PLAN FOR
A NATIONAL CBD PROGRAMME
KENYA

Developed for the National Council for Population and Development

by

The Pathfinder Fund

FINAL DRAFT

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Ag. Regional Representative.

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EXECUTIVE SUMMARY

To expand and extend family planning services beyond limited clinical facilities, which are often inaccessible to the majority of rural residents, many countries have experienced success with the introduction of programs for contraceptive distribution by trained villagers to residents of their own communities. This plan for a national program for the community based distribution of contraceptives (CBD) in Kenya proposes moving from limited experience in several pilot projects funded and implemented by non-governmental organizations (NGO) to a major nationwide, village-based effort within a seven year period. It is proposed that the program be coordinated by the National Council for Population and Development (NCPD). Field program planning and coordination will take place at the district level in keeping with the District Focus Strategy for Rural Development. Program implementation, in the form of contraceptive distribution, will take place at the village or community level.

Building on the base of existing CBD projects, the program will be introduced in three phases starting in those districts where NGO projects are already in operation. When the program gets underway in the near future, it is projected to serve 500,000 contraceptive users by 1992 and 1.1 million by the year 2000.

The program design calls for cooperation and collaboration between various Ministries and other bodies, both public and private, in Kenya. Overall program coordination will be the responsibility of the NCPD--more specifically of a Standing Committee on CBD of the NCPD--and of the development committees and their population subcommittees at district, divisional, locational and sublocational levels. Major responsibility for program implementation will rest with the personnel specifically selected for this program at various levels and with the Ministry of Health (MOH) and the NGOs. Program support will be provided by personnel of the Office of the President (Provincial Administration), Ministry of Planning and National Development, Ministry of Culture and Social Services and of the Ministry of Local Government.

Program personnel will be largely volunteers or staff coopted for specific tasks from other organizations. Two new categories of staff are proposed, however. One is that of district level field staff (titled District Population and Development Officer, or DPDO, in this Plan) belonging to the NCPD, twelve of whom have already been appointed. These individuals (41 are proposed in the plan--one for each district) will have vital responsibilities as the NCPD's representatives for CBD program coordination and supervision at the district level. The other new category of personnel, which is essential for the success of CBD, is that of supervisor to be hired from and based at the locational level. Rather than creating new civil service positions for these staff, the Plan proposes they be employed on contract by the District Development Committees and supervised by the DPDOs.

To enhance and maintain the interest of village volunteers who, as distributors of contraceptives, form the backbone of this program, it is proposed that village development committees be charged with the responsibility of determining how these workers should be remunerated. The most viable suggestion is for the sale of contraceptives at a fixed national price with the distributor retaining all or part of the income from the sales.

Extensive efforts will be devoted to training various workers in the CBD program. The design and content of each training course is suggested. Special attention will be given to organizing and training village committees for their important role in selection and support of village distributors and in general promotion of the CBD concept at the community level.

The plan presents specific suggestions regarding the design, management and training for an information, education and communication component; a management information system; and a logistics plan in support of the CBD program. In each of these areas, existing systems were examined and applicable elements have been proposed for adaptation to or adoption by the CBD Plan.

A number of specific potential problem areas were identified for special focus and examination. In particular, certain unique or unusual components of the proposed program were assessed and found to be relevant and feasible.

The seven year budget, calculated at 1985 prices and with no allowance for inflation, totals more than K.Sh. 901 million. Suggestions are made regarding the budget items which are most likely to be of interest to external donors and those which may need to be financed by the Government of Kenya.

Extensive annexes supplement the text of the Plan with statistical, analytical, descriptive and graphic presentations.

ACRONYMS FORTERMS USED IN THE NATIONAL CBD PROGRAM PLAN

AIE - Authority to Incur Expenses

AMREF - African Medical & Research Foundation

ASDO - Assistant Social Development Officer

CBD - Community Based Distribution

CBHC - Community Based Health Care

CBS - Central Bureau of Statistics

CHW - Community Health Workers

CMS - Central Medical Stores

CO - Clinical Officer

CPR - Contraceptive Prevalence Rate

DC - District Commissioner

DDC - District Development Committee

DDO - District Development Officer

DHEO - District Health Education Officer

DHMT - District Health Management Team

DMOH - District Medical Officer of Health

DO - District Officer

DPDO - District Population and Development Officer

DPHN - District Public Health Nurse

DPHO - District Public Health Officer

DSDA - Divisional Social Development Assistant

DSDO - District Social Development Officer

DTT - District Training Team

ECN - Enrolled Community Nurse

Acronyms (Continued)

FP - Family Planning

FHFE - Family Health Field Educator

GOK - Government of Kenya

HUT - Health Unit Team

IEC - Information, Education and Communication

IRHFP - Integrated Rural Health and Family Planning Program

LSDA - Locational Social Development Assistant

MCH - Maternal and Child Health

MCSS - Ministry of Culture and Social Services

MIS - Management Information System

MOH - Ministry of Health

NGO - Non-Governmental Organization

NTT - National Training Team

OC - Oral Contraceptive

RHTC - Rural Health Training Center

SDP - Service Delivery Point

VC - Village Committee

1. INTRODUCTION

More than half of all households in Kenya are located four or more kilometers from the nearest health facility, and only about one-half of the Government of the Republic of Kenya (GOK) rural health facilities offer family planning (FP) services. Although the number of facilities offering FP services is increasing--from 505 in 1979 to 719 by January, 1985--Ministry of Health (MOH) family planning service statistics have not reflected this increase. The 1978 Kenya Fertility Survey revealed that only 7 percent of Kenyan couples were using an effective method of contraception. This percentage had increased to 14.9 percent by 1984 as determined by the National Contraceptive Prevalence Survey.

Kenya's present population growth rate is estimated to be 4.1 percent per annum, one of the highest in the world. At this rate, the current population of approximately 20 million will grow to more than 37 million by the year 2000. The Government has recognized the gravity and potential consequences of this rapid population growth and has taken several steps to rectify the problem. Efforts have begun by both the GOK and by non-governmental organizations (NGO) to train staff and upgrade rural health facilities to provide family planning services. However, a parallel national program for community based distribution of contraceptives would allow many more couples, who desire to space or limit births but who live great distances from health facilities, to enjoy the benefits of family planning.

2. COMMUNITY BASED DISTRIBUTION - AN OVERVIEW

Community based contraceptive distribution (CBD) systems, in which contraceptives are delivered to couples by community leaders, are intended not to replace clinical services but rather to extend them. By placing the contraceptive methods which are most popular and easiest to distribute within easy reach of users, the time consuming burden of providing these simple services is lifted from busy clinical facilities thereby freeing professional staff to carry out tasks requiring greater technical skills. In order to function most effectively, CBD programs must be closely linked to the life of the community and designed especially to suit the convenience of the users and the prevailing cultural patterns.

In general, CBD programs include the following essential features:

- Contraceptive supplies are delivered by community residents who are not health professionals but who are trained especially for CBD.
- Community distributors deliver supplies directly in the community, most often in the acceptors' own home.
- CBD workers operate relatively autonomously, without direct day-to-day supervision.

3. CBD EXPERIENCE IN KENYA

To date, CBD activities in Kenya have been carried out largely in the private sector and implemented by NGOs. More than a dozen pilot projects have provided substantial experience in this field and have yielded considerable information on which to base a broader national effort (See Annex 3-1).

3.1. Lessons Learned from Existing CBD Projects

General characteristics of the existing projects are as follows:

- o INTEGRATION.
  In many of the projects, family planning is implemented as part of a primary health care package which is itself part of an overall community development effort.

- o PERSONNEL.
  There are three types of personnel directly involved in CBD implementation: coordinators, supervisors and distributors. Generally,the coordinators and supervisors are paid staff while distributors are usually volunteers.

- o TRAINING.
  Training of these key personnel is similar. Once selected, the distributors are trained in primary health care and FP. The training period varies from one to three weeks. Upon completion of training, distributors are provided with contraceptives and start distribution within a predetermined geographic area. Supervisors and coordinators are trained in project management skills and in FP if they are not enrolled community nurses (ENC) who already have special training in FP.

- o SUPPORT.
  The implementing agencies for these projects provide other support functions such as provision and analysis of statistical records, trainers, and commodity procurement and storage which are carried out by their existing personnel.

- o VILLAGE COMMITTEES.
  The projects enter the community through village committees which are normally responsible for the selection of distributors and which support the distributors in their motivational activities. In programs which charge a fee for service or commodities, the committee is also responsible for accounting for revenue and expenses.

- o CLINICAL REFERRAL.
  The projects have either their own private clinical back up arrangements or referrals are made to government health facilities.

- IMPLEMENTATION.
  Nearly all projects have similar implementation strategies including community involvement through the formation of village committees, selection of distributors having similar qualifications by these committees, distribution of the same kind of contraceptives, and similar recording systems.

- TYPES OF CONTRACEPTIVES.
  Five types of contraceptives are being used in CBD projects: condoms, foaming tablets, jellies, creams, and oral contraceptives.

- SOURCE OF CONTRACEPTIVES.
  All projects receive contraceptives either from the GOK Central Medical Stores or directly from foreign donors. Supplies are usually available in sufficient quantity and quality.

- DONOR SUPPORT.
  All projects are supported financially by foreign donors for a period ranging from three to five years. Several of the ongoing projects are approaching the end of their funding period.

- LOCAL FINANCING.
  All executing agencies of the existing projects expressed their intention to continue the projects beyond the current funding period by charging a fee for service or for contraceptives. In fact, many of the projects already charge for other medicine, but they report they have not charged for contraceptives because these supplies are provided free and because donors are providing for project operating expenses.

3.2. Recommendations for the Future

Future CBD program development in Kenya should take advantage of the experience of these several pilot projects. In particular, the national CBD program should:

- Seek to build upon the base of the ongoing CBD projects of NGOs as well as coordinating fully with other governmental efforts for the provision of community based primary health care, e.g. Integrated Rural Health and Family Planning Program (IRHFP).

- Insure that the existing CBD project efforts are enabled to continue beyond the withdrawal of external funding and to expand beyond their present geographic coverage.

- Examine the experience to date to determine the potential for community remuneration of village-based distributors either through the sale of contraceptives or other means.

4. FAMILY PLANNING AND CBD PROGRAM GOALS

The ongoing Integrated Rural Health Family Planning Program-Phase II Draft Plan sets out objectives for Kenya of reaching a 2.8 percent population growth rate and a crude birth rate of 35 per 1,000 population by the year 2000. To achieve these objectives, it has been calculated that 40 percent of Kenya's fertile aged couples will need to practice contraception by that year. The Central Bureau of Statistics (CBS) projects that by 2000 the total population of Kenya will reach approximately 37 million, which implies approximately 7.4 million couples in the fertile age group. Thus, contraceptive services must reach approximately 3 million couples to achieve 40 percent prevalence by the turn of the century.

The 1984 Contraceptive Prevalence Survey for Kenya revealed a contraceptive practice rate of 15 percent or approximately 600,000 couples using contraception. Increasing this number to 3 million over the next 15 years implies a five-fold expansion of the existing contraceptive delivery systems. By the widespread expansion of CBD services, in addition to the planned acceleration in the provision of clinic-based contraceptive services (including voluntary surgical contraception), national goals for reducing the runaway growth rate can be achieved.

Specific goals for the national CBD program have been set for two points between the present and the year 2000. Assuming constant fertility and mortality, CBS has projected a total population of approximately 27 million by 1992 growing to 37.5 million by the year 2000. For the purpose of planning the national CBD program, it has been assumed that 38 percent of all contraceptive users by 1992 and beyond will obtain contraceptive supplies, primarily oral pills, condoms, and vaginal foams, through community-based channels. Thus, if the current overall contraceptive prevalence rate (CPR) of 15 percent is to grow to 25 percent by 1992 and 40 percent by 2000, a national CBD program would be expected to serve approximately 500,000 and 1.1 million users in 1992 and 2000, respectively (See Annex 4-1).

5. PHASED INTRODUCTION OF CBD

The introduction of the national CBD program is designed to occur in three distinct but overlapping programmatic phases preceded by a seven-month preproject period. No months or dates are given as the actual starting point for the program is not yet known. However, it must be noted that to achieve the goals outlined in the previous section it will be essential to begin the CBD program as soon as possible. Annex 5-1 presents the timeframe for the activities proposed for each phase of the project.

5.1. Preproject Period (Months 1 - 7)

Recognizing that a national program of the magnitude proposed herein cannot be achieved all at once, CBD activities will be introduced in several overlapping phases. A seven-month preproject period is proposed to allow for the achievement of basic preparatory activities such as national level orientation and training; ordering and distribution of essential supplies and equipment; and the design, testing and distribution of materials and reporting forms. This preproject period will lead to the gradual introduction of the actual community based program by districts.

Since introduction of the CBD program will be carried out by district, district preparedness for undertaking the program should be assessed during the seven-month preproject period. Criteria for evaluating preparedness should be primarily programmatic and should include:

- o establishment of population subcommittees of the district, divisional, locational and sublocational development committees, and
- o an assessment of the availability of trained MOH and NGO staff and service delivery points (SDP) to handle referrals from the CBD program.

Those districts proposed for Phase I introduction of the program should be encouraged to effect the above measures during the preproject period.

5.2. Phase I (Months 8 - 26)

In keeping with GOK policies for the planning and implementation of development activities with a district focus, the proposed CBD program is based at the district level. Accordingly, CBD activities will be introduced during Phase I in those districts having existing or planned CBD projects carried out with funding and technical assistance from several indigenous and international NGOs. As can be noted in Annex 5-2, these 14 districts are generally high density areas. Seven of the 14 have current CPRs at or above the national average of 15 percent; the remainder have rates ranging from 9 to less than one percent. The population of these Phase I districts is greater than 11 million, representing more than 50 percent of the nation's total.

Most of the ongoing CBD projects have received external funding for three to five years. Several of the pilot projects are approaching the end of their funding commitments. Although the implementing agencies have expressed an intention to continue the projects after the present funding periods, it will be most unfortunate if these successful pilot efforts are unable to continue for lack of funds. Therefore, to ensure that these projects survive to serve as models and centerpieces for district expansion of the national CBD program, Phase I is slated for introduction and coordination in those districts with existing or planned NGO-funded CBD projects. Accordingly, very early in Phase I

or even in the Preproject Period, if feasible, the National Council for Population and Development (NCPD) should request all NGOs, which are currently involved with CBD projects, to submit comprehensive plans of action for the continuation and expansion of CBD efforts for review by NCPD and by the relevant District Development Committees. These plans should include comprehensive budget statements, including the source of funds for proposed future activities. The GOK should make every effort to see that NGO activities continue through external funding or through allocation of government funds, if necessary.

As described in a separate section of this plan, training activities for village committees and village distributors should begin in Phase I districts, starting with those districts in which the NGO proposed expansion plans noted above are seen to be leaving gaps in CBD coverage. Also as described elsewhere in this plan, logistics and management systems to ensure the smooth introduction and/or expansion of CBD efforts should be instituted.

Finally, a process evaluation of progress in the activities described above for Phase I districts should be undertaken by NCPD after Phase I activities have been operating for about 12 months, i.e., during month 20 of the national program.

5.3. Phase II (Months 20 - 31)

During Phase II, CBD efforts will continue in the 14 Phase I districts and new focus will be given to 17 additional districts as noted in Annex 5-3. These districts were chosen for Phase II implementation based on their population densities. In addition to repeating the same training, logistics, management and evaluation activities for Phase II districts as those listed above under Phase I, the NCPD should assess the achievement of program objectives at regular intervals. Evaluation should identify areas of potential problems and gaps in information which might possibly affect program outcome. Well coordinated operational research studies of various aspects of the program may be instituted during Phase II. These studies should also be planned with the move into Phase III in mind and should be coordinated by the NCPD.

5.4. Phase III (Months 26 - 31)

This phase is designed to extend the CBD program to the remaining 10 districts which are low density, primarily pastoral areas (See Annex 5-4). Recognizing that these will be exceptionally difficult areas in which to effectively provide adequate clinical family planning services, it will be even more important to try to reach the residents of these districts with services provided directly in their communities. Findings and experiences of Phases I and II, as well as the results of any operational research undertakings, should be utilized in adapting the CBD approach for the predominantly nomadic residents of the Phase III districts.

6. ORGANIZATIONAL STRUCTURE FOR THE NATIONAL CBD PROGRAM

The organizational structure proposed for coordinating and implementing the national CBD program for Kenya is predicated on several needs. Success of this program will depend on cooperation and collaboration among several sectors--both public and private--at different levels in the geopolitical hierarchy of Kenya.

Policy matters and overall planning for the CBD program will be handled at the national level with the NCPD playing the key role. Other ministries and national bodies involved in the program will participate in this process by virtue of their membership on the NCPD.

Program planning, implementation and coordination will be based at the district level, in keeping with the GOK District Focus Strategy for Rural Development. Specific implementation activities will take place at division, location and sublocation levels. Similar to activities at the national level described above, all ministries and other bodies involved with the CBD program at each of these levels will participate by sitting on a subcommittee for population of the local development committee.

Actual distribution of contraceptive supplies will occur at the community or village level. All participants in the program, including NGOs, will be required to plan and implement their activities within existing district focus parameters.

Program planning and implementation will be carried out primarily by the personnel of the NCPD, the MOH and certain NGOs. Support functions will be the responsibility of several other bodies including the Office of the President (Provincial Administration and Ministry of Planning and National Development) and the Ministry of Cultural and Social Services. (See Annex 6-1)

6.1 Role of the National Council for Population and Development

Established by an Act of Parliament in 1982, the NCPD is charged with the responsibility for policy guidance on all population matters. Responsibilities of the Council are discharged through a Secretariat which is headed by a Director. The Council is based in the Office of the Vice President, Ministry of Home Affairs and is chaired by a part time Chairman. Members of the Council represent major GOK ministries, national NGOs and the private sector.

6.1.1. NCPD Secretariat

The NCPD Secretariat is currently divided into the Office of the Director, headed by a Director assisted by a Deputy, and four functional divisions--Programs; Information, Education and Communication (IEC); Planning, Research and Evaluation; and Finance and Administration. Recently, several proposals for the reoganization of the Secretariat have been put forward by the World Bank and other donors; however, it is felt the existing structure will adequately serve the national CBD program. All four functional divisions will have responsibilities in the CBD program.

The national CBD program will be supervised by the Programs Division, which should designate an Assistant Secretary with at least five years of family planning field experience and training in demography or a related field to be Program Officer for CBD. Coordination of CBD program implementation will be the responsibility of this Division. Activities will include the mobilization of the GOK and NGOs to undertake CBD, as well as the coordination of on-going CBD activities.

The IEC Division's workplan needs to include the development of messages regarding the CBD program. The population media program of the Division and the information it is expected to disseminate should include information on the CBD program. The Division should also provide technical assistance in the development and use of relevant media and materials to the agencies which implement the CBD program.

Responsibilities for arranging and assisting in the planning process for the CBD program will rest with the Planning, Research and Evaluation Division. Other activities to be undertaken by this division include review and coordination of operations research in CBD and coordination of the CBD evaluation process.

The Finance and Administration Division will handle all financial, personnel and other administrative matters related to the CBD program. (See Annex 6-2 for NCPD Organogram).

6.1.2. Standing Committee on CBD

In addition to an Executive Committee, the Council has authority to establish standing committees as required. Presently there are two standing committees--one for information, education and communication (IEC) and the other is a Technical Advisory Committee for the Family Planning Private Sector (FPPS) project. Additional standing committees for research and evaluation and for programs have been proposed recently; however, these have not been approved yet.

In the recent past, the NGOs implementing CBD projects joined with the MOH and the NCPD to form an informal CBD Coordinating Committee. This committee, which functioned under the aegis of the MOH's National Family Welfare Center, served as a forum for the exchange of project information and ideas. With the proposed elevation of CBD to a national program, a more formal coordinating committee is required. Therefore, a National CBD Committee, established as a standing committee of the NCPD, is recommended as a replacement for the informal CBD Coordinating Committee. Functions of the new committee will be to:

- Set policy for the national CBD program,
- Act as a technical advisory body for the national program, establishing subcommittees as needed towards this end,
- Act as ultimate supervisor and coordinator of all CBD activities, and
- Review and approve plans and funding for the national CBD program including donor relations.

Membership in the CBD Committee should include those involved in the Council who are able to provide not only technical but also planning and operations inputs. At a minimum it should have representatives from:

- NCPD (Director, Head of Programs Division and CBD Program Officer should be specifically designated),
- MOH (Permanent Secretary and Director of Medical Services should be specifically designated),
- Ministry of Finance,
- Ministry of Planning and National Development,

- o Ministry of Culture and Social Sciences,
- o Ministry of Local Government
- o International NGOs,
- o Local NGOs,
- o Office of the President (representatives from Development Coordination and Provincial Administration), and
- o Selected private sector representatives.

To give this Committee the visibility it deserves the Chairman should be the Chairman of the NCPD. He should have the option of designating either the Director of Medical Services to chair meetings on technical and medical issues or the Director of NCPD to deal with planning, implementation and evaluation issues. He should chair all the policy issue meetings. The CBD Program Officer should act as secretary to the Committee.

6.1.3. NCPD Field Staff

Prior to 1985, the NCPD, as a policy-making rather than an implementing body, had no staff posted outside headquarters. Twelve positions were recently allocated to the NCPD by the Directorate of Personnel Management. It is understood that the officers recruited for these positions will be posted to the field, with special responsibilities at the district level. For the purpose of this plan, these officers are referred to by the title District Population and Development Officers (DPDO) since they have been given no other specific title as of this writing.

The roles and responsibilities of the DPDOs have not been fully defined. The terms of reference for the creation of this plan indicated that the roles of DPDOs with regard to the national CBD program might be suggested. This has been done in Section 7.2.1.2. of the plan.

6.2 Role of the Ministry of Health

The present infrastructure of the MOH is as follows:

Administrative Unit (Number)	Primary Staff	Facilities
Province (8)	Provincial Medical Officer of Health	Provincial Hospital
District (41)	District Medical Officer of Health	District Hospital
Division (210)	Clinical Officer	Subdistrict Hospital/Rural Health Center
Location (800)	Enrolled Community Nurse	Health Subcenter Dispensaries
Sublocation (3,000 ±)	Enrolled Community Nurse	Dispensaries

The programs of the Ministry of Health are organized into eight major areas: preventive and promotive health services, rural health services, curative health services, manpower training and development, administration and planning, medical supplies services, national health insurance fund, and medical research.

The GOK's 1984-88 Development Plan notes with respect to the health sector that there is a substantial, increasing demand on medical services and that the provision of good quality medical care has doubled in cost. The plan suggests the need to explore alternative mechanisms for financing health care and to determine a more rational provision of services where the user shares the cost of service and where there is more participation by the community in the provision of services. As is discussed later, methods for community financing of the CBD program will need to be considered.

In order to avoid competition and duplication of efforts, the CBD program has been designed to take into account the existing MOH units, staff and programs which have a bearing on it. The implementation of the CBD program will call for collaboration and coordination with the MOH at all levels to maximize the use of existing resources and personnel. The MOH will also be responsible for establishing and revising medical policies for family planning in the CBD program.

Various MOH units will be called upon to play a role in the proposed CBD program, as will certain categories of MOH staff. Furthermore, several ongoing programs of the Ministry will be expected to intersect with the CBD program.

6.2.3. Health Unit Team

Each rural health unit, corresponding roughly to a division, has a health unit team (HUT) made up of the Clinical Officer (CO), ECNs and statistical clerks. The HUT will act as a technical resource on the medical aspects of the local CBD program to the DDC and its population subcommittee with the CO coopted to be secretary to the latter. It is recommended that each division be assigned one ECN, with specialized training in FP, to serve as divisional coordinator for CBD. Hereinafter, this individual will be referred to as ECN Coordinator. Responsibilities of this position are discussed in Section 7.2.2. of this plan.

6.2.4. Family Health Field Educators

This cadre of personnel is found at the locational level, usually working under the supervision of the rural health unit but reporting to the DHEO. Although the MOH has discontinued the training of new FHFEs, approximately 780 remain in posts scattered throughout the country. As they have been trained in FP motivation techniques, the CBD program will coopt these workers to assist with village and locational level training.

6.2.5. Integrated Rural Health and Family Planning Program

The Integrated Rural Health and Family Planning (IRHFP) Program, which is a major development program within the (MOH) Ministry of Health, continues the efforts of the Rural Health Development Program started in 1972 and the Maternal Child Health (MCH/FP) Program, which operated from 1975 to 1979. The current program, started in 1982, consists of twelve different but related components, all aimed at strengthening rural health and family planning services. Phase I (1982-85) of the program has included the following components: MCH/FP services; drug supplies; transport for rural health services; maintenance of a health information system; health education activities; community based health care; manpower training and development; construction and upgrading/improvement of rural health facilities; and collaboration with NGOs.

The objectives of Phase II (1986-89) of the IRHFP program will be to continue with the fertility reduction efforts begun under Phase I, and to improve the accessibility and quality of rural health services to further reduce rural mortality and morbidity. The specific components of the ongoing IRHFP program, which are considered to have a direct bearing on a national CBD program, are community based health care (CBHC), MCH/FP, health education, training, contruction of rural health facilities, essential drug supply system, and the health information system. These elements are described in more detail below.

6.2.5.1. Community Based Health Care

The CBHC component of the IRHFP program, implemented under the direction of the Division of Family Welfare, has the greatest direct bearing on the national CBD program. CBHC calls for the integration and expansion of the following health interventions at the community level: MCH/FP, malaria control, immunization, nutrition, prevention of diarrheal diseases, environmental sanitation, prevention of endemic diseases, supply of essential drugs, and health education.

In April 1985, the CBHC project reported having trained almost 300 multipurpose volunteer community health workers (CHW) to provide the services listed above at the community level. More CHWs are slated for training during Phase II of the program. To the extent CHWs are trained for CBHC and are providing village-based services, they should be given refresher training to become distributors for the national CBD program. Every effort must be made to coopt these workers for the CBD program and otherwise to coordinate CBD with the ongoing CBHC activities.

6.2.5.2. Other IRHFP Components Relevant to CBD

- MCH/FP - The main objective of this component is to increase the number of SDPs providing FP and to train essential primary health care personnel to provide FP services. These will be referral points for CBD clients.

- Health Education - Activities planned under this component include the production of a film on FP and other media efforts to encourage FP acceptance, which will benefit CBD motivational efforts.

- Training - The most significant activity of this component having relevance to CBD is the accelerated program for training of ECNs in specific FP skills. These personnel will be recuited as ECN Coordinators for the CBD program and will also be clinical service providers for clients referred to SDPs.

- Construction/Improvement of Rural Health Facilities - This component will construct or upgrade existing facilities at various levels, to provide FP and other primary health services. The component includes upgrading 22 district hospitals to provide voluntary surgical contraception.

- Essential Drug Supply System - Future efforts to be undertaken under this component include further improvement in distribution and storage of drugs and other supplies. Contraceptive commodity logistics for CBD should be enhanced by these efforts and every effort must be made to collaborate with those responsible for this component of the IRHFP program.

- Health Information System - Efforts in this component have included computerization, decentralization and a revised reporting system designed to improve availability of information for better program management. The CBD program should explore ways to utilize existing, functional systems to the mutual advantage of both programs.

6.3. Role of the Non-Governmental Organizations

The contribution of NGOs to the CBD experience to date in Kenya is fully described in Section 3 of this plan. Section 3.2 suggests specific future roles for NGOs to play in the expanded national CBD effort. NGOs at the international, national and local levels need to be encouraged to participate fully in Kenya's national CBD program by contributing technical skills and expertise learned from the pilot projects as they apply in the national effort. Furthermore, their full cooperation should be solicited at all levels to coordinate existing and expanded CBD projects with the new activities to be introduced under this national plan. In the future, all NGOs should discuss their existing and planned programs with the DDC to insure coordination, report to the DDC on their CBD activities and participate on population committees.

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6.4. ROLE OF THE OFFICE OF THE PRESIDENT - PROVINCIAL ADMINISTRATION

6.4.1. District Level

The District Focus Strategy, initiated by the GOK in 1983, gives the District Commissioner (DC) a major responsibility for coordinating and directing all development activities at the district level. The DC chairs both the DDC and its Executive Committee, which is the body responsible for providing technical expertise to the DDC. It will be important that DCs receive a full orientation to FP and to CBD. Their understanding and full commitment to FP is critical in population matters.

As far as the CBD program is concerned, the role of the DC will be to:

- ensure that planning, implementation, monitoring and evaluation are coordinated and within the District Focus policy guidelines for the DDC.
- ensure that the various CBD technical personnel are given adequate support by the Provincial Administration at all levels, especially at locational and sublocational levels.
- coordinate with NGOs to ensure that their CBD activities fit into DDC priorities for the districtwide CBD program.

6.4.2. Divisional Level

At each division a District Officer (DO) is responsible for administration and now, under District Focus, for development activities as well. The responsibilities of the post include among others, chairing of both the Divisional Development Committee and the population subcommittee.

Although detailed project planning activities are primarily the function and responsibility of the district level, promotion and priority setting for development projects takes place at the division. Thus, the DO must be oriented and encouraged to include general FP and CBD in divisional development activities.

More specific to CBD it is recommended that all DOs:

- be oriented in CBD.
- ensure that all agencies involved in CBD coordinate project planning and implementation at the divisional level.
- have responsibility for coordinating activities of the divisional level officials, e.g. COs, ECN Coordinators,Assistant Social Development Officers (ASDOs), and Divisional Social Development Assistants (DSDAs), who will be involved in CBD at this level.
- ensure that CBD data and information flow efficiently both to the field and to the district levels for the purposes of planning, implementation and evaluation.

6.4.3. Locational Level

Each location is administered by a Chief. Where they are actively interested in a particular project, tremendous public mobilization in support of that activity takes place. The Locational Chief is the chairman of the Locational Development Committee, as well chairman of its population subcommittee. Seminars are currently being held to orient Chiefs in FP. They should also get specific orientation in CBD.

For the CBD program it is recommended that the Chiefs:

- o take part in CBD promotional activities.
- o be responsible for ensuring that community processes are set up to select village distributors for CBD; however, the Chief should not directly select or appoint distributors as this may lead to confusion and lack of community support.
- o assist the CBD supervisors at locational level.
- o report on CBD to the Locational Development Committee and population subcommittee routinely.

6.4.4. Sublocational Level

Assistant Chiefs form the last rung of formal employment in the Provincial Administration ladder; they are found at the sublocation. They are responsible for collections of villages but their units are generally small enough to form communities in a sociological sense. Most people know each other at the sublocational level.

The national CBD program will be dependent on this level of government, since the Assistant Chiefs know who the community opinion leaders are, who would be acceptable distributors and which individuals take their community work seriously. This is the level at which the process of selecting distributors and creating their support system will take place.

To facilitate a positive role by Assistant Chiefs it is recommended that they get detailed orientation and training in CBD, over and above what they have in FP. They should also be encouraged in efforts to mobilize communities for the process of distributor selection and creation of support systems for those distributors.

6.5. Role of the Office of the President - Ministry of Planning and National Development

In each district, there is a District Development Officer (DDO). Although DDOs are appointed by the Ministry of Planning and National Development, in the field they are supervised by the DC, who is under Office of the President-Provinical Administration. District Development Officers are planning specialists for the Districts. They act as secretaries to the District and Divisional Development Committees. With the District Focus Strategy, their workload has increased and there are proposals to provide them with assistants who will handle some of their work.

For the National CBD program, the DDOs will have to assume the planning and coordination responsibilities as they do for other specialized sectorial activities at the district level. More specifically, it is recommended that DDOs:

- o assume responsibility for ensuring that District and Divisional Development Committees take on their CBD responsibilities within local priorities and national plans.
- o coordinate with the district level representative of the NCPD--the DPDO--on all population programs, including CBD.
- o participate in the population subcommittee of the DDC and act as its secretary in those districts where DPDOs are not yet deployed.

6.6. Role of the Ministry of Culture and Social Services

6.6.1. District Level

The representative of the Ministry of Culture and Social Services (MCSS) at the district level is the District Social Development Officer (DSDO). Responsibilities of this office include registration and advice to rural development groups which allows social development staff to become involved in a wide range of development activities. Many agencies, including some which have implemented the CBD pilot projects, utilize the DSDO and his staff to assist with gaining access to the rural communities. The office of the DSDO should be involved in planning and implementation of the CBD program to facilitate entree into the communities.

More specific recommendations for MCSS collaboration at this level are:

- o that the DSDO be a member of the population subcommittee of the DDC, and
- o that the DSDO monitor the activities of any MCSS staff involved in the CBD program.

6.6.2. Divisional Level

In each of the administrative divisions, a Divisional Social Development Assistant (DSDA) is responsible for community development, welfare, sports, and youth programs.

It is recommended for the CBD program that the DSDA:

- o be a member of the population subcommittee of the Divisional Development Committee,
- o act as a resource person for the subcommittee in motivational work, and
- o act as a coordinator for the activities of the Locational Social Development Assistants who are involved with the CBD program.

6.6.3. Locational Level

Locational Social Development Assistants (LSDA) are Ministry of Local Government (MLG) staff based at the locational level who are involved with community organization and development. They are usually members of the community they serve. These individuals will be recruited wherever they are available to assist with training and village mobilization for the national CBD program. Their specific roles will be described in more detail in Section 7.4.3. of this plan.

7. IMPLEMENTATION OF THE NATIONAL CBD PROGRAM

7.1. Role of the District Focus Strategy Units

Major responsibility for the coordinating field implementation of the national CBD program will rest with the population subcommittees of the development committees at district, divisional, locational and sublocational levels. These subcommittees have been formed already in many districts and divisions. A recent government order mandating the formation of locational and sublocational population subcommittees should ensure that subcommittees also will be established at those levels in time to play a significant role in the national CBD program.

To give these subcommittees the status they deserve and to ensure that adequate attention is given at each administrative level to the importance of FP and CBD, it is recommended that the subcommittees be chaired by the ranking officer within the Provincial Administration, i.e. DC, DO, Chief and Assistant Chief. Likewise, it is recommended that the key personnel of the CBD program serve as secretaries to these subcommittees, i.e., DPDO at district level; CO, Medical Officer or ECN Coordinator at divisional level; and LSDA or FHFE at the locational and sublocational levels.

At each level the subcommittee membership should include representatives of the various ministries implementing or supporting the CBD program, e.g., MOH, MCSS, Agriculture, Education, as well as local political and religious leaders, NGO representatives, private medical practitioners, and other local community leaders. Specific responsibilities for population subcommittees are recommended below.

The District Population Subcommittee should:

- set district CBD goals, targets and plans,
- coordinate GOK and NGO activities in CBD,
- monitor the implementation of CBD activities, and
- identify FP information and data needs for planning and monitoring the CBD program.

The role of the Divisional Population Subcommittee should be:

- to coordinate FP/CBD activities at the Divisional level,
- to receive and utilize reports from the District Population Subcommittee and District Documentation and Information Centre for planning and monitoring CBD program implementation,
- to provide guidelines and processes for the selection of supervisors and distributors, and
- to ensure regular commodity deliveries.

The Locational Population Subcommittee will be responsible for:

- o overseeing the selection of supervisors,
- o the coordination of CBD training and field activities at this level,
- o the supervision of the CBD distributor selection process, and
- o facilitating the work of NGOs involved with CBD at this level.

Activities of the Sublocational Population Subcommittee should include:

- o assisting distributors in their relations with the community,
- o handling rumors on FP in the community,
- o monitoring to ensure that distributors do not overlap in coverage, and
- o coordinating community distributor remuneration systems.

Although the lowest formal committee in the District Focus Strategy is the Sublocational Development Committee, this plan proposes the selection and training of a village committee which will serve the purpose of bringing the CBD program, as well as other development efforts, even closer to the people of Kenya. The importance of an investment in community organization and local support for CBD should not be underestimated. Therefore, this plan presents an elaborate and costly scheme for organizing village committees and training them for their role in support of the national CBD program. This crucial element of the plan will be further described in Section 7.2.5. It deserves in-depth understanding and priority attention.

7.2. Personnel for the National CBD Program

The success or failure of the national CBD program will depend to a large extent on the selection, training, development and dedication of program personnel. The terms of reference for the development of this plan precluded creating any new GOK civil service positions. Therefore, working within the constraints imposed by that directive, the following sub-sections set out the roles and responsibilities as well as the selection qualifications for paid, coopted, and volunteer personnel required for the national CBD program. Annex 7-1 presents field staff to supervisor ratios by province.

7.2.1. NCPD Staff

Section 6.1 of this plan sets out the overall role of the NCPD in the national CBD program. Several of the NCPD staff have special responsibilities for CBD--the CBD Program Officer and the District Population and Development Officers (DPDO).

7.2.1.1. CBD Program Officer

It is recommended that this officer, serving with the rank of Assistant Secretary within the Programs Division of NCPD, have at least five years of family planning field experience. The roles and responsibilities of the position include having overall responsibility for the smooth functioning of the national CBD program. He/she must ascertain that CBD program personnel at all levels perform their functional responsibilities as planned and the CBD activities are implemented in a timely fashion according to the schedule of

activities in the plan of operations. The head of the Programs Division should monitor this officer's workload and assign other staff to provide assistance as may be required.

7.2.1.2. District Population and Development Officers

As noted in Section 6.1.3., this new cadre of NCPD personnel will play a key role in representing the Council at the district level. As such, these officers will perform a vital function with respect to translating national policies into field implementation for the CBD program as well as for all other FP field activities. It is strongly recommended that NCPD post the 12 officers already appointed to the field as soon as possible. Furthermore, in recognition of the importance of this CBD program and the necessity for NCPD, as the body responsible for its ultimate success, to keep well abreast of field implementation, it is also recommended that the NCPD seek the allocation of additional officers to be posted as DPDOs in the remaining districts. The capital and recurring costs for a total of 41 DPDOs are presented in the budget for this plan (Section 10).

Since this is a newly allocated position, the roles and responsibilities of DPDOs have not been fully elaborated. The terms of reference for the development of this CBD plan invited suggestions for the DPDO's job description, especially as it relates to CBD. Accordingly, it is recommended that the DPDOs be responsible for:

- Coordinating all population activities, including CBD, in the district.
- Participating in the DDC.
- Serving as secretary and technical advisor to the District Population Subcommittee.
- Planning promotional activities in FP and CBD for the district.
- Assisting in training for district and divisional CBD staff.
- Moving contraceptive supplies from the district to divisions during visits to divisions for monthly meetings and ensuring that adequate supplies are always available for the CBD program.
- Supervising the officer in charge of the district store to ensure that an adequate supply of contraceptives is maintained and issued appropriately.
- Collecting, analyzing and publicizing data on FP and CBD performance in the district. This should include feedback to program managers for use in program implementation and evaluation.
- Reporting the data noted above to the District Documentation and Information Center and promoting its use in development planning.
- Attending all monthly supervisor's meetings organized by the ECN Coordinators in each division.
- Providing participatory supervision during monthly meetings to all supervisors in conjunction with the ECN Coordinators.

- Exercising authority in the recruitment, placement, reprimand, and dismissal of supervisors in the district.
- Setting standards of performance for ECN Coordinators, reviewing their performance periodically and making recommendations to the CBD Program Officer and appropriate MOH officials for action.
- Preparing the district budget for CBD program implementation.
- Maintaining and reviewing the accounting records on CBD program expenses of the district.
- Preparing necessary reports as required.
- Providing orientation for the District Helth Management Team and keeping them informed of CBD project activities and coordinating CBD activities with the DHMT's activities as appropriate.
- Performing any other duties related to CBD program as may be assigned by the CBD Program Officer.

In establishing the DPDO field positions it is important to note that these officers will have to function in a manner similar to the DDO, i.e. to serve the District and Divisional Development Committees with a special emphasis on FP. This will entail significant travel for field supervision, data collection, and commodity distribution. It is therefore recommended that these officers be provided a four-wheel drive vehicle.

The DPDO will be responsible for processing FP program information for the various development committees and for the District Documentation and Information Center. Therefore, competent secretarial and messenger services are recommended as is a data handling system such as a microcomputer. Office space and equipment will be required for the DPDO and support staff. Costs for all of these inputs have been included in the budget for this plan (Section 10).

7.2.2. ECN Coordinators

As recommended in Section 6.2.3. of this plan, the key CBD program staff at the divisional level will be an ECN Coordinator coopted for this fulltime position from the MOH. The specific responsibilities related to this position will be to:

- attend training of District Training Teams and specialized training for the ECN Coordinators on divisional management of the CBD program as well as other subsequent training and meetings as required.
- work with other District Training Team members in developing the curriculum for training village committees.
- participate as facilitator in the training of supervisors.
- work in conjunction with supervisors, FHFEs and LSDAs to organize village committees in every village in the division.
- organize a monthly meeting for all supervisors in the division.
- ensure that every supervisor has a sufficient supply of contraceptives to resupply distributors.

- o ascertain that recording of CBD program information for the division is accurate and up to date.
- o make field supervision visits to each location in the division twice a year.
- o set standards of performance for supervisors and review their performance monthly and annually, and to make recommendations for disciplinary or dismissal action to the DPDO as appropriate.
- o prepare the annual budget for implementation of the CBD program in the division.
- o prepare necessary reports as required.
- o orient and keep the Divisional Health Management Team informed of CBD activities and coordinate these activities with other health programs in the division as appropriate.
- o perform any other duties related to CBD as may be assigned by the DPDO.

7.2.3. Supervisors

The national CBD program supervisors, based at the locational level, will be called upon to perform what might be considered the most vital function in the entire program. They provide the critical link between the salaried staff in the hierarchy of the program and the volunteer distributors at the community level. the supervisor will have the major responsibility for translating the essential policies of the CBD program in to understandable, acceptable and operational actions at the community level. The success of CBD efforts around the world has often been compromised due to inadequate attention being given to the selection, training, and ongoing support of supervisory staff.

In keeping with the terms of reference which precluded the addition of new civil service posts in the CBD program, a number of alternatives for coopting existing community oriented workers were explored. In particular, the possibilities of utilizing field staff of the MCSS (LSDAs) or of the MOH (FHFEs) were examined. Other potential supervisors such as teachers and agricultural extension workers were also considered. In all cases, however, it was felt that selecting any of these personnel as supervisors would only give the CBD program someone who had a divided commitment between CBD work and his or her other responsibilities. Furthermore, in some instances, the lines of responsibility would become rather cumbersome. Ultimately, it was determined that recruiting any of the abovementioned individuals as CBD supervisors would only mean additional work for them, and the result would probably be that all responsibilities would suffer. Experience from the successful existing CBD projects in Kenya indicates that supervisors usually had specific responsibility for primary health care and CBD only, and that these responsibilities keep them fully occupied.

Having carefully examined the alternatives presented above, it is strongly recommended that CBD supervisory personnel be recruited at the locational level and hired on a contractual basis for three years with options for renewal. Since the supervisors will be working at the locational level they must be contracted at a higher level, to break local favoritism for employment. The DDCs, which have power to negotiate and sign contracts, should be the unit responsible for contracting CBD supervisors. Review of applications should be done by the DPDOs in liaison with the DC. It is recommended that the DPDO serve

as supervisor for this cadre with powers to terminate their contracts on recommendation of the ECN coordinator.

The qualifications for supervisors, should be:

- Minimum high school (Form IV) education.
- A mature person, either male or female.
- Willingness to travel extensively in the location and to the divisional center periodically by motorcycle.
- Ability to relate to others, particularly older people.
- Practicing contraception, or at least fully committed to the concept.

The cost for deployment of these personnel should constitute part of the project funding and has been presented as such in the budget. The salary for supervisors should be approximately K.Sh. 1,5000 which is in the same range as the ECN; however, the ECNs receive other civil service benefits which nearly double their salary. Allowance for annual salary increases based on performance should be considered for this cadre.

Because it is considered essential that these personnel be mobile in order to carry out their supervisory responsibilities, it is recommended that they be provided with sturdy off-road motorbikes. These vehicles, which will be donated and imported under the project, will be "sold" to the supervisors upon payment of monthly installments over a period of 5 to 7 years. When the price of the motorbike has been fully paid, it will become the personal property of the supervisor. The program budget provides for a modest operating and maintenance allowance for these vehicles during the course of the program. It is assumed that the potential for eventual ownership and the monthly investment of a portion of ones salary as a reminder will ensure that these motorbikes are well maintained. Annex 7-2 sets out the implications of payment for motorbikes by monthly installments over the life of the program.

Specific roles and responsibilities of CBD program supervisors will be to:

- o participate in training on locational management of the CBD program and other subsequent training courses or meetings as required.
- o work in conjunction with the ECN Coordinator and selected LSDAs and FHFEs in organizing village committees (VC) in all villages in the location.
- o participate as a facilitator in training of the VCs.
- o assist the VCs in the selection of the village distributor.
- o assist the VCs and the distributors in preparing village maps and undertaking baseline surveys of the village.
- o coordinate with the VCs in planning and overseeing the distributor's work.
- o conduct training for distributors in village management of the CBD program.
- o visit every distributor in his/her location at least once a month.
- o supervise the management of the VC of any distributor incentive system
- o ensure that every distributor has sufficient contraceptive supplies on hand for distribution.
- o ensure that every distributor understands and maintains the CBD record and information system.
- o assist VCs and distributors with IEC activities.
- o assist distributors in the follow up of clients who drop out.
- o prepare necessary reports as required.
- o maintain his/her motorbike in good condition.
- o coordinate with other government field staff in their work with the VCs.
- o provide orientation and keep locational and sublocational Health Management Teams informed about CBD project activities.
- o perform any other duties as may be assigned by the ECN Coordinator or DPDO related to the CBD program.

7.2.4. Village Distributors

In CBD programs throughout the world, experience has varied in both the methods used to select village level distributors and the characteristics and qualifications of these workers. Recognizing that first and foremost the success of CBD will depend on the acceptability of the distributor to those served, the community must be involved in the selection of these workers. Distributors have been nominated, screened and selected by the entire community to be served or by a specified group of community members, e.g. the Village Health Committee, in

some programs. In others, the community may nominate candidates who are then screened and selected by an external organization, e.g. the implementing agency or supervisor. A checklist or brief training session which sets out the selection process and characteristics to look for in nominating and selecting distributors has proven useful in facilitating community involvement. Also, involving CBD supervisory staff and personnel from the SDPs to which the worker will be referring clients will help to ensure cooperation and good relations between the distributors and these key people.

The characteristics of community distributors are as important to the success of CBD programs as is their means of selection. The following characteristics have been used successfully in the selection of distributors for CBD pilot projects in Kenya:

- Residence in the community
- Basic literacy (4-7 years of schooling)
- Married
- Willingness to work as a volunteer
- Respected by the community
- Maturity (some projects specify an age range)
- Sex is not always specified, but experience elsewhere indicates female distributors may have better rapport with CBD acceptors, the majority of whom are expected to be females.

Personal use of contraception does not seem to have been a criterion for selection of CBD workers in the Kenyan experience; however, experience elsewhere has shown this to be an important factor contributing to the success of CBD programs. An analysis of three CBD projects supported by The Pathfinder Fund in Kenya found that all community distributors interviewed were either practicing contraception or were not in need due to divorce, widowhood or having aged beyond the reproductive years.

Recommendations for the selection of distributors include the following:

- Distributors for the national CBD program should be selected with participation from the members of the community they will serve.
- CBD supervisors and personnel of SDPs should assist or participate in distributor selection.
- Criteria for the selection of distributors should be standardized taking into consideration community residence; literacy adequate to deal with the CBD information system; culturally acceptable marital status, age and sex; and personal use of contraception.

Based on the experience in pilot CBD projects in Kenya and elsewhere, it is proposed that the number of distributors selected to serve the national CBD program be determined based on the ratio of one distributor to 1,500 total population. This would mean one distributor serving approximately 300 eligible couples (using the standard calculation of 20 percent of any given population as falling into the fertile age range of 15-44 years). Thus, using the 1985 population projections for Kenya, Annex 7-3 presents the approximate number of

distributors required to serve a total population of 1,500 each. This annex also presents districts by the phases for program introduction so that the number of distributors required for each phase can also be determined. Obviously, population growth between 1985 and actual program start up will affect the population figures and thus the number of distributors required to maintain the 1/1500 ratio. Therefore, this plan has utilized 15,000 distributors as a planning figure rather than the total of 13,570 indicated in Annex 7-3.

Combining the above projections of numbers of distributors and eligible couples, with the CBD program goals set out in Section 4, overall CBD caseload per distributor may be readily determined, (see Annex 7-4),assuming the existence of 15,000 distributors. The ratio of distributors to population will be 1/1800 in 1992 and 1/2500 in 2000. The number of eligible couples (normally calculated as 20% of total population) per distributor will be 360 in 1992 and 500 in 2000. If the contraceptive prevalence goal is 25% in 1992 and 40% in 2000, then the total number of contraceptive users per distributor among eligible couples will be 90 in 1992 and 200 in 2000. For the purpose of planning the national CBD program, it has been assumed that 38% of all contraceptive users by 1992 and beyond will obtain their contraceptives through CBD channels. As a result, the number of users to be served per CBD distributor will be 34 in 1992 and 76 in 2000. This level of users being served being served by each distributor is a manageable figure which is in keeping with CBD experience in Kenya and elsewhere.

As noted in Section 6.2.5.1., the CHWs already selected and trained for the IRHFP program of the MOH will be further trained to take on CBD activities as well. This may reduce the overall number of individuals required for selection and training exclusively as CBD distributors, but the exact number of existing CHWs and the training and appointment schedule for new ones was not readily available for the purposes of developing this plan. Furthermore, it should be noted that those CHWs coopted for the CBD program may not be able to carry the same CBD caseload as the single-purpose CBD distributors due to the press of other primary health care activities. This has been the case with integrated community-based health and FP projects both in Kenya and elsewhere.

The following functional responsibilities are proposed for village distributors:

- to attend training on village management of the CBD program, and other subsequent training or meetings as required.
- to act as the contraceptive supply depot in the community.
- to perform the necessary screening of acceptors, including use of the checklist for oral contraceptives, prior to distribution.
- to follow up acceptors who drop out.
- to keep records of acceptors on the forms provided.
- to keep inventory records of contraceptive supplies on the forms provided.
- to work with the VC and supervisor in preparing a village map showing all households in village and a minisurvy of baseline community data.

- o to act as the referral agent between clients and SDPs, for complications or for individuals wishing to use clinical methods.

Experience world wide with community based health programs has shown that over time volunteer health workers have a high turnover rate, low productivity or both. This leads to unmet program goals, service disruptions and unacceptable high retraining costs.

Programs such as these are beginning to experiment with incentives, both monetary and other types, to improve distributor morale, productivity and longevity. A complete discussion of incentives lies outside this scope of work; however Annex 7-5 discusses some of the potential options for distributor remuneration. It is strongly recommended that some sort of incentive or remuneration system be worked out for administration by the VC at the community level.

7.2.5. Special Role of the Village Committee

Although not qualifying as CBD program staff parallel to the categories listed above in this section, this important volunteer committee at the village level will be the lowest unit of the CBD program organizational structure. The number of village committees (VC) shall correspond with the number of distributors, i.e., 15,000, which is assumed to represent the approximate number of villages in Kenya chosen by the community. On average, each committee will be comprised of 10 to 15 village leaders. This brings the total number of VC members to approximately 200,000. The members of the VC should elect among themselves a Chairman, Secretary and any other officials as they decide are required.

In accordance with the District Focus Strategy of the GOK, community organization at the village level should receive special attention. This applies not only to the CBD program, but also to all village based development activities. Encouraging and organizing a strong VC in each community will have an impact on future rural development of the country as a whole. It is recommended, therefore, that government functionaries implementing activities at this level, e.g. LSDAs, teachers, agricultural extension workers, livestock officers, be coopted as ex-officio members of the VC. They should organize themselves into a technical working group to advise the VC in their specialized fields and coordinate their activities in the village among themselves and with the VC.

It is recommended that the specific responsibilities of the VC for the CBD program will be:

- to attend training on village management of the CBD program and other subsequent training courses or meetings as required.
- to select the village distributior for CBD.
- to conduct the community mapping and baseline survey with the distributor and assisted by the supervisor.
- to plan and oversee the distributor's performance in coordination with the supervisor.
- to assist the distributor in her motivational and educational efforts.
- to determine and oversee a remuneration scheme for the distributor.

- o all chairmen of VCs and village distributors in each division at divisional headquarters.

The general objective of these meetings is to review progress of the CBD program at each level which will facilitate planning for the following year. On these occasions, special recognition for staff demonstrating outstanding performance during the year should be given along with token incentives, if possible. The meetings also provide a forum for sharing experience and joint problem solving among personnel who operate at the same level in the program. Each annual meeting should last three days. A budget is presented for these annual events.

The supervisory functions of each level of CBD program personnel are described as follows:

7.3.1. Distributor

In addition to the distributor's responsibilities for dissemination of FP information and supplies, she also performs a supervision or oversight function at the village level through keeping client records and making home visits to those clients who do not come for resupply. This is an important task that will assure user satisfaction and continuation in the CBD program.

7.3.2. Supervisor

It is the duty of the supervisor to visit each distributor in the location at least once a month. The monthly visit is to be prearranged between the supervisor and each distributor so that they will not miss each other, however an alternate date will be selected to provide a fall back in case they do miss the first appointment. During the monthly visit, the supervisor will collect data on distribution and resupply contraceptives. The supervisor's signature on the distributor's record form and the distributor's signature on the supervisor's record form are required to document that the visit occurred and to confirm the quantity of contraceptives resupplied at each visit. The supervisor will assist the distributor in following up dropouts. The supervisor will advise the distributor on any other matters related to CBD implementation. After completing visits to all distributors, the supervisor will prepare a summary record on distribution and contraceptive supply for his/her location, to be brought to the monthly meeting with the ECN Coordinator. The supervisor will also keep the VC informed of progress of the CBD program in their village and seek their advise on how to advance CBD activities.

7.3.3. ECN Coordinator

The primary supervision by the ECN Coordinator will be performed during the monthly meeting organized at her work station for all supervisors in her division. During this meeting, the ECN Coordinator will perform the following tasks:

- o Check every supervisor's records to see that all distributors have signed indicating a supervisory visit for the month. A missing signature requires a written explanation by the supervisor.
- o Replenish contraceptive supplies to each supervisor.
- o Review each supervisor's performance with the entire group attending the meeting so that they can compare achievements.

- Issue salaries and other allowances to supervisors. This will ensure attendance at the meeting. In case of any absence without notification, the ECN Coordinator will take note and can then make a supervisory field visit to the location of the absent supervisor.

- Advise supervisors on matters related to the CBD program implementation.

The secondary supervision by ECN Coordinators will be performed if a supervisor does not attend the monthly meeting and at least once every six months through field visits to each supervisor under her responsibility. During these one-week visits, she will randomly visit distributors to get direct feedback from them regarding the CBD program. Finally, in conjunction with the DPDO, she will review performance of her supervisors annually and recommend salary increases and other incentives for approval by the CBD Program Officer. At any time, the ECN Coordinator can recommend reprimand or dismissal of supervisors who have been found to be performing unsatisfactorily.

7.3.4. DPDO

It is the responsibility of the DPDO to coordinate with ECN coordinators so that monthly meetings of supervisors are not scheduled on the same day. Prior to each meeting, the DPDO will requisition an adequate quantity of contraceptive supplies from the district store to take with him. During the meeting, he will provide participatory supervision of the supervisors with the ECN Coordinator. He will also collect supervisor's summary reports from the ECN Coordinator to forward for data processing.

At the district level, the DPDO is also responsible for supervising the district store officer and staff responsible for contraceptive supply storage and movement. This will ensure the availability of adequate supplies for the CBD program.

7.3.5. CBD Program Officer

This individual has overall supervisory responsibility for the CBD program. He/She must also ascertain that the proposed supervisory system is carried out according to the plans.

7.4. Training for CBD

Three categories of personnel must be trained for successful implementation of the national CBD program. These categories and the courses for each are noted below.

Training of trainers will include courses for:

- A national training team (NTT) on CBD curriculum development and training skills and methodology (Course 1)
- District training facilitators (Course 3)
- District training teams (DTT) (Course 4)

Training for CBD program personnel will provide courses for:

- District management of the CBD program (Course 2)
- Divisional management of the CBD program (Course 5)
- Locational management of the CBD program (Course 6)

Finally, training activities for village volunteers will include courses on:

- Village management of the CBD program (Course 7)
- Training of village distributors (Course 8)
- Refresher training for distributors (Course 9)

A summary of these nine training courses including location, duration, numbers of sessions and trainees, facilitators or trainers and cost of each course is presented in Annex 7-6.

7.4.1. National Training Team - Identification and Training

This seven person team, comprised of one coordinator and six members, will be a temporary entity responsible for concentrated training activities during the seven-month preproject period. They will facilitate all training of trainers for the CBD program as well as training for the DPDOs in district management of the CBD program. Because of its temporary nature, the training budget has allowed honoraria rather than salaries for this group. It is widely acknowledged that individuals with training expertise are readily available in several public and private agencies in Kenya. Therefore, it is recommended that NTT members be coopted from these other agencies either in their individual capacities or as part of a training contract arrangement between NCPD and another agency.

Functional responsibilities of the NTT will include:

- the development of curricula for district management of the CBD program and training of District Training Facilitators.
- the training of 41 DPDOs.
- the development and/or identification of training materials and resource persons for the courses listed above.
- the training of 41 District Training Facilitators.

- o determination that the curricula developed by District Training Teams are of the quality and standard relevant and timely to CBD program implementation.

Furthermore, the NTT coordinator will assist the CBD Program Officer in matters related to training for the CBD program. Each of the 6 NTT members will advise, assist, coordinate and participate in the development and implementation of training to be carried out in the CBD program at the district level.

The actual training course for the seven NTT members (Course 1) will be of four weeks duration and it will be held in Nairobi. Facilitators will be two training consultants experienced in CBD curriculum development and management training. They will be hired as short term consultants and provided honorarium. The CBD Program Officer will assist as a third facilitator for the course. Training objectives and an outline of course content for this and all other courses are noted in Appendix 7-7.

7.4.2. District Training Facilitators

To facilitate and accelerate the training and development of the DTTs, one district training facilitator will be selected and trained for each district. It is recommended that the DPHN, DHEO, or District Public Health Officer (DPHO) be selected as facilitator. In addition, since many of the CBD training sessions are expected to utilize the Rural Health Training Centers (RHTC) as training sites, the officers in charge of the six RHTC should be coopted as district training facilitators.

The responsibilities of these facilitators will be:

- o to develop two curricula on Locational Management of the CBD Program and training of District Training Team.
- o to develop and/or identify training materials and resource persons for both of the courses noted above.
- o to assist in training members of District Training Team in his/her district.
- o to facilitate in the training course for the Locational Management of the CBD Program.
- o to advise, assist, coordinate and participate in the development and implementation of training to be carried out by the District Training Team.
- o to assist the DPDO in matters related to CBD training in the district.

The training course for district facilitators (Course 3) will be held in Nairobi and will be of four weeks duration. Trainers will include the NTT, the CBD Program Officer and the same consultants utilized in Course 1. As noted above, the training objectives and suggested course content for Course 3 are included in Annex 7-7.

7.4.3. District Training Teams

Each of the 41 districts is to have a District Training Team comprised of 12 to 15 persons, including four or five FHFEs, four or five ECN Coordinators and four or five LSDAs. Each division in the district should be represented by at least one person. LSDAs have been included on the DTTs because one of their functional responsibilities is to organize village committees prior to giving the village management of CBD training courses. Community organization is the main task of LSDAs; therefore, it is assumed that including LSDAs in the District Training Team will strengthen the CBD program's efforts in organizing village committees. The FHFEs are also recommended for DTT membership. This cadre has already been trained in FP motivational skills. Furthermore, where FHFEs still exist they appear to be involved with community organization along with their FP motivational tasks. Thus, their cooperation for the CBD village organization and training efforts is a logical addition to the DTT.

Following their own training, DTTs will be expected:

- to train supervisors in the district.
- to develop a one-week curriculum for training the VCs.
- to develop and/or identify training materials and resource persons for the VC training.
- to assist the trained supervisors in organizing and training VCs in all villages in their division. (This will be done in teams of two made up of an ECN Coordinator or supervisor with an FHFE or LSDA.)
- to support DPDOs and District Training Facilitators in matters related to training for the CBD program in the district.

Details of the training objectives and course content for DTTs (Course 4) are included in Annex 7-7.

7.4.4. Other Training Courses

The training courses for CBD program personnel and village volunteers will be conducted, for the most part, by other personnel in the CBD program. The training functions of those individuals have been included in their responsibilities outlined in Section 7.2 of this plan. The individuals having specific training responsibilities related to each course are noted in the summary chart presented as Annex 7-6. The training objectives and course content for CBD personnel (Courses 2, 5 and 6) and for volunteers (Courses 7, 8 and 9) are presented in Annex 7-7.

7.4.5. CBD Orientation for Public Leaders

Successful implementation of the CBD program will require the support and cooperation of many agencies within and outside the GOK. To gain this support, personnel in those agencies will have to be oriented to the concept and details of how the CBD program is to operate and how CBD will impact on the country. In particular, the high ranking officials in those agencies will have to be convinced about CBD so that they will encourage their subordinates to support and cooperate with CBD program implementation.

It is recommended that high ranking officials at the national level in the NCPD, government and non-governmental organizations be oriented and exposed to

the CBD concept and to successful CBD experience both within and outside Kenya. This can be carried out in the form of orientation workshops held for a half-day at the national level. Study tours to visit successful CBD projects both within and outside Kenya might also be arranged; however, this plan does not include a budget for such trips.

District leaders consisting of the DC, DDO, DDC members, DMOH, DSDO, NGO representatives, DHEO and political leaders (about 15 persons per district) also require CBD orientation. For this group a half-day orientation session is also proposed. Subjects to be covered will include the concept of CBD, their expected involvement in the CBD program and an overview of the program planning techniques, coordination approaches, and the system for program data storage and processing and feedback. The facilitator for these sessions will be the DPDO in each district.

The Chiefs, DO, ASDO, Clinical Officer, women leaders, political leaders, Assistant Adult Education Officer, ECNs and other clinic personnel, representatives of NGOs and private medical doctors are some of the divisional leaders. Their half-day orientation session will include the discussion of population dynamics and the local situation, CBD program approaches, community mobilization through meetings and seminars, program performance appraisal, management of project activities and development of communication materials. The DPDO will also facilitate these sessions.

Section 10 presents a detailed budget for these orientation sessions.

7.5. Information, Education and Communication Requirements for CBD

Several target audiences have been identified for CBD related information, education and communication (IEC). There is the general public under whom the CBD clients and leaders at various levels fall. The CBD personnel comprise a second audience. Requirements for IEC equipment and materials, as well as the information needs of each audience, have been determined on the basis of the tasks or activities of each target group. These are presented below. The orientation and training required by each group are specified in Section 7.4. of this report.

7.5.1. Clients

Women in the reproductive ages (15-44 years) and their male partners are potential CBD clients. Some will be new family planning acceptors, others will be non-acceptors or continuing users. Satisfied family planning users are expected to act as motivators in their informal interactions with their neighbors.

The information needs of clients will depend on the different categories to which they belong. In general, adults need information on the health and other benefits of practicing family planning. New acceptors will be receptive to information on the benefits of family planning and the currently available methods of contraception. Non-acceptors need to be motivated on the benefits of family planning. Information on the side effects of contraception and also on reproductive physiology is likely to be sought by continuing users. The IEC materials which will be of greatest use to each group are partly determined by their information needs.

Leaflets and functional literacy materials on the health and other benefits of practicing family planning are appropriate for adults in general and for non-acceptors in particular. Non-acceptors will require additional materials on human physiology. New acceptors will find pamphlets on family planning methods and their side effects relevant to their needs. Rural newspaper supplements and pull-outs on the side effects of family planning methods and physiology, among others, are useful materials for continuing users of family planning. There is no IEC equipment envisaged for clients.

7.5.2. Leaders

Leaders exist at the national, district, divisional and lower levels of the Provincial Administration. Their needs for IEC equipment and materials depend largely on the tasks they are expected to undertake for the national CBD program.

7.5.2.1. National Leaders

The national leaders consist of the NCPD Secretariat, NCPD Standing Committee on CBD, executive directors/managers of NGOs involved in CBD, and donors. These individuals are responsible for setting policy, establishing national CBD goals and monitoring progress in implementation of the program as well as achievement of objectives, project identification and implementation, operational research, dissemination of research findings, development of national IEC strategies, coordination of materials development, establishing and operating CBD information clearing houses, procurement and distribution of equipment and materials, and finally procurement of technical support for districts.

Population data obtained through national censuses and projections, inventory of CBD plans and targets, prevailing problems, and findings of completed research are the primary information needs of national level leaders. Films on CBD programs in other countries, a library with relevant books, as well as booklets, CBD manuals, calendars, flip-charts, video equipment and projectors, an overhead projector, a film projector and slide/film-strip equipment are some of the materials and equipment which these individuals require.

7.5.2.2. District Leaders

The leaders at the district level include the DC, DPDO, DMOH, DSDO, DHEO, political party leaders, other members of the DDC and local managers of NGO programs. They will be responsible for a wide range of IEC tasks, including publicity for the CBD program.

District leaders will require data for district level planning including national plans and projections for CBD as well as statistics on divisional operations which include prevailing problems, population dynamics, plans, activities and targets.

Film, overhead, and slide projectors are the equipment suitable for the district. They should be available from the DPDO's office. Motivational films relating to CBD programs in other countries, posters, flip-charts, pamphlets, booklets and manuals on CBD are the materials required for district leaders.

7.5.2.3. Divisional Leaders

The divisional leaders include Chiefs, Assistant Chiefs, DOs, ASDOs, Locational Social Development Assistants, women leaders, party officials, Assistant Adult Education Officer, ECNs and private medical doctors.

These leaders will be responsible for divisional level project planning and monitoring as well as coordination with other agencies' programs. They will also monitor development and use of local IEC materials.

The information needs for the foregoing tasks are: district development plans, national and district guidelines on CBD plans and targets, as well as logistics, training, supplies, finances, monitoring and other progress reports of the program and prevailing motivational problems.

Cassette players, recorded cassette programs and motivational films, some of which will be on CBD case studies, are required at this level. Materials essential for this group include brochures, booklets, pamphlets, CBD manuals, calendars and flip-charts.

7.5.3. CBD Personnel

The critical CBD personnel are the ENC Coordinators, supervisors and distributors, as well as clinical staff based at the SDPs.

7.5.3.1. ECN Coordinators and SDP Personnel

The CO, nurses, midwives, ASDO and record clerks are among the crucial personnel at SDP. They will attend to and counsel referral cases. The ECN Coordinator will supply contraceptives through supervisors to distributors, provide technical assistance on contraception and reproductive physiology, summarize and forward records from CBD workers, and store and provide IEC materials to the supervisors.

To facilitate these activities, projectors for films and film-strips and cassette players/recorders should be available at SDPs and with the ECN Coordinators. Posters, booklets, and pamphlets on family planning methods, calendars, anatomic models and basic family planning manuals are the materials required by these two groups.

7.5.3.2. Supervisors

The supervisors will oversee the day to day functioning of distributors, guide and orient distributors, resupply contraceptives, engage in promotion and motivation at meetings, evaluate the performance of distributors, find out their information needs and assist them to follow-up dropouts. To effect these tasks, their specific information and equipment needs for cassette players/recorders, posters, pamphlets, flip-charts, booklets on family planning methods, and flannel-graphs should be met.

7.5.3.3. CBD Distributors

Distributors will be involved in motivating clients by explaining the benefits of family planning, educating them on contraceptive methods and availability of family planning facilities, counselling for choice of method, distribution and resupply of contraceptives, allaying fears, countering rumors and referring difficult cases to the nearest SDP.

Their information needs include explanations of family planning methods and their side effects, knowledge of human physiology, benefits of family planning, motivation techniques and communication approaches and use of simple communication aids.

The materials which the distributors require are booklets and pamphlets on family planning methods; flip-charts and promotional materials such as khanga and T-shirts bearing family planning messages.

In summary, the specific recommendations regarding the IEC component of the national CBD program are as follows:

- Leaders at various levels should have information and educational materials to explain the CBD program objectives and tasks, as well as the purpose of the program and the relevant government policies to their target audiences.

- The development, selection and pretesting of IEC materials should be done at the national level by the IEC and Research Divisions of the NCPD secretariat.

- The district and divisional CBD personnel will be responsible for orientation, training, monitoring and evaluation of IEC activities.

- As far as possible, the IEC equipment and a supply of posters, flip-charts and other communication materials should be available at the division with ECN Coordinators for distribution to supervisors and distributors.

- The distributors, supervisors and VCs will be involved in promotional and motivational activities which will include client motivation, recruitment of acceptors, persuasion of hesitant and late adopters of family planning and retention of drop outs and those likely to drop out.

- The adaptation and development of IEC materials should be done by local people in the local language if possible. SDP staff, supervisors and divisional leaders should be involved in the development of the materials. The printing of posters, booklets and pamphlets on family planning methods may be done either at the district or national level.

- Distributors will require materials which can be used in face to face interactions or in a small group of about five people. These materials, therefore, should be fairly simple and easily interpreted even by non-literates. Local language material should be available for those who are literate.

- Films in Kiswahili should be produced nationally. One of the films should be on general family planning methods with a special focus on CBD. Another film should focus on the benefits of practicing family planning at the individual, family and national levels. Funding for the latter film could perhaps be obtained from other sources and has not been included in the budget. Films and video materials should be distributed to districts from which divisions can borrow.

Annexes 7-8 and 7-9 provide further information regarding IEC equipment requirements and sources of existing materials.

7.6. Management Information System for CBD

Most health information systems suffer from the collection and submission of too much information; information oriented neither to decision-making nor to program action. The information is often late, inaccurate, and poorly presented. Inundated with such data, there is little wonder why those who receive the information at headquarters of a program use it poorly.

At the other end of the information stream are those who collect health information, primarily those associated with service delivery at the periphery. They also lack appropriate information related to improving their performance, but in contrast to managers burdened with a surfeit of inappropriate information, the peripheral personnel are often starved for information about how well their unit or the overall program is faring and how they can improve their activities. Without adequate feedback, their zeal flags, and they pay little attention to the accuracy or timely reporting of their activities.

A review of the CBD pilot projects in Kenya revealed that although these projects were operated and funded by different organizations and donors, they tended to have similar reporting procedures and record keeping systems. The information systems of these projects were not without problems, however, and they present some interesting lessons (See Annex 7-10). With these lessons in mind, the following uniform management information system (MIS) is proposed for the national CBD program in Kenya. It should be noted that although this is proposed and should be implemented as a uniform system, some NGO projects may wish and should be allowed to undertake the collection of additional information, as may be required by their donors or for research purposes.

The information required for the program and methods for its collection which are proposed in this Section presume that at the village level the system will be:

- collecting not only important inforrmation that will be used at the distributor level but at the same time provide crucial information for the whole program.
- simple so that the worker with minimal literacy can understand and use it.
- fast to use--not burdensome or time consuming.
- effective in providing accurate, timely information useful for action and decision making.

7.6.1. Definitions of MIS Terms

An active user is defined as a person who at any given point has sufficient means to practice his or her selected method of contraception. For pill users, an active user is one who has a sufficient quantity of pills, where sufficient is defined as one cycle of pills per month. For example, a women who receives three cycles of pills on any day in November is considered active in November, December and January. For condoms and foaming tablets the program must establish a standard usage per month, subject to more precise information from the user. If the standard is set as 12 per month, a condom user who receives 36 condoms in November would be considered active in that month and the months of December and January. Since condom and foam tablet users may actually use fewer or more than 12 per month, a user can override the standard estimate by indicating a more realistic personal estimate to the distributor.

A new user is a client who receives a method of contraception for the first time or after a break in use. Some clients may have used contraception previously, from the same distributor or even from another distributor in the same program, but for both practical and statistical purposes this client is defined as a new user. The distributor should provide extra counselling for all new users because she cannot presume that orientation by the previous source was adequate. A new user becomes an active user on receipt of contraceptive supplies.

A drop out is a client who no longer has sufficient supplies to practice contraception or stops using a method of contraception supplied by the distributor for any reason except referral for a clinical method. Reasons for drop out may include rumors, side effects or no longer in need due to menopause, divorce, widowhood or other causes.

A pill user automatically becomes a drop out if she has not obtained new supplies prior to the month when the cycles of pills she received are expected to be exhausted. Thus, a client who receives three cycles of pills in January is considered an active user through the last day of March. For reporting on the last day of April she is considered a drop out if she has not received new supplies.

For estimates of condom and foaming tablet usage, if records indicate that a client no longer has sufficient supplies to practice family planning, then the client automatically becomes a drop out, unless the distributor follows up the client and finds that the client does in fact have sufficient supplies.

Effective referrals are those clients the distributor refers to a SDP for contraceptive service and who in fact receive a contraceptive method. The distributor also may refer clients for side effects, check up or other reasons, but such referrals are not counted as effective referrals.

Clients referred for clinical methods should be credited as effective referrals for the CBD program and as active users for the establishment where the service is provided. IUD acceptors are considered active for a standard number of months from time of insertion, e.g., two years, unless the user informs the service point to the contrary or unless the user attains the age of 49. Injectable users are considered active for the duration of the injection. Female sterilization users are considered active until the age of 49, and male sterilization users until their wives attain the age of 49.

The sum of active clients served by the distributor and effective referrals made by the distributor is an important indicator of the distributor's contribution to the program. The effective referrals should be counted as active clients by the SDP where they receive service, but they also represent a major contribution of the CBD program as well as a continuing responsibility for the distributor.

7.6.2. Methods and Purpose of Data Collection

7.6.2.1. Baseline Information

Following VC and distributor training, the distributor, with the help of the VC and supervisor, should make a simple map of the households in the community. The map need not be drawn to scale, but should show all the houses which are the distributor's responsibility.

This should help to avoid duplication of effort with other distributors and will also facilitate initial community contacts. The distributor and the VC should know which households are their responsibility and where they are located. The information on location and number of households also helps the supervisor to evaluate the performance of the distributor and to assist the distributor in covering all the households to which she is assigned.

7.6.2.2. Programmatic Information

Major categories of information to be collected during field program implementation include:

- Quantity and type of contraceptive distributed each time the distributor delivers contraceptive supplies. She must record the date, method, and amount distributed in a manner that associates these data with the name of a particular client. If the amount delivered is generous, recording the month rather that the exact day of delivery is sufficient.

  Knowing the total amount of contraceptives distributed by method is important for anticipating needs for future supplies. However, to ensure continuing and effective usage among her clients, the distributor also must be able to identify those clients who have not received adequate supplies during the current month. For the purposes of follow-up, it is essential to know the date, method, and amount distributed for each individual client. Follow-up means that the distributor takes the initiative in contacting the client to motivate, resupply, or refer the client as the case requires. The number of different contraceptives or contraceptive mix is the sum of the different types of contraceptives used by active users or referred clients. For example, if the distributor serves pill and condom users and has referred clients who received IUDs, the number of different methods or method mix would be equal to three. A summary of each distributor's contraceptive mix helps indicate whether or not she is informing the community about all possible methods they may select.

- Records on new and active users. The distributor should question the client at the time of acceptance regarding her previous contraceptive usage. Recording this information accurately will alert the distributor to counsel the client accordingly. New users are likely to require more orientation and instruction in the use of their chosen methods. By identifying those clients who have never previously used a particular method, the distributor can help educate these clients more adequately.

- Number of program dropouts and the reasons for discontinuation. If the distributor learns the reason for dropout, she may be able to help the client resume use or select another method. When these reasons are tabulated at the district and national level, the findings may be helpful in establishing new program strategies.

- Number of referrals and effective referrals. The distributor should record the names of any clients referred to a SDP for service, plus the date and contraceptive method for which the client was referred. The distributor also needs to know from the SDP which clients actually received service. By recording this information, the distributor should be able to follow up the client after a reasonable period of

time to be certain that the client has gone to the referral clinic and has obtained service there, and if not, why not.

- Client characteristics. Knowing the age and number of living children is useful in helping the client select an appropriate contraceptive method. This information is also useful for the supervisor to know whether or not the distributor is reaching the appropriate clients with suitable methods. Information on breastfeeding status serves as a warning to the distributor to screen the client in order to make sure the right contraceptive method is being provided. Knowing whether or not clients have used contraception previously serves as an indicator of whether the program is reaching new users or those switching from other methods or programs.

7.6.3 Forms to be used in MIS

The forms recommended for the MIS of the national CBD program are as follows:

- o Client form (with continuation supplements)
- o Client summary form
- o Contraceptive supply form
- o Check list form (for oral contraceptive acceptors)
- o Referral form

Examples of the first three forms are included as Annexes 7-11, 7-12 and 7-13 of this plan. Forms have been designed to allow for computer coding if the MIS is to be computerized.

In addition to the above forms, it is also recommended that a diary be kept by each distributor to be used as a planning tool. Information to be recorded in the diary might include:

- o monthly date for submitting reports,
- o dates for important meetings and activities,
- o important appointments, e.g. with supervisor, collection of contraceptives supplies, and
- o dates for client follow up.

All program forms will be kept in a small ring (1/4 inch) looseleaf binder. This will protect the forms when being carried to the field and will allow for ease of addition or removal of forms when required.

7.6.3.1. Client Form

The CBD client form is designed to allow the distributor to know whether or not an individual client has sufficient contraceptives at any given time. For this purpose, it is essential to record the client's name, type of method, quantity provided and date.

Several other CBD project information systems were examined to determine the best client forms to suggest for the national program. Recording successive visits to clients, one line per visit, is not satisfactory since it is difficult to determine multiple and follow-up visits to a single client and to determine the status of that client. A more practical alternative, often used in clinics, is to establish a card for each client, but a card system is bulky and cumbersome to handle in a field program, especially when only minimal information is required.

In light of the above, it is recommended that the national CBD program adopt a client form in which a single row is assigned to an individual client. (See Annex 7-11). On that card one may record each client's number, name and address/location, age, number of living children, education, marital status, family planning status, and breast feeding status. To the right are a set of columns, one for each month. Under each month, the distributor records the

method selected, using a code for each method, and also notes the quantity of contraceptives supplied per month. The distributor marks additional columns for those months for which she has given the client sufficient contraceptives. For example, if the distributor gives a client three cycles of Microgynon pills in January, she marks the symbol "M" for this particular pill in the January column, "M" in February and "M" in March.

Active users are easily identified on the client form as those with adequate contraceptives in a given month. The number of new users can be calculated simply by summing the number of new rows filled since the last reporting period plus the number of any drop outs who have re-entered the program.

Rows for 25 clients and sufficient columns for one year will fit comfortably on each side of a single form, thus allowing space for 50 clients per page. Supplementary half-forms containing only the 12 month columns will be used for continuing clients after the first year. These supplements will be stapled or pinned over the month columns on the original form to avoid the need to recopy the name and client characteristics of continuing users. A new client form will be provided for new clients when the 50 spaces on the original form are exhausted. These forms should be printed on manila stock to ensure durability.

7.6.3.2. Summary Client Form

At the end of each month, the distributor, with the help of the supervisor if necessary, should sum the results of her work, and record the information on the client summary form (See Annex 7-12). Like the client form, columns correspond to months, and the results for a single month fill one column.

The recommended items for inclusion in the summary form are new clients, active clients, effective referrals, drop outs, and active users plus effective referrals. The form also provides space for the supervisor to initial each month when she checks the form.

The row that sums active clients and effective referrals, is in itself a good summary of distributor effectiveness. The supervisor will maintain copies of these forms for each distributor in the location and the original summary form is kept by the distributor.

7.6.3.3. Contraceptive Supply Form

Annex 7-13 is the suggested contraceptive supply form to be maintained by village distributors. For each type of contraceptive the items recorded are initial balance, amount received during the month, amount distributed during the month, and final balance. The number of contraceptives distributed are derived from the client form. Like the summary form, there is simply one column per month with the rows corresponding to the types of contraceptives distributed. This form will be utilized during monthly supervisory visits to determine additonal supplies needed by the distributor. Further users of the supply information will be described in more detail in the Logistics section (Section 7.7).

7.6.3.4. Referral Form

It is recommended that referral forms be designed for the use of clients referred to SDPs from the CBD program. If possible, a system should be arranged whereby this referral form would give these clients some sort of priority status at the SDPs. The SDPs should maintain these forms so that they can be checked to verify effective referrals. The verification of effective referrals should be the work of the supervisor.

7.6.3.5. Check List Form

It is recommended that CBD distributors utilize the MOH checklist before prescribing oral contraceptives. The use of this list and other medical norms applicable to the CBD program are outlined in Annex 7-14.

7.6.4. Information Flow, Methods of Tabulation and Feedback Mechanisms

Information generated at the distributor level will be passed to the supervisor by way of the supervisor keeping a copy of the summary client form. The supervisor will put his/her signature on the summary client form thus meaning that the information has been discussed with the distributor and the supervisor has given on the spot feedback. The client form thus serves as part of the feedback system.

The supervisor and ECN coordinator will prepare an aggregated report based on the data collected by the distributor in each location. These reports will include information on percentage of couples covered, number of new acceptors, continuing users, and drop outs. This information will be used to provide feedback for the distributors during the scheduled monthly group supervision meetings.

At the divisional level, the ECN Coordinator should retain the original of the aggregated data and pass a copy to the DPDO. The DPDO should prepare district summaries, give feedback to the ECN Coordinators, and pass a copy to NCPD headquarters. For all reports, deadlines should be set to insure timely submission of information to the next level in the supervisory ladder. Since monthly data are collected from the distributor in aggregate or summary form, there is no need for a computer to sum the data at the locational or divisional levels. Summation of these data can be done by pencil and paper or by calculator. The supervisor will tabulate information at the location level and the ECN Coordinator at the divisional level. If a microcomputer is available at the district and/or central level, the computer can be used to tabulate the data in a spreadsheet mode and to rank the results by district, division, location and distributor using indicators such as percentage of households served and growth in number of acceptors. The only advantages of using a microcomputer would be speed and thus more rapid feedback, as well as accuracy in printing the results.

Although the information should be used at the community level without a formal report, printing of reports at the central level is essential for summary of nationwide information and for feedback to all program personnel and VC members, as well as policy makers. For this large audience, the annual publication of an attractive brochure which summarizes program accomplishments is recommended. The brochure, printed in color, should contain photographs, textual accounts of how communities have been successful and one or two graphs to show how the national program is progressing. Production of the brochure should be the responsibility of the NCPD.

For a smaller audience of central and district level managers, ECN Coordinators, and policy makers, more complete quarterly statistical reports are recommended. This should be done by NCPD headquarters. NCPD should also prepare Annual Reports of the program for senior staff, policy makers and donors.

7.6.5. Pretesting and Evaluating the MIS

During the seven month preproject period, the information system should be thoroughly pretested. Pretesting should include training, data collection, tabluation, and presentation of reports, and observation, review, and revision of all these facets of the systems. It is essential that distributors with minimal education successfully complete the training and prove their ability to use the system. If, for example, the distributors are not able to manage the client form, then that form must be redesigned and retested.

During the implementation of the CBD program the MIS should be evaluated periodically. This may be done through spot checks to ascertain whether or not active users and effective referral reports are valid. These checks should involve very small household surveys by independent investigators, who compare distributors' records, clinic records and responses of purported users. It is also recommended that the NCPD or an independent consultant evaluates the MIS after it has been in operation for at least 6 months in order to obtain further insight into the system. This might be accomplished through independent interviews with CBD personnel and policy makers who receive reports and feedback from the information system. These interviews should ascertain whether or not the respondents received, read, understood and used the reports for decision making and for actions to improve the programme. The investigators should ask for specific examples.

7.6.6. Training Required to Implement the Information System

Training of distributors for the use of the forms should include an explanation of the reasons for collecting the information so that the distributor is motivated to use the forms. This explanation should show the distributor why she herself needs this information for her work. This training should be participatory and lead the distributors through a discussion on the importance and uses of the information. For example, the training leader can discuss the need to identify those clients who have not returned for supplies and then lead the participants in a discussion of the necessity of collection of information to identify such clients. This discussion should take place before the distributors have a chance to see the forms.

Once the forms are introduced, the distributors should do role playing as both distributors and clients to practice using the forms. This initial training and practice should require the equivalent of one day. After at least a month of field work, there should be feedback and discussion during the monthly meeting with the supervisor to clarify doubts and answer any questions.

Supervisors and ECN Coordinators must be trained not only to collect summary information from distributors and supervisors but also be help distributors record information. They should be taught to use summarized information to provide feedback to distributors on how well they are performing relative to their peers. For example, supervisors should be able to calculate the percentage of eligible couples covered in a community and compare that percentage with the average in the location. They should also be able to help the distributors review their community maps to sum the number of households and clients served. It is recommended that the training of supervisors and ECN

Coordinators include a session on the role of information and its utilization. A full day would be appropriate.

7.6.7. Summary of Advantages of the Proposed MIS

The proposed MIS will allow the distributor to effectively:

- o Follow progress of individual clients.
- o Record reasons for drop out and follow up those clients with the objective of bringing them back to the program.
- o Record both referrals and effective referrals.
- o Determine which clients are to be followed up and to organize effective and regular contact.
- o Monitor effective referrals and make sure that they continue to use their selected contraceptive methods.
- o Monitor the flow of contraceptive supplies.
- o Use monthly totals to determine trends and progress within her area of coverage.

Likewise, the proposed MIS will allow the supervisor to:

- o Calculate the percentage of eligible couples contacted and served by each distributor in the location.
- o Calculate a series of monthly averages of new acceptors, continuing users and effective referrals by distributor and location.
- o Calculate the proportion of drop outs by distributor and location.
- o Determine the contraceptive mix and calculate commodity needs in the location.

Using the above information the supervisor can therefore provide monthly feedback to the distributors in his/her area of coverage. Also, by examining all the forms regularly, the supervisor can determine whether the distributor is making regular follow up visits, getting information on referrals and making sure that all the forms are completed correctly.

The MIS described will generate the following program information each month.

- o Number and percentage of eligible households covered,
- o Number and percentage of new users,
- o Number and percentage of continuing users,
- o Number and percentage of drop outs and reasons for drop out,
- o Number of monthly referrals,
- o Number of drop outs returning into the program,

- o Quantity and type of contraceptives distributed,
- o Mix of contraceptives distributed in the community, and
- o Methods used by effective referrals.

7.7. Logistics

A review undertaken as part of this planning process indicated there do not appear to be major problems in the present flow of contraceptive commodities to FP programs in Kenya. This comes about in part because there is a remarkable degree of cooperation between the public and private sectors and in part because the GOK has obviously invested significant resources in the development of an efficient and effective supply system for primary health care activities, of which FP is but one component. Nevertheless, minor bottlenecks can become major logistics problems when rapid expansion of any program occurs or with the introduction of a new program activity such as a large-scale CBD effort.

The observations and recommendations presented in this section are oriented towards identifying potential logistics problem areas and suggesting remedial actions. Given the inherent time delay in training service personnel and developing the other organizational support systems needed to implement CBD program activities, the plan presented here, if acted upon early, should minimize stock-outs and disruption of program services.

7.7.1. Review of Existing Contraceptive Supply Systems

In order to make recommendations for a logistics plan for a national CBD program, it is important to understand the systems that currently exist.

The Central Medical Stores (CMS) of the MOH is the principal importing agent and storage facility of contraceptives for FP programs in Kenya. The CMS receives contraceptives from a variety of donors, e.g., FPIA, USAID, and SIDA, and stores them for distribution to both MOH and NGO programs.

For GOK family planning programs, the CMS receives its contraceptives from SIDA in kit form. Several years ago, the MOH began using kits for essential medications and contraceptives in order to reduce the frequency of stock-outs due to huge requisitions of open stock by hospitals. The kit system appears to have improved the supply of essential medication and in the case of contraceptives, no stock-outs have occurred in the past several years. For the GOK FP program, the CMS distributes contraceptive kits to district hospitals, and district hospitals provide them to all SDPs within the district.

Contraceptives for other programs, e.g., FPAK, are received as bulk shipments. Since these come from a different donor, they are packaged differently than the MOH contraceptives. They are stored in a different section of the warehouse to prevent confusion.

The GOK logistics system uses three basic inventory management records at all levels.

- o Form S3, Stores Ledger and Stock Control Card, which provides a continuous record of receipts, issues, and stocks on hand. It also provides space for maintaining monthly consumption records that facilitates calculation of average monthly usage. Space is also provided for forecasting annual requirements for an item based on the average usage and buffer stocks needed.

- Form S11, Counter Requisition and Issue Voucher, which is used by all SDPs to request supplies from the District Hospitals. It is a very simple form that serves its purpose well.

- Form S12 (revised), Issue and Receipt Voucher, which is used by district warehouses to request stock from the CMS. Likewise, it is well designed and functions appropriately.

This well designed system can form the basic logistics record system for the CBD logistics plan, as the Permanent Secretary for Health indicated to the planning team that both the CMS and district warehouses can be the major supply facilities for the national CBD program.

7.7.2. Projecting Contraceptive Requirements

The general plan for the national CBD program presents estimates of the number of active users anticipated in the program by 1992 and by the year 2000 (see Section 4). Using these estimates as a base, contraceptive needs have been calculated for each of the first eight years of the program. The results are presented in Annex 7-15. Cost calculations based on these projections are presented in Annex 7-16.

The following assumptions have been made in calculating contraceptives requirements:

- Estimates are given only for those contraceptives to be distributed by the CBD program. No provision is made for referrals for IUDs, injectables, or sterilization.

- Each oral contraceptive (OC) user will require 13 cycles of pills per year.

- Users of condoms and foaming tablets will need 125 condoms and/or foam tablets per year. (Some clients may choose to use these two methods in combination for better protection). It should be noted that this figure of 125 has been selected based on international experience. The Kenyan experience should be monitored closely and changes made in projections of condoms and foam tablets if use rates are much higher.

- Of CBD users, 70 percent will select OCs, 10 percent condoms only, 10 percent foam tablets only and 10 percent will use condoms and foam tablets in combination. This contraceptive mix was selected based on limited pilot project experience. Actual mix in the national program should be monitored closely and the commodity projections adjusted accordingly.

In actual practice, as the program grows and progresses through the phased introduction, commodity projections can be made more accurately based on actual demand. In order to ensure that this occurs, it is recommended that Form S3, Stores Ledger and Stock Control Card, be used as the basic inventory management record for contraceptives by CBD program staff at the national, district, divisional and locational levels. (Supply forms to be used by distributors are described in Section 7.6.). All personnel who use the S3 forms will need to be trained or retrained to effectively utilize the sections of this form for monitoring monthly usage and forecasting needs. If implemented in the very beginning, the national CBD program will have accurate and concise information on actual usage at each level of the program every year. Districts can then be grouped into categories according to population density and program data on

contraceptive use per distributor for each category. Thus, projections can be made within each group on the amount of additional contraceptives that will be needed based on plans for selection and training of more distributors, i.e., annual forecasted need will be the actual demand of the previous year plus the amount needed for the new distributors who will be trained in the present year. This assumes a steady state of use, which is never the case. Established distributors will continue to increase the number of active users they serve each year for at least the first four or five years before their number of acceptors reaches a plateau. However, actual monthly consumption data will allow the program to more precisely plan needs for contraceptives. The use of micro-computers at central and district levels will allow simple modeling and construction of a demand curve that will reflect this yearly increase in number of active users by distributor.

7.7.3. Procurement of Commodities

All OCs used by the GOK at present are procured through SIDA, and this program appears to functioning effectively. Microgynon and Eugynon are provided in distinctively colored foil packets of 21 day cycles. It is recommended that the national CBD program use this same packaging, but it is strongly suggested that 28 day cycles be adopted. Reports from the CBD pilot projects indicate it is easier to train distributors to dispense a 28 day supply and also easier to educate clients in their use. In a national program that will utilize close to 15,000 community distributors, this simplified training will also mean significant savings in training costs. In addition, the 28 day cycles should contain iron supplement for the seven "spacer" pills so that women can be automatically involved in an anemia prevention program. Expiration dates should be printed on all OC packets and boxes. Informal discussions with a representative of SIDA in Kenya indicated a willingness to support the above recommendations and an intent to continue support to Kenya for the provision of OCs.

It is understood that USAID would be willing to supply condoms and foaming tablets to the CBD program. This agency has supplied these commodities in the past, and no problems are anticipated in continuing that arrangement. Dates of manufacture should be printed on all boxes of these commodities as well. It might be useful to institute a program of periodic quality control and testing of condoms from distribution points throughout the system. Simple machinery to do this testing is available through PIACT in Seattle, Washington. USAID could facilitate the purchase.

7.7.4. Storage and Distribution of Supplies

Section 7.7.1. described the existing MOH system for storage and distribution of medical supplies from the central to the district level. It is recommended that this system be used for the national CBD program with one exception -- the CBD program should be supplied through open stock, not through kits. Since different program locations will undoubtedly have a different number of users and a different contraceptive mix, the problem of shifting stocks of unused items between program levels will become a significant problem if kits are used.

It is further recommended that NGO CBD projects registered with the MOH be allowed to requisition stocks directly from the district stores.

The commodity storage and distribution flow (presented graphically in Annex 7-17) will proceed as follows:

- CBD supplies will be cleared and stored centrally by CMS
- They will be requisitioned by districts and stored in district warehouses which may require physical improvements and staff training.
- DPDOs will deliver supplies to ECN Coordinators during regular monthly supervisory meetings in the division and during other extraordinary visits.
- Small storage facilities will need to be maintained at the divisional level under the supervision of the ECN Coordinator. These can be clean, dry closets with shelves.
- Supervisors will collect commodities from the division during the monthly meetings with the ECN Coordinator and at other times when they visit divisional headquarters.
- Supervisors, in turn, will deliver commodities to distributors during supervisory visits to each distributor each month.
- At the community level, each distributor will need to provide a clean, dry space for contraceptive storage. The program should provide strong wooden boxes to facilitate this, if possible with the program logo and some simple instructional messages printed on them. These storage boxes could be designed as a display case to facilitate promotion of contraceptives at barazas or other community meetings.
- For actual distribution of contraceptives during home visits, each distributor will require a shoulder bag, similar to an airline bag. These should also be printed with the program logo and FP slogans and will serve to identify the distributor in the community.

Further details about warehouse maintenance and improvements and the principles of inventory are included in Annex 7-18 and 7-19 of this plan.

7.7.5. Training Needs for CBD Logistics

The specific training needs required for management of the CBD logistics system are outlined below.

District warehouse staff, including managers, clerks and administrative supervisors, will need training in the special skills required for their jobs. This should take place in a two-day course sited in a district where the warehouse or storage areas will be reorganized for the CBD program as part of the course.

Supervisors' training should include approximately two to four hours on contraceptive logistics including: principles of commodity storage, inventory management, distribution procedures, the logistics information system, and evaluation of the logistics system. Distributors should receive at least two to four hours of training devoted to critical aspects of the logistics plan including: special handling needs of contraceptives, appropriate storage conditions, and maintaining and using the logistics information system.

7.7.6. Supervision and Evaluation of the Logistics System

The DPDO should be given responsibility for supervising FP logistics, including CBD, at the district stores. Supervision of the linkages between

district stores and the NGO projects and ECN Coordinators will also be the responsibility of the DPDO. This will include maintenance of accurate logistic records at all levels of the program. DPDO training should include one day of training in logistics.

Two key indicators of the logistics system's success should be monitored throughout the program:

- o Percent of commodity requests filled

  Based on Form S11, Counter Requisition and Issue Vouchers available at district and divisional stores, the percentage of requests filled each quarter can be monitored by the DPDO and ECN Coordinators. Theoretically, this figure should be 100 percent, if the system functions as designed.

- o Number of stock-outs

  This is the number of times the stock for a particular contraceptive at any level in the program was zero and requests could not be filled. Theoretically, this should not occur.

If a particular district or division is found to have frequent stock-outs or a lower percentage of orders filled than others, this should trigger a more intensive supervision visit to identify the reasons why.

8. FEASIBILITY OF THE NATIONAL CBD PROGRAM - POTENTIAL PROBLEM AREAS

This plan for a national CBD program proposes moving from limited NGO experience in about one dozen pilot projects scattered throughout Kenya to a major nationwide effort in a very short period of time. The proposed program will be coordinated by the NCPD. It will be planned and coordinated at the district level to be in keeping with the District Focus Strategy, and the program will be implemented at the village or community level.

In developing this plan, the following potential problem areas were identified:

- Need for village level organization and commitment.
- Creation of a commitment to the program by the DDC.
- A significant training component requiring careful planning and coordination with existing related programs.
- Need for strong and effective management and coordination throughout the program from the NCPD to the local community.
- Staffing issues at all levels of the program.
- Transportation for effective supervision and distribution of commodities.
- Long term, continued distributor motivation.

These issues were examined in detail and have been addressed by the planning team in the subsequent sections.

8.1. Village Level Organization

Organizing villages is going to be important for initial motivation of communities about family planning, selection of distributors, and management of CBD at the community level.

Heretofore, many programs have sought to create specialized committees at the village level, e.g. health and agriculture. Given the small size of Kenyan communities, the formation of specialized committees is impractical. This plan proposes a general village development committee, with specialized subcommittees if desired, as a more meaningful approach to village organization.

For programs to work at the community level, the villages should actively participate in the selection of these committees. This would eliminate domination by assistant chiefs, village elders, and local elites.

In terms of the national CBD program, the proposed village committee brings the project as close as possible to the people. To do this, the CBD plan has budgeted time and finances for organizing villages and instilling a sense of commitment to the CBD program.

8.2. DDC Commitment to the Program

Right from the beginning, it should be recognized that the success of the CBD program depends on the DDC, and the DDC should be made to feel, therefore, that it has a stake in the program. The NCPD's coordinating and liaison role will be decentralized by having a DPDO based at the district.

All plans for CBD activities, for both NGO and GOK efforts, must be examined and approved by the DDC so that they fit with other district development plans. A DDC subcommittee on population should be established and activated. The DPDO will be a crucial element at this level to ensure that the subcommittee is established and functional.

It is also proposed that the DDC be given the power to select and engage CBD supervisors through a contract arrangement. This should further ensure DDC involvement with and commitment to the program.

8.3. CBD Training

To a large extent, successful implementation of the national CBD program will depend on the pace of training the various individuals and groups at several levels for their roles in the program. Training needs have been carefully considered and planned for phased implementation, with provision made for periodic evaluation to ensure efficient handling of this crucial program activity.

The plan strongly recommends that top priority be given to development of a national training team for CBD with adequate resources and a strong mandate to go ahead with training. The staff identified to undertake training tasks at all levels must be released to devote full time to training. Given the current experience and skills in Kenya, there is no reason why the envisaged training should not succeed.

8.4 Management and Coordination Requirements

The plan proposes that the NCPD establish a Standing Committee for CBD under the Program Division of the Secretariat and designate an officer to coordinate CBD work. Strong liaison will have to be maintained with the district, division and grassroots level staff in order to ensure that program implementation is carried out. Uniform logistics and information systems will be created and should be closely monitored along with training activities to ensure that program management and coordination are progressing as planned. All elements of the program will require process evaluation carried out at regular intervals. This should be organized and coordinated by the NCPD.

8.5 Staffing Issues

The terms of reference for developing the national CBD program clearly stated that no new civil service positions were to be created. Accordingly, the plan proposes to use existing staff to the extent possible. These include NCPD field officers (DPDO), ECNs of the MOH at the divisional level, and CHWs, at the village level, where they exist. In addition, FHFEs and LSDAs will be coopted from the MOH and MCSS, respectively, to assist in village organization and training.

The posting of DPDOs to cover districts is in the line with current NCPD thinking; however, adequate posts have not yet been allocated to cover all 41 districts. The phasing of the CBD program will allow the use of available staff and the establishment of additional posts as the program progresses.

The MOH has indicated a willingness to make 210 ECNs available for the CBD program. The plan calls for careful selection of these ECNs to be coordinators for CBD at the divisional level.

The only new staff proposed are 800 locational supervisors. Because the success of CBD will depend on community participation and close supervision of community workers, the locational supervisor is a vital element in the program. These staff will be employed on three year renewable contracts. The concept of contracts is not foreign even within the public service.

Establishing a supervisor at the location level will ensure that the supervisory machinery is linked at all levels, thus enhancing successful implementation of the logistics, information, training, and IEC activities. To strengthen the CBD program and avoid or minimize undercutting, the existing field staff of other development programs, e.g. FHFEs of the MOH, LSDAs of the MCSS, and PVO field staff, will be given orientation in CBD. They will also be coopted to assist with VC training. The concept of utilizing these workers as supervisors was considered but was found to be impractical as they have a different orientation and competing responsibilities. A completely new cadre was thought to be a preferable arrangement.

8.6. Transportation for Supervision and Logistics

Transport is an issue in the successful implementation of a CBD program. After careful consideration of alternatives, this plan proposes that DPDOs will be supplied with a vehicle and the supervisors with a motorbike. The supervisor's contract will stipulate that he/she will purchase (over time, with monthly payments) and maintain a motorbike provided by the CBD program. It is believed that this arrangement will ensure better maintenance and a longer lifespan for the motorbikes. The issue of what happens to the motorbike if a supervisor's contract is terminated has been considered and dealt with in the plan.

Experience in other countries suggest that motorbikes may not serve all needs. Motorbikes are good where the population lives near good roads, they will be less appropriate in dispersed rural areas with poor roads. Accidents can be frequent, motorbikes have problems in maintenance and in rainy weather it is difficult to use them. Female supervisors are often uncomfortable riding motorbikes under difficult conditions, and if the supervisor has large quantities of commodities to carry motorbikes may not be appropriate. Consideration was given to purchasing four-wheel vehicles but they will be too expensive to buy for a national program. Funds were therefore allocated for motorbikes.

The planning team also considered the idea of providing the ECN Coordinator with a vehicle to enhance her ability to provide medical back up and move commodities. The idea was rejected due to the expense and other priorities within the MOH. Requiring an ECN to purchase a vehicle was not a viable idea given her income and the loan repayment period. For the most part, ECN Coordinators' duties are based at the divisional headquarters; however, funds have been proposed to allow her to travel if and when required as an alternative to providing costly vehicles and drivers for this cadre.

8.7. Long Term Distributor Motivation

The problem of long term distributor motivation was considered at length. Several suggestions were put forward, including the sale of contraceptives at a fixed national figure with the possibility of some flexibility in payment. Under this arrangement, the distributor might be allowed to keep the money generated or the village committee might collect and then pay the distributor a "salary", thus avoiding problems of record keeping. Other incentives might include occasional cash or in-kind rewards derived from activities the communities develop, e.g. income generating projects. However, this will depend very much on the CBD program ensuring that the communities participate fully in the plan. (See Annex 7-5 for a more detailed discussion of this issue).

9. FINANCIAL MANAGEMENT OF THE NATIONAL CBD PROGRAM

The smooth transfer or flow of funds from donors and the GOK Treasury through the NCPD, cooperating ministries, and other relevant bodies to the various individuals and units charged with program implementation is crucial to the success of the national CBD program. The NCPD has indicated it would be the recipient of most donor funds and the coordinating body for the entire CBD plan. This will break with the previous funding experience for CBD projects in Kenya in which most implementing agencies received funds directly from donors. In fact, in most cases international NGOs were acting as or on behalf of the actual donors since they received funds centrally rather than through the bilateral route. It is anticipated that future funding committed to a national CBD effort will be allocated from bilateral or multilateral funds. There will be two main implementing entities in the national program--NGOs and the DDCs. The NGOs involved with the pilot CBD projects generally report their activities to the NCPD and sometimes but not always, coordinate their projects with the DDC in the areas in which they work.

9.1. Role of the NGOs

During the early phases of the national CBD program, the NCPD may need to allocate CBD program funds to some of the international NGOs. This is proposed because the plan calls for expansion of the existing CBD projects; however, many of the NGO activities are in the final months of their current external funding commitments. Although it is recognized the NCPD could decide to fund directly the local NGOs who are implementing ongoing CBD projects, there are two potential drawbacks to such an arrangement. First, this would increase significantly the coordination and direct supervision load of the NCPD. Secondly, such a shift in funding sources may cause a break in project momentum while new funding, management and supervision mechanisms are established. Furthermore, these international NGOs, in partnership with the local CBD implementing agencies, may have other resources or technical skills such as training, materials development, or information systems which could be utilized to benefit the national program.

Therefore, it is recommended that if required, the international NGOs who have been funding and monitoring the existing CBD projects receive some of the external resources allocated for this national program. Regardless of whether these NGOs receive funding through the NCPD or directly from external sources, they should submit their proposals and workplans to the appropriate DDCs and to the NCPD for approval. Agreement on expansion of their activities or on other roles they might play in the national program should be a matter for NCPD to decide. Once projects are approved, the international NGOs should account for any project funds received from the NCPD, as well as reporting on all project activities to the NCPD. This is an essential step in coordinating CBD, for in the past international NGOs often have reported only to their donors, and NCPD has had a very limited coordinating role in CBD activities.

9.2. Role of District Development Committees

As the bulk of future expansion of CBD efforts into a national program will occur within the framework of the District Focus Strategy, the DDC will be responsible for the initiation of all new CBD activities in each district. Funds for district CBD activities will be agreed upon by the NCPD and the DDC. At the district, the authority to incur expenses (AIE) for CBD activities should be held by the NCPD representative, the DPDO. Should the DPDO not yet be posted when a particular district is ready to begin CBD activities, NCPD should give the AIE to the DC (as in the case of the Rural Development Fund) until a DPDO has been assigned to the district.

In some districts, the DDC may have to provide CBD funds to several entities, e.g. local NGOs, MOH, private SDPs. All of these bodies must be carefully coordinated at the district level to follow standard GOK accounting procedures for the use of CBD program funds. The AIE holders (DPDO or DC) will be supervised for accounting activities by the NCPD.

10. BUDGET FOR THE NATIONAL CBD PROGRAM

The following seven-year budget for the national CBD program has been calculated based on 1985 figures. No allowance has been made for inflation, except in the contraceptive commodity category which is calculated on a five percent annual inflation basis. In addition, the commodity budget is for eight years to allow for filling the supply pipeline at the end of the seven-year project period.

The overall budget of K.Sh. 901,095,944 has been broken down into donor (K.Sh. 748,949,842) and GOK (K.Sh. 152,146,102) contributions. It should be noted, however, that the GOK contribution does not include calculations for NCPD administrative costs allocated to the program, nor does it account for salaries of staff coopted for training and motivational activities from other ministries.

In discussing the plan informally with several representatives of the donor community in Kenya, it was learned that the budget items assigned to the donor contribution category appear to be those likely to qualify for external support. In particular, the training activities, contraceptive commodities, vehicles and their operating costs, and support for contract staff (supervisors) appear to be of interest to various donors. It is recommended that after examining this plan, the NCPD call together the donors to solicit specific support for the various budget items. Key donors to participate in this exercise would include World Bank, USAID, SIDA, ODA, and JICA.

10.1. Seven-Year Budget Breakdown

CONTRACEPTIVE COMMODITIES

	Kenya Shillings
Year 1	3,784,853
Year 2	7,341,543
Year 3	10,884,159
Year 4	14,930,768
Year 5	22,791,698
Year 6	30,925,802
Year 7	40,706,820
Year 8*	54,334,649
COMMODITIES - GRAND TOTAL	185,700,292

* Eight years calculated to allow for filling the supply pipeline at the end of the funding period.

TRANSPORT

		K.Sh. - 7 Year Total
DPDO		
Landrover	260,000 x 41	10,660,000
Operating/Maintenance (30,000 km. @ K.Sh. 8)	240,000 x 41 x 7	68,880,000
Driver (K.Sh. 17,300 + 6,500 + 4,000)	27,800 x 41 x 7	7,978,600
SUPERVISOR		
Motorbike (off road)	20,000 x 800	16,000,000
Operating/Maintenance (10,000 km @ K.Sh. 1)	10,000 x 800 x 7	56,000,000
ENC COORDINATORS		
Operating costs (10 trips/year @ 200 km = 2,000 km @ K.Sh. 5)	10,000 x 210 x 7	14,700,000
TRANSPORT - GRAND TOTAL		174,218,600

SALARIES/ALLOWANCES

		K.Sh. - 7 Year Total
DPDO (Job Group K) (K.Sh. 60,000 + 20,000 + 4,000 + 16,000 + 20,000*)	120,000 x 41 x 7	34,440,000
DPDO Support Staff		
Secretary (Job Group G) (K.Sh. 32,000 + 12,000 + 4,000)	48,000 x 41 x 7	13,776,000
Messenger (K.Sh. 14,000 + 6,500 + 2,500)	23,000 x 41 x 7	6,601,000
ECN Coordinator (K.Sh. 24,000 + 11,640 + 4,000 + 5,000)	44,640 x 210 x 7	65,620,800
Supervisor (K.Sh. 1,500/month x 12)	18,000 x 800 x 7	100,800,000
SALARIES/ALLOWANCES GRAND TOTAL		221,237,800

* Field Allowance

EQUIPMENT AND SUPPLIES

	K.Sh/Units/Time	K.Sh.-7 Year Total
DPDO - Establishment		
Equipment/furnighsing	310,000 x 41	12,710,000
Office space	24,000 x 41 x 7	6,888,000
Utilities	16,000 x 41 x 7	4,592,000
Stationery	30,000 x 41 x 7	8,610,000
	Subtotal	32,800,000
Logistics		
Commodity storage boxes	495 x 15,000	7,425,000
Shoulder bags	413 x 15,000	6,195,000
Motorbike box/carrier	825 x 800	660,000
District commodity warehouse improvements	80,322 x 41	3,293,202
Division commodity storage	1,650 x 210	346,500
	Subtotal	17,919,702
Training		
Stationery	10,000	10,000
Films - 5 copies	10,000 x 5	50,000
Flip charts - districts & national	200 x 42	8,400
Contraceptive boxes - districts and national	600 x 42	25,200
Contraceptive kits	500 x 42	21,000
	Subtotal	114,600

EQUIPMENT AND SUPPLIES (continued)

	K.Sh/Units/Time	K.Sh. 7 Year Total
Information, Education and Communication		
Materials		
Leaflets, pamphlets	2 x 1,010,000	2,020,000
Booklets	5 x 10,000	50,000
Brochures	10 x 35,000	350,000
Functional Literacy Materials	50 x 5,000	250,000
Books	100 x 5,200	520,000
CBD Manuals	300 x 2,050	615,000
Flip charts	100 x 2,050	205,000
Cassettes (pre-recorded)	80 x 850	68,000
Posters - Purchase	10 x 150,000	1,500,000
Local Production	10,000 x 1	10,000
Films - Purchase (One/ district & 5 for national)	10,000 x 46	460,000
Local production	348,150 x 1	348,150
Calendars	50 x 54,000 x 7	18,900,000
Anatomical Models	400 x 250	100,000
Flannel graphs	100 x 800	80,000
Khangas	50 x 30,000	1,500,000
T-shirts	50 x 30,000	1,500,000
Stationery	4,000 x 800	3,200,000
	IEC Material Subtotal	31,676,150
Equipment		
Projector (film)	35,000 x 211	7,385,000
Projectors (slide/film strip)	10,000 x 211	2,110,000
Projector (overhead)	10,000 x 41	410,000
Cassette recorders/players (two/division & one/location)	8,000 x 1220	9,760,000
Video rental	165,000 x 1 x 7	1,155,000
	IEC Equipment Subtotal	20,820,000
	IEC Subtotal	52,496,150

EQUIPMENT AND SUPPLIES (continued)

	K.Sh/Units/Time	K.Sh. 7 Year Total
Management Information System		
Binders (1/4 inch, looseleaf)	20 x 20,000	400,000
Forms		
Client	0.60 x 30,000	18,000
Monthly summary	0.40 x 50,000	20,000
Continuation (half forms)	0.40 x 20,000	8,000
Referral	0.50 x 300,000	150,000
Checklist	0.25 x 600,000	150,000
Brochure (annual summary)	2 x 450,000 x 7	6,300,000
Annual Reports	5 x 1,000 x 7	35,000
Quarterly reports	2 x 1,000 x 28	56,000
Diaries	50 x 16,500 x 7	5,775,000
	Subtotal	12,912,000

EQUIPMENT AND SUPPLIES - GRAND TOTAL 116,242,452

ORIENTATION FOR NATIONAL, DISTRICT AND DIVISIONAL LEADERS

	K.Sh/Unit/Courses	K.Sh. Total
National Leaders		
Lunch	150 x 75	11,250
Trainer's honorarium	2,000 x 2	4,000
Stationery	5,000 x 1	5,000
	Total	20,250
District Leaders		
Lunch	50 x 15 x 41	30,750
Stationery	2,000 x 41	82,000
	Total	112,750
Divisional Leaders		
Lunch	50 x 3,500	175,000
Stationery	500 x 210	105,000
	Total	280,000
ORIENTATION-GRAND TOTAL		413,000

TRAINING COURSES

			K.Sh. Total
Course 1 - National Training Team			
Accommodation/meals (@ 1,000/day, 10 persons, 28 days)	1,000 x 10 x 28		280,000
Travel - N/A (Trainees Nairobi based)			
Consultant honorarium (@ 4,000/day, 2 persons, 28 days)	4,000 x 2 x 28		224,000
		Subtotal	504,000
Course 2 - DPDOs			
Accommodation/meals (@1,000/day, 41 persons, 14 days)	1,000 x 41 x 14		574,000
Travel (@ 5,000/person, 41 persons)	5,000 x 41		205,000
NTT honorarium (@ 4,000/day, 7 persons, 14 days)	4,000 x 7 x 14		392,000
		Subtotal	1,171,000
Course 3 - District Facilitators			
Accommodation/meals (@1,000/day, 47 persons, 28 days)	1,000 x 47 x 28		1,316,000
Travel (@ 5,000/person, 47 persons)	5,000 x 47		235,000
Consultant/NTT honorarium (@ 4,000/day, 9 persons, 28 days)	4,000 x 9 x 28		1,008,00
		Subtotal	2,559,000
Course 4 - District Training of Trainers			
Accommodation/meals (@ 300/day, 615 persons, 14 days)	300 x 615 x 14		2,583,000
Travel (@ 200/person, 615 persons)	200 x 615		123,000
NTT honorarium (@ 4,000/day, 1 person, 41 districts, 14 days)	4,000 x 41 x 14		2,296,000
		Subtotal	5,002,000

TRAINING COURSES (continued)

			K.Shs. Total
Course 5 - ECN Coordinator/Divisional Management			
Accommodation/meals (@ 300/person, 210 persons, 3 days)	300 x 210 x 3		189,000
Travel - N/A (Trainees will stay on to complete this course following Course 4).			
		Subtotal	189,000
Course 6 - Supervisor/Locational Management			
Accommodation/meals (200/person, 800 persons, 5 days)	200 x 800 x 5		800,000
Travel (@100/person, 800 persons)	100 x 800		80,000
Trainer per diem (@ 200/person, 123 persons, 5 days)	200 x 123 x 5		123,000
Trainer travel (@ 100/person, 123 persons)	100 x 123		12,300
		Subtotal	1,015,300
Course 7 - Village Committees			
Training allowance (@50/person, 187,500 persons, 5 days)	50 x 187,500 x 5		46,875,000
Trainer per diem (@ 160/person, 3 persons, 75,000 days)	160 x 3 x 75,000		36,000,000
Trainer travel (@ 50/person, 3 persons, 75,000 days)	50 x 3 x 75,000		11,250,000
		Subtotal	94,125,000
Course 8 - Distributors			
Training allowance (@ 50/person, 15,000 persons, 5 days)	50 x 15,000 x 5		3,750,000
		Subtotal	3,750,000

TRAINING COURSES (continued)

		K.Shs. Total
Course 9 - Refresher for Distributors		
Training allowance (@ 160/person, 15,000 persons, 3 days)	160 x 15,000 x 3	7,200,000
Trainer per diem		
ECN	160 x 210 x 15	504,000
SDA & FHFE	160 x 1,200 x 5	960,000
Trainer travel		
ECN	50 x 210 x 15	157,500
SDA & FHFE	50 x 1,200 x 5	300,000
	Subtotal	9,121,500
District Warehouse Staff Training (Logistics)		
(3 persons/district)		
Curriculum Development		50,000
Accommodation/meals (@1,000/day, 123 persons, 2 days)	1,000 x 123 x 2	246,000
Travel (@ 5,000/district, 41 districts)	5,000 x 41	205,000
	Subtotal	501,000
	TRAINING--GRAND TOTAL	117,937,800

ANNUAL MEETINGS - CBD PERSONNEL

		K.Sh.	
DPDOs (Nairobi)			
Accommodation/meals (@ 1,000/day, 41 persons, 3 days)	1,000 x41 x 3	123,000	
Travel (@ 5,000 persons, 41 persons)	5,000 x 41	205,000	
Stationery		2,000	
	Annual Total	330,000	
	Six Year Total*		1,980,000
ECN Coordinators (Province)			
Accommodation/meals (@300/day, 210 persons, 3 days)	300 x 210 x 3	189,000	
Travel (@200/person, 210 persons)	200 x 210	42,000	
Stationery		5,000	
	Annual Total	236,000	
	Six Year Total*		1,416,000
Supervisors (District)			
Accommodation/meals (200/day, 800 persons, 3 days)	200 x 800 x 3	480,000	
Travel - N/A (Trainees have own transport)			
Staionery		10,000	
	Annual Total	490,000	
	Five Year Total*		2,450,000

Village Committee Chairman/Distributors (Divison)

Accommodations/meals (@ 160/day, 30,000 persons, 3 days)	160 x 30,000 x 3	14,400,000	
Travel (@ 50/person, 30,000 persons)		1,500,000	
	Annual Total	15,900,000	
	Five Year Total*		79,500,000
ANNUAL MEETING -- GRAND TOTAL			85,346,000

* Five and six year totals used to account for project phasing which will negate the need for annual meetings in project year one for DPDOs and ECN Coordinators and for Supervisors and VC/Distributors in years one and two.

10.2. BUDGET SUMMARY

DONOR CONTRIBUTION

	K.Sh. - 7 Year Total	
Salaries/Allowances		
Supervisor	100,800,000	
Subtotal		100,800,000
Transport		
DPDO vehicles	10,660,000	
DPDO operating/maintenance	68,880,000	
Supervisor motorbikes	16,000,000	
Supervisor operating/maintenance	56,000,000	
ECN Coordinator operating costs	14,700,000	
Subtotal		166,240,000
Training		
Initial CBD Personnel Training (9 courses)	108,315,300	
Refresher Training-Distributors	9,121,500	
District Warehouse Personnel Training	501,000	
Annual Meetings-CBD Personnel	85,346,000	
Orientation for Leaders	413,000	
Subtotal		203,696,800
Equipment/Supplies		
Commodities	185,700,292	
DPDO Equipment/Furnishings	12,710,000	
Commodity Storage Boxes and Bags	13,620,000	
Motorbike Box Carriers	660,000	
Training Equipment/Supplies	114,600	
IEC Equipment/Materials	52,496,150	
MIS Materials	12,912,000	
Subtotal		278,213,042
DONOR CONTRIBUTION - GRAND TOTAL		748,949,842

GOK CONTRIBUTION

	K.Sh. - 7 Year Total
Salaries/Allowances	
DPDO Salaries and Allowances	34,440,000
DPDO Secretary	13,776,000
DPDO Messenger	6,601,000
ECN Coordinator	65,620,800
DPDO Driver	7,978,600
Equipment and Supplies	
DPDO office space/utilities/stationery	20,090,000
District commodity warehouse improvements	3,293,202
Divisional commodity storage	346,500
GOK CONTRIBUTION TOTAL	152,146,102

NATIONAL CBD PROGRAM - 7 YEAR GRAND TOTAL

	K. Sh. Total
DONOR CONTRIBUTION	748,949,842
GOK CONTRIBUTION	152,146,102
7 YEAR TOTAL - K.Sh.	901,095,944

ANNEXES

NATIONAL CBD PROGRAM

Annex Number	
I	Terms of Reference
II	Reference Consulted in Preparing National CBD Plan
3-1	Existing CBD Projects and Staff
4-1	National Population Projections and Family Planning Goals
5-1	Time Frame for National CBD Plan
5-2	National CBD Program - Phase I Districts
5-3	National CBD Program - Phase II Districts
5-4	National CBD Program - Phase III Districts
6-1	CBD National Plan - Summary
6-2	NCPD Secretariat Organogram
7-1	Staffing Ratios by Province for National CBD Program
7-2	Income Implications for Supervisors Paying for Motorbikes in Monthly Installments
7-3	Projected Distributor Requirements by District and Program Phase
7-4	Village Distributor Caseload Projections - 1992 and 2000
7-5	Analysis of Distributor Compensation Schemes
7-6	Summary of Training Courses and Costs
7-7	Training Objectives and Course Content
7-8	Basic IEC Equipment for CBD Required at Various Levels
7-9	Availability of IEC Materials by Source
7-10	Review of CBD Pilot Project Information Systems
7-11	CBD Client Form
7-12	CBD Client Summary Form
7-13	CBD Contraceptive Supply Summary Form

Annexes (Continued)

Annex Number	
7-14	Medical Norms
7-15	Projected Contraceptive Requirements for National CBD Program by Year
7-16	Financial Implications of CBD Commodity Requirements
7-17	Model Design for Logistics Plan for the National CBD Program
7-18	Warehouse Maintenance and Space Requirements
7-19	Inventory Management Procedures

ANNEX I

TERMS OF REFERENCE FOR THE DEVELOPMENT OF A NATIONAL CBD PROGRAM PLAN FOR KENYA

Objective: To assist the NCPD with the development of a plan (1986-2000) for a National CBD Program in Kenya.

In order to prepare a plan, information will be gathered on the following topics:

- Updated information on the operation of existing CBD programs in Kenya, including their costs, staff, supply systems, management and contraceptive coverage;
- Existing and projected (1986-2000) resources in the national health structure, including staffing, facilities and referral mechanisms;
- Existing and projected resources in development organizations to suggest potential participating personnel and community groups through which to implement CBD services;
- District level population projections (1986-2000) to use as the basis for suggesting program goals and staffing projections;
- Experience with worker incentives and suggestions on whether or not workers should sell contraceptives or their services, how communities might compensate distributors and what resources, such as uniforms, bags, boots and transport allowances, the program should provide.
- A reveiw of the medical norms and standards of the MOH and their impact on program design, including the issue of first prescription of oral contraceptives by non-physicians.

Based on the above findings, the consultants will suggest:

- An organizational structure for the national program and identify the roles and responsibilities of all praticipating organizations including the NCPD, MOH, other GOK organizations, NGOs and donors;
- How the program should be managed including staffing patterns, financial management and review, definition of the roles of the personnel and the development of job descriptions.
- What training is required for each level of personnel and who will do the training.
- A supervisory system.

- A management information stystem.
- A commodity logistics system.
- An IEC program to support the delivery of CBD services.
- A seven year budget (1986-1992) to cover the different components of the program.

ANNEX II

REFERENCES CONSULTED IN PREPARING NATIONAL CBD PLAN

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ANNEX 3-1

EXISTING CBD PROJECTS AND STAFF

District *	Project/Sponsor	Number of Supervisors	Number of Distributors	Supervisor/ Distributor Ratio
Kakamega	FPAK	1	15	1/15
	MYWO/PF	10	40	1/4
Kericho	Tenwek/CORAT	--	73	--
Kirinyaga	Mt. Kenya/CORAT	3	67	1/22
Meru	Chogoria/FPIA	20	350	1/18
Mombasa	Mkomani/FPIA	1	8	1/8
Muranga	MYWO/PF	10	33	1/3
Nairobi	ICA/FPIA	8	26	1/4
	MOH	--	28	--
Nyeri	FPAK	1	15	1/15
Siaya	Saradidi/FPIA	1	90	1/90
South Nyanza	Karachuonyo/PF	5	125	1/25
Uasin Gishu	Eldoret/FPIA	--	--	--
TOTAL		60	870	1/13 **

* Additional NGO projects, as well as expansions of the existing efforts are currently planned for several of these districts and also for Bungoma, Kisii and Kisumu. These new activities will add 75 more supervisors and 960 more distributors.

** Overall ratio calculation based only on those projects having both supervisors and distributors.

Acronyms:
CORAT - Christian Organizations Research Advisory Trust
FPAK - Family Planning Association of Kenya
FPIA - Family Planning International Assistance
ICA - Institute of Cultural Affairs
MYWO - Maendeleo ya Wanawake Organization
PF - The Pathfinder Fund

ANNEX 4-1

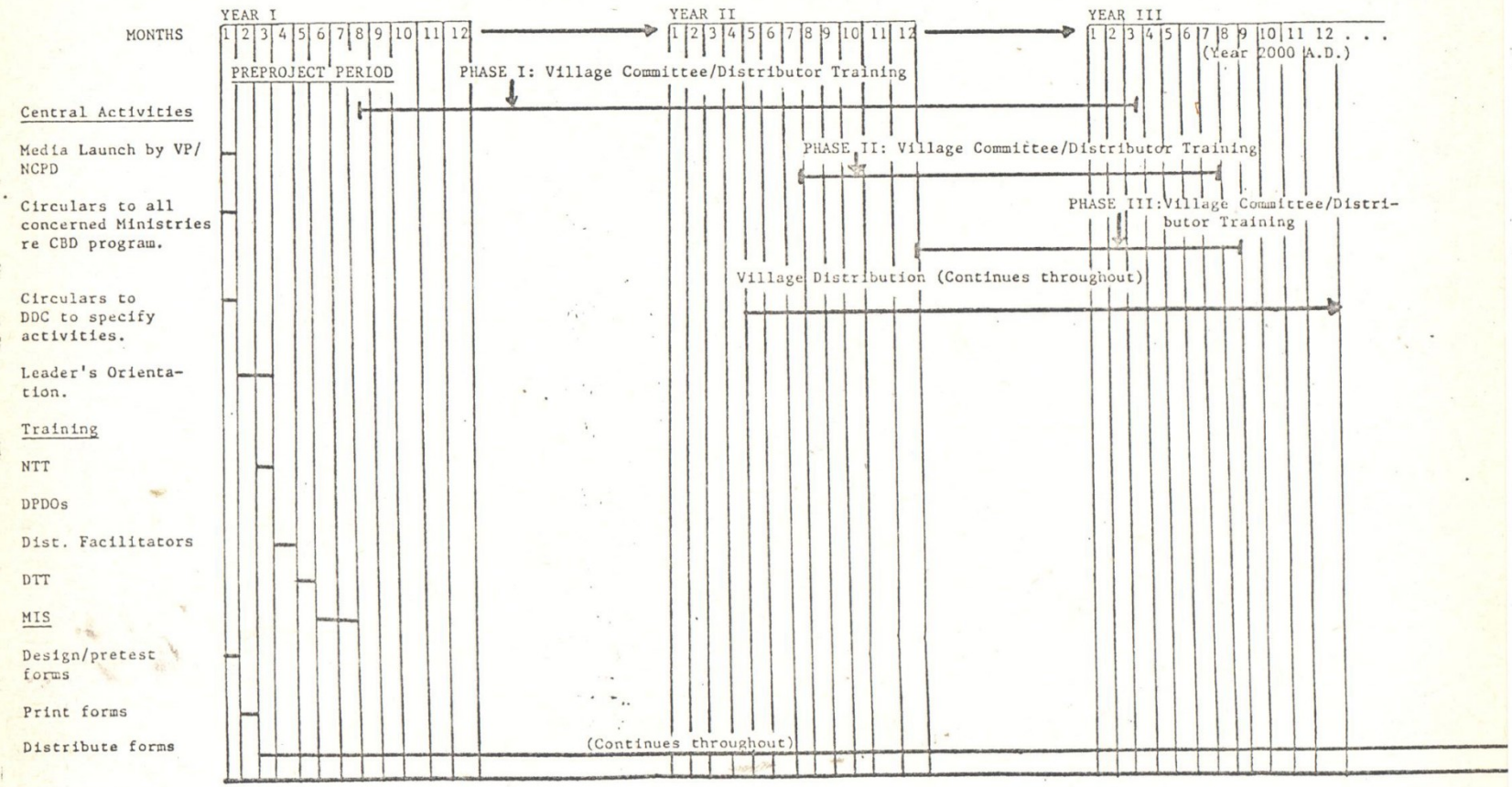
NATIONAL POPULATION PROJECTIONS
AND FAMILY PLANNING GOALS

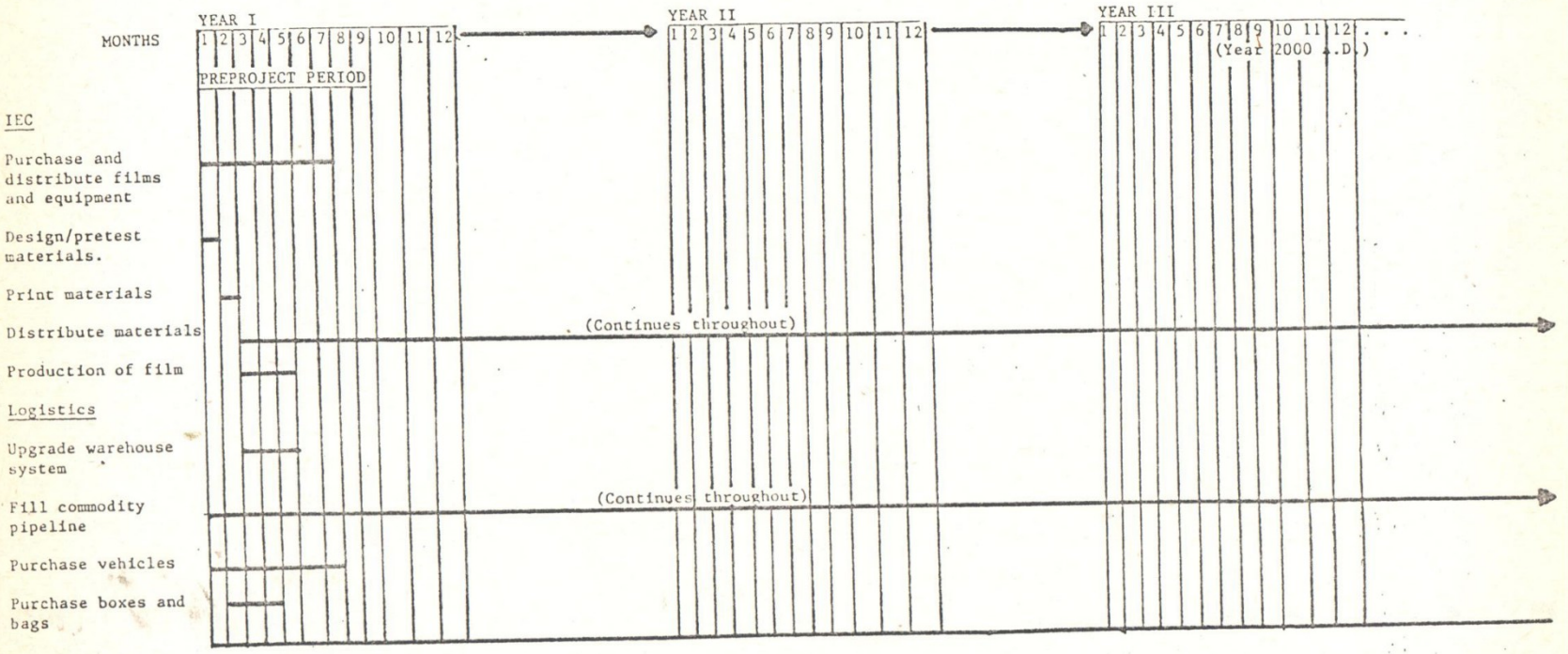
Year	Total Population (Projected)* ('000)	Eligible Couples (20% of Total) ('000)	Total Contraceptive Users		Community Based Distribution Users	
			% of Eligible Couples	Number ('000)	% of Total Users	Number ('000)
1985	20,333	4,067	15	610	Unknown	Unknown
1992	26,985	5,397	25	1,349	38	513
2000	37,505	7,501	40	3,000	38	1,140

* Based on Population Projections for Kenya 1980-2000.
(assuming constant fertility and constant mortality)

ANNEX 5-1

TIMEFRAME FOR NATIONAL CBD PLAN




YEAR I
YEAR II
YEAR III
MONTHS
1 2 3 4 5 6 7 8 9 10 11 12
1 2 3 4 5 6 7 8 9 10 11 12
1 2 3 4 5 6 7 8 9 10 11 12 . . .
(Year 2000 A.D.)
PREPROJECT PERIOD
IEC
Purchase and distribute films and equipment
Design/pretest materials.
Print materials
Distribute materials
(Continues throughout)
Production of film
Logistics
Upgrade warehouse system
Fill commodity pipeline
(Continues throughout)
Purchase vehicles
Purchase boxes and bags

ANNEX 5-2

NATIONAL CBD PROGRAM

PHASE I DISTRICTS

District	CPR*	Total Population** ('000)	Population Density (Km2)
Nyeri	30.9	623	190
Muranga	27.6	850	343
Kirinyaga	25.8	373	260
Meru	24.6	1,080	109
Nairobi	22.6	1,162	1,699
Mombasa	18.3	442	2,105
Kericho	14.9	816	208
Siaya	9.2	651	258
Kisumu	9.0	656	313
Kisii	7.9	1,206	549
South Nyanza	7.3	1,120	196
Bungoma	4.2	658	214
Kakamega	3.4	1,306	374
Uasin Gishu	0.8	409	121

Total Population Phase I Districts - 11,352,000

* Based on Contraceptive Prevalence Survey, 1984 (Provincial Data).

** Based on Population Projections for Kenya 1980-2000 for the year 1985 (Assuming Constant Fertility and Mortality).

ANNEX 5-3

NATIONAL CBD PROGRAM

PHASE II DISTRICTS

District	CPR*	Total Population ('000) **	Population Density (Km2)
Machakos	24.5	1,346	96
Kiambu	23.6	898	367
Nyandarua	22.4	297	85
Nakuru	22.1	734	126
Embu	20.0	348	129
Taita Taveta	11.3	189	11
Kitui	11.1	599	21
Baringo	9.1	258	26
Nandi	7.7	396	147
Busia	6.1	391	244
Kwale	6.0	376	45
Kilifi	5.1	561	47
West Pokot	4.6	226	25
Trans-Nzoia	4.2	376	179
Laikipia	Unknown	194	20
Elgeyo Marakwet	Unknown	164	71
Lamu	Unknown	59	9

Total Population Phase II Districts - 7,412,000

* Based on Contraceptive Prevalence Survey, 1984 (Provincial Data).

** Based on Population Projections for Kenya 1980-2000 for the year 1985 (Assuming Constant Fertility and Mortality).

ANNEX 5-4

NATIONAL CBD PROGRAM

PHASE III DISTRICTS

District	CPR*	Total Population ** ('000)	Population Density (Km2)
Tana River	---	129	3
Isiolo	---	57	2
Marsabit	---	135	2
Narok	---	291	18
Kajiado	---	208	10
Turkana	---	150	2
Samburu	---	92	5
Garissa	---	188	4
Mandera	---	128	5
Wajir	---	193	3

Total Population Phase III Districts - 1,571,000

* Contraceptive Prevalence Survey sample too small to provide rates for these districts.

** Based on Population Projections for Kenya 1980-2000 for the year 1985. (Assuming Constant Fertility and Mortality).

ANNEX 6-1

CBD NATIONAL PLAN - SUMMARY*

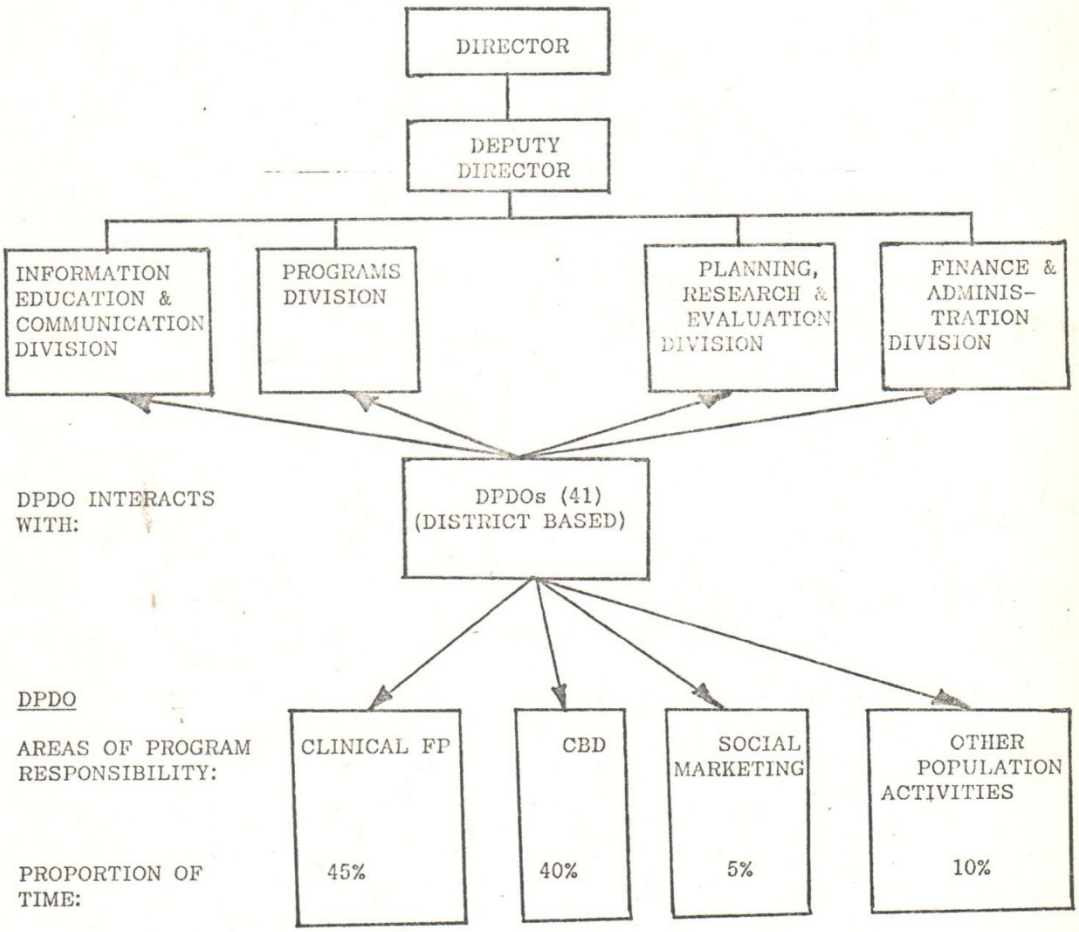
ACTIVITY		PERSONNEL					
		IMPLEMENTATION			SUPPORT **		
FUNCTIONS	COORDINATION	OVP/MOHA NCPD " Secretariat " Program Dir. " CBD Program Officer	MOH Dir. of Medical Services IRHFP Div. of Family Health	NGOs CBD/Pop. Program Officer	MCSS Dir. of Social Services	OP	OP/MOPND
Policy Planning Finance & Admin.	NCPD (CBD Standing Committee)						
Field Planning	District Development Committee (Pop. Subcommittee)	DPDO	DMOH DPHN DHEO DHMT		DSDO	DC	DDO
	Divisional Develop. Committee (Pop. Subcommittee)		CO ECN Coord.	CBD Coordinator	ASDO Div. SDO	DO	
Field Coordination	Locational Development Committee (Pop. Subcommittee)		ECN Coord. FHFE		LSDA	Chief	
Field Implementation	Sublocational Development Committee (Pop. Subcommittee)	Supervisor	ECN Coord. Patient Attendant	Supervisor		Asst. Chief	
	Village Committee	Distributor	CHW	Distributor		Elder	

* All acronyms listed on attached page.

** It is assumed that other field ministries, e.g. agriculture, will contribute some support staff to the CBD effort particularly in community motivation.

ANNEX 6-2

NCPD SECRETARIAT ORGANOGRAM



7.3. Supervision

Supervision is the most important element in the success of CBD programs worldwide. This plan for a national CBD program includes an elaborate, but essential supervision system which should make a significant contribution to the program's success. Supervision will be supportive rather than punitive.

Primary supervision will be carried out on a monthly basis at several levels. The supervisor will make a monthly visit to each distributor in the location under his/her supervision. There will also be a monthly meeting of all distributors at the locational level with their supervisor and a monthly meeting of all supervisors with their ECN Coordinator at the divisional level.

This system will require supervisors to be mobile. They will need to move out to the villages for supervision and to resupply contraceptives to distributors on a regular basis each month. Supervisors will also need to travel to divisional headquarters for monthly meetings with the ECN Coordinator and to collect commodities as required. As outlined in Section 7.2.3, motorbikes are proposed for supervisors.

The proposed supervision system also requires the mobility of DPDOs, who will have to participate in approximately five monthly meetings of supervisors, one in each division in his district. The meeting not only provides the DPDO the opportunity for participative supervision over supervisors and divisional ECN Coordinators, but also gives him an opportunity to move contraceptives from district to division -- a logistics function. He will bring contraceptive supplies to replenish those distributed by the ECN Coordinator to supervisors. In return, he will collect from the ECN Coordinator the supervisors' reports to forward for processing -- an information support function. In the event of an emergency, whereby the ECN Coordinator cannot attend the scheduled meeting, the DPDO can take over and perform her functions at that meeting, an important fallback function. To adequately perform these functions and others, the DPDO will require a vehicle as outlined in Section 7.2.1.2.

Secondary supervision takes place during the twice a year field visit made by the ECN Coordinator to check each supervisor's field work at the locational level. With approximately four to five supervisors under her jurisdiction, each ECN Coordinator will make eight to ten one-week visits a year. Assuming the ECN Coordinator can requisition a divisional vehicle and driver, the budget includes operating cost funds for these visits.

For the supervision system to work effectively, standards of performance and targets must be set for supervisors. A review of supervisors' performance should be made regularly by the ECN Coordinators. Any supervisor whose performance is not satisfactory should be reprimanded and if the work does not improve, he/she should be dismissed by the DPDO in consultation with the ECN Coordinator.

In addition to the primary and secondary supervision efforts noted above, it is recommended that annual meetings be organized for:

- all DPDOs in Nairobi,
- all ECN Coordinators for each province at provincial headquarters,
- all supervisors in each district at district headquarters,

ANNEX 7-1

STAFFING RATIOS BY PROVINCE FOR NATIONAL CBD PROGRAM

Province	Population Density (Km^2)	No. Districts (DPDOs)	DPDO/ECN Ratio	No. Divisions (ECN Coords.)	ECN/Supervisor Ratio	No. Locations (Supervisors)	Supervisor/Distributor Ratio	No. Villages ** (Distributors)
Central	178	5	1/4.4	22	1/4.2	92	1/23.9	2200
Eastern	17	6	1/4.8	29	1/3.5	101	1/24.8	2500
Rift Valley	19	13	1/3.6	47	1/3.4	160	1/18.8	3000
Coast	16	6	1/3.7	22	1/4.1	90	1/14.4	1300
Western	233	3	1/5.7	17	1/2.5	42	1/47.6	2000
Nyanza	211	4	1/5.3	21	1/4	84	1/29.8	2500
Nairobi	1210	1	1/6	6	1/1	6	1/166.7	1000
Northeastern	2	3	1/6.7	20	1/1.8	36	1/13.9	500
NATIONAL TOTAL	27	41	1/4.5	184*	1/3.3	611*	1/24.5	15000

* These figures have increased to 210 and 800, respectively, but district distributions were not available to the team so 1979 data are used here.

** Distributor figures are rounded based on an approximate ratio of one distributor/1500 population in base year 1985.

ANNEX 7-2

INCOME IMPLICATIONS FOR SUPERVISORS
PAYING FOR MOTORBIKES IN MONTHLY INSTALLMENTS

Supervisor's Monthly Salary	K.Sh. 1,500
Supervisor's Monthly Operating/ Maintenance Costs (K.Sh. 10,000/year - 12 months)	833
Total monthly income =	K.Sh. 2,333

Motorbike Costs K.Sh. 20,000

Repayment in equal monthly installments

Over 3 years = K.Sh. 556/month or 24% of income

Over 5 years = K.Sh. 333/month or 14% of income

Over 7 years = K.Sh. 238/month or 10% of income

ANNEX 7-3

PROJECT DISTRIBUTOR REQUIREMENTS BY DISTRICT AND PROGRAM PHASE

NUMBER		PROVINCE	DISTRICT	NUMBER OF DIVISIONS	NUMBER OF LOCATIONS	NUMBER OF SUB-LOCATIONS	DISTRICT POPULATION (1985)	PROJECTED NUMBER OF DISTRIBUTORS (1500/DISTR.)
PHASE I	(14)							
	1.	Central	Nyeri	5	20	148	623,000	416
	2.	Central	Muranga	4	24	124	850,000	567
	3.	Central	Kirinyaga	3	10	77	373,000	249
	4.	Eastern	Meru	6	26	125	1,080,000	720
	5.	Nairobi	Nairobi	6	6	40	1,162,000	775
	6.	Coast	Mombasa	4	18	37	443,000	296
	7.	R. Valley	Kiricho	4	14	86	816,000	544
	8.	Nyanza	Siaya	4	18	131	651,000	434
	9.	Nyanza	Kisumu	5	14	95	656,000	438
	10.	Nyanza	Kisii	4	18	88	1,206,000	804
	11.	Nyanza	S. Nyanza	8	34	165	1,120,000	747
	12.	Western	Bungoma	5	14	72	658,000	439
	13.	Western	Kakamega	9	21	184	1,306,000	871
	14.	R. Valley	Uasin Gishu	3	66	27	409,000	372
		Subtotal -- Phase I		70	243	1,399	11,353,000	7,573

ANNEX 7-3

PROJECT DISTRIBUTOR REQUIREMENTS BY DISTRICT AND PROGRAM PHASE

NUMBER	PROVINCE	DISTRICT	NUMBER OF DIVISIONS	NUMBER OF LOCATIONS	NUMBER OF SUB-LOCATIONS	DISTRICT POPULATION (1985)	PROJECTED NUMBER OF DISTRIBUTORS (1500/DISTR.)
Phase II (17)							
15.	Eastern	Machakos	7	29	221	1,346,000	898
16.	Central	Kiambu	6	25	167	898,000	599
17.	Central	Nyandarua	4	13	47	297,000	198
18.	R. Valley	Nakuru	5	14	46	734,000	490
19.	Eastern	Embu	3	10	78	348,000	232
20.	Coast	Taita Taveta	3	9	42	189,000	126
21.	Eastern	Kitui	5	27	150	599,000	400
22.	R. Valley	Baringo	4	20	128	258,000	172
23.	R. Valley	Nandi	4	9	69	396,000	264
24.	Western	Busia	3	7	49	391,000	261
25.	Coast	Kwale	4	21	62	376,000	251
26.	Coast	Kilifi	3	19	86	561,000	374
27.	R. Valley	West Pokot	4	16	48	226,000	151
28.	R. Valley	Trans-Nzoia	3	4	19	376,000	251

ANNEX 7-3

PROJECT DISTRIBUTOR REQUIREMENTS BY DISTRICT AND PROGRAM PHASE

NUMBER	PROVINCE	DISTRICT	NUMBER OF DIVISIONS	NUMBER OF LOCATIONS	NUMBER OF SUB-LOCATIONS	DISTRICT POPULATION (1985)	PROJECTED NUMBER OF DISTRIBUTORS (1500/DISTR.)
29.	R. Valley	Laikipia	4	9	20	194,000	130
30.	R. Valley	Elgeyo-Marakwet	3	11	91	164,000	110
31.	Coast	Lamu	5	7	31	59,000	40
	Subtotal -- Phase II		70	250	1,254	7,412,000	4,947
Phase III (10)							
32.	Coast	Tana River	3	16	18	129,000	86
33.	Eastern	Isiolo	3	4	21	57,000	38
34.	Eastern	Marsabit	5	5	38	135,000	90
35.	R. Valley	Narok	3	16	49	291,000	194
36.	R. Valley	Kajiado	3	14	31	208,000	139
37.	R. Valley	Turkana	5	20	39	150,000	100
38.	R. Valley	Samburu	2	7	29	92,000	62
39.	N. Estrn	Garissa	8	8	21	188,000	126
40.	N. Estrn	Mandera	6	22	22	128,000	86
41.	N. Estrn	Wajir	6	6	21	193,000	129
	Subtotal - Phase III		44	118	289	1,571,000	1,050
	GRAND TOTAL		184	611	3,042	20,336,000	13,570

ANNEX 7-4

NATIONAL CBD PROGRAM
VILLAGE DISTRIBUTOR CASELOAD PROJECTIONS
1992 and 2000

	YEARS	
	1992	2000
Population Projection*	27,000,000	37,500,000
Distributor/Population Ratio (Assumes 15,000 Distributors)	1/1800	1/2500
Eligible Couples/Distributor (20% of total population)	360	500
Contraceptive Prevalence Rate Goal	25%	40%
Total Contraceptive Users Among Eligible Couples/Distributors	90	200
Number of Users to be Served per CBD Distributor (38% of total of contraceptive users)	34	75
TOTAL CBD Users Nationally (15,000 Distributors/CBD Users)	510,000	1,140,000

* Based on Population Projections for Kenya 1980-2000 (assuming constant fertility and mortality).

** For the purpose of planning the national CBD Program, it has been assumed that 38 percent of all contraceptives users by 1992 and beyond will obtain contraceptives through CBD channels.

ANNEX 7-5

ANALYSIS OF DISTRIBUTOR COMPENSATION SCHEMES

Internation experience in CBD projects, as well as experience in the existing CBD efforts in Kenya, has demonstrated a variety of methods for reimbursing community workers for their activities related to the distribution of contraceptives. The ongoing projects in Kenya have used a number of direct compensation and incentive schemes. Three projects on which data were available provide no monetary compensation at all but these projects provide a variety of items related to the volunteer distributor's work, including bags or kits for holding commodities and records, umbrellas, boots, and badges. The value of these items ranges from K.Sh. 175 to 485 for each distributor. The managers of these projects contend that these in-kind contributions are adequate to satisfy the distributor's needs for an incentive to perform the work; however, the team heard anecdotes regarding a desire for monetary compensation among these volunteer workers.

Several existing projects pay community workers a monthly salary ranging from K.Sh. 250 to 2,200. In these particular projects there are other in-kind incentives as follows:

Distributor Compensation in Four CBD Pilot Projects
Kenya

	Cash (Per Month) K.Sh.	In-Kind Items	In-Kind Value K.Sh.
Project A	600	Umbrellas, book, bags	485
Project B	100-600* **	Bicycles for some workers	3,500
Project C	540+ 60 (Travel)	Boots, coats, bags	670
		and bicycles	3,500
Project D	2,200 - +	Uniforms and bags	1,500

* Decided upon and paid by the community.

** This project also has a group of "contract" distibutors or sub-supervisors who are paid K.Shs. 20/month for each distributor supervised.

As can be readily observed, these levels of compensation could quickly exhaust the relatively limited funds available for a national CBD effort.

While recognizing that the spirit of "harambee" is very strong in Kenyan communities and that many volunteers have made extraordinary efforts on behalf of their communities, the level of volunteer effort required for CBD could probably not be sustained over long periods of time, e.g., the 10-20 years that will be needed if this program is to have a major impact on long-term fertility rates. Given the large number of distributors that will eventually be involved in this program (15,000), it is doubtful that any agency, government or donor would want to assume the large recurring costs to pay salaries for this cadre. Thus, the community will have to rely on its own resources. Since these are usually restricted, the conclusion reached is that selling contraceptives and using the proceeds to compensate health workers may be the most logical solution for distributor remuneration.

The sale of contraceptives directly to clients at a standardized national price has not been attempted yet in Kenya. In programs elsewhere, workers either retain all or a percentage (usually one-half) of the income from contraceptive sales. Apart from producing compensation for workers, there are some advantages and disadvantages to schemes of this type (which are described in Table 1, which is attached). However, in reviewing the apparent inequalities in the other systems attempted in Kenya and recognizing the expense and other implications to a national program if these workers were to become salaried government employees, it is strongly recommended that the NCPD give consideration to allowing CBD wokers to sell commodities and retain all or part of the proceeds as compensation.

By 1992 each CBD distributor is expected to recruit and serve at least 30 users. The contraceptive mix is expected to be 70% orals, 10% foam tablets, 10% condoms alone, and 10% combined condoms and foam. If contraceptive supplies are to be sold, a standard national price should be set and well publicized. The potential monthly earnings have been calculated for distributors serving 30 clients and selling contraceptives, giving two possible prices for approximately one month's supply of contraceptives (Table 2). A second calculation indicates monthly income if the number of clients served increases to 50 with the same contraceptive mix and prices (Table 3).

ANNEX 7-5

TABLE1

Advantages and Disadvantages of Distributor Compensation Through the Sale of Contraceptives in CBD Programs

Advantages

- Provides incentives to expand coverage
- Minimizes drop-out of CBD distributors
- Purchase of contraceptives implies the client places some value on the commodity and therefore will be more likely to use it.
- Sale of contraceptives encourages more accurate reporting, especially if the alternative is free distribution with worker compensation based on performance, e.g. number of clients or amount of supplies distributed.
- Income to the worker is immediate.

Disadvantages

- Administration and accounting are difficult, especially if a portion of the proceeds is to be returned to the project.
- Free distribution elsewhere, e.g. MOH clinics or NGO projects, may divert acceptors from CBD.
- Sales may exclude the poorest clients.
- Government policy towards the sale of donated contraceptives with retention of the proceeds at the local level is unclear.

ANNEX 7-5

TABLE2

30 CBD Clients

At K.Shs. 5/One Month (Approximate)*

Method	Number of Users	Number of Cycles/ Pieces Per Year	Unit Cost K.Sh.	Annual Income From Sales K.Sh.
Pills	21	13	5.00	1,265.00
Condoms	3	125	0.50	187.50
Foam Tablets	3	125	0.50	187.50
Condoms and Foam Tablets	3	250	0.50	375.00
Total	30			2,015.00

Monthly Income = K.Shs 176.25

* Figures for condoms and foam based on 125 pieces per year. Actual use may vary for individual couples.

At K.Shs. 10/One Month (Approximate)*

Method	Number of Users	Number of Cycles/ Pieces Per Year	Unit Cost K.Sh.	Annual Income From Sales K.Sh.
Pills	21	13	10.00	2,730.00
Condoms	3	125	1.00	375.00
Foam Tablets	3	125	1.00	375.00
Condoms and Foam Combined	3	250	1.00	750.00
Total	30			4,230.00

Monthly Income = K.Sh. 352.50

* Figures for condoms and foam based on 125 pieces per year. Actual use may vary for individual couples.

ANNEX 7-5

TABLE3

50 CBD Clients

At K.Shs. 5/One Month (Approximate)*

Method	Number of Users	Number of Cycles/ Pieces Per Year	Unit Cost K.Sh.	Annual Income From Sales K.Sh.
Pills	35	13	5.00	2,275.00
Condoms	5	125	0.50	312.50
Foam Tablets	5	125	0.50	312.50
Condoms and Foam Tablets	5	250	0.50	625.00
Total	50			3,525.00
			Monthly Income = K.Shs	293.75

* Figures for condoms and foam baed on 125 pieces per year. Actual use may vary for individual couples.

At K.Shs. 10/One Month (Approximate)*

Method	Number of Users	Number of Cycles/ Pieces Per Year	Unit Cost K.Sh.	Annual Income From Sales K.Sh.
Pills	35	13	10.00	4,550.00
Condoms	5	125	1.00	625.00
Foam Tablets	5	125	1.00	625.00
Condoms and Foam Combined	5	250	1.00	1,2500.00
Total	50			7,050.00
			Monthly Income = K.Sh.	587.50

* Figures for condoms and foam based on 125 pieces per year. Actual use may vary for individual couples.

ANNEX 7-6

SUMMARY - TRAINING COURSES AND COSTS

TRAINING COURSE	DURATION	SITE	FACILITATORS	NUMBER OF TRAINEES	NO. OF TRAINING SESSIONS	TOTAL COSTS K.SH.
1. National Training Team	4 weeks	Nairobi	2 Consultants CBD Program Officer	7 NTT Members	1	504,000
2. District Management of CBD Program	2 weeks	Nairobi	NTT, CBD Program Officer, NCPD Staff	41 DPDOs	1	1,171,000
3. Training of District Training Facilitators	4 weeks	Nairobi	NTT, CBD Program Officer, 2 Consultants	41 District Facilitators (PHN, HEO or PHO) and 6 RHTC Facilitators	1	2,559,000
4. Training of District Training Teams	2 weeks	District or RHTC	1 NTT Member Facilitator, DPDO	210 ECNs 210 FHFEs 210 SDAs	41	5,002,000
5. Divisional Management of CBD Program	3 days	District or RHTC	DPDO	210 ECN Coordinators	41	189,000
6. Locational Management of CBD Program	5 days	District or RHTC	DPDO with ECN, FHFE, LSDA	800 Supervisors	41	1,015,300
7. Village Management of CBD Program	5 days	Village	Teams of two-ECN or Supervisor & FHFE or LSDA	10-15 VC members per village	15,000	94,125,000
8. Training of Distributors	5 days	Village	Supervisor	25 Distributors/ course	600	3,750,000
9. Refresher Training for Distributors	3 days	Location	One each - DPDO, ECN, Supervisor, FHFE, LSDA	25 Distributors/ Course	600	9,121,500

ANNEX 7-7

TRAINING OBJECTIVES AND COURSE CONTENT

Training Course 1: National Training Team

Training Objectives

- o to review existing knowledge and skills of NTT members
- o to update the NTT on curriculum development and training skills and methodologies.
- o to equip the NTT with details on the national CBD program.
- o to conduct task analysis of DPDOs.
- o to conduct task analysis of District Training Facilitators.
- o to develop a two-week competency based curriculum for training of DPDOs.
- o to develop a four-week competency based curriculum for training District Training Facilitators.
- o to develop and/or identify training materials and resource persons for both training courses.

Course Content

To include but not limited to:

1. Community based distribution of contraceptives
   - o The concept of CBD in general
   - o The national CBD program implementation plan
   - o The impact that CBD will have on rapid population growth
2. Competency based curriculum development
   - o Definition of tasks of the DPDOs and District Training Facilitators
   - o Task analysis
   - o Objective writing
   - o Content identification
   - o Methods of teaching

- o Teaching materials
- o Evaluation of Training

3. Management of training programms
4. Development of training materials
5. Training techniques and methodologies
   - o lectures
   - o discussion
   - o role playing
   - o demonstration

Training Course 2: District Management of CBD Program

Training Objectives

- o to orient DPDOs to different FP delivery systems.
- o to update DPDOs knowledge of the human reproductive system and modern contraceptive technology.
- o to assist DPDOs in describing their functional responsibilities and how to effectively perform them.
- o to assist DPDOs in identifying possible obstacles in performing their duties and how to overcome them.
- o to strengthen DPDOs skills in participatory training and supervision techniques.
- o to instruct DPDOs on contraceptive supply movement and storage.

Course Content

To include but not limited to:

1. The concept of CBD and the national CBD program implementation plan
2. Family Planning
   - o Human reproductive system
   - o Modern contraception
   - o Supervision of ECN Coordinators and the District Storekeeper

3. Logistics

   - o Movement of contraceptives in the CBD program
   - o Contraceptive storage procedures

4. Financial Management

   - o Budgeting
   - o Accounting
   - o Reporting

5. Monitoring and Evaluation

   - o Indicators of program achievements
   - o Data management to include analysis and presentation of data, feedback to the NCPD population sub-committees, program staff and volunteers

6. Curriculum Development

   - o training methodology
   - o development of training materials
   - o task analysis
   - o session plans
   - o training evaluation

Training Course 3: Training of District Training Facilitators

Training Objectives

- o to review existing knowledge and skills of District Training Facilitators.
- o to update District Training Facilitators on curriculum development and training skills and methodologies.
- o to equip District Training Facilitators with detailed knowledge of district management of the CBD program.
- o to conduct a task analysis for supervisors.
- o to conduct a task analysis for district trainers.
- o to develop a two-week curriculum for supervisors.

- to develop a two-week curriculum for district trainers.
- to develop and/or identify training materials and resource persons for both training courses.

Course Content

To include but not limited to:

1. Community based distribution of contraceptives
   - the concept of CBD in general
   - the national CBD program implementation plan and specifically the district implementation process
   - the impact of CBD on rapid population growth
   - the role of the District Training Facilitator in CBD
2. Competency based curriculum development
   - definition of tasks of the DTT and the tasks of the supervisor
   - task analysis
   - objective writing
   - content identification and selection
   - material selection
   - teaching methods
   - evaluation of training
3. Management of training programs in the districts
4. Development of training materials
5. Teaching techniques and methodology
   - the learner centered approach
   - use of lectures
   - discussion
   - demonstrations
   - role playing
   - pictures

Training Course 4: Training of District Training Teams

Training Objectives

- o to review the existing knowledge and skills of DTT members on training.
- o to update DTT members on curriculum development and training skills and methodologies.
- o to equip DTT members with detailed knowledge of divisional, locational, and village management of CBD project.
- o to conduct a task analysis of village committees.
- o to develop a one-week curriculum on village management of the CBD program.
- o to develop and/or identify training materials and resource persons for the training.

Course Content

To include but not limited to:

1. The concept of CBD in general
   - o The impact CBD will have on rapid population growth
   - o The role of the trainers in the implementation process in the village
   - o The role of the village committees
   - o Creating awareness about CBD in the villages
2. Competency based curriculum development for the village committee
   - o definition of tasks
   - o task analysis
   - o objective writing
   - o content selection for the village committees
   - o selection of teaching materials
   - o use of appropriate methods
3. Training techniques and methods of training the village committees
   - o role playing

Training Course 4: Training of District Training Teams

Training Objectives

- o to review the existing knowledge and skills of DTT members on training.
- o to update DTT members on curriculum development and training skills and methodologies.
- o to equip DTT members with detailed knowledge of divisional, locational, and village management of CBD project.
- o to conduct a task analysis of village committees.
- o to develop a one-week curriculum on village management of the CBD program.
- o to develop and/or identify training materials and resource persons for the training.

Course Content

To include but not limited to:

1. The concept of CBD in general
   - o The impact CBD will have on rapid population growth
   - o The role of the trainers in the implementation process in the village
   - o The role of the village committees
   - o Creating awareness about CBD in the villages
2. Competency based curriculum development for the village committee
   - o definition of tasks
   - o task analysis
   - o objective writing
   - o content selection for the village committees
   - o selection of teaching materials
   - o use of appropriate methods
3. Training techniques and methods of training the village committees
   - o role playing

- o discussions
- o lectures
- o demonstrations
- o field visits

4. Management of training in the villages

5. Development of training materials for village committees and distributors

Training Course 5: ECN Coordinator Training for Divisional Management of CBD Program

Training Objectives

- o to develop skills in examining the records compiled by supervisors to identify program short falls and offer corrective instructions to the supervisors.
- o to give coordinators the knowledge and skills that will enable them to supervise supervisors and distributors effectively.
- o to impart an understanding of the process of financial management.
- o to instruct the coordinators on the contraceptive supply movement and storage.
- o to develop supervisor performance standards.

Course Content

To include but not limited to:

1. Supervision
   - o Record systems
   - o Techniques and methods of reviewing supervisor and distributor performance
2. Inventory
   - o maintaining stock
   - o storage of the contraceptives at the divisional headquarters
   - o commodity storage by supervisors and distributors
   - o procurement by supervisors and supply to the distributors

3. Financial Management

   - o budgeting
   - o accounting
   - o reporting

Training Course 6: Supervisor Training for Locational Management of CBD Program

Training Objectives

- o to provide knowledge on the benefits of family planning, methods of contraception, human reproductive system and the concept of CBD, and its implementation process at the locational level.
- o to identify the supervisor's role in CBD and develop skills in carrying out their assigned tasks.
- o to identify the roles of other people involved in CBD implementation and understand how these roles interrelate.
- o to develop skills in training the VCs and the distributors for their roles.
- o to develop skills in creating awareness about CBD in the villages.
- o to provide knowledge and skills in supervising distributors with a view to identifying program shortfalls and solving problems.
- o to instruct in the process of procuring commodities and the system of supplying them to the distributors, maintaining and storing stock.
- o to instruct in the process of compiling information at the locational level and develop skills in doing so.

Course Content

To include but not limited to:

1. Family Planning
   - o Benefits
   - o Methods of contraception including how they are used, side effects, contraindications, and instructions to clients.
2. Human reproductive system
   - o female reproductive system
   - o male reproductive system

- o conception
- o natural family planning

3. CBD
   - o the concept
   - o the role of village committees
   - o the role of distributors
   - o the role of the supervisor and ECN Coordinator
4. Program management
   - o the management structure from the district to the village
   - o the locational implementation plan
5. Community education and awareness creation
   - o target audience - village committees, general public
   - o special groups for education - women, churches, chief's barazas
6. Method of education
   - o songs
   - o pictures
   - o role plays
   - o discussions
7. Styles and techniques of supervision
   - o individual or group supervision
   - o observation
   - o listening
   - o examining records
   - o discussion with the distributors
   - o problem solving
   - o types of contraceptives used in CBD
   - o information required for each contraceptive used

- o conception
- o natural family planning

3. CBD
   - o the concept
   - o the role of village committees
   - o the role of distributors
   - o the role of the supervisor and ECN Coordinator
4. Program management
   - o the management structure from the district to the village
   - o the locational implementation plan
5. Community education and awareness creation
   - o target audience - village committees, general public
   - o special groups for education - women, churches, chief's barazas
6. Method of education
   - o songs
   - o pictures
   - o role plays
   - o discussions
7. Styles and techniques of supervision
   - o individual or group supervision
   - o observation
   - o listening
   - o examining records
   - o discussion with the distributors
   - o problem solving
   - o types of contraceptives used in CBD
   - o information required for each contraceptive used

- o system of getting supplies and supplying them to the distributors
- o maintaining and storing the contraceptives

Training Course 7: Village Management of CBD Program

Training Objectives

- o to assist the VC to understand the concept of family planning in general.
- o to gain basic knowledge on the human reproductive system.
- o to understand the impact of rapid population growth on the development of the family, community and the country as a whole.
- o to gain knowledge on the impact that CBD will have on the rapid population growth.
- o to understand the VC's role in CBD and the selection of the distributors.
- o to develop skills in conducting community mapping and baseline survey activities at the village level.
- o to gain skills in creating community sensitization about CBD in their village.

Course Content

To include but not limited to:

1. Population and Family Planning
   - o Family planning concept
   - o Impact of population on development
   - o The CBD approach
   - o The impact that CBD will have on rapid population growth
   - o Techniques of sensitizing the community for CBD action through community meetings and home visits
2. Community mapping and baseline survey
   - o Number and location of households in the village
   - o Number and characteristics of people in all the households
   - o Family planning and reproductive histories

3. Support systems for distributors

- o Determining ways of supporting the distributor
- o Moral support
- o Award for the best distributor
- o Remuneration

Training Course 8: Training of Distributors

Training Objectives:

- o to educate communities about family planning benefits, types of contraceptives available and where to find them.
- o to identify clients for contraceptive use by conducting a community mapping and baseline survey.
- o to motivate clients for contraceptive use.
- o to screen clients and recommend appropriate methods of contraceptives.
- o to provide contraceptives to clients, instruct them on how to use them and what to expect.
- o to refer clients desiring clinical methods.
- o to identify and manage side effects in the village and to identify clients needing referral to the clients.
- o to record types of contraceptives distributed and the particulars of the clients using the contraceptives.
- o to compile recorded information and present and discuss it with the supervisors.
- o to interpret the information recorded in such a way as to identify defaulters and reasons for defaulting, active users, and amount of commodities used and amount in stock.

Course Content

To include but not limited to:

1. Family planning
   - o basic human reproduction
   - o concept of family planning and health benefits
   - o the concept of CBD

- o distributor's role in CBD
- o modern methods of contraceptives including the benefits of each, methods of use, side effects and complications, and contraindications.

2. Motivation/counselling

- o interviewing techniques
- o listening exercises
- o leadership skills
- o taking history from the clients
- o home visiting
- o approaching clients for family planning
- o motivation talks, songs, role plays, use of posters
- o counselling new clients to make choice of contraceptives
- o counselling for referrals for clinical methods
- o counselling clients who wish to discontinue due to side effects or rumours
- o counselling defaulters

3. Education

- o forums for educating the community, including women's groups, church groups, chief's barazas, harambee groups, and parents associations
- o planning educational talks
- o methods of presenting family planning information to communities including discussions, role playing, songs, stories, and pictures

4. Distribution

- o community mapping and survey
- o use of check list for pill users
- o guiding clients to choose contraceptives
- o instructions to clients
- o follow up of clients

5. Record keeping

   - o forms used - tupe of information to be entered
   - o importance of keeping records
   - o practice record keeping
   - o compiling the information recorded
   - o interpreting records kept
   - o ordering and storage of commodities

Training Course 9: Refresher Training for Distributors

Training Objectives

- o to enable the distributors to share their experiences with each other.
- o to identify common problems and gain knowledge from each other on how best these problems can be tackled.
- o to assist the trainers to identify the learning needs of the distributors and give training accordingly.

Course Content

To include but not limited to:

1. Review of previous training subjects
   - o contraceptive methods
   - o checklist for OC distribution
   - o record keeping: clients record, contraceptive supply, referral
   - o motivation and counselling techniques
2. Identification of problems
   - o problem solving among the distributors
   - o retraining by the trainers
   - o other agendas related to the distributor's work will also be addressed in this forum

ANNEX 7-8

BASIC IEC EQUIPMENT FOR CBD REQUIRED AT VARIOUS LEVELS

EQUIPMENT	DISTRICT	DIVISION	SDP
Anatomical model			X
Cassette recorders	X	X	X
Film projector	X	X	Borrowed from Division
Slide projector	X	X	Borrowed from Division
Films, filmstrips and slide	X	X	
Overhead projector	X	X	

ANNEX 7-9

AVAILABILITY OF IEC MATERIALS BY SOURCE

Type of Material	Subject	Source*
Printed booklets/pamphlets	Pill	FPAK
	IUD	FPAK
	Condom	FPAK/FPIA
	Sterilization	FPAK
	Foams/Jellies	FPAK
Posters	General FP	MOH, FPPS
Films	CBD in: Colombia, Thailand, Indonesia, Zimbabwe (in progress)	USAID/FPAK
Video	CBD: MYWO	MYWO (in progress)

*FPAK - Family Planning Association of Kenya
FPIA - Family Planning International Assistance
MOH - Ministry of Health
FPPS - Family Planning Private Sector Project
MYWO - Maendeleo Ya Wanawake Organization

ANNEX 7-10

REVIEW OF CBD PILOT PROJECT INFORMATION SYSTEM

A review of seven of the pilot CBD projects' information systems revealed a number of issues and problems useful in designing a uniform system for a national CBD program. Findings of this review are presented below.

Community Diagnosis

Prior to the implementation of CBD projects, most organizations undertook what they considered to be a community diagnosis which was aimed at determining the existing health and FP practices of the community to be served by the project. However upon review, it was revealed that this information was not used in any way to plan subsequent activities.

Existing Forms

In most projects, distributors kept the following forms, many of which had been translated to Swahili or the local language.

- client chart or client register
- contraceptive monitoring forms
- client referrals forms
- check list
- diary

Information collected by most programs was on family planning users by type of method, numbers of drop outs, and referrals. Data were being aggregated at the distributor's level in very few programs.

The supervisor aggregated information collected from individual distributors in some form usually showing number of clients by method per month, quantity and type of contraceptives distributed, referrals and drop outs. The supervisor in most cases passed the information on to the national level or headquarters.

The following problems were encountered in implementing the pilot projects' information systems:

- Forms were designed for recording information for only one year. For that reason, the distributors had difficulty in distinguishing between new and old users. A user not previously registered in the current year might be a new user or a user in the prior year.
- Some systems registered each client visit in the order in which the clients were served. Each visit occupied a line. As the number of visits accumulated, the distributors had difficulty associating visits of the same client and determining at any given moment whether or not a client had sufficient supplies.

- Some distributors had difficulty maintaining a record of the quantity of contraceptives distributed. It took the supervisor a long time to determine the quantity and type of contraceptives used.

- Some distributors lacked forms and had to sketch their own forms as best they could. The resulting forms lacked uniformity, and it is probable that the quality of the data suffered.

- Some projects did not have adequate client referral systems. Distributors did not know whether patients they referred were actually served at the SDPs.

- Illiterate distributors were unable to fill out forms.

- Distributors, supervisors, district and central level personnel had difficulty summarizing and using information.

ANNEX 7-11
CBD CLIENT FORM
Year ____

Name of Distributor _____
Village _____
Location _____

	CHARACTERISTICS																					
CLIENT NAME	SEX	ADDRESS/ VILLAGE	AGE	MARITAL STATUS	NO. OF CHILDREN	EDUCATION	USED FP	BREAST FEEDING	MONTHS 1	2	3	4	5	6	7	8	9	10	11	12
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
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16																				
17																				
18																				
19																				
20																				
21																				
22																				
23																				
24																				
25																				

* Codes used for completing this form listed on the attached page.

CBD CLIENT FORM CODES

Sex

Female = F
Male = M

Maritial Status

Married = 1
Single = 2
Separated/Divorced = 3
Widowed = 4

Ever Used FP and Breastfeeding

Yes = ✓
No = ✗

Contraceptives*

Mycrogynon = M
Eugynon = E
Foam Tablets = F
Condoms = C
Jelly = J

Reasons for Drop Out **

Rumor = 5
Disease = 6
Side Effects = 7
Religion = 8
Pregnancy = 9
Spouse's Objection = 10
Other = 0

Reasons for Referral

Injection = 11
IUD = 12
Check up = 13
Disease = 14
Side Effects = 15
Tubal Ligation = 16
Vasectomy = 17

* The program will have to fix a standard quantity of contraceptives to be supplied per month. If and when new methods/brands are introduced, new codes may be added.

** Reasons for drop out are very subjective; therefore, these codes will need to be carefully pretested and adjusted accordingly.

ANNEX 7-12

CBD CLIENT SUMMARY FORM

	Name of Distributor _____
	Village _____
	Sub-Location _____
	Location _____
	Division _____
	District _____

Name of Supervisor _____ Year 19___

Months

ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
NEW ACCEPTORS												
ACTIVE USERS-TOTAL												
Pills												
Condoms												
Foam Tablets												
Jelly												
EFFECTIVE REFERRALS-TOTAL												
IUD												
Injection												
Tubal Ligation												
Side Effects												
Check Up												
OTHER REFERRALS												
DROP OUTS												
ACTIVE USERS + EFFECTIVE REFERRALS												
INITIALS OF SUPERVISOR												

ANNEX 7-13

CBD CONTRACEPTIVE SUPPLY SUMMARY FORM

Name of Distributor _____
Village _____
Sub-Location _____
Location _____
Division _____
District _____

Name of Supervisor _____ Year 19___

Months

ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
PILLS												
Beginning Balance												
Amount Received												
Amount Distributed												
Final Balance												
CONDOMS												
Beginning Balance												
Amount Received												
Amount Distributed												
Final Balance												
JELLY												
Beginning Balance												
Amount Received												
Amount Distributed												
Final Balance												
FOAM TABLETS												
Beginning Balance												
Amount Received												
Amount Distributed												
Final Balance												

ANNEX 7-14

MEDICAL NORMS

The current norms for dispensing of contraceptives in Kenya are a major improvement on the practice in the past.

These norms now allow:

a. Oral pills to be given by non-clinical staff.

b. Initial oral pill supply to be given using a checklist for screening clients.

c. Up to nine cycles of oral pills to be supplied to those who have been screened by the check list, without a clinical examination.

d. Injectable to be given to anybody with proven fertility, i.e., one pregnancy, by trained clinical staff. (For purposes of CBD program, the ECN Coordinators would be qualified to give injectables).

e. Breastfeeding mothers to be given the mini-pill (progestrone only).

The norms on IUD insertion are that SDPs have personnel to insert the IUDs. The planning team was unable to determine, despite repeated requests, where the ECNs trained in FP are posted. However, the team was assured that the information will be generated and ECNs trained in FP will be made available to SDPs in each district to coincide with CBD introduction. They will be needed to support clinical referrals.

ANNEX 7-15

PROJECTED CONTRACEPTIVE REQUIREMENTS FOR NATIONAL CBD PROGRAM BY YEAR

YEAR	(A) Total Users	(B) Pill Users (70%)	(C) Condom Users (10%)	(D) Foam Tablet Users (10%)	(E) Condom/ Foam Tab. Combined (10%)	(F) Pill * Cycles Required (B) x 13	(G) Condoms Required (C+E) x 125	(H) Foaming Tablets Required (D+E) x 125
1	50,000	35,000	5,000	5,000	5,000	455,000	1,250,000	1,250,000
2	90,000	63,000	9,000	9,000	9,000	819,000	2,250,000	2,250,000
3	130,000	91,000	13,000	13,000	13,000	1,183,000	3,250,000	3,250,000
4	170,000	119,000	17,000	17,000	17,000	1,547,000	4,250,000	4,250,000
5	250,000	175,000	25,000	25,000	25,000	2,275,000	6,250,000	6,250,000
6	320,000	224,000	32,000	32,000	32,000	2,912,000	8,000,000	8,000,000
7	400,000	280,000	40,000	40,000	40,000	3,640,000	10,000,000	10,000,000
8**	510,000	357,000	51,000	51,000	51,000	4,641,000	12,750,000	12,750,000

* No distinction has been made between Microgynon and Eugynon, since standard norms for treatment have not been developed for all programs. Thus, no estimates of breakdown of pills by brand are possible at this time.

** Projections are made through year 8 to allow filling the contraceptive pipeline at the end of this program plan.

ANNEX 7-16

FINANCIAL IMPLICATIONS OF CBD COMMODITY REQUIREMENTS

1. Oral Contraceptives (OCs)

In 1984, SIDA purchased Microgynon for $0.1333/cycle. Since the majority of oral contraceptives for the CBD program should be Microgynon, this figure is utilized to give appropriate budget figures for each year based on the projections presented in Annex 7-15. Inflation is figured at five percent/year.

YEAR	Number of OC cycles	Unit Price	Total Price US $
1	455,000	0.1470	66,885
2	819,000	0.1543	136,692
3	1,183,000	0.1620	191,646
4	1,547,000	0.1701	263,145
5	2,275,000	0.1786	406,315
6	2,912,000	0.1876	546,291
7	3,640,000	0.1970	717,080
8	4,641,000	0.2068	959,759
		OC TOTAL	$ 3,287,813

2. Condoms

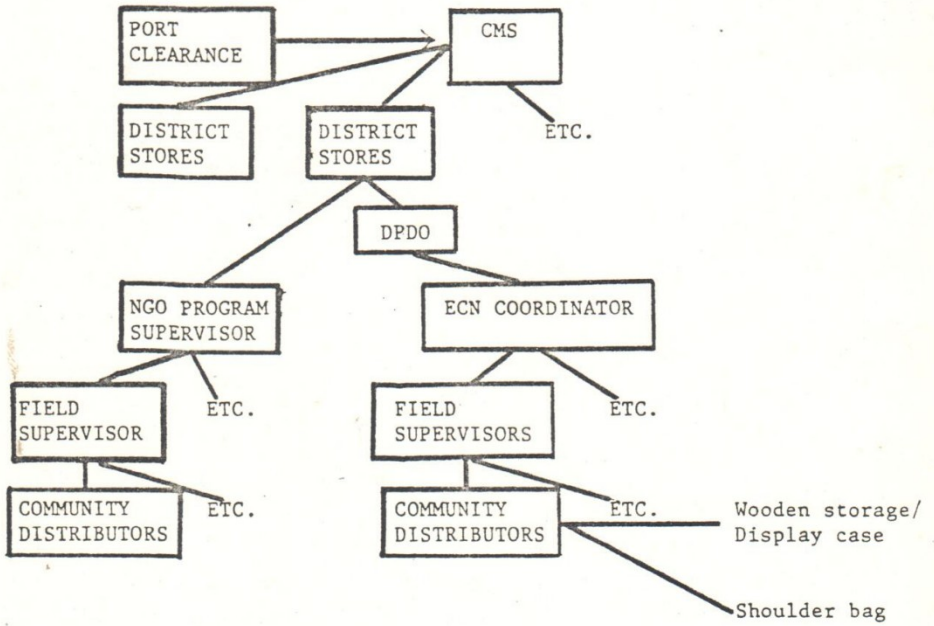
YEAR	Number of Units (000)	Unit Price US $	Total Price US $
1	1,250	0.046	57,500
2	2,250	0.049	110,250
3	3,250	0.051	165,750
4	4,250	0.054	229,500
5	6,250	0.056	350,000
6	8,000	0.059	472,000
7	10,000	0.062	620,000
8	12,750	0.065	828,750
		TOTAL CONDOM	$2,833,750

3. Foaming Tablets

YEAR	Number of Units (000)	Unit Price US $	Total Price US $
1	1,250	0.084	105,000
2	2,250	0.088	198,000
3	3,250	0.093	302,250
4	4,250	0.097	412,250
5	6,250	0.100	625,000
6	8,000	0.107	856,000
7	10,000	0.113	1,130,000
8	12,750	0.118	1,504,500
		TOTAL FOAMING TABLETS	$ 5,133,000

ANNEX 7-17

MODEL DESIGN FOR LOGISTIC PLAN FOR THE NATIONAL CBD PROGRAM



ANNEX 7-18

WAREHOUSE MAINTENANCE AND SPACE REQUIREMENTS

As noted in Section 7.7.1., the Central Medical Stores is a well organized warehouse operating under adequate conditions with good management. However, it was felt that the district warehouses will need some improvements to be able to respond to the needs of the national CBD program. The following recommendations are oriented towards the districts warehouse, but the principles outlined here are equally applicable to storage facilities in NGO's or at the Divisional level.

1. Physical Space

To determine the amount of warehouse floor space needed, several factors must be considered:

a. warehouse space is measured in terms of square feet of useable floor space.

b. good storage practice for contraceptive supplies packed in cardboard shipping cartons requires that stacks of cartons be no higher than 8 feet (2.5 meters).

c. net storage space must be increased by approximately 50 percent for handling.

d. the storage space selected must be able to accommodate expansion over time. Therefore, the calculations suggested here are based on estimated demand by 1993.

A case of oral contraceptives containing 1200 cycles measures 1 cubic foot. A case of condoms containing 6,000 units measures 3.8 cubic feet. A similar space is required for an equal amount of foaming tablets.

Based on the projections included in Annex 7-15, approximately 4.6 million oral contraceptive cycles and 12.8 million condoms and 12.8 million foaming tablets/year will be distributed through CBD programs by 1993. This will average approximately 112,000 pill cycles, 312,000 condoms, and 312,000 foaming tablets/district /year. However, we estimate that CBD programs will represent approximately one-third of the total contraceptive use. Since District warehouses will serve all FP program, the total demand on them by 1993 will average 336,000 pill cycles, 936,000 condoms and 936,000 foaming tablets/year.

Using the space requirements presented above, 280 cubic feet will be required for oral contraceptives; 590 cubic feet for condoms; and 590 cubic feet for foaming tablets for storage space. The total amount of storage space, 1460 cubic feet, must be multiplied by 1.5 for handling space, for a total of approximately 2200 cubic feet of space required for contraceptives in an average district. Since boxes may be stacked 8 feet high, the amount of square feet of storage space required will be 2200/8 or 275 square feet. This is equivalent to a room measuring approximately 14 feet by 20 feet if the maximum amount to be

stored in a district warehouse will be one year's supply (see discussion in Annex 7-19 on inventory management for recommendations in this regard).

Therefore, it is recommended that district warehouses establish a separate room or area for contraceptives only that measures 14 x 20 feet. This should allow for rapid expansion as demand grows, even though initially all this space may not be utilized. This space must be clean, dry, well ventilated and protected from the elements.

2. Warehouse Organization

It is appropriate to use boxes stacked on pallets for bulk storage, but one section of the CBD storage room should have shelves available for open stock that has been broken out of bulk containers or for unused items returned for redistribution. Shelves should be numbered and contents of each clearly marked. Either bin cards or Form S3 should be immediately available to record receipts and issues. A common warehousing mistake is to keep ledger cards in an office, with the result that the warehouse or stock clerk may forget how much was dispensed or received by the time it is recorded. This obviously leads to discrepancies between stock records and physical inventories. Having bin cards or ledger forms immediately available in the storeroom also allows the store clerk to rapidly complete physical inventories during the course of receiving or issuing supplies and thus detect discrepancies early.

A second issue involves implementation of the first-in/first-out (FIFO) system. Although practiced at the CMS, this system does not appear to operate at the district level. The simplest way to do this is for the CMS to write on the outside of the boxes which they ship to district warehouses the date of manufacture in large black letters. This information can be derived by personnel at the CMS using the coded lot number. Boxes are then stacked according to date of manufacture, i.e. those expiring sooner are stacked in front for early usage. Under tropical conditions, the shelf life of orals and condoms is approximately five years, so dates of manufacture give a rough estimate of expiration dates.

A second method will be available if the program adopts the recommendation to stamp expiration dates on each cycle and packing box. This will allow use of the FIFO system on open stocks placed on shelves at all levels of the system, as well as the bulk containers at central and district levels.

The attached figures graphically illustrates a model warehouse for contraceptive supplies. The second attachment presents guidelines that are used in Bangladesh for contraceptive storage.

FOOTNOTE: A complete description of the principles of warehousing is included in Chapter IV.2 of the manual Managing Drug Supply. This manual was developed by Management Sciences for Health but has been adopted by WHO/PAHO as their official training manual for the essential medication program. Many of the principles are also found in the Center For Disease Control Logistics Guidelines for Family Planning Programs. Both documents can be obtained from the original sources or from The Pathfinder Fund in Nairobi or Chestnut Hill, Massachusetts, U.S.A.

Storage Guidelines Used in Bangladesh

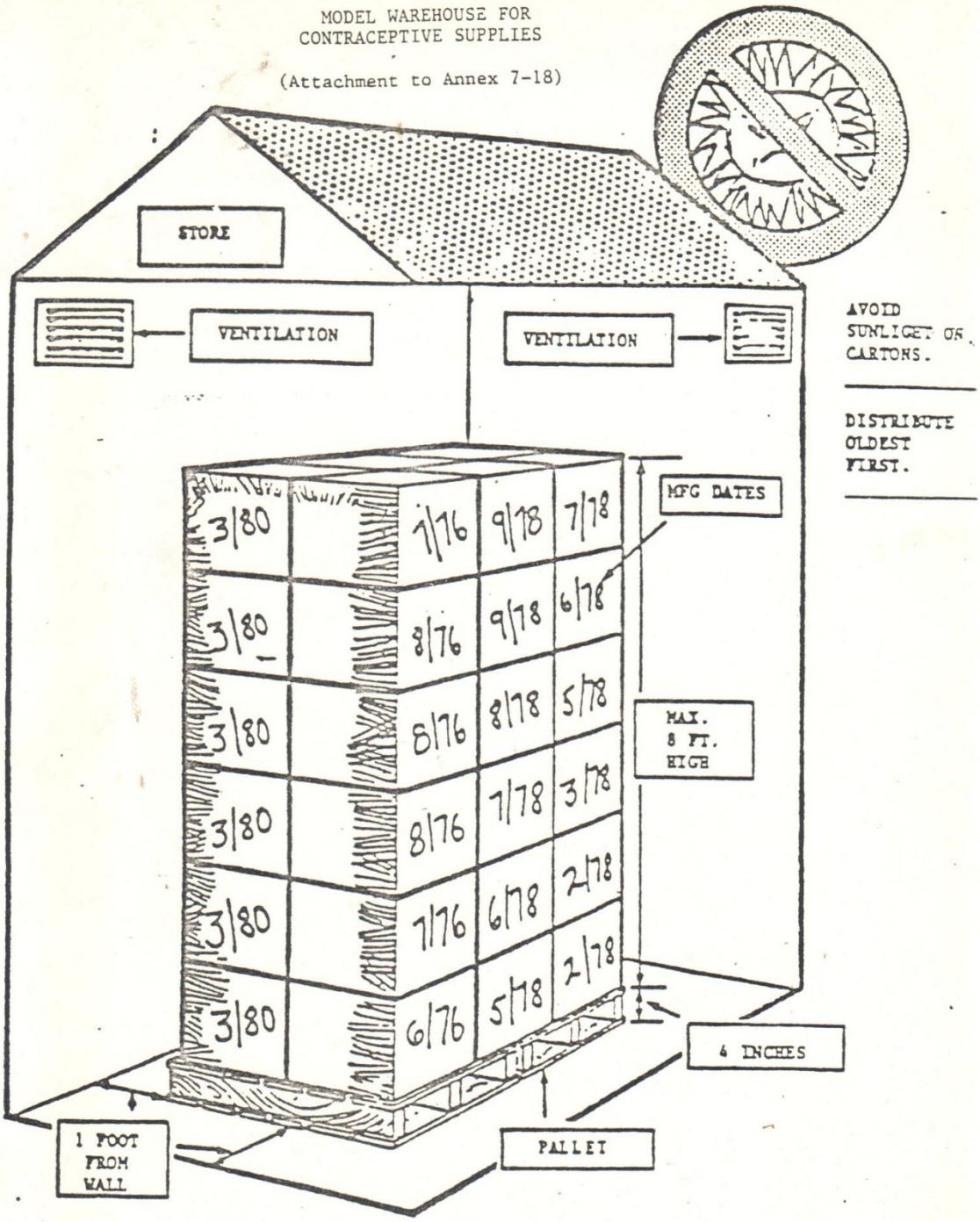
(ATTACHMENT FOR ANNEX 7-18)

GUIDELINES FOR PROPER STORAGE

1. Clean room and white wash walls.
2. Check roof for water leakages.
3. No direct sunlight on the supplies.
4. Storeroom not subject to water penetration.
5. Supplies to be stacked at least 4" (10 cm) from floor (Arrange dunnage of wood or steel).
6. Supplies to be stacked at least 1' ft (35 cm) from any wall.
7. Separate stacks accessible for "First In First Out"" (FIFO), counting and general management.
8. Stacks not more that 8'ft. high (2.5. m).
9. Identification marks and other labels visible.
10. Issue supplies by carton or box lot if possible.
11. Well ventilated.
12. Well lighted.
13. Fire extinguishers not blocked.
14. Vaccines and sera must be stored in refrigerator.
15. Old files, information material, offices supplies etc. should be stored separately.
16. Insecticides and other chemicals not to be stored together with contraceptives and medical supplies.
17. The storeroom to be disinfected and sprayed against insects every third month.
18. Damaged and condemned supplies to be separated and disposed of without delay.
19. Store keys must be available at all times.
20. Daily cleaning of store room.

MODEL WAREHOUSE FOR
CONTRACEPTIVE SUPPLIES

(Attachment to Annex 7-18)



ANNEX 7-19

INVENTORY MANAGEMENT PROCEDURES

The attached figure (Figure 1) shows the ideal inventory model (taken from Chapter IV.B of Managing Drug Supply*). The stock of contraceptives on hand will consist of two components--the working stock and the safety stock. The working stock represents the stock which is used to satisfy demand between deliveries, and will vary from zero to the order quantity (Q). Safety stock (S), also called reserve stock, buffer stock or fluctuation stock, exists to protect against stock-outs which would otherwise occur when deliveries are delayed for any reason or the working stock is consumed at an unexpectedly high rate. The safety stock will be critically important as the CBD program expands, since initially it will be difficult to predict how rapidly demand for contraceptives will expand.

In the ideal model, drugs are issued in response to demand and the stock on hand steadily declines until the point is reached where an order must be placed. Following the lead time for procurement, the quantity ordered (Q) is received and the inventory level returns to its maximum starting point (Q+S). From this figure it is clear that the average working stock is 1/2 the order quantity.

Average Working Stock = 1/2 Q.

The average inventory (I) or average stock on hand is the safety stock plus the average working stock.

$$I = S + 1/2\ Q$$

In this ideal model, it is desirable to maintain inventory holding costs at a minimum by keeping working stock stable and reducing safety stock. However, the national CBD program will deviate significantly from the ideal model. With national mobilization and political support, the program could expand quite rapidly. If stock outs occur because of poor inventory planning, the most negative effects will be felt at the community level. Women who enthusiastically endorse family planning services initially may quickly become disillusioned if a resupply of contraceptives is not rapidly available. Once disillusioned, they will prove very difficult if not impossible to recruit back into the program. Therefore, the model for CBD must take into account the need to maintain adequate stocks at all levels in the face of rapidly expanding demand of an unknown magnitude. This requires maintaining high levels of safety stock initially until the demand becomes more stable. This will mean maintaining a higher level of average stock on hand (I) than would normally seem justified.

The second figure attached (Figure 2) shows the impact of order interval on average inventory. One can readily appreciate that more frequent order intervals allow the system to maintain lower stock levels. This is possible when the procurement cycle is well controlled, e.g., when the contraceptives are already in country or in the CMS. If a major part of the procurement cycle is outside of control of the program, e.g., manufacturing, packaging, shipping, and importation, then the order interval needs to be longer, and the inventory of stock on hand must be high.

Following these principles, the following recommendations are made for CBD stock levels:

LOCATION	STOCK LEVELS	DELIVERY FREQUENCY
CMS	1 yr. average working stock 1 yr. safety stock	Every year
District Stores	6 mo. average working stock 6 mo. safety stock	Every 6 months
Divisional Coordinator or NGO Program	3 mo. average working stock 3 mo. safety stock	Every 3 months
CBD Distributor	2 - 4 mo. stock	Every 2 months

In this model, the largest stocks will be held at the central and district warehouses. Relatively smaller stocks will be held by the ECN Coordinator and lower levels. This will require frequent supervision, delivery of supplies, and adjustment of inventory at the service levels as needed. This model will allow maximum flexibility to demands at the local level while assuring sufficient stock at higher levels to respond to the demand.

*FOOTNOTE: Managing Drug Supply was developed by Management Sciences for Health and can be obtained directly from them or from The Pathfinder Fund in Nairobi or Chestnut Hill, Massachusetts, U.S.A.

FIGURE 1

(Attached to Annex 7-19)

Ideal Inventory Model

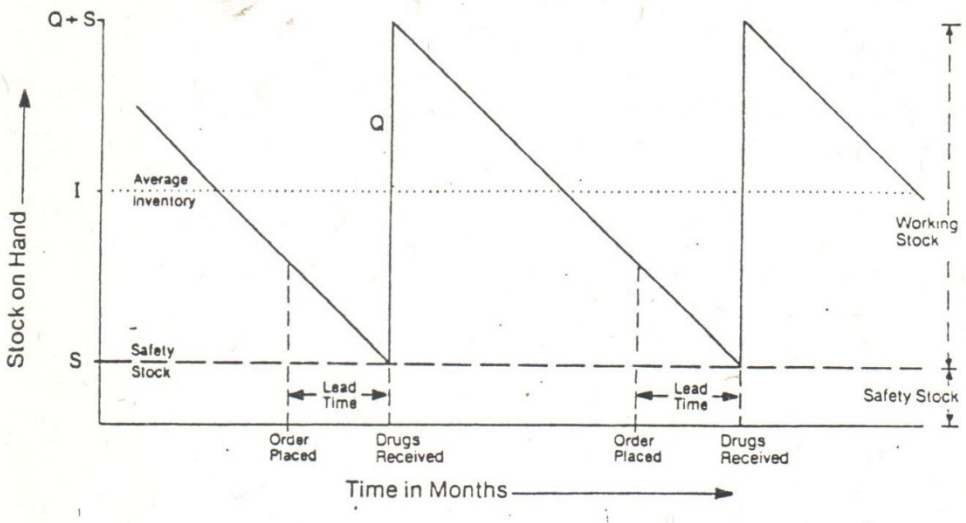
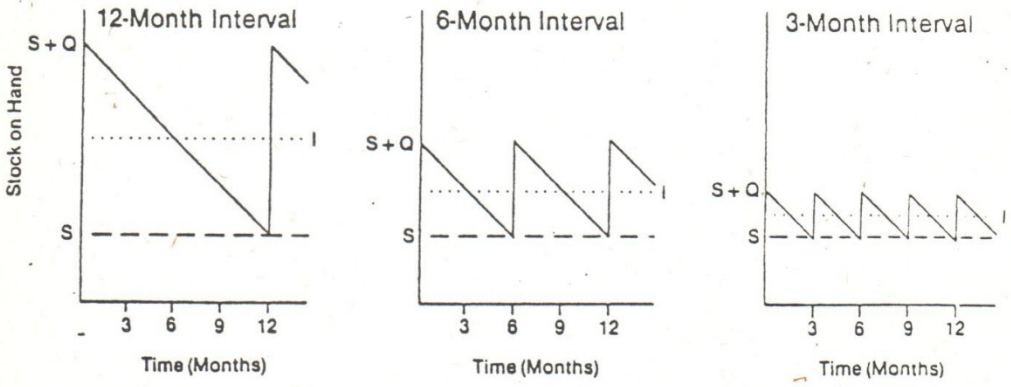


FIGURE 2

(Attached to Annex 7-19)

Impact of Order Interval on Average Inventory



Key: I = Average Inventory Q = Order Quantity S = Safety Stock