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A COMPREHENSIVE EVALUATION
OF THE REGIONAL PROGRAMS
OF THE PATHFINDER FUND

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EXECUTIVE SUMMARY

An evaluation team composed of Cyril Crocker, Susan Goodwillie, Sallie Craig Huber, Keekee Minor, and Deirdre Strachan was recruited by the American Public Health Association to undertake a comprehensive evaluation of the Agency for International Development grant to the Pathfinder Fund (AID/pha-G-1138). The fundamental purpose of the evaluation was to assess Pathfinder's program, to identify successes that should be commended and replicated, and to note any deficiencies that should be corrected.

The Terms of Reference for the evaluation elaborated the fundamental purpose and identified the following specific areas for team observation and assessment:

- Pathfinder's top management and Board of Directors;
- the two new divisions--Women's Programs and Population Policy--in the organization;
- Pathfinder's performance in remaining on the "cutting edge" of innovation in family planning;
- Pathfinder's commodity support system, especially in Latin America;
- the organization's Africa program--its current activities and potential for the future;
- Pathfinder's field structure and staffing pattern; and
- the future of Pathfinder-supported activities following the withdrawal of Pathfinder funding.

The Terms of Reference was used by the team to develop the frameworks for the general and country evaluations (see Appendices A and B), which were the working documents for the report on the evaluation. The two items listed in the Terms of Reference were to be evaluated from a regional perspective: Pathfinder's commodity support system, especially its system in Latin America, and the Africa program. The details of specific recommendations on these two subjects are provided in the regional reports in Part II. They are also summarized in Chapter II, Part I, "Recommendations".

The team had briefings in Washington and Boston on October 27-31. The members then dispersed to the field to visit the country and regional offices of Pathfinder and its projects in Nigeria, Kenya, Zaire, Brazil, Peru, Colombia, Guatemala, Indonesia, Bangladesh, and Egypt. The visits were made on November 2-22. A draft evaluation report was prepared for discussion with Pathfinder staff in Boston on December 12. A debriefing was held in Washington on December 17.

In general, the team concluded that the Pathfinder Fund is using the AID grant wisely and effectively. Specific projects are innovative, evidence of the pioneering spirit for which the Pathfinder Fund has long been known. The team observed no major insurmountable problems in the field.

The team's general recommendations (see Chapter II, Part I) are applicable to Pathfinder's overall program. Recommendations or suggestions specific to a region, country, or project are given in the individual regional reports (see Part II). Separate reports were submitted by the members of the team after they investigated Pathfinder's work in the different regions.

ABBREVIATIONS

ADIFAM	Private Family Planning Organization
AFPA	Alexandria (Egypt) Family Planning Association
AID	Agency for International Development
ALAFARPE	National Association of Pharmaceutical Laboratories
APHA	American Public Health Association
APROFAM	Affiliate of IPPF
AVS	Association for Voluntary Sterilization
BENFAM	Affiliate of IPPF
BKKBN	National Family Coordinating Board
CACEX	Agency of the Government of Brazil
CBD	Community-Based Distribution
CBS	Central Bureau of Statistics
CDCZ	Community of the Disciples of Christ in Zaire
CEFPA	Centre for Population Activities
CMI	Centro Medio Indianapolis
CNND	National Committee for Desired Births
CRS	Commercial Retail Sales
DPH	Doctorate in Public Health
ECZ	Church of Christ of Zaire
FLE	Family Life Education
FP	Family Planning
FPAK	Family Planning Association of Kenya
FPIA	Family Planning International Assistance
FWVTI	Family Visitors Training Institute

GSA	General Services Administration
IBRD	International Bank for Reconstruction and Development
ICARPAL	Committee on Applied Research in Population
IEC	Information, Education, Communication
IPAVS	International Project Association for Voluntary Sterilization
IPPA	Indonesian Planned Parenthood Association
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KFS	Kenya Fertility Survey
KNH	Kenyatta National Hospital
LDC	Less Developed Country
LNA	Letter of Notification of Award
MCH	Maternal Child Health
MCI	Movimiento Campesino Independiente
MOH	Ministry of Health
MPH	Masters in Public Health
MYWO	Maendelo Ya Wanawke Organization
NGO	Non-Governmental Organization
NPC	National Population Commission
OB/GYN	Obstetrics/Gynecology
PHC	Primary Health Care
PHN	Public Health Nurse
POP	Population
PPFN	Planned Parenthood Federation of Nigeria
PVO	Private Voluntary Organization

TBA	Traditional Birth Attendant
UNAZA	University of Zaire
UBTH	University of Benin Teaching Hospital
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNTHE	University of Nigeria Teaching Hospital at Enugu
VD	Venereal Disease
VTPF	Vocational Training and Productive Families
ZPRA	Zaire Protestant Relief Agency

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I. INTRODUCTION AND BACKGROUND

The Pathfinder Fund is a public, non-political, non-profit foundation. Incorporated in the District of Columbia, it has its headquarters in Boston, Massachusetts, and international offices in Bogota, Colombia; Santiago, Chile; Salvador, Brazil; Geneva, Switzerland; Dacca, Bangladesh; Cairo, Egypt; Jakarta, Indonesia; and Nairobi, Kenya.

Pathfinder promotes and supports population and family planning activities in less developed countries (LDCs). Depending on the project, support usually is provided for one to three years. Rather than supplying outside experts for a project, Pathfinder generally assists the nationals of the country where the project is located. The organization is well known for its willingness to take the risks required to promote or explore a particularly creative idea, to invest in able, energetic people who can bring new ideas to the population field, and to be flexible in responding quickly to new opportunities and situations.

The United States Agency for International Development (AID) began providing assistance to the Pathfinder Fund in 1968. A firm, collaborative relationship has since developed between the two institutions, as is illustrated by the progressively increasing amounts of AID grant funds that were provided in the 1970s.

Pathfinder's project development activities overseas have increased correspondingly. Having given its tentative approval for one year, and following a favorable evaluation in 1978, AID awarded the remaining four years of a five-year grant (1978-1982).

On behalf of AID, the American Public Health Association (APHA) requested a second evaluation of the Pathfinder Fund grant (AID/pha-G-1138) to determine how well the organization is fulfilling the terms of the grant and how much progress has been made since the last evaluation. The fundamental purpose of the evaluation was to assess Pathfinder's program, to identify successes that should be commended and replicated, and to note any deficiencies that should be corrected.

Terms of Reference

AID's Terms of Reference for the evaluation required an assessment of:

1. Changes to and improvements in the top management structure of Pathfinder and the composition of the Board of Directors.

2. Progress in and implications of establishing two new divisions--Women's Programs and Population Policy (recommended by the New Paths Committee in 1976 and implemented in 1978).
3. Performance of Pathfinder in attempting to remain on the "cutting edge" of innovation in family planning and population rather than serving purely as a source of funds to maintain project activities abroad.
4. Effectiveness (responsiveness and accountability) of Pathfinder's commodity support system in providing contraceptives, medical kits, audiovisual equipment, etc., particularly in Latin America.
5. Pathfinder's program of ongoing projects in Africa and, more important, its technical, administrative, and financial capacity to pursue a substantial number of new initiatives in the region and perhaps to become the principal family planning service-oriented private voluntary organization (PVO) operating in Africa.
6. Adequacy and competence of current field representatives and the need for additional field staff, especially in "select emphasis" countries and areas such as Turkey, Peru, and West Africa.
7. Ability of sub-grantees (recipients of Pathfinder grants in LDCs) to become self-sufficient, to locate another source of funding, or to absorb Pathfinder-subsidized activities into their routine programs after Pathfinder assistance has been terminated.

The evaluation team used the Terms of Reference to design a framework for the general evaluation and for the evaluations of programs in various countries (see Appendices A and B).

Composition of Team and Itinerary

The evaluation team included Sallie Craig Huber (team leader), Cyril Crocker, Susan Goodwillie, Keekee Minor, and Deirdre Strachan.

Briefings with APHA and AID staff were held in October 27 and 28 in Washington. The next three days, October 29-31, were spent at the organization's headquarters in Boston, where the team received thorough briefings from Pathfinder staff. The team then dispersed, Minor and

Strachan to Brazil, Peru, Colombia, and Guatemala; Crocker and Goodwillie to Nigeria, Kenya, and Zaire; Huber, accompanied by Robert Haladay, grant manager, to Indonesia, Bangladesh, and Egypt. The three groups examined specific Pathfinder projects in each country.

The team reassembled in Washington for three days (November 24-26) to draft a report. The report was presented to Pathfinder for review before the team's debriefing in Boston on December 12. A debriefing was held at AID/Washington on December 17.

II. RECOMMENDATIONS

Policy

A. Board

1. Third World representation on the Board of Directors is recommended to give the Board a broader perspective and to enhance Pathfinder's credibility in other countries.
2. As positions on the Board become vacant, preference should be given to women with interest and experience in women's programs.
3. Fundraising is and should continue to be a primary role of the Board.

B. Project Development Strategy

4. At the annual meeting there should be a thorough discussion and review of the priorities for program areas in each region and of the criteria for selecting projects within each program.
5. To better support field staff while developing women's projects that have an income-generation component, the Women's Division should employ an additional staff member with expertise in management, business, or economics.

Pathfinder Management

A. Boston Organization

6. Within six weeks of the acceptance of this evaluation by AID, the roles of the chairperson, executive director, and associate director should be clarified, specified in writing, and communicated to all staff in Boston and the field.

7. Within two months of the acceptance of this evaluation by AID, Pathfinder should have complete job descriptions for all staff and an organizational chart that shows clear lines of authority and communication.
8. The responsibilities of and relationships between the functional and regional divisions should be clearly delineated. The Regional Division should bear primary responsibility for the management of operations. The Functional Division should provide technical support to the Regional Division and to field staff.
9. The Evaluation Unit should become a separate entity with a support function and should report directly to the associate executive director.

B. Field Organization

10. The field staff should have greater responsibility and authority for all phases of project development, implementation, and evaluation.
11. In "special-emphasis" countries or regions and in areas where large numbers of projects are operating, Pathfinder should consider relocating existing staff or placing additional field staff. The team recommends that a resident contact person be appointed in Nigeria and that the South American regional office be relocated to Peru.
12. Field staff should receive in-service training and participate in exchange visits.
13. A system for evaluating the performance of field staff should be instituted.
14. Management training should be provided to all field staff and to sub-grantees whenever feasible.

Project Management

15. Field staff should participate actively in the effort to redesign the project review and selection process.
16. Proposals should include realistic, time-phased workplans for implementing and evaluating projects.

17. The starting dates for projects should be set by sub-grantees, in consultation with field staff, after project funds have cleared the bank. If projects depend on commodities, project activities should not begin until the commodities have been received.
18. After a project starts, field staff should schedule a site visit within two months to assist sub-grantees with project management, including the use of report forms.
19. Evaluation criteria should be established in the field by representatives and sub-grantees at the time of project development. Boston staff should provide any required technical assistance.
20. Field staff should be given authority to make changes, up to a specified limit (e.g., 25 percent), in line-items in approved budgets without having to refer to Boston for approval.
21. To improve the commodity support system in Latin America, it is suggested that country and regional representatives become more knowledgeable about the process of importation and keep up to date on changes. Also, wherever possible and legal, shipping documents should be written in the local language.
22. It is recommended that additional financial and human resources be allocated to the Africa program to enable Pathfinder to respond to opportunities to pursue new and expanded program initiatives. Pathfinder should not, however, be encouraged to become the principal PVO providing family planning services in Africa.

III. OBSERVATIONS AND FINDINGS

Policy

A. Board

This evaluation of the Pathfinder Fund included an examination of the composition and functions of the Board of Directors. It is the opinion of the evaluation team that the Board is well balanced, with adequate representation by family planning professionals and members of the Gamble family. Although in the past there has been concern about the involvement of the Gamble family, this no longer seems to be a problem. The family is active on the Board, and its participation is considered to be useful.

The evaluation team recommends the appointment of a Third World representative to the Board in order to broaden the Board's perspective and to enhance Pathfinder's credibility in other countries (RECOMMENDATION 1). The need for such expanded representation is exemplified in the Nairobi office. The team was told that, under Kenyan law, to receive status as an international organization, an organization must have international representation on its Board of Directors. In Kenya, Pathfinder must qualify as an international organization to receive and clear duty-free commodities.

In support of the new Women's Division, the evaluation team recommends that, as positions on the Board become vacant, women with interest and experience in Women's programs be appointed (RECOMMENDATION 2).

Staff develop the organization's policy and the Board either supports or reacts to it. A primary function of the Board should be to raise funds for the organization (RECOMMENDATION 3). In light of recent cuts in funding, this function is of critical importance. The Board is to be commended for electing and using a professional treasurer.

Since the 1978 evaluation, the role of the chairperson had been more clearly defined. Primarily a fundraiser for the organization, the chairperson also is an adviser to the new executive director in the field of family planning and a general sounding board on organizational and program development.

Efforts have been made to educate Board members about project activities through workshops and other activities at the time of Board meetings. These efforts, and efforts to provide more opportunities for Board members to interact with field staff, should be continued. Board members' visits to the field are considered by some field staff to be

useful, but others find them burdensome. Field visits by Board members should be coordinated with field staff in advance so that they will be constructive.

B. Project Development Strategy

An assessment of the project development strategy of the Pathfinder Fund included appraisals of the countries' and projects' processes for setting priorities and an evaluation of the implementation and implications of the organization's "New Paths" activities. Country priorities have been set well in all regions and have been adequately communicated to field staff. Pathfinder would like to phase out activities in Colombia so that it can move on to countries which it has established as higher priority countries. However, because Pathfinder can undertake some project activities which AID cannot conduct, the organization is being urged by AID to remain in Colombia.

In Asia, Pathfinder is working in countries with supportive national family planning programs. For this reason, its pioneering projects in that region have a slightly different focus than its projects in other regions. Pathfinder's projects in Asia seem to be filling the gaps in government programs, often left at the request of the government, but unlike projects in other regions, they are not demonstration projects that are out in front of government efforts.

Although priorities for the countries are clear, field staff are confused about how Pathfinder establishes criteria for selecting and giving priority to projects. This confusion was apparent during the teams' field visits. Some Latin American staff do not understand why one type of approach (e.g., integrated maternal-child health/family planning (MCH/FP) projects) is approved for another region, say, Africa, but not for their own region. In Latin America, one field representative suggested that the project approval process include a ranking or rating scale standardized for all countries. In Africa, staff do not believe that AID or Boston ever turns down projects without good reason. In Asia, field staff have considerable freedom to set priorities for projects in their countries in close consultation with the leaders of national family planning programs. Field staff need to understand better the organization's priorities for project activities. At the annual meeting, there should be a thorough discussion and review of the priorities for program areas in each region and of the criteria for selecting projects within each (RECOMMENDATION 4).

In spite of the confusion over project priorities, most of the projects are innovative and responsive to their particular settings. Reliance on indigenous field staff is the most significant factor in designing projects that are realistic and responsive to the cultural setting in which they are located. Pathfinder is to be commended for its use of indigenous field staff.

In addition to being economical, this policy also ensures the development of professional family planning leaders at the national level. AID population officers strongly support Pathfinder's use of indigenous field staff. One officer indicated that he uses Pathfinder field staff not only as a sounding board, but also as a resource for handling politically and culturally sensitive issues. Another stated, "We don't have to spend so much time with Pathfinder field staff since they know much better than we do what will and will not work in their own setting."

The Terms of Reference included a question about Pathfinder's ability to carry out AID population grant activities in light of additions of non-population AID grants to the organization's total budget. The diversification of Pathfinder's funding sources does not seem to have had an effect on the organization's capacity to operate. The evaluation team strongly endorses and encourages continued diversification of an expanded funding base for Pathfinder, including increased efforts in private fundraising. In addition, Pathfinder should explore other AID sources, (e.g., Operational Program Grants, Bureau of Program and Policy Coordination).

In 1976, the New Paths Committee, made up of selected Board members and outside consultants, recommended the formation of two new divisions-- Women's Programs and Population Policy--to complement the long-standing Fertility Services Division. These divisions became operational after the last evaluation in 1978. Their activities were an important focus of the present evaluation.

Although the Population Policy Division is the newer of the two divisions, the team was able to discuss its planned activities in the field and in Boston. As the final guidelines of the division are not operational, the field staff could give few responses to questions about the division's plans for a program. Because policy is a sensitive issue, Boston staff should depend on field staff for major inputs to program development in this area.

The team commends the way the Population Policy Division now operates, providing support and advice to the regional divisions and field staff. Before the Policy Division proceeds in developing its guidelines and implementing projects, the chief of the division should visit the field.

Another important role for the Population Policy Division is to provide researchers and policymakers with comparative data that show how Pathfinder-funded projects lead to changes in national policies.

The policy implications of Pathfinder projects should be an important consideration in an evaluation of a project's impact.

The Women's Programs Division has been operational for about two years. Integrated women's projects funded from population grant monies have taken too much time, money, and effort to design. A major problem has been AID's insistence that all integrated family planning and women's projects include a research component to demonstrate impact. Although the importance of evaluating the impact of women's programs is recognized, Pathfinder's comparative strength is as an innovative service-oriented agency. It is thus somewhat unrealistic for AID to expect Pathfinder to develop and carry out rigorous research within these projects.

During the field visits, the team noted the mixed reactions to the concept of integrated family planning and women's projects. Staff of the regional office in Africa are supportive of women's programs, recognizing that family planning will succeed only if it is integrated into programs and addresses the more basic issues of food, housing, health, and income-generation--the fundamental concerns of women in Africa.

In Latin America, women's projects have been developed primarily by outside consultants or by Boston staff who have visited the field. Consequently, field staff in Latin America do not feel they have made a basic investment in or commitment to these projects. Because the approach to the development of women's projects in Latin America had been atypical, a realistic compromise might be the placement of an indigenous field staff member in Latin America to assist with the development of field projects. The evaluation team suggests that Pathfinder use more local technical assistance in all women's projects. An example of the successful use of local talent is found in Guatemala. The local AID mission requires that all women-in-development projects match by 20 percent the grants provided by local institutions. This ensures the availability of essential technical assistance.

To better support field staff in the development of women's projects that have an income-generation component, the Women's Programs Division should employ an additional staff member with expertise in management, business, or economics (RECOMMENDATION 5). Pathfinder recently received a Women-in-Development Grant from the PPC. Undoubtedly, the new staff person will serve both the new grant and the Population Grant. Therefore, funding for the new staff position might be obtained from either grant, or both.

Another issue in the Terms of Reference is what kind of organization Pathfinder wants to be in five years. Pathfinder continues to respond to the needs of the moment to fill the gaps in family planning activities in the countries where it works. To encourage long-term planning or a more highly structured focus would hinder Pathfinder's ability to respond rapidly to innovative new initiatives. However, Pathfinder needs to continue to set regional and country priorities in order to plan adequate resource allocations. The "New Paths" initiatives are laudable and will be strengthened, it is hoped, over time. In a few years Pathfinder may wish to re-examine progress in these areas and to redirect efforts if necessary.

Pathfinder Management

A. Boston Organization

Since the 1978 evaluation, the Pathfinder Fund has made progress in defining staff and Board functions. In particular, the chairperson and the new executive director have sorted out responsibilities. A healthier atmosphere now exists. The evaluation team commends the organization for these efforts, but notes that two issues cited in the last evaluation remain to be addressed. First, the roles of the top three management positions must be clearly defined and communicated to all staff. Depending on the particular expertise of each person, among other responsibilities, the chairperson should coordinate fundraising; the executive director should be responsible for final project and program decisions, referee staff differences, and coordinate with other donors; and the associate executive director should manage the daily operations of the organization. It is recommended that within six weeks of the acceptance of this evaluation by AID, the roles of the chairperson, executive director, and associate executive director be clarified, specified in writing, and communicated to all staff in Boston and the field (RECOMMENDATION 6).

The second issue to be addressed is the need for clarified staff roles and lines of authority. Within two months of the acceptance of this evaluation by AID, Pathfinder should develop complete job descriptions for all staff and an organizational chart that indicates clear lines of authority and communication (RECOMMENDATION 7).

A third issue which has arisen since the last evaluation is the relationship between the functional and regional divisions. The Regional Division should bear primary responsibility for the management of operations; the Functional Division should provide support to the Regional Division and to field staff (RECOMMENDATION 8). This action is urgently required to resolve the conflicts and confusion that are affecting the organization's ability to function efficiently and effectively.

Field staff and sub-grantees are experiencing difficulties with the project evaluation process as it now operates at headquarters. Program evaluation staff should assist, train, and teach field staff to develop evaluation criteria. Evaluation staff should not have an operational role. It is recommended that the Evaluation Unit become a separate entity with a support function and that it report directly to the associate executive director (RECOMMENDATION 9).

Boston staff recently instituted a process for staff evaluation. This effort is to be commended. The process should be refined and its use continued.

Coordination with donors and AID is a crucial activity for the top management, especially in light of recent cuts in funding for centrally-funded population grantees. Although AID should be the ultimate central coordinator of AID-funded donors, this is not always the case, and gaps in communication do occur. Pathfinder should, therefore, make coordination a prime concern. Continuous coordination should be the primary role of the executive director, but the staff of the functional and regional divisions also should be in touch with their counterparts in other donor agencies. Staff generally keep AID/Washington and the missions well informed of their activities. It would be useful for AID population officers to be briefed by Pathfinder staff, both in Boston and in the field, before taking assignments in countries where Pathfinder has programs.

B. Field Organization

Pathfinder's use of indigenous field staff to assist with the implementation of field projects is commendable. However, field staff should have greater responsibility and authority for all phases of project development, implementation, and evaluation (RECOMMENDATION 10). For example, evaluation and monitoring systems are now designed in Boston. They should be designed in the field by field staff and developed with sub-grantees to ensure their relevance to project activities. For the design of the project evaluation, Boston staff should provide primarily the information required for accountability to AID and to make decisions about renewals. Pathfinder staff in Boston must make the roles and responsibilities, as well as the particular authority of field staff, absolutely clear to sub-grantees when project awards are made. Some sub-grantees are confused about the roles of field staff and the lines of communication with Boston.

The importance of placing field staff in "emphasis" countries or regions is clear. However, these staff placements should be reviewed continuously. In line with this policy, the team recommends that a resident contact person be appointed in Nigeria and that the regional office in South America be relocated to Peru (RECOMMENDATION 11).

Several specific suggestions about the roles of field staff evolved directly from field visits. Field staff need to be more involved in assisting sub-grantees early in project design and implementation. Field staff should monitor more closely the receipt, clearance, and use of commodities. Because a new and important role in each region is the development of women's programs, the evaluation team examined this activity during its field visits. In Africa and Asia, field staff generally seem to have adequate skills to undertake this new activity. In Latin America, Pathfinder might consider employing a field representative to develop women's projects.

Relationships between the Boston headquarters and field staff appear to be excellent. In most cases, field staff indicated that they communicate with Boston through regional directors, but they are confused as to whom

they are to report on major issues. These lines of authority should be specified as part of the organization's effort to clarify reporting relations.

To better understand and to have a better overview of Pathfinder's operations, field staff should receive in-service training and participate in exchange visits (RECOMMENDATION 12). Some field staff seem to be unaware of the opportunity to visit Boston a second time each year. The evaluation team endorses this policy that allows individual field representatives to visit Boston twice a year and it urges that all field staff be made aware of it. Field staff consider the annual group meeting in Boston to be useful, but they suggest that the meeting be shortened to one week and that more individual meetings and fewer large group meetings be scheduled. Of the two types of visits to Boston, the individual visits are considered by field staff to be the more useful.

The team also recommends the institution of a system for evaluating the performance of field staff (RECOMMENDATION 13). The process might be designed along lines similar to the process for evaluating Boston staff. The evaluations could be made during the annual field staff meeting in Boston.

The feelings of field staff about visits to the field by Boston staff are mixed. Latin American staff feel that too few visits are made. Asian staff think they receive too many visitors. African staff welcome and appreciate all visitors. In all regions, the same number of field visits should be made by the staff of the Technical Division. There should be set agendas for all field visits and these should be communicated to field staff well in advance of the visits. All field staff seem to welcome the visits of Regional Division staff, recognizing that their first-hand knowledge of projects ensures better support from Boston when projects are considered for refunding. Several have suggested that joint visits by regional and technical staff would be useful.

The field staff commented that most materials and communications from Boston are helpful. They find that status reports and short project descriptions are useful and a good means for exchanging ideas. They do not consider the exchange of trip reports outside their region of responsibility to be useful and they seldom read such reports. Boston might consider halting this particular exchange, except in specific instances.

In-country coordination between Pathfinder field staff and local AID missions is generally good. The presence of AID population officers makes a big difference in coordination efforts. Ideas for projects are usually discussed with AID mission staff early in the project development process, and the missions report that they are kept abreast of project activities as they develop. Coordination with other donors working in the same countries appears to be a more random activity. AID/Washington and AID missions

are assisting in this effort. Continuous, informal coordination in all countries where Pathfinder is working, using whatever means is most feasible in the particular country, is to be encouraged. In some countries, governments try to coordinate the various donors involved in family planning. Such efforts have been more successful in some countries (e.g., Indonesia) than in others (e.g., Kenya). Coordination will become more important if AID funding is reduced still more.

C. Program Support

1. Commodities

The last aspect of Pathfinder management examined by the evaluation team was program support, including commodities, communications, and training. Problems in delivering commodities to Pathfinder projects are not unique to Pathfinder, nor are they the fault of Pathfinder. Most delays in delivery can be attributed to problems in clearing customs in-country and to transporting commodities from the port to project sites. At the time projects are designed, field staff should assist sub-grantees in preparing a strategy for clearing customs. They also should assist in expediting in-country transport and delivery of commodities. Often, delayed commodity receipt affects the implementation of project activities. In Peru, Pathfinder has instituted a process whereby project funding is withheld pending receipt of commodities at the project site. This procedure is endorsed for all projects.

With the exception of follow-up, Pathfinder's logistical system for processing and shipping commodities is good. The steps now being taken to develop a system for follow-up upon receipt of commodities by sub-grantees are to be commended. Shipping documents should be printed in the language of the receiving country whenever possible.

Several problems with the commodity orders processed by the General Services Administration (GSA) were apparent during the field visits. Incorrect shipments sometimes have been sent to field projects. Pathfinder should seek help from AID to determine the cause of and find solutions to this problem.

Vehicles are urgently required for the successful implementation of many Pathfinder projects. AID often discourages vehicle purchases because of the expense. When, for instance, the strategy of a project is to cover a large rural area, project goals cannot be achieved without adequate transportation. Vehicles that meet the needs of projects and that are appropriate, given the peculiarities of the individual countries, often are

available in-country at prices far lower than the costs of vehicles purchased and shipped from the United States. AID should continue to assist Pathfinder in seeking waivers, where appropriate, that would permit the in-country purchase of vehicles urgently needed for project work.

2. Communications

Communications materials produced by Pathfinder are well received in the field and are considered to be useful by both field staff and sub-grantees. In some regions, most notably in Africa, sub-grantees have not received materials from Boston and are not aware of the kinds of materials Pathfinder produces. Pathfinder should inform new sub-grantees of the availability of materials and, where appropriate, list in the project document the materials that will be sent. It should be standard policy to make materials available as soon as the initial project award is made. Field staff should be encouraged to monitor the distribution and use of materials sent by Pathfinder to sub-grantees.

The development of indigenous materials is a new, much needed effort. An excellent model which Pathfinder might want to replicate elsewhere is the Guatemalan project, which developed materials for rural Indians.

3. Training

The evaluation team emphasizes that proper management of a project is important to the success of program activities. Management training should be provided for field staff and sub-grantees whenever feasible (RECOMMENDATION 14). In particular, the team found that the country office in Egypt and the regional office in Colombia are good examples of well managed field offices and these might be good sites for exchange visits by other field staff.

Whenever possible, Pathfinder should tap AID-funded projects which specialize in training grants (e.g., Development Associates in Latin America). To date, Pathfinder has done a good job of following up and following through on individuals sponsored for project-specific training. For example, the trainees from the Family Planning Association of Kenya (FPAK) who were sent to study community-based distribution (CBD) projects at the Asian Training Center in Thailand (another Pathfinder project) returned to develop a similar CBD project for their own country which will be funded by Pathfinder. Also, the management courses of the Centre for Population Activities (CEFPA) have, it is reported, provided useful training for a number of Pathfinder project managers.

Project Management

The evaluation team endorses Pathfinder's recognition of the need to revise the project development process, to move away from the old mechanism of the "Project Hearing Meeting." Field staff should participate actively in the effort to redesign the project review and selection process (RECOMMENDATION 15).

Boston staff should suggest project goals and evaluation criteria during initial discussions of a project, not when a finished proposal is received. Field staff should have the major responsibility for designing projects and for establishing project goals and evaluation criteria appropriate to a given situation in the field.

The various projects that were visited are exemplary in that they respond to specific needs in specific countries and complement other programs. Although the criteria are unclear to field staff, project selection, in general, seems to be quite good. Existing projects fulfill Pathfinder's pioneering role of complementing government programs and filling gaps that governments and other donors do not or cannot fill. After years of experience and expansion, project proposals are now being submitted spontaneously to Pathfinder, and in numbers greater than the organization is able to fund. This is adequate evidence of the desire of the sub-grantees to be affiliated with an organization that has an exceptional record and reputation.

To improve monitoring and management, the team recommends that proposals include realistic, time-phased workplans for implementing and evaluating projects (RECOMMENDATION 16).

The timely implementation of projects by sub-grantees is often impeded by problems related to the receipt of commodities, conversion to local currency, and the clearance of project funds. To better phase implementation with receipt of commodities and funds, the initiation dates for projects should be set by sub-grantees, in consultation with field staff, after the bank has cleared the project funds. Projects that depend on commodities should not initiate activities until the commodities have been received (RECOMMENDATION 17).

Once a project has been started, field staff should begin to monitor its implementation. Field staff should schedule a site visit within two months after a project starts to assist sub-grantees with project management, including the use of report forms (RECOMMENDATION 18).

The capacity of field staff to solve implementation problems is seriously limited because Boston must approve all changes in budgets and all other decisions related to implementation of a project. Field staff

should be given authority to make changes, up to a specified limit (e.g., 25 percent), in the line-items in approved budgets without having to refer to Boston for approval (RECOMMENDATION 19).

There is confusion in the field about the procedures to be followed in submitting reports to Pathfinder. The team suggests the following to clarify and standardize the reporting process:

1. Boston headquarters staff need to make clear the reporting process and the required contents of reports when grants are awarded.
2. Financial and progress reports should be sent, simultaneously, directly to Boston and to appropriate field representatives.
3. Communications and questions about reports from Boston and sub-grantees should be channeled through field staff.
4. Field staff need to develop a system for tracking the submission of reports. (The field offices in Indonesia and Colombia have already developed systems and they could assist other field staff in their efforts.)

Project monitoring should be a primary responsibility of field staff. Country representatives do an excellent job of project monitoring, but regional representatives find the task more difficult, particularly when projects are outside the countries where they reside. The regional office in Colombia does a good job of monitoring projects in the interim between visits by using the mail to react to reports and assist with problem-solving. This approach would be less effective in regions such as Africa, where there are few dependable postal systems. To provide better technical assistance and support for project implementation and monitoring, local organizations or consultants who can provide such services should be identified and used whenever possible.

Pathfinder's project evaluation process is too complex. It was designed, out of context, in Boston. Evaluation criteria should be established by field staff and sub-grantees in the field at the time of project development. Staff in Boston should provide any required or requested technical assistance (RECOMMENDATION 20).

The staff in Boston can make an important contribution to the evaluation process by helping to standardize the definitions of terms regularly used as evaluation measures and by disseminating these definitions throughout the field. As a way of disseminating the finds on successful projects, Boston should continue to sponsor and encourage other donors to sponsor workshops in the implementation of specific types of projects.

The timing of the evaluation process to correspond to the renewal of projects should be reconsidered. Project renewal is now unnecessarily delayed, resulting in a hiatus between the first and second or second and third years of project funding. Consequently, projects often lose momentum and staff. The suggestions from Boston for revising a project design to ensure renewals should be forwarded at the time of the second quarterly report, and not at the end of a project year. This would prevent delays in renewals.

Pathfinder has been very successful in fulfilling its mandate of "pathfinding"--leading the way in recognizing and responding to innovative and often high-risk local initiatives. Field staff have informed and assisted sub-grantees in their efforts to create self-sufficient projects or to find support from other donors when Pathfinder funding is discontinued. In some projects, charging for services and commodities is appropriate and to be commended because it contributes to self-sufficiency. Other kinds of projects (e.g., rural CBD activities) may never become self-sufficient.

Pathfinder's projects complement and make a significant contribution to the accomplishment of AID goals. An organization like Pathfinder is able, with relatively low levels of funding, to carry out important projects which AID cannot undertake directly. Because many Pathfinder projects are high-risk activities, it should be recognized that a certain percentage will not succeed. The evaluation team commends the organization for its willingness to take risks and to learn from its mistakes.

Part II
EVALUATIONS BY REGION

**PATHFINDER FUND EVALUATION:
AFRICA**

By

**Cyril Crocker
Susan Goodwillie**

November 2 - 21, 1980

I. INTRODUCTION

Cyril Crocker and Susan Goodwillie were the evaluation team for Africa. From November 2 to November 21, 1980, the team visited the three countries that Pathfinder has designated "emphasis countries" in the region: Nigeria (November 3-7), Kenya (November 8-15), and Zaire (November 16-21).

To cover as much territory and to talk to as many people as possible, the team often split up, each member going in a different direction. In Nigeria, both members visited the Enugu project, but only Dr. Crocker visited the Benin project. Ms. Goodwillie remained in Lagos to interview the leaders of population programs and other donors.

In Kenya, both team members spent considerable time with Pathfinder's regional staff, together and separately, and both reviewed the FPAK clinic expansion project and the Thika project, which is 30 kilometers north of Nairobi. Dr. Crocker visited the Maendeleo and Busia projects. A number of interviews were conducted jointly, but Dr. Crocker saw several leaders in the medical community on his own while Ms. Goodwillie met with representatives of the UNDP, UNFPA, UNICEF, FPIA, and the Ford Foundation. The team regrets that it was not possible to meet with the staff of the IBRD or the IPPF. Although the USAID population officer was out of town, the team fully debriefed other mission staff, including the director and deputy director.

As three of the five days of the team's visit to Zaire were holidays, it was more difficult to schedule appointments there than in Kenya and Nigeria. To use most efficiently the limited time, the team again split up, Ms. Goodwillie spending three days up-country to review the CDCZ (Community of the Disciples of Christ in Zaire) project in Mbandaka, and Dr. Crocker remaining in Kinshasa to meet with the director of the CNND (National Committee for Desired Births) and the UNFPA coordinator to debrief the USAID population officer. Dr. Crocker then returned to the United States to review files at Pathfinder's headquarters in Boston.

Though the trip was strenuous and presented a number of logistical challenges, the team's experience was stimulating and rewarding. Both members are indebted to the many people who assisted them in their evaluation. They are particularly grateful to Pathfinder's staff in Kenya and to the Galloways in Zaire for their constant support and unfailing kindness.

The report that follows is in six sections. Chapter II is a summary of recommendations for Pathfinder's regional program in Africa. Chapter III is a review of Pathfinder's organization and management in Africa. As there is only one Pathfinder office for all of sub-Saharan Africa,

general organization and management issues, including Pathfinder's relationship with other donors and its program support services--commodities, communications, and training--for the entire region are addressed. The questions of whether Pathfinder's program in Africa should be expanded and of whether there is a need for additional representation outside Kenya are discussed also in this section. The remaining three sections cover the team's findings in each of the countries visited. Each report begins with a brief review of the country's demographics, family planning services, and population policy. This is followed by an assessment of Pathfinder projects now in progress in the country. The country reports conclude with a list of the people the evaluation team met during the visits.

II. SUMMARY OF RECOMMENDATIONS

Organizational Structure

1. The job descriptions of all five staff members in the regional office in Africa should be reviewed and clarified.
2. In particular, Ms. Mudoga's job description should be expanded to increase the number and kinds of program activities for which she is responsible and to clarify the division of labor among Ms. Mudoga, Dr. Marasha, and Ms. Chavanga. Ms. Mudoga also should be relieved of her administrative duties and should be designated officer in charge in Dr. Marasha's absence.
3. Ms. Chavanga should continue to serve as office manager, with responsibility for bookkeeping, collection and maintenance of information to support program development, travel arrangements and logistical support for staff and visitors, and secretarial functions for the entire program.
4. Messrs. Kombo and Mwondera should be trained and upgraded to assist Ms. Chavanga with routine filing and clerical and reception duties.

Relationship with Pathfinder Headquarters

5. Greater authority and responsibility for decision making in project monitoring and evaluation should be assigned to the regional office, particularly with respect to payment procedures, project implementation, and reporting.
6. All communications between the regional office for Africa and the headquarters in Boston should be channeled through the regional director for Africa.

Relationship with AID and Other Donors

7. Pathfinder should encourage AID/Washington to review the comparative advantages of each of the PVOs active in family planning programs in Africa. There is a need to clarify for all concerned the areas where each PVO is particularly competent to administer the funds AID provides.

8. Pathfinder should encourage the PVOs to meet periodically to resolve practical and procedural problems related to their activities in the field.

Program Support Services: Commodities, Communications,
and Training

9. A system should be developed to enable the regional representative to monitor more closely shipments of commodities and to assist sub-grantees in clearing customs and in transporting commodities from ports of entry to project sites.
10. Boston staff should ensure that all African sub-grantees are on the mailing list for Pathfinder communications.
11. The Communications Program should encourage and support--both financially and technically--the local production by sub-grantees of simple educational materials about family planning in local languages.

Expansion in Africa

12. Additional financial and human resources should be allocated to the Africa program so that it can respond to the many existing opportunities for new and expanded program initiatives in the region.
13. Pathfinder should not, however, be encouraged to become the principal family planning service-oriented private and voluntary organization operating in Africa.

Additional Representation in Other Areas of the Region

14. A qualified Nigerian should be identified, recruited, and trained to serve as Pathfinder's resident contact person in Nigeria. His duties would be to assist in project development and the provision of logistical, technical, and administrative support to current sub-grantees.

III. ORGANIZATION AND MANAGEMENT IN AFRICA

One of the seven principal issues on which the evaluation team was to focus was:

Pathfinder's program of ongoing projects in Africa and, more important, its technical, administrative, and financial capacity to undertake a substantial number of new initiatives in the region, and perhaps to become the principal family planning service-oriented private and voluntary organization (PVO) operating in Africa.

On behalf of the entire evaluation team, the two consultants who traveled in Africa gave particular attention to this issue. The Africa team reviewed the organizational structure of the regional office for Africa, its staff capability, its relationship with Pathfinder headquarters, its relationship with other donors, and its program support services. The team also assessed Pathfinder's capacity and potential to conduct an expanded program in Africa and the need for additional representation in other parts of the region.

Organizational Structure and Staff Capability

Among the other donor agencies, Pathfinder has been creative and unique in insisting on the recruitment, placement, and support of truly regional representatives. Its staff in Africa is small but highly qualified and effective. The regional representative, Dr. Marasha, is a Zimbabwean who received his medical degree at Prague and further training in obstetrics and gynecology at Makerere University. He holds a master's degree in public health from Berkeley. He has served as Pathfinder's regional representative since 1974. The other professional staff member for program development and management is Ms. Freda Mudoga, a Kenyan who holds a B.S. degree from the University of Oklahoma. Ms. Mudoga did graduate work in social welfare at the University of Pittsburgh. She is an accomplished professional, with broad experience in home economics and family planning program management in Kenya. Ms. Felicity Chavanga, also a Kenyan, holds diplomas in secretarial management, administration, and bookkeeping and is the office manager. She attended the CEFPA course in Washington, D.C., in May-June, 1980, thereby further enhancing her already excellent administrative skills. Justus H. Kombo and David Mwondera, Kenyans who have received apprentice-training in storekeeping, are messengers/and storekeepers.

The smallness of the staff has a number of advantages. The operation is lean and efficient. The atmosphere in the office is characterized by an easy flow of communications. Issues and problems are discussed openly as they arise, and all staff are kept well informed of each other's work. One disadvantage of the small staff size, however, is that Dr. Marasha, Ms. Mudoga, and Ms. Chavanga often fill in for one another, thus blurring their roles or overlapping areas of responsibility. Although job descriptions do exist for Ms. Mudoga and Ms. Chavanga, they are insufficiently distinct in their assignment of respective tasks. As a result, the actual operation is rather free-wheeling and functionally task-oriented.

Ms. Mudoga's job description, in particular, needs to be clarified. Currently, she is responsible for all Pathfinder projects in Kenya. She has, in the year since she joined Pathfinder, worked diligently and successfully to resolve problems in each of the five ongoing projects in the country. She also is required to maintain her own files and to assume routine administrative chores in connection with Kenyan projects. These tasks, she feels, unduly cut into the time she could be spending on program development and the revision of technical and management assistance to grantees. Although she clearly has some responsibility for the ongoing monitoring of the Kenyan program, Ms. Mudoga is eager and able to assume additional responsibilities. She is particularly interested in developing women's programs in other parts of Africa and in developing projects with the community of non-governmental organizations (NGOs) which she knows well from her previous experience. She is willing to consider a variety of approaches to an expanded role.

Another concern is the process by which responsibility is delegated in Dr. Marasha's absence. Until Ms. Mudoga's arrival last year, Ms. Chavanga was the only other professional on the staff. Historically, she has been the person who has taken charge when Dr. Marasha traveled. Continuation of this practice no longer seems appropriate, now that a senior program officer has joined the staff.

The two messengers/storekeepers are not fully employed and have demonstrated a potential to assume additional responsibilities following appropriate training. Training would not only enhance their satisfaction with their job and their future employability; it also would enable Ms. Chavanga and Ms. Mudoga to assume additional, more substantive work commensurate with their own skills and interests.

Recommendations

1. The job descriptions of all five staff members in the regional office for Africa should be reviewed and clarified.
2. In particular, Ms. Mudoga's job description should be expanded to increase the number and kinds of program activities for which she is responsible and to clarify the division of labor among her, Dr. Marasha, and Ms. Chavanga. Ms. Mudoga also should be relieved of her administrative duties and should be designated officer in charge in Dr. Marasha's absence.
3. Ms. Chavanga should continue to serve as office manager, with responsibility for bookkeeping, collection and maintenance of information to support program development, travel arrangements and logistical support for staff and visitors, and secretarial functions for the entire program.
4. Messrs. Kombo and Mwondera should be trained and upgraded to assist Ms. Chavanga with routine filing and clerical and reception duties.

Relationship with Pathfinder Headquarters

The African staff welcome their growing involvement in project development decisions as Pathfinder's response to the recommendations of the New Paths Committee evolves. They are, nonetheless, concerned that their capacity to operate effectively in the region is constrained still by their limited participation in program management. They see themselves more as advisers than as full participants in the decision making process. The evaluation team for Africa concurs and believes that greater authority and responsibility for decision making in project monitoring and evaluation should be assigned to the regional office.

The current mode of operation is problematic, in terms of policy and procedure. It is a policy issue because it runs counter to Pathfinder's underlying philosophy about the importance of employing local, regional staff. To recognize the inherent strength of qualified local staff, and then to dilute it by insisting that all program management decisions be made in Boston, is contradictory and weakens the organization's effectiveness and efficiency.

Specific improvements should be made in payment procedures, project implementation decisions, and reporting.

Sub-grantees in Africa often experience inordinate delays in receiving grant funds in cash because of the time it takes them to clear dollar payments from Pathfinder in Boston and to convert them to local currencies. If in Kenya grant funds were transmitted to sub-grantees via the regional representative, they could be converted immediately and payments made to grantees in local currency without delay. In other countries it should be possible to establish a local account into which payments are made via bank drafts that could be immediately cleared and converted to local currency.

The mixed use of dollars and equivalents in local currency poses a problem in financial reporting. Project administrators have suggested that financial reporting would be simpler and clearer if they were permitted to report their expenditures and budget balances consistently and only in local currency. Sub-grantees should be encouraged to report their financial data as equivalents in local currency, leaving the responsibility for conversion back to dollar amounts to Pathfinder staff in Boston.

Additional, often seriously debilitating setbacks occur when necessary revisions in implementation plans are held up because the regional office does not have the authority to approve them and must defer to Boston--in some cases, even to AID/Washington--for a decision.

The mechanism for transmitting sub-grantees' reports directly to Boston requires that the regional office once again be bypassed at a critical stage in the implementation process. As a result, further delays often occur, because reports are incomplete or inadequate or because the regional office is not aware that reports that are due have not been submitted on time. If the sub-grantee's reports were submitted to Boston via the regional office, inadequacies could be corrected immediately and the regional office would be better able to track reports to ensure that they are submitted properly and on time.

In sum, as a matter of principle, the regional office should become more involved in the management of the implementation process. Deeper involvement would enable regional staff to assist sub-grantees more effectively, thereby ensuring more efficient operations and the achievement of more project goals. At the moment, the ability of the regional office to manage projects is seriously hampered; grantees are deprived of the kind of technical assistance and support the regional office is prepared to offer, and they are unsure about which office in the Pathfinder organization is responsible to them.

There also is confusion about the lines of communication between the regional office and Pathfinder headquarters. Though the relationship between the regional representative in Nairobi and the regional director in Boston is excellent and consistently effective, not all communication

between the two offices flows directly between these two people. There have been a number of instances recently when separate lines of communication between the Nairobi office and other staff at headquarters were established without adequate coordination with or the involvement of the regional director for Africa. The result has been mixed signals from headquarters to the field and confusion about who in Boston has final authority for program decisions.

Recommendations

5. Greater authority and responsibility for decision making in project monitoring and evaluation should be assigned to the regional office, particularly with respect to payment procedures, project implementation, and reporting.
6. All communication between the regional office for Africa and the headquarters in Boston should be channeled through the regional director for Africa in Boston.

Relationship with AID and Other Donors

The evaluation team is concerned that AID/Washington has been lax in coordinating family planning organizations operating with AID funds in Africa. There is a strong sense of unnecessary competition, and not cooperation, among AID-funded organizations. Although it is important that each agency maintain its own professional integrity and independence in the field, AID/Washington should issue clearer policy statements and guidelines on the respective roles each member of the PVO "family" is expected to play, in accordance with his own specific objectives.

In Africa, the relationship between Pathfinder and AID varies, depending on the presence of a population officer on the AID mission staff and the particular individual employed.

In Nigeria, there is no AID mission, and most AID-supported population projects are initiated by PVOs that are centrally funded by AID/Washington. U.S. Embassy staff are trying to encourage more cooperation with the Government of Nigeria (e.g., providing assistance through the U.S. Department of Health and Human Services and the Nigerian Ministry of Health Task Force). There is a Nigerian on the U.S. Embassy staff in Lagos who is responsible for monitoring AID-funded population and family planning projects. Unfortunately, she, too, was out of town when the evaluation team visited the country. The team was told that she and

Dr. Marasha keep in touch with one another, but communication is limited because of distance and the vagaries of the postal service in the region.

The USAID/Kenya population officer was out of the country at the time of the evaluation team's visit and could not be interviewed. Reportedly, Dr. Marasha is pleased with the closeness and cordiality of his relationship with the officer. There is considerable evidence that the relationship is effective and mutually supportive.

Until six months ago, no population officer had served on the USAID/Zaire mission staff since August 1978. The presence of a population officer in Zaire now is assumed to be, at least partly, a consequence of a recommendation by an AID/APHA-commissioned consultant who assessed population/family planning program activities in Zaire in the fall of 1979. Although the consultant strongly recommended the appointment "specifically to enhance the mission's capability to help in family planning program development, particularly with respect to coordination of intermediary inputs," the current USAID population officer reported that he did not believe that it was AID's job to coordinate intermediary inputs. Because he has neither met Dr. Marasha nor had an opportunity to travel outside Kinshasa to visit Pathfinder projects, little can be said about Pathfinder's relationship with AID in Zaire.

Pathfinder's relationship with other donors in Africa seems to be good. Only a few other donor agencies are operating in the population field in Nigeria. The most important are the IPPF and the UNFPA. The IPPF affiliate, the Planned Parenthood Federation of Nigeria (PPFN), is eager to know more about Pathfinder and hopes that the two organizations can collaborate in the future. Until the evaluation team visited the country, the executive director of the PPFN had been unable to locate Pathfinder's Africa office. Although the UNFPA coordinator for Nigeria had met Pathfinder staff who visited the country after attending the Sierra Leone conference last October, he said that he was not as aware of Pathfinder's programs as he might be because no Pathfinder staff were living in Nigeria.

The regional staff's attention to coordination with other donors in Kenya is particularly appreciated because coordination generally is lacking. Given the large number of agencies involved in population projects in Kenya, the absence of coordination is a matter of considerable concern to the government. Apparently, it is the larger donors who are least interested in a better organized, more coherent approach to family planning program development. Given these odds, Dr. Marasha's efforts to avoid duplication and to complement other program initiatives are to be highly praised. The donors who share Dr. Marasha's desire for improved coordination hope that the creation of a National Council for Population and Development (scheduled for mid-1981) will strengthen the government's hand in the process.

Pathfinder staff maintain close communications with the agencies working in the population/family planning field in Zaire.

Recommendations

7. Pathfinder should encourage AID/Washington to review the comparative advantages of each of the PVOs active in family planning programs in Africa. The areas where each is particularly competent to administer the funds AID provides should be identified.
8. Pathfinder should encourage the PVOs to meet periodically to resolve practical and procedural problems related to their field activities.

Program Support Services: Commodities, Communications, and Training

Experience with the provision and timely receipt of commodities has been mixed. Although no difficulties have been reported in Kenya, projects in Nigeria and Zaire have suffered setbacks because commodities have been handled inefficiently.

In Nigeria, almost two years elapsed before the University of Benin Project received the first consignment of commodities it requested. A second consignment was requested last February, but had not been received at the time of the evaluation team's visit in November. Another project received a consignment of diaphragms with no creams or jelly. In Zaire, a consignment was delivered to the port of Kinshasa, but because the shipping instructions had not been followed properly, local authorities were unable to clear the commodities through customs. Eventually, the goods were stolen.

In addition to these problems, the regional office does not know what the GSA sends to projects. To solve the various problems, regional staff need a system to monitor commodity shipments and to assist sub-grantees in clearing customs and transporting consignments from ports of entry to project sites.

Pathfinder's publications are appreciated, but they are not as widely known as they should be, nor are they considered to be on the "must read" list of most program leaders. Many recipients keep Pathfinder communications in their libraries but do not use them daily or often in training programs.

Some project administrators are not as fully aware as they should be of Pathfinder's communications program. By chance, one project coordinator in Zaire had seen a Pathfinder communication, but he did not know about others, including the Pathfinder study on traditional birth control methods in his own country. Several copies of all Pathfinder publications printed in French and the "Pathpaper" on Zaire should be sent to the CDCZ project in Mbandaka and to other Zairois sub-grantees.

There is an urgent need for simple but informative materials about family planning. These should be produced by the sub-grantees and printed in local languages. Pathfinder's willingness to support the reproduction of "Etre Maman, Etre Papa" in Lingala in Zaire is most appreciated and highly commended.

The regional office for Africa has used well training funds. Staff have identified excellent candidates for training and have kept in touch with them after they have returned to their homes. There is evidence that most of the people who Pathfinder has trained in Africa have put their training to good use and are serving in leadership positions in family planning projects.

A notable example of the effective use of training funds is the Family Planning Association of Kenya, which attended a two-week training program in community-based family planning systems and community development at the Asian Center for Population and Community Development in Bangkok. When the team returned to Nairobi, it proposed a carefully phased approach to the development of a CBD system in two areas in Kenya. Following the team's recommendation, a group of Kenyan doctors made a feasibility study and found the climate conducive to developing a CBD program. Within a year of the training course, the FPAK team developed an experimental program and received Pathfinder's approval for funding.

Pathfinder's support of training programs that might otherwise not be considered an important part of program implementation is truly "pathfinding" and should be continued.

Recommendations

9. A system should be developed to enable the regional representative to monitor commodity shipments more closely and to assist sub-grantees in clearing customs and transporting commodities from ports of entry to project sites.
10. Boston staff should ensure that all African sub-grantees are on the mailing list for Pathfinder communications.

11. The Communications Program should encourage and support--both financially and technically--the sub-grantees' local production, in local languages, of simple educational materials on family planning.

Expansion in Africa

There is no question that, among the developing regions of the world, Africa is the "sleeping giant" that has only recently become aware of the serious consequences of high population growth rates and the role of family planning programs in modifying them. Although in some areas severe economic constraints are causing people to seek family planning services, awareness of the desirability of family planning is still almost solely associated with maternal and child health needs. It is thus still true that attempts to establish freestanding family planning programs that do not address primary maternal and child health needs have little chance of succeeding. It also is clear that if family planning programs are to be effective in reducing population growth rates, they must be comprehensive, go beyond childspacing, and address the issues of family-size limitation and reduction of unplanned and unwanted pregnancies. Moreover, it must be recognized that in many areas segments of the population, including opinion leaders and policymakers, are hostile to family planning in any context.

Given the realities of demographic, economic, and health conditions in Africa, sensitive, creative, and courageous approaches to the expanded provision of family planning services and education are definitely needed. There is a growing sense among government officials and donors that it is the smaller, non-governmental agencies that operate most effectively in the family planning field. They are the ones who can take high-risk initiatives, who can prod, who can show the way.

Among the smaller agencies, Pathfinder has taken a relevant, pioneering, and programmatic approach; its demonstrated capacity to operate effectively with relatively small amounts of money and the fine reputation it enjoys in Africa suggest that it certainly could and should play an expanded role in that region. Given the magnitude of the job to be done, however, and the variety and quality of other agencies' contributions, the evaluation team and others believe that it would be a serious mistake to encourage Pathfinder to become the principal family planning service-oriented private and voluntary organization operating in Africa. There will continue to be sufficient opportunity for all agencies in the field to contribute to and complement one another's efforts in the years ahead. Reliance on Pathfinder as the principal agency in the field would place an inappropriate burden on that agency and no doubt greatly reduce its capacity to take high-risk initiatives and be flexible in responding to program opportunities.

An expansion of Pathfinder's role in Africa would require the allocation of additional financial and human resources to the program. The evaluation team believes that if the recommendations offered in this report are followed, Pathfinder will be able to pursue a substantial number of new initiatives, because its technical and administrative capacity is appropriate and adequate. In the three countries visited by the team, many new opportunities suited to Pathfinder's philosophy and program thrust were found.

In Nigeria, where the desire for family planning services appears to be more latent and is more subtly expressed than in Kenya or Zaire, population program leaders, government officials, and other donors discussed several opportunities to undertake projects. Among them are the following:

- University teaching hospitals are eager to extend their services to rural areas and to expand their preventive health services to include Pap tests in routine examinations.
- The nascent National Population Commission is seeking support for research design and to provide comparative data from other countries for policy information.
- The UNFPA and the National Basic Health Services Scheme are searching for innovative ways to introduce family planning in the context of maternal and child health programs in rural areas.
- The National Council of Women's Societies is trying to develop outreach programs in IEC for family planning in rural areas.
- Church groups also are working with integrated development, MCh, and family planning programs to improve the quality of women's lives in rural areas.

In Kenya, those who support family planning and who deliver services have been given a tremendous boost by President Moi, who strongly advocates a reduced national population growth rate. In this newly charged atmosphere, a number of opportunities are emerging:

- There is a growing and unmet demand for surgical contraception.
- The Family Planning Association of Kenya and the Ministry of Health are eager to analyze carefully the first attempts at CBD to improve and extend the program to other areas.

- There is an urgent need to encourage women to become involved in all development efforts. There also is a strong sense among women leaders that family planning will not succeed unless and until it is associated with opportunities that enable women to become economically self-reliant.
- There is increasing interest in and support for family planning among church and local leaders. The result is that an increasing number of men are supporting and seeking services.
- The National Family Welfare Center needs help in developing family planning curricula and materials for its nurse-training programs.
- The Ministry of Health is seeking assistance to evaluate its initial efforts to integrate family planning with primary health care.

In Zaire, the delivery of health and family planning services is virtually limited to what the church system is able to provide. The current demand for services greatly exceeds supply, and the need for the most basic primary health care and for the expansion of family planning services is urgent. In the Mbandaka project alone, there are a number of opportunities for expansion. There is a growing and unmet demand for surgical contraception in urban areas. And there is a strong desire throughout the country for Pap tests because the incidence of cervical cancer is high.

Recommendations

12. Additional financial and human resources should be allocated to the Africa program so that it can respond to the many existing opportunities for new and expanded program initiatives in the region.
13. Pathfinder should not, however, be encouraged to become the principal family planning service-oriented private and voluntary organization operating in Africa.

Need for Additional Representation in Other Areas of the Region

The regional representative based in Nairobi is Pathfinder's only representative for all of sub-Sahara Africa. There is no question that Dr. Marasha is well known throughout the continent and admired for his energetic effort to keep abreast of and in touch with current and potential programs in countries other than Kenya. It is also true, however, that the complexity and subtleties of each country's situation and the sheer vastness of the region mean that no single person can possibly stay in close touch with developments everywhere. These factors suggest that the presence of a resident contact person--at least one in each of Pathfinder's three "emphasis countries"--is crucial to the development and management of projects.

The Reverend and Ms. Ralph Galloway, "friends of Pathfinder," admirably perform this function in Zaire. The absence of a similar "friend" in Nigeria, however, is a serious constraint on Pathfinder's capacity to develop and manage programs and to ensure efficient logistical arrangements, especially in Nigeria, a large and complex country. Decentralized, with several different, significant population concentrations, Nigeria has a transportation/communication infrastructure that is so inadequate that logistics are extremely difficult. In the absence of a Pathfinder contact, sub-grantees must turn to Boston, and not Nairobi, when they need help--a practice which further reduces regional staff involvement in program management.

In view of the limited project activity in Nigeria, the evaluation team does not believe that full-time representative is needed at this time. However, given the very real potential for program development and expansion, particularly of women's programs and policy, and the requirements for logistical support for existing projects, the team believes that a qualified Nigerian should be identified and recruited to help monitor current programs and to develop new projects. The cost of establishing such a position would most likely be offset by the reduction in the number of trips by Nairobi- and Boston-based staff that would be necessary.

Recommendations

14. A qualified Nigerian should be identified, recruited, and trained to serve as Pathfinder's resident contact person in Nigeria. His duties should be to assist in developing projects and providing logistical, technical, and administrative support to sub-grantees.

IV. COUNTRY REPORT ON NIGERIA

Demographics

As the regional representative has observed, Nigeria is the richest, most powerful, most populous nation in sub-Saharan Africa. With approximately 80 million people, Nigeria contains one-quarter of Africa's total population.

Little information is available on the components of population change in Nigeria. Recent censuses and sample surveys have been controversial at best. The last major census, in 1973, was declared null and void. Numbers, rates, and measures of fundamental demographic characteristics and processes in Nigeria are therefore crude estimates, often grossly inadequate.

With a total estimated fertility rate of 6.9, Nigeria has an extremely high fertility level. Its mortality rate also is high, but declining. The combination of high fertility and declining mortality produces one of the world's highest population growth rates--3.2 percent. This rate may increase in the years ahead as improvements in health, medical care, and nutrition further reduce infant and child mortality. The most dire estimate suggests that the population will double in 20 years, reaching 160 million by 2000.

There are considerable internal migration streams, both between rural areas and from rural to urban areas, but the growth rate of urban populations far exceeds that of rural groups. In Nigeria, unlike most African countries, nearly 50 percent of the population are city dwellers. The physical and social infrastructure of a city such as Lagos, with its teeming population of 6 million, is strained far beyond capacity.

As one leader in the medical community put it, "We have a population problem. Any agency committed to working in the population field must be in Nigeria."

Family Planning Services

The current five-year development plan accords high priority to food production and the extension of maternal and child health, family planning, and nutrition services. The need to encourage childspacing is recognized and is a primary thrust in the government's National Basic Health Services Scheme. But in many areas in the country family planning remains a controversial issue.

Service delivery is beginning to move out of static health institutions, but progress is slow. Motivation to continue attending family planning clinics is poor. Lack of drugs, staff shortages, and inconvenient clinic hours are among the factors that mitigate against more popular use of family planning clinics. Perhaps the greatest boost for motivation toward family planning is the severe economic pressures most families face for food, shelter, and education for their children.

One of the most serious obstacles to more widespread practice of family planning is lack of information and knowledge among rural women. The presence of traditional birth attendants (TBAs), who used to give advice and help to women desirous of spacing their children, is becoming less common, and no significant organized effort has been made to make modern contraceptives available in rural areas.

Family planning is now an integral part of government-sponsored medical and paramedical training, but the current, largely Muslim government refrains from strong advocacy. A more aggressive and positive population policy, combined with extensive IEC outreach, must be formulated before much progress can be made in providing advisory services in childspacing.

Pathfinder is to be commended for having been among the first foreign voluntary assistance agencies to provide support services and supplies to initial family planning efforts in the late 1950s. At the time, these were pioneering initiatives, and they became the basis for the family planning programs that exist in Nigeria today.

The Family Planning Council of Nigeria was formed in 1964. Subsequently disbanded, its successor, the Planned Parenthood Federation of Nigeria, was established in 1967. An IPPF affiliate with an annual budget of \$1 million, the PPFN maintains a network of clinics in urban areas throughout the country, but it has yet to open its first rural clinic.

Following a needs assessment conducted in July 1980, the UNFPA made a commitment to spend \$18.5 million in Nigeria over the next 4-5 years. At least one-half of that amount will be allocated to support the maternal and child health and family planning components of the National Basic Health Services Scheme. The UNFPA also is exploring the possibility of establishing a centrally-administered inventory of contraceptive commodities to ensure more systematic distribution, probably through UNICEF, to ongoing projects.

Leaders in family planning are hopeful that, as health care improves and the still high infant mortality rate declines further, the demand for family planning services will increase and that the services will become increasingly integral parts of basic health care programs.

Population Policy

It was stated in the July 1980 UNFPA report, "Needs Assessment for Population Assistance to Nigeria," that:

Nigeria does not have a population policy per se. This stems largely from the fact that until now there has been relatively little recognition of possible population problems outside the academic community; the Government has been most reluctant to intervene directly in population concerns, beyond the reduction of mortality and of international migration.

This observation was corroborated by most of the population leaders who were interviewed by the evaluation team. According to those who advocate more aggressive support of family planning, many government officials strongly believe that Nigeria has a wide and varied resource base which can be developed to the advantage of a growing population. What is needed, it is thought, are measures to ensure the effective mobilization of the nation's human and material resources for development. There is, in short, a sense of abundant resources and development potential relative to population. The oil boom of the 1960s and early 1970s certainly contributed to this optimism. Moreover, many believe that, given Nigeria's vast space, the danger of population pressure is not a cause for concern. As a result, the official attitude toward population issues has been cautious, laissez-faire, and often neutral.

In recent years, however, the government has recognized that the lack of a clear and comprehensive population policy has hampered its capacity for development planning and multi-sectoral economic growth. The new Constitution, approved in 1979, provides for the establishment of a National Population Commission (NPC), which will include a member from each of the 19 states in the Federation and which will be the principal agency representing the government's views on population. The operational mandate of the Commission is to establish a framework for collecting and analyzing demographic data to facilitate economic and development planning and to advise the president on population issues.

Those with whom the evaluation team discussed policy issues agreed that it is fundamentally important that procedures and mechanisms be established to increase the flow of information between the users and suppliers of demographic data. Coordination and liaison among data collectors, analysts, and policymakers and program planners are sorely needed.

An urgent need for population education was noted by many of those interviewed. The Federal Ministry of Agriculture, for instance, is reported to be concerned about the lack of a thorough understanding of the rural population structure, occupational distribution, and manpower stock and requirements. The Ministry would like to establish this as a prerequisite for achieving rural development objectives, including the increased involvement of women in the process of economic growth.

Laws and Legislation

Abortion is illegal in Nigeria. Therapeutic abortions are allowed only on medical grounds and after certification by three doctors, one of whom must be a psychiatrist. The Society of Obstetrics and Gynecology is trying to encourage legislative change, because it believes that medical professionals should be allowed to make decisions about abortion free of legal constraints.

Project Reviews

A. PIN 6297: The University of Nigeria Teaching Hospital, Enugu, Family Planning Project

1. Description

The grantee for this project is the University of Nigeria Teaching Hospital at Enugu (UNTHE). It is part of the University of Nigeria, Nsukka, which was established in 1960 and became Nigeria's second university, but the first to award its own degrees. The Faculty of Medicine was founded in 1966.

The university is one of the foremost teaching hospitals in the country, with a large population of clinical students (300), student-nurses (300), and student-midwives. It offers a wide range of medical and surgical services to the public, including outpatient and inpatient care supported by an extensive laboratory.

The Department of Obstetrics and Gynecology provides inpatient and outpatient gynecological services, as well as antepartum, intrapartum, postpartum, and post-abortion care to women in the community at large.

The Pathfinder project has two components:

1. It provides all aspects of family planning to postpartum, post-abortion, and non-pregnant women in the community.

2. It has introduced family planning into the curricula for medical students and nursing and midwifery students, thus exposing them to the principles, ideas, and methods of family planning and giving them theoretical and practical training.

The project director is Professor W. O. Chukudebelu, head of the Department of Obstetrics and Gynecology at UNTHE and a consulting obstetrician/gynecologist. A knowledgeable and experienced gynecologist, he has advanced training in the fertility field. In 1975 he attended a course offered by the Johns Hopkins Program for International Education in Gynecology and Obstetrics in Baltimore, Maryland.

The project was to have started in October 1979; it became operational in April 1980.

2. Design and Selection

The Pathfinder Fund has supported MCH/FP activities in Enugu for at least seven years. Its support dates back to the grant awards to Professor O. L. Ekpechi, Department of Medicine, UNTHE, to support the Information and Research Center for Life.

The need for an expanded hospital-based family planning program at the UNTHE had been felt for some time. At the end of 1975, Professor Chukudebelu, who had worked in the project with Professor Ekpechi, outlined such a program, indicating short- and long-term objectives and enumerating several built-in advantages. His work led to the development of a project proposal, which was submitted at the end of June 1977.

As of September 1978, Professor Chukudebelu had had no word on the project, but he wrote to Mrs. James Crawford, regional director for Africa (Boston), requesting training courses for himself, Dr. Peter Gini, and Mrs. Malinde Chinyelu. Toward the end of 1978, Mr. Crawford and Dr. Marasha visited the UNTHE and made some alterations in the project design. The project was approved in August 1979. A letter dated August 30, 1979 from Professor P. O. Chuke, acting director of UNTHE, indicated acceptance of the terms of the grant for the period October 1, 1979 - September 30, 1980.

3. Implementation and Monitoring

Dr. Peter Gini, an assistant to Professor Chukudebelu, is responsible for directing and overseeing the Family Planning Clinic and the day-to-day operations of the project. A gynecologist with years of experience in family planning procedures in Britain, he seems to be especially bright.

UNTHE is the largest hospital east of the Niger, indicating the presence of a large population for services. The hospital's gynecological clinic provides adequate services. The Family Planning Clinic meets once a week on Saturdays. An additional session is planned but will not be held until the number of acceptors justifies it. At present, two to three physicians, assisted by nurses, operate the clinic.

On their day-to-day ward rounds and in the antenatal and postnatal clinics, nurses give motivational talks to patients and educate or inform them of the various family planning methods available. Prospective acceptors are referred to the clinic. On arrival at the clinic, patients are registered and interviewed by a nurse. All methods of contraception are discussed and one method is selected by the patient. A physician gives the patient a complete examination and provides the contraceptive the patient has chosen, unless it is contradicted by medical findings. Patients are then counseled about their particular methods and given an appointment for a revisit.

Medical students and nursing and midwifery students observe clinic operations. Family planning is presented as part of the respective curriculum, and lectures, film shows, and demonstrations are given.

The program is monitored by the project director, Professor Chukudebelu.

4. Evaluation

Although the check for the first quarter of the project was sent in September 1979, it was not cleared through the Nigerian Central Bank and converted to local currency for approximately six months. This and other constraints have delayed the achievement of project objectives.

Quarterly and financial and program reports are sent to Pathfinder in Boston and to the regional office in Nairobi. Though the project was slow in getting started, the number of acceptors is increasing.

Professor Chukudebelu is an impressive, pleasant, personable, and gracious person, but his manner seems reserved, even cautious.

Nigeria has a large Catholic population which, traditionally, has believed that large families are necessary. In the aftermath of the civil war, family planning programs, the perceived objective of which is to limit the size of the population, were affected adversely. However, the motivational activities of the Enugu project are beginning to have a positive impact. In the first quarter of the project, 925 women were reached with talks by nurses; in the second quarter, the total reported was 14,699. The number of acceptors also doubled, from 30 to 67. In the third quarter, between 100 and 120 new acceptors received services. Sixty medical students and 20 nursing and midwifery students have observed clinic operations.

The provision of other gynecological services and the receipt of referrals from other wards of the hospital and other areas in the community seems to be enhancing acceptance of the program.

5. Effectiveness

This project is part of a strategy to establish the university teaching hospital as a central location from which to deliver family planning services and at which to train health professionals in reproductive anatomy and physiology. With the introduction of family planning into the curricula of medical and nursing and midwifery students, knowledge and understanding of the benefits of such a program will increase. It is expected that the students will become more receptive to the idea of family planning and that the program will pave the way for wide dissemination of services throughout Nigeria. In the long run, expanded delivery will have a far greater impact than the increased number of acceptors using the teaching hospital's services.

Once it is introduced into the curricula of medical and nursing and midwifery students, family planning information probably will remain an integral part of the teaching program after the project ends. Similarly, family planning services will remain part of the services offered by the Department of Obstetrics and Gynecology; ultimately, they will be financially supported by the teaching hospital. In fact, the project's director envisions the establishment of satellite clinics in rural communities as more medical personnel are trained in family planning. Once such clinics are established, the number of referrals to the teaching hospital will increase, thereby making the hospital a secondary and tertiary care facility.

B. PIN 6424: University of Benin Teaching Hospital Family Planning Training

1. Description

The grantee for this project is the University of Benin Teaching Hospital (UBTH). The Department of Obstetrics and Gynecology, established eight years ago, is under the direction of Professor L. N. Ajobor. The department provides obstetrical and gynecological services for in- and outpatients. The Fertility Counseling Clinic of the UBTH provides FP services. All routine services are provided: oral contraceptives are prescribed; IUDs are inserted; long-acting hormonal contraceptives are injected; diaphragms are fitted; and jellies, foams, and condoms are provided.

This project will train 12 fieldworkers to provide basic health education and family planning motivation in local communities around Benin City. Both male and female fieldworkers will be hired.

Training will have a didactic component and a practical component. The period of training will be three months.

The project director is Professor L. N. Ajabor, a knowledgeable, experienced, enthusiastic, and dynamic individual. He is positive and forthright in his conversation. His commitment to the concept and goals of the project seems real and sincere. Professor Ajabor will be responsible for implementing the project.

2. Design and Selection

At a conference in Ibadan in 1974, Dr. Marasha and Professor Ajabor met and discussed Pathfinder programs, interests, and opportunities. As a result, in March 1975, Professor Ajabor was awarded a grant to travel to Birmingham, England, for training in laparoscopy, contraception, family planning methods, research administration, and clinic organization. It was understood that after training, Professor Ajabor would return to Benin City and establish a family planning clinic in the Department of Obstetrics and Gynecology at UBTH. After further discussions with Dr. Marasha, Professor Ajabor developed and submitted a project proposal to Pathfinder in June 1977. In 1978, Pathfinder decided to fund the first stage of the project.

Three nurse-practitioners from the UBTH were selected for training at the Margaret Sanger Center in New York City. The training lasted from June to September 1978. Also, Pathfinder awarded a grant to Dr. M'beye Faal of the UBTH to cover tuition and travel expenses while he attended the Management and Administration Seminar at the Training and Research Center of Planned Parenthood (Chicago area) from November 6 to December 1, 1978.

In January 1979, Mr. Jim Crawford, Dr. Marasha, and Mr. Peter J. Purdy, the administrative director of the Margaret Sanger Center, visited UBTH and discussed the project. A request for commodities was made at that time.

Dr. F. M. E. Diejomaoh of the UBTH was awarded a grant to participate in the Fourth International Conference on Voluntary Sterility in Seoul, Korea, from May 6 to May 10, 1979. Two additional UBTH nurse-practitioners were selected for training at the Margaret Sanger Center, beginning in July 1979.

In January 1980, Pathfinder awarded the UBTH a bulk procurement grant which included:

- 500 Cu T IUDs;
- 15,000 cycles of 30 mcg. pills;
- 1,500 condoms; and
- 1,000 Lippes Loops (size D).

Dr. Marasha and Ms. Marianne Burkhart, of Pathfinder's Evaluation Unit, visited the UBTH in February 1980 and redrafted the original project proposal. They also discussed the possibility of obtaining support to train two nurses in cytology. In September 1980, the UBTH was visited by Dr. Marasha and Dr. Robert H. Holtrop, chief of Pathfinder's Services Division.

The letter of approval was dated October 9, 1980, but it did not arrive until after October 23, at which time Professor Ajabor was away from the campus. Upon his return on November 3, Professor Ajabor found the Letter of Award, with no attached budget but a condition that acceptance of the terms must be received by November 15. He sent a telex to comply, but advised Pathfinder that approval by the university administration was necessary to finalize the contract.

In summary, this project has been in various stages of development for five years. Although services have been provided at the UBTH, and although Pathfinder has trained some project staff, the number of acceptors has been relatively low. The major thrust of the project will be implemented only after the grant funds have been received.

3. Implementation and Monitoring

Dr. Diejomaoh, a young, knowledgeable, and experienced gynecologist, is responsible for the day-to-day operations of the project and supervises the clinic. A well qualified, full-time field coordinator has been identified and is receiving advanced training at the University of Minnesota. Two supervisors will be hired and based at the UBTH. They will assist in training and scheduling fieldworkers' activities and will give general supervision. They also will give educational talks to community groups (e.g., women's groups, industries, other institutions).

Following training, the fieldworkers will be assigned to specific health zones. Female fieldworkers age 18 to 25 years will work among the village women. Male workers will be older, 25-31, and have more training and experience. They will be responsible for persuading village elders to allow and encourage the village women to participate in the project.

All fieldworkers will provide some basic health education and family planning motivation in the communities and at government health centers in their zones. They will provide prospective new acceptors with a referral coupon to be presented at the clinic. Referrals will be made primarily to the UBTH clinic, but family planning services may be provided at some government clinics as well.

The project will be monitored by Professor Ajabor.

Services are provided in the gynecological clinic of the UBTH, a more than adequate facility. Patients are registered and interviewed. After they are informed of the various methods of contraception, they are asked to select one. They are then examined (a Pap smear is taken) by a clinician who provides the contraceptive method of choice, unless a medical contraindication exists. The patient is then counseled about her chosen method and given an appointment for a revisit.

4. Evaluation

Since the fieldworkers' training is not an operational aspect of the project, it was discussed with Professor Ajabor, Dr. Diejomaoh, and Sister Ajueyingho from historical and prospective points of view. The project will take advantage of the motivational skills of the trained fieldworkers to inform and motivate the local community toward the goal of increased use of available services. Quarterly financial and program reports will be sent to Pathfinder in Boston and to the regional office in Nairobi.

The advanced training of project staff, including five nurse-practitioners, has improved the delivery of services. However, there seem to have been inordinate delays in the interim after initial project design and before full implementation. The role of the regional representative in the project review process is not clear to the project director. Direct correspondence between the project director and Pathfinder's headquarters in Boston raises questions about the function of the regional representative. The absence of a contact person in the country contributes to some of the project's problems. In spite of the frequent visits by the well respected regional representative, it is felt that the logistical problems in covering an area as wide as sub-Saharan Africa are insurmountable.

There have been long delays in the receipt of commodities. Almost two years elapsed between the request and delivery of the first consignment. Commodities requested in February 1980 had not been received at the time of the team's visit in November.

It is felt that the special conditions attached to the grant award (e.g., cancellation of a vehicle request from the contract) hamper the program's flexibility and effectiveness.

5. Effectiveness

The project will capitalize on the prestige of a university teaching hospital and its qualified staff. The concept of a university-based program with outreach activities conducted by trained fieldworkers is not new, but it still needs to be proven in some geographic and psychosocial environments. In Nigeria, the approach seems to be appropriate and, if it is successful, it may demonstrate the acceptance of non-academic personnel in a teaching hospital and become a model for other parts of the country.

The involvement of a major clinical discipline of the university in an innovative program is reason for optimism about self-sufficiency. In any event, it is difficult for service institutions to discontinue programs once their clients' expectations have been raised. Therefore, it is expected that UDTH services will become a permanent clinical activity of the Department of Obstetrics and Gynecology.

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V. COUNTRY REPORT ON KENYA

Demographics

Kenya has a population of nearly 16 million people spread over a half million square kilometers, only one-third of which are arable. Though this gives a relatively low population density (about 26 persons per square kilometer) nationwide, there are strong concentrations of population in the coastal region, the central highlands, and the eastern region. The majority of the population, 86 percent, lives in rural areas.

With a crude birth rate of 54/1,000 and a crude death rate of less than 15/1,000, Kenya has a population growth rate of about 3.9 percent per annum, one of the highest in the world. Given current trends, the country's population will double in less than 20 years, reaching 32.3 million in the year 2000.

A principal reason for high fertility in Kenya is that couples traditionally and genuinely desire large families--a fact borne out by the Kenya Fertility Survey (KFS; undated) conducted by the Central Bureau of Statistics (CBS). A spontaneous demand for family planning services, especially to limit family size, cannot be expected to be very high.

An additional factor is that the population is composed of a large number of tribes of different ethnic origins. The consequent cultural and linguistic differences within the country, compounded by ecological variations and differences in agricultural patterns, mean that the delivery of social services--and particularly of family planning services--must be sensitively planned, and the nation's internal diversity taken into account.

Family Planning Services

The family planning movement began in Kenya long before the Government of Kenya made it national policy.

As early as 1956, Edith Gates, a representative of the Pathfinder Fund, visited Kenya and encouraged the proponents of family planning to form family planning associations in Nairobi and Mombasa. The Family Planning Association of Kenya was formed in 1957. It became an IPPF affiliate in 1963, the first in sub-Saharan Africa.

The FPAK, with Pathfinder's help, played an important part in encouraging the government to launch a national family planning program in 1972. But it was not until 1975 that the government inaugurated a comprehensive and systematic national MCH/FP program designed to provide integrated family

planning and other rural health services. The five-year program received \$38 million in funding from the major bilateral and multilateral donors in the population field. It recently was extended for another five years and received additional funds totaling \$120 million. The Ministry of Health is the operating agency for the program. The National Family Welfare Center has been established to administer it.

In spite of generous external funding, the program's achievements have been modest. The number of active participants is low and the drop-out rate, at 80 percent, is extraordinarily high. Rather than declining, the crude birth rate has risen, from 48/1,000 in 1974 to 51/1,000 in 1979.

The plan of action for the next five years of the program is to strengthen the implementative capacity of the National Family Welfare Center and to intensify efforts to increase public awareness of the consequences of high population growth at all levels. The plan also gives a nod to the FPAK for its efforts and provides for the training and deployment of field staff for the program.

In sum, the program aims to reduce the rate of population growth while enhancing the health of Kenyans, particularly mothers and children, by strengthening the rural health delivery system and by providing family planning services at all health delivery points.

According to Dr. S. Kanani, director of the national program, community involvement and the training of medical and paramedical personnel are being encouraged in a new way. "Now," said Dr. Kanani, "the doctor or nurse who does not talk about family planning is not talking about health." Dr. Kanani would like to involve more women as managers in the program.

The director of the National Family Welfare Center, Dr. A. Gathenji, is equally forward-looking. "As long as we stay with hospital-based family planning," she said, "we will get nowhere." Even though the use of non-physicians is a sensitive issue, Dr. Gathenji believes that the national program must encourage developments in community-based distribution. Dr. Gathenji is most appreciative of Pathfinder's willingness to support such high-risk initiatives.

All these efforts recently received a tremendous political boost from President Moi, a consistent and vocal advocate of family planning. Despite official rhetoric during the Kenyatta years, government support for family planning was not as strong then as it is today. As one family planning leader suggested, "Members of Parliament have turned around; those who used to be bitterly opposed to family planning are now the most ardent champions of the cause."

Population Policy

Although Kenya was the first country in sub-Saharan Africa to adopt a national population policy (in 1967), many leaders thought it ill-advised to take such action at the time. Its policy stance, however, made Kenya the "darling" of the international donor community, and an extraordinary amount of money for population activities flowed into the country in the late 1960s and 1970s.

Many consider the subsequent rise in the population growth rate to be bizarre and inexplicable. One explanation is that as a result of family planning initiatives, basic health care services improved immediately and infant and maternal mortality were then reduced. Another theory is that there was in fact some backlash (and therefore increased fertility) against the too zealous foreign donors who responded to a policy statement that did not accurately reflect the mood of the country.

Today, the government clearly recognizes that high population growth is impeding its ability to foster development and improve the quality of life. President Moi has referred to population policy in practically every public address he has made in the country in recent months. Consequently, many organizations, such as the FPAK and Maendeleo ya Wanawake (MYWO), have been inspired to play a more aggressive role in support of the national family planning campaign. (President Moi is a patron of both the FPAK and MYWO.)

A National Council for Population and Development is to be established officially in mid-1981. It will be the policy body for population and will be responsible for information and education on population. The concern of deliverers of family planning services is that the existence and activity of the council will so increase the demand for services that existing facilities will need to be improved and expanded quickly. At this time, only 33 percent of all rural health units are equipped to provide family planning services. In spite of the huge amounts of aid that continue to flow into Kenya for the national program, the need for innovative assistance, even in relatively small amounts, is urgent.

Project Reviews

The evaluation team together visited two current Kenyan projects. Three others were visited by a single member of the team.

A. PIN 6269: Family Planning Clinic Expansion Project

1. Description

The grantee for this project is the Family Planning Association of Kenya. Pathfinder Fund played a prominent and pioneering role in the history of this organization. Now well known and well established, the FPAK was recently honored when His Excellency, President Daniel arap Moi, agreed to serve as its Patron. It has more than 60 branches, membership in the thousands, and a volunteer force numbering in the hundreds. An affiliate of the International Planned Parenthood Federation, the FPAK is linked with the National MCH/FP Program (many of its staff and operational activities are financed by the government). It has managed to recruit, train, and retain capable and dedicated staff.

As one objective, the project will try to improve family planning services in eight separate clinic locations by employing additional staff and increasing the hours of service. The project also intends to recover 10 percent of each clinic's previous year's dropouts and to maintain 85-90 percent of all acceptors as continuing acceptors.

The project director is Mrs. Angela Gethi, also executive director of the FPAK. She is an able administrator with background and training in social work.

The project coordinator, Dr. Walter Ochieng, is extremely well qualified. He has a master's in public health from the University of Minnesota, a certificate in community health from the University of Michigan, and a certificate in family planning administration from Chicago University. He has been the medical officer of health in various districts in Kenya and is keenly interested in family planning work, including surgical contraception.

2. Design and Selection

During a visit to Nairobi in February 1978, Mr. Richard Gamble, chairperson of the Board of Pathfinder, discussed with Mrs. Gethi and Dr. Marasha the activities in Kenya of the Pathfinder Fund and the FPAK. It was felt that family planning services were being limited by the less than optimal circumstances under which clinics were operating. Because of staff shortages, clinics were unable to remain open for the intended number of hours. A request was made for funds to employ 11 enrolled nurse-midwives and 8 clinical clerks. These personnel would be assigned to the 8 FPAK clinics around the country. One of each would be assigned to each clinic, and an additional enrolled nurse-midwife would be appointed to the Nyeri, Nakuru,

and Mombasa clinics. A proposal was submitted which described the plan and established quantifiable contraceptive goals for each facility. It was approved in May 1979.

The clinical clerks conduct interviews with clients and take their histories, direct clients to proper clinical personnel for services, and record clinical actions in clients' records. The enrolled nurse-midwives provide clinical family planning services.

3. Implementation and Monitoring

With the aid of Ministry of Health family planning fieldworkers, the FPAK has embarked on a major program to educate the population in the objectives of the national family planning effort in order to increase demand for services. Increased demand has been met by hiring additional staff, re-defining staff roles and responsibilities, and increasing clinic hours (clinics now operate full time).

After they were recruited and hired, personnel received an orientation on FPAK philosophy and all program objectives. The Ministry of Health's MCH/FP Program also was described in full. A local orientation was given before clinical services were expanded.

At each clinic site, patients are registered by the clerk and necessary data are collected. The clerk determines what services are required and at the same time instills in the client complete confidence in the clinic's capacity to serve patients competently and efficiently. The patients are then seen by an enrolled nurse-midwife, who provides the necessary information, counseling, and services. If more than one enrolled nurse-midwife is available, responsibilities may be divided. The project coordinator at the clinic supervises the enrolled nurse-midwife, but may also be called on to provide services to clients. She also is responsible for the administrative functions of the clinic, including reviews and data reporting. Clients who present difficult problems, who develop complications, or who simply require additional information are scheduled to see the sessional doctor.

The project coordinator is responsible for monitoring the clinic's progress and for lending regular and required technical assistance to each clinic.

4. Evaluation

The goals and objectives of the project are monitored by clinic staff and at FPAK headquarters in Nairobi. The project director submits quarterly program and financial reports to Pathfinder. The forms are sophisticated and the data are detailed and complete. In the first year,

the target for new acceptors--98 percent--was achieved, though figures varied from clinic to clinic, with a low of 63 percent and a high of 173 percent. Similarly, the target for continuing acceptors--95 percent--was achieved, the figures varying from a low of 51 percent to a high of 152 percent.

Each person who comes to a FPAK clinic is registered. A prenumbered Family Planning Clinic Record is completed in duplicate. One copy is sent to the Ministry of Health, where it is entered into the National Family Planning Program files; the other copy remains at the clinic of service. The data that are collected and recorded are analyzed and become the basis for statistical reports.

5. Effectiveness

The increase in the number of clinic personnel and service hours has resulted in quantitative and qualitative improvements. The need to expand existing programs in the country is so great that the project can be justified and should be commended, even though it is not, unlike most Pathfinder projects, a pioneering effort. The prospects that this project will become self-sufficient seem good. The IPPF has taken over some of the added positions. It is likely that either the International Planned Parenthood Federation or the National MCH/FP Program will support the project after Pathfinder terminates its funding.

B. PIN 6272: Thika Family Planning Clinic

1. Description

The grantee for this project is the Family Planning Association of Kenya. The ninth urban clinic to be supported by the FPAK, the project provides family planning services to the population of Thika, an industrial complex 30 kilometers northeast of Nairobi.

The hours of the clinic are set for the convenience of factory workers and clients from the coffee and sisal estates surrounding Thika. A social worker has been added to the medical staff to enhance motivational activities and to provide welfare counseling for patients and their families.

The project has two objectives. One is that 10 percent (950) of the fertile women in Thika will avail themselves of family planning services for the first time at the clinic during the project's first year. The other is that the clinic will receive 8,000 referrals from other clinics.

2. Design and Selection

The FPAK believes that the establishment in Thika of a clinic which will provide family planning services to industrial workers, the majority of whom are women, is necessary and desirable.

There has been considerable industrial development in the area in the past 10 years. Approximately 25 major industries have been established there since 1969. The Thika Municipality estimates that the population is approximately 43,000. The estimated number of women of childbearing age (i.e., 15-49) is approximately 9,500.

A project proposal was developed and submitted in December 1978 and was approved. A Letter of Grant Award was sent May 10, 1979 for the project period June 1, 1979 - May 31, 1980. A request to extend the project to October 31, 1980 also was submitted and approved.

3. Implementation

The search for a clinic facility ended with the identification of a private clinic that is shared with a doctor who also serves as a part-time sessional doctor. The area is small, but adequate when combined with part of the veranda, where patients are registered and interviewed. Patients are referred to the clinic by field educators who are responsible for motivational activities. A driver/projectionist is used to bring audiovisual presentations to group. At the clinic motivational activities are conducted by a social worker, fieldworker, or nurse-midwife. Family planning services are provided by the enrolled nurse-midwife, except when the demands of the caseload or the patient's problem requires the services of the Sister in charge.

Complicated or problem cases are referred to the sessional doctor. The Sister in charge is responsible for the administrative functions of the clinic, including recordkeeping, data analysis, and reporting to FPAK headquarters.

4. Evaluation

The clinic was slow to start because of difficulties in finding a site and delays in hiring staff. Quarterly financial and program reports are sent to the Pathfinder Fund in Boston and to the regional office in Nairobi.

The statistics for the first year are as follows:

	<u>1st Quarter</u>	<u>2nd Quarter</u>	<u>3rd Quarter</u>	<u>4th Quarter</u>
New Acceptors	85	191	200	193
Revisits	<u>147</u>	<u>344</u>	<u>462</u>	<u>547</u>
TOTAL	<u>232</u>	<u>535</u>	<u>662</u>	<u>740</u>

The total of 669 new acceptors represents 70 percent of the original target. To date, there have been no dropouts reported. The number of referrals from other clinics was 374, only 5 percent of the 8,000 target. It is thought that the major factor in the low referral rate is patients' difficulty in getting their records transferred. Often, they register at another clinic as new acceptors. Moreover, it is unclear how the original target figure was set. It seems most unrealistic. Most clients are referred to the project by friends. Referral by friends is one of the best methods for promoting the project.

5. Effectiveness

The project may be considered part of the expansion program of the Family Planning Association of Kenya. It will continue the efforts of the organization to meet increased public demands for family planning services. Government support for the program, and particularly the pronouncements of President Moi, have increased the acceptance of family planning not only by Kenyan women, but also by men.

Pathfinder's readiness to take advantage of this opportunity and to offer its support is characteristic. The expectation and even the probability that the project will be taken over by the FPAK, with IPPF or government support, are high.

C. PIN 6345: Reproductive Health Training Center Project

1. Description

The grantee for this project is the Department of Obstetrics and Gynecology, Kenyatta National Hospital (KNH), Nairobi. The project is a cooperative effort with the Johns Hopkins Program for International Education in Gynecology and Obstetrics. The purpose of the project is to renovate and equip an outpatient surgical facility for the Department of Obstetrics and Gynecology. The facility would be used for training and services in diagnostic and therapeutic endoscopic techniques. Training is to be provided for provincial physicians and district health personnel in endoscopy, surgical contraception, cancer screening, and management of high-risk pregnancy.

The project director is Professor J.K.G. Mati, chairperson of the Department of Obstetrics and Gynecology. Professor Mati has had advanced training in endoscopic techniques and is a member of the Steering Committee of the World Health Organization (WHO) Task Force on Infertility.

2. Design and Selection

In March 1979, a contract was signed with the Johns Hopkins Program for International Education in Gynecology and Obstetrics to develop in Kenya a National Endoscopy and Reproductive Health Education Program. The program would be implemented by the Department of Obstetrics and Gynecology of the Kenyatta National Hospital and would continue for three years.

Ronald T. Burkman, M.D., acting director of JHPIEGO, and Eliot Putnam, associate executive director of Pathfinder, discussed the possibility of obtaining Pathfinder's support to renovate a clinical area in which to conduct the program. Pathfinder is interested in surgical contraception, and it thought that, in addition to endoscopic techniques, the technique of minilaparotomy could be taught at the same facility. The minilaparotomy procedure is particularly adaptable to use in health centers and rural dispensaries, requires less sophisticated skills and equipment, and can be performed using local anesthesia.

A proposal for the project was approved in January 1980.

3. Implementation and Monitoring

The project coordinator is Dr. Wilson M. Ngoka, senior consultant in obstetrics and gynecology at Kenyatta National Hospital. Dr. Ngoka is responsible for the day-to-day management of the program. He has had advanced training and is skilled in laparoscopic techniques. Under the JHPIEGO grant, provincial physicians interested in surgical contraception are identified, selected, and sent to Kenyatta Hospital for training. The training may last one week or longer, depending on the needs of the trainee. The initial cases are handled by the trainee under the supervision of the project coordinator. The program is limited by the availability of the operating theatre. At this time, approximately 300 patients are on the waiting list.

Under this project, an under-used area of the hospital was identified and renovated. The area, including the operating theatre, is now ready for use. Full implementation of the project has been delayed because there is no full-time anesthetist. An anesthetist has been identified but is available only part time. Nevertheless, the program can be carried out, although not with the effectiveness or efficiency desired.

Each patient who undergoes surgical contraception has a sterilization record and a proforma follow-up is completed. Follow-up visits are scheduled for one week, three months, six months, one year, and two years. Data will be collected and prospective outcomes will be analyzed. The program is monitored by the project coordinator and the project director.

The program provides clinical training to allow each physician to acquire initial experience and to become qualified in the use of the equipment. The program includes didactic as well as clinical training. The didactic portion covers:

- patient selection and informed consent;
- indications for laparoscopy;
- complications of procedures;
- techniques using general or local anesthesia;
- patient follow-up and education;
- care of equipment; and
- related topics.

During clinical training, each trainee observes and performs a minimum of 10-15 procedures, depending on the individual's surgical skill and adaptation to the procedure.

4. Evaluation

This project will do much to meet the increasing demand for surgical contraception. The Department of Obstetrics and Gynecology cares for approximately 7,000 obstetrical and gynecological inpatients and 12,000 outpatients annually. Kenyatta National Hospital is the main referral center for the Ministry of Health System, which also has facilities in Kenya's six provinces. The project will provide additional clinical facilities to accommodate patients seeking sterilization and to train physicians and other health personnel in the techniques of surgical contraception.

To date, 12 medical doctors have been trained in laparoscopy and laparoscopic tubal ligation. Training in endoscopy has been a higher priority because hospital facilities are needed and because the skills of the qualified faculty are best suited to this type of clinical training. Clinical training in minilaparotomy will be easier when the endoscopic program is implemented fully. Faculty have not been available to supervise trainees at other facilities.

Quarterly financial and program reports are sent to Pathfinder in Boston and to the regional office in Nairobi.

The minilaparotomy film sent by Pathfinder/Boston was never received.

5. Effectiveness

This project is consistent with Pathfinder's pioneering efforts, in this case, surgical contraception. It also is evidence of Pathfinder's willingness to cooperate with other agencies in the field of family planning. The combined efforts of JHPIEGO and Pathfinder are likely to have a greater impact than the efforts of agencies acting alone.

The project's prospects for self-sufficiency or for support from another donor agency are excellent. Surgical contraception must be an ongoing service of the Department of Obstetrics and Gynecology at the KHH; however, initial support by Pathfinder will enhance the capacity and capability of the department to cope with current and overwhelming demands.

D. PIN 6438: Family Planning Motivational Services

1. Description

The grantee for this project is the Maendeleo Ya Wanawake Organization. It is the largest women's organization in Kenya, with over 6,000 local groups and 200,000 registered members. Maendeleo groups organize at the grass roots level to develop and implement self-help projects designed to improve the standard of the community and the economic condition of women. The organization was founded in 1952 and is active among all tribal groups.

MYWO is the first women's organization in sub-Saharan Africa to arrange to build its own office structure and to rent other offices in the building to businesses and embassies. The money from the rentals will be used to offset bank loans, and subsequent monies will be allocated to rural development projects and to training programs for rural members.

The MYWO building was inaugurated by President Moi in April 1980. The inauguration received nationwide publicity, and the Pathfinder Fund was cited for its assistance with the family planning program. This is the second year of the project, which is being conducted by Maendeleo leaders and volunteers in rural areas of four provinces in Kenya: the Central, Western, Nyanza, and Coast provinces. The campaign enlists support for the National MCH/FP Program in rural areas that have been resistant in the past. Five provincial coordinators work with local and village leaders, teaching them how to motivate villagers, how to distribute coupons, and how to keep records on family planning acceptors.

The project director is Jane Kiano, a prominent leader in Kenya. In addition to serving as national chairperson of Maendeleo Ya Wanawake, Ms. Kiano holds prominent positions in several national and international organizations. In recognition of her services to the community and for her dynamic leadership, President Moi made her an Elder of the Order of the Burning Spear. She is the first Kenyan woman to be so honored.

The project administrator is Jennifer Mukolwe. Ms. Mukolwe has a master's degree in nutrition from Nairobi University and is completing work for her Ph.D. She worked as a lecturer and nutritionist for two years in the Kenyan Ministry of Health.

2. Design and Selection

As a result of recommendations by the New Paths Committee, the Women's Programs Division was established in 1977 as one of two new divisions of the Pathfinder Fund. In the same year, Jane Kiano approached Dr. Marasha to discuss the possibility and feasibility of funding through Pathfinder a program that would integrate family planning with the existing activities of the organization. Letters from Mr. J. S. Matherge, deputy permanent secretary and external aid in the Ministry of Finance and Planning, and Dr. S. Kanari, director of Medical Services, Ministry of Health, supported the concept and outlined the requirements for cooperation.

In February 1978, Freya O. Bicknell, chief of Pathfinder's Women's Programs Division, visited Nairobi and, in conjunction with Dr. Marasha and leaders of the Maendeleo Ya Wanawake Organization and the Ministry of Health, developed a project proposal. After review by AID, a grant award was made in January 1979.

The project was designed to involve the MYWO in the National MCH/FP Program by organizing a motivational and educational family planning program that would be integrated into the development programs of local Maendeleo self-help projects. The campaign enlisted support for the national program in four provinces in Kenya--rural areas where the national program and the FPAK encountered resistance when they tried to promote the use of available family planning services. Since the MYWO is a grass roots organization with many local branches, many rural communities were reached. The integration of family planning motivational and educational activities with self-help projects (e.g., poultry farms, potable water projects, etc.) is recognized as leading to the greater acceptance by rural women of family planning services.

3. Implementation and Monitoring

In the first year of the project, provincial coordinators were hired to work in the Western, Central, Nyanza, and Coast provinces. A series of workshops and seminars was held at provincial, district, divisional, and local levels for leaders of Maendeleo clubs. Instruction was given in motivational techniques for family planning, recordkeeping, and coupon distribution. Linkages were established with the FPAK and the national program. With the cooperation of community development officers, agricultural extension agents, nutrition educators, and other technical experts, local Maendeleo groups developed self-help projects and integrated family planning with other activities.

In the second year, a local expert in family planning and community education will be hired to help the coordinators develop and implement a refresher training course for local leaders.

The consultant will spend up to two weeks with one or more of the coordinators to identify communication problems and to develop a simple educational package for use with local leaders. The coordinators will meet in Nairobi for one week of training and return to their provinces for meetings with local leaders.

Each coordinator will work in an average of 16 divisions, with an average of 6 locations per division. Two local leaders from each locale (a total of 960) will be trained or retrained. The local leaders will work in the villages, providing individual and group motivation, distributing coupons, referring clients to FPAK or MOH clinics, and keeping records on family planning acceptors.

A member of the evaluation team and the program officer, from Pathfinder's regional office met with the coordinator for the Western Province, Mrs. Perus Abura, and members of the Essaba Maendeleo group. After being greeted by the group's choir, they were shown examples of the group's handcrafts. An organized program to demonstrate how group motivational activities are carried out followed.

Approximately 80 members of the Essaba group and 40 leaders from neighboring sub-locations assembled in the Church of God. The group included local government leaders (the chief and sub-chiefs), church leaders, school teachers, and other opinion leaders.

The program was opened by the program organizer, Mrs. Alice Otenjo, who explained the purpose of the meeting and introduced the chairperson, Mrs. Abura. The purpose of the visit was further explained, as were the activities of the day, which included an audience-participation question-and-answer session on children's diseases and problems or complications in childbearing. The philosophy, methodologies, advantages, and availability of family planning were discussed, and women in the audience were urged to use the services. The men, who made up 20-25 percent of the audience, were urged to support the efforts.

Mrs. Abura further commented on the integration of family planning in maternal and child health nutrition and developmental programs, including income-generating projects. She then called on the visitors to speak.

After thanking the group for the warm welcome, the evaluation team took advantage of the opportunity to emphasize what had been said earlier and to make a clear distinction between birth control and birth choice. The group's efforts were supported and applauded. Members of the press were present, and the group's remarks were mentioned in the Nairobi Standard the following day.

4. Evaluation

Quarterly financial and program reports are sent to Pathfinder headquarters in Boston and to the regional office in Nairobi.

The number and location of workshops and seminars held in the first year and the number of participants are a matter of record. No quantifiable and more important are the villagers' changes in attitude toward family planning. As one of the earliest women's programs funded by Pathfinder, and the only women's program in Africa, the project will be scrutinized closely for the lessons it reveals and for positive aspects that can be replicated elsewhere.

One of the strengths of the program is the Maendeleo ya Wanawake Organization. Not only its size and nationwide distribution, but also its leaders, are important. The director of the MYWO, Jane Kiano, the project coordinator, Jennifer Mukolwe, and the provincial coordinator, Perus Abura, are impressive. It is particularly important, and fortunate for Maendeleo and Pathfinder, that the project has a local leader like Ms. Abura. She is a teacher, an ordained minister, an elected county councilor, and an individual respected by all with whom she has contact. Ms. Abura has recognized the project's problems. In the past nurses sent patients away without treating them. This no longer happens--a result of discussions with local authorities. Patients were once asked to pay for injections; this requirement was rescinded after discussions with Ministry of Health personnel at Bungona. There was some confusion about the role of Maendeleo ya Wanawake, but that role and the organization's relationship to other agencies have been clarified. Additional clinics have been established. Though some church leaders have hesitated to espouse family planning, they have begun to discuss the issue. Although lack of office space was a serious problem at the beginning of the project, local authorities in Kakamega have now provided space.

Ms. Abura has identified additional problems that remain to be solved.

1. Relationships between clinic staff and patients need to be improved to correct rudeness and to prevent unnecessary delays in service.
2. Ms. Abura needs a deputy or assistant who can carry on her work when she is unavailable.
3. A telephone needs to be installed.
4. The project needs a vehicle to deliver services to many hard-to-reach areas.

In spite of these difficulties, the statistics for 1979-1980, though incomplete, are impressive. The project has formed 405 groups in the provinces. Approximately 1,630 coupons have been issued and 940 clients have received services. The prospects for successful women's programs would be enhanced if more local leaders like Ms. Abura were identified.

5. Effectiveness

The success of the Maendeleo project may be attributed to several factors, both single and combined. There is qualified, experienced, and strong leadership in the organization. Government, church, school, and local opinion leaders have participated actively in the design and implementation of the project. Family planning activities have been integrated into the self-help projects of the organization and efforts to reach rural women, those who ultimately use the services, are being emphasized. The major constraint is the delay in the funding for the renewed project.

This project should prove to be a model for other women's programs throughout Kenya and in other parts of the world. The government is cooperating with the project and has expressed an interest in providing long-term support. The project's prospects for self-sufficiency are excellent.

E. PIN 6442: Busia District Training Project

1. Description

The grantee for this project is the Agenga Committee, which takes its name from the nearby Agenga Mountains. A group of local opinion leaders, it is responsible for a multidisciplinary program in community development, including health, nutrition, agriculture, livestock, beekeeping, family life education, homecraft, and handcraft. It began as a self-help group. Local people joined in the Kenyan tradition of Harambee, contributing money and labor. The Agenga Nutrition Center was established in 1972.

In the first year of the project, 165 women and men were trained in general public health, MCH, nutrition, and family planning. The three-month program included lectures and demonstrations in nutrition, family relationships, public health, family planning, home economics, and handcraft. Following training, students went into the villages and discussed with individuals and groups what they had learned. Referrals for FP services were made to Ministry of Health clinics and to the Mangina Mission Hospital's mobile clinics.

In the second year, the project will evaluate the performance in the field of the trainees, 40 of whom will be selected for retraining to conduct a community-based distribution program. The graduates will receive additional training in general public health, family planning services, client selection and counseling, client recordkeeping and referrals, distribution of non-prescription contraceptives, and program planning and implementation. Seventy additional volunteers will be selected for the basic three-month training course in motivation and education.

The project director is Dr. Hannington O. Pamba, a microbiologist at the University of Nairobi and Kenyatta National Hospital.

2. Design and Selection

Dr. Julia Ojiambo, M.P., is the Assistant Minister for Housing and Social Services. She worked in Busia District to collect data for her Ph.D. thesis. It was her idea to integrate nutrition, MCH/FP, and development projects in this area. Later, Dr. Ojiambo met Eliot Putnam, who discussed with her her ideas and the possibility of Pathfinder support.

In 1977, Dr. Ojiambo wrote and submitted to Pathfinder a project proposal. The proposal was funded in October 1978 as PIN 6136. The Agenga Committee was designated to be the grantee and Dr. Ojiambo was selected to be the director of the project. A proposal to renew the project is awaiting the approval of Pathfinder and AID.

3. Implementation and Monitoring

In the first year, the project director was the Honorable Dr. Julia Ojiambo who, by that time, had received a Ph.D. in public health. Her major interests were nutrition and MCH. Her home was in Busia District, which she represented as a Member of Parliament. She was and continues to be active and effective in bringing various development projects to the area.

The project was supervised by the Agenga MCH/FP Project Committee, which is composed of an Advisory Committee, made up of members of the faculty of the University of Nairobi, the medical officer of health, and district and divisional officers; a local Steering Committee, made up of the chief and local opinion leaders; and a Village Committee, made up of the assistant chief, a Kanu member, and opinion leaders from the village.

Four three-month training courses were designed for 50 trainees each. Five trainees from each of 10 locations were chosen by local opinion leaders. There were 46 in the first course, 36 in the second, 34 in the third, and 49 in the fourth. Medical students from the University of Nairobi, Department of Community Health, were assigned to the project because of their field experience and helped train the villagers.

The project was monitored by Dr. Ojiambo. The staff of the regional office in Nairobi also monitored the project, reviewed reports, and provided necessary technical assistance. Although the project period was January 1 - December 31, 1979, the project did not begin until February 1979, and it continued only through March 31, 1980.

4. Evaluation

The project had problems from the beginning. The selection of the trainees is said to have been influenced by political considerations. The high office held by the project director complicated the decision making process of the Steering Committee and the relationship between the project and the regional office. When problems in administering the project were identified, the program officer in the regional office visited the project in January 1980 and talked with the project director and members of the Steering Committee. Her observations included a description of the temporary facilities at Sio Port. She recommended that an accountant be hired. The year-end audit of the project, required by Pathfinder, identified a number of fiscal problems related to deviations from budget line-items.

Pathfinder decided to retain Dr. Donald Minkler to assess the project's status and the feasibility or desirability of renewing it. Dr. Minkler visited the project in July 1980 and reported his findings. He recommended that renewal be delayed until certain corrective actions were taken, but he stated that supplemental funding during the interim should be provided to maintain essential core staff.

Dr. Minkler recommended the following:

1. Hire a full-time project coordinator for day-to-day management.
2. Correct identified accounting deficiencies.
3. Clarify personnel policies.
4. Involve the faculty of the University of Nairobi, especially the Department of Community Medicine and the Institute of Population Studies and Research, in the project.
5. Cooperate with the government, especially the Ministry of Health and the National Family Welfare Center.
6. Cooperate with appropriate local agencies (e.g., the Nangina Mission Hospital).

On November 12, 1980, a member of the evaluation team and the program officer from the regional office visited the project and met with Mr. David Majale, the project administrator (hired August 1, 1980), Mr. Wellington Mudibo, the accounts officer, Mr. Tobi Malimer, the local chief, and other members of the local Steering Committee. Many of the identified problems have since been addressed and corrected. The administrator is able to provide improved day-to-day management. The accounts officer has implemented suggested accounting procedures, but reporting remains to be improved. The Ministry of Health has seconded staff to the project to assist in training and to make family planning services available. Nevertheless, problems still exist.

The project coordinator, Dr. Pamba, is physically located in Nairobi and, although his visits to the project are frequent, the administrator often has to make on-the-spot decisions without Dr. Pamba's input. Communications between the Advisory Committee and the local Steering Committee are poor. The decisions of the Advisory Committee are not always immediately communicated to local groups. The University of Nairobi has not absorbed the cost of medical students sent to the project, and this has placed an unexpected burden on the project's budget. In spite of the funding for the interim period, April 1 - October 31, 1980, expenditures to maintain the core staff and the temporary facility have exceeded available funds. At the time of the evaluation, the proposal to renew the project had not been approved.

5. Effectiveness

The concept of the project is fundamental: the integration of family planning with maternal and child health, nutrition, and development programs. Despite the many problems in its implementation, the project may well become a model for other areas of the country. The objective of the Harambee approach, whereby leaders and villagers work together and contribute to the building of a permanent structure, will be realized when the new facility, which was visited by the team, is occupied. The support of this project is consistent with Pathfinder's pioneering philosophy and programs.

The project's prospects for self-sufficiency are excellent. The Ministry of Health of Kenya already has expressed an interest in the project and a desire to replicate it in other parts of the country.

The increasing production of income-generating projects will further contribute to the project's self-sufficiency.

CONTACTS IN KENYA

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Ms. Felicity Chavanga, Office Manager
Mr. Justus Kombo, Stores Clerk
Mr. David Mwongera, Stores Clerk

Ministry of Health

Dr. S. Kanani, Director, National MCH/FP Program
Dr. A. Gathenji, Deputy Director, National MCH/FP Program;
Director, National Family Welfare Center
Mrs. Waithaka, Senior Nursing Officer
(in charge of family planning training)

Family Planning Association of Kenya (PIN 6269 and PIN 6272)

Mrs. Angela Gethi, Executive Director
Dr. Walter Ochieng, Project Coordinator,
Clinic Expansion Project, FPAK
Sister Florence Rach, Nursing Sister in Charge,
Nairobi Clinic
Mrs. Grace Maina, Enrolled Nurse-Midwife, Nairobi Clinic
Sister M'Muthara, Project Coordinator,
Thika Family Planning Clinic
Ms. Isabelle Njagi, Social Worker, Thika Clinic
Mrs. Tabitha Khasiani, Sister in Charge, Kakamega Clinic
Mr. Zedekiah Luvavo, Fieldwork Supervisor, Acting Area
Officer, Western Province
Ms. Ester Ali Senjour, Field Educator, Lurambi Division
(formerly, Deputy Mayor, Kakamega)

Maendeleo Ya Wanawake (PIN 6438)

- Ms. Jane Kiano, National Chairperson
- Ms. Jennifer Mukolwe, Project Director
- Ms. Persus Abura, Project Coordinator,
Western Province
- Ms. Alice Otenjo, Program Organizer,
Western Province
- Ms. Jane Ekambi, Group Leader,
Western Province
- Reverend Michael Mukhwana, Guest Minister,
Western Province
- Reverend Mika Obayi, Pastor, Church of God,
Western Province
- Mr. Dishon S. Odawa, Officer in Charge/Tutor,
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Mbale, Western Province

Busia District Training Project (PIN 6442)

- Mr. David Majale, Project Administrator
- Mr. Wellington Mudibo, Accounts Officer
- Mr. Tobi Malimer, Local Chief
- Sister Marianna Hulshof, Mangina Hospital
- Sister Kathleen Brown, Mangina Hospital
- Dr. Hannington O. Pamba, Project Coordinator
- Professor Nimrod Bwibo, Advisory Committee

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- Mr. Freeman Pollard, Regional Director

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VI. COUNTRY REPORT ON ZAIRE

Demographics

Located in the center of Africa, Zaire is one of the largest countries on the continent. Its estimated population of 29.3 million is among the fastest growing in Africa, with an annual growth rate of 2.7 percent. It is likely that the population of Zaire will double in 25 years, reaching 48.1 million in 2000.

Despite its wealth of natural resources, Zaire has been in a state of economic and political crisis for several years. With a per capita income of \$210, it is among the poorest countries of the world. The government of President Mobutu Sese Seko Kuku Ngbendu Waza Banga is bankrupt and unable to deliver the most basic of human services. Official corruption and inefficiency are rampant.

Zaire's health problems are severe. Communicable diseases are endemic and malnutrition is widespread. Because of chronic shortages of food and woefully inadequate transportation and marketing systems, large portions of the rural population and the urban poor are ill-nourished and underfed. Lack of trained medical personnel, poor communications, and neglect of agriculture have seriously constrained the efforts, primarily of the private and voluntary sectors, to improve the quality of life. The birth rate is 46/1,000 and the death rate is 19/1,000. The infant mortality rate is 160. Life expectancy at birth is 46 years.

As the regional representative observed, given these dismal statistics and the drastic state of the economy, interventions in the field of health or family planning are not likely to succeed unless they are closely linked to efforts to rehabilitate agriculture, provide education, and encourage employment opportunities.

Family Planning Services

Family planning activities in Zaire are limited, in part because the government has not made a commitment to a family planning/population policy. There is, nonetheless, considerable demand for services among the population.

The National Committee for Desired Births (CNND) was established in 1973. It is the central and only coordinating body for family planning services in the country. Though it operates with the sanction of the government, it receives no government support. It is an IPPF affiliate, and the IPPF is

is its principal source of support. Some observers suggest that, because it is not a full-fledged agency of the government, its influence is limited. Indeed, it is viewed by many as no more than the local branch of an international PVO. The USAID population officer in Kinshasa reports that the CNND has a dozen or so members who represent various disciplines, but that it is dominated by a few physicians. Its administrator is Mr. Mwamba Mutela. It has 99 delivery points throughout the country.

There are a number of relatively small PVOs contributing to family planning information and service programs--the Population Council, the FPIA, and Pathfinder among them. Most work through the Eglise du Christ au Zaire (ECZ)*, as well as the CNND. The ECZ, a consortium of 58 Protestant groups, maintains 67 hospitals and 500 dispensaries throughout the country. The ECZ operates the only viable health delivery system in Zaire.

Since 1974, nearly all government health services have broken down. In that year, all hospitals previously run by the government were turned over to missionary groups, and it is likely that they will continue to be administered and supported by these groups. The government health budget was cut by 50 percent this year. There is a new Minister of Health, Dr. Kalumi Lushikwa Mulamba, who is knowledgeable and concerned about maternal and child health and family planning. Many are optimistic that he will bring a fresh, positive attitude to the Ministry.

Although the Catholic Church, which is the largest single religious group in the country, is officially opposed to family planning, some individual Catholic missionaries are willing to provide services. A leading figure among Catholic missionaries is Sister Betsy Brock, who serves on the National Educational Policy Council and is responsible for family life education (FLE), including sex education, throughout the country. She has produced an excellent series of pamphlets for use in schools.

When the Pope visited Zaire earlier this year, a group of Zairois bishops met with him privately to try to encourage him to modify his position on family planning. Though they were unsuccessful, their courage and their conviction about the importance of family planning in Zaire are noteworthy.

The Medical Faculty of the University of Zaire (UNAZA) is located in Kinshasa and is responsible for the administration of the country's largest health facility, the Mama Yemo Hospital. There are 150 deliveries a day at Mama Yemo. The director of the hospital is Dr. Miatudila, who was out of the country at the time of the evaluation team's visit. Dr. Miatudila is an associate of Mr. Mwamba on the CNND and, according to all reports is an able and forward-thinking force in the medical community.

* Church of Christ of Zaire.

Population Policy

The Government of Zaire is officially pro-natalist, perceiving the country as physically large enough to contain more people. In fact, according to the AID population officer, a principal development objective of the government is to populate the country more fully.

The government does recognize the health needs of mothers and children, however. It was an appreciation of the severe health pressures on the population that ostensibly inspired President Mobutu's "Naissances Desirables" speech to the nation in 1972. Since then, the government has fully supported programs to encourage childspacing in the interests of better maternal and child health. There is a national law that all babies must be delivered in a hospital. But, because hospitals are accessible to only a small minority of women and because the cost of a hospital delivery is 15 zaires, as compared to a penalty of 5 zaires for delivery outside a hospital, most women choose to deliver outside.

Mobutu's 1972 speech led to the creation of the CNND in 1973. Though support was offered originally by the IBRD and USAID, the committee depends now on the IPPF, FPIA, and Pathfinder for the financial sustenance it needs to continue functioning.

In recent years, AID has not been involved in direct bilateral assistance to family planning programs. Until the current population officer arrived six months ago, there had not been a population officer on the AID mission staff since August 1978. Recent AID bilateral programs have been restricted to community health.

The UNFPA supports three programs in Zaire: a census project, which has been operating for the past four years (although government reluctance to become seriously involved has slowed its implementation); a project to provide training in demography at the National University of Zaire; and a project to introduce population education to union groups, maternal and child health program managers, and nutrition and agricultural extension workers.

Project Reviews

Members of the evaluation team visited three current Pathfinder projects in Zaire.

A. PIN 6224: ECZ Family Planning Service Project

1. Description

The grantee for this project is the Church of Christ in Zaire, the organization that coordinates all Protestant missionary activities in Zaire. The ECZ maintains a network of 67 hospitals and 500 dispensaries throughout the country.

The objective of this project is to establish 80 medical facilities that have the capacity to provide family planning services. Staff training is conducted at each facility and appropriate supplies and equipment for the program are provided.

The project director is the Reverend Ralph K. Galloway. Reverend Galloway and his wife, Florence, give advice on education for family life and health to the ECZ. Mrs. Galloway is a nurse-midwife who received family planning training at the Downstate Medical Center in New York City. She is certified by the CNND for training in family planning. The Galloways have been in Zaire for almost eight years and are well known to Pathfinder. They are pioneers in the field of family planning in Zaire and have conducted other Pathfinder projects. The grant period for this project is April 1, 1979 - December 31, 1980.

2. Design and Selection

In December 1977, Mr. Mbualangu Ganuma, general secretary of the ECZ, corresponded with Dr. Marasha about ECZ's family planning activities in Zaire and other matters related to the extension of their programs. He also addressed possible funding levels for ECZ programs for three years, 1978-1980. He was advised that Dr. Marasha was expected to visit Zaire in April, at which time a possible proposal would be discussed. The proposal to provide family planning in 80 dispensaries throughout Zaire was developed and submitted. In October 1978, Reverend Galloway wrote to James Crawford, in Boston, indicating that, since submission of the proposal, inflation had increased 100 percent and modification of the budget was necessary. In November, Mr. Crawford cabled Reverend Galloway that the proposal had been approved with the original budget, but negotiations were being conducted with AID for a new budget.

In his letter of acceptance of the terms of the contract, Reverend Galloway said that a vehicle was needed to begin the project. He also advised Pathfinder that customs approvals would be needed from the Zaire

Protestant Relief Agency (ZPRA) and that specific shipping instructions would be needed to ensure customs clearance.

3. Implementation and Monitoring

At the beginning of the project, the FP activities of the clinics and dispensaries of the ECZ in Kinshasa were evaluated. Where no family planning activities existed, the project director worked with the coordinator to introduce services. Appropriate training was given and, depending on the skills of the staff, one of two programs was started. Comprehensive services, including IUD insertion, were reserved for those facilities where staff had appropriate skills. Other facilities would offer oral contraceptives, condoms, foams, and injectables.

At the invitation of church communities, a team consisting of the project director, Reverend Ralph Galloway, Mrs. Galloway, and Citizen Diasotuka, a licensed medical assistant who received a certificate in MCH/FP from the School of Public Health in Rennes, France, traveled to the interior of Zaire and held seminars for the personnel of ECZ medical facilities. The team also consulted with parish leaders to sensitize them to the need for family planning services in their medical facilities. The team trained medical personnel at each facility to provide family planning services.

At each place visited, the medical staff of the hospital or clinic were asked to meet first for a training session with the team. At this session the trainees were appraised of the purpose of the project, the importance of family planning in preventive medicine, and the methods available for controlling fertility.

At each dispensary, the names of the personnel, their qualifications, and their experience were recorded. Training sessions began with a discussion of the importance of recordkeeping. Various contraceptive methods were discussed, including advantages and disadvantages, indications and contraindications, effectiveness, side effects, and complications. Role-playing was used to demonstrate how prospective acceptors should be approached and instructed. The team then examined the women who had come for service and finally allowed the trainees to examine patients under its supervision. The time spent in the training sessions varied, depending on the background and skills of the trainees. At the end of the training sessions, sufficient supplies to start a clinic service were left with the trained personnel.

A report on the personnel who were trained and the facilities that were visited by the team was given to the CNND. CNND staff made follow-up visits to enroll the trainees in the national program.

4. Evaluation

Quarterly financial and program reports are sent to the Pathfinder Fund in Boston and to the regional office in Nairobi. The reports of Reverend Galloway are detailed and descriptive. The statistics are often incomplete because it is difficult to obtain reports from facilities in the interior of Zaire. At the end of the first project year, 71 of the expected 80 medical facilities had participated in the project, and 238 medical personnel had been trained. The project has been extended for another six months, to December 31, 1980.

The quarterly report for the period ending September 30, 1980 indicated that 91 medical facilities were then participating and 265 medical personnel had been trained. In addition, there were 4,836 new family planning acceptors and 4,541 active family planning acceptors.

The goals of this project have been achieved, in spite of the difficult circumstances under which project staff have had to work. Travel in Zaire is difficult at best. Special vehicles are needed, gasoline is not always available, roads are often impassable, and some places are accessible only by boat or small aircraft. Communications are limited, telephones are few or nonexistent, and mail service is poor. Communications are often by radio, through Peace Corps facilities and personnel. Zairois in the interior of the country are attached to ancient traditions, and traditional methods for childspacing are still used. Illiteracy is high and differences in languages pose a problem.

The rate of infection is high and there is a serious lack of basic medicines. Where treatment is available, the medical facility is often a great distance from the patient's home.

The achievements of the project under these conditions are remarkable.

5. Effectiveness

This project is the epitome of what is implied in Pathfinder's name. The delivery of family planning information, services, and supplies to the interior of Zaire requires the ingenuity and personal sacrifices of the Galloways. Reading the detailed narrative reports of Reverend Galloway, one is reminded of the Africa described by Stanley. Dispensaries accessible only by small aircraft, river boats, or long walks have been reached by the Galloway team and the personnel who have been trained to provide family planning information and services.

The long-term impact of this project will exceed what is indicated by the statistical data being reported at this time. However, the hope that this program will become self-sufficient is unrealistic. It is possible that if the CNND is able to follow up the Galloways' visits, and if it is able to enroll the medical facilities of the church system in the national program, the government may one day be able to support the program.

The Pathfinder Fund is to be commended for its support of this project and of the Galloways, who have been described as "friends of Pathfinder," but who also are doing God's work for the benefit of mankind.

B. PIN 6282: Maternal and Child Health/Family Planning Training for Doctors and Nurses

1. Description

The grantee for this project is the National Committee for Desired Births,* established in 1973. The purpose of the project is to train 32 nurses and 16 doctors to deliver MCH/FP services.

The project director is Mr. Mwamba Muteba, administrator of the CNND. Mr. Muteba has a master's degree in economics and received additional training while attending the Administrators' Training Program at Johns Hopkins University.

The grant period is from September 1, 1979 to February 28, 1981, during which time four training courses are to be conducted.

2. Design and Selection

The project director, Mr. Mwamba, joined the CNND in 1977, at which time other Pathfinder projects were in place. The CNND has conducted two previous family planning training courses with Pathfinder funding. From 1976 to 1978, approximately 90 nurses were trained by the CNND in family planning.

The project proposal was developed and submitted in 1978 and approved in May 1979.

* In French, Comite National des Naissances Desirables.

3. Implementation and Monitoring

Invitations were extended to the proper authorities in each region to select nurses and doctors to participate in the CNND family planning training program. The period of training is six weeks for nurses and three weeks for doctors, with some overlapping to allow for team training. Didactic and practical training is given at the Mama Yemo Hospital in Kinshasa, and some practical training is provided at other clinic sites. The curriculum includes discussions on the history of contraception and theoretical and practical training in:

- motivation;
- IUD insertion;
- psychological, social, and cultural aspects of desired births;
- demography;
- cervical and vulvo-vaginal pathology;
- pelvic infections;
- endocrinology;
- hormonal contraception and its secondary effects;
- genetics;
- modern methods of contraception;
- adolescent sexual problems;
- infertility;
- nutritional immunization of the newborn;
- anatomy and physiology; and
- adult education.

Instructors in the program received family planning training at the Downstate Medical Center in New York City. The supervisor of the model clinic is Dr. Mguma Mongonza, who received clinical training at the Johns Hopkins Program for International Education in Gynecology and Obstetrics.

4. Evaluation

Quarterly financial and program reports are sent to Pathfinder in Boston, and copies are sent to the regional office in Nairobi. Reports for the first session indicate that 2 doctors and 12 nurses received training. Several financial problems were experienced. Trainees complained that they had to share rooms (2-3 persons per room) and follow drastic diets because of inadequate funds. Since budget increases are neither likely nor feasible, some modification in the training program is necessary. It has been suggested that training be conducted at regional sites rather than at a central site in Kinshasa. Another alternative is to try to identify a school with dormitory facilities to accommodate the trainees. The monetary devaluations and extraordinary inflation in Zaire have compounded budgetary problems.

5. Effectiveness

This project addresses the critical shortage in Zaire of health professionals with family planning training. The problem is especially serious in the interior of the country. The lack of a government health infrastructure compounds the problem. If it were not for the church network and missionaries, basic health needs would not be met.

This kind of project should not be expected to become self-sufficient. It is hoped that training programs will become an integral part of CNND activities, which should be supported by the IPPF or with government funds.

C. PIN 6342: CDCZ Family Planning in Equateur Region

1. Description

The grantee for this project is the Community of the Disciples of Christ in Zaire (CDCZ),* which is one of the 58 religious groups that form the ECZ. The CDCZ is the most prominent of the Protestant sects in Equateur Region, and its programs address a broad range of economic and social needs, including family health and family planning, housing, school construction, the provision of teachers, the promotion of agriculture production, and other income-generating projects.

* In French, Communauté des Disciples du Christ au Zaïre.

Project 6342 has three components:

1. Training of personnel in 20 CDCZ dispensaries and 5 hospitals in the region to provide comprehensive family planning services.
2. Training of 10 pastors of CDCZ churches as fieldworkers and motivators to provide education and information on family planning.
3. Training and provision of supplies to pastors so that they can coordinate the distribution of non-medical contraceptives throughout their parishes and refer acceptors or prospective acceptors with contraindications and fertility-related problems to an appropriate dispensary or hospital.

The project coordinator is Mr. Njali I. Bofeloyau, who was trained as a medical assistant (six years after completing secondary school and an additional year at the Institut de Medicine Tropical at Antwerp). He is the regional medical coordinator for the CDCZ in Equateur. Mr. Njali works closely with Reverend Botongo Ifefe, pastor for Ikongowasa Parish and director of the Women and Family Health Bureau of the CDCZ. These two men and others in the CDCZ Secretariat operate under the continuous guidance and inspiration of the Reverend Dr. Elonda Effefe, secretary-general of the CDCZ.

The project, which is in accord with the policy of the Government of Zaire, began officially on September 22, 1979.

2. Design and Selection

From all accounts, this is truly a project of the people. Its development was encouraged by numbers of couples in the Mbandaka area who came to the CDCZ requesting help in family planning. As Mr. Njali explained, "It's simply too difficult to have babies now and they demanded family planning services." Economic and health pressures on families in the region are stupefying. Unemployment is 80 percent. Malnutrition is severe. The economic base of the region is agriculture, but it is primarily cash, and not food crops. Those families that are able to produce food in excess of what they themselves require have difficulty getting their surpluses to markets because of the woefully inadequate and expensive transportation system. The consequence is a severe food shortage, particularly in Mbandaka, the region's capital.

In response to the demand from parishioners for family planning services, the CDCZ asked the ECZ headquarters in Kinshasa for help. The ECZ advisers in Education for Family Life and Health, the Reverend and Mrs. Galloway, suggested Pathfinder. Marianne Burkhart, a member of Pathfinder's headquarters staff, spent several days at the CDCZ headquarters in Mbandaka to help design the project.

3. Implementation and Monitoring

Following approval of the project in the fall of 1979, the Galloways spent a month with CDCZ staff, traveling throughout the region to visit all 5 hospitals and 14 of the 20 dispensaries and to train personnel to provide family planning services. Staff at the 5 hospitals were trained to provide comprehensive services, including IUD insertions. Staff at 4 of the dispensaries are now qualified to insert IUDs, but those at the other 10 facilities may offer only condoms and pills. Outreach to the remaining 6 outlying dispensaries, additional training, and the upgrading of staff at the 10 dispensaries where IUDs are not offered have been curtailed by the lack of a project vehicle.

The pastors at the 10 parishes in Mbandaka have been trained as field-workers to provide education and information on family planning. In addition to this planned component of the project, Mr. Njali has tried wherever possible to include staff from the Women and Family Life Bureau of the CDCZ as trainers so that the pastors who are trained can provide information and guidance on maternal and child health, as well as home economics and nutrition, when they talk about family planning. As Dr. Elonda put it, "We often do double duty in this project."

The evaluator who visited the project participated in motivational meetings with couples at four different sites--two in Mbandaka proper and two in villages 30 kilometers outside Mbandaka. At each meeting there were 200-300 people--as many men as women. They heard motivational speeches in their own language from two pastors and the secretary-general. Their enthusiastic response was remarkable. It is clear that the people are firmly committed to family planning and are eager to receive services.

The third component of the project, coordination by the pastors of the distribution of contraceptives throughout their parishes, also has begun and will be intensified after CDCZ staff and the Galloways make a follow-up visit to the parishes where pastors have been trained. Such a visit is planned in 1981, after a project vehicle arrives. To date, pills and condoms have been given only to those pastors whose parishes have neither a dispensary nor a hospital.

The seminar for pastors in the interior has not been held, but Dr. Flonda and Mr. Njali are planning to conduct it at the hospital in Lotumba in March or April of 1981. They are reserving funds from the first year's budget for this purpose but fear that, given inflation and the need to involve more people for a longer time than was originally planned, the 24,000 zaires that were budgeted will not be sufficient. They have requested that an additional 16,000 zaires be included in the second-year budget for the seminar. The Galloways consider even the amount total, 40,000 Z, to be modest for the purpose.

Ideally, the CDCZ would like to hold two 7-10 day seminars a year involving the following 60 persons: the 20 persons in charge of each of the 20 dispensaries, the 16 regional pastors, the 20 lay motivators from the parishes, and the 4 representatives of the government (Sante Publique). The CDCZ also very much hopes that a Pathfinder staff member will attend the first seminar next spring. It is strongly recommended that Dr. Marasha and Freda Mudoga arrange their schedules so that they can be there as well.

The provision of equipment to the project has been slow, but all Pathfinder-supplied equipment has arrived in Kinshasa. It has been put on the boat for Mbandaka and is expected to arrive soon. Commodities from USAID are expected to arrive shortly.

4. Evaluation

The progress of the project is monitored closely by Mr. Njali, who, in addition to his technical medical skills, demonstrates good administrative skills and an abundant enthusiasm for and dedication to the project.

The achievement of project goals in terms of numbers of acceptors is difficult to measure accurately because of serious constraints on reporting, particularly from the interior parts of the region (see below). It is, however, likely that the goal of 1,000 new acceptors in the first year has not been reached (e.g., Mr. Njali reports 47 for the period June-September 1980). This is not necessarily a cause for concern, for a variety of reasons. One, the goal was probably unrealistically high for the first year. Two, the constraints on adequate and timely reporting are horrendous (i.e., there are, no doubt, many more new acceptors than have been recorded). Three, at least 500 women who were met in Mbandaka and its environs during the evaluation appeared to be enthusiastic supporters of the project and begged for continued Pathfinder assistance.

a. Reporting

For each person who comes to the CDCZ center, dispensary, or hospital, two forms are completed. One, the official form of the Zairois IPPF affiliate, the CNND, is stamped with a patient identification number and is completed in two copies, one of which is sent to the CNND headquarters in Kinshasa, where it is recorded, and one of which remains at the local center. The second form is used to record the patient's medical history after the first visit, the family planning method selected, and subsequent visits to the center. This form is kept on file at the center.

In addition, Mr. Njali also keeps track of the amounts each client pays for services. The issue of appropriate levels of payment for services is controversial. Dr. Van Herck, a Belgian who serves as the government's regional medical coordinator, believes that the cost of family planning services should be relatively high ("Otherwise they will sell them [contraceptives] on the black market," he is reported to have said.). CDCZ staff believe that some payment should be made (with a view toward the project's eventual self-sufficiency), but that the fee should be kept at a minimum so that as many people as possible can afford it. The CDCZ's basic charge for examining a patient, establishing the patient's record, and providing the method of the patient's choice is 5 zaires (roughly U.S.\$1.30). Subsequent cycles of the pill cost U.S.\$0.13 each, and 15 condoms can be purchased for the same amount. These prices seem to be appropriate and could perhaps even be raised slightly.

Mr. Njali and the Galloways developed a third reporting form which the hospitals and dispensaries participating in the project complete each quarter. This report indicates how many new acceptors have chosen which methods with what complications. One constraint on the efficiency of this system is the time it takes to receive reports. Three months may elapse before Mr. Njali receives the reports from the interior posts. Furthermore, some dispensary staff are unable to complete the form because they are illiterate.

Mr. Njali also completes comprehensive reports for the Pathfinder Fund. The first of these, a report on progress during the first year of the project, was submitted to Pathfinder in Boston. Mr. Njali was not aware that the reports were to be submitted each quarter, that a report form was available, that particular information was required (see the project description), and that copies of the reports were to be sent to Dr. Marasha in Nairobi.

Mr. Njali is now fully prepared to submit quarterly reports. He has made copies of the Pathfinder report form and will use them (he completed one for June-September 1980 and transmitted it to regional staff for Africa in Boston), has a French translation of the information requested in the project description, and has Dr. Marasha's address so that he can forward to him copies of subsequent reports.

It is clear that better communication of reporting responsibilities and a streamlined reporting system are needed. Mr. Njali appreciates very much the Pathfinder reporting form, but both he and the evaluation team were somewhat confused that the form (as appended to the project description) did not provide space for the information requested under Section X of the project description. A single comprehensive report form is recommended.

b. Constraints and Needs

The lack of a project vehicle has been a serious constraint on activity and progress. A vehicle has been approved and is on its way. This is cause for great joy among all.

Other equipment and medications (especially for malaria and worms in children) are sorely needed. In Mbandaka, equipment is much more important than cash. It is much more expensive, if not impossible, to buy equipment locally than in the United States, and the conversion of U.S. dollars into zaires is extremely difficult because of the severe economic effect of the black market on the value of legally exchanged dollars.

5. Effectiveness

a. Cutting Edge

This project is pioneering because it is part of the CDCZ, which is the only provider of human services in the Equateur Region. CDCZ's trail-blazing involvement in the most crucial development sectors gives it force and credibility that are matched by no other organization. For its time and place, the CDCZ has been revolutionary, but in a quiet way. An ardent participant at one meeting, a Catholic whom the nursing sisters had advised must separate from his wife forever because she was so feeble from childbearing, put it this way: "You Protestants brought me a miracle--you showed me family planning. Now I can stay with my wife and she is no longer sick."

The team asked project staff what would happen if Pathfinder did not exist. Their brave answer was, "We would go on, but at a much reduced rate." They suggested that the only alternative to the Pathfinder project would be government clinics, which are not viable because they have no supplies.

One could suggest in this case that it was not Pathfinder that led the way, but the people themselves, who demanded services. That would be true. But it also seems to be true that Pathfinder is uniquely capable of responding to demand and of enabling the regional leadership, through the CDCZ, to take the lead from the people and carry the effort beyond what the people could have done alone.

b. Potential for Self-Sufficiency or Other Donor Support

Project staff are fully aware that Pathfinder support will most likely not continue beyond three years, and they are eager to ensure that the project becomes self-supporting. At one of the meetings the team attended, someone asked why the CDCZ could not deliver services at no cost since the project was supported by Pathfinder. In answer, CDCZ authorities explained that they insisted on minimal charges to ensure that the project ultimately becomes self-sustaining.

Mr. Njali keeps careful records of income, and he has been urged to continue his recordkeeping so that, after another year, he can begin a financial analysis to compare the costs of the program with income and to determine how many acceptors at what level of charges would constitute a break-even point.

c. Accomplishment of Stated Goals/Output

The project has not achieved all the stated goals for the first year. These goals were grossly unrealistic, given the inherent constraints on operating in the Equateur Region, particularly without a vehicle. What is obvious is the dedication and skill of CDCZ staff and the enthusiasm of the people to whom this project is directed. The potential for intensification and expansion is great, and every effort should be made to help the CDCZ realize it.

Plans for the second year of the project, in accordance with the original project description, include:

1. The first region-wide seminar for dispensary staff and pastors, to be held in March-April 1981.
2. A second visit by CDCZ staff and the Galloways to hospitals and dispensaries for follow-up training.

3. The serious exploration of methods to broaden the CBD program using pastors in the region.

In addition, other items on the CDCZ "wish list" are:

1. Employment of a short-term (1-2 months) medical consultant (preferably an ob/gyn familiar with tropical medicine) who could help Mr. Njali survey complications among acceptors, not only to provide treatment, but also to understand whether such complications are, in fact, a result of the use of the contraceptive or symptoms of other problems that arise coincidentally with contraceptive use. A better understanding of the many possible causes of "contraindications of contraceptive use" would enable CDCZ staff not only to better treat their patients, but also to deflect future setbacks to the program because of incorrect perceptions of causal relationships.
2. Preparation of more vernacular literature on family planning use by the CDCZ, hospital and dispensary staff, and pastors and lay motivators. The CDCZ has at its disposal illustrators and others who would help produce materials. It also agrees that the messages and ultimate design of such materials should be determined by people in the community. What is needed from the outside is guidance in basic design and procedures and modest, additional financial support.
3. Provision of short-term training for female nurse-midwives in the delivery of family planning services. To date, all service deliverers in the Equateur Region are male, and they are the first to admit that the program would have much greater momentum if women were involved in the delivery process.
4. Provision of photocopying equipment. Given the need to disseminate information and report feedback, the project is seriously constrained by the lack of photocopying equipment.

5. Establishment by the CDCZ of a "Maison de Famille," which could offer a broad range of services and training to families, including:

- a. medical services and family planning;
- b. marriage counseling;
- c. legal services and counseling in the rights of couples, wives, and children;
- d. nutrition education;
- e. home economics and family budgeting; and
- f. functional literacy, especially for mothers.

Dr. Elonda believes that with less than \$40,000 he could build such a modest, but permanent and complete center. He would like to establish a Regional Family Association to help families, through training and extension services, to improve the quality of their lives.

As Dr. Elonda put it on the last day of the visit, "Ici le médecine c'est une ministère de guérison où il faut la joie et tout le cœur." Dr. Elonda and his staff at the CDCZ bring the critical ingredients in full measure to their ministry. As the only source of service or hope in a vast region of thousands of people ill-served by their economy, and their environment, they make the CDCZ a unique and extraordinary force for the promotion of family planning.

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Reverend Dr. Elonda Effefe, Secretary-General

Mr. Njali I. Bofeloyau, Regional Medical Coordinator;
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Mr. Ikete Eselenga Mbongo, Director of Development;
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**PATHFINDER FUND EVALUATION:
LATIN AMERICA**

By

**Keekee Minor
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November 2 - 21, 1980

I. INTRODUCTION

This report on the Pathfinder Fund's regional operations in Latin America is a supplement to the general evaluation (see Part I). It contains a discussion of Pathfinder-supported projects in Brazil, Peru, Colombia, and Guatemala and of the work of the country and regional offices and representatives.

Pathfinder maintains two regional offices and one country office in Latin America. The northern regional office, in Bogota, is responsible for project activities in Colombia, Central America, and the Caribbean. The southern regional office, in Santiago, Chile, is responsible for project activities in South America, excluding Colombia and Brazil. The country office in Brazil, opened one year ago, is responsible for projects in Brazil.

The team assigned to Latin America visited the regional office in Bogota and visited or talked with the staff of 20 projects in Brazil, Peru, Guatemala, and Colombia. The team was accompanied by the country representative while visiting Brazil and by the regional representatives while in Peru and Guatemala. The schedule of visits in Latin America was as follows:

Brazil: November 2-8
Peru: November 8-15
Colombia: November 15-17
Guatemala: November 17-22

Based on the observations and findings of the evaluators, this report provides summarized background on family planning and population policy for each country visited, a brief description of the management of each of the offices, and a review of the projects visited. Information is provided on the demographic situation in each country, local mechanisms for the delivery of family planning services, and the existence of relevant legislation or policies on family planning.

The description of the management of each office includes information on the training and background of the staff, the roles and responsibilities of the staff, the relationship between the country office and headquarters, and the mechanisms for coordination with other donors. In addition, a description of how support from Pathfinder is used in the country (e.g., to provide commodities and communications materials) is given. Some suggestions and assessments follow the description of the management of each office.

Information on each country is provided in a separate chapter. Each chapter contains a section that describes the projects in each country. The selection, design, implementation, and monitoring of each project are described. The effectiveness (i.e., success in achieving stated goals) and innovativeness of each project, given local constraints on and opportunities for family planning initiatives in the country, are assessed. The writers comment on each project's prospects for self-sufficiency only when they can identify some special opportunity for involving another agency, or when they feel the design particularly encourages self-sufficiency. In general, Pathfinder has done an excellent job of explaining to project directors that its support is short-term and that they should seek support from other institutions. Various suggestions for and observations on each project follow the subsections on self-sufficiency.

II. RECOMMENDATIONS

Before describing Pathfinder's operation in Latin America, the writers wish to present the following list of recommendations. These suggestions are generally applicable throughout Latin America and deserve special attention.

Commodities

The importation of commodities has been and continues to be an important problem in Brazil and Peru. It is imperative that country and regional representatives become more knowledgeable about the process of importation and keep up to date on changes. Where contraceptives have not been available, the effectiveness of projects has suffered. The policy introduced in Peru to make the disbursement of funds contingent on receipt of commodities is excellent and should be followed throughout Latin America.

Because the cost of insuring a shipment is high and because insurance may not be required in all cases, a cost analysis should be made to determine whether insurance is necessary at all. In Brazil, the team was told that there was little pilferage and that shipments were not lost. In this case, consideration might be given to under-insuring shipments or dropping insurance altogether. In Peru, where loss is frequent, this approach would not be advisable.

Many of the individuals who were interviewed indicated that, if shipping documents were in the local language, there would be fewer difficulties in clearance. Whenever possible and legal, all shipping documents should be printed in the local language.

Training Needs

Many projects, particularly some of the more innovative projects, need to improve their management capabilities. Money for training is available from other funding organizations in Latin America. Pathfinder should tap these sources of funds and work jointly with the organizations to design and develop training programs that respond to the specific needs of their grantees.

Reporting Forms

Many grantees stated that they have difficulty reporting information because the reporting forms from Pathfinder are in English. Indeed, the grantees wanted the Pathfinder representative to make more visits than was feasible to translate the forms. Pathfinder's forms should be printed in the local language if the grantees do not speak English.

Location of Southern Office

In the last several years, there has been growing interest in family planning in Peru, and Pathfinder's project activity in that country has increased substantially. At this time, Pathfinder has only one project in Chile. With this shift in emphasis, and given the need for more monitoring in areas where a large number of projects are located, the southern regional office in Santiago should be relocated in Peru.

Women's Projects

Projects developed by the Women's Programs Division are now being turned over to regional staff for monitoring. This arrangement has created problems for the grantees, who must adjust to new styles of operation, and often to a change in expectations. The problem is compounded because the representatives do not feel qualified to monitor the implementation of projects, especially if they have an income-generating component for which special technical expertise is required. One solution might be to hire another representative for the region who could design and monitor those women's projects which require an expertise that the current representatives do not have. The additional staff member could be funded under the AID Population Grant or the Women-in-Development Grant.

Quality of Care

The quality of care provided to patients was a major concern to the team, and many in the health care profession think it is a problem. In monitoring projects, the representatives need to pay particular attention to the care being provided. They should note how clients are handled, what type of counseling is given (especially about side effects of methods), and the quality of the training. The Fertility Service Division should work to establish minimum standards for training. The Women's Programs Division should promote, when appropriate, the inclusion of a module on client relations in training programs funded by Pathfinder.

III. COUNTRY REPORT ON BRAZIL

Introduction

Brazil is a "priority" country for Pathfinder because it has a large population and because some of its policy makers and professionals have recently developed an interest in family planning. One year ago, Pathfinder hired a country representative, the first in Latin America.

While in Brazil, the team traveled with the country representative and visited three projects.

Background

In 1980, the population of Brazil was estimated to be 122 million--the largest in Latin America.¹ Brazil has an annual growth rate of 2.8 percent, a birth rate of 36, a death rate of 8, and an infant mortality rate of 109. Sixty-one percent of the population live in urban areas.

Before 1974, family planning in Brazil was considered to be contrary to the national interest. But in the last few years Brazil has begun to move noticeably forward in family planning.² The 1974 Bucharest Conference contributed substantially to a shift in government policy.

Today, approximately 75 percent of the population support family planning. The Catholic Church has been unsupportive of family planning, but with 29 percent of all Brazilian women resorting to illegal abortion at least once, it is beginning to change its attitude. Family planning groups have been telling the Church and policy makers that a good family planning program will lead to a decrease in the number of illegal abortions.

The major problem now in implementing family planning programs in Brazil is the regulation prohibiting the import of IUDs, because they are considered to be abortifacients. Entry of IUDs into the country is often denied, and many programs must borrow IUDs from other programs or make do with limited supplies. A second problem is the difficulty of providing sterilizations. Three doctors' signatures are required for a sterilization, and the criteria for selection are strict. Most sterilizations are, therefore, done at the time of caesarean sections. As a result, women who want to be sterilized must deliver a final child by caesarean.

Forty-seven private organizations are working in the population field, the principal one of which is BENFAM, an IPPF affiliate. To date, the Ministry of Health has not provided family planning services at its clinics. In some states, however, BENFAM has used Ministry of Health or municipal government facilities for its community-based distribution program. This has created enormous public support for family planning service delivery. For example, in one state, the governor tried to close all family planning clinics. He was deluged with cables and letters from local mayors and from the public, all asking that services be continued. He subsequently reversed his decision. In another instance, a key legislator proposed legislation to ban the distribution of contraceptives in the country. The Pathfinder representative persuaded him to attend a seminar in Mexico on family planning. When he returned to Brazil, the legislator withdrew the legislation and is now supportive of family planning programs.

Despite these positive steps, much opposition still exists. For example, in the summer of 1980, the Rio Medical Association sponsored a prime-time television program on the dangers of the pill. The impact was enormous. Some programs experienced a decrease in the number of users. In others, however, women came to the clinics in increased numbers, fearing that the programs would be closed and they would no longer be able to get pills. Some new users were enrolled because a family planning method was advertised on the television program. Although opposition still exists, everyone who was interviewed felt that public knowledge of and interest in family planning are becoming strong enough that the government will eventually be forced to provide services.

Pathfinder projects are all viewed as appropriate bridges to the eventual integration of family planning into the health system. Pathfinder's efforts to incorporate family planning into the national medical school curriculum, to expand the availability of services in clinics and through community-based distribution programs, and to change the attitudes of medical professionals and legislators are considered to be very important to the evolution of family planning in Brazil. It was suggested that Pathfinder work also with women. The development of women's projects and the training of key women leaders were viewed as useful ways to change attitudes and increase the pressure on the government to provide services.

Management

A. Organizational Structure and Operation of Office

1. Background and Training of Staff

The Brazilian country office is located in Salvador, Brazil, and is staffed by the country representative, Jose de Codes, and a secretary.

The representative is a well respected ob/gyn who is a part-time professor of preventive medicine at the Bahia Medical School. He received his Medical degree from the Federal University of Bahia, a master's in public health from Berkeley, and a doctorate in public health from Johns Hopkins University. When he began work for Pathfinder 15 months ago, he received an orientation in Boston and then stopped for a day to visit the northern regional office.

The country representative is extremely well qualified for the technical aspects of his job. He still requires some on-the-job training in managing the project and would benefit from exposure to the operations of the northern office.

2. Roles and Responsibilities of Staff

The country representative developed six projects and monitored seven others in the last year. These projects have attempted to add family planning information to medical school curricula, support the training of personnel to deliver family planning services, extend services through community-based distribution programs, and work within the political networks in the country to change attitudes toward family planning. The representative has used the "rapid-response" mechanism to send two key politicians to Mexico, and he has begun to design a seminar for heads of Ob/Gyn departments in Brazil to discuss the official introduction of family planning into the medical school curricula of the country. To date, most of his time has been spent on the development of projects and on contacting key individuals in the medical and political power structures. He has been less involved in monitoring and evaluating projects.

All the grantees who were visited expressed positive feelings toward the country representative. His personal relationships with the grantees are excellent. He is able to relate well to individuals at all socio-economic levels. A number of the grantees emphasized that it is important that the representative be a well trained national who can understand the political realities of the country. All the grantees stated that the representative's field visits were useful, and a number indicated that they would like him to visit more often to provide technical and managerial assistance. Several grantees were unclear about the representative's role in implementing and evaluating projects, and they expressed concern that he did not have enough authority over the design, approval, and renewal of projects.

Suggestions

Now that seven projects have begun, the country representative should try to provide more supervision and technical assistance to the projects. In particular, he should give attention to:

- The quality of care, including:
 - the treatment of clients by service providers;
 - the explanation of family planning methods and their side effects; and
 - the availability of more than one dosage of pill and of more than one type of method.
- The management of projects, including:
 - the development, with the grantee, of project goals and a data collection system to monitor achievement;
 - the careful development, with grantees, of time-phased workplans to achieve goals;
 - the provision of feedback to grantees on the achievement of goals and discussions with grantees on ways to overcome obstacles to the achievement of goals; and
 - the close monitoring of the process by which grantees import commodities into the country.
- Technical assistance in developing the content of training programs, especially minimum, acceptable standards for the clinical practice of medical procedures.

To date, the country representative has initiated projects only to train the medical profession and to provide clinic services in urban settings. Because of the political sensitivity of family planning, first priority has appropriately been given to motivating and training the medical profession. In the future, however, the country representative should be alert to opportunities to train other professionals and paraprofessionals and to provide services in urban slums and rural areas.

3. Relationship Between Field and Headquarters

The country representative has received excellent support from Boston. The regional director has referred all field inquiries to him and has supported his authority over grantees; he also has established an extensive system of communication with him, via memos and telephone calls, and has encouraged him to develop new ideas.

Suggestions

Despite this support, some improvements can still be made.

- The role of the representative needs to be further clarified, both for him and for the grantees. When projects are first approved, the role of the representative should be outlined to the grantee in writing and discussed verbally with the grantee.
- An opportunity should be provided, perhaps at the annual meeting, for the representative to exchange ideas on quality-of-care issues, especially the provision of service from the user's perspective.
- Criteria for evaluating the job performance of the representative need to be developed. The country representative would welcome the opportunity to discuss his performance and to receive feedback on his work.

4. Relationship with Other Donors and AID

The relationship between the USAID representative in Brazil and the country representative has been excellent. The country representative is considered to be doing an outstanding job of understanding political problems, explaining Pathfinder's purposes, establishing good relationships with politicians, and identifying good projects. He has been especially helpful to the USAID official in clarifying or explaining sensitive political issues.

In addition, the country representative has worked jointly with Development Associates and improved relationships with the local IPPF affiliate. He has had minimal contact with other donors.

B. Program Support

1. Commodities

The biggest obstacle in Brazil to the success of projects is obtaining commodities. The cause of this problem is complex and is covered in more detail in the descriptions of each project. In general, the difficulties are political, and not a consequence of Pathfinder's commodity system. Both the size and content of the shipments have caused problems in

clearing the commodities through customs. The major problem is with IUDs, which are considered to be abortifacients by the government. It is not easy to clear them through customs. In general, it is agreed that problems will continue for some time and that the rules of the game will probably continue to change.

Commodities are approved in two ways. For projects consisting of only commodities, the country representative sends his approval directly to Boston for the processing and shipment of the commodities. In other projects, the list of commodities required is outlined in the project document and is approved as part of the Letter of Notification of Award (LNA). A Letter of Donation is then sent from Pathfinder to the project director. It includes a list of the items, by number and cost, and must bear the Brazilian Consulate's seal. The Letter of Donation is then sent to a Brazilian government agency, CACEX, for permission to import the commodities. Boston is advised of approval from CACEX, and the shipment is then sent. If the date of shipment precedes the date of CACEX's approval, the duty on the commodities is set at 100 percent. In addition to CACEX's approval, approval is also required from the state Ministry of Health, except when shipments are small.

2. Communications Materials

All of Pathfinder's educational materials are widely distributed and well received. In particular, the Casebook on Family Planning Management and the clinic guides on orals and IUDs are used widely or have been found to be useful. One of the grantees indicated that his staff need a booklet that describes the technology for preparing audiovisual materials and radio programs.

Project Reviews

The country representative has initiated or is monitoring seven projects. The team visited three of the projects--two training and clinic service delivery projects and the BENFAM community-based distribution project.

A. PIN 6347, Minas Gerais: Expansion of Family Planning Services and Training

Dates: March 1, 1980 - February 28, 1981
Amount: \$40,078

1. Description

This project provides funds to hire additional medical staff for the Hospital da Cruz Vermelha, one of Brazil's most active family planning clinics, so that an increased number of clients can be served and an increased number of medical students and physicians can be trained in family planning procedures.

2. Design and Selection

The project director, Dr. Alberto Henrique Rocha, is the former head of the ob/gyn department at the local medical school. The project provides funds to hire staff to teach six courses in family planning to 100 medical students from the local medical school and to run two courses for 70 rural physicians during vacation periods (February and July). The project is supposed to increase the number of family planning acceptors in the hospital clinic from 9,000 to 12,600.

3. Implementation and Monitoring

Students are trained in two outpatient family planning clinics, one in the Hospital da Cruz Vermelha, the other in the Red Cross Hospital, of which Dr. Rocha is president. Because the hospitals are research facilities, approximately 80 percent of the clients in the clinics use IUDs and 20 percent use pills.

Commodities for the clinics are supplied in various ways. The Brazilian IPPF affiliate, BENFAM, used to supply the clinics with free pills. BENFAM recently changed its policy and has begun to charge for pills. Because Dr. Rocha does not want to pay for pills, he has solicited donations from a number of Brazilian pharmaceutical companies. Because the supply of pills has been sporadic, clients have been switched from one brand and dosage of pill to another.

The lack of IUDs is easily the major constraint in this project. To date, IUDs have been supplied to the project by a Brazilian doctor, who is allowed to import IUDs in small quantities, and by the country representative. The lack of IUDs once forced the project to stop operations for 20 days. The project has on hand now a two-month supply of IUDs.

According to the original plans, Pathfinder was to supply the IUDs for the project. Headquarters sent a shipment of IUDs in January 1980. Initially, the commodities were requested in the name of both the university and the Red Cross. Staff at each institution thought the other was getting the required approvals. The question of responsibility was finally settled, and the Red Cross asked the state minister of health for approval to clear the IUDs through customs. Definite approval was not granted until October. Now, the Red Cross must pay large storage fees (reported to be more than \$30,000). A lawyer paid with Red Cross funds has been hired to release the commodities from storage. Meanwhile, a new requirement has been added. Because the Red Cross has already received three shipments, approval for duty-free entrance must be obtained from the federal Ministry of Health. At this time, Dr. Rocha feels that, because of the high storage cost and the missing federal agency signature, he should return the entire shipment to Boston and start the process again, making the necessary political contacts and obtaining the necessary approvals before the commodities are shipped.

In addition to the training that medical students and doctors receive during vacations, two other types of training are offered. Two weekend courses in family planning methods have been given to groups of doctors in different parts of the state and requests for the course have been received from five other groups. When the participants in the weekend courses express an interest in learning how to insert IUDs and perform sterilizations, arrangements are made for them to spend a week in the hospital for training.

In a follow-up questionnaire on the weekend training course, the participants revealed that they liked the courses but wanted more practical training. In the other, regular courses, the volume of patients has been sufficient for adequate training.

4. Effectiveness

During the second quarter, the project more than reached its goals in all areas except sterilization.

	<u>Goal for Year</u>	<u>Achieved 2nd Quarter</u>	<u>Percent Goal Achieved in One Quarter</u>
New Users	12,600	3,215	25.5
Sterilizations	780	137	17.6
Medical Students Trained	100	32	32.0
Rural Physicians Trained	70	30	43.9

Dr. Rocha pointed out that one of his goals, which was not incorporated into the original design, was to have the hospital serve as a resource center for other medical schools which want to integrate family planning into the curriculum. To date, he has received several requests for assistance. This is a good example of a non-measured output.

Given the stage of family planning development in Brazil, it is important to gain the acceptance of the medical community. The training of medical students and doctors is critical to this process. This project is not only training students and physicians; it also is encouraging the introduction of family planning into other medical schools' curricula. This is improving the project's prospects for significant impact.

5. Evaluation

A major constraint on the effectiveness of this project is the lack of IUDs. In the future, Pathfinder should be sure that commodities are cleared through customs before funding is made available. The country representative should monitor the process which the grantee uses to clear commodities through customs.

The country representative should provide technical supervision during his field visits to ensure that the students and physicians in training receive a sufficient amount of clinical experience and that clients are treated well and not forced to switch from one pill to another.

B. PIN 6397, BENFAM: Pernambuco and Alagoas Community Family Planning Program

Dates: January 1, 1980 - December 31, 1980

Amount: \$600,120

1. Description

Funding for this project began April 1, 1978. It is a continuation of support for a part of BENFAM's community-based family planning and contraceptive distribution program. Project funds cover expenses for CBD programs in two northeastern Brazilian states, Pernambuco and Alagoas. The goal of the program was to distribute one million cycles of pills in 1980. The team visited BENFAM's central offices and the CBD project in Pernambuco.

2. Design and Selection

In 1980, Pathfinder provided \$600,120 for the operation of the CBD projects in the states of Pernambuco and Alagoas. However, records show that, of this sum, \$481,440 were unexpended balances of two earlier grants. This quantity represented 10.1 percent of BENFAM's total international support. Pathfinder is one of many donor agencies that channels funds through BENFAM for CBD projects. The CBD design, regardless of the funding source, is basically the same. BENFAM/Rio provides technical advice on administration, training, recordkeeping, evaluation, and communication. In each state where there is a program, contraceptives are provided to clients in Ministry of Health or municipal health posts by distributors

who are local leaders or nurse-auxiliaries. Motivation and education for the program are provided by educators who are community leaders. The work of the promoters and distributors is checked by field supervisors. At the state level, the program is administered by a technical coordinator, a medical supervisor, and an administrative coordinator. Educational efforts and training are the responsibility of an educational assistant, a training aide, and a communications assistant.

The project funded by Pathfinder in the states of Pernambuco and Alagoas has a medical component in which doctors back up the distributors who refer women with problems or women who desire IUDs. Another component, recently incorporated into the program, ensures the provision of a variety of contraceptives, including condoms, foam, and IUDs, instead of the pill alone.

3. Implementation and Monitoring

The implementation of project activities depends on the political environment. In Pernambuco, the health posts that deliver services belong to the municipalities. The local mayors are supportive of and donate space in their clinics for service delivery. In Alagoas, the Ministry of Health funds the health posts that provide family planning services.

The Pernambuco CBD project employs 14 supervisors, 208 educators, and 346 distributors (70 of whom are also educators). The central staff are strongly committed and enthusiastic.

In September 1980, Pathfinder's country representative spent one week in Pernambuco to review project activities. In view of the findings of that visit, Pernambuco staff have tried to increase the number of distribution posts by attempting to open new posts with the assistance of neighborhood associations, religious groups, unions, and factories and by formalizing a contract to establish posts with the support of the state sugar cane association. Discussions are being held with the representative on the involvement and supervision of municipal doctors who receive an honorarium. The object of these discussions is to determine how to discourage these doctors from opposing the program and how to provide medical backup. To date, the involvement of municipal doctors in the program has been minimal.

Despite the project design, only oral contraceptives are distributed. The team observed a 38-year-old woman who had had 12 pregnancies and who was being given pills. The medical supervisor indicated that no other methods were available and that the user could not afford a trip to the state capital for sterilization. In many posts, users are switched from one brand of pills to another when they come to clinics for a resupply, because the types and dosages of pills sent from Rio vary. IUDs and IUD

kits have not been widely available because BENFAM/Rio has had trouble importing Pathfinder-supplied IUDs into the country. Some IUDs and IUD kits, however, arrived in Pernambuco in early November.

4. Effectiveness

a. Accomplishment of Goals

Between January and November 1979, 985,000 cycles of pills were distributed in Pernambuco and Alagoas. In 1980, 1,000,000 cycles were to be distributed. The following statistics are for January-June 1980.

	<u>Eligible Population</u> ²	<u>New Users</u>	<u>Revisits</u>	<u>Cycles</u>	<u>Active Users</u>	<u>Program Prevalance</u> ¹
Pernambuco	808,739	22,542	132,119	418,899	88,569	10.95
Alagoas	248,690	<u>7,392</u>	<u>29,614</u>	<u>96,235</u>	<u>19,753</u>	7.94
TOTAL		<u>29,934</u>	<u>161,733</u>	<u>515,134</u>	<u>197,322</u>	

¹ Prevalence = $\frac{\text{Active Users} \times 100}{\text{Eligible Population}}$

² Women 15-44 in union or married (52 percent total WFA)

To date, the participation of the 171 municipal doctors in Pernambuco has been minimal. In 1980, the distributors referred less than one patient per doctor for treatment of side effects.

At the beginning of January 1980, 324 distribution posts were operating in Pernambuco; 188 were operating in Alagoas. By August 1980, 333 posts were operating in Pernambuco and 162 in Alagoas. Although 16 new posts were opened in Pernambuco and 5 in Alagoas, many either were closed or did not function in both states. This fact accounts for both the slow increase in the total number in Pernambuco and the decrease in Alagoas.

b. Self-Sufficiency

This project will not become self-sufficient until the government changes its attitude toward family planning. The project is so well designed that, should the government's attitude change, the project can be integrated into the health system. Many individuals doubt, however, that the government health system is or will be managed well enough to deliver services effectively.

c. Cutting Edge

The basic design of this project is similar to that of the project BENFAM instituted in 1973. What makes Pathfinder's project unique is the introduction of the controversial method, the IUD. If this Pathfinder project can introduce new methods into BENFAM's basic design, it will improve the quality of care provided to users and, in the process, probably reduce the number of program dropouts.

5. Evaluation

The program in Pernambuco has done remarkably well, considering the opposition from the state minister of health and the results of a television program aired nationwide in August 1980. Several things can be done, however, to improve the delivery and quality of the services Pathfinder funds.

The country representative should work more closely with the project's medical director to develop a strategy for training and supplying doctors funded by the project. All agree that this component has political implications, but it is believed that these doctors can be part of the solution, and not the problem. A system could be devised whereby interested municipal doctors could be trained in IUD insertion and then given a certain number of IUDs. Resupply could be tied to the insertion of IUDs in a percentage of patients. The remainder of the IUDs could be provided to private patients, and thus constitute an incentive and a source of income. A reporting mechanism would have to be established so that distributors who referred patients would know whether their referrals received IUDs and so that the central office could track the percentage of IUDs that municipal doctors inserted in women in the project.

Non-health agencies and households should be identified and used to augment the network of distribution posts.

Management training in the use of information systems and supervision to measure goal achievement and to provide feedback on performance are desired and required for the staff of the Pernambuco program. The staff director and state-level staff would benefit from observations of well organized CBD projects in other countries and from more formal, short-term management training. The country representative should attempt to provide more technical assistance to the medical director responsible for the administration of the program.

The project could be strengthened by giving attention to:

- the development of more specific goals for each distribution post;
- the development of a data collection system to monitor the achievement of goals at both state and post levels; and
- the training of supervisors to provide regular feedback to distributors, promoters, and doctors on the achievement of goals and methods to overcome obstacles to that achievement.

The country representative should be more active in monitoring the availability of IUDs and IUD kits for the project.

C. PIN 6259: Family Planning Training, Research, and Service Center

Dates: July 1, 1979 - October 1, 1980
Amount: \$129,982

1. Description, Selection, and Design

This project was designed by the country representative in collaboration with Dr. Milton Nakamura, project director. The objective was to establish a family planning service, training, and research center at the Centro Medio Indianapolis (CMI) in Sao Paulo. During the first year of operation, the center was to serve 1,500 new family planning acceptors and train medical students, doctors, midwives, and nursing students in all family planning methods, except abortion. Students were to come from Brazil and other Portuguese-speaking countries.

The project has just completed its first year of operation and the project director has requested funding for a second year. Funds for the second year will be used to train 120 more professionals and to serve 1,650 new and 1,000 continuing family planning users at the center. In addition, two community-based distribution posts in low-income areas of Sao Paulo will be opened to serve 500 new users of pills and condoms and to refer 500 clients to the center for sterilization or IUDs.

The team visited the center, where staff gave a presentation on the program. The project director was not present.

2. Implementation and Monitoring

a. Implementation of Service Delivery Component

The clinic is well organized, attractive, and well staffed with a social worker, nurse, psychologist, receptionist, and seven part-time doctors who provide services and sterilization (minilap and laparoscopy). Because the CMI is located in a suburban, middle-income area of Sao Paulo and because most of the clients pay for services, approximately 80 percent of the clients served during the first year were middle class.

To make this project more consistent with its guidelines, Pathfinder has encouraged the development of a community-based distribution component in the design for the second-year project. The aim is to reach poorer clients and to create a mechanism for referring these clients to the center.

Unfortunately, Dr. Nakamura's goals seem to be inconsistent with those of Pathfinder. Dr. Nakamura's goal is to develop a well staffed, high-quality and self-sufficient family planning clinic and research unit. To date, he has not shown any interest in subsidizing a community-based distribution project with funds from his paying clients. In fact, staff indicated that the middle-class clients do not like to wait in a waiting room with poor clients and they are thinking of creating a separate waiting room for the latter. Poor clients seem to create problems for the center.

b. Implementation of Training Component

Project staff and Pathfinder view the selection of candidates for training differently. Pathfinder did not specifically state in the original project description that it wanted the center to train professionals from throughout Brazil who could return to their posts and train others in family planning. This was clarified by mail after the project began. The

The staff of the center thought that they were to select candidates who could practice family planning in their own centers after they were trained. Although the staff recruited candidates for training from medical and nursing schools in three states, most of the applicants who were trained were professionals from Sao Paulo, in particular, the city. According to staff, it was not politically feasible to turn down requests for training from professionals from the city of Sao Paulo. The proposal for second-year funding clarifies the criteria for selecting the trainees. No mention is made, however, of training trainers.

c. Monitoring

The country representative visited the project three times. Because of differences of opinion about goals for the project, the staff wanted more communication with the country representative than they had had during the year. The problems could not be solved over the telephone.

3. Effectiveness

a. Goal Achievement

For the first year of operation, the goal was to register 1,500 new users; 1,569 were registered. Among these users, 40 chose IUDs; 27 percent selected sterilization; 12 chose the pill; and 21 percent chose either the rhythm method, condoms, or foam. Although 60 percent of the users stated in an intake interview that they did not want any more children, only 37 percent of these were sterilized. The criteria for sterilization were established at staff meetings. Usually, these criteria were that the woman must be 30 years old and have 5 children.

The project met its goals for the number of individuals trained. The goals and output for the year are as follows:

<u>Professional</u>	<u>Goal</u>	<u>Output</u>
Doctors	10	15
Interns	20	20
Midwives	10	12
Nursing Students	80	81

About 70 percent of those trained came from Sao Paulo and Sao Paulo State. Only one student came from outside Brazil. In a follow-up questionnaire, the trainees indicated that a considerable number of nurses were not able to use their training in their own settings.

One of the major deficiencies of this project is the lack of commodities for trainees. The program was supposed to provide the following:

<u>Trainee</u>	<u>Equipment to be Provided</u>
Medical Doctor	1 Minilap Kit 100 IUDs 300 Cycles Pills Audiovisual Material
Interns	100 IUDs 300 Cycles Pills Audiovisual Material
Midwives	300 Cycles Pills

In fact, the program has not been able to provide any minilap kits, and only a few IUDs have been given to each trainee.

The problem with commodities apparently arose because the project director asked a doctor with import privileges to receive and clear commodities for the project. Given the list of commodities, this doctor indicated that the quantity was too large and would have to be broken up and sent in smaller, separate shipments. The first of these smaller shipments has been sent, and no problems are anticipated in clearing it through customs. This shipment will be used to repay individuals who loaned supplies to the project. It will not be used to supply trainees.

b. Self-Sufficiency

If the center's population remains middle-class, the clinics may soon become self-sufficient. Training, by definition, is a one-shot approach. However, the self-sufficiency of the CBD component has yet to be addressed realistically.

c. Cutting Edge

A high priority in Brazil is the training of professionals in family planning. If this program can train professionals to train others, especially in rural areas, the project may have a significant impact. Given the current method of implementation and the confused and disparate purposes of Pathfinder and the grantee, the project's impact is questionable.

4. Evaluation

A number of issues need to be further clarified before this project is refunded.

Training. A mechanism is needed to ensure that candidates selected for training can in fact practice in the settings to which they return. One approach would be to train teams (doctors, nurses, social workers) from the same institution. If Pathfinder wants to train trainers, it must clarify its intention to do so.

CBD Component. Given the current design of the CBD program, which employs a social worker, a nurse, and a medical supervisor, the cost per user is high. The use of a distributor to refer to the CMI clients for IUDs and sterilization will broaden the clientele the center serves. Whether or not the center is equipped to serve low-income clients is a question. Neither the staff nor the country representative is clear about how this component will be funded after Pathfinder withdraws its support. Local community support was mentioned. This issue should be clarified with the grantee.

Commodities. Because sufficient commodities to support the students who have been trained have yet to reach Brazil, the second-year training component should not be funded until commodities are available in the country. The country representative should be actively involved in monitoring the process the grantee uses to obtain commodities.

Sterilization Criteria. The country representative should review the criteria for selecting candidates for sterilization to ensure the delivery of this service to as many interested clients as possible.

CONTACTS IN BRAZIL

Pathfinder Fund and USAID

Dr. Jose de Codes, Country Representative, Pathfinder

Mr. Sam Taylor, Social Development Officer, USAID

BENFAM/Rio

Dr. Walter Rodriguez, Executive Director, BENFAM

Ms. Carmen Gomez, Coordinator, Programming and Planning

Ms. Eliane Reis, Director, Department of Evaluation

Projects

A. PIN 6347: Minas Gerais

Dr. Alberto Henrique Rocha, Project Director; President,
Red Cross; President, CEPECS

Dr. Delzio Bicalho, Head, Obstetrics/Gynecology Department;
President, CEPECS; President, Red Cross

Dr. Roberto Marcio Lana Peixoto, Assistant Professor

Dr. Antonio Aleixio Neto, Assistant Professor

Family Planning Clinic, Hospital da Cruz Vermelha:

Sociologist

Nurse

Doctor

B. PIN 6259: Family Planning, Training, Research and Service Center

Centro Materno-Infantil

Lic. Maria Estela F. Goncalves, Coordinator, Planning
and Training

Mr. Jorge Seho, Director, Administration and Finances

Ms. Hilda Ahmed, Head, Social Work and CBD Program

Ms. Margareth Guedes, Nurse-Supervisor, CBD Program

Dr. Rioti Hayashida, Program Doctor

C. PIN 6397: Pernambuco Family Planning Program

Dra. Denise Barbosa, Consultant to BENFAM Programs for
Northeast States

Pernambuco State-Level Staff

Dra. Maria Vilma de Olivera, Technical Coordinator,
CBD Program, BENFAM

Dr. Jose Marco Ionas Barbosa, State Medical Supervisor

Ester de Fatima Addobbati Barros Alves, Director of Training

Aldamara de Souza Costa, Director of Education

Aida El-Deir Cavalcanti Albuquerque, Director of Communication

Vera Lucia Peiroto de Macedo, Field Supervisor for
Sao Lorenzo da Mata

Distribution Posts

A. Igarassu County

Clovis Lacerda Leite, Mayor

Maria da Luz Tavares, Distributor and Educator,
Posto de Saude Sao Lucas

B. Jaoboatao County

Geraldo Jose de Almeida Melo, Mayor

Maria de Fatima Almeida, Distributor, Health Post,
Cavaleiro District

Dr. Romulo, Director, Health Post, Cavaleiro District

C. Sao Lourenco da Mata County

Marilene Alves, Distributor and Educator, Camaragibe District,
Centro Social Urbano Governador Paulo Pessoa Guerra

Dr. Airton Vieira do Nascimento, Doctor, Centro Social

IV. COUNTRY REPORT ON PERU

Introduction

The southern office, located in Santiago, Chile, oversees projects in Ecuador, Peru, Paraguay, Bolivia, and Chile. Of these countries, the team visited Peru, because it is one of Pathfinder's top-priority countries. The team was accompanied by the regional representative. The discussion of operations of the southern office will, therefore, focus on the work of the regional representative in Peru.

Background

In 1980, the population of Peru was estimated to be 17.6 million.³ Peru had a growth rate of 2.8 percent, a birth rate of 40, a death rate of 12, and an infant mortality rate of 92. Sixty-two percent of the population lived in urban areas. Fifty percent were Indian. Fifty-nine percent of Peruvian women exposed to pregnancy were not using any contraceptive method.⁴ Twenty-seven percent of exposed women did not want any more children and were not using any contraceptive method. This suggests that a large number of women at risk might desire voluntary sterilization if the service were made available.

Until recently, the bulk of contraceptives in Peru was distributed through the commercial sector at a price beyond the reach of the population at risk; through private physicians, who supplied contraceptives to the upper class; and through small-scale private sector projects (e.g., those of Pathfinder) which delivered contraceptives to the poor.⁵ The Ministry of Health, which is responsible for 68 percent of the population, the Social Security Institute, which is responsible for 18 percent, and the Armed Forces Medical Services, which is in charge of another 10 percent, did not provide such services.⁶ However, this pattern is beginning to change.

In May 1980, Fernando Belaunde Terry was elected president. Terry supports family planning and has requested that the Ministry of Health provide services. Government personnel are now being trained, and there is pressure to integrate family planning into health services as soon as possible. The new director of MCH is hopeful that family planning services will be offered in health clinics in all 22 regions of the country by the end of the year.

Many individuals still oppose family planning for political and religious reasons. The extreme left and extreme right, including the Church, lead the strongest opposition movement. Some individuals, especially in the Ministries of Health and Education, have been instrumental in impeding the clearance of commodities through customs.

As elsewhere in Latin America, abortion is considered to be a problem, and the strategy of family planners is to convince religious leaders that, if family planning services are available, abortion rates will decrease. Women's groups are seen as a new political force in Peru which could become a vehicle for disseminating family planning information and for supporting family planning as women's right.⁷

To date, Pathfinder projects which incorporate family planning into medical school curricula and which provide clinic services have been appropriate. As the government begins to take more responsibility for providing clinic services and as the AID bilateral program makes funds available to support government efforts, Pathfinder should lead the way in developing new modes of service delivery, especially in urban slums and rural areas. To date, the government has not endorsed community-based distribution. If Pathfinder moves cautiously, it may be able to make this an important area for future activity. Many opportunities to work with women's groups exist and should be pursued.

The location of the office in Chile, a low-priority country where Pathfinder operates only one project, is impractical. Given the large number of projects, the increased interest in family planning, and the opportunities to pursue many more important initiatives in Peru, it would be appropriate to relocate the southern regional office in Lima. This move would greatly facilitate the development and monitoring of Peruvian projects.

Management

A. Organizational Structure and Operation of Office

1. Background and Training of Staff

The Pathfinder representative for Latin America/South is Werner Bustamante, a pediatrician with a master's degree in public health. He was Pathfinder's regional representative for Latin America from 1968 to 1977. He has been the regional representative for Latin America/South since 1977. Dr. Bustamante has taught social pediatrics at the University of Chile and was the UNICEF representative for Bolivia, Peru, and Paraguay from 1951 to 1954. The representative is well qualified for the technical aspects of his job.

2. Roles and Responsibilities of Staff

The regional office, which is staffed by the representative, a part-time executive secretary, and an assistant secretary, was not visited because it is located in Santiago, Chile. Between July 1979 and June 1980, the regional representative worked in Peru, Ecuador, Paraguay, and Chile and spent four months in Brazil before the country representative took over the work. In these countries, he initiated or monitored 26 projects valued at \$1,566,070.8 Of this amount, approximately 60 percent was invested in Brazil, mainly in BENFAM's CBD program. During the year, the representative traveled one-third of his time (72 days). In addition, he spent 21 days in Boston. During his field trips, he observed and supervised ongoing projects and explored possibilities for new projects. He also was a guest speaker at four seminars. As elsewhere in Latin America, the representative has not been significantly involved in the procurement or distribution of commodities. He needs to provide more technical assistance to grantees who are having problems with commodity clearance.

A majority of the projects supported by this representative provides funds for the delivery of clinic services and training. Of the 26 projects operating during the fiscal year, 13 provided training, 6 were designed to deliver family planning clinic services, 4 funded seminars, 6 established a CBD program, 1 was an evaluation project, and 1 addressed other needs.

In Peru, the regional representative has been in contact with medical and academic groups. He relates well to these groups. His relationships with community-level groups are considered to be less comfortable, and they may be affecting his ability to identify ideas for proposed or prospective projects.

3. Relationship Between Field and Headquarters

The regional representative has good communications with Boston. He maintains that support from the regional director has been excellent. The technical support which Boston provides (it sends clippings from journals) has been useful. The telex should be used to reduce the cost of frequent phone calls.

4. Relationship with AID

The regional representative contacts the USAID population officer whenever he is in Peru. Many projects seeking funding are referred to Pathfinder by the population officer. The relationship between the population officer and the regional representative is less than optimal, however.

B. Program Support

1. Commodities

It is difficult to import commodities into Peru because individuals opposed to family planning for religious reasons have interfered with the duty-free entrance of shipments. Importation has also been delayed by a series of strikes, which have involved staff from the Ministry of Health, Customs, the Post Office, and the Social Security health system.

The Ministry of Education, which must approve commodities for any project involving the medical schools, is the greatest obstacle to commodity clearance. Because the Ministry of Health supports family planning, it may now grant permission for the duty-free entry of commodities. The approval process is, however, considered to be slow and bureaucratic.

The general process for obtaining commodities is as follows. First, a Certificate of Donation is sent from Pathfinder/Boston to the grantee. With a Certificate of Donation, the grantee can usually get a Certificate of Liberation, which allows the grantee to import goods without paying duty. Grantees mentioned that this process would be greatly facilitated if shipping documents were printed in Spanish.

Until now, many private agencies were subject to duty payments or forced to use their personal contacts to avoid duty. Even when they did have to pay duty, the private agencies had to pay the costs of clearing commodities through customs. Inexplicably, clearance costs have varied from project to project, and they are now decreasing.

It is expected that the family planning training center will receive funds to hire an individual to clear commodities and to store supplies for all private agencies. Construction of the warehouse is not completed. Individuals in Peru believe that with this new mechanism private agencies will have fewer problems with commodity clearance.

Suggestions

- Until the situation changes, commodities should be channeled or rechanneled through the Ministry of Health, and not the Ministry of Education.

- All shipping documents should be printed in Spanish.
- No project should be funded until commodities are received. The representative should become more knowledgeable about the process of commodity clearance in order to better assist the grantees.

2. Communications Materials

All Peruvian project staff have received materials from Boston which they consider useful. The directors of training programs report that the booklets on orals and the IUD are well designed and practical.

Project Reviews

The following discussion of projects in this region is limited to Peru, the only country in the region visited by the evaluators. The team talked to the directors of nine projects that are either in operation, about to start, or have been terminated recently.

A. PIN 6320: Victoria District Market

Dates: To be started
Amount: \$8,255

1. Description

This project will provide family planning information and distribute contraceptives to Victoria, a poor district in downtown Lima. Pills, condoms, and foam will be sold in a small office at the local market. Two promoters will provide information and supplies in the surrounding community. Women who want other kinds of contraceptives or medical services will be referred to a nearby municipal health center.

The team discussed the project with the executive director of the grantee, ADIFAM, a private family planning organization, and the project director and visited the site at the Victoria Market, where the distribution post will be located.

2. Selection and Design

The project was developed by Augustina Robles, a public health nurse (PHN) who has worked for many years for the Ministry of Health. She has trained 30 health promoters to work in the Victoria District. When she asked the Ministry of Health if she could add family planning to the training, they referred her to the USAID population officer who, in turn, referred her to Pathfinder. She designed the project with the assistance of the associate of the Women's Programs Division.

Two promoters and the project director will staff the project. One of the promoters will provide family planning and maternal and child health information and services in the morning at the market office. She will refer women who want IUDs to the nearest municipal health center. The second promoter will work at the health center in the mornings, providing family planning information and services. Both promoters will spend the afternoon in the community visiting families to promote and provide family planning services. The project director will supervise the promoters. Commodities for the project will be provided by ADIFAM.

3. Implementation and Monitoring

Although the project was developed by the Women's Programs Division, it will be monitored by the regional representative. The project director has reservations about this change in Pathfinder personnel because she already enjoys a good relationship with the representative of the Women's Programs Division.

4. Effectiveness

The project director has good relationships with those in the market area. They seem to trust her and feel comfortable with her. For Pathfinder, this small project, which identifies a local woman who had the ability to relate comfortably to the user population and who can provide services in urban slum areas, is a positive effort.

5. Evaluation

The project design would be strengthened if the project director could be trained to insert IUDs and provide service at the market instead of referring women to the health center.

B. PIN 6377: Instituto Marcelino, Family Planning Training Center

Dates: June 1, 1980 - May 31, 1981
Amount: \$61,026

1. Description

This project will establish a center for training medical and paramedical personnel in family planning techniques and services. The center will be located at the Instituto Marcelino in Lima. Sixty doctors, 60 midwives, and 50 nurses will be trained.

2. Selection and Design

The project director founded and runs the Instituto Marcelino, a family planning clinic in downtown Lima near two large maternity hospitals. USAID has provided funds for his work and referred him to Pathfinder for this project.

Training is offered to general physicians, midwives, and nurses in a position to apply the training. Preference is given to those in contact with large groups of patients or employees of the Ministry of Health. Each course is limited to six participants. The training will cover family planning methods, the organization of a family planning service, practical training in IUD insertion, pelvic examinations, and contraceptive follow-up. Each trainee will do 15-20 IUD insertions. Doctors and nurses will receive one week of training; midwives will be in training for two weeks. The trainees will be evaluated before and after the course; 10-20 percent will be visited three months after the course to evaluate their competence, activities, and experience with family planning.

3. Implementation and Monitoring

All the applicants who have been trained have come from the Ministry of Health. The director plans to cover the country within the year. He would like to train in teams doctors, nurses, and midwives from the same setting. Although he has made some progress, he has not been able to team-train personnel as often as he would like.

The goal for doctors and nurses is to insert 15 IUDs in one week. One of the major problems is finding enough patients for these trainees' clinical practice. Many trainees insert only two IUDs during the week of training. The midwives who stay two weeks insert an average of 20 IUDs.

Another problem is commodities. The director gives each trainee 10 IUDs, but he does not know how often he can resupply them. Ideally, the Ministry of Health should be able to supply their personnel with commodities after they have been trained. This has not been the case, however.

4. Effectiveness

Between June and November 1980, the following number of individuals were trained:

	<u>Outside Lima</u>	<u>Lima</u>	<u>Total</u>	<u>Yearly Goal</u>	<u>Percent Goal</u>
Doctors	32	5	37	60	62%
Midwives	24	7	31	60	52%
Nurses	27	0	27	30	90%

In six months, the project more than met its mid-year goal for "total trained" and "percentage trained" from outside Lima. The trainees have not been followed up.

At this stage in the development of family planning in Peru, the project is important. It is supplying the Ministry of Health with trained personnel, a function that will continue to be vital until the Ministry can provide its own training.

5. Evaluation

This is a well organized and designed project. The project director is energetic, enthusiastic, and creative, and he will continue to be a key force in the expansion of services in the country.

Top priority should be given to evaluating the effectiveness of the trainees in the field. Particular attention should be given to the nurses and midwives to determine whether they are allowed to use their skills. To the extent possible, to avoid problems for these two groups, candidates should be recruited in teams so that they can support each other when they return to work.

The training for nurses should be extended to two weeks to provide sufficient time for practicing the insertion of IUDs. In this arrangement, the doctor-trainees should be given top priority for patients so that they, too, can have time for sufficient practice.

The course in family planning management should cover not only the review of forms; it also should include information on setting targets and monitoring their achievement.

C. PIN 6382: Limoncarro Family Planning Services

Dates: June 1, 1980 - May 31, 1980 (Delayed)

Amount: \$9,857

1. Description

This project will provide family planning services at the health post of a rice cooperative in Limoncarro, a rural agricultural community. After clinic services begin, a CBD component will be added to serve the surrounding community.

2. Selection and Design

The project director first talked with the USAID population officer about this project in 1977. He was referred to Pathfinder, and, with the aid of the regional representative, developed the project over the last three years.

The cooperative which will receive this service has 3,000 families. During the first three months, the cooperative health post will be remodeled to accommodate a family planning service, and the doctor and auxiliary nurse who serve the clinic will be trained in Lima. The information personnel of the cooperative, the auxiliary, and a social worker who works with a local mothers' club will promote the new family planning program. The medical director will try to involve local midwives.

Services, including pills and IUDs, will be provided by two auxiliary nurses. A doctor will provide backup three times a week. The project director, who lives in Lima, will visit the project once a month to supervise and perform minilaps. After six months, community leaders will be trained to promote family planning and to distribute contraceptives in the community.

3. Implementation and Monitoring

As of November 1980, the project had not begun because the project director had not been able to clear Pathfinder's commodities through customs. The commodities are in port, but the duty charges are \$1,250 and the cooperative cannot afford to pay them. The project director is at a loss as to how to proceed.

4. Effectiveness

According to the project design, the cooperative will take over the operation and funding of the clinic. Because Limoncarro is suffering an economic crisis, and has little water and therefore little rice (currently, members work seven days and are paid for three), the economic base of the cooperative is weak. It seems somewhat unrealistic to expect the cooperative to take over the project.

Once this project begins to operate, it will bring much-needed services to a rural area by community-based distribution. The approach, in the Peruvian context, is innovative.

5. Evaluation

The design is generally good, but the project is not part of an infrastructure capable of resolving the commodity problem. In Peru, it is vital that, while projects are being designed, the Pathfinder representative help the grantees to determine how staff can import commodities into the country.

The project has a significant weakness: the project director lives in Lima and must travel 12 hours by car or charter and pay for a plane to supervise the project on site. Ideally, the supervisor should live in or near the site he supervises.

D. PIN 6321: Pueblo Libre and Magdalena Del Mar, FP/MCH Services

Dates: To be established

Amount: \$13,486

1. Description

This project will provide information and services in maternal and child health and family planning to two large market districts in Lima, Pueblo Libre, and Magdalena del Mar. Pills, condoms, and foams will be dispensed from an office at each market and referrals for IUD insertion will be sent to the Instituto Marcelino. The project hopes to serve 1,800 acceptors and to provide 96 educational talks on health and family planning in each district.

The team talked with the project director and visited both market sites.

2. Selection and Design

The project was designed by the project director. The USAID population officer referred it to Pathfinder for funding. The services for this integrated MCH/FP project will be provided three afternoons a week by two auxiliary nurses. The nurses will be supervised by the project director. Promoters will also provide information and motivation in a nearby community. The activity will begin with a survey on family planning knowledge and attitudes. The survey was designed by staff of the Women's Programs Division.

Space for clinics was donated by the mayors. Municipal medical facilities that now have no staff will be used. The mayors will promote the project at their monthly meetings with the community.

3. Implementation and Monitoring

The project was approved in February 1980, but has not been started, pending clearance of commodities and approval of the project by a new, recently elected mayor. Commodities were sent as a test case, and the project director was able to clear them through customs without paying duties or warehouse fees.

4. Effectiveness

The two mayors involved in the project have indicated that they will take over the cost of the clinics after they are established. If costs are kept low and the goals are achieved, the project will become self-sufficient in a few years.

The regional representative has reservations about funding a project not run by a doctor. This is one of the more innovative projects that Pathfinder is funding. It is run by a well trained nurse, is potentially low in cost, and reaches a low-income group.

5. Evaluation

The project director is an impressive person. She is well trained, energetic, and enthusiastic about the project. She should be encouraged to insert IUDs at the two market distribution sites.

This is one of the few integrated MCH/FP projects that Pathfinder is funding in Latin America. Its design may make it more costly but also more acceptable to the target audience. Because the project director is interested in family planning service delivery, she will probably deliver more services than are provided in most integrated projects. Evaluators of the project should carefully examine the effect of integration on the cost and effectiveness of the project. The use of information gathered in the survey should be clarified.

E. PIN 6417: Family Planning Training and Service Program, "Federico Villareal"

Dates: April 1, 1980 - March 31, 1981
Amount: \$11,000

1. Description

This project funds the continuation of training for medical students from the Universidad Nacional Federico Villareal and the provision of family planning services in the Ministry of Health gynecology clinic in Lince, one of the clinics where medical students are trained. Fifty students will be trained and 1,300 women will be served. A survey of student attitudes and skill in family planning will be taken.

The team talked with the project director, visited the Lince Health Center, and talked with five medical student-trainees.

2. Selection and Design

This project was developed by the project director in collaboration with the regional representative. The primary objective of the project is to train medical students so that their attitudes toward family planning will change. The design is unusual, for the project is connected with the Ministry of Health. Under the guise of a training and cancer detection program, the project will provide services for the first time in a government facility

3. Implementation and Monitoring

Students from the medical school rotate through the family planning clinic for three months. Approximately 70 percent of the patients who attend the ob/gyn clinic where students are trained come for family planning service. Most patients are referred to the clinic by medical students. The patient population is middle-class, has 2.5-3.5 children, and is 22-26 years old. Approximately 67 percent of the patients use IUDs.

While the team observed the operation of the clinic, two users of IUDs were seen, one for a checkup, the other for an insertion. Neither patient was counseled on the method. The patient in whom the IUD was inserted was not given an adequate explanation of or reassurance about the procedure. Students obviously had not been taught how to handle patients or how to explain the methods.

The project director has had problems obtaining commodities. A shipment from Pathfinder has been in port since October 1979, but the project director has been unable to get it cleared. To date, he has been able to obtain small quantities of IUDs through the mail and has had to depend on donations from a drug company for pills. Donated pills are a problem, because the clinic often only has one brand of pills for resupply, and the brand and dosage available change. The high dropout rate in the project is attributable to a lack of pills.

4. Effectiveness

Between April 1979 and October 1980, the project served more users than it proposed: 1,185, as compared to a goal of 1,300.

	<u>Continuing Users</u>	<u>New Users</u>
TOTAL	1,313	1,185
IUD	1,003	775
Pills	265	232
Other	45	178

Of the total number of new users, 65 percent use IUDs, 20 percent pills, and 15 percent other methods. Because of the lack of commodities, continuation rates for the pill are low.

At the same time, three three-month courses were given for 97 students. The students inserted a total of 270 IUDs at the clinic (an average of 2.8 each). Fortunately, the students inserted many more IUDs at the maternity hospital. (The number was not recorded.)

As a result of training, students have become enthusiastic about family planning. They have even convinced doctors at the maternity hospital to insert IUDs, though they complain that the doctors are not trained for the job.

The team talked with six students in their last year of training. All had inserted between 25 and 60 IUDs each. They had received no training in the management of a family planning clinic or community-based services. Several indicated a desire for more experience with poor patients at the community level.

The students were evaluated before and after the course. The evaluation includes information on grades, ability to insert IUDs, and relationships with patients. It is not clear how or even if this information will be used to change the curriculum.

This project is important because it uses a government clinic for the delivery of services and has generated high demand among users for services. It also has generated enthusiasm among the students and stimulated interest in IUDs among doctors at maternity hospitals.

5. Evaluation

A component needs to be added to the family planning curriculum on quality-of-care issues, including relationships with patients and explanations of side effects.

If the project is extended, consideration should be given to training doctors in the maternity hospital to insert IUDs or to referring them to another training facility.

If the project is extended, and if it is politically feasible, Pathfinder should consider including training in minilap. The project director should be trained in minilap technique. The project director also should receive some management training.

The regional representative should provide more assistance to the project director in clearing commodities through customs. Until commodities become available, the representative should encourage the project director to stock more than one brand and dosage of pill at one time. A woman should not be switched from one pill to another.

F. PIN 6406: ALAFARPE Family Planning Program

Dates: March 1, 1980 - February 28, 1981

Amount: \$47,850

1. Description

This project is funding for a second year the continued provision of family planning services to 4,000 women in four centers located in slums on the outskirts of Lima. The funds will be used to develop a community-based distribution program using local leaders as distributors and promoters.

The team talked to the project director and the medical director and visited two of the four centers.

2. Selection and Design

The initial idea for this project was presented by the project director to the USAID population officer, who referred the director to Pathfinder. The project was developed jointly with the Pathfinder regional representative and personnel from ALAFARPE, the National Association of Pharmaceutical Laboratories. Four clinics were built to provide 50 percent general health services and 50 percent family planning services. A community-based component was added by Pathfinder to attempt to increase the number of family planning acceptors. Distributors sell pills and condoms, retaining 80 percent of the sales price, and receive 80 percent of the cost of an IUD for each referral.

3. Implementation and Monitoring

When the project began, a community survey was taken to gather information and to introduce clinic services to the population. Each clinic has a part-time doctor, an obstetrical nurse, and two auxiliaries. Fees are charged for all services, including family planning. In addition to clinic staff, distributors were chosen and trained for three days by the medical director. At the two sites visited, 14 of the 16 trained staff are still working.

The project has had problems clearing commodities through customs. Although the process still takes time, the project uses Hipolito Una to clear commodities. The director indicated that the high cost of the insurance which Pathfinder requires results in higher import duties than are necessary. He suggests under-insuring shipments.

The medical director of the project thinks that the visits of the regional representative are useful, but he feels he needs much more guidance during the initial stages of project implementation. He wants the help of a consultant during the first three months.

4. Effectiveness

Statistics for each clinic from the beginning of the project until October 1980 are as follows:

	<u>JC Mariategui</u>	<u>Jardin</u>	<u>Virgen de Lourdes</u>	<u>Sta. Isabel de Villa</u>	<u>TOTAL</u>
Months of Operation	23	20	15	10	
Medical Consultations	14,191	10,298	5,729	4,612	34,830
New Users	684	654	377	245	1,960
Continuing Users	973	1,086	462	312	2,840
New Users/Month	29.7	32.7	25.1	24.5	
Continuing Users/ Month	42.3	54.3	30.3	31.2	

Because 50 percent of the budget is for family planning, Pathfinder has been concerned about the low number of family planning acceptors relative to other services provided by the program. As the figures above show, only 13.8 percent of the total number of medical consultations in all clinics has been for family planning users. The 1980 quarterly report (March-May) reveals that the dropout rate among pill users is high, ranging from 14.6 percent in one clinic to 40.4 percent, 50.6 percent, and 71.7 percent in others. By the end of August 1980, 23 distributors were working and had enrolled 84 new pill users (3.7 each), a low number. No information was available on the number of users referred for IUDs.

5. Evaluation

Because family planning is new to Peru and because few services are available for low-income groups, this project has the potential to become important. It is not realistic, however, to think that the project can become self-sufficient without a subsidy from some organization.

To increase the use of the family planning program, the distributors need to spend more time in the community promoting service. They should also promote the program among community groups.

The project was established as an integrated health and family planning program to make the family planning component more acceptable to the population. To date, the health component consumes much of the financial and human resources of the project. A mechanism is needed (e.g., integration of general health services with the Ministry of Health) to find funds for the general health services or support from another group.

The medical director of this project should have received more technical assistance during the first two months of the project. The regional representative should have visited the project immediately after it was initiated to provide assistance and, if necessary, a consultant should have been hired.

It is not clear how much of the survey data has been used. Before a survey is taken, an outline should be prepared to show how the information will be used to implement the project.

G. PIN 6419: Chosica Integrated CBD

Dates: September 1, 1980 - August 31, 1981
Budget: \$29,454

1. Description

This project funds an integrated community-based distribution women's program which will provide three different kinds of services to women living in squatter settlements in suburban Lima. It also will cover family planning, consciousness-raising, and technical training in plumbing. A clinic- and community-based program will provide to 2,400 women family planning information and services. Among the users recruited, 200 will be involved in consciousness-raising exercises and 200 will be trained in basic plumbing. Research will be undertaken to try to determine whether technical training or consciousness-raising is more of an incentive for continued family planning than information and services alone.

The team talked to project staff and visited the clinic and several communities where the project will be implemented.

2. Selection and Design

The project director participated in the CEFPA course in Washington, which stimulated his interest in developing a project to encourage women to seek alternative roles. The regional representative referred the director to the Women's Programs Division in Boston. The project was developed by staff of the Women's Programs Division, the AID Office of Population, a number of Pathfinder consultants, and the grantee. The research component was added at the insistence of AID/Washington; its development created many delays, because Pathfinder is not a research organization and does not have staff trained to develop research proposals. In fact, Pathfinder has a strongly stated policy not to fund research proposals or projects with research components. In the past, it has turned down projects with fairly simple research components.

3. Implementation and Monitoring

Clinic services were initiated at the end of September 1980. The promotion of family planning services in the community and by radio recently began. The clinics will not provide IUDs, but they will refer interested patients to Lima.

The project will be monitored by the regional representative, although the Women's Programs Division developed it. There has been some confusion because the regional representative did not design the project.

4. Evaluation

The auxiliaries who staff the clinic should be trained to insert IUDs. To date, the research component of this project has required the enormous use of human resources and time, probably in excess of the cost of the project. The research component will also add to the cost per acceptor. As has been noted by AID/Washington, the research design has a number of fundamental problems. Both the consciousness-raising and plumbing groups will be involved in small-group discussions for three months after the intervention. Because these sessions will provide opportunities to discuss the side effects of methods, and raise doubts about the methods, and because questions will be answered by a knowledgeable and supportive professional, continuation rates will probably be influenced much more directly at these meetings than during either the consciousness-raising or training sessions.

Another problem is that research will not provide much relevant information on the impact of changed roles for women on fertility behavior. This is a complex issue and should be researched more formally by an organization with personnel trained for the task.

A major issue in the design of the training component is the number of women being trained in the same skill in a relatively small area. No market survey was made to determine whether or not the area can support 100 plumbers or to determine the level of income the plumbers expect to earn. If the area cannot support 100 plumbers, the trained women will compete for scarce jobs and their roles will not be significantly different. A major determinant of women's changed roles is ability to earn a significant portion of the family's income. It would be advisable to hire someone to take a market survey in the area and to diversify the training the women will receive. The teacher who was hired for the plumbing course also teaches electricity. This and other topics for training should be explored.

Completed Projects

A. PIN 6265: Rural Family Planning Program (Tarma)

Dates: August 1, 1979 - July 31, 1980
Amount: \$40,745

1. Description

This project funded the promotion and delivery of family planning services in a remote, rural area of Peru 100 miles northeast of Lima. Family planning services were to be offered in the regional Ministry of Health hospital and in clinics in four neighboring towns. Pills, condoms, and IUDs were to be provided. The project director also planned to conduct low-cost research on the prevention and treatment of goiter and its effect on fertility. The team talked with the project director.

2. Selection and Design

This project was developed by the project director and presented to Pathfinder. Approval of the project was delayed because Pathfinder does not usually fund projects with a research component.

3. Implementation and Monitoring

The commodities required to implement this project were never released from customs. Because the project had ties to the university, the project director had to obtain approval from the Ministry of Education to receive commodities. Because an influential person in the Ministry of Education was opposed, for religious reasons, to the project, approval to import duty-free commodities was never granted. However, because the grantee

assumed that he would eventually receive duty-free status, he hired personnel and paid their salaries. The project ran for one year. Two-thirds of the budget was spent.

A psychologist instead of two auxiliary nurses was hired with Pathfinder's approval. Personnel provided general medical services to the community and education in family planning. They found that there was much greater resistance to family planning, and especially to methods requiring pelvic exams, than they expected. Although the women wanted to control their fertility, the men were strongly opposed. For these reasons, the project director doubted that goals could be met even if commodities were available.

The regional representative tried to assist the project by providing small quantities of supplies when he visited the country. Once funds were disbursed, however, he had no control over the situation.

4. Effectiveness

This project was a disaster. Only 10 percent of the user goal was met and few among the user population were educated.

5. Evaluation

Pathfinder learned from this experience. It subsequently instituted the policy that, in Peru, funds could be disbursed only after commodities were received. This policy is strongly endorsed.

The number of professional personnel hired for the project seems excessive. Furthermore, personnel were imported, a step that cannot be considered wise. It would have been more appropriate to recruit staff who lived near the project site.

When a research component of a project does not add significant cost to a project and when staff have the expertise to conduct research, it is appropriate for Pathfinder to fund a project that has a small research component.

B. PIN 6244: Family Planning Training for Drugstore Employees

Dates: August 1, 1979 - May 31, 1980

Amount: \$17,411

1. Description

This project supported a 28-hour course for 500 drug store employees. The course provided information on family planning, communication techniques, and methods to promote contraceptives commercially. It was held in Lima and four northern cities. Trainees were tested before and after the course to determine what they knew.

The team discussed the project with the project director and the project coordinator and visited one pharmacy, where they interviewed two trained employees.

2. Selection and Design

The regional representative asked the head of ADIFAM, a private family planning organization, to recommend individuals to attend a Pathfinder-funded seminar on drug-store distribution in Colombia. The project was designed by those who were selected for training as part of the seminar.

3. Implementation and Monitoring

The project was carried out as planned. The two drugstore employees indicated that many men and women have asked them about contraceptives. Some men have even asked where they could get a vasectomy.

4. Effectiveness

The project trained 470 trainees, 30 less than the goal of 500. It was unable to determine whether contraceptive sales increased, because the owners of the pharmacies objected to a check before and after sales, fearing that they would have to pay additional taxes if their sales increased.

5. Evaluation

Because it is difficult to measure the impact of training on contraceptive sales, this drugstore training project has been a source of controversy within Pathfinder. In Latin America, drug stores frequently are the first level of health care for many individuals, and in many more developed national family planning programs commercial outlets are the major source of contraceptives. It is therefore important to train and motivate drug store personnel to sell contraceptives. Until a more effective and simple method is found to measure the increase in sales, projects such as this should be considered training, and not service, programs. The purposes of a subsequent evaluation would then be to determine the projects' impact on knowledge about family planning methods and trainees' use of their knowledge to promote sales.

Contacts in Peru

PIN 6320: Victoria District Market

Augustina Robles, Project Director

PIN 6321: Pueblo Libre and Magdalena del Mar, FP/MCH Services

Lilia Gomez Gonzalez, Project Director

PIN 6377: Family Planning Training Center (Instituto Marcelino)

Dr. Alfredo Larrañaga, Project Director

Nurse-Auxiliary

PIN 6382: Limoncarro Family Planning Services

Dr. Dante Castro Nestarez, Project Director

PIN 6406: ALAFARPE Family Planning Program

Dr. Alfredo Brazzoduro, Project Director

Dr. Alfredo Guzman, Medical Director

Clinic Personnel and Distributors,
Clinics at Santa Isabel and Jose Carlos M.

PIN 6417: Family Planning and Service, "Federico Villareal" University

Dr. Jorge Vereau, Project Director

Doctor in charge of student training

6 Medical Students

PIN 6419: Chosica Integrated CBD/Women's Project*

Irma de Subiria, Project Director
Carmen Derpich de Lopez, Coordinator
Mary Centeno, Obstetrician
Ana de Ballen, Social Worker
Bernarda Subiria, Research Assistant
Damiana Gamarra, Field Supervisor
Julia Gamarra, Clinic Assistant

PIN 6244/6439: Family Planning Training for Drugstore Employees

Olga Mondragon, Project Coordinator
Victoria Manrique, Project Director

PIN 6265: Rural Family Planning Program

Dr. Eduardo Pretell, Project Director

Others

Helene Kaufman, Population Officer, USAID
Dr. Luz Jefferson, Professor, Cayetano Heredia University
Dr. Luis Sobrevilla, Director, Maternal Child Health Services,
Ministry of Health
Dr. Hugo Exebio, President, Coordinating Committee of Family
Planning, Social Security Hospital No. 2
Dr. Ricardo Subiria, Director, ADIFAM
Dr. Carlos Munoz, Adviser to President**

* On its visits to Villa de Sol, Sauce Grande, and Miguel Gray, the team talked with the members of 10 mother's clubs, 2 distributors, and the mayor.

** Key family planning leader.

V. NORTHERN LATIN AMERICA: GUATEMALA AND COLOMBIA

Introduction

The regional office in Bogota is responsible for projects in Colombia, Central America, and the Caribbean. The team visited the office in Colombia, talked with the regional representative and his assistant, and interviewed two Colombian grantees. It then traveled with the regional representative to Guatemala, visited four active projects, and talked with the director of two terminated projects.

Background

A. Guatemala

Guatemala has the largest population in Central America.⁹ In 1980, the population of Guatemala was 7.0 million, the growth rate 3.1 percent, the birth rate 43, the death rate 12, and the infant mortality rate 76. Thirty-six percent of the population were urban, and approximately 40 percent were Indian.

The majority of family planning services is provided by the Ministry of Health and APROFAM, an IPPF affiliate. The MOH provides services as part of its MCH program in rural health centers; APROFAM provides services through a network of urban clinics. In 1976, only 2.6 percent (33,869) of women of fertile age were active participants in both programs.¹⁰ At this time, it is estimated that 43 percent (602,000) of women of childbearing age are prospective clients.

Guatemala's government acknowledges the constraints on national development, the consequence of the high fertility rate, and it is interested in reducing morbidity and mortality and improving the spatial distribution of the population.¹¹ To date, however, it has not established a national population policy and it has been inconsistent in its support of family planning service delivery. For example, in the summer of 1980, the MOH prohibited the delivery of family planning services, but services are once again available in Ministry of Health clinics.

USAID provides phased bilateral assistance. APROFAM's share is decreasing as the government takes on more activity. Private donor agencies, including Pathfinder, are encouraged to explore alternatives to the clinic-based distribution of family planning; to train paramedical personnel to deliver non-clinical contraceptives and to insert IUDs under the supervision of a

physician; to incorporate family planning into the curricula of medical schools; to provide training to health personnel; and to fund seminars for government and industrial leaders on the implications of population growth for the country's socioeconomic status.¹²

Pathfinder has responded well to these directives, working with both the government and APROFAM. It has funded projects to train paramedical personnel for the government, to develop promotional materials for Indian populations, and to develop services for hard-to-reach groups, such as adolescents and rural campesino organizations. Pathfinder has chosen to fund innovative projects in Guatemala and has filled important gaps in the delivery of service and training.

B. Colombia

In 1980, the population of Colombia was estimated to be 26.7 million. The growth rate was 2.1 percent, the birth rate 29, the death rate 8, and the infant mortality 77.¹³ Sixty percent of the population were urban-based.

The Colombian government's population policy aims to reduce the rate of population growth by decreasing fertility, morbidity, and mortality. Colombia has one of the most dramatically and rapidly declining fertility rates in the world. The government considers the decrease to be satisfactory. Family planning services are provided by the government through the MCH program, by the commercial sector, and by a number of private organizations, the major one of which is PROFAMILIA, an IPPF affiliate.

Colombia's national program is becoming increasingly successful, and donor agencies are beginning to withdraw their funds, shifting them to other countries. As one of these agencies, Pathfinder now accords Colombia low priority. Colombian family planners feel that they are being punished for doing a good job. An AID official disagrees with Pathfinder's strategy, believing that well developed, rich programs (e.g., PROFAMILIA's CBD project) should continue to be funded.

Positive tradeoffs follow success. Colombia has become a training site for individuals from all over Latin America. Pathfinder has funded seminars in Colombia for private physicians, drugstore employees, and the staff of CBD programs. Colombia's family planning program has evolved and it is now mature. Considering Pathfinder's mandate to be on the cutting edge, the organization's decision to phase out its funding and move its resources to other countries where the need for initiatives is greater was appropriate.

Management

A. Organizational Structure and Operation of Office

1. Background and Training of Staff

The Pathfinder regional representative for Latin America/North is Dr. Alberto Rizo Gil. Dr. Gil holds a master's degree in public health. Formerly the head of the Maternal Child Health Division, Ministry of Health of Colombia, Dr. Gil has worked with Pathfinder for nine years.

The assistant to the regional representative is Elena Prada, M.A. Formerly a demographic researcher, she has been with Pathfinder for two years.

The office also employs a temporary secretary. The representative is seeking a full-time secretary to handle the administrative details of the office.

2. Roles and Responsibilities of Staff

The roles of the regional representative and his assistant are not defined clearly, and both share in the development and monitoring of projects. They take turns visiting the projects and working in the office. The assistant has special responsibility for revising the quarterly reports and writing to the grantees to clarify issues in the reports and to suggest ways to improve the projects. She is responsible for preparing the first draft of each project proposal and also helps the regional representative with general correspondence. The working relationship between the representative and his assistant seems to be good.

The major role of the regional representative and his assistant is to develop and monitor projects. Project ideas come mainly from USAID population officers and others in the region with whom the representative has established an extensive network of contacts. The staff work closely with the grantee in writing a project proposal that will be acceptable to both Pathfinder/Boston and AID/Washington. The representative has developed this skill over the years. Few project proposals from his office have to be changed significantly in Boston.

To monitor the projects, the director and his assistant visit each project site twice a year. In the first 10 months of 1980, the representative traveled 50 days on field visits; the assistant traveled 40 days. In addition,

the representative traveled 49 days to Boston and Southeast Asia, and the assistant 19 days to Boston and London. In 1979, the representative traveled 84 days in the field and spent 17 days in Boston; the assistant traveled 42 days in the field and spent 13 days in Boston between June and December. Despite their frequent travel, they receive many complaints from grantees that they do not spend enough time at a site or make frequent enough visits. Grantees request more visits to resolve problems created by the evaluation system. For most projects, and especially for those with less sophisticated grantees, it is thought that the evaluation requirements are too academic and sophisticated and that project staff do not have the expertise to handle them.

The office also monitors projects by writing a Letter of Comment on each quarterly report. A careful record is kept of quarterly reports that have been received or are pending. Reports that are not received on time are requested. Comments on the reports are sent to the grantee by mail and are also discussed with them over the phone. During field visits, the representative also discusses output measures and results with the grantees to identify successes or obstacles to program achievement.

In FY 1979 and 1980, the office initiated and monitored 46 USAID-funded grants worth approximately \$2.5 million. The majority of these projects was for training personnel, especially drugstore employees and paramedical personnel, and for providing education in low-technology sterilization techniques (12 projects); for community-based distribution (12); for service delivery in rural and slum areas (3); and for support of travel and regional workshops (9). Funds also were used to develop and distribute communications materials, to deliver contraceptives through the private sector, to support two research projects, and to support the establishment of a center for adolescents.

The office has been asked to develop women's projects. The regional representative and his assistant have identified leads for project development and have referred them to the Women's Programs Division. Projects have been designed and monitored by the Women's Programs Division. Neither the representative nor his assistant wants to monitor most women's projects because neither feels (s)he has sufficient technical expertise, especially to monitor women's projects with income-generating or training components.

The regional representative's relationships with grantees are generally positive. Most think he is helpful and supportive of their work. Because he is working with many less sophisticated grantees, more assistance than he is able to give is often requested. One grantee mentioned that the representative seemed to have little power to make decisions about project development and renewal and that, consequently, he preferred to talk with local USAID mission staff.

Suggestions

- The field representative should take major responsibility for developing the evaluation criteria with the aid of the grantee. If the Evaluation Unit must modify the criteria, it should do so before the project is approved. The project proposal should include a plan to train the grantee to gather and record the required information. If the grantee has little education and if the evaluation criteria are complex, a local consultant should be hired to help gather information on the program.
- Because the representative and his assistant do not have the expertise to monitor women's projects that have an income-generating component, Pathfinder should recruit a trained Latin American woman to do this work.
- When funds are provided to less sophisticated grantees, efforts should be made to establish close relations with local agencies that can provide technical assistance or money to hire local, short-term consultants. The consultants would work with the grantees on project implementation. Given the current workload, the regional office cannot realistically be expected to provide the amount of assistance that is needed.
- Although Pathfinder/Boston and AID/Washington must assume final responsibility for project approval and renewal, the field representative should have more authority over projects.

3. Relationship Between Field and Headquarters

Relationships with Boston are generally good. Support has improved considerably in the last two years. Project summaries and reports on the status of projects are considered by regular staff to be useful. Trip reports are not. The representative believes that the annual meetings would be more useful if more time was set aside for individual conferences. Priority should be given to meetings at which regional directors, division staff, and other Latin American representatives share experiences. Less time should be spent in large general meetings.

The roles of the Boston staff are still not clear to field staff. This has created problems in the region, for both the project approval and evaluation processes, and in the allocation of visits to Boston. The long process

of approving and renewing projects creates many problems for grantees. The representative has suggested that a weighted score or some other non-arbitrary mechanism be used so that he can explain to grantees why projects are approved or renewed.

The regional representative would like to have all Boston staff visit the field more often. In particular, he would like staff of the Fertility Division to come to Peru more often. The regional representative would welcome a yearly evaluation of all field staff. In his opinion, the evaluation criteria should be discussed jointly by each representative and Boston and reflect consideration of regional differences in budgets, experience in the program, and opportunities for program development.

Suggestions

- The team agrees that division staff should visit the region more frequently for well defined purposes.
- Other suggestions about reports, staff evaluation, and the roles of Boston staff are incorporated into the general recommendations in this evaluation.

4. Relationships with Other Donors and AID

The two AID population officers with whom the team talked were extremely positive about the capacity and relationships of Pathfinder staff. The representative maintains good relationships with other donors, especially the IPPF affiliates and Development Associates, and shares trip reports with the two groups. He has established informal relationships with the AVS and the FPIA.

B. Program Support

1. Commodities

The importation of commodities has not been a major problem in Colombia and Guatemala. In Colombia, the importation of vaginal suppositories was delayed, but the problem has since been resolved. In some instances, the wrong commodities have been shipped and some IUD and minilap kits have been incomplete.

2. Communications Materials

The materials sent to grantees are well received and considered to be useful. The regional office maintains a library of periodicals and technical information supplied by the Fertility Division. This information has been helpful to the representative, keeping him and some of the grantees abreast of new technological developments.

The Communications Office in Boston is considering the preparation of a manual for grantees that explains how promotional materials can be developed. This office could probably learn a good deal from the experiences of a Guatemalan project which funded the production of indigenous materials. That project could be the subject of a "pathpaper."

PROJECT REVIEWS: GUATEMALA

The team talked to the directors of two projects in Colombia and of six projects in Guatemala. Four Guatemalan projects were visited.

A. PIN 6407: Movimiento Campesino Independiente (MCI), Family Planning Information and Services

Dates: September 1, 1980 - February 28, 1981
Amount: \$21,544

1. Description

This project funds the continuation of a community-based contraceptive information and distribution program for campesinos affiliated with a national trade union. It covers eight provinces in Guatemala. A total of 1,440 family planning acceptors is expected. The team talked with central-level staff of the MCI and visited two promoters in Izabal, in northeast Guatemala.

2. Selection and Design

The MCI is a national campesino trade union. Created in July 1969, it has 103 local units and 8,000 members. MCI's primary functions are to provide technical assistance in forming cooperatives and teaching

agricultural techniques, to establish relationships with agricultural institutions in the country and abroad, and to improve the welfare of the campesino family by delivering health, education, and other services. The total monthly budget, derived from memberships fees and external support, is \$1,000. Technical assistance is received from a number of national organizations.

In 1976, the executive secretary of the MCI was invited to a Pathfinder seminar in El Salvador on family planning. After gaining support from union members to develop a family planning program, the project director contacted Pathfinder and developed a project in collaboration with the regional representative.

3. Implementation and Monitoring

Beginning in early 1978, Guatemala's IPPF affiliate, APROFAM, was involved in training MCI's 8 promoters and 128 distributors to distribute pills and condoms in their communities and to refer women to APROFAM clinics for IUDs and treatment of complications. The project was funded for two years but then stopped because goals were not met. The goals were not met because the distributors were unable to promote family planning effectively among the Indian population. They also had many problems in understanding and completing evaluation forms.

The project was refunded for six months in September 1980. APROFAM will provide refresher courses for the eight promoters. The two distributors know nothing about sterilization and little about IUDs. Both want to learn more.

The project has been frequently monitored in the last year by the regional office. Much time and effort have been devoted to the development of an understandable reporting system. To increase the knowledge of the grantee, the project coordinator visited PROFAMILIA in Colombia in 1978.

4. Effectiveness

According to the reports of the project director, the project is making good progress to meet its goal to register 1,446 new users in six months. At the end of October, after two months of work, the achievements were as follows:

New Users	618
Active Users	722

Referrals for Sterilization	8
Supervisory Visits to Distributors	195
Supervisory Visits to Promoters	24

Seven of the eight promoters reported that 2,255 talks had been given and 641 motivational visits had been made.

During the team's visits, it was apparent that MCI promoters and distributors were reaching not just members of the MCI, but the general population as well. The records do not differentiate the two groups.

5. Evaluation

Because this is one of the only projects in Latin America to reach a campesino organization, it is an important learning laboratory. The lessons learned in the project could be described in a report which might be useful to other organizations.

The ability of this project to become self-sufficient is questionable. It may be able to tie itself to the government health structure.

The distributors and promoters need more training and information on methods (e.g., IUDs, sterilization) so that they can refer patients to health centers and hospitals.

For this project, the evaluation criteria designed in Boston were too sophisticated for the recipients. The reporting system should have been simplified, and staff and promoters should have been trained more thoroughly to implement it.

The suspension of the program was a hardship on the program. In the future, similar projects should be designed and monitored to guard against suspension.

B. PIN 6293: Contraceptive Distribution By Private Doctors

Dates: October 15, 1979 - October 15, 1980
Amount: \$51,677

1. Description

This project funded a short, practical course on family planning methods for private physicians in Guatemala and provided to the doctors a supply of contraceptives for distribution to private patients. Of the 800 doctors contacted, 560 became distributors and 200 were trained in IUD insertion. The emphasis was on reaching doctors in rural areas; the goal was to talk to 80 percent of the rural and 20 percent of the urban doctors.

2. Selection and Design

In 1978, the project director, who has extensive contacts with the medical profession as the result of his work as a detailman and supervisor for drug companies, was invited by Pathfinder to a seminar on contraceptive distribution to private doctors. During the seminar, which was held in Colombia, the director designed the project and later modified it in coordination with the Pathfinder representative.

3. Implementation and Monitoring

a. Implementation

Two detailmen with extensive experience were selected and trained in family planning and marketing. They first contacted doctors who were friends to obtain feedback on their approach. Each detailman was then assigned to a geographical area of the country. Each spent three weeks in rural areas and one week in the capital.

The promotion and supply component of this project was problematical. The initiation of the project was delayed because the detailmen were ready to start in December, when most people take their vacations. Approximately 5 percent of the doctors who were contacted were not interested in family planning. Another 20-25 percent agreed to receive information and to refer patients to pharmacies for commodities, but they were not interested in

becoming distributors. In these communities, the detailmen sold commodities to local pharmacies. The remainder of those contacted agreed to participate in the project.

Commodities were sold to doctors at a cost higher than the fee charged to clients in the CBD program of APROFAM. This did not create any problems for two reasons. One, the cost of the commodities was incorporated into the cost of the patient's visit. Two, the clientele served by the two programs belonged to different socioeconomic groups.

A number of different approaches were tried to interest, select, and train doctors in IUD insertion. Initially, the detailmen promoted the idea of IUD training among doctors. In February 1980, a conference was held with 150 doctors. Those who were interested in training were supposed to schedule at least three patients for IUD insertion. This approach was not successful because there was an insufficient number of interested patients. The medical instructor then invited trainees to Guatemala City for training in an APROFAM clinic. Again, patient volume was too low. In May, an interested gynecologist in the Social Security system was contacted and 10 doctors were trained. At the beginning of the summer, an official from the University of San Carlos Medical School asked the project director to train medical students. Given the difficulties in training doctors from rural areas, the project director decided to train medical students. He assumed that, because the students would provide services for one year in rural areas, they could be counted as rural doctors and included in the figure for goal achievement. By the end of July 1980, the project had trained 132 doctors (41 rural and 91 urban).

Finally, in September, the staff discovered a successful approach to training. Two sites were selected for training: a hospital clinic and an APROFAM clinic. In October, the staff arranged for two doctors to serve as trainers without salaries. Each trainer spent one week in the field recruiting trainees and one week in the capital training those he had motivated. Each received \$25 for each doctor trained. The trainees received \$25 for per diem and travel. Twenty-three doctors were trained to insert IUDs.

b. Monitoring

The regional representative and the assistant visited the project in September 1980 and expressed concern about the lack of trained non-rural doctors. They worked with the director to develop a more successful plan. The director feels that the representative and his assistant have been supportive and helpful.

4. Effectiveness

a. Goal Achievement

The project director released the following data on the distribution of methods (November 1979 - October 1980):

<u>Method</u>	<u>Goal</u>	<u>Achieved</u>
Pill	50,000	48,619
Condoms	334 gross	2,059 gross
IUDs	3,000	1,728
Other (Foam)	-	3,652 tubes

No data on the number of users served were collected.

b. Self-Sufficiency

Because doctors pay for commodities, this project should become self-sufficient.

c. Cutting Edge

Doctors in Guatemala are a major obstacle to program expansion. This project offers an opportunity to coopt the medical profession. Educated and supplied with contraceptives, physicians will become part of the solution to the population problem, and not part of the problem itself. The renewal project plans to train doctors to perform minilaps and vasectomies.

5. Evaluation

The medical training component should be supervised more closely and coordinated with the medical director of APROFAM. Responsibility for medical supervision should be clarified when the project is renewed. The Fertility Services Division should work with the representative to develop training standards.

Charging doctors for commodities is a good idea, because it allows the program to become self-sufficient and increases the value of the commodities, thus ensuring their use. Charging a different fee to CBD and private patients is not considered to be a problem.

Before this project is refunded, the number of patients seeking a mini-lap or vasectomy should be determined.

C. PIN 6285: Production of Educational Materials for the Promotion of Family Planning in Indigenous Areas

Dates: April 1, 1979 - September 30, 1980

Amount: \$28,405

1. Description

This project funded the development of educational materials, radio spots, flip-charts, and pamphlets to increase non-Spanish-speaking indigenous populations' knowledge of and interest in family planning. After materials were developed, they were distributed throughout isolated indigenous areas and a survey was taken to calculate the number of family planning users.

2. Selection and Design

The development of these training materials was part of a larger project funded by the USAID and the Population Council and implemented by APROFAM. The goal of the project was to determine how culturally-sensitive family planning information and services could be delivered to Indian populations in Guatemala. The provision of such services was the idea of the USAID population officer. A workshop for linguists and anthropologists was held to design the project. After the workshop, Pathfinder was asked to fund the materials development component.

The project operated in two regions where a majority of the population speaks the same language. Four Indian couples with a high school education were selected and trained as communicators of information on family planning, preventive health, and nutrition. The communicators were registered as Ministry of Health promoters to give them credibility. Two of the couples were selected to visit communities and to determine the best way to convey the public health and family planning messages.

3. Implementation and Monitoring

The materials development component of the project was funded for 12 months, but work was delayed for a number of reasons. One, USAID funding was delayed. Two, the Ministry of Health prohibited the delivery of family planning services for four months during the summer of 1980. Three, the first artist who was hired, Ladino, produced materials that the target population would not understand. The project director was able to find an Indian artist who made better drawings. The materials were tested and well received. By the end of 1980, the drawings had been made into filmstrips, posters, and flip-charts.

The project director feels that support from Pathfinder, especially to complete the work, has been excellent.

4. Effectiveness

The goal of producing materials was met at the end of December 1980. In 1981, the materials will be used in a larger program to reach Indian populations. The existing institutional link will ensure that the materials are widely used.

Given the need for cultural sensitivity, time was needed to develop the project. The effort will prove worthwhile, for rural indigenous populations of Guatemala, which until now received no effective promotion or services, will now be reached. If the materials are used successfully, they and the process used to develop them will become models for other countries.

5. Evaluation

This is one of the most innovative of Pathfinder's projects, and it has the potential for great impact. Apparently, excellent materials have been developed with donor funds, and the project has become a model for reaching indigenous groups.

If Pathfinder develops a manual for producing promotional materials, this project should be studied by the Communications Division.

The importance of using an Indian artist to communicate with Indians was one of the lessons learned in this project.

D. PIN 6249: Adolescent Care Center, "El Camino"

Date: Approval by AID is pending.

Amount: \$41,685

1. Description

Approval for the second year of funding is pending. Funds for the project will be used to continue supporting an adolescent care center, El Camino, which provides social and psychological counseling and some health services, including family planning, to teenagers. The goals for the second year will be to enroll 4,500 new adolescents in the center and to continue to serve 2,500 of those who attended during the first year.

2. Selection and Design

APROFAM identified the need for services for teenagers. Pathfinder was contacted for funding because the project was considered to be innovative. It invited an individual from an adolescent center in New York (The Door) to come to Guatemala to assist Pathfinder staff in designing and developing the project.

The design is modeled after The Door, which provides a wide variety of services on-site to teenagers. The Camino Adolescent Center provides vocational and recreational opportunities for teenagers. It also provides family planning education, counseling, and FP services.

3. Implementation and Monitoring

Adolescents are referred to the center from a number of sources, including factories served by the Social Security Institute, Ministry of Health clinics, and high schools run by the Ministry of Education. Because APROFAM provides sex education in the schools, students are among the referrals.

In addition to these external sources of referrals, the center's social worker gives four short talks each day on topics such as venereal disease, prostitution, alcoholism, drugs, family planning, and sex. The social worker also leads eight groups (each group has 12 young people) each week. These groups, for teenagers with problems, meet for seven weeks. Focused on the personal problems of teenagers, the groups' activities include discussions of family planning and sex.

The staff of the center have visited and discussed the program with key people in the Ministry of Education and Ministry of Health and in factories employing large numbers of youths. Because of the political sensitivity of providing information and services to adolescents, the staff do not openly advertise family planning services.

Currently, the center is open from 8:00 a.m. to 12:00 p.m. and from 2:00 p.m. to 6:00 p.m. At Pathfinder's suggestion, the hours will be changed in January 1981 to begin at 1:30 p.m. and end at 7:30 p.m. On the staff serving the center are a doctor, who works from 3:00 p.m. to 5:00 p.m., a part-time psychologist, a full-time social worker, a director, and eight part-time volunteers who assist with vocational and recreational activities. The doctor provides general medical care, contraceptives, treatment for VD, and prenatal care. Although the social worker normally refers teenagers to the doctor for services, she sometimes gives them pills and condoms. A core group of male adolescents who have received special family planning education also distributes condoms, emphasizing the importance of using condoms to prevent venereal disease.

4. Effectiveness

By the end of September 1980, the center had registered 5,129 adolescents aged 11-26. The majority was 15-17; 2,999 were girls and 2,130 were boys. Of this group, approximately 60 percent were students. According to staff, 701 family planning users have been served. As reported in the last quarterly report (July-September 1980), 106 adolescents received family planning services; however, staff suggested that the number of users is underreported. For example, the social worker often does not report the number of boys to whom she distributes condoms.

The director of APROFAM is aware of the need to find other support for the program and is exploring the possibilities of linking up with the Ministry of Education and of raising funds in the private sector.

5. Evaluation

This project is important because it is one of the few projects able to reach Guatemalan teenagers with family planning services.

The project must develop better mechanisms for identifying the sources of referrals, the type(s) of services provided to each adolescent, and the number of adolescents served by the family planning program. If the project can document the source of referrals, it will be able to justify the need for support, especially from the Ministry of Education and the Social Security Institute. If it can identify the type of services it provides, it can better serve the adolescents. Some youth leaders at the center might be trained to help collect and compile needed information.

Although the center may need a psychologist to lend it the credibility it needs to receive support from the Ministry of Education, it is not a legitimate cost for Pathfinder. An arrangement should be made to phase funding and to find other donors to cover the project's general operating costs.

Closer monitoring of project implementation is essential. Either APROFAM or an outside consultant should be involved in supervising the development of a data collection system. When center personnel visit The Door in New York, they might request help to set up an information system.

When the condom is promoted, responsible sexual behavior, as well as use of condoms to prevent VD, should be discussed.

Terminated Projects

A. PIN 6228: Family Planning Training for Traditional Birth Attendants

PIN 6232: Family Planning Training for Auxiliary Nurses

1. Description

There were problems in implementing these two recently funded projects. The first project was to provide funds for selecting, training, and supervising 150 traditional birth attendants (TBAs). These empirical midwives, who were to work in six rural health facilities, were to provide family planning in their communities and be supervised by the staff of the health centers. The second project was to train 72 auxiliary nurses working in government health facilities to insert IUDs and to prescribe orals.

The team talked with the Head Nurse of the Maternal Child Health Division (in the Ministry of Health), who is also the director of PIN 6228 and PIN 6232, about the problems in implementing the two projects.

2. Implementation

During the implementation, similar difficulties plagued both projects.

- The director feels that she needed more supervision, especially in conducting the required evaluation. She feels that she also could have used more help in designing an appropriate follow-up for the traditional birth attendants.
- The director does not speak English. The reporting forms were initially printed in English, which created difficulties for her.
- The project director and the trainer do not speak any Indian language, yet they were training Indian-speaking midwives.
- Often, transportation from the central office to the regions was not available. Vehicles assigned to the project were used for all MCH programs.
- The Minister of Health's decision to stop family planning from June to September 1979 slowed down the programs.
- The project director had many responsibilities as head nurse and had had too little time to devote to the project.

Problems specific to the project for auxiliary nurses were as follows:

- While auxiliary nurses were being trained, the trainer was unable to find a sufficient number of patients, which meant that no more than two auxiliaries could be trained at one time to insert IUDs. On some occasions, doctors who worked in the centers where auxiliaries were to be trained refused to allow the training to proceed. As a result, the training took longer than expected (18 months to train 72 auxiliaries).

- The project director requested a budget that was insufficient to meet the project's needs, especially for gas and materials. She also discovered that she needed a person to compile statistical reports for Pathfinder.
- The director feels that she really needed an assistant to run the project.
- When the auxiliaries returned to the health posts and centers, they were unable to use their skills because the doctors would not allow them to do so.

3. Plans for the Future

A new project with an improved design takes into account all these difficulties. It should be easier to implement because the Ministry of Health recently developed norms stating that auxiliary personnel may provide family planning services. The project will use a team approach: TBAs will be supervised by trained auxiliaries who, in turn, will be supervised by the program nurse.

4. Evaluation

Although the norms now state that nurses and TBAs may provide training in family planning, those who are trained to work with doctors must be encouraged to feel positively about their work and support this change. Involving the doctors in the team approach should increase the success of the project. Pathfinder and project staff have learned much from the initial projects.

In funding these projects, Pathfinder has succeeded in reaching a different group. It has been politically useful to convince the MOH to train personnel at lower levels. The TBAs trained in the initial program have been absorbed into the health structure.

For this project, and for others in the region where English is not used, forms for reporting should be printed in Spanish. Because different words mean different things to different people, depending on their individual experiences, it is important that trainers have a knowledge of the reference base. A glossary of terms would improve communications.

PROJECT REVIEWS: COLOMBIA

A. PIN 6381: Family Planning Information and Contraceptive Distribution Program in National Territories

Dates: January 1, 1980 - December 31, 1980
Amount: \$47,593

1. Description

This project funds the continuation and expansion of a family planning information and contraceptive distribution program in remote rural areas of Colombia. The project expects to organize 120 family planning lectures and 140 film sessions and to sell 1,000 gross of condoms, 3,000 tubes of vaginal tablets, and 180,000 cycles of oral contraceptives.

2. Selection and Design

The initial research to justify this project was done in 1977, with funds from PROFAMILIA, the IPPF affiliate in Colombia. The Pathfinder representative was contacted at the end of 1977, and the project was started in 1978.

The goal of the project was to reach individuals in low-population-density areas of Colombia, which are largely jungle areas with few roads. A coordinator and promoter were responsible for contacting civic groups in remote towns to show community films and lectures and to educate local pharmacists. The promoter supplied the local pharmacist with commodities and issued sample condoms at community meetings. Pharmacists received supplies on credit for three months. An estimated 5 percent fee was levied for failure to pay. (PROFAMILIA's rate for the CRS program was 1 percent.) Commodities were sold at a price lower than the commercial rate to provide a higher profit margin for the pharmacists.

3. Implementation and Monitoring

During the project, as members of communities and pharmacists were educated, the CRS program of PROFAMILIA began to resupply the areas. Commodities for the project were supplied by the IPPF through PROFAMILIA. During the project, vaginal suppositories were exhausted. The director was not able to import more because the Colombian agency responsible for drug control had not given permission for their use. This problem has been resolved.

The Pathfinder representative and his assistant were extremely helpful to the project director. As one example, they helped him locate a film the project needed. The director would like him to visit certain project sites but realizes that the time required for travel is prohibitive.

4. Effectiveness

To date, there has been a good deal of confusion about the project's achievements because responsibility for resupplying some of the pharmacies was transferred to the commercial retail sales program and data were not recorded on Pathfinder's evaluation form. As a result, the figures appear to be low. At the end of September 1980, the project computed the results to include those areas that had been transferred. The achievements were as follows:

<u>Goal</u>	<u>Achievement</u>	<u>Percent</u>
120 Family Planning Lectures	84	70
140 Film Sessions	149	107

The goal to supply 150 distribution posts was met. Data on the distribution of contraceptives are given below.

	<u>Goal</u>	<u>Achievement, Territories</u>	<u>Achievement, Commercial Retail Sales</u>	<u>Total</u>
Condom	1,000 gross	320 gross (32%)	664 (67%)	989 (99%)
Vaginal Product	8,000	1,680 (21%)	540 (7%)	2,200 (28%)
Orals	180,000	54,422 (30%)	63,240 (35%)	117,662 (65%)

Even after results were recomputed, it was discovered that the project had not met its goal for orals. The project director indicated that low achievement in this area reflects the difficulty of reaching the target audience and pharmacies during the six-month rainy season.

5. Evaluation

The area covered by this project is inaccessible and extremely poor. If continued coverage is desired, it will be difficult for the program to become self-sufficient. PROFAMILIA could subsidize the project eventually, but it considers it to be a low priority project because so few of the population are covered.

In Colombia, pharmacies are often the first source of health care. Their use constitutes a relatively low-cost and particularly viable method for reaching this otherwise inaccessible population.

Pathfinder should encourage the transfer of areas where populations have been educated to the commercial retail sales program. When the project is evaluated, the number of areas that have been transferred should be emphasized and less attention should be given to the number of sales.

In addition to this project, PROFAMILIA funds an urban CBD, a rural CBD, and a commercial retail sales project. With a cutback in funds, it might be appropriate to combine these projects under a single administration.

B. PIN 6385: Family Planning Promotion Among Private Physicians

Dates: October 1, 1980 - November 30, 1981
Amount: \$44,557

1. Description

This project provides education about family planning to private physicians, using a detailman who visits the doctors and offers and supplies information and contraceptives. Interested physicians are given a short course on methods. The goal is to contact 600 doctors on the Atlantic coast of Colombia.

2. Selection and Design

As president of ICARPAL (the Committee on Applied Research in Population), the project director visited projects for private physicians in Asia and attended a Pathfinder seminar on the distribution of contraceptives by private physicians. He designed a project with a comparative research component to determine the least expensive way to approach doctors (mail as opposed to visits). When the project was developed with Pathfinder, the research component was eliminated.

An area of Colombia with low numbers of family planning users was chosen. The doctors are not paid, but they do receive supplies for which they must pay a small fee. SOMEFA, a non-profit organization, will supply the commodities and literature to the doctors.

3. Implementation and Monitoring

Although funds for the project were received in August, the project did not begin on time. The project director had to leave the money in the bank for four months so that he would not have to pay a 9 percent surcharge. He decided not to start the project in December because that is a vacation month and because he himself will have more time available after January, when he resigns from ICARPAL.

Training for doctors will be conducted in PROFAMILIA training centers in the region. The training will last 3-4 days. Doctors will receive tuition and money to cover transportation and per diem.

4. Evaluation

This project should become self-sufficient because it charges doctors for commodities. It makes good use of Pathfinder funds, reaching an area where use of family planning services is low. The project director is realistic about implementation and has established good linkages with other institutions to train doctors.

This project is designed to provide answers to simple research questions. The director is well qualified to do the research. Implementation of the research component would not significantly interfere with the delivery of services.

The project director, Dr. Alcides Estrada, was once a consultant to Pathfinder. Because he is well qualified and articulate, he would be an excellent consultant for other Pathfinder projects.

Contacts

Guatemala

PIN 6285: Production of Indigenous Educational Materials

Enrique Soto, Project Director

PIN 6293: Contraceptive Distribution by Private Doctors

Rolando Sanchez Paiz, Project Coordinator

Hugo Paz Limares, Detailman

PIN 6407: Movimiento Campesino Independiente (MCI) Family Planning Information and Services

Lic. Mario Castillo Parada, Project Director

Marcial Hernandez Gutierrez, Executive Secretary, MCI

Sofia Magdalena, Project Operations

Jose del Carmen Oliva Bolivar, Promoter, Guatemala City

Felicita Milagro Lopez, Distributor, MCI

Rosa Odilia Chacon, Wife of MCI Distributor

PIN 6429: Adolescent Care Center ("El Camino")

Carlos Rafael Echeverria, Coordinator

Yolanda de Martinez, Social Worker

Elizabeth de Contreras, Nurse

Substitute Doctor for Dr. Roberto Villatorio

Rebeca de Montalvan, Chief, Educative Programs Unit, APROFAM

PIN 6228: Family Planning Training for TBAs

PIN 6232: Family Planning Training for Auxiliary Nurses

Joseta Isaacs, Head Nurse, Maternal Child Health Division,
Ministry of Health; Project Director

Others

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Dr. Walter Antulio Maldonado, Medical Director, APROFAM Clinic,
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Olga de Monterrojo, Auxiliary Nurse, APROFAM Clinic, Zacupa

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Colombia

PIN 6381: Family Planning Information and Contraceptive Distribution
Program in National Territories

Santiago Plata, Project Director

PIN 6385: Family Planning Promotion Among Private Physicians (SOMEFA)

Dr. Alcides Estrada, Director, ICARPAL; Project Director

Others

Marvin Cernik, Population Officer, USAID

NOTES

- 1 Carl Haub and Douglas Heisler, "1980 World Population Data Sheet," Population Reference Bureau, Inc., 1980.
- 2 Walter Rodrigues, The Evolution of Family Planning in Brazil, February 1980.*
- 3 Haub, loc. cit.
- 4 USAID/Lima, "Population Programs and Strategy," p. 21.
- 5 Ibid., p. 16.
- 6 Ibid., p. 26.
- 7 Ibid., p. 4.
- 8 Report on Fiscal Year July 1979-June 1980.**
- 9 Haub, loc. cit.
- 10 Frederick Schieck, George Hill, Norma Parker, and E. Croft Long, Health Sector Assessment Guatemala, November 1977, p. 110.
- 11 United Nations Fund for Population Activities, Inventory of Population Projects in Developing Countries Around the World 1978-79, p. 137.
- 12 Schieck, loc. cit., pp. 145-147.
- 13 Haub, loc. cit.

* All background information on family planning in Brazil is taken from this source.

** The report was prepared by the regional representative, the only representative who provides this annual report on activities. Note, however, that the country representative for Egypt has begun to submit a similar summary of his activities.

**PATHFINDER FUND EVALUATION:
ASIA AND MIDDLE EAST**

By

Sallie Craig Huber

November 3 - 21, 1980

I. INTRODUCTION

The field visits for Asia and the Middle East were undertaken by Sallie Craig Huber, who was accompanied by Robert Haladay, the AID grants manager of the Pathfinder Fund grant. Three countries--Indonesia, Bangladesh, and Egypt--were visited during November 3-21, 1980. Pathfinder has country representatives in all three countries.

The evaluation included an examination of the management of Pathfinder's country offices, including the staffing pattern, the roles and responsibilities of the staff, relationships between the country office and Boston headquarters, and local coordination with the AID mission and other donors.

A number of projects were visited in each country. Individual country reports contain observations on each project, a brief description of the project, including its design and selection, and descriptions of the implementation and monitoring process, of evaluation measures, and of the project's effectiveness.

Specific suggestions for the programs in these countries are summarized below.

1. Field staff and projects would benefit from more involvement in efforts to establish evaluation criteria and design reporting forms that are better suited to local situations.
2. In Indonesia, Pathfinder is encouraged to continue supporting sterilization activities as this contraceptive method is not yet part of the national program.
3. The Evaluation Unit in Boston should provide field and project staff with analyses of project data, including operational interpretations, so that informed decisions may be made about redirecting the project and renewing the design.
4. The Aisyiyah Rural Women Family Planning Program (PIN 6316) should be renewed; however, no expansion should be attempted in the second year of the project.
5. Staff of the country office in Bangladesh should seek Boston's assistance in overcoming the difficulty of many Bangladesh projects in understanding and properly completing evaluation forms.

6. The introduction and outcome of a performance-based incentive scheme for workers in the two Bangladesh CBD projects (PIN 6319 and PIN 6339) should be observed and analyzed to determine whether replication is possible.
7. In the Bangladesh project for industrial workers (PIN 6360), the team suggests that the country representative work with the project director to improve cooperation between the UNFPA and Pathfinder projects in an effort to increase referrals to Pathfinder-funded clinics.
8. Pathfinder should consider providing a vehicle for the Metropolitan Dacca Satellite Clinic Project (PIN 6363) if the country representative's efforts to secure a government vehicle fail.
9. The evaluation team suggests that Pathfinder/Boston use, or otherwise take advantage of, the experience and positive attitude of the country representative for Egypt toward project evaluation to change the system now used to evaluate projects.
10. The Egyptian country representative's Arabic translation of Pathfinder's grant application booklet should be noted and used in other Arabic-speaking countries as Pathfinder spreads its program elsewhere.
11. Dr. Dahab (Egypt) should be given the opportunity to show his "Family Planning Communication Doll" to his counterparts so that it might be applied elsewhere.

Because the three countries the team visited are predominantly Islamic, one common issue which was discussed and which is unique to this regional report is the planned Islamic conference on family planning. The planning meeting for the conference is to be funded by Pathfinder. All three country representatives expressed concern that they were not adequately consulted when this activity was being planned. They reported considerable disagreement between Boston and field staff over this conference. Field staff are concerned about the planned timing of the conference, given the current political situations in the Islamic world, prospective participants (an issue is the inclusion of government officials and policy makers), and the project director who was selected to conduct the planning meeting. It must be recognized, in defense of Pathfinder/Boston's decisions about this project, that political situations have deteriorated since the initial planning for this conference. Only a planning meeting has been funded thus far; one field staff representative from an Islamic country has been selected by Pathfinder to attend the planning meeting. Plans are too advanced to withdraw the project at this time.

II. REPORT ON INDONESIA

Background

The population of Indonesia was approximately 139 million in 1979. Overall, density is 186 persons per square mile; but for the highly populated islands of Java, Bali, and Madura, the density is 1,725 persons per square mile. With a crude birth rate of 33/1,000 and a crude death rate of 14/1,000, the annual rate of natural increase was 1.9 percent in 1979, giving a doubling time of 37 years. There are an estimated 21 million married women of reproductive age (15-44 years). The literacy rate for persons above 15 years of age is 64 percent. The per capita gross national product increased from \$80 to \$370 between 1970 and 1979, primarily because of increased revenues from recently discovered oil.

Indonesia's national family planning program has developed in phases, spreading from the most densely populated islands of Java, Bali, and Madura to two groups of the less populated outer islands. Services were delivered initially in general clinics of the Ministry of Health and other PVOs. As the program developed, village programs began to spread from Java and Bali, where they were first started, to the outer islands. In the village program, the villagers assume responsibility for information, motivation, and contraceptive supplies. Numerous variations on the clinic and village modes of service delivery are being tested by the various participating units of the National Family Planning Coordinating Board (BKKBN), a non-ministerial body which reports directly to the president. These units include both government and private sector organizations. The third phase of the program is moving beyond family planning to try to change the norms that influence family size. This phase includes activities designed to integrate family planning with other development activities and it is stressed only in those areas where a certain level of contraceptive prevalence (i.e., 35 percent) has been attained. The national figure for prevalence of contraceptive use was 30.7 percent in 1979.

Promotion of the concept of the small, healthy, and prosperous family is the centerpiece of the Indonesian Government's population policy. This broad goal is to be achieved within the context of overall economic development and improved social equity. Government policy is to significantly reduce the rate of population growth through the family planning program, ameliorate the maldistribution of the population through the transmigration program, and improve the socioeconomic conditions of all citizens through development programs. The goal of the family planning program is to reduce the crude birth rate, which was 46/1,000 in 1971, to 23/1,000 by 1990. By early 1980, the birth rate was 33/1,000, which indicates that the government achieved more than half the proposed fertility decline in the first decade of the national family planning program.

The main contraceptive methods used in the Indonesian program are pills and IUDs. The government still requires women to obtain their first prescription for pills from a clinic following a physical examination. Thereafter, pills may be distributed by community workers. Neither sterilization nor abortion is an officially sanctioned method for the government program; however, sterilization is performed in NGO-sponsored programs with the tacit approval of the government. Likewise, it is recognized that abortion is widely available from private medical practitioners.

Pathfinder Management

A. Organizational Structure

The professional staff at the Pathfinder Fund's country office for Indonesia includes Dr. Does Sampoerno, who is the country representative, and Ms. Purbatin Dharmabrata, who is the program assistant. Among the support staff are a secretary/bookkeeper, an office boy, and a driver.

Dr. Sampoerno is a medical doctor who, in addition to his Pathfinder activities, is head of the Department of Demography and Family Planning, School of Public Health, University of Indonesia. He was recently elected Dean of the School of Public Health, but government approval to assume that post has not been received. Dr. Sampoerno does not expect the government to approve his appointment for several more months. Except for a short break in the mid-1970s, Dr. Sampoerno has been affiliated with Pathfinder since 1969. He is the honorary chairperson of the Indonesian Association for Voluntary Sterilization (PUSSI), but he expects to relinquish that position soon.

Ms. Dharmabrata's appointment to the position of program assistant in the Indonesian office of Pathfinder was a direct result of a recommendation in the 1978 evaluation. Ms. Dharmabrata has been working with Pathfinder for just over one year. Her professional training is law, and she still retains her appointment on the Faculty of Law at the University of Indonesia. She still does a limited amount of teaching, but neither she nor Dr. Sampoerno feels that this interferes with her work with Pathfinder. Soon after her appointment to Pathfinder, Ms. Dharmabrata attended a course sponsored by the Centre for Population Activities (CEPPA), "Women in Management."

Dr. Sampoerno is responsible for all project development and monitors clinical or medically-oriented projects. He is training Ms. Dharmabrata to increase her involvement in project development activities. Ms. Dharmabrata has primary responsibility for project evaluation and recordkeeping; she also monitors projects with a women-in-development component. She translates all reporting forms (financial and progress reports) into Indonesian.

Both Dr. Sampoerno and Ms. Dharmabrata regularly visit project sites. Each makes about six trips each year, covering several projects in a single trip. They try to arrange travel so that both are not away from the office at the same time. The purposes of these visits are routine monitoring, trouble-shooting, and project development.

According to Indonesian office staff, relationships with the Boston staff are very good. Dr. Sampoerno reported that his first line of contact in Boston is always the chief of the Asian Regional Division, although he does send copies of some relevant communications to the functional divisions.

Mail communication with Boston is good, taking only 7-10 days each way. Telephone communication is generally good, and often is used for urgent matters. Pathfinder/Indonesia has access to telex facilities within its own office building; however, staff seldom use this service.

Sub-grantees in Indonesia send quarterly financial and progress reports directly to the Asian Regional Division in Boston. A copy also goes to the Jakarta office. Pathfinder/Indonesia has developed an excellent tracking system to ensure the timely submission of reports. Reminders are sent to sub-grantees if reports are not received in the specified period. In the early stages of project implementation, sub-grantees are assisted to understand the reporting process and receive translations of forms, if necessary. Thus, Pathfinder staff in Indonesia report that they have little difficulty in receiving reports that are completed incorrectly.

The Indonesian staff feel that the evaluation forms (progress reports) are often more complicated than is necessary, because evaluation criteria and forms are developed and designed in Boston without consulting field staff. Since the amount of information requested on these forms differs greatly from project to project, field staff are confused about the use to which the information is put and about the necessity of collecting it. It is suggested that field staff become more involved in establishing evaluation criteria and designing reporting forms that are better suited to local situations (SUGGESTION 1). In addition, field staff would benefit if they received feedback on any analysis of reported data done in Boston and suggestions for interpreting these data. These actions might stimulate field staff to become more interested and involved in the entire evaluation process. Alternatively, if data are not being analyzed or put to use, they should not be requested.

The Indonesian program includes a considerable number of projects that have a women's component. This is commendable. There is considerable concern, however, about the lack of guidance on what constitutes an "integrated" women-and-family-planning project. Dr. Sampoerno thinks this problem stems from a misunderstanding or disagreement between Pathfinder/Boston and AID/

Washington. He sincerely hopes that this situation will be clarified as soon as possible, as he wishes to develop more projects with a women's component. He clearly feels such efforts will be a waste of time until guidelines are clarified and communicated to him.

Coordination among Pathfinder/Indonesia, the AID mission, and other donors is excellent, the result in large part, of the efforts of the BKKBN, which holds an annual national coordinating conference of all NGOs involved in planning in Indonesia. Special meetings on various topics are held in the interim between the annual coordinating meetings. A mid-year review of all NGO activities is also undertaken by the BKKBN. There does not seem to be a problem with competition for projects among the donors in Indonesia. One AID officer commented that Indonesia is a big country with lots of unmet needs for family planning services, so there is no need for competition. The team feels that the BKKBN and AID have helped to create this situation through a very good coordinating process.

Dr. Sampoerno telephones the AID mission almost every week and he meets AID staff in person when necessary. He always discusses new project ideas with AID staff before undertaking extensive project development. This is crucial to the success of good in-country coordination and should be encouraged in all countries where Pathfinder has programs. The procedure can also accelerate the AID mission's concurrence process.

Briefing and debriefing sessions with the AID mission were helpful and constructive. The AID staff had one complaint about Pathfinder's proposal format, which is submitted to them for concurrence: that only one year of project activity is described for their consideration. They would find it helpful to receive a description of proposed second- and third-year activity, including a projected budget for the same.

In discussing the role of Pathfinder in Indonesia, AID staff are unsure about the direction that future activities should take. They agree that Pathfinder is responding to the Government of Indonesia's mandate to integrate or go "beyond family planning" efforts by combining women's programs with family planning in high performance areas. Although AID staff question the advisability of Indonesia's policy, since family planning alone is progressing well without integration, they must consider the host government's policy when determining which activities AID will support in that country. The evaluation team pointed out that U.S. Government policy also calls for the integration of women in development in all development activities supported by AID. The response to this was that population funds should not be used for this purpose. When pressed further to identify areas where AID might encourage Pathfinder to increase its involvement in Indonesia, mission staff suggested that efforts be focused in geographic areas recently added to the national family planning program or in old areas where performance was low, and that efforts to provide sterilization services be continued.

B. Program Support

Pathfinder/Indonesia has not experienced problems in receiving and clearing project commodities because the BKKBN is the consignee and arranges clearance. All family planning project commodities that are received by the BKKBN are shipped to the country duty-free. In the past, the BKKBN commodity unit also arranged the delivery of commodities to project sites. Dr. Sampoerno indicated that this practice was discontinued because of a lack of funds and that now the BKKBN only delivers commodities to the Pathfinder office in Jakarta. From there, Pathfinder must arrange shipment to project sites. This approach has caused slight delays in some cases. When the team mentioned this change in procedure, staff of the AID mission expressed surprise and said they would investigate the matter with the BKKBN. It would be helpful to Pathfinder if the BKKBN could once again ship commodities directly to the projects, as there is inadequate space to store commodities in the Pathfinder office.

Pathfinder publications were in evidence in most of the projects the team visited. Field and project staff consider these communications to be important and useful in their work. Distribution from Boston seems to be adequate. The evaluators did not discuss with Dr. Sampoerno or his staff distribution activities in the country office.

The major training activity discussed in Indonesia was the CEFPA courses, "Women in Management" and "Family Planning Administrators," which are offered in Washington and Indonesia. Several key women in Pathfinder's Indonesian projects, as well as the program assistant for the country office, have attended the Washington course and have found it beneficial. At least one of the projects was conceived and developed in CEFPA courses. The in-country women-in-management courses are well received and more are desired. These courses are a good source of project ideas for Pathfinder and an excellent training ground for project managers.

Project Management

Pathfinder is supporting 17 ongoing projects in Indonesia; another four are in various stages of the approval process. Given the brevity of the team's stay in Indonesia (November 4-10) and the difficulty of traveling in-country, only four of the active projects could be visited. They were:

- PIN 6340: Minilaparotomy Services on an Outpatient Basis
- PIN 6434: South Sulawesi Development and Family Planning

- PIN 6315: Women's Banjar Family Welfare Program
- PIN 6316: Aisyiyah Rural Women Family Planning Program

The first two projects are based at Ujang Pandang, South Sulawesi. PIN 6315 is based at Denspasar, Bali. PIN 6316 is based at Yogyakarta. The team visited four project sites of the latter program.

A. PIN 6340: Minilaparotomy Services on an Outpatient Basis

1. Project Description

The objective of this project is to demonstrate the feasibility of providing minilaparotomy services to outpatients at the ob/gyn department of the Navy Hospital at Ujang Pandang, South Sulawesi. Before this project was introduced, the local norm was for women to be hospitalized for several days after being sterilized. Dr. Rudi Hendrawijaya, the project director, proposes to demonstrate that minilaparotomy can be provided safely to outpatients.

2. Design and Selection

Dr. Hendrawijaya, who is a personal friend of the Pathfinder country representative, had been performing outpatient sterilizations (minilaparotomies) in his private clinic several years before this project began. Because this practice was considered to be irregular and because Dr. Hendrawijaya is a general practitioner with no special training in obstetrics and gynecology, his colleagues complained to the local health officer, who suspended his license to practice medicine. Dr. Sampoerno encouraged Dr. Hendrawijaya to compile the statistics and write an article about his activities. The publicity about the article, which was published by the Indonesian Association for Voluntary Sterilization, legitimized Dr. Hendrawijaya's activities and his license subsequently was restored. Dr. Sampoerno worked with Dr. Hendrawijaya to prepare the proposal for this project. Their document was designed to demonstrate the safety and acceptability of outpatient sterilization services.

3. Implementation and Monitoring

The team was unable to observe a sterilization procedure during its visit as there were no clients on that particular day. However, the team did visit the Navy Hospital to see the renovated sterilization unit, which consists of an operating room, space for several hours' recovery, a reception area, and a doctor's office which also doubles as a changing and scrub room. On the day of the team's visit, new lights were being installed and the unit looked rather dusty and unkempt; however, the facility, when in proper order, is obviously adequate and serves the project well.

The project, which has completed one year of operation, has been monitored by Pathfinder staff, who have made field trips, and by the project director, who has traveled to Jakarta. Project and financial reports have been submitted as required and all are on file in the Jakarta office. During implementation, the project director encountered one problem with regard to Banking. He has had difficulty in clearing checks from Boston at the local branch bank in Ujang Pandang. As a consequence, he has had to use personal funds to pay the costs of the project. He is holding now the last two quarterly checks from Boston because his bank will not cash these until the old checks clear. This matter was explained to the country representative, who intends to investigate the matter and find a solution.

4. Evaluation and Effectiveness

In the first project year, which ended October 31, 1980, the target of 200 sterilizations was exceeded by 59 percent. In total, 319 minilaparotomies were performed. Eight minor complications occurred, but all were resolved with no long-term negative effects. Dr. Hendrawijaya will be reporting on his experience with this project at the international meeting ("New Advances in Family Planning") in Surabaya in December. The meeting, which will be sponsored by the BKKBN and several international fertility research organizations, will be attended by a number of Indonesian doctors as well as international participants. Dr. Hendrawijaya and Dr. Sampoerno feel that this presentation will be an effective way to document the success of the project and to encourage the replication of these findings elsewhere in Indonesia and in other countries.

Many of the Indonesian sterilization demonstration projects that were funded by Pathfinder were turned over to the PUSSI during the maintenance phase. Until the government integrates sterilization into the national program, these projects must continue to be supported by outside donors. As sterilization activities spread throughout the country, however, it is hoped that the government will recognize the method and incorporate it into the national program. Pathfinder is encouraged to continue supporting sterilization activities in the interim (SUGGESTION 2).

B. PIN 6434: South Sulawesi Community Development and Family Planning Program

1. Project Description

This project integrates family planning services and information with income-generating activities in horticulture and poultry production in four areas of Maros Regency, South Sulawesi, Indonesia. In the project selected, women are trained to participate in the ongoing Village-Based Family Planning Program while they learn skills to increase their incomes and to teach other women the new techniques. In keeping with the philosophy of the government's Family Planning Program, this project strives to rise above the current plateau of family planning acceptance in the project area by adding a development component. The project, which was begun with private funds from Pathfinder and renewed with AID funds in August 1980, is being implemented by the local branch of the Indonesian Planned Parenthood Association (IPPA), an IPPF affiliate. The project director is Dr. Adnan Mahmood.

2. Design and Selection

The project director, Dr. Adnan Mahmood, attended a CEFPA management course in 1977 sponsored by Pathfinder. While in the U.S., he met with Ms. Alicia Szendiuch, the regional director for Asia from Pathfinder/Boston, who encouraged him to design a special project which Pathfinder would consider for funding. The country representative followed up this discussion by writing to Dr. Mahmood to encourage him to develop a proposal. In 1978, Dr. Sri Tajuddin Chalid, chairperson of IPPA/South Sulawesi, attended a CEFPA women-in-management course. She presented the first draft of the project proposal to Ms. Szendiuch while in the U.S. The project was further refined by Ms. Freya Bicknell and Dr. Sampoerno and was presented for funding in April 1979. Since the use of AID population grant funds for integrated family planning/women's projects was still being debated at the time, Pathfinder's private resources were used to seed the project for the first year. AID funds were approved for the second-year renewal of the project.

3. Implementation and Monitoring

In the first year of this project, 16 groups of 5 women each (80 women) were brought together for 4 days for intensive training in 5 basic areas of responsibility: skill development; family planning motivation and referral to clinic for first contraceptive supply; contraceptive distribution; teaching of skills to other women; and recording/reporting of activities. After training, these women returned home to practice the

activities under the supervision of 6 family planning and 6 community development workers. The supervisors were primarily government employees who were employed part-time by the project. During the second project year, which will be funded by AID, the original 16 groups will receive three days of refresher training to review and share experiences and to upgrade skills. Eight new groups will be selected and trained according to the original model.

Project staff monitor field activities by visiting regularly the field, by reviewing supervisors' reports, and by scheduling regular meetings with project supervisors. Project participants collaborated with project staff to develop the reporting forms that are submitted and compiled monthly at project headquarters. These reports are used to collect information that is later included in the quarterly progress reports submitted to Pathfinder. Pathfinder staff have also visited the project several times to monitor activities.

4. Evaluation and Effectiveness

The project's objectives for the second year are subdivided into specific objectives for the 16 ongoing groups and 8 new groups. It is planned that the 8 original groups involved in poultry activities will attain self-sufficiency and double the number of poultry at each site from 30 to 60. In addition, 200 other women will be trained in income-generating poultry activities; 1,200 new family planning acceptors will be recruited; and contraceptives will be resupplied to maintain an 80 percent continuation rate of family planning practice. Among the objectives for the 8 new groups are the training of 40 new women leaders, the training of 360 other women in income-generating activities, the recruitment of 900 new family planning acceptors, and the resupply of continuing users to maintain an 80 percent continuation rate.

Even though horticultural activities were less than successful in the first year of the project (because of poor weather conditions and measurement by level of income derived), the project plans to try horticulture again in the second year. It will also train the women in those 8 groups to undertake poultry activities as well. From a review of the limited information available in the Jakarta office (progress reports only, no analysis), it appears that, despite the low income derived from horticultural activities, the groups performed well in family planning recruitment and continuation. Perhaps they had more time for family planning activities, or perhaps increased family income does not influence family planning behavior. These suppositions should be tested further. The team has no evidence that such an analysis has been done; if such an analysis has been made, it has not been conveyed to the field by Boston.

According to project staff, during the first year, the project accomplished about 76 percent of its target for new acceptors and achieved a 68 percent continuation rate, not the 80 percent planned. Boston requests information on the project which is submitted in quarterly progress reports to both Boston and Jakarta. However, because no totals of data are requested on quarterly forms and no analyses of data are available in the Jakarta office, it is difficult to judge the project's performance in detail. Field and project staff need summaries or analyses with operational interpretations of the project's progress and data so that they can make informed decisions about the need to redirect and design appropriate project renewal requests (SUGGESTION 3). The Evaluation Unit in Boston should provide such analyses or assist field staff in preparing these important project tools.

Project and field staff feel that this project has a high potential for self-sufficiency because it incorporates an income-generating activity. The particular poultry-raising group that was visited reported that it is pooling income to develop a capital fund which it will then use to provide small loans to group members. In addition, one important spinoff from the project is that the eggs produced by the group's poultry flock are not all being sold. A small number are being distributed among the members in an effort to improve family nutrition.

C. PIN 6315: Women's Banjar Family Welfare Program

1. Project Description

This project was designed to assist women belonging to 32 banjars (neighborhood councils) with low family planning performance in organizing and operating their own family welfare projects. Village-based family planning services and information will be offered in addition to other information deemed appropriate for expanding the scope of women's decision making. The sub-grant for this project was made to the Tantri Kencana Women's Organization, a private organization whose membership consists of the wives and female workers of the BKKBN. The project director is Mrs. Wirati, who is head of the Planning, Reporting and Evaluation Division, BKKBN, Bali Provincial Office. Mrs. Wirati has been closely involved with the Bali branch of the IPPA for almost 20 years. The project began in September 1979, was extended through December 1980, and is being considered for renewal.

2. Design and Selection

The program that uses Bali's banjar system for family planning motivation and contraceptive distribution began in 1974. By 1978, the program was well established, but it was recognized that about 200 of the more than 3,700 banjars were experiencing low family planning performance. In early 1979, Alicia Szendiuch, from Pathfinder/Boston, visited Bali, where she discussed with Mrs. Wirati and others at the BKKBN the possible causes of low family planning performance in the 200 banjars and ways to increase family planning acceptance. It was thought that because all the banjars are headed by men and only men attend banjar meetings, perhaps the female members of the community were not receiving proper motivational messages. The project was thus designed around the hypothesis that low performance might be improved by improving the status of the women in the banjars and by bringing them together in their own motivational groups.

3. Implementation and Monitoring

The workplan for the project includes the training of one Tantri Kencana member and three other representatives from each of 32 banjars (4 banjars were selected from each of the 8 regencies of Bali), for a total of 128 trainees. The women were trained for 5 days at the BKKBN Provincial Training Center in the following subjects: family planning registration, motivation and methods, and family welfare activities (e.g., money management, health, and nutrition). After they completed their training, the trainees organized monthly meetings of the married women in their banjar to register new and continuing family planning users, to resupply contraceptives, to provide family welfare information, and to conduct a lottery.

Project staff visit each banjar in the project once each quarter to deliver operating funds and to supervise and monitor activities. Each banjar participating in the project receives Rps. 10,000 (\$16.25) each month to purchase materials for their activities or to provide small loans to group members. The 32 banjars submit progress and financial reports to project headquarters in Denpasar, and the compiled data are then sent to Boston. A copy is sent to Jakarta. Pathfinder field staff from the Jakarta office are well informed about the project. They visited it several times in the first year.

4. Evaluation and Effectiveness

When asked to define "low-performance" banjars, the project director informed the team that anything below 50 percent prevalence was considered low for Bali, since the overall prevalence for that province is

now 76 percent. The 32 banjars selected for the project ranged in a baseline prevalence from about 10-25 percent.

Specific objectives for this project are to increase the number of eligible couples practicing family planning by at least 50 percent and to give 384 talks on the improvement of family health and nutrition to approximately 3,200 women. Thus, the only measures requested in the project progress reports are family planning acceptors and continuing users, and the number of talks and number of attendees at each talk. Project supervisors can collect and transmit this information easily. The information provided is sufficient for determining whether the project is meeting its stated objectives.

The team visited one of the project sites, Banjar Bantang Banua, which is on the northern side of Bali, near the city of Singara. Before this project was initiated, the base prevalence of contraceptive practice for this banjar was 26 percent. By the time of the team's visit, after one year of project activities, the prevalence was 62.8 percent, an increase of 142 percent. Effective methods were being used by the majority of these acceptors: 35 percent were sterilized, 22 percent used oral contraceptives, 20 percent used IUDs, and 22 percent used condoms. This banjar group was undertaking some income-generating activities which were demonstrated for the team. The group makes baskets and shrimp chips for sale in the local market and makes laundry detergent for sale to other group members.

For the project as a whole, the prevalence of contraceptive use was 44 percent after the first quarter of the project. It rose to 65 percent by the end of the fourth quarter, representing a 48 percent increase. After two quarters, 249 talks had been given for more than 8,400 participants. It appears that the project's objectives have been exceeded.

Plans for the second project year include expansion to 32 additional low-performance banjars and the addition of a concentrated nutrition program component, which includes baby weighing and special nutrition lectures modeled after a broader AID nutrition project now operating elsewhere in Indonesia.

D. PIN 6316: Aisyiyah Rural Women Family Planning Program

1. Project Description

In this project, 50 women's Koran reading groups were selected to receive family planning motivation and services linked with health and nutrition information and appropriate vocational training. The selected groups are based in five regencies near the cities of Jakarta and Yogyakarta,

which are considered to be typically rural, strongly Islamic in religious orientation and, from the viewpoint of family planning, to have reached the stage where maintenance of acceptors is the focus of local BKKBN efforts. The grantee for this project is Aisyiyah, the women's branch of Muhammadiyah, an Islamic missionary organization involved in religious propagation and social services. Aisyiyah believes that, by linking family planning to other issues of interest to women, this project will contribute positively to acceptor recruitment and motivation. The project director is Professor Barorah Baried, chairperson of the Central Board of Aisyiyah.

2. Design and Selection

Mohammediyah, the organization of which Aisyiyah is the women's branch, received project funds from Pathfinder for six years. Parts of the original project have become self-sufficient, and Family Planning International Assistance (FPIA) now funds certain aspects of the work. Towards the end of the Pathfinder grant to Mohammediyah, Pathfinder and the Mohammediyah staff decided to determine how interested Aisyiyah was in undertaking a project. This action meshed well with Pathfinder's "new paths" efforts to develop women's projects and to respond to the 1978 decision of the National Convention of Mohammediyah and Aisyiyah to institute rural women's programs. The project was designed by Aisyiyah with the assistance of Ms. Alicia Szendiuch and Ms. Freya Bicknell, from Pathfinder/Boston, and Dr. Does Sampoerno.

3. Implementation and Monitoring

The workplan included a complex program to train project directors, vice directors, and administrators in a four-day workshop. The workshop was followed by the selection of project supervisors and two assistants for each of the five project regencies. Members of the regency staff then attended a 10-day training course, after which they returned to their respective regencies to train 10 Koran reading teachers in each regency for four days. The training and selection process consumed the first six months of the first year's workplan, leaving little time to implement activities in the village.

The complexity of this project's organizational structure and the number of staff involved, in addition to confusing requirements for collecting and submitting project data, seem to have diverted the project from its original goals or, at least, to have postponed their accomplishment. The project directors and administrators seem somewhat overwhelmed by the project, but they are doing a commendable job, given the circumstances. In

the future, Pathfinder projects with such a complex design might benefit if they are initiated on a smaller, more controllable scale--perhaps in only one or two regencies in this case--and then expanded as experience is acquired.

Monitoring of this project is done at meetings and on site visits. The following schedule is used:

- Koran teachers meet at regency headquarters once a month.
- Regency staff visit each Koran group once a month.
- Project staff visit each regency three times a year.
- Pathfinder field staff visit the project whenever necessary.

Apparently, because of its size and complexity, this project has required the extensive technical assistance of field staff.

4. Evaluation and Effectiveness

The team visited four Koran reading groups participating in this project, two in Sleman Regency and two in Bantul Regency. These groups have had varying degrees of success in promoting family planning among their members. One group went from no acceptors in the beginning of the project to 40 percent acceptance at the end of the third quarter. Another increased baseline prevalence from 47 percent to 50 percent in the same period. All the groups were involved in learning income-generating skills, but they are experiencing difficulty in these activities because they need a capital fund with which to purchase supplies and equipment. Aisyiyah has included a request for such a fund and for a marketing consultant in its proposal for renewal. The project should be renewed; however, no expansion should be attempted in the second year (SUGGESTION 4). This is suggested because the project's initiation was delayed and there is a need to concentrate on the improvement of the first year's activities during the second year using the existing groups.

The Community Incentive Fee (outlined in the project description) is an innovative idea but completely misunderstood by project staff. Rps. 30,000 (\$48) have been budgeted for each Koran group. The money is to be used to pay for the teachers' increased transportation costs, since they are

expected to meet with the group twice a week instead of once a week, as they did before the project. All the groups the team visited meet the required number of hours--four per week, as outlined in the project description--but they continue to meet only once each week. Therefore, the teachers make no more weekly trips than they did before the project began. When the team inquired about the prospective uses of the Community Incentive Fee, project staff said that it would go directly to the teachers as "their right." When the team suggested that this fee might be used by the group to establish a capital fund, project staff continued to insist that the money belongs to the teachers, not to the group. Perhaps this incentive fee and its use should be clarified.

The project has met its specific objectives of training 30 Aisyiyah leaders and selecting 50 Koran groups to participate in the project. It has exceeded its goal of attracting 2,000 women to participate. Project statistics available in the office in Jakarta are not complete enough to compute the accomplishment of objectives related to family planning practice. The data have not been analyzed as far as the team could determine. The final specific objective to reach at least 10,000 Aisyiyah followers with family planning information is unclear, and the timeframe for its achievement is not stated. Project staff are uncertain about how this objective is to be achieved.

Discontinued Projects

The team requested a status report on the projects which were originally funded by Pathfinder but for which funding had been discontinued. It was informed that the BKKBN has begun funding the North Sulawesi Private Family Planning Clinic Project (PIN 6002/6123). Other donors are funding several other projects, including the Medan Sterilization Training Program (PIN 6219), the Purwokerto Vasectomy Project, and the Jember Voluntary Female Sterilization Project (PIN 6132/6245/6359). All were taken over by the International Project Association for Voluntary Sterilization (IPAVS). Part of the Mohammediyah project has been taken over by FPIA. The team was informed that a number of old Pathfinder projects have become self-sufficient, including the Dharma Dutta Clinics (PIN 6144/6246), the Nahdlatul Ulama Project (PIN 6025), the women's clinics in Magelang and Samarang, and part of the Mohammediyah project.

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* The team did not visit this project.

** Training program for Bangladesh family planning workers.

III. REPORT ON BANGLADESH

Background

Bangladesh has an area of approximately 55,000 square miles, an estimated population of 85 million, and a growth rate of approximately 2.8 percent. If this rate continues, Bangladesh's population will double in size in 25 years. With an annual per capita income of approximately \$80, Bangladesh is one of the world's poorest countries. Infant mortality is 140/1,000; 25 percent of children die before reaching age 5. Literacy is estimated at 12 percent for females and 27 percent for males.

Since the War of Liberation in 1971, Bangladesh has taken some effective steps to accomplish the extremely difficult tasks of economic development, social change, and population control. The approach of the family planning program in Bangladesh before 1975 was largely clinic-oriented, isolated birth control activities. With limited clinical facilities and maldistribution of medical manpower, the program was primarily an urban service. It suffered from lack of a comprehensive population policy, lack of village workers, inadequate training and supervision, irregular logistic support and supplies, isolation of family planning from maternal and child health care services, and lack of a viable institutional framework.

Despite the absence of any historical guidelines for a successful population control program in a poor and underdeveloped country, the Government of Bangladesh recognized the disastrous consequences of an unchecked population explosion and decided to follow a deliberate interventionist policy of population control. In January 1976, the National Population Council, presided over by the president, declared that the population explosion was the "number one national problem." Population control programs were accorded top priority.

In June 1976, a National Population Policy was declared, outlining the basic objectives of and the approach to population activities in Bangladesh. These include reduction of population growth and stabilization of population size consistent with the country's available resources; regulation of family size to ensure better health for women and children, a higher standard of living, and the welfare of the family; and reduction of the burden of large families to release time and energy for increased production. The policy outlined specific objectives to achieve an average population growth rate of 1.5 percent between 1976 and 1990 and to contain the population at about 121 million by the year 2000.

In working toward the achievement of these objectives, the National Family Planning Program of Bangladesh operates a comprehensive service delivery system that includes both clinical and non-clinical methods--sterilization, IUDs, menstrual regulation, injectables, pills, condoms, and

various traditional methods. Maternal and child health has been integrated with family planning services. The major responsibility for delivering clinical methods has been assigned to paraprofessionals. Conventional and traditional methods are delivered by fieldworkers and social marketing and voluntary agencies. To date, however, all these efforts have reached only about 15 percent of all eligible couples in Bangladesh.

Pathfinder Management

A. Organizational Structure

Dr. Subhan Chourhuri, a medical doctor, has been Pathfinder's country representative in Bangladesh since May 1978. He is a retired member of the Government of Bangladesh Civil Service, where he acquired experience as Director-General of the Family Planning and Population Control Division, as Joint Secretary of the Ministry of Health Population Control and Family Planning Division, and as Chief of Health and Family Planning, Planning Commission. He also was an academic and a medical officer in the industrial sector.

The staff of the country office includes two program officers, Mr. S. Murshed and Mr. Habibur Rahman, an administrative officer, an accounts officer, and a secretary, clerk/typist, and various other support staff.

Dr. Choudhuri feels that the present staff is inadequate to handle the 19 existing projects and 4-5 other projects in various stages of development. The portfolio includes several projects which are funded with private Pathfinder funds. These are largely the responsibility of the program officer for MR projects, Mr. Rahman. Dr. Choudhuri would like to employ a medical officer for the country office, because many of the existing and planned projects include a clinical component and because Dr. Choudhuri is the only medical person now on the staff. He indicated that he has a sanction from Boston to hire a medical officer, but he is having difficulty identifying an appropriate person for the position. (The person must have considerable project experience and adequate seniority to deal with project directors who, in many cases, are physicians themselves.)

Most project development activities have been conducted by the country representative, who is now teaching these skills to his program officers. The program officers have as their major responsibility the monitoring and evaluation of ongoing projects. Mr. Murshed had just returned from the CEFPA course on monitoring and evaluation at the time of the team's visit. He found the course to be most useful and applicable to his work with Pathfinder. All three top field staff travel extensively for project development and monitoring.

Relationships between the Bangladesh country office and Boston appear to be very good. Dr. Choudhuri indicated that his first line of communication with Boston is always the chief of the Asian Regional Division; however, since a large number of the country projects have a clinical component, the Fertility Services Division has been heavily involved with the Bangladesh program. Dr. Holtrop arrived for a three-week visit on the day of the team's departure, and Ms. Burkhart arrived soon thereafter, also for three weeks.

Most communication with Boston is by post; however, the turnaround time for letters and other mail is about 22-30 days, which sometimes delays important project action. For matters of immediate importance, Dr. Choudhuri uses telephone or cable services, which are generally dependable. He does have an arrangement with a local bank to use its telex facilities when necessary. Payment for this service is "per use."

In discussing ways to improve communication between Boston and the field, Dr. Choudhuri indicated a desire for two meetings in Boston each year. He agreed with the finding in the general evaluation: that the annual meeting is too long and involves too many large group meetings. He feels that more individual sessions with regional and functional staff would be more helpful. Apparently, since joining Pathfinder, Dr. Choudhuri has not had an opportunity, like other field representatives, to visit Boston. Because of logistics and time constraints, such a visit has been impractical. Dr. Choudhuri has, however, come one week early to annual meetings, an approach that has somewhat the same purpose as a second annual visit.

Project sub-grantees in Bangladesh send quarterly progress and financial reports either directly to Boston or through the country office. Dr. Choudhuri decides which approach is most appropriate, given the sub-grantees' understanding of the reporting forms and their ability to complete the forms correctly. The Dacca staff feel that the evaluation criteria and the forms designed in Boston are often too complex for project staff to understand. Field staff have, consequently, designed their own monthly reporting forms to collect project data. Their forms are more simple, translated into Bengali when necessary, and have adequately and completely defined terms. Data from the monthly forms are compiled quarterly by field or project staff who have the capability to do this work and are transferred to Boston's forms for submission to Pathfinder headquarters. Since this system seems to create more work for grantees and field staff, perhaps the Dacca staff should ask Boston to help them find a more satisfactory solution to this problem (SUGGESTION 5).

When questioned about the development of integrated family planning and women's projects, Dr. Choudhuri indicated that he does not feel ready yet to develop such projects in Bangladesh. Such work would be complicated in Bangladesh because the government requires that voluntary agencies concentrate their efforts only in urban areas unless their projects include a clinical

component, in which case they are allowed to work in rural areas. Most of Pathfinder's integrated projects are rural-based. Pathfinder/Bangladesh is supporting two women's CBD projects that are run entirely by women for women. Two other similar projects have been designed and are being considered for funding.

Coordination among Pathfinder/Bangladesh, the AID mission, and other donors was examined. The team was unable to hold a briefing session with AID health and population staff because they were out of the office or otherwise occupied with the bilateral population project review team. The evaluators left for the field at 0600 hours the first full day they were in Bangladesh, thus precluding a briefing that day as well. They did hold a short debriefing with some members of the AID health and population staff; the session was useful and instructive.

AID/Dacca staff commend Pathfinder for its use of indigenous field staff. They feel strongly that Dr. Choudhuri and his staff know better than AID what will work in Bangladesh and they trust Dr. Choudhuri's judgment on these matters much more than they do that of the representatives of other intermediaries, who are foreigners. The AID staff regard this as a saving of their time, since they have to do less monitoring of Pathfinder's activities and project development strategies.

Donor coordination has been attempted by AID and other donors in Dacca many times in the past. Most of these efforts have been unsuccessful. Coordination is now done informally by AID for centrally-funded intermediaries. The team discussed the issue of intermediaries who steal each other's projects. AID is not aware that this happens often and tries to prevent it by scheduling regular meetings with field representatives and by reviewing proposals for duplication whenever possible. In the new AID bilateral population project, AID will fund direct support to Pathfinder and many other intermediaries working in Bangladesh. The plans for the new project include regular coordinating meetings of the intermediaries. The Government of Bangladesh has attempted to coordinate NGO activities through various committees and by other means. Most government coordination is done by decree (e.g., the regulation forbidding NGO involvement in rural areas, the necessity for government registration and approval of all family planning efforts).

B. Program Support

Family planning projects in Bangladesh do not require contraceptive commodities from foreign donors because the Population Control and Family Planning Program supplies commodities to most NGOs. This is the practice for most Pathfinder activities in the country. For projects requiring equipment and other non-contraceptive commodities, there have been no undue problems with receipt and customs clearance. All equipment requests are project-related.

The team observed that Pathfinder publications were in evidence in all the project offices it visited. Project and field staff find these publications to be useful and they encourage the production of similar materials. Pathfinder films are widely used throughout Bangladesh--not only in Pathfinder-sponsored projects, but elsewhere as well.

Pathfinder training grants and non-project commodity grants do not appear to be widely used by the Bangladesh office. As was noted above, there may be no need for commodities, since the government fills most requests. The team questions whether Dr. Choudhuri has a full understanding of these two types of rapid-response grants, since they have not been used as much in Bangladesh as in the other countries the team visited. Pathfinder/Bangladesh has sponsored a few trainees to attend CEFPA courses. Both project and field staff have benefited from these programs.

The team discussed with Dr. Choudhuri the proposed activities and the general direction of the new Policy Division in Boston. He feels strongly that Pathfinder should not be involved in making decisions on a country's policy. Such decisions should be made by the government with assistance from AID. Dr. Choudhuri feels that Pathfinder's role is to support and implement policy established by the host government.

Project Management

In Bangladesh, Pathfinder lists nine AID-funded projects and one other project that is in the approval process. Several of these projects operate at more than one site. During the team's four days (November 12-15) in Bangladesh, five projects and two proposed project sites were visited. Among them were PIN 6319: CBD Moulvibazar; PIN 6121/6360: Family Planning for Industrial Workers (two sites); PIN 6339: CBD Chittagong, PIN 6418: Family Planning for Railway Employees; and PIN 6120/6363: Metro Dacca Satellite Clinics (four sites). The proposed project sites were PIN 6366: Family Planning in Tea Estates (Deanston Estate, Sylhet) and PIN 6437: Zinjira Basic MCH and Family Planning Program (Mr. Robert Haladay visited this site).

A. PIN 6319: CBD Moulvibazar (Sylhet District)

1. Project Description

This project, modeled after the Concerned Women for Family Planning Project in Dacca, involves the door-to-door distribution of contraceptives to women by women in the town of Moulvibazar. Eight fieldworkers and two supervisors, all women, were recruited to serve a population of approximately

30,000, of which about 6,000 are eligible couples. The grantee for the project is the popularly-elected Municipal Council of Moulvibazar. The project director is Ms. Kazi Asma Feroz, a member of the Municipal Council.

2. Design and Selection

Since the Government of Bangladesh has restricted NGOs from operating family planning projects in rural areas of the country, Dr. Choudhuri wrote to all the Municipal Councils in Bangladesh to solicit ideas for urban-based projects. The Municipal Council of Moulvibazar was the first to respond to his request. The project proposal was developed jointly by the members of the Municipal Council and the country representative. The proposal, as are all Pathfinder/Bangladesh proposals, was approved by the government as well as by Boston and AID. It was implemented in October 1979. Actual fieldwork began in December 1979.

3. Implementation and Monitoring

The Technical Committee, which includes all 12 members of the Municipal Council and eight selected leading citizens of the town, assists the project director with project implementation. In the initial months of the project, the director and two supervisors received training at the Concerned Women Project in Dacca and at the Family Welfare Visitors Training Institute (FWVTI) at district headquarters. Each of these training experiences lasted one week. Eight fieldworkers, selected by the director and supervisors, were trained for one week at the FWVTI and for an additional week in a nearby field project of another NGO working in health and family planning.

Fieldworkers are expected to visit the homes of approximately eight eligible women each day. On their visits they are to give family planning motivational talks, supply or resupply oral contraceptives and condoms, refer clients for clinical services and ICH, and provide information on family nutrition. Supervisors are responsible for community education, data collection, and the supervision of fieldworkers. The project director monitors field activities by accompanying supervisors and fieldworkers on their rounds. Pathfinder/Dacca staff visited the project several times while it was being implemented to monitor activities.

4. Evaluation and Effectiveness

The objectives of the project are to motivate 30 percent of the eligible couples in the area (1,800 acceptors), achieve a 50 percent continuation rate, and visit 13,800 homes during the first year. Project performance data that were collected and filed in the Dacca office indicate that, during the first 10 months of field activities, the project made 49 percent of the projected home visits (6,706 visits), recruited 801 new acceptors, and achieved a 72 percent overall continuation rate for users of pills and condoms (76 percent for pills and 57 percent for condoms).

One constraint to complete achievement of project objectives may be the complex data collection and recordkeeping system, which was designed for the project by a gentleman in the town who seems to be unemployed and who has volunteered his services to the project. The system requires that fieldworkers and supervisors spend two of six working days each week in the project office completing various forms and record books. The field staff told the evaluators that they would be able to reach many more family planning acceptors if they could spend more time doing fieldwork and less time recordkeeping. The workplan for this project indicated that the purpose of training with Concerned Women for Family Planning was to replicate that project's simplified data collection and recordkeeping system. This goal does not seem to have been achieved. It is suggested that the country representative intervene to correct this situation and thereby prevent the further delay in achieving project objectives.

An important innovation in this project, worth analyzing for replication, is the introduction of incentives for workers, based on performance (SUGGESTION 6). Fieldworkers and supervisors who are responsible for the highest continuation rates and the least turnover among field staff, respectively, will receive the highest salary increases at the end of the first project year. The project director has been promised a trip to the Asian Training Center in Bangkok for further training in community-based activities if the project objectives are achieved. Project staff are well aware of these incentives and are working competitively to win them.

B. PIN 6360: Family Planning Services for Industrial Workers

1. Project Description

The current project is a renewal to continue the operation of clinics at three industrial sites in Bangladesh: Adamjee Jute Mill, and the Labour Welfare centers in Tongi and Srimongul. The team visited the Adamjee and Srimongul sites during this evaluation. The clinics complement community-based services in these areas by providing a referral center for

clinical methods, including IUDs, injections, and sterilizations. The UNFPA funds the CBD activities linked with this clinic project.

The grantee for this project is the Ministry of Labour and Social Welfare, Government of Bangladesh. The project director is Mr. Zahirul Huq, who is the director of the Population Planning Unit, Ministry of Labour. He is assisted by local project managers at each project site-- the local Department of Labour officer in the Labour Welfare centers and the chief medical officer at the jute mill.

2. Design and Selection

This project fits in well with the government's effort to involve other ministries in the national family planning campaign. The original project, which started in 1977, was designed by Mr. Huq, with the approval of the Ministry of Labour. Renewal proposals have been designed by Mr. Huq with the assistance of Pathfinder's country representative.

3. Implementation and Monitoring

Community-based motivation and the distribution of conventional contraceptives are accomplished in the project areas by a UNFPA-funded project with the Ministry of Labour. The clinics are a referral point for clinical methods for clients motivated by UNFPA project fieldworkers. The clinics are open five or six days each week. Surgical clients on whom ligations or vasectomies are performed stay overnight at the clinics.

The project director monitors the project by visiting it regularly. In addition, local project managers monitor it daily. The project director holds monthly meetings with medical officers and clinic managers to review progress and problems. Pathfinder field staff visit this project whenever their assistance is needed.

4. Evaluation and Effectiveness

Both project sites seem to be clean, well maintained, and well equipped clinics. At neither, however, was an over-abundance of clients evident during the team's visits. Renovations to clinic facilities seemed to be reasonable, and they have contributed to a smoother-running service.

The general objective of the project--to make clinic-based family planning services available in selected industrial sites--has been met. Specific objectives for each clinic are not being met, and a year-end analysis of performance is likely to reveal serious shortfalls in projected accomplishments. This situation may be attributable to the project's passivity. The clinics are completely dependent on another project's workers for the referrals that keep them in business.

During the first eight months of this project year, the overall performance of the three clinics was as follows:

- 21 percent of the new acceptor goal had been met.
- 18 percent of the counseling goal had been met.
- 33 percent of the sterilization goal had been met.
- 22 percent of the sterilization follow-up goal had been met.

The team understands that these goals were revised for the project renewal proposal, but it suggests that the country representative work with the project director to improve cooperation between the UNFPA and Pathfinder projects in order to increase the number of referrals to Pathfinder-funded clinics (SUGGESTION 7).

C. PIN 6418: Family Planning Services for Railway Employees

1. Project Description

This project is designed to establish clinics in the hospitals at the five divisional headquarters of the Bangladesh Railway. The project sites are Dacca, Chittagong, Ishurdi/Paksey, Saidpur, and Lalmonirhat. The clinics will offer a full range of family planning methods. Once fully established, they will become training sites for the staff of other Railway health facilities, including three other hospitals and 46 dispensaries. The facilities will serve the 60,000 employees and 400,000 dependents of the Bangladesh Railway system.

The grantee for this project is the Bangladesh Railway. The project director is the chief medical officer of the Railway, Dr. M.A. Chowdhury.

The team visited only one site of this project, the Chittagong Hospital. The visit was short, and the team received no description of the project. The analysis is, therefore, more brief than other analyses.

2. Design and Selection

Design and selection were not discussed.

3. Implementation and Monitoring

The Chittagong Railway Hospital clinic began to offer services on September 11, two months before the team visited it. The clinic employs two male and three female fieldworkers to motivate railway workers and their dependents in their homes and at group meetings. Motivation in the homes of these clients is easily accomplished, because they live in housing colonies provided by their employer. Thus, the population that is motivated lives in a well defined geographic area. The workers distribute pills and condoms in the homes and refer clients to the clinic for clinical methods. Family planning services at the hospital are the only services available to the general public and to employees and their dependents.

The hospital itself is an adequate facility compared to other hospitals in Bangladesh. Family planning services are provided by three male and three female doctors, who rotate at the family planning clinic. All have been trained in family planning at the Pathfinder-funded Model Clinic in Dacca.

4. Evaluation and Effectiveness

The team did not have information on project objectives since it did not receive a project description; however, the team was given client statistics for the period September 11 - November 12, 1980. The data are as follows:

Home Visits: 1,301

Total Individuals Motivated: 801 females, 147 males

Total Tubectomies Performed: 10

Total Pill Acceptors: 120

Total Condom Acceptors: 84

D. PIN 6339: CBD Chittagong

1. Project Description

Also modeled after the Concerned Women for Family Planning Project in Dacca, this project employs women to deliver contraceptives door-to-door to other women. Twenty-six fieldworkers and four supervisors serve an approximate population of 125,000, of which 25,000 are eligible couples. They work in Ward No. 15, City of Chittagong. The project grantee is Ghashful Family Planning and Family Welfare Association. The project director is Mrs. Paran Rahman, a well known social worker who attended the CEFPA course, "Women in Management," in June 1979.

2. Design and Selection

This project, originally designed by Mrs. Rahman with the assistance of Dr. Choudhuri and the Concerned Women group, included family planning motivation, contraceptive distribution, and income-generating activities for acceptors. Pathfinder or AID approved only the family planning and contraceptive distribution components for Pathfinder funding. Mrs. Rahman has been able to implement some of the income-generating activities with a grant from the president of Bangladesh. Another family planning project donated sewing machines.

3. Implementation and Monitoring

Similar in design to the Moulvibazar CBD project, this project began in October 1979. Rahman directs the implementation of the project with the assistance of a five-member Technical Committee, which includes one medical doctor and which is made up entirely of women. The project is being implemented in two phases. In the first phase, supervisors and 10 fieldworkers were selected, trained at the FIVTI in Chittagong, and fielded in part of Ward No. 15, a geopolitical subdivision of the city of Chittagong. The supervisors also spent one week in training with the Concerned Women group in Dacca. After these workers were actively working, two more supervisors and 16 additional fieldworkers were selected and similarly trained to cover the other part of Ward No. 15.

In the project, fieldworkers are expected to visit approximately 10 eligible women each day to motivate them to use family planning, to supply or resupply contraceptives, and to refer women for clinical methods and MCH services. Supervisors and the project director monitor field activities. Pathfinder field staff visited this project on several occasions during the first project year.

4. Evaluation and Effectiveness

The general objective of the project was to bring family planning information and services to the congested slums of Chittagong. The specific objectives were to motivate 40 percent of the eligible couples (10,000 couples) to accept a method of family planning; to achieve a 50 percent continuation rate (5,000 couples) among acceptors at the end of the first year; and to visit a minimum of 47,000 homes during the year. Complete statistics on the achievement of these objectives were either not available or not fully analyzed in the Dacca office of Pathfinder. The team did determine that, after about 10 months of fieldwork, the total number of new acceptors was 5,220, or 52 percent of the target, and the continuation rate was about 60 percent at the end of the first nine months of the project.

Plans for the project include an incentive scheme similar to the scheme in Moulvibazar, which rewards those fieldworkers and supervisors who show the best performance at the end of the year. Results of this innovative scheme should be noted for possible replication in other Pathfinder projects (SUGGESTION 6).

E. PIN 6363: Metropolitan Dacca Satellite Family Planning Clinics

1. Project Description

This renewed project permits the continued operation of clinics established in the Mirpur, Bashaboo, Rangpura, and Narayangang areas of Dacca. The clinics offer a full range of family planning methods--minilaparotomy, injectables and oral contraceptives, IUDs, and condoms. They serve congested urban areas where no other family planning clinics are readily accessible.

The project grantee is the Division of Population Control and Family Planning, Ministry of Health, Government of Bangladesh. The project director, who was appointed in September 1980 after serving as the medical director of a Pathfinder-funded industrial clinic, is Dr. Mina Chowdhury. Dr. Chowdhury recently returned to Bangladesh after training and working for many years in Europe.

2. Design and Selection

The original project was designed and approved before Dr. Choudhuri's appointment as Pathfinder's country representative. Thus, exact details are unavailable. It was thought that the proposal was prepared by several officers of the Population Control and Family Planning Division in collaboration with Pathfinder/Boston staff.

3. Implementation and Monitoring

The team visited all four clinic sites, which were clean and well arranged for client flow. The staff were friendly and most enthusiastic about their work, especially the doctors, who seemed to be inspired by the project director to perform well. Each clinic has three motivators to increase client motivation and recruitment and to improve follow-up. The clinics are open six days a week from 8:00 a.m. to 2:00 p.m. All were very crowded when the team made its visit.

Project monitoring is taken seriously by the project director, who tries to visit each clinic once a week for half a day. The project director's efforts are constrained because she has no car, which she needs to do an adequate job. Dr. Choudhuri has been trying to obtain a car for the project from the government pool but, to date, she has not been successful. She will continue to pursue this matter; however, Pathfinder should consider providing a vehicle (SUGGESTION 8).

In addition to the director's visits to clinics, clinic doctors and counselors meet with the director twice a month at different clinics as they rotate. All project staff also meet once a month at the central project office. Both of these meetings serve as a monitoring tool. Pathfinder field staff visit periodically, and since the project is located in Dacca, the project director has ready access to the country office should problems arise during implementation of the project.

4. Evaluation and Effectiveness

The general objective of the project is to make family planning services available in the congested areas of metropolitan Dacca. Specific objectives for each clinic are as follows:

- Contact 5,400 women for motivation and follow-up.
- Counsel (at the clinic) 1,100 women.
- Register 1,500 visits for clinical follow-up.
- Register 1,080 new acceptors of family planning.
- Perform 675 female sterilizations.
- Register 675 sterilizations follow-up visits.

From January through August 1980, the following progress in achieving objectives was reported for individual clinics:

- 60-140 percent of the new acceptor goals were met.
- 31-63 percent of follow-up goals were met.
- Only 3-14 percent of sterilization goals were met.
- 16-80 percent of home visit goals were met.

The team are uncertain about how these objectives were set, but it assumes that Pathfinder will reevaluate and set new goals if the project is renewed.

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B. Srimongul Labour Welfare Center**

Mr. Zahirul Huq
Mr. Islam
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C. Adamjee Jute Mill

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Dr. Najmul Hossain
Mr. Saidul Huq

D. Family Planning Services for Railway Employees, Chittagong Railway Hospital

Dr. M.A. Chowdhury

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** Family Planning Services for Industrial Workers.

E. Chittagong CBD

Mrs. Paran Rahman
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F. Metropolitan Dacca Satellite Family Planning Clinics

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Dr. Ferdous Ara Begum
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IV. REPORT ON EGYPT

Background

In 1976 the population of Egypt was estimated to be 38.2 million. With a 2.5 percent annual rate of natural increase, Egypt's population will double in 29 years. The Egyptian population is heavily concentrated in approximately 4 percent of the country's land area, along the Nile River and in the Delta. The population density in the habitable area is approximately 1,030 people per square kilometer. Egypt's population is highly urbanized. The 1976 census estimated that approximately 44 percent of the population is concentrated in towns and cities with populations greater than 20,000. This compares with urban concentrations of 37 percent in 1960 and 41 percent in 1966.

Between 1967 and 1973, Egypt experienced a decline in fertility. The factors that were thought to have contributed to this decline were rising age of marriage, increased urbanization, rising educational levels, extended military service, and the early influence of the national family planning program. Beginning in 1973, however, Egypt's birth rates began to rise, in part because of the partial demobilization of armed forces personnel at the time and the concurrent deterioration in family planning services.

In the 10-year plan formulated by the Government of Egypt in 1972, specific demographic targets were outlined, including reduction in the population growth rate, from 20/1,000 to 10.6/1,000 by 1982; reduction in the birth rate, from 33.7/1,000 to 23.6/1,000 by 1982; and attainment of a population size no greater than 41 million by 1982.

The Ministry of Health (MOH) has major responsibility for the delivery of family planning services. During the latter part of 1977, it specified and quantified the additional contraceptive usage required to attain the national objectives and translated the demographic goals into family planning targets. Among the specific objectives for achieving family planning goals were the following:

- To increase the contraceptive acceptance rate to at least 25 percent of the target population in rural areas and to at least 35 percent in urban areas.
- To increase the recruitment of low-parity couples by approximately 25 percent and to increase child-spacing.

- To increase participation in the postpartum contraception program by 30 percent.

From 1965 through 1973, the Egyptian Family Planning Program concentrated primarily on the provision of clinic-based and other health services delivered through a single infrastructure. A policy to reduce population growth was established in 1973. Reduced population growth has been the major objective of the program since 1975. Population policy is the responsibility of the Supreme Council for Population and Family Planning. Policy coordination, monitoring, and evaluation are the responsibility of the Population and Family Planning Board, the secretariat of the Supreme Council.

Family planning services are delivered in MOH facilities by MOH personnel. About two-thirds of the 3,500 service delivery units are located in rural areas; the rest are in urban locations. In addition, contraceptives are available in over 2,000 pharmacies, primarily in urban areas. Initially, oral contraceptives were the primary method used in the program. The IUD, which required that a physician be trained in the proper method of insertion, was available only at a limited number of urban clinics. This method is more widely available now. Sterilization is not an officially sanctioned method in the government program, but it is available in a number of urban health facilities in Egypt.

Pathfinder Management

A. Organizational Structure

The Pathfinder country office for Egypt was established in March 1978. It is a small operation, staffed part-time by the country representative, Dr. Tarick Aboud Dahab, and a part-time secretary and office boy. At this time, this small staff is quite adequate for the size of the Pathfinder program in Egypt; however, as the program grows it may be necessary to increase the size of the office staff.

Dr. Dahab is an obstetrician-gynecologist, a member of the Faculty of Medicine, Ain Shams University Hospital. Dr. Dahab has been involved with a number of research projects that investigated various fertility control and family planning subjects.

The building where the country office is located is owned by Dr. Dahab. The office space is divided to accommodate Dr. Dahab's private practice, a consultation room, an examination room, and a waiting area.

A separate room in the same office is used for Pathfinder activities. Dr. Dahab and his family live in apartments in the same building. Pathfinder pays no rent for the office space which, in addition to the small, part-time staff, is an advantage. Dr. Dahab feels that this economy in core support leaves more funds for project activities in Egypt.

The country representative assumes complete responsibility for the development of project ideas, preparation of proposals, and monitoring of project implementation. He participates in the design of the project evaluation much more than do other field staff. His approach to project development is to receive an idea for a project from a potential grantee, and to discuss it with AID to determine whether the project is needed and whether it might overlap with other AID-funded activities. If AID agrees to develop the project, Dr. Dahab and the grantee then develop a proposal. Draft workplans, evaluation criteria, and data collection forms are included in the project portfolio submitted to Boston. The complete background file is sent to Boston, where the proposal is put into the Pathfinder format. Family planning officials in the particular governorate where the project will be conducted must clear the grantee to do the project. Dr. Dahab encourages grantees to seek this approval only after the final award for the project is received from Boston, and not before approval is received. This ensures that local government officials do not become confused if the project is not approved.

When asked about the new project development process, Dr. Dahab indicated that he did not participate in its development. Nor was he aware that a new process was being considered. He supports any effort that will accelerate the project review and approval process in Boston and Washington.

Dr. Dahab feels that he enjoys excellent relations with the staff in Boston. His first line of contact is the African Regional Division. Copies of relevant materials are sent to the functional divisions. Communication is usually by letter, which does not take too long, or by telephone, which is used only for more urgent matters. Dr. Dahab keeps a log of points to discuss during phone calls; the log is prepared in advance to avoid wasting time. The outcome of the discussion of each point is recorded on the same sheet during the call. Dr. Dahab reports that these calls are not too expensive and are definitely useful for clarifying issues that are urgent or difficult to communicate in letters.

The annual meeting of all Pathfinder field staff in Boston is considered to be useful and well organized, but other field staff and Dr. Dahab feel that they involve too many large group meetings and do not provide enough opportunity for individual meetings on specific projects and other issues. Dr. Dahab suggests that the second individual trip to Boston each year be linked with the opportunity for professional development (e.g., attendance at meetings or courses designed to upgrade the skills of the country representatives).

Exchange visits to other Pathfinder regions would be useful to field staff. Dr. Dahab thinks that the visits by Regional Division staff are most important and welcomes them at any time. They should be made regularly. Visits by staff of the Functional Division are considered to be more useful during project implementation, and not during the planning stages.

Dr. Dahab explained that he operates under a particular philosophy about the role of Pathfinder in Egypt, which, to date, seems to have served him well. He feels that Pathfinder projects should be innovative, pioneering efforts that demonstrate, on a small scale, family planning activities that have the potential to be replicated by the government or other major donors if they prove to be successful. He sees Pathfinder building systems for inter-governorate exchanges by developing different types of project activities in different geographic areas. Replication would be encouraged through exchanges among governorates (i.e., interested parties from other locations would visit demonstration projects and try to replicate the projects in their own areas).

Despite the excess of family planning money in Egypt and the consequent competition for projects in the country, coordination among AID, Pathfinder, and other donors seems to be quite good. AID coordinates AID-funded activities informally by encouraging representatives of centrally-funded organizations to discuss project ideas with agency staff.

The Government of Egypt is attempting to formalize coordination among external donors. The Supreme Council recently held a meeting of external donors to discuss the conceptual framework for planning a cohesive population policy for Egypt. The Family Planning Board was charged with designing the framework. The framework designed by the Board will be the subject for discussion at a January meeting, at which time donors will be invited to fit their programs into the overall scheme of family plans for Egypt.

Contrary to the situation in other countries, Dr. Dahab is very interested in project evaluation, and he participates actively in efforts to establish evaluation criteria, design data collection forms, and analyze project data for projects he designs in Egypt. He firmly believes that evaluation should be controlled by field staff and grantees, and not be imposed from Boston. The team suggests that Pathfinder/Boston use or otherwise capitalize on Dr. Dahab's experience and positive attitude toward evaluation to change the project evaluation system now used by the organization (SUGGESTION 9). During the annual meeting, Dr. Dahab could be enlisted to conduct a workshop on project evaluation for other field staff.

Most project reporting forms--both financial and progress--are sent to Boston through Dr. Dahab. The exceptions are the two projects with the Alexandria Family Planning Association (AFPA). Reports from these projects are sent directly to Boston, and copies are mailed to Pathfinder's office

in Cairo. This action has caused some problems. For example, payments for the Alexandria projects have been delayed because financial reports have been submitted late. The country representative has attempted to solve this problem by encouraging project staff to submit their reports on time.

Dr. Dahab is very pleased with Pathfinder's "new paths" efforts. In particular, he feels that the efforts of the new division for women's programs offer to Pathfinder's field program a new opportunity to strengthen family planning activities. He thinks that all field staff should view these new directions as opportunities to become more involved. But he agrees with other field staff that there is a great deal of confusion about the design and approval process for women's projects, especially for integrated projects. An example is the Vocational Training and Productive Families Project (PIN 6386), which was submitted to Boston for approval on January 1, 1979. The award letter for the project was dated March 31, 1980; the first check arrived on September 24. Dr. Dahab believes he followed the Women's Program Guidelines when developing the project but, because of confused communications between Pathfinder/Boston and AID/Washington, the project was delayed almost two years. He finds this situation most frustrating, as do other field staff.

The new Policy Division and its proposed activities are viewed as another incentive to create innovative projects. Dr. Dahab feels strongly that Pathfinder should not follow the route of some other organizations (e.g., IPPF) to change policy. He feels that during project development, the conscientious consideration of the policy implications of projects which will be undertaken by Pathfinder can have a long-term impact on national policy reform. Carefully planned and implemented private sector projects can form a groundswell to change national policy. Dr. Dahab views this as the main operational guideline for the Policy Division.

B. Program Support

The country representative in Egypt has actively supported and made good use of commodity grants. Commodity awards are used to initiate project activities. Sometimes they are given to a prospective grantee at the time the field representative is working with the grantee on project development. This encourages interest and reveals to the prospective grantee Pathfinder's interest in working with him. The awards are also used to fill in gaps in ongoing programs. Clinical kits (IUD and minilaparotomy), IUDs, pelvic models, and films have constituted the bulk of these awards.

Project-related commodities have not presented serious problems in the Egyptian program. The team heard no major complaints about commodity shipments or late receipt of equipment. In one project, it was noted that project staff were unfamiliar with a particular piece of anesthesia equipment

sent from the U.S. The equipment was missing an important part when it was delivered, rendering it useless in any event. The field representative is trying to help locate the missing part and will arrange local training in the use of the equipment. Much of the equipment for projects is available and is purchased in Egypt. Contraceptives for Pathfinder-funded projects are readily available in the country.

Pathfinder's communications materials are supplied to all projects in Egypt, and they were in evidence everywhere the team went. The representative has done a commendable job of distributing materials to organizations that are not involved in Pathfinder projects, including Alexandria Family Planning Association, Alexandria Federation for Social Services, Alexandria University, Assuit University, Ninia University, Suez University, Tanta University, American University, Mahalla El-Kobra, Al-Galaa Teaching Hospital, Population and Family Planning Board, and the CEFPA (in-country training courses on women in development).

The field representative has developed several communication items. Though used in Pathfinder's work in Egypt, they have application outside Egypt. The field representative is to be commended for his creative efforts and should be encouraged to continue similar activities.

One such effort was the translation of Pathfinder's grant application booklet into Arabic. The booklet was translated especially for use in the in-country CEFPA training courses; the objective was to assist the trainees and other prospective Pathfinder grantees in expressing their ideas freely in Arabic when developing project ideas. The booklets should be used in other Arabic-speaking countries as Pathfinder spreads its program elsewhere (SUGGESTION 10).

A second communication tool, which was developed by Dr. Dahab, is the Family Planning Communication Doll. This innovative item is a kit bag containing a doll and other contraceptive items which family planning field-workers can use to discuss family planning with prospective clients. It has been tested in the field and in clinics. Initial results with 200 cases seem promising. Dr. Dahab should be given the opportunity to share this concept with his counterparts at the next annual meeting, as it seems to have international application (SUGGESTION 11).

The country representative in Egypt has encouraged and supported a number of training and travel grants. Response to these experiences and results in terms of project development and management improvements have been noted. Training awards cover attendance at medical conferences and workshops for clinicians and attendance at the CEFPA women-in-management courses held in Washington.

Project Management

Pathfinder is funding four ongoing projects in Egypt. Two have been completed and five are at various stages in the approval process, having been submitted to Boston in June 1980. The five pending projects have been prioritized by Boston headquarters, in consultation with the field representative, and their approval will be phased, based on the availability of funds for their implementation. During the team's stay in Egypt (November 17-21), all four projects were visited. They are PIN 6387: Vocational Training and Productive Families (VTPF), Women's Club in Cairo; PIN 6247: Kafr El-Sheikh Hospital Family Planning Program, in Kafr El-Sheikh Governorate; PIN 6161: Alexandria Comprehensive Family Planning Clinic; and PIN 6372: Family Planning Registration and Service. The latter two projects are located in Alexandria.

A. PIN 6387: VTPF Women's Club

1. Project Description

This project uses two different plans to integrate a family planning information and motivation program into the income-generating activities of the urban chapters of the Society of Vocational Training and Productive Families. In Plan A, 150 leaders from 70 chapters will be trained as family planning/MCH instructors and motivators for other members of the Society. In Plan B, a concentrated effort will be made by one chapter in Cairo to offer a wide range of other activities to 100 women, who will serve as motivators for their friends and neighbors. A comparison of the results of these two approaches will be made.

The grantee for the project is the Society of Vocational Training and Productive Families. The project director is Mrs. Senab Mohamad Ezzat, president of the Society.

2. Design and Selection

Staff of the Women's Programs Division, who were seeking promising women's groups with which to work, encouraged the design of this project. The country representative had met the women involved in this project and observed their income-generating activities, which had received support from the United Nations and other donors. He stimulated their interest in integrating family planning into their other activities.

With the assistance of the leaders of the VTPF, the project was designed during Dr. Dahab's first year with Pathfinder. (The VTPF has been operating throughout Egypt since 1968. It has strong government support and has received several awards from the government for excellence in social service.) A proposal was submitted for approval in early 1979. After an inordinate amount of time, the proposal was approved in March 1979. The project did not begin, however, until October 1, 1980, because a check did not arrive until the end of September.

3. Implementation and Monitoring

Plans to implement the project are outlined in the project description. They include the training of four trainers who will form a central project training team. These four persons will train 150 other leaders from 70 VTPF chapters throughout the country. These leaders will come to the Cairo headquarters for a one-week training course in family planning information and motivation techniques. After they are trained, each of the 150 women will be expected to motivate 30 new family planning acceptors in her own VTPF chapter.

Another aspect of this project is the establishment of a special "women's club" in Cairo. The four-member specially-trained project training team will be in charge of this activity. The purpose of the special women's club will be to integrate family planning information and motivation into the group's vocational training in income-generating activities.

The evaluators went to the center in Cairo to meet the project staff, including the four women selected for the training team, and to examine the facility which will be used for the project. Because the project began only one month before the team's visit, only one of the four women had begun training in family planning. She went to Alexandria, where she spent time observing the activities of the Alexandria Family Planning Association, including its two Pathfinder-funded projects. The other three women will receive similar training. Dr. Dahab has volunteered to assist with the training.

4. Evaluation and Effectiveness

The project description includes an elaborate list of objectives for the project; however, because the project has just begun, there are no indications of progress toward achieving those objectives. Plans call for a comparison of the two aspects of the project.

B. PIN 6247: Kafr El-Sheikh General Hospital Family Planning Program

1. Project Description

This project involves the establishment of a contraceptive outreach program at the Kafr El-Sheikh General Hospital, which will use a satellite system of referrals and follow up cases in the vicinity of the hospital. Social welfare and rural comprehensive health units will be established and the public will be informed about the availability of contraceptives and family planning services at the hospital. The clinic offers minilaparotomy and plans to offer laparoscopy after one of the project staff is trained in the methodology. Training for physicians in minilaparotomy is being conducted at the hospital. Nurses are being trained to assist with these procedures, and social workers are being trained in contraceptive counseling.

The project grantee is the Kafr El-Sheikh Hospital. The project director is Dr. Mohamed Fouad Abdel Meguid, assistant supervisor, ob/gyn, Kafr El-Sheikh Hospital.

2. Design and Selection

At the 1978 annual conference of the Egyptian Ob/Gyn Society, Dr. Dahab presented a paper on new techniques in minilaparotomy. Dr. Meguid, from Kafr El-Sheikh Hospital, attended the conference and expressed an interest in learning the techniques Dr. Dahab described. Dr. Dahab subsequently visited Kafr El-Sheikh Hospital to demonstrate the procedures to Dr. Meguid and his colleagues. This demonstration stimulated a desire to apply for a Pathfinder grant to introduce minilaparotomy as part of the ob/gyn services of Kafr El-Sheikh Hospital, in addition to a comprehensive family planning service and training program. The country representative assisted Dr. Meguid in designing a project proposal which was submitted to Boston and AID. The project was approved and began operating in November 1979.

At the time of the team's visit, the first year of the project had just ended and project staff were awaiting approval of a request for renewal. It is anticipated that the project director will receive laparoscopy training during the second year so that that technique can be added to others now used in the project. Laparoscopy equipment (provided by Pathfinder) is available at the project site.

3. Implementation and Monitoring

Early in the project implementation process, the facilities for the family planning unit were renovated as planned. The unit is well designed and remarkably clean and tidy, especially in comparison with the rest of the hospital. Project staff seem to take great pride in their unit. They showed the team through the area with enthusiasm. The evaluators met the nurses and social workers in the project as well as several resident doctors who are being trained in the unit.

Project implementation seems to be proceeding according to the steps outlined in the project workplan. Procedures are being performed (there was one post-operative patient in the unit's ward on the day of the team's visit). Training has taken place as planned.

The country representative seems to enjoy excellent relations with the project staff. He reports that all project reporting forms are completed and submitted satisfactorily. It appears that he and the project director and other hospital staff are in regular contact either in Cairo or at the project site to solve problems that arise during implementation of the project.

4. Evaluation and Effectiveness

The project has accomplished its general objectives of establishing a contraceptive service, including sterilization, at a general hospital run by the Government of Egypt. Specific objectives for the first year have also been attained and exceeded. It was planned that the project would perform 100 sterilization procedures; this target was exceeded by 98 percent. Other objectives included the training of specific numbers of doctors, nurses, and social workers--10 in each group. These targets were met. In addition, 210 in-clinic talks were given, although only 200 had been targeted. Forty referrals from MCH and social welfare centers were planned; 71 were made.

The project staff display impressive enthusiasm and interest in upgrading their skills and in learning new techniques. They are to be commended for their pioneering and courageous efforts to provide sterilization, which is not an officially sanctioned method in the government's family planning program. This activity truly exemplifies the Pathfinder spirit.

C. PIN 6161: Alexandria Comprehensive Family Planning Clinic

1. Project Description

The intent of this project is to provide family planning services and pediatric services in a model clinic in central Alexandria. The clinic focuses its services on sterilization. It is the first non-hospital facility to offer sterilization services in Egypt. It is also a referral center for family planning problem-cases referred by other AFPA clinics in the city.

The grantee for the project is the AFPA. The co-directors of the project are Mrs. Zahia Marzouk, who is the president of the AFPA, and Dr. Hafiz Youssef, who is the medical director.

2. Design and Selection

The team did not learn the details of the design and selection process.

3. Implementation and Monitoring

The clinic operates six days a week from 8:00 a.m. to 3:00 p.m. It is located in the center of Alexandria's urban area in rented space in the same building that houses the local office of the Ministry of Religion. The clinic has a license from the MOH to perform medical and clinical services. It is the first and only non-hospital facility in Egypt to perform minilaparotomies. Dr. Youssef, medical director of the AFPA, is the co-director of the project and the chief doctor at this clinic. He was attending the training sessions in laparoscopy, sponsored by the IPAVS and held at Chatby Hospital, during the team's visit. The team did have the opportunity to meet and discuss clinic activities.

In addition to family planning services, the clinic provides pediatric and general gynecological services. Many clients for these services are referred by the 36 other clinics of the AFPA, as are those suffering complications from contraceptives and women seeking sterilizations. The project staff and the country representative feel that it is important to extend these other health services to give the clinic credibility and to attract new clients for family planning services. The clinic was very busy on the day of the evaluators' visit.

Dr. Youssef feels that the clinic has a good chance to become self-sufficient in three years. Clients are charged fees. The donated Copper-T IUDs are inserted free of charge, but if a woman brings a Copper-T with her that she has purchased elsewhere, she must pay the clinic LE 1.50 (U.S. \$1.90) to have it inserted. Clients pay LE 0.50 (U.S. \$0.63) for an examination or for insertion of a Lippes Loop IUD. The project staff calculate that it costs the clinic approximately LE 25 (U.S. \$31.25) to perform a minilaparotomy. Clients who are sterilized are asked to pay whatever they can afford for that procedure. To date, only two persons have paid the full amount.

The clinic began its activities in April 1979, six months after the project was funded; the first months were used to renovate the clinic. A renewal application to continue the same activities has been submitted, but notification of renewal had not been received at the time of the team's visit.

4. Evaluation and Effectiveness

The general objective of this project, which has been accomplished, is to operate a clinic that offers a full range of family planning services, including treatment for complications referred from other AFPA clinics and routine pediatrics services. Specific objectives and actual performance during the first year are outlined below.

<u>Method or Service</u>	<u>First Year</u>		<u>April-October 1980</u>
	<u>Target</u>	<u>Actual No.</u>	
IUDS	350	403	701
Pills	300	355	76
Other Conventionals	100	110	20
Voluntary Sterilizations	225	6	28
Pediatric Services	500	582	745

The team was informed that the sterilization shortfall is due, in large part, to the negative publicity about sterilization that appeared when the clinic opened. Subsequently, the MOH requested that no general hospital perform sterilizations unless they are warranted by extreme medical indications. These two factors--negative publicity and government restrictions on sterilization--caused clients to hesitate to request and staff to hesitate to perform the sterilization procedures until pressure against the method relaxed.

D. PIN 6372: Alexandria Family Planning Registration and Service Project

1. Project Description

This renewed project received continued funding in April 1980 because of its satisfactory progress and achievements. It is located at the Federation of Social Services in Alexandria and is monitored by the AFPA. The project attempts to locate recently delivered women and to provide them with family planning information and services in an area of Alexandria serviced by five AFPA clinics and two government facilities. The project is also conducting a series of training courses for various groups. New objectives have been introduced into this renewal project; they cover newly-wed couples, couples eligible for surgical contraception, and counseling for women who need to be educated about the health hazards of such traditional practices as female circumcision.

The project grantee is the AFPA. The project director is Mrs. Zahia Marzouk.

2. Design and Selection

The team did not learn the details of the project design and selection process.

3. Implementation and Monitoring

The explanation of the implementation of this project was confusing, the team thought. An elaborate system of cards and other forms, which appeared to be records of the women in the communities served by the project, were displayed for the team. The volume of recordkeeping seemed to be overwhelming, but project staff assured the evaluators that the

information collected was important and useful to their objective of motivating and recruiting new family planning acceptors. The special-emphasis groups that will be visited and motivated for special types of services are adequately outlined in the project description and are not listed here.

The team was informed that a training course for 30 sheikhs (religious leaders who conduct marriage ceremonies) had been conducted since the project was renewed. The team attended the awards ceremony at the end of a second course for 30 trainees, who were social workers attached to a number of different government ministries. These trainees had attended the two-week course in family planning motivation, a subject they will incorporate into their regular course of work.

The country representative reported that grantee reporting and performance in the project have been good. He seems to enjoy excellent relations with project staff. The project is monitored by field staff who visit the site and by project staff who visit the country office in Cairo. Quarterly progress and financial reports are sent directly to Boston; a copy is sent to Cairo. The staff complained about the late receipt of project funds, a problem that Dr. Dahab attributes to delayed submission of financial reports.

4. Evaluation and Effectiveness

The specific objectives for the project are numerous, and few data on their accomplishment are obtainable. However, statistics for several objectives were available. The project plan included motivation of 50 percent of the women giving birth during the year to accept family planning. It seems that of the 10,106 letters sent to newly delivered mothers, 2,766 women (27.4 percent) actually visited a clinic. The total number of new family planning acceptors for the year was 7,620. The target of training 50 natural leaders to provide family planning information and education was exceeded: 52 were trained. As was noted above, project staff seem to have some difficulty explaining the project to the evaluators. The team wonders whether they also have a problem understanding the data required for reporting. When questioned about the above statistics, the staff were a bit unclear in defining terms. This seeming lack of understanding may be only a language problem, but the country representative may need to assist the project staff with data collection, reporting, and interpretation.

Discontinued Projects

PIN 6226: Training Institute for Nurse-Midwives

This project progressed well in its early stages; however, because the MOH hospital and the university involved in the project disagreed over the management of the project, no one completed the required financial and progress reports. Thus, funding was withdrawn and an audit was required. The project could be revived with a change in personnel and with resolution of the political differences of the two institutions, although Pathfinder's role in a new or revised project would probably be different. In a new or revised project, technical assistance, consultants, etc. would be needed. Moreover, another medical facility could be established as the training institute.

CONTACTS IN EGYPT

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Projects

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Mrs. Senab Mohamad Ezzat

Mrs. Karima

B. Kafr El-Sheikh General Hospital Family Planning Program

Dr. Mohamed Fouad Abdel Meguid

Dr. Abdullah Mohsen

C. Alexandria Comprehensive Family Planning Clinic

Mrs. Zahia Marzouk

Dr. Hafez Youssef

D. Alexandria Family Planning Registration and Service Project

Mrs. Zahia Marzouk

Mrs. Amal Fouad

Mrs. Sawsan el Sheikh

Part III
APPENDICES

Appendix A
PATHFINDER FUND
GENERAL EVALUATION FRAMEWORK

Appendix A
PATHFINDER FUND
GENERAL EVALUATION FRAMEWORK

I. POLICY

A. BOARD

1. Composition
2. Functions

B. PROJECT DEVELOPMENT STRATEGY

1. Country Priorities
2. Project Priorities
3. Non-Aid/Pop Projects
4. Implementation and Implications of New Paths

C. FUTURE PLANNING

II. PATHFINDER MANAGEMENT

A. BOSTON ORGANIZATIONAL STRUCTURE

1. Assignment of Staff Roles and Responsibilities
2. Relationship Between Board and Staff
3. Coordination with Other Donors and AID

B. FIELD ORGANIZATIONAL STRUCTURE

1. Assignment of Staff Roles and Responsibilities
2. Relationship Between Headquarters and Field
3. Coordination with Other Donors and AID

C. PROGRAM SUPPORT

1. Commodities
2. Communications
3. Training

III. PROJECT MANAGEMENT

- A. PROJECT DESIGN AND SELECTION
- B. PROJECT IMPLEMENTATION AND MONITORING
- C. PROJECT EVALUATION
- D. PROJECT EFFECTIVENESS
 - 1. Cutting Edge
 - 2. Potential for Self-Sufficiency
Donor Funding
 - 3. Relationship to AID Goals
 - 4. Accomplishment of Project Goals/Outputs

Appendix B
PATHFINDER FUND
COUNTRY EVALUATION FRAMEWORK

Appendix B
PATHFINDER FUND
COUNTRY EVALUATION FRAMEWORK

- I. COUNTRY BACKGROUND
 - A. DEMOGRAPHICS
 - B. OVERALL FAMILY PLANNING SERVICES
 - C. POPULATION POLICY
 - D. LAWS AND LEGISLATION

- II. PATHFINDER MANAGEMENT
 - A. ORGANIZATIONAL STRUCTURE
 - 1. Training and Background of Staff
 - 2. Roles and Responsibilities of Staff
 - 3. Relationship Between Field and Headquarters
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 - B. PROGRAM SUPPORT
 - 1. Commodities
 - 2. Communications
 - 3. Training

- III. PROJECT MANAGEMENT
 - A. PROJECT DESCRIPTION
 - B. DESIGN AND SELECTION
 - C. IMPLEMENTION AND MONITORING
 - D. PROJECT EVALUATION

E. EFFECTIVENESS

1. Cutting Edge
2. Potential for Self-Sufficiency
Donor Support
3. Accomplishment of Stated Goals/Outputs

IV. LIST OF COUNTRY CONTACTS