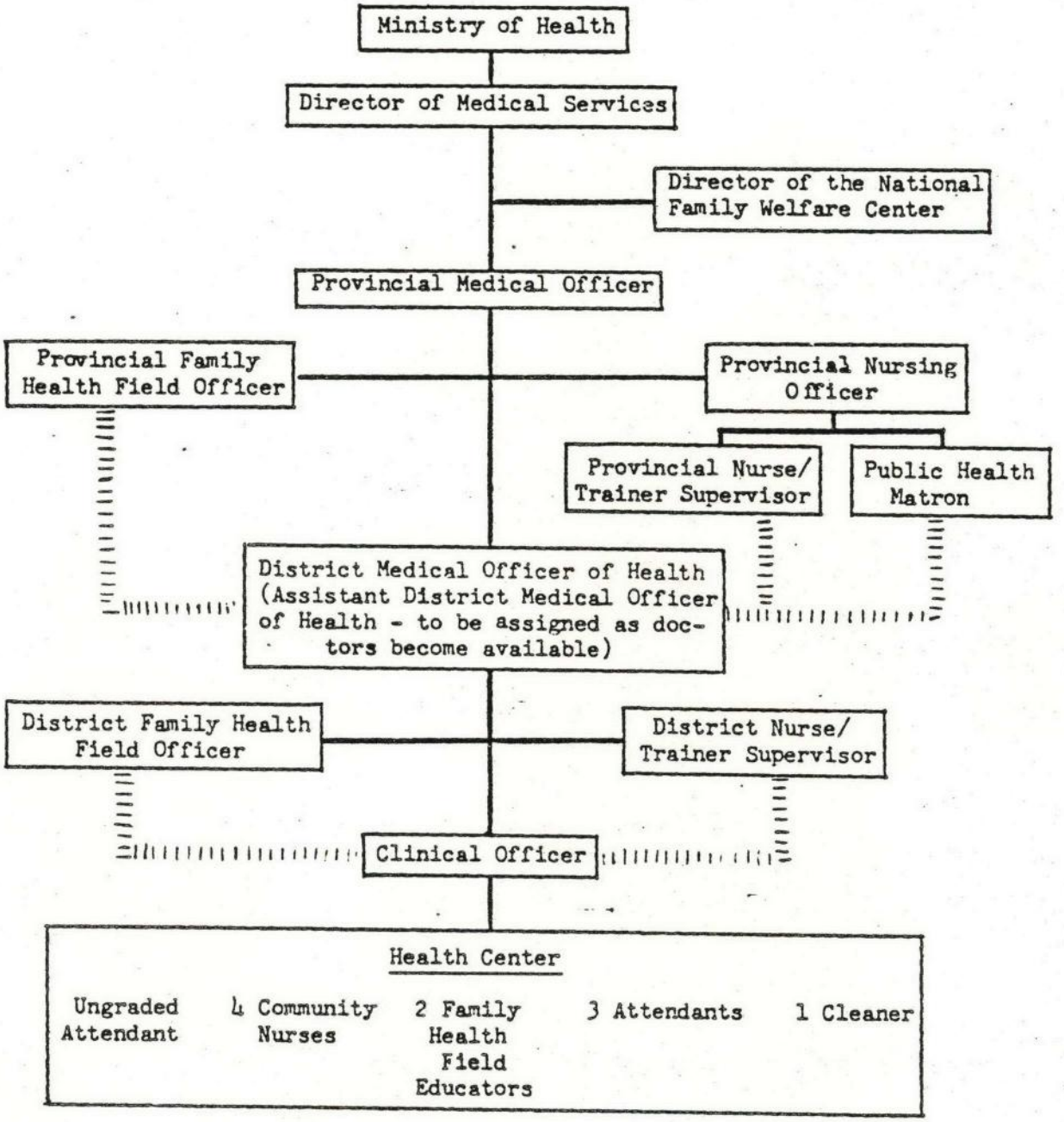
33. Due to the concern among the Kenyans about generating excessive visibility for the FP program, the design concentrated heavily on providing inputs for the supply of services and gave much less attention to the demand constraints. As it turned out, achieving the targeted reduction in population growth required a strategy to increase demand. The provision of services made an easier project to fund and manage, however, compared to the more abstract and uncertain task of assessing fertility determinants and developing appropriate mixes of strategies to deal with the findings.

34. Even given the chosen strategy, insufficient attention was given to institutional and management constraints. Early indications were available of the kinds of problems likely to be encountered, but it was felt that the project would be unduly delayed if they were studied. In setting up the NFWC as the centerpiece for project implementation the designers either underestimated the resistance it would create within the MOH or overestimated the amount of influence the NFWC would be able to wield. The design allowed for an appropriate degree of integration of MCH and FP activities at the service delivery points. It also planned for reasonable differentiation at the national level. However, it did not work out an appropriate mix at the

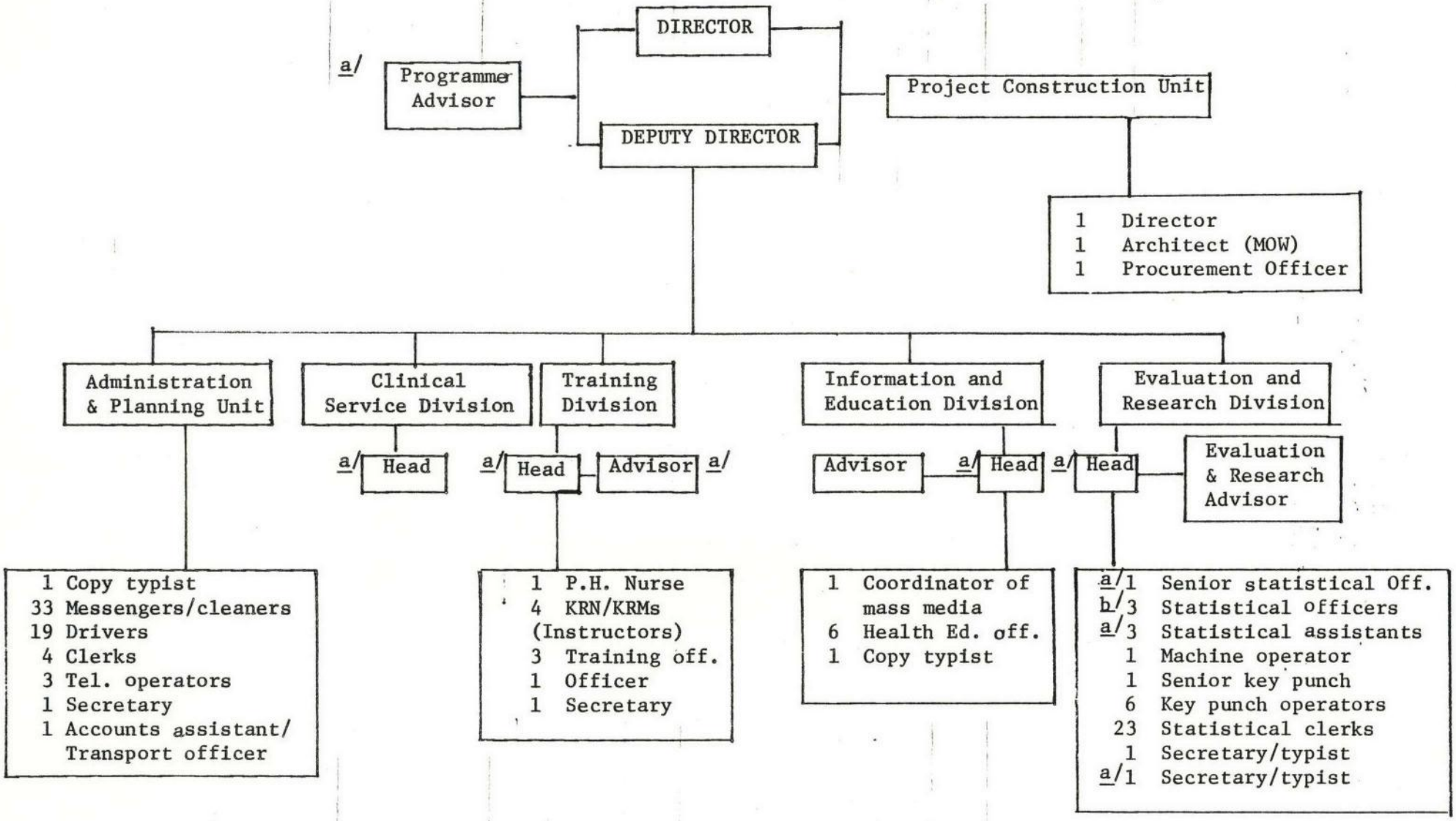
intermediate provincial and district levels. The nursing organization, which was very strongly controlled, was thus able to see that its interests were taken care of, but family planning activities never became an effectively integrated part of the provincial and district organization. The NFWC never became adequately linked to its institutional environment and thus lost potential means of support and influence. It was never provided with, or was shorn of, essential resources such as staff, buildings and vehicles; until at the end of the project it is no longer a viable organization for directing national population effort.

35. The relative successes of the project, on the supply side, are well documented in the completion report. Quantitatively, the project achieved most of its construction and training targets. The program has increased the awareness of the need for family planning both within the Government and outside. It has provided a physical and human resource base with which to supply services; however, it has not provided either the intelligence or the organizational means with which to effectively use those resources.

B. Administrative Structure at Provincial and District Levels



Source: Ministry of Health.



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THE WORLD BANK

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

April 28, 1981

Operations Evaluation Department

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

TABLE OF CONTENTS

ABBREVIATIONS

CN	Community Nurse
CNTS	Community Nurse Training School
CO	Clinical Officer
EN/CN	Enrolled Nurse/Community Nurse
FHFO	Family Health Field Officer
FP	Family Planning
FPAK	Family Planning Association of Kenya
GOK	Government of Kenya
HEO	Health Education Officer
HEU	Health Education Unit
I & E	Information and Education
MCH	Maternal and Child Health
MOEPD	Ministry of Economic Planning and Development
MOH	Ministry of Health
MOW	Ministry of Works
NFWC	National Family Welfare Center
NT/S	Nurse Tutor/Supervisor
PSRI	Population Studies and Research Institute
RHC	Rural Health Center
RHDC	Rural Health Development Center
RHF	Rural Health Facility

GLOSSARY

Crude Birth Rate:	Number of live births per year per 1,000 population.
Crude Death Rate:	Number of deaths per year per 1,000 population.
Rate of Natural Increase:	Difference between crude birth and crude death rates; usually expressed as a percentage.
Rate of Population Growth:	Rate of natural increase adjusted for (net) migration, and expressed as a percentage of the total population in a given year.
Infant Mortality Rate:	Annual number of deaths of infants under 1 year per 1,000 live births during the same year.
Total Fertility Rate:	The average number of children that would be born per woman if she were to live to the end of her child-bearing years, and bear children according to a given set of age-specific fertility rates. The Total Fertility Rate often serves as an estimate of the average number of children per family.
Life Expectancy:	Average number of years expected to be lived by children born in the same year if mortality rates for each age/sex group remain the same in the future.
Contraceptive Prevalence Rate:	Percentage of married women of reproductive age group (15-49 years) using some method of contraception at a given point in time.

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT (CREDIT 468-KE)

PREFACE

This report presents the performance audit of the First Population Project in Kenya, for which a Credit of US$12.0 million was approved on March 19, 1974. The credit was fully disbursed on December 31, 1979.

The audit report comprises: (a) a Project Performance Audit Memorandum (PPAM) prepared by the Operations Evaluation Department (OED); and (b) a Project Completion Report (PCR) dated January 1981, prepared by the Population Health and Nutrition Department (PHN). The PCR incorporates the findings of a mission which visited Kenya in April 1980 for the preparation of the second Rural Health and Family Planning Project, as well as the collection of data for the PCR on the first project.

An OED mission visited Kenya in February 1981. The mission held discussions with officials of the Ministries of Health and Finance and Planning, as well as representatives of IPPF, SIDA, UNDP/UNFPA and USAID, and visited a number of rural health facilities in three different provinces. The audit memorandum is based on the findings of that mission and a study of the PCR; the Appraisal Report (No. 266a-KE dated February 20, 1974); the Credit Agreement (No. 468-KE dated April 1, 1974); and the report of the mid-term review (No. 1713-KE, datd August 18, 1977). Correspondence with the Borrower and the other donors and internal Bank memoranda and reports contained in the project files have also been reviewed, and Bank staff and other individuals associated with the project have been interviewed.

The audit finds that the PCR covers the project's main features and lessons adequately; however, the PPAM elaborates further on the underlying organization and management issues affecting project strategy, design, implementation and lesson-learning, matters which are relevant not only to this project and its successor but to other projects in socially-oriented development sectors.

The valuable assistance provided by the Government of Kenya, SIDA, UNDP/UNFPA and USAID and their staff met during the preparation of this report is gratefully acknowledged.

PROJECT PERFORMANCE AUDIT BASIC DATA SHEET

KENYA FIRST POPULATION PROJECT (CREDIT 468-KE)

KEY PROJECT DATA

Item	Appraisal Estimate	Actual or Current Estimate
Total Project Cost (US$ million)	15.4	17.9
Overrun (%)		16.0%
Credit Amount (US$ million)		12.0
Disbursed		100.0%
Dates for Completion of Physical Components		
National Family Welfare Center	03/77	03/78
Community Nurse Training Schools	12/77	09/79
Rural Health Demonstration Centers	03/77	03/80

OTHER PROJECT DATA

Item	Original Plan	Revision	Actual or Current Estimate
First Mention in Files		-	-
Government's Application		-	-
Negotiations		-	-
Board Approval	03/19/74	-	-
Loan Agreement Date	04/01/74	-	-
Effectiveness Date	07/31/74	-	-
Closing Date	06/30/78	06/30/79	12/31/79
Borrower	Government of Kenya		
Executing Agency	Ministry of Health		
Fiscal Year of Borrower	July 1 - June 30		
Follow-on Project	2nd Population/Health Project		Appraisal 10/78

MISSION DATA

Item	Month/ Year	No. of Days	No. of Persons	Staff Days	Interval Between Missions (Months)
Reconnaisance	05/71				
Identification					
Preparation					
Preappraisal					
Appraisal	11/12/72	30	8		
Total					
Supervision I	06/74	7	2		
Supervision II	10/74	5	2		4
Supervision III	03/75	10	3		5
Supervision IV	06/75	7	2		3
Supervision V	11/75	12	3		5
Supervision VI	03/76	6	3		4
Supervision VII	09/76	11	4		6
Supervision VIII	04/77	20	4		7
Supervision IX	10/77	7	1		6
Supervision X	04/78	14	5		6
Supervision XI	07/78	17	3		3
Supervision XII	12/78	10	3		5
Supervision XIII	03/79	10	1	10	3
Supervision XIV	08/79	19	5	95	5
Supervision XV	12/79	12	1	12	4

COUNTRY EXCHANGE RATES

Name of Currency	Kenyan Shilling (K.Sh.)	
Appraisal Year Average	Exchange Rate: US$1	= 6.9 K.Sh.
Completion Year Average (November 1979)/a	US$1	= 7.4 K.Sh.

/a In October 1975, the Kenya Shilling was devalued and pegged to the SDR 1 = K.Sh. 9.66, and the rate vis-a-vis the US dollar has fluctuated since that time.

PROJECT PERFORMANCE AUDIT MEMORANDUM

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

I. SUMMARY

1. From late 1969 to 1973 the Bank participated in negotiations with the Government of Kenya (GOK) and seven international donors to develop a five-year program (1974-79) for family planning that would be integrated with maternal and child health care. The goals of the program were to reduce the population growth rate from 3.3 to 3% and improve the health of mothers and children. The strategy developed was to remedy what was perceived as the principal constraint, lack of trained paramedical staff. The specific components of the plan called for: (a) the introduction of full-time maternal and child health/family planning (MCH/FP) services in over 400 government health facilities; (b) an extension of those services through the use of 17 mobile teams to some 190 facilities without staff trained in FP; (c) the establishment of eight enrolled community nurse (ECN) training schools and 30 associated rural health centers; (d) training, and establishing a new class of supervisors for, 600 ECN's; (e) introduction and training of a new class of field workers, family health field educators (FHFE's) and their supervisors; (f) provision of increased capacity within the Ministry of Health (MOH) to produce health education materials; and (g) the establishment of a new organizational unit, the National Family Welfare Centre (NFWC), to plan and support the activities of the MCH/FP program.

2. The total cost of the plan was estimated at $38.8 million. It was to be financed in part (32%) by the GOK and in part by seven donors: IDA, UNFPA, SIDA, USAID, DANIDA, the Federal Republic of Germany, and ODA. The IDA credit of $12 million financed mainly the physical infrastructure.

3. In general the quantitative targets of the program were achieved. By the end of 1979, 90% of the service delivery points had been established. The mobile teams were severely delayed in operation and not deployed till 1978. The target for nurse training was increased from 600 to 1,000, and 950 actually received the FP training, but, many of those trained were deployed where their training could not be utilized.

4. Major problems were experienced in providing organizational support and effective integration of family planning activities with MCH activities. The NFWC was never provided with the staff required to fulfill its function. Though FHFE's were trained in sufficient numbers, 750 versus a planned 800, they were inadequately supervised and supported, and their performance was poor relative to the provision of clinical MCH services. A new building provided for the Health Education Unit (HEU) was completed by mid 1977 but not occupied till late 1979. The Information and Education (I&E) activities of the NFWC were not well managed. The planned resources were merged with those of the HEU and diverted to more general purposes. Some progress was made in I&E activities in 1979.

5. Evaluation and Research provided some useful statistics and reports but failed to provide the monitoring and evaluation function necessary for management and redesign of the program. The establishment of the Population and Research Center at the University of Nairobi to provide demographic

research in support of the program did not achieve its objectives and had little impact on implementation of the project.

6. The primary objective of the project was not achieved. The population growth rate rose to a startling 3.9% rather than declining to the 3.0% hoped for. The number of acceptors of family planning services was 310,000 as opposed to the revised goal of 450,000, which had already been reduced from 600,000. The project was not designed in a way that adequate information was available to explain the shortfalls, thus valuable opportunities for learning were lost. The MCH component performed much more satisfactorily than the FP component; between 65-75% of pregnant women were being reached by the program by the end of 1979. The success of the program, however, was inhibited by bottlenecks in training due to the takeover of an IDA-financed nurse-trainees' dormitory at the NFWC by medical students, severely limiting the number of in-service FP training opportunities; by the failure of the drug supply system to keep rural health facilities stocked; and by the diversion of project-financed transport to more general services.

II. COMMITMENT TO PROJECT PURPOSES

7. An evaluation of the successes and failures of the First Population Project requires an interpretation of the relative weight given to its two major components, MCH and FP. From initial conception of the project through preparation, appraisal and implementation, the major stakeholders (the donors, the Ministry of Finance and Planning (MOF&P), the MOH, NGO's, provincial and district staff, politicians, and the intended beneficiaries) held widely differing levels of commitment to the two parts. A successful process of design would have required that the differing levels of commitment be understood and accurately perceived by each of the stakeholders and that a means be found that would satisfy the proposed stake each had in the project outcomes. Many of the problems of design and implementation can be traced to the inappropriateness of the fit between project strategy and structure and the relative commitment of the stakeholders to the two major components.

8. As early as October 1967 the GOK demonstrated its relative lack of commitment to family planning by disbanding the interministerial Family Planning Council and relegating control of the Government's family planning effort to the MOH. At that time the primary commitment to family planning came from the private sector. The Family Planning Association of Kenya (FPAK) had such a strong commitment that the government could not successfully compete with it in hiring the best qualified Kenyans to run its own programs. The international donors were also strongly committed to FP and provided the country with its major source of expertise. So strong was the donors' commitment that some felt they created undesirable competition in their effort to assist the Government.

9. From the earliest days of project conception in 1969, the Kenyan Government made it clear that its primary interest was rural health and that it would only consider family planning as part of a maternal and child health program. The MOF&P took the early lead in negotiating with the Bank and at that time saw more clearly the economic necessity of family planning than did the other ministries. It was also clear that the Kenyan population, especially the 75% living outside of the urban areas, was not in favor of family planning. A 1968 survey covering the six largest tribes revealed a high ideal family size of six children, only slightly less than the 6.8 actually achieved. The survey did, however, also indicate a positive correlation between improvements in education and improved living standards and interest in family planning.

10. The theme of population and its critical relationship to economic growth was stressed strongly in Mr. McNamara's September 1968 address to the Board of Governors. The address was followed by the establishment of the Population Projects Department within CPS in the Fall of 1969. The new department was under considerable pressure to produce projects. By the time of preparation of the Kenya project, it had assembled a staff of approximately 10 professionals, most of whom were unfamiliar with Bank procedures. They faced additional difficulties of dealing with a "soft" sector and found dialogue with Bank economists frustrating. Their organizational position in CPS also weakened them in their relationship with the Regions. The department had worked on several projects; however, these were not regarded as making the kind of impact envisaged by the Bank. In preparing the Kenya project, the first large multi-donor project and the first population project ever in

sub-Saharan Africa, the staff were under tremendous pressure to produce a "bankable project".

11. During preparation the differences of priority attached to the two components became more evident as specific proposals for project design began to take shape. The Bank supported the GOK's position, giving priority to the MCH component. The UNFPA and USAID objected that the emerging strategy, with its massive assistance for construction of rural health facilities and training schools, would slow down the implementation of family planning activities and provide only modest returns in terms of reducing the rate of population increase at very high cost. The difference of viewpoint helped fuel a struggle between the UNFPA and the Bank for the prime coordinating role relative to the other donors. The role was ultimately assigned to the World Bank. The difference, however, probably influenced the Bank's choice of tactics for completing the appraisal report. It declined to mount a joint appraisal by all the donors because:

> "past experience has shown that the technical quality of reports has suffered from having various agencies who tend to press for their agencies' interests rather than the technical quality....The mission will be comprised of impartial experts and will have a low profile given existing political sensitivities."1/

1/ Internal Bank memorandum, September 27, 1972. Underlining added by the audit.

III. THE CHOICE OF STRATEGY AND STRUCTURE

12. The choice of project strategy was influenced by the process and outcome of the struggle to determine the relative priority of the MCH and FP components. As the struggle continued up to the time of the appraisal mission, a factor of time pressure was added to the negotiations. A five-year family planning program provided the vehicle for the discussions of strategy. The plan was sponsored by the MOF&P and the MOH. It was cross-sectoral in nature and included an integrated plan for the development of manpower for a range of rural health services. The plan had been largely prepared by expatriate advisors in the MOF&P and had not been extensively reviewed within the MOH in the context of the overall development of health services in Kenya.

13. The Bank mission reviewed the plan as part of its appraisal mission in December 1972. The problem the mission faced was to design a strategy that would reconcile the MCH services and construction of facilities favored by the MOH with its own mandate as the Population Projects Department and the family planning mandates of the key contributors. The strategy it chose was to concentrate on removing what was then perceived as the key constraint to improved MCH/FP services: the shortage of trained paramedical staff. It concentrated more on the supply of services than on stimulating demand. Its key elements were: staffing 450 service points, recruiting new acceptors, establishing an organizational center to spearhead a national program and providing it with functional support, increasing information and education activities and providing research and evaluation.

14. The GOK was disappointed with the proposal because it only provided enough physical facilities to keep pace with the rate of training provided by the program itself. The WHO criticized the plan for its lack of emphasis on rural health services and its excessive concern with population growth reduction. The UNFPA felt that it did not sufficiently reflect and build on many of the related health activities already ongoing in the country. The program was too expensive and was really a health program "masquerading" as a population project. The USAID felt that the program lacked appropriate emphasis on the organizational and management constraints within the MOH that would be likely to hamper the implementation of the project.

15. Pressed for time, the Bank felt that it would be impossible to develop or study any radically different approaches without delaying the appraisal. It incorporated what suggestions were feasible and agreed with the GOK to proceed with the modified appraisal report, if necessary, without the support of the dissident donors.

16. The difficulties experienced in developing a common strategy were equally manifest in the choice of organizational form to implement the project. Up until 1970 family planning activities and rural health services had been conducted under the decentralized control of the County Councils. At the time of project preparation the MOH had still not developed, institutionally, an ability to handle large projects that demanded centralized control.
The centerpiece of the proposed organizational strategy was the creation of a unit within the MOH that would spear-head the formulation and implementation of the family planning component of the project. It was initially referred to as the National Family Planning Center, but under the influence of political

sensitivity and the integrated MCH/FP strategy became the National Family Welfare Center. It was to be housed in the new Kenyatta National Medical Center and, in addition to an administrative unit, would accommodate four functional support units: Clinical Services, Information and Education, Training, and Evaluation and Research. Physical facilities would include a dormitory for FP trainees, a family planning clinic and a Health Education Unit (AEU) for production of family planning educational materials.

17. It was hoped that the special status imparted to the NFWC through external project funding would enable it to overcome the major barriers facing implementation of such a program within the MOH, shortage of skilled managerial staff and procedural constraints. The Director of Medical Services in the MOH would oversee the program and head an Advisory Working Committee to formulate policy and coordinate with participating agencies. Three advisory sub-committees would provide the working committee with program support in the areas of training, research and information. The NFWC would also closely coordinate its activities with a Project Construction Unit established within the MOH and with the new HEU. Details of how this coordination would be achieved were left unspecified. What is clear is that the NFWC's primary role was to support the family planning activities of the integrated MCH/FP strategy. The evaluation and research, and information and education were to provide the fundamental intelligence for FP training and provision of clinical FP services. The construction component would primarily serve the interests of general rural health and MCH.

18. The organizational linkage between the intelligence and training resources provided by the NFWC and the physical and human nursing resources provided by the MOH was the offices of the provincial and district medical

staff (see Chart I). Unfortunately the staff had not been very much involved in the project design process and by inclination did not tend to give family planning activities a high priority. The nurses' organization was most closely integrated with the project's purpose through the training and supervision of community nurses. The initial plan called for the 46 registered public health nurses trained as Provincial and District Nurse Trainer/Supervisors (NT/S) to report to the head of the Clinical Services Division in the NFWC. The Chief Nursing Officer (CNO), reflecting the general political mood of the country, was not favorably disposed to give family planning activities a high priority in relation to general nursing duties, nor was she favorably disposed to the degree of power sharing suggested by the proposed organizational arrangements.

19. A parallel organization was planned to supervise the family planning field workers, a Provincial Family Health Officer as a counterpart to the Provincial Nursing Officer and a District Field Officer equivalent to the District Nurse Trainer. The proposed compensation for these positions and for the new category of FHFE, had been based on that paid by the FPAK. Unfortunately this created a disparity with nurses' salaries and added to the difficulties of the family planning specialists.

20. The organizational strategy for family planning, in summary, relied on strong vertical integration through the provincial and district medical offices and strong lateral coordination with the nursing organization and the HEU, with interministerial coordination provided by the committees. It failed to supply linkages to external sources of support for family planning activities, e.g. the MOF&P and the NGO's. Its design relied heavily on the MOH where the commitment to family planning was not very strong.

IV. IMPLEMENTATION

21. Staffing. The organizational strategy depended on the NFWC to rapidly accelerate the normal rate of FP activity within the MOH in order to move the project forward. The Credit Agreement called for appointment of all key staff within 90 days of project start-up. Six months after start-up, however, none of the four division heads of the NFWC had been appointed. During the life of the project the NFWC never had a full-time Director nor full-time head of the I&E division. No Kenyan head was ever found to run the research and evaluation unit, which was run by a relatively junior UNFPA advisor. There was considerable delay in appointing a program advisor. The GOK preferred a Kenyan, but none could be found with the necessary experience of running a family planning program. The most serious effect on the project came from the lack of a full-time, relatively independent director. As a result, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out the role envisaged, and the principal task of directing NFWC activities fell to the deputy directors, who were changed three times during the life of the project and themselves received little support.

22. The current (February 1981) state of staffing is reflected in Chart II. There is no operating clinical division. The public health nurse who was supposed to head the division was never transferred from the MOH to the NFWC. There are no heads for any of the other three functional support areas, and the administrative unit has no professional staff.

23. Support Functions. The second part of the strategy required the NFWC to develop the intelligence and support systems necessary for the training and service activities of the clinical group. Unlike the provision of

physical facilities, which requires a relatively simple implementation strategy, the provision of intelligence and support activities required a relatively sophisticated adaptive strategy. Little was known about fertility determinants in the Kenyan context, or about methods to use in the different local contexts to persuade Kenyans to adopt family planning practices. For planning purposes models drawn from the Asian context had been employed. Both targets and choice of strategy were based on assumptions that required testing. Major revisions in strategy and tactics should have been expected and planned for. The GOK was not in favor of a pilot project approach, but little attention was given to developing a variety of implementation strategies to foster and accelerate the amount of required learning. For example, the need for information about fertility determinants was identified, and a Population Study and Research Center was established in the University of Nairobi to carry out relevant studies. Due to internal difficulties within the University, however, the studies did not materialize during the life of the project, and no serious alternatives were developed to obtain this essential information.

24. The evaluation and research unit, though operating without a head, managed to produce a number of useful studies and sets of statistics. It did not provide the management information system envisaged in planning. The project was left without the information necessary to test the assumptions on the basis of which it was designed, and the insights necessary to revise its strategies, structure and operating systems.

25. The I&E division and the HEU throughout the life of the project were never able to adequately differentiate their roles. The I&E division thus never developed a strategy backed by an action plan that was implemented.

Mid-way through the project the Bank, in particular, gave very detailed assistance to the I&E division in drawing up a plan of action, but it was never followed through. The two major successes of I&E were not even envisaged in the original design. The division, with considerable help from the Institute of Adult Education, undertook the training of the family planning field workers, a role originally envisaged for the training division. It also mounted a series of seminars to communicate to, and motivate, the provincial and district medical and clinical officers. Evidence indicates that these seminars were successful in gaining acceptance of the concept of integrating MCA and FP activities but not necessarily in gaining the active support and cooperation of the medical officers for the FP component. This is probably best evidenced by the officers' lack of support in freeing transportation allocated to the FP program for use by field supervisors. The HEU, sharing the same manager as the I&E division, suffered from similar problems. 50% of its resources were meant to be devoted to producing materials for the program; however, the unit's staff had little experience of FP, and general health priorities tended to supercede those of FP.

26. The training division found it impractical to carry out its original mandate to provide all short and long term basic and in-service training. The responsibility had to be shared with several other divisions of NFWC and other organizations. The confusion of priorities attached to the MCH and FP components had its effect also in the training of field workers. The trainers were originally unclear about the kind of worker they wanted to produce, how much MCH versus FP. It took till 1977 for the trainers to develop their own clarity based on feedback from early intakes. In spite of the difficulties of

role clarity and lack of informational support the result of the training can be seen as one of the highlights of the project. This is particularly true of the training of NT/S's, whose numbers exceeded those estimated by a considerable margin. The success of this training effort has been hampered by the failure of the Director of the NFWC to negotiate an agreement with the CNO on deployment of FP-trained nurses. Many are posted to units which do not make use of their training. Similarly the failure of the NFWC director or the Ministry of Health to intervene to restore the project-financed dormitory facilities to the in-service FP trainees at the NFWC after their unlawful takeover by medical students has caused a serious bottleneck in the flow of training recruits. At the end of the project, in service training of clinical officers, essential to the effective supervision of field workers, had not yet begun.

27. Clinical services. The strategy of combining MCH/FP at service delivery points has worked well. The quantity of service provided has approximated planned levels but the quality is hampered by lack of supervision, failure of the material supply system, and lack of transport. The CNO never relinquished control of the NT/S's to the clinical services division, nor did the public health nurse chosen to head the division ever transfer to an office in NFWC. In general the impact of the MCH component at the service delivery points has been much greater than that of the FP component. Although 42% of all married women had heard of family planning services, less than 6% actually visited one in the surveyed period (12 months), while 65-75% of all pregnant women were being reached by the MCH program.

V. MANAGEMENT INFORMATION

28. Weaknesses in the evaluation and research division left the project with an inadequate internal system for learning where its strategies, structure and operating systems needed to be revised. The provision of such information was, by default, left to an external mechanism, the supervision missions of the donors, and in particular the mid-term review. As no GOK or MOH officials were involved directly in either the supervision or mid-term review, the donors were left with the same problem they faced in initiating the original design process - how to translate their learning into actions that had the genuine commitment of the relevant Kenyan officials. The lack of an effective internal learning system caused the donors as a result of the mid-term review to miscalculate the strength of the program. At the time of the review the program was going as well as it had ever been. The program advisor was in place and had developed an effective team including an effective deputy director and several other key staff in the NFWC. However, the basic problems of commitment had not been solved. The evaluation team foresaw an increase in influence for the NFWC. This failed to materialize. The program advisor left and was not replaced; the deputy director was transferred along with the other key staff. To correct the fundamental problems would have taken strong intervention from outside of the MOH. The Ministry of Finance and Planning had no active role in the project. The international donors, if well coordinated, might have been able to bring about such an intervention, but their position had been weakened by the internecine struggle over project priorities. As the second project is being appraised, the same fundamental problems remain:

how to design a project that has the genuine commitment and support of the most influential officials of the Ministry of Health; how to develop a learning process within the MOH that will enable it to increase its capacity to manage its own staff and resources more effectively. Considerable learning from the first project has been incorporated in the design of the second. This time the other donors have been involved in a joint appraisal, allowing the diversity of their knowledge and experience to enrich the design process. Greater emphasis has been placed on management of the external environment of the project by involving more ministries and private organizations in the project. There has been a wider participation of MOH officials in the gathering of information, if not in the decision-making process.

29. Information and education activities, designed to stimulate demand for FP services, have been given much greater emphasis in the second project, and a stronger differentiation has been made between MCH and FP activities and their organization. The need for more powerful support for family planning activities has been recognized by the proposal of a National Council on Population Development. The Council would be placed in the President's Office and would include members of participating ministries and NGOs. It would have budget approval powers over I&E spending.

30. Three of the organization issues raised in the first project still appear to require more attention in the design of the second, however: (i) clarity of the role of the NFWC and reasons for the continuing lack of support for its activities, (ii) the lack of commitment and support for program activities from key officials of the MOH, and (iii) the management capacity of the MOH to implement the much larger planned program.

The Bank's Role

31. The technical assistance role of the Bank in the design of the project was well appreciated both by the GOK and other donors. Its role on supervision missions was regarded as very professional and considerate. A less obvious function the Bank performed was that of a third party to facilitate negotiations during design, implementation and evaluation between the GOK and the other donors. This role was particularly important due to the multi-purpose, multi-donor nature of the project. The Bank performed this role best during the early stages of identification and preparation and during the mid-term evaluation. It performed it less well during the appraisal process. Apparently, norms of technical efficiency and internal Bank time pressures to produce a significant population project influenced Bank staff to press for rapid agreement and firm decision making inconsistent with the long term uncertain nature of the family planning components of the project. The primary effect was for undue emphasis to be placed on the technical, quantifiable elements of the project and too little on the institutional objective: i.e., developing a process of commitment, adaptive planning and learning.

VI. CONCLUSIONS

32. Most of the problems of project design and implementation can be traced to the differing levels of commitment on the part of the major stakeholders to the two project components, MCH and FP. Developing a consensus on project priorities took so long that the Bank felt pressured to move ahead with a project design that had not adequately involved the nursing organization, the provincial and district staff, other ministries, NGOs and possibly the other international donors themselves.

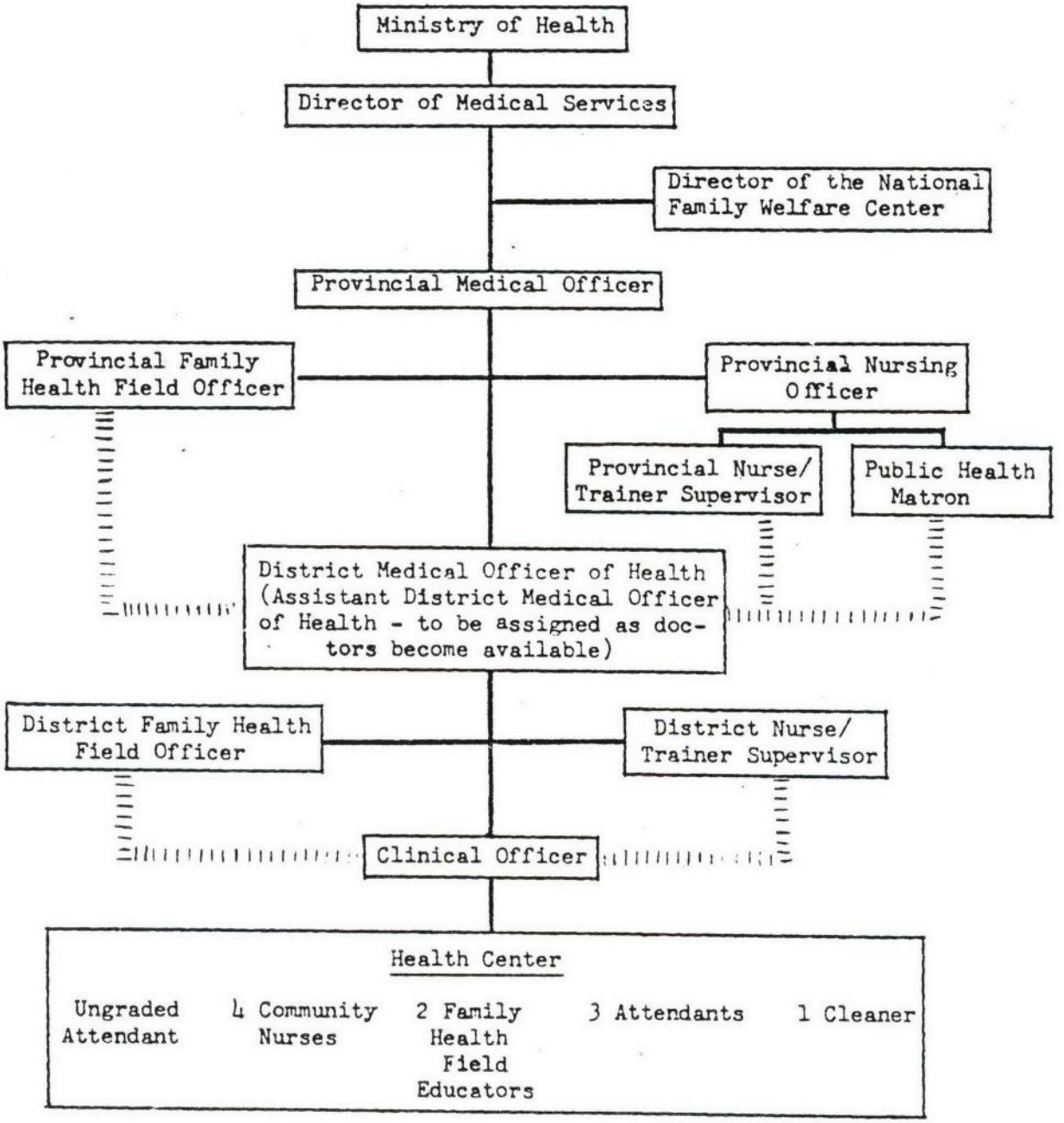
33. The design concentrated heavily on providing inputs for the supply of services and gave much less attention to the demand constraints. As it turned out, achieving the targeted reduction in population growth required a strategy to increase demand. The provision of services made an easier project to fund and manage, however, compared to the more abstract and uncertain task of assessing fertility determinants and developing appropriate mixes of strategies to deal with the findings.

34. Even given the chosen strategy, insufficient attention was given to institutional and management constraints. Early indications were available of the kinds of problems likely to be encountered, but it was felt that the project would be unduly delayed if they were studied. In setting up the NFWC as the centerpiece for project implementation the designers either underestimated the resistance it would create within the MOH or overestimated the amount of influence the NFWC would be able to wield. The design allowed for an appropriate degree of integration of MCH and FP activities at the service delivery points. It also planned for reasonable differentiation at the national level. However, it did not work out an appropriate mix at the

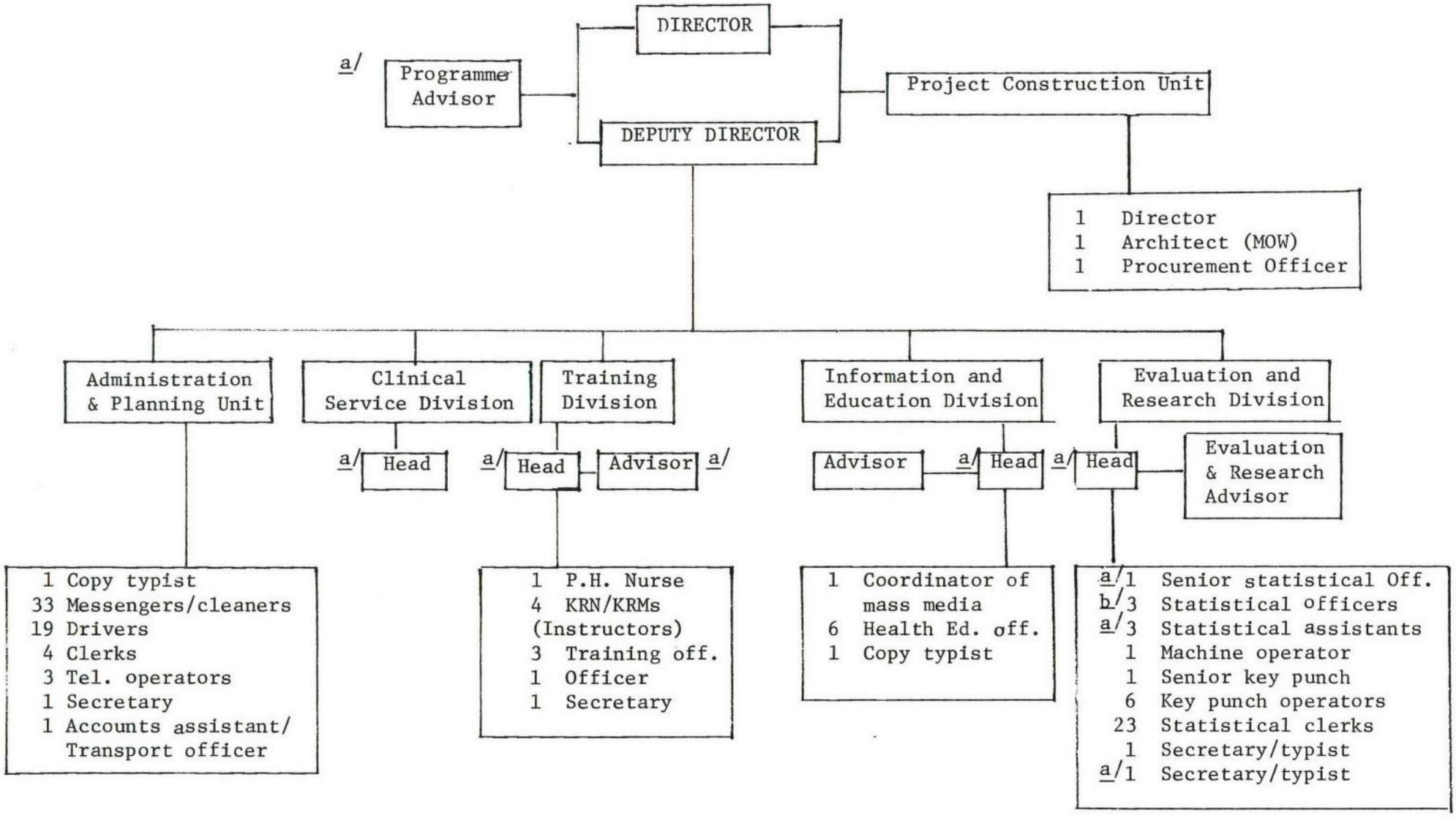
intermediate provincial and district levels. The nursing organization, which was very strongly controlled, was thus able to see that its interests were taken care of, but family planning activities never became an effectively integrated part of the provincial and district organization. The NFWC never became adequately linked to its institutional environment and thus lost potential means of support and influence. It was never provided with, or was shorn of, essential resources such as staff, buildings and vehicles; until at the end of the project it is no longer a viable organization for directing national population effort.

35. The relative successes of the project, on the supply side, are well documented in the completion report. Quantitatively, the project achieved most of its construction and training targets. The program has increased the awareness of the need for family planning both within the Government and outside. It has provided a physical and human resource base with which to supply services; however, it has not provided either the intelligence or the organizational means with which to effectively use those resources.

B. Administrative Structure at Provincial and District Levels



Source: Ministry of Health.



a/ Vacant

b/ 1 vacant

CHART II

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Warren C. Baum, Vice President, CPSVP
Mr. Willi A. Wapenhans, Vice President,

DATE: April 10, 1981

FROM: Shiv S. Kapur, Director, OED

SUBJECT: Project Performance Audit Report: Kenya First Population Project (Credit 468-KE)

1. I attach, for your review and comments, the draft of a Performance Audit Report on the project supported by Credit 468-KE. I would appreciate receiving any comments you may have by May 15, 1981.

2. On April 24, we plan to send the audit report to the Government of Kenya for their comments. Your comments at this stage should normally concern themselves only with factual inaccuracies and with statements that could injure Bank/country relationship. More detailed comments are requested by the date mentioned in para. 1 above.

Attachment

cc: Messrs. Kraske EA1
Rajgopalan, PAS
Drs. Evans, PHN
Kanagaratnam, PHN
Messrs. Sandberg, EA1
Hendry, EAP
North, PHN
Messenger, PHN
Hall, EA1
Diaz-Etchevehere, PHN
Radel, PHN
Dr. Pratt, PHN
Tsui, EA1
K. Miller, CTR
Van Puymbroeck, LEG

Ms. Goris, RMEA

DRAFT

CONFIDENTIAL

THE WORLD BANK

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

April 10, 1981

Operations Evaluation Department

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

TABLE OF CONTENTS

PROJECT PERFORMANCE AUDIT REPORT

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

Preface

This report presents the performance audit of the First Population Project in Kenya, for which a Credit of US$12.0 million was approved on March 19, 1974. The credit was fully disbursed on December 31, 1979.

The audit report comprises: (a) a Project Performance Audit Memorandum (PPAM) prepared by the Operations Evaluation Department (OED) and (b) a Project Completion Report (PCR) dated January 1981, prepared by the Population Health and Nutrition Department (PHN). The PCR incorporates the findings of a mission which visited Kenya in April 1980 for the preparation of the second Rural Health and Family Planning Project, as well as the collection of data for the PCR on the first project.

An OED mission visited Kenya in February 1981. The mission held discussions with officials of the Ministries of Health and Finance and Planning, as well as representatives of IPPF, SIDA, UNDP/UNFPA and USAID, and visited a number of rural health facilities in three different provinces. The audit memorandum is based on the findings of that mission and a study of the PCR; the Appraisal Report (No. 266a-KE dated February 20, 1974); the Credit Agreement (No. 468-KE dated April 1, 1974); and the report of the mid-term review (No. 1713-KE, dated August 18, 1977). Correspondence with the Borrower and the other donors and internal Bank memoranda and reports contained in the project files have also been reviewed, and Bank staff and other individuals associated with the project have been interviewed.

The audit finds that the PCR covers the project's main features and lessons adequately; however, the PPAM elaborates further on the underlying organization and management issues affecting project strategy, design, implementation and lesson-learning, matters which are relevant not only to this project and its successor but to other projects in socially-oriented development sectors.

The valuable assistance provided by the Government of Kenya, SIDA, UNDP/UNFPA and USAID and their staff met during the preparation of this report is gratefully acknowledged.

PROJECT PERFORMANCE AUDIT BASIC DATA SHEET

KENYA FIRST POPULATION PROJECT (CREDIT 468-KE)

KEY PROJECT DATA

Item	Appraisal Estimate	Actual or Current Estimate
Total Project Cost (US$ million)	15.4	17.9
Overrun (%)		16.0%
Credit Amount (US$ million)		12.0
Disbursed		100.0%
Dates for Completion of Physical Components		
National Family Welfare Center	03/77	03/78
Community Nurse Training Schools	12/77	09/79
Rural Health Demonstration Centers	03/77	03/80

OTHER PROJECT DATA

Item	Original Plan	Revision	Actual or Current Estimate
First Mention in Files		-	-
Government's Application		-	-
Negotiations		-	-
Board Approval	03/19/74	-	-
Loan Agreement Date	04/01/74	-	-
Effectiveness Date	07/31/74	-	-
Closing Date	06/30/78	06/30/79	12/31/79
Borrower	Government of Kenya		
Executing Agency	Ministry of Health		
Fiscal Year of Borrower	July 1 - June 30		
Follow-on Project	2nd Population/Health Project		Appraisal 10/78

MISSION DATA

Item	Month/ Year	No. of Days	No. of Persons	Staff Days	Interval Between Missions (Months)
Reconnaisance Identification Preparation Preappraisal Appraisal	11/12/72	30	8		
Total					
Supervision I	06/74	7	2		
Supervision II	10/74	5	2		4
Supervision III	03/75	10	3		5
Supervision IV	06/75	7	2		3
Supervision V	11/75	12	3		5
Supervision VI	03/76	6	3		4
Supervision VII	09/76	11	4		6
Supervision VIII	04/77	20	4		7
Supervision IX	10/77	7	1		6
Supervision X	04/78	14	5		6
Supervision XI	07/78	17	3		3
Supervision XII	12/78	10	3		5
Supervision XIII	03/79	10	1	10	3
Supervision XIV	08/79	19	5	95	5
Supervision XV	12/79	12	1	12	4

COUNTRY EXCHANGE RATES

Name of Currency	Kenyan Shilling (K.Sh.)
Appraisal Year Average	Exchange Rate: US$1 = 6.9 K.Sh.
Completion Year Average (November 1979)/a	US$1 = 7.4 K.Sh.

/a In October 1975, the Kenya Shilling was devalued and pegged to the SDR 1 = K.Sh. 9.66, and the rate vis-a-vis the US dollar has fluctuated since that time.

PROJECT PERFORMANCE AUDIT MEMORANDUM

KENYA FIRST POPULATION PROJECT
(CREDIT 468-KE)

I. SUMMARY

1. From late 1969 to 1973 the Bank participated in negotiations with the Government of Kenya (GOK) and seven international donors to develop a five-year program (1974-79) for family planning that would be integrated with maternal and child health care. The goals of the program were to reduce the population growth rate from 3.3 to 3% and improve the health of mothers and children. The strategy developed was to remedy what was perceived as the principal constraint, lack of trained paramedical staff. The specific components of the plan called for: (a) the introduction of full-time maternal and child health/family planning (MCH/FP) services in over 400 government health facilities; (b) an extension of those services through the use of 17 mobile teams to some 190 facilities without staff trained in FP; (c) the establishment of eight enrolled community nurse (ECN) training schools and 30 associated rural health centers; (d) training, and establishing a new class of supervisors for, 600 ECN's; (e) introduction and training of a new class of field workers, family health field educators (FHFE's) and their supervisors; (f) provision of increased capacity within the Ministry of Health (MOH) to produce health education materials; and (g) the establishment of a new organizational unit, the National Family Welfare Centre (NFWC), to plan and support the activities of the MCH/FP program.

2. The total cost of the plan was estimated at $38.8 million. It was to be financed in part (32%) by the GOK and in part by seven donors: IDA, UNFPA, SIDA, USAID, DANIDA, the Federal Republic of Germany, and ODA. The IDA credit of $12 million financed mainly the physical infrastructure.

3. In general the quantitative targets of the program were achieved. By the end of 1979, 90% of the service delivery points had been established. The mobile teams were severely delayed in operation and not deployed till 1978. The target for nurse training was increased from 600 to 1,000, and 950 actually received the FP training, but, many of those trained were deployed where their training could not be utilized.

4. Major problems were experienced in providing organizational support and effective integration of family planning activities with MCH activities. The NFWC was never provided with the staff required to fulfill its function. Though FHFE's were trained in sufficient numbers, 750 versus a planned 800, they were inadequately supervised and supported, and their performance was poor relative to the provision of clinical MCH services. A new building provided for the Health Education Unit (HEU) was completed by mid 1977 but not occupied till late 1979. The Information and Education (I&E) activities of the NFWC were not well managed. The planned resources were merged with those of the HEU and diverted to more general purposes. Some progress was made in I&E activities in 1979.

5. Evaluation and Research provided some useful statistics and reports but failed to provide the monitoring and evaluation function necessary for management and redesign of the program. The establishment of the Population and Research Center at the University of Nairobi to provide demographic

research in support of the program did not achieve its objectives and had little impact on implementation of the project.

6. The primary objective of the project was not achieved. The population growth rate rose to a startling 3.9% rather than declining to the 3.0% hoped for. The number of acceptors of family planning services was 310,000 as opposed to the revised goal of 450,000, which had already been reduced from 600,000. The project was not designed in a way that adequate information was available to explain the shortfalls, thus valuable opportunities for learning were lost. The MCH component performed much more satisfactorily than the FP component; between 65-75% of pregnant women were being reached by the program by the end of 1979. The success of the program, however, was inhibited by bottlenecks in training due to the takeover of an IDA-financed nurse -trainees' dormitory at the NFWC by medical students, severely limiting the number of in-service FP training opportunities; by the failure of the drug supply system to keep rural health facilities stocked; and by the diversion of project-financed transport to more general services.

II. COMMITMENT TO PROJECT PURPOSES

7. An evaluation of the successes and failures of the First Population Project requires an interpretation of the relative weight given to its two major components, MCH and FP. From initial conception of the project through preparation, appraisal and implementation, the major stakeholders (the donors, the Ministry of Finance and Planning (MOF&P), the MOH, NGO's, provincial and district staff, politicians, and the intended beneficiaries) held widely differing levels of commitment to the two parts. A successful process of design would have required that the differing levels of commitment be understood and accurately perceived by each of the stakeholders and that a means be found that would satisfy the proposed stake each had in the project outcomes.. Many of the problems of design and implementation can be traced to the inappropriateness of the fit between project strategy and structure and the relative commitment of the stakeholders to the two major components.

8. As early as October 1967 the GOK demonstrated its relative lack of commitment to family planning by disbanding the interministerial Family Planning Council and relegating control of the Government's family planning effort to the MOH. At that time the primary commitment to family planning came from the private sector. The Family Planning Association of Kenya (FPAK) had such a strong commitment that the government could not successfully compete with it in hiring the best qualified Kenyans to run its own programs. The international donors were also strongly committed to FP and provided the country with its major source of expertise. So strong was the donors' commitment that some felt they created undesirable competition in their effort to assist the Government.

9. From the earliest days of project conception in 1969, the Kenyan Government made it clear that its primary interest was rural health and that it would only consider family planning as part of a maternal and child health program. The MOF&P took the early lead in negotiating with the Bank and at that time saw more clearly the economic necessity of family planning than did the other ministries. It was also clear that the Kenyan population, especially the 75% living outside of the urban areas, was not in favor of family planning. A 1968 survey covering the six largest tribes revealed a high ideal family size of six children, only slightly less than the 6.8 actually achieved. The survey did, however, also indicate a positive correlation between improvements in education and improved living standards and interest in family planning.

10. The theme of population and its critical relationship to economic growth was stressed strongly in Mr. McNamara's September 1968 address to the Board of Governors. The address was followed by the establishment of the Population Projects Department within CPS in the Fall of 1969. The new department was under considerable pressure to produce projects. By the time of preparation of the Kenya project, it had assembled a staff of approximately 10 professionals, most of whom were unfamiliar with Bank procedures. They faced additional difficulties of dealing with a "soft" sector and found dialogue with Bank economists frustrating. Their organizational position in CPS also weakened them in their relationship with the Regions. The department had worked on several projects; however, these were not regarded as making the kind of impact envisaged by the Bank. In preparing the Kenya project, the first large multi-donor project and the first population project ever in

sub-Saharan Africa, the staff were under tremendous pressure to produce a "bankable project".

11. During preparation the differences of priority attached to the two components became more evident as specific proposals for project design began to take shape. The Bank supported the GOK's position, giving priority to the MCH component. The UNFPA and USAID objected that the emerging strategy, with its massive assistance for construction of rural health facilities and training schools, would slow down the implementation of family planning activities and provide only modest returns in terms of reducing the rate of population increase at very high cost. The difference of viewpoint helped fuel a struggle between the UNFPA and the Bank for the prime coordinating role relative to the other donors. The role was ultimately assigned to the Bank. The difference, however, probably influenced the Bank's choice of tactics for completing the appraisal report. It declined to mount a joint appraisal by all the donors because:

> "past experience has shown that the technical quality of reports has suffered from having various agencies who tend to press for their agencies' interests rather than the technical quality....The mission will be comprised of impartial experts and will have a low profile given existing political sensitivities."1/

12. The alliance of the Bank and the GOK and their willingness to proceed, if necessary, without the participation of the dissenting donors, was enough to bring about a consensus for an integrated MCH/FP strategy. The consensus

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1/ Internal Bank memorandum, September 27, 1972. Underlining added by the audit.

was not achieved without cost. Several donors delayed or reduced their financial commitment and one did not participate. The difference of opinion may also have resulted in a relative loss of influence for the dissenting donors which was eventually to have an effect on the performance of the project.

III. THE CHOICE OF STRATEGY AND STRUCTURE

13. The choice of project strategy was influenced by the process and outcome of the struggle to determine the relative priority of the MCH and FP components. As the struggle continued up to the time of the appraisal mission, a factor of time pressure was added to the negotiations. A five-year family planning program provided the vehicle for the discussions of strategy. The plan was sponsored by the MOF&P and the MOH. It was cross-sectoral in nature and included an integrated plan for the development of manpower for a range of rural health services. The plan had been largely prepared by expatriate advisors in the MOF&P and had not been extensively reviewed within the MOH in the context of the overall development of health services in Kenya.

14. The Bank mission reviewed the plan as part of its appraisal mission in December 1972. The problem the mission faced was to design a strategy that would reconcile the MCH services and construction of facilities favored by the MOH with its own mandate as the Population Projects Department and the family planning mandates of the key contributors. The strategy it chose was to concentrate on removing what was then perceived as the key constraint to improved MCH/FP services: the shortage of trained paramedical staff. It concentrated more on the supply of services than on stimulating demand. Its key elements were: staffing 450 service points, recruiting new acceptors, establishing an organizational center to spearhead a national program and providing it with functional support, increasing information and education activities and providing research and evaluation.

15. The GOK was disappointed with the proposal because it only provided enough physical facilities to keep pace with the rate of training provided by the program itself. The WHO criticized the plan for its lack of emphasis on rural health services and its excessive concern with population growth reduction. The UNFPA felt that it did not sufficiently reflect and build on many of the related health activities already ongoing in the country. The program was too expensive and was really a health program "masquerading" as a population project. The USAID felt that the program lacked appropriate emphasis on the organizational and management constraints within the MOH that would be likely to hamper the implementation of the project.

16. Pressed for time, the Bank felt that it would be impossible to develop or study any radically different approaches without delaying the appraisal. It incorporated what suggestions were feasible and agreed with the GOK to proceed with the modified appraisal report, if necessary, without the support of the dissident donors.

17. The difficulties experienced in developing a common strategy were equally manifest in the choice of organizational form to implement the project. Up until 1970 family planning activities and rural health services had been conducted under the decentralized control of the County Councils. At the time of project preparation the MOH had still not developed, institutionally, an ability to handle large projects that demanded centralized control. The centerpiece of the proposed organizational strategy was the creation of a unit within the MOH that would spear-head the formulation and implementation of the family planning component of the project. It was initially referred to as the National Family Planning Center, but under the influence of political

sensitivity and the integrated MCH/FP strategy became the National Family Welfare Center. It was to be housed in the new Kenyatta National Medical Center and, in addition to an administrative unit, would accommodate four functional support units: Clinical Services, Information and Education, Training, and Evaluation and Research. Physical facilities would include a dormitory for FP trainees, a family planning clinic and a Health Education Unit (HEU) for production of family planning educational materials.

18. It was hoped that the special status imparted to the NFWC through external project funding would enable it to overcome the major barriers facing implementation of such a program within the MOH, shortage of skilled managerial staff and procedural constraints. The Director of Medical Services in the MOH would oversee the program and head an Advisory Working Committee to formulate policy and coordinate with participating agencies. Three advisory sub-committees would provide the working committee with program support in the areas of training, research and information. The NFWC would also closely coordinate its activities with a Project Construction Unit established within the MOH and with the new HEU. Details of how this coordination would be achieved were left unspecified. What is clear is that the NFWC's primary role was to support the family planning activities of the integrated MCH/FP strategy. The evaluation and research, and information and education were to provide the fundamental intelligence for FP training and provision of clinical FP services. The construction component would primarily serve the interests of general rural health and MCH.

19. The organizational linkage between the intelligence and training resources provided by the NFWC and the physical and human nursing resources provided by the MOH was the offices of the provincial and district medical

staff (see Chart I). Unfortunately the staff had not been very much involved in the project design process and by inclination did not tend to give family planning activities a high priority. The nurses' organization was most closely integrated with the project's purpose through the training and supervision of community nurses. The initial plan called for the 46 registered public health nurses trained as Provincial and District Nurse Trainer/Supervisors (NT/S) to report to the head of the Clinical Services Division in the NFWC. The Chief Nursing Officer (CNO), reflecting the general political mood of the country, was not favorably disposed to give family planning activities a high priority in relation to general nursing duties, nor was she favorably disposed to the degree of power sharing suggested by the proposed organizational arrangements.

20. A parallel organization was planned to supervise the family planning field workers, a Provincial Family Health Officer as a counterpart to the Provincial Nursing Officer and a District Field Officer equivalent to the District Nurse Trainer. The proposed compensation for these positions and for the new category of FHFE, had been based on that paid by the FPAK. Unfortunately this created a disparity with nurses' salaries and added to the difficulties of the family planning specialists.

21. The organizational strategy for family planning, in summary, relied on strong vertical integration through the provincial and district medical offices and strong lateral coordination with the nursing organization and the HEU, with interministerial coordination provided by the committees. It failed to supply linkages to external sources of support for family planning activities, e.g. the MOF&P and the NGO's. Its design relied heavily on the MOH where the commitment to family planning was not very strong.

IV. IMPLEMENTATION

22. Staffing. The organizational strategy depended on the NFWC to rapidly accelerate the normal rate of FP activity within the MOH in order to move the project forward. The Credit Agreement called for appointment of all key staff within 90 days of project start-up. Six months after start-up, however, none of the four division heads of the NFWC had been appointed. During the life of the project the NFWC never had a full-time Director nor full-time head of the I&E division. No Kenyan head was ever found to run the research and evaluation unit, which was run by a relatively junior UNFPA advisor. There was considerable delay in appointing a program advisor. The GOK preferred a Kenyan, but none could be found with the necessary experience of running a family planning program. The most serious effect on the project came from the lack of a full-time, relatively independent director. As a result, the NFWC never managed to obtain the degree of autonomy or influence necessary to carry out the role envisaged, and the principal task of directing NFWC activities fell to the deputy directors, who were changed three times during the life of the project and themselves received little support.

23. The current (February 1981) state of staffing is reflected in Chart II. There is no operating clinical division. The public health nurse who was supposed to head the division was never transferred from the MOH to the NFWC. There are no heads for any of the other three functional support areas, and the administrative unit has no professional staff.

24. Support Functions. The second part of the strategy required the NFWC to develop the intelligence and support systems necessary for the training and service activities of the clinical group. Unlike the provision of

physical facilities, which requires a relatively simple implementation strategy, the provision of intelligence and support activities required a relatively sophisticated adaptive strategy. Little was known about fertility determinants in the Kenyan context, or about methods to use in the different local contexts to persuade Kenyans to adopt family planning practices. For planning purposes models drawn from the Asian context had been employed. Both targets and choice of strategy were based on assumptions that required testing. Major revisions in strategy and tactics should have been expected and planned for. The GOK was not in favor of a pilot project approach, but little attention was given to developing a variety of implementation strategies to foster and accelerate the amount of required learning. For example, the need for information about fertility determinants was identified, and a Population Study and Research Center was established in the University of Nairobi to carry out relevant studies. Due to internal difficulties within the University, however, the studies did not materialize during the life of the project, and no serious alternatives were developed to obtain this essential information.

25. The evaluation and research unit, though operating without a head, managed to produce a number of useful studies and sets of statistics. It did not provide the management information system envisaged in planning. The project was left without the information necessary to test the assumptions on the basis of which it was designed, and the insights necessary to revise its strategies, structure and operating systems.

26. The I&E division and the HEU throughout the life of the project were never able to adequately differentiate their roles. The I&E division thus never developed a strategy backed by an action plan that was implemented.

Mid-way through the project the Bank, in particular, gave very detailed assistance to the I&E division in drawing up a plan of action, but it was never followed through. The two major successes of I&E were not even envisaged in the original design. The division, with considerable help from the Institute of Adult Education, undertook the training of the family planning field workers, a role originally envisaged for the training division. It also mounted a series of seminars to communicate to, and motivate, the provincial and district medical and clinical officers. Evidence indicates that these seminars were successful in gaining acceptance of the concept of integrating MCA and FP activities but not necessarily in gaining the active support and cooperation of the medical officers for the FP component. This is probably best evidenced by the officers' lack of support in freeing transportation allocated to the FP program for use by field supervisors. The HEU, sharing the same manager as the I&E division, suffered from similar problems. 50% of its resources were meant to be devoted to producing materials for the program; however, the unit's staff had little experience of FP, and general health priorities tended to supercede those of FP.

27. The training division found it impractical to carry out its original mandate to provide all short and long term basic and in-service training. The responsibility had to be shared with several other divisions of NFWC and other organizations. The confusion of priorities attached to the MCH and FP components had its effect also in the training of field workers. The trainers were originally unclear about the kind of worker they wanted to produce, how much MCH versus FP. It took till 1977 for the trainers to develop their own clarity based on feedback from early intakes. In spite of the difficulties of

role clarity and lack of informational support the result of the training can be seen as one of the highlights of the project. This is particularly true of the training of NT/S's, whose numbers exceeded those estimated by a considerable margin. The success of this training effort has been hampered by the failure of the Director of the NFWC to negotiate an agreement with the CNO on deployment of FP-trained nurses. Many are posted to units which do not make use of their training. Similarly the failure of the NFWC director or the Ministry of Health to intervene to restore the project-financed dormitory facilities to the in-service FP trainees at the NFWC after their unlawful takeover by medical students has caused a serious bottleneck in the flow of training recruits. At the end of the project, in service-training of clinical officers, essential to the effective supervision of field workers, had not yet begun.

28. Clinical services. The strategy of combining MCH/FP at service delivery points has worked well. The quantity of service provided has approximated planned levels but the quality is hampered by lack of supervision, failure of the material supply system, and lack of transport. The CNO never relinquished control of the NT/S's to the clinical services division, nor did the public health nurse chosen to head the division ever transfer to an office in NFWC. In general the impact of the MCH component at the service delivery points has been much greater than that of the FP component. Although 42% of all married women had heard of family planning services, less than 6% actually visited one in the surveyed period (12 months), while 65-75% of all pregnant women were being reached by the MCH program.

V. MANAGEMENT INFORMATION

29. Weaknesses in the evaluation and research division left the project with an inadequate internal system for learning where its strategies, structure and operating systems needed to be revised. The provision of such information was, by default, left to an external mechanism, the supervision missions of the donors, and in particular the mid-term review. As no GOK or MOH officials were involved directly in either the supervision or mid-term review, the donors were left with the same problem they faced in initiating the original design process - how to translate their learning into actions that had the genuine commitment of the relevant Kenyan officials. The lack of an effective internal learning system caused the donors as a result of the mid-term review to miscalculate the strength of the program. At the time of the review the program was going as well as it had ever been. The program advisor was in place and had developed an effective team including an effective deputy director and several other key staff in the NFWC. However, the basic problems of commitment had not been solved. The evaluation team foresaw an increase in influence for the NFWC. This failed to materialize. The program advisor left and was not replaced; the deputy director was transferred along with the other key staff. To correct the fundamental problems would have taken strong intervention from outside of the MOH. The Ministry of Finance and Planning had no active role in the project. The international donors, if well coordinated, might have been able to bring about such an intervention, but their position had been weakened by the internecine struggle over project priorities. As the second project is being appraised, the same fundamental problems remain:

how to design a project that has the genuine commitment and support of the most influential officials of the Ministry of Health; how to develop a learning process within the MOH that will enable it to increase its capacity to manage its own staff and resources more effectively. Considerable learning from the first project has been incorporated in the design of the second. This time the other donors have been involved in a joint appraisal, allowing the diversity of their knowledge and experience to enrich the design process. Greater emphasis has been placed on management of the external environment of the project by involving more ministries and private organizations in the project. There has been a wider participation of MOH officials in the gathering of information, if not in the decision-making process.

30. Information and education activities, designed to stimulate demand for FP services, have been given much greater emphasis in the second project, and a stronger differentiation has been made between MCH and FP activities and their organization. The need for more powerful support for family planning activities has been recognized by the proposal of a National Council on Population Development. The Council would be placed in the President's Office and would include members of participating ministries and NGOs. It would have budget approval powers over I&E spending.

31. Three of the organization issues raised in the first project still appear to require more attention in the design of the second, however: (i) clarity of the role of the NFWC and reasons for the continuing lack of support for its activities, (ii) the lack of commitment and support for program activities from key officials of the MOH, and (iii) the management capacity of the MOH to implement the much larger planned program.

The Bank's Role

32. The technical assistance role of the Bank in the design of the project was well appreciated both by the GOK and other donors. Its role on supervision missions was regarded as very professional and considerate. A less obvious function the Bank performed was that of a third party to facilitate negotiations during design, implementation and evaluation between the GOK and the other donors. This role was particularly important due to the multi-purpose, multi-donor nature of the project. The Bank performed this role best during the early stages of identification and preparation and during the mid-term evaluation. It performed it less well during the appraisal process. Apparently, norms of technical efficiency and internal Bank time pressures to produce a significant population project influenced Bank staff to press for rapid agreement and firm decision making inconsistent with the long term uncertain nature of the family planning components of the project. The primary effect was for undue emphasis to be placed on the technical, quantifiable elements of the project and too little on the institutional objective: i.e., developing a process of commitment, adaptive planning and learning.

VI. CONCLUSIONS

33. Most of the problems of project design and implementation can be traced to the differing levels of commitment on the part of the major stakeholders to the two project components, MCH and FP. Developing a consensus on project priorities took so long that the Bank felt pressured to move ahead with a project design that had not adequately involved the nursing organization, the provincial and district staff, other ministries, NGOs and possibly the other international donors themselves.

34. The design concentrated heavily on providing inputs for the supply of services and gave much less attention to the demand constraints. As it turned out, achieving the targeted reduction in population growth required a strategy to increase demand. The provision of services made an easier project to fund and manage, however, compared to the more abstract and uncertain task of assessing fertility determinants and developing appropriate mixes of strategies to deal with the findings.

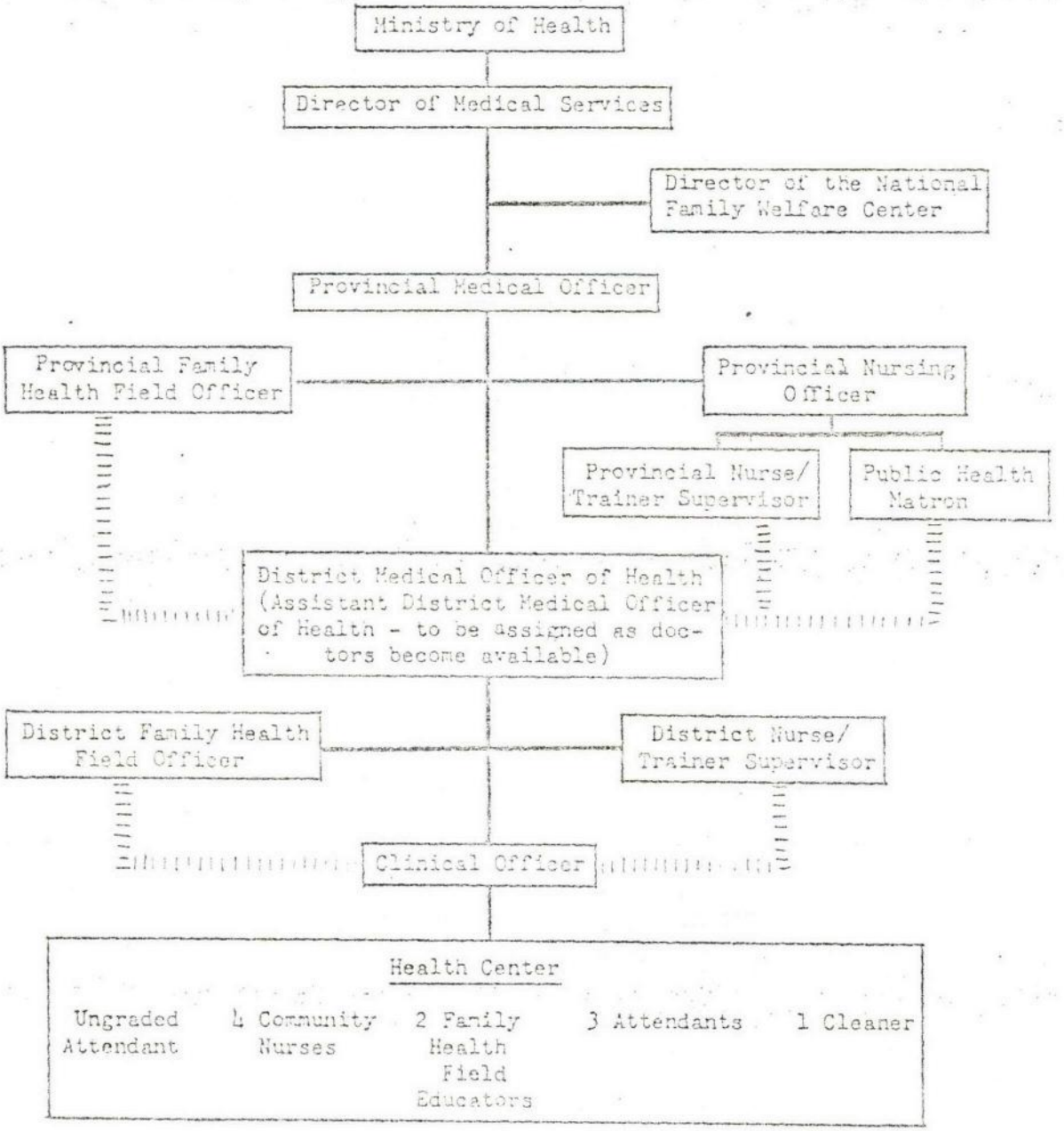
35. Even given the chosen strategy, insufficient attention was given to institutional and management constraints. Early indications were available of the kinds of problems likely to be encountered, but it was felt that the project would be unduly delayed if they were studied. In setting up the NFWC as the centerpiece for project implementation the designers either underestimated the resistance it would create within the MOH or overestimated the amount of influence the NFWC would be able to wield. The design allowed for an appropriate degree of integration of MCH and FP activities at the service delivery points. It also planned for reasonable differentiation at the national level. However, it did not work out an appropriate mix at the

intermediate provincial and district levels. The nursing organization, which was very strongly controlled, was thus able to see that its interests were taken care of, but family planning activities never became an effectively integrated part of the provincial and district organization. The NFWC never became adequately linked to its institutional environment and thus lost potential means of support and influence. It was never provided with, or was shorn of, essential resources such as staff, buildings and vehicles; until at the end of the project it is no longer a viable organization for directing national population effort.

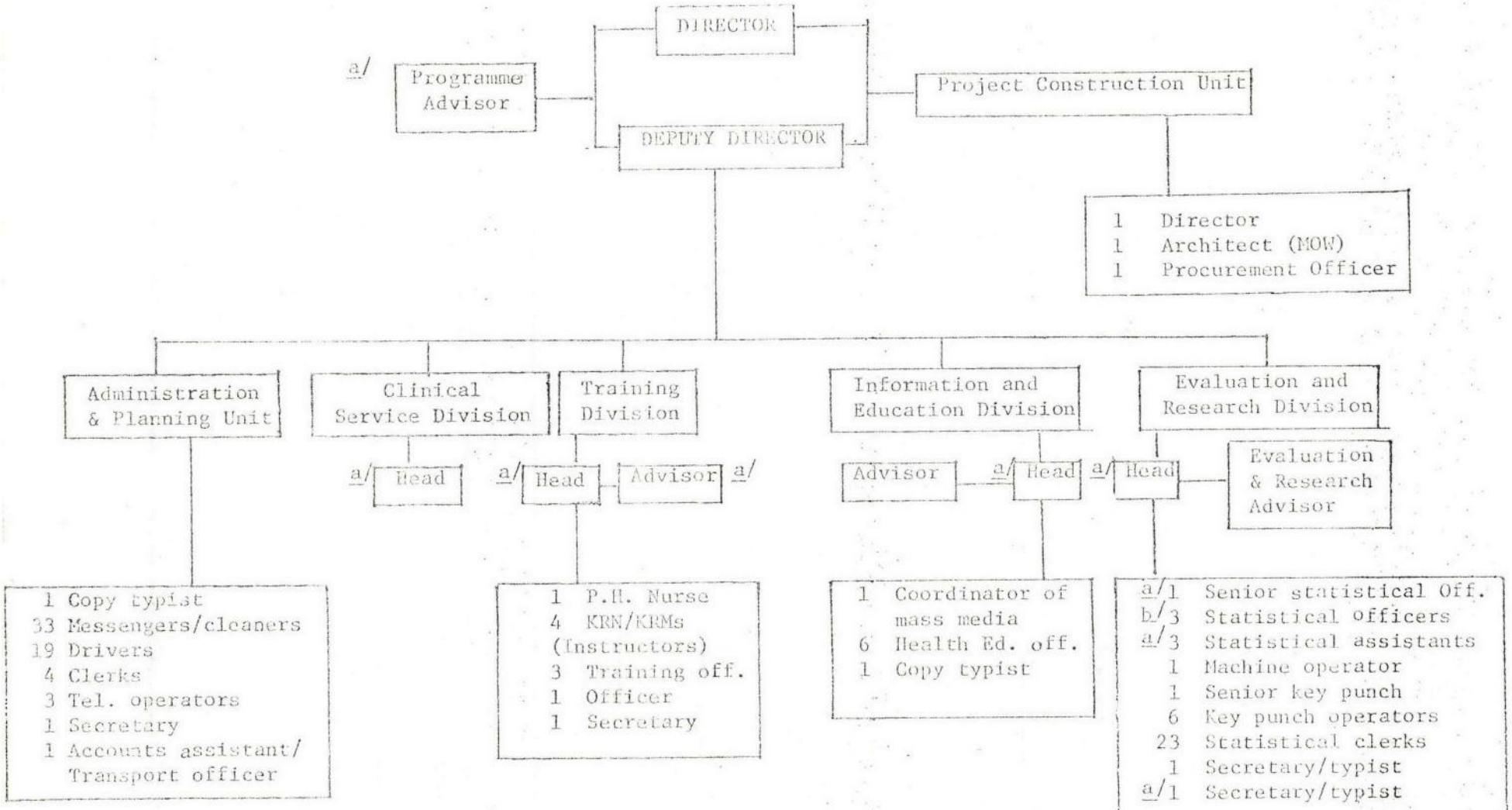
36. The relative successes of the project, on the supply side, are well documented in the completion report. Quantitatively, the project achieved most of its construction and training targets. The program has increased the awareness of the need for family planning both within the Government and outside. It has provided a physical and human resource base with which to supply services; however, it has not provided either the intelligence or the organizational means with which to effectively use those resources.

CHART I

B. Administrative Structure at Provincial and District Levels



Source: Ministry of Health.



a/ Vacant

b/ 1 vacant

CHART II