

EVALUATION
OF THE
ZIMBABWE CHILD SPACING AND FERTILITY PROJECT (613-0219)

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I. EXECUTIVE SUMMARY

The Zimbabwe Family Planning Program is widely recognized as one of the most advanced in Africa. Through both clinics and a network of well organized community based Educators/Distributors, the Child Spacing and Fertility Control Association (CSFA) has delivered family planning information and services for a number of years. In September 1982, AID approved a four year 8.5 million dollar project with CSFA. The purpose of the project is to expand the coverage of child spacing services through strengthening the existing program and assisting to develop new programs in Research and Evaluation Information, Education and Communication.

The first evaluation of the Zimbabwe Child Spacing and Fertility Project took place from October 1-14, 1983. This evaluation focused on the accomplishment of project activities in relation to the need for mid-course changes in project design and to determine how well project activities were progressing. (The evaluation scope of work can be found in Annex D of the report). The team consisted of Barbara L. Kennedy, REDSO/ESA Population Officer; Dr. James Haiby, AID/W Population/CED Specialist; Karen Murick, AID/W and Dr. Ester Boohene, the AID Project Coordinator. Interviews were held with key CSFA staff and Ministry of Health Officials. Meetings were also held with other ministries and donor groups. Field visits were made to two CSFA Provincial offices where time was spent observing first hand the Community Based Distribution (CBD) program through the work and performance of the Educators/Distributors and their supervisors.

The team found the project design to be sound, and progressing according to schedule. All activities in the implementation plan have taken place within or close to the planned time frame except for the establishment of the research and evaluation program. Centrally funded projects have assisted in providing technical assistance to better implement the CSFA project and have focused on specific areas identified in the project. The need for future centrally funded assistance should continue to be carefully reviewed, prioritized and scheduled to assure that adequate staff time is available and that it coincides with priority needs of the program.

At the time of the signing of the Project Agreement, CSFA was faced with severe management problems due primarily to the mass resignation of all members of the administrative staff of the former Family Planning Association. A Management Review, to be conducted by an outside management firm, was scheduled as an early project activity to help identify some of the management and organizational problems of the CSFA and to recommend ways to strengthen the administration of the program. The management review was conducted in May 1983. The team agreed with the major recommendations of the review which centered around hiring additional management staff, decentralizing responsibility and improving upon personnel management by developing written job descriptions for all CSFA staff along with reviewing salary schedules. In spite of the fact that CSFA management problems were exacerbated by the resignation of the Executive Director in January 1983, and that this post has remained vacant for eight months, the MCH assignment of an able and energetic

AID Project Coordinator has assisted in keeping project activities on schedule and alleviating many of the management problems. If recommendations of the management review are accepted and implemented and if the CSFA hires an Executive Director soon, then the team feels that CSFA leadership and project management will greatly improve.

The establishment of the Research and Evaluation Unit is behind schedule. A U.S. university is expected to assist the CSFA in this area by placing a long term advisor at CSFA headquarters and providing additional technical assistance as needed. Applications for bids have been sent out to 19 U.S. Educational Institutions and it is expected that a contractor will be selected and begin working soon after the beginning of 1984. As the Research and Evaluation Unit has not been established the team's observations focused on those areas of the program where we believed efforts of the Unit are likely to be productive. A list of studies that should merit early consideration has been drawn up and listed under the Research and Evaluation Section of the Report. Overall, the team feels that the chief purpose of the Unit should be to serve the practical needs of the CSFA program and not to produce academic studies.

The Youth Advisory Service is progressing well and the team encourages that an evaluation of the program be scheduled soon in light of the large expansion of this program under the project. The Training Program has successfully carried out all scheduled training activities to date. The Training Department has begun an overview and update of all existing courses, and with INTRAH assistance, will be focusing on improving the training and management skills of their trainers. The team fully supports these new efforts. However, the team cautions against the Unit scheduling training programs and activities so tightly that time to complete training activities and time for staff development does not take place. The team also recommends that the department begins plans for evaluating the impact of some of their courses.

The information and Education and Communication (IEC) Program is a new department created as part of the AID project. An excellent five year IEC strategy and Plan of Action has been developed with assistance from the centrally funded Population Communication Services (PCS) Program. The major problem with IEC is lack of money and staff. The team recommends that additional resources be made available to support the carefully detailed IEC program. PCS should also continue to offer technical assistance, as needed.

The team was impressed with the excellent implementation of the Community Based Distribution (CBD) program, particularly the effective supervisory system, a model from which virtually any community based program could learn a great deal. The program, however, is costly and the team lists a number of recommendations to both document the success of the program by developing case study material on actual field problems and their resolution and studies to help determine ways to increase the cost-effectiveness of the CBD program.

The Medical-Clinical Program, while a relatively small component of the Association's activities, provides what the team feels are consistently high standards of patient care and well maintained records. The team would, however, encourage that CSFA take steps to limit the level of resources devoted to untreatable sub-fertility cases and begin to promote methods such as voluntary surgical contraception and the IUD - both of which are utilized by a comparatively small percentage of clients. Likewise, the CSFA needs to review the implementation of existing guidelines to encourage breastfeeding women to switch from the mini-pill to a combined oral contraceptive after a specified period.

Commodity procurement and plans for construction are currently underway and are detailed in the report. Twenty-two of a planned 33 vehicles to be purchased under the project have been ordered and received. The team discourages the purchase of any additional vehicles until the overall usage of the present vehicles are analyzed and justifies the need for further procurement.

The major concern the team found in the evaluation was a lack of funds to implement project activities. For example, under the section on training, while large numbers of workers are to receive training, monies to cover costs of training were never included in the project. If the IEC Unit is to implement their program it would require a doubling of existing project resources for IEC. But, perhaps most important, the CSFA has requested that AID contraceptives be purchased through the agreement. As the Association is experiencing a chronic shortage of contraceptives and, in addition, is having foreign exchange problems in purchasing their own contraceptives, the team strongly recommends that funds also be added to the project for contraceptives.

If the recommendations of this evaluation are accepted, then approximately \$2.0 million of additional monies would be required. Even if existing project monies could be reprogrammed, based on our preliminary analysis, there will still be a substantial shortfall. The team strongly encourages AID to provide the additional funds necessary to effectively implement what the team feels is a well-designed, well-implemented project.

Last, certain encouraging developments have taken place within a short time after the completion of this evaluation which bear mention. In December 1983, the CSFA became a parastatal under the Ministry of Health and has been renamed the Child Spacing and Family Planning Council (CSFPC). The Permanent Secretary of the Ministry of Health is the Chief Executive Officer for the Council. The final management review report was also issued in November 1983. The CSFPC has prepared and presented a plan of action to the MOH for implementing the recommendations of the report. The MOH has accepted the plan and has requested AID concurrence to proceed. Clearly, within a short period of time the family planning program has overcome organizational and management problems and with AID assistance, is expanding and strengthening their program efforts.

II. OVERVIEW OF CHILD SPACING AND FERTILITY PROJECT (613-0219)

A. BACKGROUND AND EVALUATION SCOPE OF WORK

The Zimbabwe Family Planning program is widely recognized as one of the best in Africa. The Zimbabwe Child Spacing and Fertility Association (CSFA), as a parastatal government institution, operates in close collaboration with the Ministry of Health and other ministries to coordinate all family planning activities throughout the country. Also through a network of their own clinics and community education/distributors, CSFA has been actively involved in providing family planning information and services for a number of years.

As of 1982, it was estimated that about 200,000 active users of contraception were being directly served by the CSFA program. Many of these were introduced to family planning through the Community-Based Distribution Program where over 300 educators/distributors deliver services directly to couples in the communities. These field efforts are supported by CSFA and Government clinics that provide family planning and referral services. In addition, CSFA serves as the national family planning training center and a few years ago initiated a successful program of youth advisory services to provide family health counseling and education to youth. Based upon the substantial accomplishments of the family planning program, AID approved a grant with CSFA in September 1982. The Zimbabwe Child Spacing and Fertility project provides 8.5 million dollars over a four-year period. The overall purpose of the project is to expand the coverage of child-spacing information and services through strengthening the management, training, and technical capacity of the CSFA.

The AID project provides assistance to the following CSFA programs: Community Based Distribution, Youth Advisory Services, Medical Clinical Services, Training and Management and Administration. AID assistance also supports the establishment of two new programs within the association, that is, and Information, Education and Communications Unit and a Research and Evaluation Unit. In support of developing a Research and Evaluation Unit, the AID agreement will provide funds to support a U.S. Resident Research and Evaluation Advisor to the CSFA for a three-year period. The Resident Advisor will work directly with CSFA staff to implement and evaluate project activities. Funds are also set aside in the project for up to 30-person months of short-term technical assistance. It is anticipated that AID centrally funded population projects will provide additional technical assistance and support.

This is the first of two evaluations planned over the life of the project. The primary purpose was to look at the project accomplishments in relation to present needs and determine what mid-course changes in project design are needed to reflect the current child-spacing needs in Zimbabwe. The evaluation focused on project activities and made recommendations for project adjustments including both activities and budget.

The evaluation team consisted of Earbara L. Kennedy, REDGO/ESA Population Officer, Dr. James Heiby, AID/W Population/CBD Specialist, Karen Nurick, AID/W, and Dr. Ester Boonene the AID Project Coordinator.

The team spent two weeks in Zimbabwe which included interviews with Ministry of Health Officials and CSFA headquarters staff. Site visits were made to two CSFA provincial offices. The field visits included time spent observing the CBD program and the work and performance of the educator/distributors and their supervisors. Interviews were also held with the Ministries of Community Development and Womens Affairs, Land Resettlement and Rural Development, Youth, Sport and Recreation and the Central Statistics Office.

B. ACCOMPLISHMENTS TO DATE

All scheduled activities in the implementation plan of the project, both bilateral and ST/POP funded, have taken place within the planned time frame except for the establishment of the Research and Evaluation Unit. Request for Bids (RFBs) were sent to 19 U.S. Educational Institutions to select a contractor to assist in setting up the Research and Evaluation Unit, which includes the placement of a full-time Research and Evaluation Advisor for three years.

The CSFA Management Assessment scheduled as an early project activity was conducted in May 1983 by Coopers and Lybrand Associates in Zimbabwe. The assessment identified some key problems and made recommendations and the draft report is currently under discussion at CSFA. Once the Ministry of Health accepts the report and findings, CSFA will develop a written plan describing how they plan to implement the recommendations. Centrally funded activities have also begun. The JHPIEGO Agreement for In-Country Training has been approved and is on schedule. Population Communication Services (PCS) from Johns Hopkins conducted an Information, Education and Communication (IEC) needs assessment. CSFA and PCS have developed a three-year IEC Plan of Action which identified various programs and impact groups. The IEC Unit also is conducting radio programs on FP in three languages with the assistance of a local production firm, Media Associates. CSFA has reviewed and updated all of their training manuals and, with assistance from INTRAH, have developed a proposal to support upgrading teaching skills of CSFA staff along with additional training activities. The Youth Advisory Service Program has hired 10 new Youth Advisors and has expanded into the five provinces of the country where CSFA has programs. The Centers for Disease Control (CDC) has reviewed the logistics, supply, and data collection systems and will be developing a scope of work to assist CSFA in evaluating their CBD program. Through project efforts, the CBD program has been expanded so that at the community level more families can be reached. At the start of the project, the number of active users per month was about 50,000 and over the past year this figure has doubled to 100,000.

CSFA is now interested in the possibility of purchasing AID contraceptives and, during their recent visit, CDC forecasted the

contraceptive requirements of the program and made recommendations on logistics as well. Westinghouse will return to Zimbabwe soon to begin the Contraceptive Prevalence Survey. Family Health International and The Population Council have also visited Zimbabwe within the past few months and once the Research and Evaluation Unit is established, will be asked to return. All additional staff to be hired under the project, except for the Research and Evaluation Unit, have been recruited. In the area of commodities and construction, twenty vehicles have been ordered and received under the project and the construction is underway for expanding the clinical facilities at Spilhaus Center, which includes a new Administrative Block, Warehouse and Hostel at CSFA Headquarters.

While the future status of CSFA remains unclear, and the Association still does not have an Acting Director, the AID project and additional AID supported ST/POP activities are progressing extremely well under the able leadership of the AID Project Coordinator. The USAID Zimbabwe Mission is also providing excellent backstopping for the Child Spacing Project and additional centrally funded activities.

C. PROJECT EXPENDITURES AND REPORTING

The four year Child Spacing and Fertility Project (613-0219) was authorized for \$8,542,000 in September 1982. Of this amount, \$5,250,000 was obligated in FY82 and the balance of \$3,292,000 is planned for obligation in FY 84. The GOZ contribution to the project was \$16,962,000 or approximately two-thirds of total project costs.

The GOZ contribution for 1982 and 1983 was to have been 3.3 and 3.8 million U.S. dollars, respectively. However, the amount actually given to CSFA for 1982 was 2.4 million. The GOZ is planning to increase its contribution next year (FY 1985) to Z \$6 million. While the amount of GOZ input is less than what was originally anticipated, it still far exceeds 25% of total project costs. In fact, as AID inputs over the life of the project average 2.1 million per year, based on commitments to date, the GOZ is contributing over one-half of project costs. During a period of severe economic problems within the country, the GOZ has still provided substantial financial support to the program and infact is planning to increase its contribution next year by \$400,000.

The Project budget for FY 1982 was \$1,822,000. CSFA expenditures at the end of the first year of project implementation (FY 1983) will be close to \$593,000 or about 30% of budgeted costs. As can be seen from the attached chart on "Expenditures of USAID Project Funds", all line items are under-expended. No technical assistance has been charged to the project primarily because the Research and Evaluation Unit has not been established, the IEC Plan of Action was just approved in August 1983, and central ST/POP funds have paid for all technical assistance to date. With the establishment of these three new units however, this is expected to change. Little has been spent for training as the short term training plan has just been developed and the two participants for long term training have not been selected as they

were to have been staff from the Research and Evaluation Unit. In the area of commodities, it has been decided that not all 33 vehicles will be purchased until it has been determined that the twenty new vehicles already ordered and received all current vehicles are sufficiently used to warrant ordering more. For the line item "other costs," the low expenditure is due to the fact that new vehicles were not received until the third quarter, therefore maintenance and petrol could not be charged for these vehicles until the fourth Quarter. Other equipment such as microcomputers and laundry equipment have not yet been ordered, but are expected to be purchased shortly. Also, the contract with a U.S. university to set up the Research and Evaluation Unit will also come out of this line item. Therefore, as the CSFA has under expended funds for the first year, this was primarily due to slow project start-up in certain areas and it is expected that this will be rectified soon.

If the recommendations of this evaluation, described in detail later in the report, are accepted, especially the approval to purchase AID contraceptives, then an additional \$2.0 million would be required. Even if existing project monies could be reprogrammed, such as not ordering the remaining vehicles, or reducing the costs for educational materials for the YAS, there will still be a substantial shortfall. It is hoped that AID will consider providing additional monies necessary to effectively implement what the team feels is an excellent project.

D. ADDITIONAL QUESTIONS AND ISSUES RAISED IN THE EVALUATION SCOPE OF WORK

In addition to evaluating the overall project design, progress to date and making recommended changes, the evaluation scope of work asked that the following questions and issues be addressed:

1. How well is CSFA managing the Child Spacing and Fertility Project which includes overall leadership, MOH oversight, project reporting and accountability? What changes, if any, are recommended to improve this management?

The CSFA has gone through a particularly difficult period this past year. The Director resigned in January 1983, and unfortunately, has not been replaced, leaving a real leadership vacuum in the Association. All major decisions concerning the running of the Association have had to be taken by the Ministry of Health. The Permanent Secretary of the MOH has had to come to CSFA quite often to deal with many of the problems of poor personnel management, financial and program management and general frustration and confusion on a number of issues. When it was realized that it may be quite sometime before naming a new Director, USAID and the MOH agreed on the need to appoint an interim Project Coordinator to assure adequate implementation of the project. The AID project and additional centrally supported activities have been progressing well under the AID Coordinator, inspite of these management problems.

The MOH and CSFA have worked together well in managing project resources, reviewing work plans, project activities and making quick decisions. All

EXPENDITURES OF USAID PROJECT FUNDS
(U.S. \$000)

<u>Budget Item</u>	<u>Budget ^{1/}</u> <u>FY 82/83</u>	<u>CSFA Expenditure</u> <u>as of 06/30/83</u> <u>Reimbursed by AID</u>	<u>Estimated</u> <u>Expenditure</u> <u>Quarter End</u>	<u>TOTAL</u> <u>CSFA Expenditure</u> <u>09/30/83</u>
T. A.	\$294	-	-	-
Training	155	12	-	-
Commodities	627	5	335 ^{2/}	-
Other Costs (CSFA Operating Expenses)	<u>580</u>	<u>155</u>	<u>86</u>	-
SUBTOTAL	1656	172	421	-
Contingency (10%)	<u>166</u>	<u>-</u>	<u>-</u>	-
GRAND TOTAL	\$1822	\$172	\$421	\$593 ^{3/}

^{1/} - Per Project Agreement.

^{2/} - Vehicles

^{3/} - USAID/Controller estimate was \$585 (including accruals)

AID reporting requirements have been met, and the CSFA has instituted extensive quarterly monitoring reports from each of the Unit Heads and Provincial Offices to track progress and highlight problems. CSFA has also been responsive in providing any additional reports or information requested by AID such as the written Vehicle Maintenance and Usage Plans.

Appointing a new Executive Director would certainly help alleviate some of the management problems. The team recommends that the MOH nominate someone as soon as possible and encourage the selection of a candidate with good management and supervisory experience, which may not necessarily be a medical doctor.

2. What are the CSFA plans for implementing the recommendations of the Management Review conducted in May 1983?

The Management Review was conducted in May 1982 by Coopers and Lybrand Associates in Harare. The review was included as one of the early project activities to help identify some of the management and organizational problems of the CSFA and to recommend ways to strengthen the administration of the program.

The Management Review recommended revising the organizational structure of the CSFA by increasing the number of central management level staff and reducing the direct supervisory responsibilities of the Director. For example, the report proposed that Unit Heads continue to be accountable to the Director but Provincial Administrators be accountable to an Operations Manager, which would be a new position. The Operations Manager should be someone with a health/FP and management background and would replace the current Administrator position. In total, Coopers and Lybrand proposed the following new positions: An Operations Manager (in charge of Provincial Staff and serves as Acting Director); a Personnel Manager and two Assistants; a Field Operations Manager (in charge of the four functional units); and, a Pilot Projects Manager. Given funding constraints, the MOH, CSFA and team feel that adding a Personnel Manager and an Operations Manager are the more important of the proposed new positions, and recommends that CSFA approve these two new slots. The team further recommends that if CSFA abolishes the current Administrator position and creates a Operations Manager position, AID continue to provide salary support. Consideration should also be given to funding the costs of a Personnel Manager.

Other recommendations suggested that CSFA develop written job descriptions, and review salary scales for all staff. CSFA has drawn up a written response to the report which responds to the recommendations and lists priority activities to take place as a follow-up to the Review findings.

3. How well is the Project meeting targeted objectives within the planned time frame? Are resources adequate to carry out planned activities especially in the establishment of the new IEC and Research and Evaluation Units?

All activities scheduled in the implementation plan of the project, both bilateral and ST/POP funded, have taken place within or close to the planned time frame with the exception of the establishment of the Research and Evaluation Unit and placement of participants for short and long term out of country training.

Research and Evaluation

It was originally thought that Columbia University would provide the Research and Evaluation Advisor. However, when it was discovered that Columbia's current cooperative agreement terminated in July 84, it was realised that there was not enough time within their present contract to provide an Advisor for the required three years. Therefore, to assist in setting up this new Unit, the MOH, CSFA and AID decided to send out a Request for Bids (RFB's) to 19 U.S. Educational Institutions to competitively select both a Research and Evaluation Advisor along with additional University technical assistance and services.

The RFB's were sent out in August 1983 and the proposals will be reviewed in mid-October 1983 in Zimbabwe. It is anticipated that an Advisor will be selected and begin working sometime in January 1984. Due to the delay in establishing the Research and Evaluation Unit, it was decided to go ahead with some of the more urgent research and evaluation activities such as the Contraceptive Prevalence Survey and Evaluation of the CBD Program. As soon as the Advisor arrives, he or she will take an active role in these activities and assist in developing a research and evaluation plan for the next year.

Training Requests

CSFA has not yet used any of the monies allocated for training, however they have drawn up a schedule and listing of courses for next year. Two participants had planned to attend the Adolescent Fertility Management course in Chicago, however at the last minute the course was cancelled. Likewise, due to the delay in establishing the Research and Evaluation Unit and hiring of staff for this unit, candidates have not yet been selected for long term training.

However, it was discovered during this evaluation that financial resources will not be adequate to meet project needs. While the Research Unit appears to have adequate resources, the IEC Unit does not. In fact, based on the recently developed IEC Plan of Action, a total of \$700,000 will be required or a 100% increase in what was originally programmed. At the same time, the monies allocated for training do not cover the actual costs of training activities targeted in the agreement. An additional \$270,000 would be needed to cover these costs. Based on this evaluation, salary support is also requested for six additional personnel which would add \$205,000 to LOP costs. CSFA also recently requested that AID purchase some of their contraceptives which would add an additional* 1 million dollars for contraceptives for the next three years. While

* This does not include the costs of shipping.

these are all estimates, there is a shortfall of approximately 2.0 million dollars over the LOP if the proposed changes are accepted. Copies of the proposed budget changes can be found in Annexes A, B and C of this report.

4. Are the commodities and construction to be furnished by the project adequate to meet project needs? How are the current vehicles and motorcycles being utilized? Would it be possible to order AID contraceptives through the project?

The status of commodity procurement is summarized in the chart on the next page. The largest procurement in the project is vehicles. Of the planned procurement of 33 vehicles, 22 have been delivered to date. Further procurement is postponed pending the completion of this evaluation.

At present, seven Mazda sedans have been assigned to various people at the Spilhaus Center. The Director, Administrator, and Program Coordinator each has been assigned a vehicle. Whether each of these positions requires full time use of a vehicle is doubtful. CSFA should analyze vehicle needs for all positions, and determine on the basis of work requirements, which vehicles should be allocated to which functional units. When overall usage of the present vehicles has been analyzed, further procurement of vehicles, if appropriate, can proceed. The team would also suggest that CSFA consider a motorpool concept rather than assigning vehicles to individuals and functional units.

CSFA had also requested that AID purchase some mobile clinics as part of the vehicles to be procured through the project in order to serve in areas where other clinic facilities are not available. The team found that existing mobile clinics have produced disappointing results, and any expansion of this component of the program would require careful analysis to justify the considerable costs involved.

The project paper included the procurement of seven microcomputers, but so far no action has been taken pending the recruitment and arrival of the new Research and Evaluation Advisor. When this person arrives, he/she should closely examine the proposed procurement in light of CSFA's current needs. Depending upon his/her expertise in this area, CSFA/USAID may want to obtain the services of a short-term consultant to determine the appropriate hardware and software mix.

To date, all contraceptives have been supplied by counterpart funds under the project. The scope of work for this evaluation raised a question about the possible need for AID support in this area. Over the past year, the CSFA has suffered a shortage of contraceptives. At the same time, the CSFA Medical Director was not interested in purchasing AID oral contraceptives.

STATUS OF COMMODITY PROCUREMENT

<u>Project Agreement</u>	<u>Status</u>
1. Light weight vehicles* 28 sedans 3 microbuses 2 4-wheel drive vehicles	CSEA has purchased and received: 7 Mazda 323 5 Toyota Landcruisers 2 Microbuses 3 Mazda pick-ups
2. Motorcycles - 90 **	70 motorcycles have been ordered and are pending payment and delivery.
3. Bicycles - 510	600 bicycles have been received and delivered to ED's.
4. Microcomputers - 7	No microcomputers have been ordered to date.
5. Audio-visual equipment	A list of equip- ment required is being prepared. No orders have yet been placed.
6. Laundry & Cooking Equipment 1 washer 1 stove 1 refrigerator misc. cooking utensils)	No orders placed yet.

* vehicles mix was revised and approved by USAID P.I.L. #4 dated 1/31/83

** The PP includes only 70

However, as AID can now provide Ovral (Femenol) and will soon be able to provide a mini-pill; and as the CSFA is experiencing difficulty in securing foreign exchange to purchase contraceptives, they have now requested AID assistance in helping to meet some of their supply requirements over the next three years. During a CLC site visit in August 1983 the contraceptive supply requirements for the next three years were forecast. Of these, AID could provide Femenol, Morninest, a Mini pill and condoms. Funds however are not currently available to support these costs through the project. A chart found in Annex B outlines the additional costs for contraceptives which would be approximately 1.3 million dollars over the next three years. It is recommended that additional funds be made available to support this which would go a long way in helping to alleviate the chronic shortage at a time when program efforts are expanding.

However, at the same time the management review identified problems in ordering, record keeping, and management of supplies. Supplies are being delivered on the basis of requisitions from the Provincial Offices. No attempt has been made, however, to monitor information on usage and match this data with requisitions. Usage reports are sent only to the medical personnel, not to the warehouse/supplies personnel. The report recommended that a form be designed to allow monitoring of use, inventories, and requisitions, and that these records be kept as management tools. CDC also reviewed the logistics and service statistics system, outlined problems and recommendations and, made forecasts for contraceptive supplies. They plan to provide technical assistance to CSFA for making improvements in this area.

Construction

The costs of the building program are financed from local currency generations under the AID Commodity Import Program. Examining rooms, an area for laundry facilities, and a roof for a large waiting room have already been added to the Spilhaus Center. Further construction to extend the Spilhaus facilities will be undertaken in two phases. Phase I will provide additional office space, a conference room, and storeroom/warehouse. The office space is required for the estimated 12 members of the staff to be added to CSFA under the project. The storeroom/warehouse space is needed to store all contraceptives for the country. Phase II will include the construction of a hostel which will serve as a residence hall for trainees brought to Harare for short training courses. The hostel will be built on the grounds opposite the Spilhaus Center. Both Phases I and II are planned for completion by the end of 1984.

5. What technical assistance expertise has been utilized through the project? Has the additional ST/POP Centrally Funded Population Assistance been adequate to compliment the AID project and CSFA program?

A number of technical assistance and outside ST/POP central support was programmed into the implementation plan of the project. All activities programmed for the first year are in the process of being implemented. The Scheduled Management Review mentioned earlier was conducted in May 1983

by Coopers and Lybrand Associates in Zimbabwe. As a result of the recommendations, Coopers and Lybrand has provided additional assistance by developing and re-writing position descriptions for key personnel at the Association. They have also stated that they would be available to assist CSFA with implementing any of the other recommendations of the management review, if requested.

As mentioned under the previous section, Accomplishments to Date, a number of centrally funded population groups have been to Zimbabwe to provide technical assistance and provide additional support. The JHPIEGO Agreement for In-Country Training has been approved and the first two-week course, "Training in Reproductive Health," is due to start on October 24, 1983. The John Hopkins University, Population Communications Services (PCS) program assisted CSFA in developing a IEC Plan and detailed strategy for the next four years. They will be expected to return to Zimbabwe to provide specific IEC expertise and support. INTRAH is assisting the CSFA in developing a training package that will focus on improving the management, training and curriculum development skills of CSFA Training Staff. The proposal should be finalized soon. CSFA has also expressed interest in collaborating with INTRAH to support Regional Family Planning training for nurses and midwives and shortly will be discussing a proposal with IRTISH to provide funds to support 30 international participants to attend CSFA courses in Zimbabwe over the next three years.

The Center for Disease (CDC) visited Zimbabwe in August 1983 to review the logistics, and data collection system at CSFA and develop a Scope of Work for assisting CSFA to evaluate their CBD program. CSFA has also asked CDC to help them conduct Patient Flow Analysis Studies. These activities are expected to start after the first of next year. Westinghouse will soon be supporting a Contraceptive Prevalence Survey in Zimbabwe and Family Health International and The Population Council have also visited Zimbabwe, and, once the Research and Evaluation Unit is finalized, a one-year plan including technical assistance requirements will be developed.

Due to the leadership and management problems experienced by the Association over the past year, it was felt that outside technical assistance should be limited and focused on priority areas identified in the project. All planned activities have taken place. Both AID and CSFA feel that ST/POP assistance has better enabled the Association to implement their project. The need for future technical assistance to CSFA should continue to be carefully reviewed, prioritized and scheduled to assure adequate staff time is available and that it coincides with the priority needs of the CSFA program.

6. During the AID review of this project in 1982, it was strongly felt that a full-time direct hire or PSC Population Specialist was needed by USAID/Zimbabwe to monitor this project. How has the AID project monitorship been, and is this concern still valid?

During the AID review of this project, it was recommended that the Mission needed and should hire a full-time direct hire or PSC Population Specialist. The project is now monitored by the USAID Deputy Director, who is assisted by the REDSO/ESA Population Officer. The USAID Deputy Director/Project Manager spends about 30-40% of his time monitoring this project, and the REDSO/ESA Population Officer travels to Harare one week every three months, or more often as the need arises.

So far this arrangement has provided adequate support and monitoring for the project. Both the Project Manager and Regional Population Officer have established close working relationships with the CSFA AID Project Coordinator, and the MOH.

In February 1983, after the CSFA Acting Director left the Association and it was not clear when a new or Acting Director would be named, USAID asked the MOH to assign someone as the AID Project Coordinator. This arrangement has worked out well due to the capability and dedication of the individual placed in this position. Without her contribution, the project could not have progressed as well as it has, especially in light of the fact that the Director's position has remained vacant for eight months, and now the Administrator is on extended leave.

In summary, the AID monitoring of the project has been adequate to date. While it would be highly desirable for the AID Mission to hire a full-time population officer, the lack of a population officer has not been critical to the implementation of this project. However, if the CSFA project continues to be implemented as well as this past year and, if the program expands, then the number of centrally funded projects would increase. This could possibly require a full-time person to monitor the program in which case given direct hire limitation, the Mission should consider a PSC*.

- G. What is the Government of Zimbabwe's new policy and mandate on integration of child spacing into other health and development programs? How is this integration plan being implemented, and will it affect the implementation of the project?

The GOZ recently issued a policy on child spacing and integration that stated that Child Spacing should be an essential element of all health and development efforts and, therefore, child spacing activities should be integrated into both health and developmental programs. The CSFA was requested by the MOH to present a Plan of Action for integration, and this has been done. The plan proposes to strengthen the child spacing activities of all other ministries and add some additional activities to the Association's Program.

However, there appears to be some confusion over the Government policy on integration along with how to implement it. While MOH Headquarters Staff have informed CSFA that the integration is functional there are

* The Evaluation Team understands that the addition of a direct hire position in the Mission is not possible in the near future due to ceiling limitations.

indications in the field that some of the provincial MOH authorities understand the integration to be both functional and administrative. For example, in one Province, the health institutions have been instructed not to give any family planning statistics to the CSFA. In another Province, the MOH requested that all educators/distributors report to the MOH and that their roles and functions be changed. Except for the MOH, most other ministries are looking for ways to expand their own FP efforts rather than take over part of the current CSFA program and activities. The MOH needs to clarify the exact requirements on integrated services and how the MOH and CSFA will work together toward this end.

8. Has there been any change in the organizational structure and status of the CSFA? What are the GOZ plans to officially sanction CSFA as a legal entity?

The CSFA still remains under the MOH by Emergency Powers Act, but a new constitution has been prepared by the MOH. Officially, CSFA has been told by the MOH that they will become a parastatal after Parliament has sanctioned the new constitution. CSFA is still waiting for the MOH to present the constitution to Parliament. Meanwhile, the Permanent Secretary for the MOH has assured AID that the CSFA will not change its program or organization such that the AID project would have to be changed or altered.

III. CHILD SPACING AND FERTILITY PROJECT COMPONENTS

A. MANAGEMENT AND ADMINISTRATION

The present CSFA Management/Administration Unit is responsible for financial management, personnel management, staff development, management information and coordination of all CSFA functional units including headquarters and provincial offices.

At the time of the signing of the AID project, CSFA was faced with severe management problems. The transition of the former Family Planning Association was not gradual and due to mass resignation of almost all former members of the administrative staff, CSFA found itself in a position of having very little experience in administration. The lack of staff with management experience and skills was seen as critical if the Association was to operate at its own potential and expand its activities and programs under the AID project. Therefore, an important objective of the project was to strengthen the management capacity at headquarters and provincial offices. AID project components include:

1. Supporting a new administrator and secretary;
2. Improving the personnel management of the Association and increasing communication among CSFA staff and coordination among CSFA programs and branches;
3. Providing support for a management review conducted by outside management experts to identify management and organizational needs and make recommendations on how to improve the management capacity of CSFA;
4. Establishing a viable logistics system to ensure the timely ordering and distribution of contraceptives and medical supplies;
5. Creating a management information system employing low-cost microcomputers;
6. Facilitating the effective utilization of research and evaluation results by the CSFA's policy and management team to guide the development of future policies and programs.

After the signing of the AID project agreement, management problems were even further exacerbated by resignation of the Acting Director in January 1983, with the post remaining vacant for the past eight months. However, at the same time, there have been some encouraging improvements as well. For example, for the first time, staff developed their own program objectives and budget to enable them to better monitor their activities. Monitoring reports are submitted to headquarters and compiled quarterly. CSFA is also conducting regular staff meetings. The management review, logistics systems and microcomputers are discussed in detail in other sections of this report. If the Executive Director vacancy could be filled and the additional proposed staff hired, including the Research and Evaluation Officer, many of these management issues could be resolved.

In addition to the overall management problems of the CSFA program, financial management of CSFA has also suffered from lack of leadership and direction. The financial personnel at headquarters, as well as in the branches, are unsure of reporting channels and lines of authority. Despite this problem, the straightforward bookkeeping aspects of financial management are being carried out adequately by both branch and headquarters personnel. Furthermore, the general perception of outsiders is that the financial personnel are honest, dedicated, and hard working.

The most serious problem in the area of financial management is that financial information is not used as a management tool. Income and expenditure reports are prepared, information is entered in ledgers, but none of this information is used to monitor performance of the organization.

This year, for the first time, CSFA staff prepared their own budgets. In the past, this exercise was done for them by MOH officials without their participation, and as such, they were deprived of an important management device. The recent management assessment recommended that the budget be used and integrated into on-going management procedures as, for example, a basis for comparing and analyzing system performance. There appears to be little understanding of this concept at CSFA.

If the recommendation to create a new position of Operations Manager is accepted and the post filled, s/he should institutionalize some simple financial management procedures such as developing a manual of standard operating procedures including reports and monitoring requirements and closely oversee deadlines for submitting reports. Short-term training in financial management procedures may also be advisable for the headquarters accounting staff.

Despite this absence of leadership, the independent auditors are impressed with the integrity of the staff and the extent to which the current system works. For example, in 1982 two petty frauds were detected by CSFA financial personnel and reported to the auditors. Both parties involved were suspended and later fired.

Provincial financial operations are fairly simple and straightforward. The provincial bookkeepers simply record expenditures, the majority of which involve salary checks, and forward these monthly reports to headquarters for processing. Since all of the procurement is centralized, the provincial level bookkeeping is adequate for current needs.

One area that should be looked into is monitoring of contraceptive sales and other revenues, most of which come through the clinics. There is presently no system for adequately overseeing contraceptive sales through the Educator/Distributors (although at present this source of revenue is not significant).

B. YOUTH ADVISORY SERVICE PROGRAM (YAS)

The Youth Advisory Services Program (YAS) was initiated in 1978 at the request of the Ministry of Education to provide Family Life Education in schools as an important part of a national effort to confront the increasingly significant problem of teenage pregnancy. Youth Advisors make presentations on family life, marriage preparation, human reproduction and responsible parenthood in college, the university, in secondary schools and at upper levels of primary schools. Talks are given to students as well as headmasters and teachers. Presentations are also made to Youth Brigades operated by the Ministry of Youth and Sport and to a wide variety of other institutions such as parents groups, religious organizations, military and police and other private businesses and companies. AID assistance provides for the expansion of the YAS program by increasing the staff from three to 33 Youth Advisors. Vehicles, traveling expenses, audio-visual equipment plus an operating budget of \$2.00 per school student for education materials, is also provided. During the four years of the project, family life education will be provided to 650 schools and an estimated 100,000 students. Also, counseling and education will be made available to an additional 20,000 people annually.

Project activities began last February when ten new Youth Advisors were hired and trained for five weeks at Spilhaus Center. The Youth Advisors were then posted to CSFA provincial headquarters. During the last eight months of the first project year, 182 schools and 11,067 students have been reached along with 11,193 others from over 200 institutions.

The YAS activities are progressing according to plan. The first ten new Youth Advisors were well selected and are doing an excellent job. One minor problem has been that as the YAS program began moving into new areas of the country, there was slight resistance by the Ministry of Education to permitting the Youth Advisors to make presentations in schools. CSFA is in the process of holding meetings with Ministry of Education, provincial education officials, parents and headmasters to gain their support of the YAS program.

RECOMMENDATIONS

Proposed Project Changes

1. In the agreement it states that \$2.00 will be provided to each student for education materials. This means a total of \$200,000 of grant funds will be spent on education materials alone. As the total cost of project exceeds currently available funds, it is recommended that this item be deleted and the monies re-programmed for higher priority needs.

General

1. Once the Research and Evaluation Unit becomes operational, an evaluation of the Youth Advisory Services should be done to determine the impact of the program and assist in making modifications or refinements to the strategy.

2. CSFA and the Ministry of Youth and Culture have identified the need to create Youth Centers in each of the country's eight provinces. There are many out of school youth that are not reached by the YAS program, and teenagers are often reluctant to go to existing Child Spacing Clinics to seek advice and services. Youth centers could provide services such as sports, recreation, skills training, family life education and child spacing information and services. While planning is still preliminary, CSFA and the Ministry of Youth and Sport have held discussions and plan to develop a joint proposal which, among other things, will support the costs of renovation and equipment and supplies to open the centers. Once the proposal is finalized, it is recommended that it be submitted to AID for review and consideration for funding out of local currencies from the Commodity Import Program.

C. INFORMATION, EDUCATION AND COMMUNICATION PROGRAM (IEC)

The Information, Education and Communications (IEC) Department is a new unit at CSFA, created as part of the AID project in 1982. The development of an IEC program comes at an important stage in the Child Spacing program in Zimbabwe, as efforts are now proceeding to strengthen and expand the program.

The project will finance the development of an IEC program which is expected to reach one million families over the four-year life of project. A formal IEC Department will be established within CSFA and AID will finance a full time IEC Specialist, audio-visual equipment, and development of IEC printed and mass media materials. After hiring the IEC Specialist, the first step outlined in the agreement was to create a committee to develop a IEC Plan of Action. It was anticipated local expert production/promotion firms would also assist CSFA in radio broadcasting and film production, as needed.

During the first project year, a nurse with advanced training in adult education was hired to head the Unit. CSFA also entered into a contract with a local media firm, Media Associates, to assist in developing regular radio broadcasts. So far, 135 radio broadcasts have been aired in Shona, Ndebele and English. There has been some confusion over the signing of the Media Associates contract. The original one-year contract, signed in November 1982 for the amount of \$19,760, called for Media Associates to assist CSFA in the production of radio programs and public relations. However, the Media Associates contract was signed before developing the IEC Plan of Action that was to be reviewed and approved by CSFA, MOH and AID before initiating any activities. Also, AID was not contacted to assure that AID Contracting Procedures were followed in the development of the agreement. When these problems were pointed out to CSFA, they held a meeting with Media Associates and the MOH to determine how the contract could be renegotiated in more acceptable terms. In May 1983, a comprehensive IEC Plan was developed by CSFA which, along with other activities, endorsed the use of radio programs similar to those developed as part of the original agreement. CSFA renegotiated the contract with Media Associates in July 1983 to cover the costs of radio broadcasts for the remaining 16 weeks of the original agreement. The IEC Unit Head reports that since the signing of the new agreement all activities are going according to schedule. Although there have been some problems with this contract, it should not negate the fact that some very useful radio broadcasts have been developed, and judging from numerous letters received by listeners, it appears to be a popular program. Any future problems with contracting can be alleviated by discussing plans with AID well in advance to assure that all procedures and guidelines are followed.

The extensive IEC Strategy and Plan of Action was developed with assistance from the centrally funded Johns Hopkins University Population Communications Services Program (PCS). The plan has been approved by CSFA, the MOH and AID. The plan outlines objectives, phasing of objectives and the schedule of activities to take place in the next four years.

Briefly, the program will be organized into three areas. The first is the design, testing, production and use of print materials. The second includes film, radio and television (mass media). The third will handle press and public relations. The plan is well presented and includes what the team feels is an excellent mix of IEC activities phased according to the priorities of the program. The team would, however, recommend that a film on the CSFA CBD program be included in the strategy as this program has some excellent features that should be documented and shared.

An IEC program of the size and complexity outlined in the plan will require additional staff and funds. It is proposed that two new staff members be added to include a Print and a Mass Media Manager. The current IEC Unit Head would remain in charge of the program and also assume responsibility for Public Relations. If implemented, the IEC program will require almost a doubling of project funds originally allocated to IEC. (e.g. an increase of about \$350,000 for the remaining three years). It is possible that funds and activities could be cut by perhaps 30%. The IEC Unit Head has been asked to develop a revised plan, that would be considered if funds are not available to support the entire proposed program.

RECOMMENDATIONS

Project Changes

1. The IEC Strategy and Implementation Plan is an excellent four year strategy that has been accepted by CSFA, the MOH and AID. The team recommends that this strategy be followed which would necessitate the following changes in project design:

- a. The addition of two staff members, Print and Media Managers;
- b. An increase in funds for a total of \$702,200 for the IEC program (including salaries, travel, print, mass media and public relations programs);
- c. That given the needs of the program, the equipment to be ordered under the project be changed to:
 - 6 16mm sound projectors
 - 12 35mm slide projectors
 - 8 portable cassette tape recorders, with micro-phones
 - 3 35mm cameras
 - 6 portable projection screens.

This will be a total cost of \$11,700.

2. The team recommends in addition to the current activities planned, that the IEC Unit develop a 15 minute 16 mm color film on their excellent CBD program, emphasising aspects of management and supervision. The film could be shown to the increasing numbers of visitors to Zimbabwe, could be used for training purposes, and shared with other countries trying develop similar community-based programs. The cost for this would be approximately \$25,000.

General Recommendations

1. The Population Communication Services (PCS) Project should be requested to provide technical assistance and project support to the development of the

IEC program. Once new staff are hired, a representative from PSC should visit CSFA to help with the preliminary development of a CSFA pamphlet and the CSFA film. At the time of this visit, a one year plan for PCS technical assistance requirements including additional support that may be required, should be jointly drawn up.

2. CSFA should be sure that AID subcontracting procedures are carefully followed prior to entering into any sub-agreement using project funds. The best way to handle this would be for CSFA to discuss the need for subcontracting and plans for securing these services, well in advance so to make sure all correct approvals and procedures are followed.

3. The CSFA should consider producing, publishing and distributing a regular newsletter focusing on program issues, technical topics and CSFA news. A newsletter can constitute a low cost means of transmitting case study material that is of general interest, to include reviews of contraceptive technology, clinical topics, and basic health issues. Such a publication could also offer the opportunity of giving recognition and encouragement to staff who have performed outstandingly. The newsletter could also be used to share information and encourage collaboration with other providers of Child Spacing services.

D. TRAINING PROGRAM

The CSFA Training Department is a well organized and a highly professional unit within the Association that provides training to CSFA, MOH and other groups in Child Spacing and related subjects. The department is staffed with nine tutors who conduct training at CSFA Training Centers in Harare and Bulawayo. The Unit is recognized as the National Training Center for Child Spacing and, as part of the recent government directive to integrate services, has been given the added responsibility of standardizing all Child Spacing Training programs throughout the country. The Training Unit Staff have a very busy schedule which includes conducting courses for medical and paramedical personnel in the provision of Child Spacing information and services along with training of Educator/Distributors and their supervisors in community based distribution of contraceptives. Yearly in-service training programs for all CSFA staff and five-day general informational courses on Child Spacing (e.g. Intergration Courses) for student midwives, nurses, pharmacists and medical students are also put on by the Training Department.

Over the past year, the Training Unit began an overall review and update of their current courses and started to focus on staff development for their tutors. Until recently, while experienced in Child-Spacing and teaching, trainers themselves had not had formal refresher courses on training methodologies, training of trainers or updates on child spacing. With the assistance of the centrally funded INTRAH program, the Department will conduct staff training in management and supervision, curriculum and training manual development and training methodologies. Given the role of this unit as the National Child Spacing Training Center, this new emphasis on improving training skills of the trainers themselves is very important. The

Training Unit plans to develop two new courses in IUD Insertion and Management and Supervision of Child Spacing Services. In line with the new integration policy, the MCH and communications and management aspects of existing programs will also be strengthened. This unit is making ambitious strides in improving the quality of their training programs. However, care will have to be taken not to overload the staff with too many new tasks nor training schedules that will not permit them to adequately incorporate and institutionalize all of these new concepts.

The project provides support for three new tutors and they have already been hired. The agreement also states that training in family planning be given to 576 Educator/Distributors, 56 Group Leaders (including 216 E/D's and 20 GL's from the Womens Affairs Ministry) and 60 Medical Assistants. Funds are also provided to support 26 Zimbabweans for short term training and observation study tours abroad, and training up to 80 students from other countries in existing CSFA courses.

In the first project year all targets have been reached. A total of 260 participants have been trained in five courses and 633 were trained in four in-service training courses. An additional 538 students received Integration courses.

The major problem in the area of training is that funds allocated for training in the project include only costs of three tutors, and short-term training and observation study tours. While the agreement states that certain numbers and categories will be trained, no funds are programmed to cover the training costs. In addition, training CBD personnel from other ministries is not a high priority now as the Ministry of Community Development and Womens Affairs is not planning a CBD effort of their own, but rather are taking an active role in the CSFA CBD program by selecting the E/D's for CSFA training. Therefore, the following has been recommended for changes in project design.

RECOMMENDATIONS

Project Changes

1. CSFA is willing to train third country participants in their "A" and "B" courses. Due to a very busy training schedule, they would be willing to take up to three participants in each course over the next three years, or a total of 36 trainees. INTRAH should be asked to collaborate in this Regional Training activity by identifying suitable participants and providing for international air fare. While the original project agreement stated that 80 students from other African countries would be trained, no monies were provided in the project to support this training. It is therefore recommended that the project support the training costs for 36 participants.
2. As the Ministry of Community Development and Womens Affairs is now directly involved in the CSFA CBD program by selecting all Educator/Distributor trainees, and as no monies were put into the original agreement to support the additional training of 216 E/D's and 20 Group Leaders, it is recommended that this activity be dropped from the project.

3. Funding support should be included in the project for the training of the 360 E/D's, 36 GL's and 60 Medical Assistants in the "A" or "B" course. These activities were mentioned in the original project, however support to cover costs of the training were not included in the budget.

General Recommendations

1. The Training Unit has not formerly evaluated any of their training courses. As the department is planning to revise and develop new courses next year, it would be beneficial to evaluate the impact of some of their current programs. The team recommends that the "A" course be evaluated first. This course has trained 1020 trainees with 334 of these from the MCH. A sample of former participants could be selected and interviewed to determine where trainees are, what learned Child Spacing skills they are using and recommendations on how to improve the course.
2. The recent emphasis that the Training Department is putting on strengthening their training and content skills is extremely important. However, the Department's training schedule is so tight that very little, if any, time is available between courses to finalize previous coursework or prepare for the following course. The team strongly urges the Training Unit to try and schedule at least one week between courses and schedule at least one month a year for refresher training and staff development for their training staff.
3. The team supports the new focus the Training Department has placed on training tutors and trainers. While attempts were not successful last year to train nursing and midwifery tutors, the team agrees that Integration Courses for pupil nurses and midwives should be phased out, and that tutors be encouraged to take the "A" course, so that Child Spacing can be included as part of the basic pre-service training for these students.

E. COMMUNITY BASED DISTRIBUTION PROGRAM (CBD)

The Community Based Distribution (CBD) program enjoys a well-deserved reputation for excellent implementation. The team would in particular note the unusually effective supervisory system, a model from which virtually any community-based program could learn a great deal. The tasks of the Educator/Distributor (E/D) are comprehensively defined in concrete, measurable terms. The supervisory staff are exceptionally capable and provide a supportive style of supervision based on well-defined tasks. Also supervisors are selected from a cadre of outstanding E/D's and therefore are aware of the work of the E/D, can recognize good performance, and directly assist the E/D based on experience. Although the team encountered E/D's who had a high degree of natural ability, we believe that the characteristics of the system itself are critical to the impressive performance we observed. To a large degree however, the E/D program operates informally, on the basis of individual interactions between supervisors and E/D's. Inevitably in an organization of this size, the resolution of specific problems and the application of innovative ideas is uneven and there is no systematic mechanism

for the program to learn from its remarkable store of field experience. Thus the team recommends an increased effort to document the process of service delivery. The current E/D training course already uses the case study approach. Similar descriptions of real-life problems and efforts to resolve them, along with successful local innovations could provide a useful addition to the present curriculum.

With an increased variety of case materials, the training potential of this approach could be extended to in-service training; in some cases, materials could be utilized in the IEC program; and if, as recommended under the IEC Section, the Association develops a newsletter, these materials could be made available to every staff member at a low cost, and even distributed to providers in other agencies such as the MOH. Particularly difficult or persistent problems or innovations with program-wide implications would also provide the Research and Evaluation (R & E) Unit with research topics of practical importance.

In addition to case-study material, there are several parameters that the team believes could be analyzed by the CBD program staff prior to the establishment of the R & E Unit. This information could be collected on a sample basis, does not require sophisticated methodologies to collect or interpret, and would be highly useful in providing direction to the R&E program. They include:

1. Contraceptive continuation rates for a random sample of acceptors;
2. Estimated number of visits made to a sample of non-acceptors since deployment of the E/D;
3. Estimated number of visits made to a sample of acceptors, prior to acceptance;
4. Estimated total population served by a sample of E/D's and estimated per cent of households contacted at least once by the E/D (either by direct count or through follow-up visits to a random sample of households);
5. The prevalence of current use of Child Spacing methods among eligible women served by the E/D;
6. For each E/D in the sample, a qualitative description of the density of households, the proximity to an urban area, availability of clinical Child Spacing services, and transportation;
7. A graph of the number of continuing Child Spacing users over time since the deployment of the E/D.

These parameters would provide a preliminary impression of how E/D's presently distribute their visits, the level of effort presently required to motivate the average Child Spacing acceptor, and the success of the E/D in supporting the use of Child Spacing methods. The estimated prevalence of use

of Child Spacing methods among eligible women is particularly useful as a summary statistic for international comparisons. The team is confident that the program will compare extremely favorably with similar programs by this measure.

Since the team was impressed with the current supervisory system in the program, we recommend that an expansion of the number of group leaders and E/D's be accompanied by a parallel increase in higher level supervisors. Transportation is a central factor in the supervision of a rural CBD program in terms of travel time for supervisors, direct costs, and the pattern of visits. We would therefore propose that the present supervisory transportation system be described and later compared to the system following the provision of motorcycles and other vehicles.

For a variety of historical reasons, program policy specifies that the E/D provide only a single cycle of OC's to any woman who has not attended a clinic and received a physical examination. This policy is also seen as an incentive to return promptly to revisit a new acceptor. Our field visits indicated that the supervisory system and the E/D's level of training are such that clients consistently receive every feasible encouragement to have such an examination. We can discern no additional incentive for the woman to do so based on the fact that she has received only a single cycle. What is evident, however, since many women are limited to one cycle per visit, is that this arrangement strictly limits the number of households that can be served by a single E/D, who must revisit every acceptor monthly. The potential to extend services to a larger population at essentially the same cost is precluded by this policy. This of course includes any other services that may be offered in the future by the E/D and sets an upper limit on the cost-effectiveness of the program. In effect, much of the rural population will be excluded from important, effective and low-cost health services if this policy remains in effect. There is a real health cost to such a limitation. The health benefits, on the other hand, are non-existent since essentially none of the postulated (and extremely rare) serious side effects of OC's are being prevented. Rather, what is needed, is to analyze and remedy the obstacles that prevent women from attending the local clinic despite the patient and sympathetic counseling that we observed and/or to train the E/D's to identify potential problems, such as taking blood pressure, so that the clinic visit becomes less important.

RECOMMENDATIONS

1. The CBD staff should initiate the collection of written case study materials describing actual field problems and their resolution, and incorporate these into the various program training activities.
2. On a sample basis, the staff should collect information on contraceptive continuation rates, average number of motivational visits made to selected acceptors and non-acceptors, the population served by selected E/D's, the estimated prevalence of use of Child Spacing methods among eligible women served by selected E/D's, and summarize trends in the use of Child Spacing methods over time in a sample of E/D's.

3. Expansion of the program should include each level of the supervisory system proportionately.

4. E/D's should be permitted to provide more than one cycle of oral contraceptives. The client's compliance with the recommendation that she obtain a physical examination at a clinic will not be so important if the E/D learns how to take blood pressure on clients in the field, as is currently planned.

F. MEDICAL-CLINICAL SERVICE PROGRAM

The project funds a relatively small component of the Association's clinical program. The team found consistently high standards of patient care and well-maintained records in both Spilhaus and smaller CSFA clinics at the provincial levels. There does appear to be some need to review implementation of existing guidelines to encourage breastfeeding women to switch from progestin-only to combined oral contraceptives after a specified period. The team also noted a pattern of low contraceptive inventories throughout the program which, while not yet critical, has already reached the point of forcing the staff to dispense fewer cycles of oral contraceptives than is customary. This is probably affecting client continuation adversely. The Association has already taken steps to order supplies through AID/Washington and is currently reviewing useful recommendations provided by a CDC logistics consultant.

The medical staff funded under the project qualified to provide surgical services, confront an extremely low level of demand for sterilization procedures, on the order of 10 per month. These have been predominantly laparoscopic procedures carried out under general anaesthesia. In contrast, about 600 patients per month present for sub-fertility evaluations. While it would be useful to assess the success rate of the therapy provided to these patients, the staff's clinic impression is that virtually none are successfully treated. Any further growth in the number of diagnostic laparoscopies would provide minimal health benefits and the team recommends that the subfertility evaluation protocol and patient scheduling procedures be reviewed with the objective of limiting the resources devoted to this area. A goal of 50% or less of the involved professional's time seems reasonable. The team would also encourage the staff to consider wider application of the minilaparotomy procedure under local anaesthesia. Further, it would be useful to collaborate with the IEC Division in developing an appropriate program to inform potential acceptors about the nature of this procedure.

We would also encourage a similar joint approach, also involving the R & E Unit, in analyzing and addressing barriers to the acceptance of the IUD, currently less than 50 per month in the Spilhaus clinic, compared to about 250 new acceptors of oral contraceptives.

Recognizing the high standards for clinical care set by the Association, the team believes that the Medical-Clinical Service could serve a national need by developing expertise in efficient management of clinical services. In

terms of staff talent and patient load, Spilhaus is an unusually attractive program to develop these methodologies. At the provincial level, the CSFA medical/clinical staff appear to have both the time and interest to apply the methodologies that are developed, with training and supervision from Spilhaus. Such a program could be one of CSFA's priority concerns, given the relatively limited development of Child Spacing services by other major providers, particularly the MCH. Since the Association is already providing these providers with training in Child Spacing services, along with supplies, it would be reasonable to explore additional approaches to improving MCH services. The team found that provincial MCH authorities acknowledge their responsibility to provide such services, but regard their clinic staff as generally over-extended with other services. To the extent that the Association can develop an effective technical assistance program to improve patient flow and overall clinic efficiency, a substantial increase in the availability of services would require only a minimal amount of cooperation from MCH clinics. As a first step, the team recommends a consultation by a patient-flow expert from CDC. If subsequent analysis indicates the need for additional resources, such as additional supervision or a part-time clerk, the resources of the R & E Unit to design the appropriate operations research project could be added to this effort.

RECOMMENDATIONS

1. The Medical/Clinical staff should take steps to limit the level of resources devoted to untreatable subfertility cases.
2. The Medical/Clinical staff should collaborate with the IEC Division to develop an information program for minilaparotomy and the IUD.
3. The Medical/Clinical staff develop a core of expertise in the management of clinical Child Spacing services and offer technical assistance not only within the CSFA, but also to other providers.

G. RESEARCH AND EVALUATION PROGRAM

The Research and Evaluation (R & E) Unit was not yet established at the time of the evaluation nor had a preliminary plan of action been developed. The teams' observations are therefore limited to areas of the program where we believe the efforts of the unit are likely to be productive, based on our assessment of current and planned CSFA activities. We wish to emphasize our opinion that the chief purpose of the unit should be to serve the practical needs of the Association's programs and not to produce academic studies. For example, existing service statistics and supervisor reports can provide operationally useful feedback at a low cost. An objective of the R & E Unit should be to plan and conduct studies that will guide management decisions. Among the issues that merit early examination, we would list the following:

1. The cost of the CBD program currently appears to be on the order of \$25 per couple year of protection. This reflects a strategy of fairly intensive contacts between the E/D and potential acceptors. The E/D makes

frequent contact with all clients and, therefore, over time the average number of contacts continues to increase. The apparent effectiveness of this strategy has been observed but it is certainly conceivable that an E/D making less frequent contacts to a larger population could be more productive at essentially the same cost. The R & E Unit, in collaboration with the CBD program, should evaluate the net impact of decreasing the number of contacts and expanding the population served by testing this out with a selected group of E/D's.

2. A basic premise to the success of any CBD program is the interchange between E/D and clients, or the ability to "motivate" a couple to use a Child Spacing method. In addition to child spacing content, the E/D learns communication skills along with how to adapt information and approaches appropriate to a particular setting. This requires knowing how to handle responses to common objections to child spacing, how to address the husband and also how to present information in a clear and understandable way. Clearly, the interaction between a client and an E/D is far from being a stereotyped exchange. On the basis of their experience, program supervisors guide the E/D's to emphasize some approaches over others. Some supervisors and E/D's are more successful than others, but at present we do not know enough about these interactions to modify E/D training and supervision based on actual field experience. The R & E Unit should assist the CBD program in a systematic observation of some of the different approaches used by E/D's and supervisors. Those that are particularly useful or effective should be documented and used as practical examples in the E/D training program.

3. Exactly how to respond to the Government's mandate to integrate Child Spacing into other services and development efforts is unclear. Certainly CFSA wants to facilitate integration yet, also expand the availability of effective Child Spacing services. The R & E Unit can assess the implications of different "integration" strategies on a small scale and thereby help select the preferred approaches for large scale implementation.

Perhaps the most straightforward modification would be to add selected health tasks and responsibilities to the E/D's role. Any additional tasks should preserve the features that have been so important to Child Spacing services, such as measurable definition of the tasks to be performed and supportive supervision by several levels of supervisors. It would seem advisable to begin with a single additional task, such as oral rehydration, which involves skills and approaches similar to Child Spacing. The impact of these services on Child Spacing is, of course, central to the study, but the effectiveness of the health service itself should not be neglected.

Another proposal that has received widespread attention is the potential use of E/D's to supervise the activities of Village Health Workers (VHW). The relatively low level of supervision received by the VHW is a commonly cited factor in their apparent low level of productivity. A number of the features of the E/D program, such as task definition and the nature of supervision may also play a role in the different outcomes of the two programs. Thus, it is desirable that any attempt made to link the E/D and VHW should incorporate the

strengths of the entire CBD program rather than assuming that individuals who happen to be E/D's will, in isolation, substantially improve VW performance. We would therefore suggest that a proposal to the MOH for a collaborative experiment be limited to supervision of Child Spacing and oral rehydration services. This would permit the Association to contribute the full strength of its supervisory system to the effort. If such an experiment revealed an overall decline in Child Spacing services despite the contribution of the VHW's, there would be little reason to attempt such supervision of a broader range of services.

4. One of the impressive features of the CBD program is the extent to which it directly encourages E/D's to perform well. Successful E/D's enjoy the prospect of promotion to Group Leaders and can continue to advance within the supervisory system on the basis of performance. Supervisors at all levels provide verbal encouragement and sympathetic assistance to those they supervise which helps to promote high performance levels. It is conceivable that additional ways to support superior performance could produce further improvements. Among the more obvious are cash bonuses, awards, prizes, and special training courses. If, however, the cost of a specific program is high relative to the increment in performance, it may be preferable to implement a very limited program or none at all. A relatively simple trial would help clarify the value of such an approach.

5. Potential areas for more conventional evaluation studies include the incidence of contraceptive failures, the effectiveness of management of contraceptive side effects and the effectiveness of the Youth Advisory Service Program.

RECOMMENDATIONS

The R & E unit should develop a research and evaluation program emphasizing studies addressing issues of practical importance to the management and design of the CSFA program, with specific attention to the population coverage of the E/D, the content of motivation visits, and the integration of Child Spacing and other services.

IV. SUMMARY OF RECOMMENDATIONS

A. YOUTH ADVISORY SERVICE PROGRAM

Proposed Project Changes

In the agreement it states that \$2.00 will be provided to each student for education materials. This means a total of \$200,000 of grant funds will be spent on education materials alone. As the total cost of project exceeds currently available funds, it is recommended that this item be deleted and the monies re-programmed for higher priority needs.

General

1. Once the Research and Evaluation Unit becomes operational, an evaluation of the Youth Advisory Services should be done to determine the impact of the program and assist in making modifications or refinements to the strategy.
2. CSFA and the Ministry of Youth and Culture have identified the need to create Youth Centers in each of the country's eight provinces. There are many out of school youth that are not reached by the YAS program, and teenagers are often reluctant to go to existing Child Spacing Clinics to seek advice and services. Youth centers could provide services such as sports, recreation, skills training, family life education and child spacing information and services. While planning is still preliminary, CSFA and the Ministry of Youth and Support have held discussions and plan to develop a joint proposal which, among other things, will support the costs of renovation and equipment and supplies to open the centers. Once the proposal is finalized, it is recommended that it be submitted to AID for review and consideration for funding out of local currencies from the Commodity Import Program.

B. INFORMATION, EDUCATION AND COMMUNICATIONS PROGRAM

Project Changes

1. The IEC Strategy and Implementation Plan is an excellent four year strategy that has been accepted by CSFA, the MOH and AID. The team recommends that this strategy be followed which would necessitate the following changes in project design:

- a. The addition of two staff members, Print and Media Managers;
- b. An increase in funds for a total of \$702,200 for the IEC program (including salaries, travel, print, mass media and public relations programs);
- c. That given the needs of the program, the equipment to be ordered under the project be changed to:
 - 6 16mm sound projectors
 - 12 35mm slide projectors
 - 8 portable cassette tape recorders, with micro-phones
 - 3 35mm cameras
 - 6 portable projection screens.

This will be a total cost of \$11,700.

2. The team recommends in addition to the current activities planned, that the IEC Unit develop a 15 minute 16 mm color film on their excellent CBD program, emphasising aspects of management and supervision. The film could be shown to the increasing numbers of visitors to Zimbabwe, could be used for

training purposes, and shared with other countries trying develop similar community-based programs. The cost for this would be approximately \$25,000.

General Recommendations

1. The Population Communication Services (PCS) Project should be requested to provide technical assistance and project support to the development of the IEC program. Once new staff are hired, a representative from PSC should visit CSFA to help with the preliminary development of a CSFA pamphlet and the CSFA film. At the time of this visit, a one year plan for PCS technical assistance requirements including additional support that may be required, should be jointly drawn up.
2. CSFA should be sure that AID subcontracting procedures are carefully followed prior to entering into any sub-agreement using project funds. The best way to handle this would be for CSFA to discuss the need for subcontracting and plans for securing these services, well in advance so to make sure all correct approvals and procedures are followed.
3. The CSFA should consider producing, publishing and distributing a regular newsletter focusing on program issues, technical topics and CSFA news. A newsletter can constitute a low cost means of transmitting case study material that is of general interest, to include reviews of contraceptive technology, clinical topics, and basic health issues. Such a publication could also offer the opportunity of giving recognition and encouragement to staff who have performed outstandingly. The newsletter could also be used to share information and encourage collaboration with other providers of Child Spacing services.

C. TRAINING PROGRAM

Project Changes

1. CSFA is willing to train third country participants in their "A" and "B" courses. Due to a very busy training schedule, they would be willing to take up to three participants in each course over the next three years, or a total of 36 trainees. INTRAH should be asked to collaborate in this Regional Training activity by identifying suitable participants and providing for international air fare. While the original project agreement stated that 80 students from other African countries would be trained, no monies were provided in the project to support this training. It is therefore recommended that the project support the training costs for thirty six participants.
2. As the Ministry of Community Development and Womens Affairs is now directly involved in the CSFA CBD program by selecting all Educator/Distributor trainees, and as no monies were put into the original agreement to support the additional training of 216 E/D's and 20 Group Leaders, it is recommended that this activity be dropped from the project.

3. Funding support should be included in the project for the training of the 360 E/D's, 36 GL's and 60 Medical Assistants in the "A" or "B" course. These activities were mentioned in the original project, however support to cover costs of the training were not included in the budget.

General Recommendations

1. The Training Unit has not formerly evaluated any of their training courses. As the department is planning to revise and develop new courses next year, it would be beneficial to evaluate the impact of some of their current programs. The team recommends that the "A" course be evaluated first. This course has trained 1020 trainees with 334 of these from the MCH. A sample of former participants could be selected and interviewed to determine where trainees are, what learned Child Spacing skills they are using and recommendations on how to improve the course.

2. The recent emphasis that the Training Department is putting on strengthening their training and content skills is extremely important. However, the Department's training schedule is so tight that very little, if any, time is available between courses to finalize previous coursework or prepare for the following course. The team strongly urges the Training Unit to try and schedule at least one week between courses and schedule at least one month a year for refresher training and staff development for their training staff.

3. The team supports the new focus the Training Department has placed on training tutors and trainers. While attempts were not successful last year to train nursing and midwifery tutors, the team agrees that Integration Courses for pupil nurses and midwives should be phased out, and that tutors be encouraged to take the "A" course, so that Child Spacing can be included as part of the basic pre-service training for these students.

D. COMMUNITY-BASED DISTRIBUTION

RECOMMENDATIONS

1. The CBD staff should initiate the collection of written case study materials describing actual field problems and their resolution, and incorporate these into the various program training activities.

2. On a sample basis, the staff should collect information on contraceptive continuation rates, average number of motivational visits made to selected acceptors and non-acceptors, the population served by selected E/D's, the estimated prevalence of use of Child Spacing methods among eligible women served by selected E/D's, and summarize trends in the use of Child Spacing methods over time in a sample of E/D's.

3. Expansion of the program should include each level of the supervisory system proportionately.

4. E/D's should be permitted to provide more than one cycle of oral contraceptives. The client's compliance with the recommendation that she obtain a physical examination at a clinic will not be so important if the E/D learns how to take blood pressure on clients in the field, as is currently planned.

E. MEDICAL-CLINICAL SERVICE PROGRAM

1. The Medical/Clinical staff should take steps to limit the level of resources devoted to untreatable subfertility cases.
2. The Medical/Clinical staff should collaborate with the IEC Division to develop an information program for minilaparotomy and the IUD.
3. The Medical/Clinical staff develop a core of expertise in the management of clinical Child Spacing services and offer technical assistance not only within the CSFA, but also to other providers.

F. RESEARCH AND EVALUATION PROGRAM

The R & E unit should develop a research and evaluation program emphasizing studies addressing issues of practical importance to the management and design of the CSFA program, with specific attention to the population coverage of the E/D, the content of motivation visits, and the integration of Child Spacing and other services.

G. OTHERS

1. Both the Management Review and CDC assessment report noted the difficulty in receiving usage statistics from non-CSFA programs. For example, CDC cites that for the month of March 1983, only 205 of approximately 500 non-CSFA facilities reported to CSFA, or 41 percent of total facilities. Provincial CSFA Staff are expected to collect statistics for their region, however, they are unaware of the amount of contraceptives sent out by CSFA Headquarters in Harare. The team recommends that CSFA Provincial Staff are either made aware of the amount and location of contraceptives sent out or that CSFA be in charge of all distribution by provincial Staff for collecting service statistics.

2. It is recommended that other units within the association develop a three-year plan and strategy similar to that developed by IEC. This strategy would include activities to take place along with an implementation schedule and budget. It would therefore be easy to chart progress, assure all project targets can be met within the time frame, and develop the quarterly reports that should measure progress, detail problems and make recommendations for improving the program.

COSTS OF
PROPOSED ADDITIONAL CSFA PERSONNEL

<u>SALARY SUPPORT (US DOLLARS)</u>	<u>ONE YEAR</u>	<u>TOTAL-THREE YEARS</u>
IEC Officers 12,000 x 2 =	\$24,000	\$ 72,000
Personnel Officer 20,000	20,000	60,000
Pharmacies/Stores 15,500	15,500	46,500
Senior Educators 4,500 x 2	<u>9,000</u>	<u>27,000</u>
TOTAL	\$68,500	\$205,500

<u>PROPOSED ADDITIONAL EQUIPMENT COSTS (U.S. DOLLARS)</u>	<u>TOTAL</u>
700 sphygomanometer Each	
anaeroid \$19.20 x 16% tax = \$22.27 each	\$15,590
700 stethoscopes \$10.02 x 16% tax = \$11.62 each	<u>\$ 8,134</u>
	\$23,724

(Exchange rate .96 ZDollars = 1.00 USDollar)

CSIA CONTRACEPTIVE SUPPLY REQUIREMENTS ^{1/}
(000's)

<u>METHOD</u>	<u>1983</u>		<u>1984</u>		<u>1985</u>		<u>TOTAL</u>	
	<u>CYCLES/ PIECES</u>	<u>COST</u>	<u>CYCLES/ PIECES</u>	<u>COST</u>	<u>CYCLES/ PIECES</u>	<u>COST</u>	<u>CYCLES/ PIECES</u>	<u>COST</u>
Femmenol ^{2/}	1,177	\$141,240	1,126	\$135,120	1,403	\$168,960	3,711	\$445,320
Mini-Pill (Ovrette)	535	63,765	660	71,940	633	68,997	1,878	204,702
Norminest	85	9,095	54	5,773	59	6,313	198	21,186
Condoms	2,704	<u>116,272</u>	1,847	<u>79,421</u>	2,031	<u>87,333</u>	6,582	<u>283,026</u>
TOTAL		\$330,372 ^{3/}		\$292,259		\$331,603		\$954,234

^{1/} Amount taken from CDC August 1983 Report and included only AID contraceptives.

^{2/} Costs: Femmenol = .12¢/cycle
 Mini-Pill (Ovrette) = 10.9¢/cycle
 Norminest = 10.7¢/cycle
 Condoms = \$4.30/100 pieces

^{3/} Does not include shipping costs.

ADDITIONAL PROPOSED TRAINING COSTS
(US DOLLARS)

Training Costs

(Room and Board)	Total Costs	Int'l Students Education Materials
A Course	\$995.00	+ \$29.00 = \$1024.00
B Course	746.00	+ 29.00 = 775.00
C Course	480.00	
D Course	384.00	
GL Course	360.00	

CBD PROGRAM

Educator/Distributors

Group Leaders

	<u>Number</u>	<u>Cost</u>		<u>Number</u>	<u>Cost</u>
1983	85	\$ 40,800	1983	9	\$ 3,240
1984	85	40,800	1984	9	3,240
1985	82	39,360	1985	9	3,240
1986	<u>83</u>	<u>39,840</u>	1986	<u>9</u>	<u>3,240</u>
TOTAL	335	\$160,800	TOTAL	36	\$ 12,960

TOTAL COSTS CBD PROGRAM \$173,760

"A" COURSES

	<u>Number</u>	<u>Cost</u>
1983		
Medical Assistants/Nurses	-0-	-0-
International Students	-0-	-0-
1984		
Medical Assistants/Nurses	20	\$19,900
International Students	12	12,288
1985		
Medical Assistants/Nurses	20	19,900
International Students	12	12,288

1986		
Medical Assistants/Nurses	20	19,900
International Students	12	12,288
TOTAL		
Medical Assistants/Nurses	60	59,700
International Students	<u>36</u>	<u>36,864</u>
	96	\$96,564

SUMMARY ADDITIONAL TRAINING COSTS

CBD	\$173,760
"A" Courses	<u>96,564</u>
	\$270,324

SCOPE OF WORK FOR THE EVALUATION OF ZIMBABWE -
CHILD SPACING AND FERTILITY PROJECT (613-0219)

BACKGROUND

The Zimbabwe Child Spacing and Fertility Association (CSFA) is widely recognized as one of the best family planning organizations in Africa. Through a network of clinics and community agents (Educators/Distributors), CSFA has, for a number of years, been actively involved in providing family planning information and services to the people of Zimbabwe. As a parastatal governmental institution, CSFA operates in close collaboration with the Ministry of Health as well as various other ministries to coordinate family planning activities. CSFA conducts short training courses in family planning for CSFA staff and staff from other ministries. CSFA is also responsible for purchasing and storing all contraceptive supplies distributed through both its own and other government and private organizations throughout the country.

As of 1982, it was estimated that there were 200,000 active users of contraception who were being directly served by the CSFA program. Many of these were introduced to family planning through the network of over 300 Educators/Distributors and 34 group leaders who function as their field supervisors. These field efforts are supported by both CSFA and Government clinic personnel who provide medical back-up from the family planning services. In addition to these efforts, CSFA has also initiated a program of youth advisory services to provide family health counseling and education to youth.

Based upon the substantial accomplishments of CSFA to date, in September 1982, USAID approved a grant with CSFA. The Zimbabwe Child Spacing and Fertility project provides \$8.5 million over a four-year period. The overall purpose of the project is to extend the coverage of child-spacing information and services through increasing the management, technical and training capacity of the CSFA.

The AID project provides assistance to the following existing CSFA programs: Community Based Distribution, Youth Advisory Service, Medical-Clinical Service, Training, and Management and Administration. AID assistance will also provide support to establish two new programs within CSFA, that is, an Information, Education and Communications program and a Research and Evaluation program. In support of developing a Research and Evaluation unit, the AID agreement will provide funds to support a U.S. Resident Research and Evaluation Advisor to the CSFA for a three-year period. The Resident Advisor will work directly with CSFA staff to implement and evaluate project activities. In addition, funds are set aside for up to 30-person months of short-term technical assistance. This short-term technical assistance, funded through the project, will be completed by AID Centrally Funded Population projects which can provide additional support.

GENERAL PURPOSE AND PLAN FOR THE EVALUATION

Evaluation is a crucial component to this project and two major evaluations are planned over the life of the project. The first is a formative evaluation focusing on early project accomplishments and making recommendations for any necessary changes in project design. The second is a final evaluation which will focus on a summary analysis and assessment of the extent to which CSFA's program and AID project assistance has had an impact on the provision of child-spacing services.

This first evaluation will take place the first two weeks in October 1983. The primary purpose will be to look at the project accomplishments in relation to present needs and determine what mid-course changes in project design are needed to reflect the current child-spacing needs in Zimbabwe.

The evaluation team will consist of REDSO/ESA Population Officer, Barbara Kennedy; AID/W Population/CBD Specialist, Dr. James Heiby; the AID Project Coordinator, Dr. Esther Boohene and an outside POP/FP Expert. The team will spend two weeks in Zimbabwe evaluating the AID project by visiting CSFA headquarters and provincial staff, facilities and services, the Ministry of Health, the Womens Affairs and Community Development Ministry, the Central Statistics Office, the University of Zimbabwe and any other appropriate groups. Site visits will be made to at least two provincial CSFA offices and PMOH facilities, one of which will include Bulawayo. The team will develop a draft evaluation report and overall findings and recommendations will be presented to USAID and the MOH by the end of the two-week period.

SPECIFIC ASPECTS TO BE ADDRESSED

In addition to the overall project design and activities, the following areas should be addressed:

- A. How well is CSFA managing the Child Spacing and Fertility Project which includes overall leadership, MOH oversight, project reporting and accountability? What changes, if any, are recommended to improve this management?
- B. What are the CSFA plans for implementing the recommendations of the Management Review conducted in May 1983?
- C. How well is the project meeting targeted objectives within the planned time frame? Are resources adequate to carry out planned activities especially in the establishment of the new IEC and Evaluation and Research program?
- D. Are equipment and supplies to be furnished by the project adequate to meet project needs?
 - How are the current vehicles and motorcycles being utilized?
 - Would it be possible to order AID contraceptives through the project?

E. What technical assistance expertise has been utilized through the project? Has the additional ST/POP Central Population Assistance been adequate to complement the AID project and CSFA program?

RELATED QUESTIONS TO BE ANSWERED

F. During the AID review of this project, in 1983, it was strongly felt that a full-time direct hire or PSC Population Specialist was needed by USAID/Zimbabwe to monitor this project. How has the AID project monitorship been, and is this concern still valid?

G. What is the Government of Zimbabwe's new policy and mandate on integration of child spacing into other health and development programs? How is this integration plan being implemented and will it affect the implementation of this project?

H. Has there been any change in the organizational structure and status of the CSFA? What are the GOZ plans to officially sanction CSFA as a legal entity?

SUPPORTING DOCUMENTS

The evaluation team should review the following documents in preparation for the evaluation:

- A. Zimbabwe Child Spacing and Fertility Project Paper (613-0219).
- B. AID - GOZ Grant Agreement.
- C. Coopers and Lybrand Management Review, May 1983.
- D. Population Communications Services IEC Strategy and Implementation Plan, June 1983.
- E. CDC - Trip Report, August 1983.

PERSONS CONTACTED

Ministry of Health

Deputy Minister	Dr. E. M. Pswarayi
Deputy Secretary	Dr. D. Makuto

Child Spacing and Fertility Association

Director, Information, Education and Communication	Sr. Florence Chikara
Acting Director, Youth Advisory Services	Sr. E. K. Makoni
Director, Training	Sr. L. Botsh
Deputy	Sr. Lynette Malianga
Director, Community Based Distribution	Mr. T. Nzuma
Director, Medical-Clinical	Dr. Bourne
Chief Nursing Officer	Sr. G. Tekere
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Ministry of Land Resettlement and Rural Development

Permanent Secretary	Dr. T. Chitsike
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Ministry of Youth Sport and Recreation

Acting Permanent Secretary	Dr. M. Senderayi
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Central Statistics Office

Director	Dr. Mandishona
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<u>UNFPA Representative</u>	Dr. Arkutu
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<u>UNICEF Representative</u>	Mr. S. M. Shomari
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<u>City Health Department</u>	Dr. Mbengeranwa
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Medical Officer of Health	Dr. Nyathi
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