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EVALUATION OF AID'S FAMILY PLANNING
INTERNATIONAL ASSISTANCE (FPIA)
COOPERATIVE AGREEMENT

by

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GLOSSARY

ABEPF	Brazilian Association of Family Planning Associations
AID	Agency for International Development (including AID/W and USAID missions)
AID/W	Agency for International Development (Washington headquarters)
ARO	Africa Regional Office
AVS	Association for Voluntary Sterilization
CBD	Community-based distribution
CDC	Centers for Disease Control
CYP	Couple Years of Protection
FDA	Food and Drug Administration
FEMAP	Mexican Federation of Private Associations for Family Planning
FHI	Family Health International
FP	Family Planning
FPA	Family Planning Association
FPIA	Family Planning International Assistance
IEC	Information, Education and Communication
LDC	Less developed country
PCS	Population Communication Services Project
PIACT	Program for the Introduction and Adaption of Contraceptive Technology
PPFA	Planned Parenthood Federation of America
RAP	Resource Allocation Plan

S&T/POP	Bureau of Science and Technology/Office of Population
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development (overseas missions)
VS	Voluntary Sterilization

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EXECUTIVE SUMMARY

1. Purpose of Evaluation

The evaluation team was requested to assess the progress of a five-year cooperative agreement between AID and Family Planning International Assistance (FPIA), which was initiated May 17, 1983, and is scheduled to terminate December 31, 1987. Planned funding is \$69.345 million.

The six-person team was requested to evaluate progress and performance relating to family planning service delivery. Management and administrative aspects of the program were not a focus of the evaluation since they were evaluated previously in the summer of 1981.

2. Methodology

The team carried out its evaluation over approximately four weeks in October and November 1985 through discussions with AID in Washington, FPIA in New York, and site visits to 25 individual subprojects in Africa, Asia, the Middle East and Latin America, representing approximately 20 percent of all active projects. Projects in Brazil, Peru, Mexico, Kenya, Zambia, Sierra Leone, Nigeria, Egypt, Sudan, Indonesia, Bangladesh and Thailand were visited. They were selected because they were important, included a variety of activities and represented projects at varying stages of development (i.e., new through mature).

3. Findings and Recommendations

3.1 General

FPIA is a creative, effective and efficient institutional resource for delivering commodities and family planning services and increasing the family planning capability and infrastructure in less developed countries (LDC). It has demonstrated dedication, leadership, creativity, courage and above all success under difficult LDC conditions.

Recommendations

- o Continued and expanded support of FPIA's program is recommended.

- o One appropriate way to increase funding would be to raise the funding ceiling for the Cooperative Agreement so mission buy-ins can be accommodated without any disruption of FPIA's basic program.
- o If additional funding is provided, FPIA staff will have to be expanded.

3.2 Programming

From a quantitative standpoint, FPIA is meeting or exceeding almost all goals set forth in AID's Project Logical Framework, AID's Resource Allocation Plan, and its own Strategic Plan. The project is behind schedule only with regard to some types of commodity assistance and a contemplated transition in the proportion of family planning/maternal and child health (MCH) subprojects to activities providing IEC, training and CBD. The absolute number of all subproject types, including IEC, training and CBD, is greater than planned.

Qualitatively, most subprojects are sound, and some are making critically important contributions to the delivery of family planning services (e.g., in such African countries as Sierra Leone, Zambia and Nigeria). FPIA has sought the innovative and experimental programming opportunity, while making particular efforts to ensure the continued existence of worthy subprojects after termination of its own funding.

Recommendations

- o In countries where family planning is already widely available (as in parts of Latin America and Asia), FPIA should make a careful assessment of the need for new service delivery projects.
- o FPIA might consider further increasing the proportion of service delivery activities by working with the organized commercial sector, especially in Africa: e.g., factories and businesses.
- o FPIA's management system should be disseminated as widely as possible. In particular, assistance should be provided to umbrella organizations since these in turn influence large numbers of smaller family planning agencies.

3.3 Technical Assistance

Technical assistance for management and administration was outstanding. Some deficiencies were found with regard to the support provided for information, education and communication (IEC) efforts and the provision of rapidly changing medical information.

- o FPIA is encouraged to ensure that all projects have adequate IEC components to enhance their effectiveness at the community and client levels.
- o To improve medical backstopping, PPFA/FPIA should employ an assistant medical director to assist the current medical director. This individual should be a qualified physician with LDC experience who would devote the bulk of his or her time to supporting the FPIA project.
- o More systematic, regular and thorough updating of the field in regard to specific contraceptive methods should be provided.
- o Procedures manuals like that on sterilization should be developed for other contraceptive methods beginning with IUDs.
- o The Fishburn anesthesia protocol should be transmitted to every subproject involved in sterilization. Follow-up and monitoring to ensure it is understood should also be provided.
- o A more systematic effort should be made to provide family planning information, including medical information, to service delivery points.

3.4 Service Statistics

Internal evaluations of project progress are extensive, and information on subproject activities is readily retrievable. The system of recording and analyzing service statistics has a number of weak points, however, with the result that couple years of protection cannot easily be computed and comparisons among various programs' cost-effectiveness are almost impossible to make. Even without exact measures of contraceptive prevalence or demographic impact, however, the rough estimate that service is provided to one million couples per year is both plausible and extremely impressive.

Recommendations

- o FPIA should undertake a thorough re-evaluation of its service statistics system.
- o One possibility would be to add commodity data to allow calculation of couple years of protection.

3.5 Staffing

Staff were found competent, dedicated and hard working.

Recommendations

- o FPIA should place a strong emphasis on family planning skills in future staff recruitment.
- o Current staff should be provided additional training in relevant family planning skills (IEC, contraceptive technology, etc.).

3.6 Commodity Assistance

Except for some isolated shortages, commodities are efficiently provided and appropriately stored.

- o AID and FPIA are encouraged to continue their careful review of commodity distribution in countries where availability of commodities may come to be a constraining factor in program implementation.

3.7 Summary

Overall, the FPIA program is outstanding, and its record of leadership and accomplishment is consistent with AID objectives and LDC needs. It is an important resource contributing to the solution of world population problems.

I. INTRODUCTION AND BACKGROUND

I.1 Purpose of the Assignment

The evaluation team was requested to assess the progress of a five-year cooperative agreement between AID and Family Planning International Assistance (FPIA), which was initiated May 17, 1983, and is scheduled to terminate December 31, 1987. Planned funding is \$69.345 million.

The scope of work called for assessment of FPIA's progress and performance since its last evaluation (May-June 1981) and to the extent possible an estimation of the impact of subproject assistance on contraceptive prevalence. The findings and recommendations were designed to provide guidance for the remainder of this five-year period and for the period beyond 1987.

FPIA is a division of the Planned Parenthood Federation of America (PPFA), created specifically to handle all its international activities. The cooperative agreement with AID is designed to enable FPIA to extend the availability of family planning services through existing medical, social, and welfare programs of less developed countries (LDC) and to encourage private and public sector agencies and organizations to institutionalize family planning services. An underlying assumption is that FPIA assistance will stimulate private and public sector LDC organizations to initiate and support family planning programs in their respective countries. FPIA's cooperative agreement calls for two principal categories of activities: operational sub-projects and commodity provision.

For operational subprojects, FPIA provides fiscal, technical and commodity assistance to support delivery of family planning services including necessary information, education and outreach activities. In general, these subprojects are carried out with the assistance of FPIA headquarters and regional staff.

The commodity aspect involves provision of AID-procured, centrally funded contraceptives and FPIA-purchased contraceptives and other equipment and supplies to AID bilateral and non-bilateral countries as requested by AID/Washington, USAID missions, FPIA-funded projects, and/or LDC institutions. All such commodity supply activities require AID and USAID concurrences.

Additionally, FPIA provides technical or advisory services related to family planning service delivery that AID may request from time to time.

I.2 Scope of Work

The scope of work lists seven specific issues:

1. Assess progress in meeting program and commodity objectives stated in the 1982-1987 Project Logical Framework (log frame). 1/
2. Assess progress in achieving project assistance goals cited in FPIA's 1984-1986 Strategic Plan and Plan Update.
3. Assess performance in attaining country program and funding goals cited in the 1984-1986 Resource Allocation Plan (RAP) of the Bureau of Science and Technology/Office of Population (S&T/POP).
4. Assess the efficacy of FPIA's technical assistance in activating and/or increasing the availability of quality, low-cost family planning services through LDC subprojects.
5. Assess the impact of FPIA's subproject and commodity assistance on contraceptive use and prevalence in localities served by subrecipients.
6. Assess the extent to which FPIA has successfully implemented its current program and increased the development and continuity of voluntary fertility control programs throughout the world.
7. Identify unmet needs and future program directions and provide recommendations for continuing AID grant assistance beyond 1987.

I.3 Evaluation Team

The six person evaluation team consisted of J. Joseph Speidel, MD, MPH (Team Leader); William Bair, MS, who visited projects in Brazil, Peru and Mexico; Catherine Cameron, MSPH, who visited projects in Egypt and the Sudan; Hugh R. Holtrop, MD, who visited projects in Indonesia, Thailand and Bangladesh; Barbara Janowitz, PhD, who visited projects in Sierra Leone and Nigeria; and Elizabeth Preble, MPH, who visited projects in Kenya and Zambia.

In aggregate, this evaluation team has 96 years of experience in population and family planning activities including work with AID, The Pathfinder Fund, Family Health International

1/ The log frame provides AID's goals for quantitative project performance.

(FHI), the Population Crisis Committee, the United Nations Fund for Population Activities (UNFPA) and the United Nations Children's Fund (UNICEF).

I.4 Plan of Work

The team spent approximately four weeks over a seven-week period in October and November 1985 evaluating FPIA's current five-year program. The evaluation was carried out through interviews with PFFA/FPIA staff members, USAID mission population and health officers, host country officials, FPIA Regional Office staff, subproject staff members and AID/Washington staff in the Office of Population and regional bureaus. In addition heads of other agencies, such as UNFPA, were consulted. FPIA has an unusually elaborate array of documents, records and reports, which were reviewed by the evaluation team. FPIA's extensive computer-based record system was quickly able to provide data and analysis requested by the team.

The evaluation included three separate trips to New York by Dr. Speidel, two trips by Dr. Janowitz and one trip by the remainder of the evaluation team. A complete listing of individuals interviewed at FPIA headquarters in New York can be found in Appendix A.

Following the two-day meeting with FPIA in New York on October 29 and 30, members dispersed to visit 25 projects in 12 countries: Peru, Brazil, Mexico, Kenya, Zambia, Sierra Leone, Nigeria, Egypt, Sudan, Indonesia, Bangladesh and Thailand. Eight are among FPIA's 11 top priority countries (see Section II.2.2) and all have major country activities. Projects represented a wide range: new, developing and/or mature projects in a spectrum of functional areas including service delivery, information, education and communication (IEC), training, and women's programs. Generally, FPIA field staff accompanied evaluators on subproject visits. A listing of individual subprojects visited can be found in Appendix B.

In preparation for the evaluation, the team prepared two lists of questions to be researched, one a list of questions on general issues and the other a set of specific questions for each site visit (see Appendices C and D). The list of questions on general issues was designed to supplement the scope of work.

Chapter II of this report is organized in two parts; the first responds to questions 1-4 of the scope of work and the second to the team's list of general questions.

Questions 4 and 6 of the scope of work, which asked in a general way whether FPIA has been successful, were not answered

directly; FPIA's success in specific areas, however, is discussed in detail in the second section of Chapter II. Question 4 was redefined to focus on FPIA's efficacy in management technical assistance. Question 5, which called for data on contraceptive use and prevalence, proved, except in a few cases, to be impossible to answer in any meaningful way, and therefore this issue is also not addressed in the main report. Question 7, which called for recommendations is addressed as appropriate within the context of specific facets of program activity. The recommendations are also summarized in Chapter III.

II. OBSERVATIONS AND FINDINGS

II.1 Underlying Considerations

Although not addressed specifically, the issue of the extent to which FPIA has successfully implemented its program and thus increased the development and continuity of voluntary family planning programs ^{2/} begs the question: What does success mean in the context of the FPIA project? From the perspective of the present, many FPIA subprojects can be judged successful; subprojects in Sierra Leone, Zambia and Nigeria are just a few of the examples of FPIA activities that are critical elements in the provision of family planning services in their countries. AID and FPIA agree, however, that if FPIA is to increase the overall capability and infrastructure available for family planning activities in Third World countries, it cannot merely fund a set of static family planning service delivery subprojects. It must continually expand the LDC family planning service infrastructure: it must identify new collaborators, train and support them, and assist them to achieve at least relative self-sufficiency through income generation and/or support from other agencies including their own governments. FPIA does not have adequate resources to support more than a small share of needed LDC family planning programs, yet through spread of FPIA-developed methodologies, management systems and technical knowledge, FPIA can have an important impact on worldwide LDC capability to solve population problems through family planning. This premise underlies most of the discussion that follows.

II.2 Issues in Scope of Work

II.2.1 Project Log Frame

1. Progress in meeting program and commodity objectives stated in 1982-1987 Project Log Frame

II.2.1.1 Planned Outputs. The log frame (see Appendix E) calls for outputs relating to commodity distribution; subproject outputs (type, numbers and location); and management and program-related technical assistance provided to LDC subgrantees. Life-of-project outputs cover a 55.5-month period. Since only 28.5 months had elapsed between the project start-up and September 30, 1985, the latest date for which data were available, only 51.4 percent of the project life had elapsed and thus

^{2/} Scope of Work, Question 6.

current progress in meeting log frame required outputs had to be prorated.

II.2.1.2 Commodity Outputs. Against a requirement that commodities be distributed in 50 to 60 LDCs over the 55.5 month period, FPIA had distributed commodities in 79 countries. The life-of-project requirement outputs called for 120 million cycles of oral contraceptives, 375 million condoms and \$5.5 million of related family planning commodities to be distributed through local family planning agencies. Current progress toward this goal, shown in Table 1 and Figures 1-3, indicates that FPIA has distributed approximately 54.5 million cycles of pills or 88.3 percent of the planned pill cycle outputs prorated at 61.7 million cycles. FPIA has distributed 135.8 million condoms or 70.5 percent of the planned prorated distribution of 192.75 million condoms. FPIA has distributed \$5.6 million of non-pill, non-condom commodities or 196.6 percent of the planned output on a prorated basis.

Table 1

FPIA Distribution of Contraceptive Commodities
May 17, 1983 - September 30, 1985

Type of Commodity	Distributed Through 9/30/85 (millions)	Prorated (51.4%) Log Frame Outputs	% of Prorated Requirements Achieved	Life of Project Log Frame Outputs (millions)	Projected Actual Amount (millions)
Pill Cycles	54.486	61.68	88.3%	120	110-120
Condom Pieces	135.815	192.750	70.5%	375	245-260
Other Commodities	\$5.557	\$2.827	196.6%	\$5.5	\$11.9-12.5

Assuming current trends continue, by the end of the project FPIA will have distributed between 110 and 120 million pill cycles, 245 to 260 million condoms, and other contraceptive commodities with a value of \$11.9 to \$12.5 million. Thus, it will be on target with pills, will have distributed more than

double the dollar value of other commodities, but will have fallen short by over 100 million in condom pieces distributed. The reason for the condom shortfall was that AID ordered less than anticipated. The projected range of outputs for pill cycles, condoms and other contraceptive commodities is provided in Figures 1, 2, and 3.

II.2.1.3 Subproject Outputs in Log Frame.

II.2.1.3.1 Activities by Countries. The log frame calls for the following outputs over the 55.5 month period:

1. Family Planning (FP) Clinic, Community-Based Distribution (CBD), and Voluntary Sterilization (VS) projects undertaken in 30-40 LDCs.
2. Women's and adolescent projects in 18-24 LDCs.
3. Information, Education and Communication (IEC) projects in 3-5 LDCs.
4. FP training projects in 5 LDCs.

Prorating the outputs for the 28.5 month period (May 17, 1983-September 30, 1985), actual results compared with planned (prorated) outputs are shown in Table 2.

Table 2

Number of Countries With Various Project Types:
Planned vs Accomplished
May 17, 1983 - September 30, 1985

Type of Project	No. of Countries, Planned (prorated) Outputs	No. of Countries, Actual Results
1) FP Clinic, CBD, VS	15 to 21	38 FP Clinic 26 CBD 12 VS
2) Women's & ado- lescent projects	9 to 12	16
3) IEC projects	2 to 3	13
4) FP training projects	3	14

FIGURE 1
ORAL CONTRACEPTIVE CYCLES:
ACTUAL PROVIDED AND RANGE PROJECTED
(1983-1987)

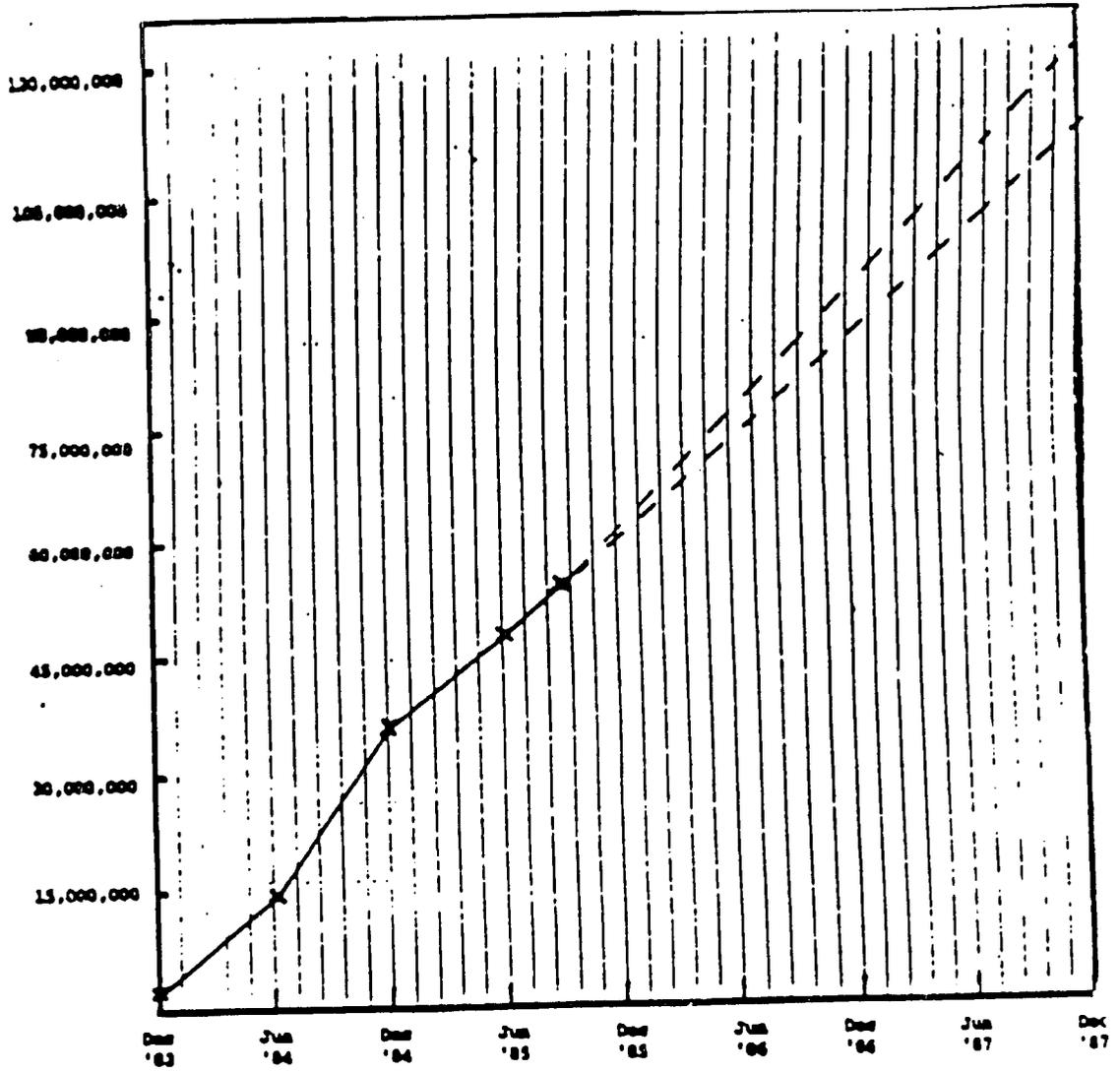


FIGURE 2

CONDOMS:

ACTUAL PROVIDED AND RANGE PROJECTED

(1983-1987)

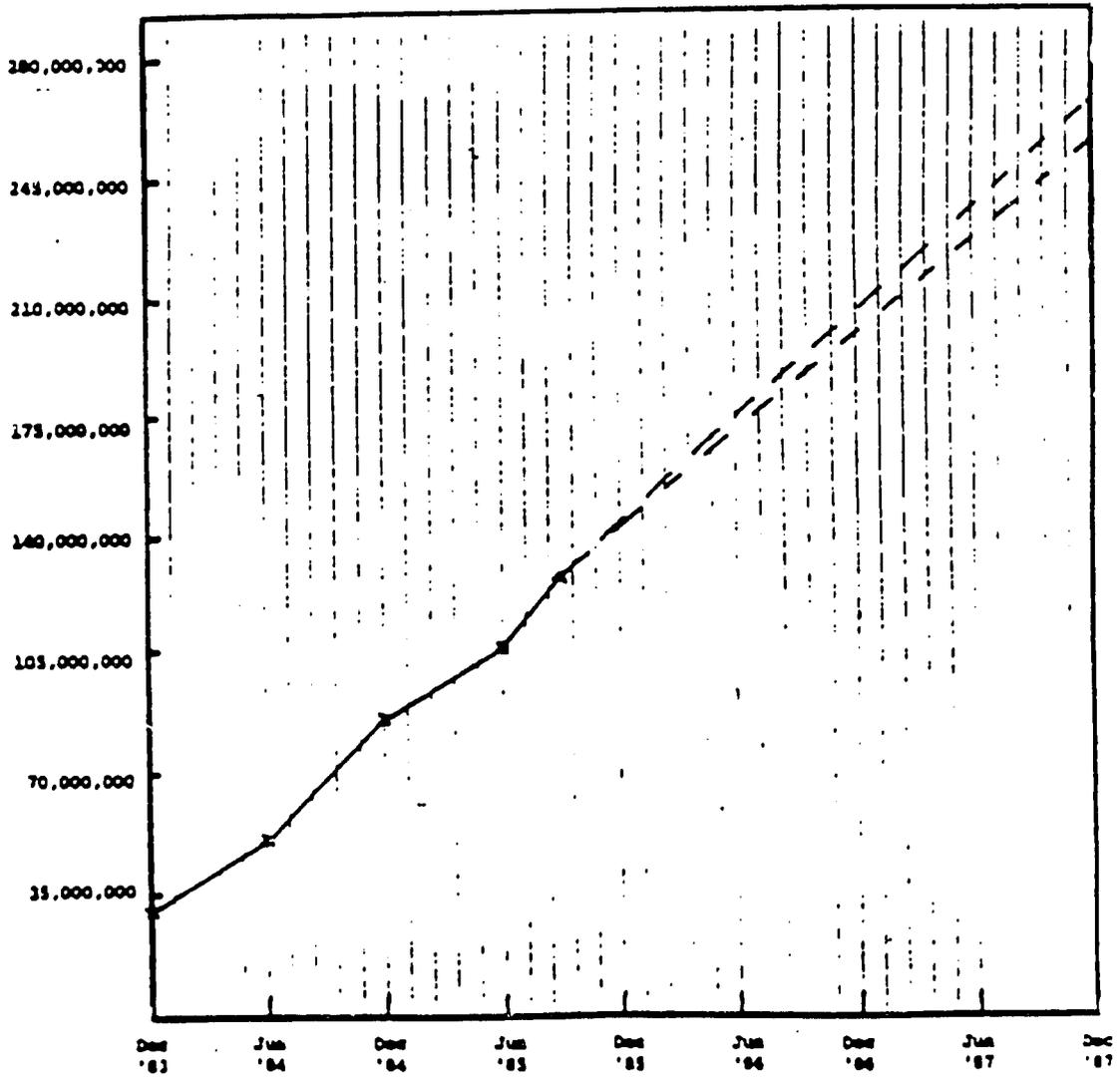
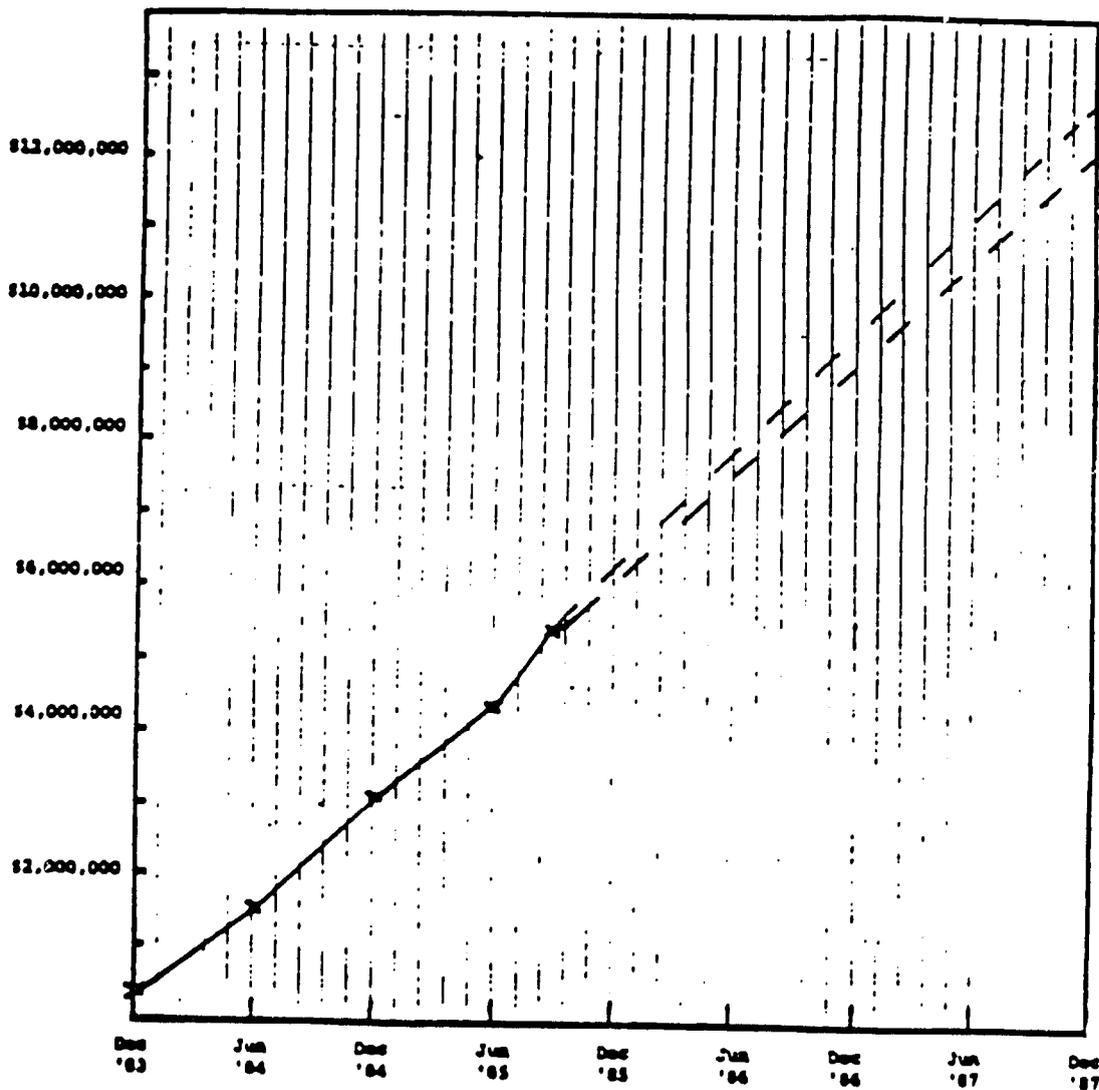


FIGURE 3
OTHER CONTRACEPTIVE COMMODITIES:
ACTUAL PROVIDED AND RANGE PROJECTED
(1983-1987)



II.2.1.3.2 Types of Project or Other Activity. The log frame refines the above, calling for the following total numbers of projects or other outputs:

1. 25 FP/MCH clinic projects
2. 35 CBD projects
3. 10 VS service projects
4. 5-15 IEC projects implemented through women's organizations
5. 1-5 adolescent projects
6. 10 training projects for 200 physicians, 1000 professionals and 15 managers of FP projects
7. 5,000 person-days of technical assistance.

Actual outputs are as follows:

- o Service Delivery Projects (items 1-5 above)

Prorating these outputs for the 28.5 month period, it is possible to compare the planned outputs (prorated) with actual data for the period January 1, 1984-September 30, 1985. Data for May 17-December 31, 1983 are not available. As can be seen in Table 3, FPIA has already exceeded even five-year planned outputs.

Table 3

Project Outputs by Type of Project: Planned vs Accomplished
January 1, 1984-September 30, 1985

Type of Project	Planned (prorated) Outputs (28.5 month period)	Actual Results (21 mo. period)
FP/MCH Clinic	13	82
CBD	18	66
VS Service	5	17
IEC	3-8	11
Adolescent	1-3	18

o Training Projects (item 6 above)

Prorated as in Table 3 above, a goal of five training projects for medical staff and project managers compares with actual results of 14 training projects over the 21-month period.

-- Training projects for physicians and paraprofessionals.

During just one year (1984, the only calendar year for which complete data are available by type of individual trained), FPIA surpassed the five-year objectives in the log frame (200 physicians and 1,000 paraprofessionals). A total of 427 physicians, 364 medical students and 1,464 other medical personnel were trained. Additionally, 6,951 community outreach personnel and 700 administrative staff received training.

Training is also provided within other projects whose major focus is service delivery or IEC. In 1983, for example, a total of 70 projects reported training 12,341 individuals associated with family planning, reproductive health and related development efforts.

-- Training of managers of FP projects.

The log frame calls for training of 15 managers of FP projects. Since May 1983, FPIA has sent 59 project directors and senior project managers to training courses at the University of North Carolina, University of California, Asian Training Centre (Bangkok), Emory University, Family Planning Services and Training Center (Bangladesh), Adolescent Fertility Training Program (Manila), the Margaret Sanger Institute and elsewhere. This volume of training represents a substantial increase over the previous funding period. Project staff have been sent from 15 different programs worldwide: Bangladesh-17, -18, -27, and -28; Thailand-11 and -19; India-02; Nepal-07; Indonesia-17; Sri Lanka-09; Zambia-04; Upper Volta-01; Nigeria-04; Egypt-05; and Mexico-23.

Project personnel have also received training through various training conferences: 30 to the International Conference of Voluntary Surgical Sterilization, 30 to the International Federation of Family Life Promotion Conference in Hong Kong, six to the sub-Sahara Conference on Reproductive Health and four to the World Assembly of Youth Conference in Jakarta. Project personnel have also been sent on invitational travel to observe other projects.

o Technical Assistance Outputs (item 7 above)

The log frame called for outputs of 5,000 person-days of management and project-related technical assistance. The actual figure from January 1, 1984 to September 30, 1985 is 3,231. This is 25.7 percent above the prorated output (for a 28.5-month period).

II.2.1.4 Subproject Outputs Not Specified in Log Frame.

II.2.1.4.1 Natural Family Planning Assistance. Although not called for in the log frame, data on natural family planning projects also show substantial progress. A summary of project-related natural family planning in 1982, 1983 and 1984 is shown in Table 4.

Table 4

FPIA Project-Related Natural Family Planning Activities
(1982, 1983 and 1984)

	No. of Projects	No. of Countries
1982	13	10
1983	17	7
1984	21	10

II.2.1.4.2 Total Number of Active Projects. Because many projects can be classified in more than one category, the total number of project outputs in Table 3 exceeds the number of active projects. The log frame did not in fact call for any specific number of projects. FPIA nonetheless has tracked progress of total numbers since 1982 and calculated the percentage that provide contraceptive service (as distinguished from IEC or training). Between 1982 and 1985, the number of active projects increased by 16.8 percent, with service projects increasing 11.6 percent during that same period (see Table 5).

Table 5

Active (contraceptive) Service Projects Funded by FPIA

Year	Total # Active Projects	# Providing Contraceptive Service	% Providing Contraceptive Service
1982	107	86	80.4
1983	113	91	80.5
1984	118	95	80.5
1985*	125	96	76.8

* Nine-month data through September 30, 1985

II.2.2 FPIA's Strategic Plan

2. Progress in Achieving Subproject Assistance Goals Cited in FPIA's 1984-1986 Strategic Plan and Plan Update

In March 1984, FPIA completed a 1984-1986 strategic plan. An elaborate 113-page document, the plan reflects FPIA's system of strategic planning, which was initiated in January 1983. The strategic plan is based on FPIA Regional Office systematic analyses of current programs and their recommendations on which of their subprojects/activities merit continued support, which should be terminated, and what new activities should be undertaken. One important purpose of strategic planning is to provide FPIA and AID with a clear rationale for continued funding of subprojects and countries at a time when resources are limited.

The three-year strategic plan is based on FPIA's Cooperative Agreement with AID and reflects numerical goals found in the log frame. Specific objectives include (1) extending existing family planning services of governmental and non-governmental institutions to new geographic areas or new populations; (2) initiating family planning service in institutions not currently involved in service provision; (3) providing parallel or complementary services; (4) transferring management technology; (5) training staff (invitational travel); (6) working with resistant

populations, adolescents, religious, and high-risk groups; (7) utilizing total resources; and (8) supplying family planning commodities to projects and non-project institutions.

Development of each regional and country-specific strategic plan was based on the above objectives and took into consideration the following factors: (1) the state of development of the family planning program in each country, including population growth rates, nature of family planning services available, and types of service providers; (2) government plans and AID and USAID mission strategies; (3) type of program FPIA, AID/W and USAID currently is funding; and (4) rationale for continued FPIA support to the country.

The net result was the identification of 28 high-priority countries with 11 countries selected to receive particular emphasis because they have larger populations and significant numbers of individuals without access to family planning services. Seventy-two percent or \$17.1 million of FPIA's projected 1984-1986 subgrant budget of \$23.7 million was allocated to the 11 countries. Five of the 11 countries (Brazil, Mexico, Nigeria, Turkey, and Colombia) have no AID bilateral programs and were selected to receive 39 percent of the subgrant budget. In addition, FPIA's strategic plan calls for consolidation of its program in Asia and Latin America with a corresponding increase of programs in Africa and increased numbers of commodity logistics projects and technical assistance.

The plan is updated annually, with the first update published in February 1985: "FPIA 1984-1986 A Strategic Plan (Progress and Update)." The update reviews progress over the previous year and revises the strategic plan appropriately. The review of 1984 shows that actual performance outpaced planned performance in most areas: active projects, dollars obligated, countries with active projects, geographic distribution of project obligations, obligations to high-priority countries, commodity assistance and technical assistance. At the end of 1984, the only area where FPIA had fallen behind its strategic plan was in regard to types of projects. It failed to initiate as many training, women's and adolescent, CBD and IEC projects as hoped, although it had surpassed its goal by nearly 100 percent in the area of FP/MCH projects. (Additional detail can be found in the pages of the FPIA strategic plan, its update, and its progress report found at Appendix F.)

II.2.3 AID's Resource Allocation Plan

3. Performance in Attaining Country Program and Funding Goals Cited in the 1984-1986 S&T/POP [AID's Office of Population in the Bureau of Science and Technology] Resource Allocation Plan

The geographic emphasis of FPIA's programs has been in accord with AID's RAP. The RAP called for an increased emphasis on Africa, offset by decreasing emphasis primarily on Latin America and to a lesser degree on Asia and the Near East. The trends of FPIA assistance have been closely aligned with these goals, although, as of FY 1985, its funding obligation levels for Africa and Latin America were somewhat lower than those called for in AID's RAP and somewhat higher for Asia and in the Near East (see Table 6 for details).

Table 6
Percentage Distribution of FPIA Obligations

Region	<u>FY1983</u>	<u>FY1984</u>		<u>FY1985</u>		<u>FY1986</u>
	FPIA Actual	AID Plan	FPIA Actual	AID Plan	FPIA Actual	AID Plan
Africa	17.3	21.7	20.2	30.1	27.2	32.3
Asia & Near East	44.2	39.5	40.4	37.5	41.7	36.2
Latin America	38.5	38.5	36.2	32.4	31.1	31.5
Other			3.2			

The increased emphasis on Africa is demonstrated again in Table 7, which shows that the number of countries assisted with project and/or commodity support in that continent has increased from 21 to 33 since May 1983. The sharp increase for Latin America over the same period may seem at variance with the drop in funding levels for the same region shown in Table 6. The explanation is that a modest amount of commodity assistance was given for the first time to a number of small Caribbean Islands during this period.

Table 7

Number of Countries Assisted with Project and/or Commodity Support
Since May 17, 1983 (Cumulative Total)

Region	At Dec. 31, 1983	At Dec. 31, 1984	At Dec. 31, 1985
Africa	21	31	33
Asia & Pacific	11	15	15
Latin America	11	29	31
	<hr/> 43	<hr/> 75	<hr/> 79

II.2.4 Management Technical Assistance

4. The Efficacy of FPIA's Management Technical Assistance in Activating or Increasing the Availability of Quality Low-Cost Family Planning Services Through LDC Subprojects 3/

It is FPIA's philosophy that family planning service projects in LDCs most often fail because of management and administrative weaknesses. Accordingly, it has evolved a highly organized and elaborate management system with carefully laid out objectives, detailed manuals, extensive reviews and approvals and intensive monitoring. Project selection is governed by a form of management-by-objectives. Close monitoring follows, with ongoing reports, adherence to a highly developed procedure for fiscal accounting, commodity management and other administrative procedures coupled with site visits, audits and evaluations. The result is a highly effective management system, repeatedly praised in successive evaluations. The only problem noted consistently was specific to Latin America only, where rapid inflation plays havoc with the budgeting process. This problem, of course, stems from conditions external to FPIA's management system, but should nonetheless be addressed.

3/ The team focused here only on the efficacy of management technical assistance.

FPIA's management assistance goes not only to individual projects but also to organizations that serve a networking function to disseminate family planning management skills: in Mexico (the Mexican Federation of Private Associations for Family Planning [FEMAP]) and Brazil (the Brazilian Association of Family Planning Organizations [ABEPF]).

Recommendation: Because FPIA's management system represents an effective and successful model, it should be disseminated as widely as possible. In particular, assistance should be provided to umbrella organizations since these in turn influence large numbers of smaller family planning agencies.

II.3 Team Questions

II.3.1 Innovative Programming

1. In selecting projects, does FPIA seek out innovative, pioneering programs in challenging settings? By contrast, what proportion of projects are easily executed: for example, those in middle-income LDC countries and/or metropolitan areas?

An evaluation of the array of FPIA-supported projects and an analysis of how these projects have progressed over time reveal that FPIA has continually sought to increase the proportion of projects carried out in difficult settings. Most striking, by augmenting its activities in Africa, FPIA has simultaneously increased the level of program challenge. Moreover, a substantial proportion of projects selected in Africa have been in difficult rural settings.

Worldwide, "innovative" has meant different things in different settings. Wherever it operates, however, FPIA's goal has been to select the untried, the experimental. For instance, in Brazil, it selected an organization (Center for Research and Integrated Attention to Mothers and Children) that was breaking new ground by delegating the service delivery function to paramedical personnel and focusing on the urban poor. Likewise, the umbrella agencies supported in Brazil and Mexico (ABEPF and FEMAP) represent new organizational approaches in both their countries (see Section II.3.4). Moreover, in Bangladesh, FPIA-supported Concerned Women For Family Planning Project had pioneered CBD in that country as well as a woman-to-woman approach. In Africa, the record is similar. CBD was relatively untried in Kenya, so there FPIA elected to work with the community health department of a hospital that provided family planning service through CBD to a widespread district population. In Zambia, where distributing condoms through retail pharmacies was a new idea, FPIA opted to support this approach through the

Private Enterprise Family Planning Project. In Sierra Leone, FPIA identified the first organization in that country to emphasize adolescent problems, especially unwanted pregnancies, and to provide its support to that group.

It is true that more traditional FP/MCH projects still tend to predominate (43 percent of project output by project type are MCH/FP projects), but if strategic plan goals materialize, MCH/FP will drop to only 20 percent of the total by 1986 (see Appendix F, p. 5).

Recommendations:

1. In countries where family planning is already widely available (as in parts of Latin America and Asia), FPIA should make a careful assessment of the need for new service delivery projects.
2. FPIA might consider further increasing the proportion of service delivery activities by working with the organized commercial sector, especially in Africa: e.g., factories and businesses.

II.3.2 Technical Assistance

Is the technical assistance provided by FPIA appropriate to host country project needs? Do family planning services receive adequate technical assistance? Or are they overshadowed by a concern with management? Is there enough medical backstopping provided to the field?

While management technical assistance is excellent (see Section II.4), technical assistance to assist project managers in the program aspects of delivery of family planning services has been less impressive. Particularly in regard to medical backstopping, however, efforts are growing to provide needed support.

II.3.2.1 General Backstopping.

II.3.2.1.1 Visits, Workshops, and Invitational Travel. FPIA's efforts to provide general backstopping to family planning service efforts have included site visits by regional staff and external consultants, workshops, and invitational travel for project participants. In addition, the New York headquarters has recently published a new technical assistance manual on methods related to service delivery, a good step although the manual is somewhat management-oriented.

The effectiveness of technical assistance at the field level varies widely. Among sites visited during this evaluation, the most impressive technical assistance seen was provided to a commodities program (Sudan), which benefited from a series of visits from an external logistics/supply consultant to assist with project design, followed by a two-week visit by a three-person team to assess training. At the other end of the scale, in Zambia, purchase of an expensive but inappropriate mobile van might have been avoided by better advice. Several project staff in Africa specifically remarked on the need for more Africa Regional Office (ARO) assistance, including feedback on progress reports. A common complaint was FPIA's practice of frequent changes in staff assigned to visit specific sites (e.g., Sudan).

Regarding workshops, one on CBD and one on family planning management have been held in Nairobi, but no data were available to judge their effectiveness. The need for site visits and workshops is certainly greater in Africa, where family planning efforts are relatively new, than it is in Latin America. Here, the project staff expressed satisfaction with the level of person-to-person technical assistance and called instead for more invitational travel.

II.3.2.1.2 Material Support. Technical support in the form of IEC materials for clients and service providers was found, in most sites, to be inadequate. In some countries (e.g., Brazil and Zambia), the political climate towards family planning may continue to dictate a fairly conservative approach to IEC activities. On the other hand, particularly in Africa, far-reaching media campaigns are seen as an intrinsic element in launching new projects (e.g., in Zambia and Nigeria for commercial commodity distribution). Among various IEC materials, films seemed to be available in most places, but in Kenya, the audience appeared inappropriate (children) and in the Sudan, family planning workers expressed boredom with viewing the same films repeatedly. Posters, flip charts, and written materials for workers seemed to be available in limited quantities in most projects visited, but there was a common dearth of materials for clients. The problem of client illiteracy was solved in one Egypt project by workers reading pamphlets out loud to clients. Another solution suggested was to contact the Program for the Introduction and Adaptation of Contraceptive Technology (PIACT) for booklets appropriate for non-readers.

FPIA is not expected to be the sole source for IEC materials. While in Mexico's FEMAP, where IEC efforts are exemplary, most materials seemed to have been provided by FPIA/PPFA, in Peru, another strong program had materials not only from FPIA but also from Peru's National Population Council, USAID, Development

Associates and the Population Communication Services (PCS) Project of Johns Hopkins University.

Recommendation: FPIA is encouraged to ensure that all projects have adequate IEC components to enhance their effectiveness at the community and client levels.

II.3.2.2 Medical Backstopping.

II.3.2.2.1 Standards. The quality of medical backstopping is of particular concern. Standards for medical procedures and policy are set at FPIA headquarters, after deliberations among FPIA staff, the 27-member National Medical Committee, and ultimately the PPFA Board of Directors. The National Medical Committee includes some of the most highly skilled medical practitioners working in family planning in the United States. Its advice about new medical procedures is reviewed and approved by the PPFA Board of Directors. This procedure provides a cautious, sound medical basis for family planning practice. On the debit side, however, it provides advice that may be more appropriate for the United States than for LDCs. The Medical Committee and Board, for example, have determined that only contraceptives that have Food and Drug Administration (FDA) approval may be used with FPIA support. While this is consistent with AID's usual practice, and while FPIA neither recommends nor disapproves of the use of non-FDA approved pharmaceuticals, it is not clear to all FPIA subprojects that may offer sound and legitimate birth control methods that are not FDA-approved using non-AID funds, e.g., Depo-Provera and NORPLANT.

II.3.2.2.2 The Role of FPIA's Medical Director. FPIA's medical director is ultimately responsible for the quality of medical services provided in all FPIA projects. As PPFA's Vice President for Medical Affairs, however, she also has responsibility for backstopping all PPFA's clinical activities in the United States. Only about 25 percent of her time, therefore, is available to devote to FPIA activities.

The Medical Director is involved in policy review through the PPFA National Medical Committee and review of all sterilization programs and IUD training programs. She also reviews all medical commodity requests before shipment overseas. During the past two years, she has served as one of three outside reviewers for the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception's Expert Committee Reports. She has had extensive inputs into FPIA's staff medical manual and FPIA's grantee voluntary sterilization handbook (see Section II.3.2.2.4).

II.3.2.2.3 Site Visits, Workshops and Training. As with technical assistance to service delivery projects, medical backstopping to specific projects includes a variety of activities: site visits by FPIA staff and consultants; workshops and training for subproject personnel; and provision of materials. The Medical Director herself provides a considerable amount of the project-specific technical assistance. As time allows, she makes site visits (she visited five of the projects with medical personnel reviewed for this evaluation) and conducts occasional workshops (three projects reviewed sent staff to such a workshop in Santo Domingo). By mail, project staff consult her on a number of matters: technical questions (e.g., IUD fittings, the efficacy of IUDs used with foam), problems that arise (generally in connection with complications in sterilizations), and routine approvals of protocols and prospective staff CVs. Her answers are routinely transmitted to projects through FPIA regional offices. (Appendix G is a listing of all medical, project-related issues with which the Medical Director has been involved since May 17, 1983.)

Medical staff attendance at training courses, workshops and seminars is described in Appendices H and I. Appendix H indicates that all projects with medical staff sent staff members to at least one conference or training session, while in some cases (e.g., Kenya-06, Peru-06), one individual staff member attended as many as six different courses and workshops. The most commonly attended conference, the Fifth International Conference in Voluntary Surgical Contraception in Santo Domingo, was attended by staff members from 19 FPIA-supported projects. The most commonly attended training program was that for nurse practitioners at the Margaret Sanger Center in New York.

II.3.2.2.4 Provision of Materials. FPIA headquarters makes a considerable effort to provide up-to-date written materials on contraceptive methods. It routinely mails direct to all projects Population Reports and International Family Planning Perspectives (Appendix I), and also provides a wide selection of handbooks, pamphlets, manuals and films on specific types of birth control modalities (see Appendices I and J). Because many of these materials are in English, they may be of little use to subproject staff (e.g., Egypt-02). FPIA makes an effort to rectify this problem by sending selected articles in translation to the field. For example, Spanish and Portuguese translations of an article dealing with the uterine perforation among IUD users were sent to 21 projects in Latin America, and French translations of several articles dealing with IUDs were distributed.

FPIA also has developed materials for project use, specifically a two-volume medical procedures handbook and medical manuals on specific contraceptive methods.

The two-volume handbook, which is available both in New York and in all field offices, is of variable quality, with some issues treated in depth and others more superficially. For example, information on sterilization is very complete and up-to-date, whereas information on IUD insertion is less current: i.e., information about infertility following pelvic disease in the presence of IUDs was not adequately detailed or up-to-date. In addition, some methods, for example natural family planning, are only superficially covered in the medical handbook, even though FPIA has initiated an increasing number of natural family planning service delivery programs.

A medical manual, entitled Voluntary Sterilization - Services and Training, was prepared by FPIA in conjunction with the Association for Voluntary Surgical Contraception and published in January 1985. It is a very carefully delineated volume, which gives detailed instructions about conduct and management of sterilization service programs. Its one major flaw is that complete details of premedication, sedation, and anesthesia are omitted. This aspect of medical care has proven difficult for LDCs and was the cause of a number of deaths in Bangladesh when an expanded sterilization program was initiated there. (None of those deaths occurred in FPIA-assisted projects in Bangladesh, however.) Based on Bangladesh's experience, a carefully constructed anesthesia protocol has been developed by Dr. Fishburn. Not all projects visited were aware of its existence. The manual, however, is a good start--one that needs to be supplemented by similar publications on other contraceptive methods.

Despite FPIA's considerable efforts, the amount of information about the various birth control modalities in individual clinics could be more extensive. One problem, which seems to exist to varying degrees throughout the FPIA network, is distribution. FPIA transmits most materials to FPIA Regional Offices for routine forwarding to the field, but not all publications seem to reach their destinations (e.g., in Egypt and the Sudan, none of the Medical Standard Manuals was available at subprojects visited).

Recommendations:

Manpower for Medical Backstopping

1. PPFA/FPIA should employ an assistant medical director to assist the current medical director. This individual should be a qualified physician with LDC experience who would devote the bulk of his or her time to supporting the FPIA project.

A less preferable alternative would be to expand the roster of available medical consultants and increase their interaction with field subprojects. This alternative would make it more difficult to develop procedures and manuals and might result in unevenness of advice. It would, however, have the advantage that language capability could be tailored to field needs.

Provision of Materials

2. More systematic, regular and thorough updating of the field in regard to specific contraceptive methods should be provided.
3. Procedures manuals like that on sterilization should be developed for other contraceptive methods beginning with IUDs, which also require a certain level of medical skill. It would make good sense to develop such procedures manuals cooperatively with other service delivery organizations to avoid duplication of effort.
4. The Fishburn anesthesia protocol should be transmitted to every subproject involved in sterilization. Follow-up and monitoring to ensure it is understood should also be provided.
5. A more systematic effort should be made to provide family planning information, including medical information, to service delivery points.

II.3.3 Evaluation

3. **What is the nature of FPIA's own evaluation system? How much is needed? How much effort goes into it? Are outside consultants used? Is it adequately quantitative? Should measures of program output include, for example, couple years of protection (CYP), prevalence surveys, commodity data, etc.?**

II.3.3.1 Program Assessment. FPIA makes a substantial effort to carry out internal evaluations at every level, supported where appropriate by external evaluations. At the subproject level, assessments are carried out by the FPIA staff, complemented by evaluations conducted by outside consultants. (A listing of 29 recent project assessments is attached as Appendix K.) At the regional level, requirements include monthly Regional Office budget reports and progress reports every four months. In addition, FPIA's Director and Deputy Director make monitoring visits to Regional Offices. Assessment of overall project progress is measured in a number of ways: FPIA data are extensively computerized and quarterly printouts are provided to PPFA's President and the PPFA Board's International Committee; progress is measured periodically against the Strategic Plan;

monthly progress reports are provided to the President of PFFA; an Annual Report is prepared; and an annual survey of service projects is published in a booklet entitled "Serving Contraceptive Clients in Developing Countries." Staff performance reviews are carried out routinely, at all levels.

II.3.3.2 Service Statistics Reporting. While monitoring and reporting of management data are outstanding, reporting of service statistics is considerably more problematic. The system was delineated in the Acceptor Reporting Manual developed in November 1980. It follows the common practice of reporting according to "new" and "continuing" clients. The system itself is explained with clear and complete instructions and is fairly easy to use. It has a number of drawbacks, however, starting with the definitions of "new" and "continuing." A "new" client is one who makes a first visit to a clinic during a funding period, which are of variable lengths (a common duration is 15 months). If this client returns during this same funding period, she (he) remains a new client but if she returns during a second funding reporting period, she is then categorized as a continuing client. The real problem is that it does not provide enough information to establish a critical fact: whether use of the method is in fact continuous. Furthermore, clients who switch methods are still counted as users of the originally selected method, so client data may distort the current method mix.

Although individual projects keep track of contraceptive inventories, this information is not routinely used to estimate contraceptive prevalence. Typically, information at headquarters reflects only numbers of users measured by service statistics. Certainly, provision of services to approximately one million couples each year is an impressive statistic (see Table 8), and available data do provide the basis for some limited trend analysis (see Tables 8 and 9). Without project-specific data on commodity use, however, measures of contraceptive prevalence, couple years of protection and demographic impact are less accurate, as are cost-effectiveness comparisons between sub-projects, regions, or other service programs.

TABLE 8

Number of Clients by Region, 1982-1984

Region	New Clients			Continuing Clients			Clients Served through Contraceptive Distribution*			Total Clients		
	1982	1983	1984	1982	1983	1984	1982	1983	1984	1982	1983	1984
Africa	71,965	74,174	82,876	59,415	54,019	73,826	5,048	34,131	13,708	136,428	162,322	170,320
Asia & Paci- fic	220,206	284,156	312,030	136,036	154,385	257,120	51,347	10,449	83,317	407,589	448,990	652,467
Latin Amer- ica	223,727	211,168	243,656	78,262	168,244	194,772	65,576	67,542	76,142	377,565	446,954	514,520
TOTAL	525,898	569,496	548,552	273,713	376,648	525,668	121,971	112,122	173,167	921,582	1,058,266	1,337,307

* Where count is calculated on basis of contraceptives distributed, not service statistics.

Table 9

Annual Client Cost Estimates, by Region, 1982-1984
\$ Cost per Client

Region	1982	1983	1984
Africa	10.16	8.83	7.22
Asia & Pacific	4.94	6.59	3.84
Latin America	7.91	5.51	4.90
Worldwide Average Cost	6.93	6.48	4.68

An improved system of service statistics could become a useful management tool for assessing individual projects and assisting those projects to become more effective and cost-efficient.

Recommendation:

1. FPIA should undertake a thorough re-evaluation of its service statistics system. This assessment should include input from field service delivery representatives, outside experts (e.g., from the Centers for Disease Control [CDC]), representatives of other AID-supported service delivery projects, and FPIA.
2. One possibility would be to add commodity data to allow calculation of CYP.

II.3.4 Staff

4. How well does FPIA use staff in New York and Regional Offices? Are their qualifications appropriate for project development, management technical assistance, and service delivery techniques?

FPIA goes to unusual lengths to recruit and train staff, very carefully checking out backgrounds and performance and choosing those with appropriate language skills. Both U.S. and

regional staff work long hours and demonstrate considerable dedication to the tasks before them.

As of October 24, 1985, FPIA had a total of 52 professional staff. Their educational backgrounds included 17 with a bachelor's degree, 31 with a master's degree and 5 with a doctoral degree. The mean number of years of family planning experience per professional staff member is 6.3, with a range of 0 to 42 years. In aggregate, FPIA professional staff possessed 237 person years of employment with FPIA. The mean number of years of employment is 4.6, and the range is 0 to 17 years. A total of 43 of the 52 FPIA professional staff have overseas working experience in family planning health and/or development. For these staff, the mean number of years of overseas experience is 4.9 with a range of .5 to 15 years. (Additional information on FPIA professional staff language ability and training can be found in Appendix L.) The mean duration of employment is 4.6 years. The recruiting staff in New York and Regional Offices appear to place too much emphasis on management skills. An FPIA organizational chart and the staffing pattern can be found in Appendices M and N.

Recommendation:

1. FPIA should place strong emphasis on family planning skills in future staff recruitment.
2. Current staff should be provided additional training in relevant family planning skills (IEC, contraceptive technology, etc.). This would allow FPIA to increase technical assistance for program design and implementation as well as medical technical assistance.

II.3.5 Subproject Continuation After Termination of FPIA Support

5. **Does the FPIA system make adequate provision to enhance the chances of projects to remain in existence after FPIA support has ended? Does FPIA provide any technical assistance, commodities or evaluation to terminated projects?**

FPIA puts a high priority on attempting to ensure that subprojects it supports continue after termination of its funding. As part of the initial programming process, a long-term plan is drawn up for each subproject that includes provisions for phase-out. These usually include a combination of several elements: ways in which capital costs might be donated, ways in which the subproject might be able to generate funds to cover some recurring costs, and ways in which some costs might be assumed by either the government or by another funding agency.

Subproject staff are expected to start working toward assuring project continuation shortly after midpoint in any given subproject life. In Latin America, there has been a tendency to focus on the self-sufficiency aspects of continuation, sometimes to the neglect of other aspects of long-range planning. In instances where a subproject is particularly important, due to the breadth of its coverage, its stature as model program, etc., FPIA will continue its own funding as necessary, while assisting subproject staff in their efforts to assure the future of the subproject.

FPIA estimates that overall, since the start of AID funding for FPIA in 1971, about two-thirds of the subprojects intended to be long term are continuing one way or another. 4/ Data from a 1982 survey show that, of 97 subprojects which it was hoped would continue after the end of FPIA funding, 34 (35 percent) were ongoing with other funds, 28 (29 percent) were ongoing with FPIA funds ("rolled over"), and 35 (36 percent) had either been cut short before the termination date or expired. By 1985, the cumulative number of subprojects intended to be long term had risen to 144, of which FPIA had certain knowledge that 45 had been rolled over (31 percent) and that 29 were continuing. Although it has no certain knowledge of the remaining 70, FPIA estimates that the proportion of continuing and terminated subprojects remains about the same as in 1982, or about one-third each.

Recommendations

1. Procedures in the subproject design phase need strengthening to maximize the likelihood that terminated subprojects will continue to be successful family planning service providers.
2. While continuing to seek relative self-sufficiency, subprojects should place appropriate emphasis on other aspects of strategic program planning.
3. Perhaps a category of partial subproject termination should be considered where support is limited to continuing technical assistance, e.g., training, journals, consultations and/or commodities, with reduced financial support for other activities.

4/ Of 264 subprojects undertaken by September 30, 1985, 101 were intended to be short-term and the termination of 18 others came about because of circumstances beyond FPIA's control: congressional mandate called for an end to aid to Ethiopia and Pakistan (six subprojects) and 13 subprojects were in countries that attained "developed status." The remaining 97 discussed above were intended to continue over the long term.

II.3.6 Commodity Assistance

6. How does the FPIA commodity assistance program fit in with the larger commodity objectives of AID and the needs of the field?

The FPIA commodity program is widely praised as being highly effective both in providing contraceptives at AID's request to non-FPIA projects and in providing contraceptives to its own subprojects. Problems of shipment delays were noted in some locations. In Brazil and Mexico, these were blamed on customs regulations. In Sierra Leone, though the cause was not immediately clear, a shortage of foam and condoms clearly had a negative impact on numbers of users and thus program effectiveness. On the whole, however, USAID and host country staff personnel interviewed praised the FPIA's responsiveness and efficiency and felt that because of this responsiveness, there were no coordination problems. Because of AID's own staff shortages, the importance of the FPIA mechanism for commodity assistance cannot be underestimated.

Recommendation: AID and FPIA are encouraged to continue their careful review of commodity distribution in countries where availability of commodities may come to be a constraining factor in program implementation.

II.3.7 Buy-ins

7. How is the existence of buy-ins to the basic project affecting FPIA's program?

FPIA has, with a few notable exceptions, been funded from S&T/POP central funds during the period of this Cooperative Agreement. In one deviation from this practice, FPIA actively sought to have the Bangladesh mission "buy-in" to its cooperative agreement for continued support for two mature projects. Another exception involved funding from Egypt's mission. In both these cases, funds were going to high priority countries, and overall project country priorities were not being distorted. In a third case, however, FPIA accepted \$119,000 for high-risk projects in the drought-afflicted Sahel region. Since these funds count against its existing ceiling, FPIA has voiced a concern that continued acceptance of field buy-ins may result in diversion of program resources from high-priority areas. It has thus made it plain that it will accept few or no more buy-ins over the remainder of the project life unless an increase to its overall ceiling is authorized. Fiscal data reflecting this situation can be found in Table 10.

Table 10

FPIA Basic and Add-On Budget
(as of October 28, 1985)

	Revised Cumula- tive Budget	Bangla- desh* Year 1	Add-Ons* Year 2	Egypt Add-On*	Sahel Add-On*
Sal- aries	\$4,493,328	\$16,552	\$68,140	\$ - -	\$- -
Fringe	610,427	829	7,863	- -	- -
Consul- tants	102,005	-0-	9,000	- -	- -
Travel	1,303,554	6,121	22,928	- -	- -
Other Direct Costs:					
Hqtrs	2,480,465	- -	- -	- -	- -
Reg. Offices	2,499,005	70,082	38,463	- -	- -
Small Grants	155,737	- -	- -	- -	- -
Sub- grants	22,999,602	400,000	483,755	363,325	119,000
Com- modi- ties	2,537,613	- -	- -	- -	- -
Freight	2,493,717	- -	- -	- -	- -
Indi- rect Costs	<u>2,721,872</u>	<u>22,114</u>	<u>54,153</u>	<u>- -</u>	<u>- -</u>
	\$42,397,325	\$515,689	\$684,302	\$363,325	\$119,000

* Included in Revised Total

Recommendation: The funding authority ceiling for the FPIA Cooperative Agreement should be raised so mission buy-ins can be accommodated without disruption of FPIA's basic program. This would be an appropriate way to increase overall FPIA funding (see Chapter III).

II.3.8 Other Family Planning Associations

8. What is FPIA's role in supporting family planning associations (FPA) that are part of IPPF's system?

Because PPFA is part of IPPF and local IPPF FPAs generally look to IPPF/London for technical assistance, support, guidance and so forth, it is a delicate situation when they look to PPFA-FPIA for similar services. Reduction in funds available from IPPF, however, may require that FPAs turn increasingly to FPIA for fiscal, commodity and technical assistance support. While the coordination of such activities will require good planning by USAID missions, IPPF/London and FPIA/New York, there is nothing intrinsically wrong with this kind of activity.

II.3.9 Replication of FPIA Experience

9. What are the policy implications of FPIA-supported programs, including commodity systems? How are lessons learned communicated to the population community? How much coordination is there with other population programs?

FPIA is one of the most effective agencies in existence that works to increase availability of family services in LDCs. The systems and expertise developed over some 14 years of experience and embodied in the institutional knowledge of FPIA include management procedures and the manuals that spell out those procedures in great detail. These lessons have been communicated to other agencies in the population community (The Pathfinder Fund, The Association for Voluntary Sterilization [AVS], PCS), through meetings and in response to specific requests (see Appendix O). Also, some former staffers now occupy senior positions in other organizations. For example, the project director of a new John Snow program is the former regional director from Africa. On the other hand, FPIA has been less effective in documenting and communicating its experience through evaluative research, formal presentations at professional meetings and publication of articles describing their program.

Recommendation: FPIA should continue to document and transmit its experience through such actions as evaluative research, formal presentations and the publication of findings describing

its program. FPIA's highly effective program and techniques deserve to be widely replicated in the Third World.

II.3.10 Progress Since Previous Evaluations

10. What progress has there been since previous evaluations?

FPIA has been highly responsive to recommendations of previous evaluation teams and to requests made by AID. Only a few of 63 previous recommendations have not been fully acted on, i.e., to increase continuing involvement in terminated projects and to increase project technical assistance.

III. RECOMMENDATIONS

III. RECOMMENDATIONS

General

1. AID should continue and even expand its support of FPIA. It is generally recognized that provision of family planning services in LDCs is a high, if not the highest, priority in AID's program of population assistance. Because FPIA's program is an extremely efficient and effective way to implement and extend such service, it deserves to be accorded a high priority among S&T/POP centrally funded projects.
2. If additional funding were provided, FPIA staff would have to be expanded.

Programming Considerations

3. The funding authority ceiling for the FPIA Cooperative Agreement should be raised so mission buy-ins can be accommodated without any disruption of FPIA's basic program. This would be an appropriate way to increase overall FPIA funding.
4. Because FPIA's management system represents an effective and successful model, it should be disseminated as widely as possible. In particular, assistance should be provided to umbrella organizations since these in turn influence large numbers of smaller family planning agencies.
5. FPIA might consider further increasing the proportion of service delivery activities by working with the organized commercial sector, especially in Africa: e.g., factories and businesses.
6. In countries where family planning is already widely available (as in parts of Latin America and Asia), FPIA should make a careful assessment of the need for new service delivery projects.

Technical Assistance

7. FPIA is encouraged to ensure that all projects have adequate IEC components to enhance their effectiveness at the community and client levels.
8. PPFA/FPIA should employ an assistant medical director to assist the current medical director. This individual should

be a qualified physician with LDC experience who would devote the bulk of his or her time to supporting the FPIA project.

9. More systematic, regular and thorough updating of the field in regard to specific contraceptive methods should be provided.
10. Procedures manuals like that on sterilization should be developed for other contraceptive methods beginning with IUDs, which also require medical training and skill. It would make good sense to develop such procedure manuals cooperatively with other service delivery organizations to avoid duplication of effort.
11. The Fishburn anesthesia protocol should be transmitted to every subproject involved in sterilization. Follow-up and monitoring to ensure it is understood should also be provided.
12. A more systematic effort should be made to provide family planning information, including medical information, to service delivery points.

Service Statistics

13. FPIA should undertake a thorough re-evaluation of its service statistics system. This assessment should include input from field service delivery representatives, outside experts (e.g., from the Centers for Disease Control [CDC]), representatives of other AID-supported service delivery projects, and FPIA.
14. One possibility would be to add commodity data to allow calculation of CYP.

Staffing

15. FPIA should place strong emphasis on family planning skills in future staff recruitment.
16. Current staff should be provided additional training in relevant family planning skills (IEC, contraceptive technology, etc.). This would allow FPIA to increase technical assistance for program design and implementation as well as medical technical assistance.

Subproject Continuation

17. Procedures in the project design phase need strengthening to maximize the likelihood that terminated projects will continue to be successful family planning service providers.
18. While continuing to seek relative self-sufficiency, sub-projects should place appropriate emphasis on additional aspects of strategic program planning.
19. Perhaps a category of partial termination should be considered where support is limited to continuing technical assistance, e.g., training, journals, consultations and/or commodities, with reduced financial support for other activities.

Commodity Assistance

20. AID and FPIA are encouraged to continue their careful review of commodity distribution in countries where availability of commodities may come to be a constraining factor in program implementation.

APPENDIX A

Persons Visited in New York City

PLANNED PARENTHOOD FEDERATION OF AMERICA (PPFA)

Faye Wattleton President, Planned Parenthood Federation
of America (PPFA)

Louise L. Tyrer, M.D. Vice President, Medical Affairs (PPFA)

INTERNATIONAL DIVISION (FPIA)

Daniel R. Weintraub Vice President for International
Programs PPFA and FPIA Chief Operating
Officer (Administration)

Carol Klein Director of Project Management (Project
Management)

Miriam Inocencio Deputy Director of Project Management
(Project Management)

Fred D. Williams Director of Grants Management (Grants
Management)

H. McKinley Coffman Director of Logistical Services (Pro-
curement and Distribution)

Hans C. Groot Director of Special Projects (Special
Projects)

APPENDIX B
SUBPROJECTS VISITED

Appendix B

Subprojects Visited

William E. Bair

LATIN AMERICA

Mature Projects

Brazil-03 (\$615,119) Located in Rio. This project has two components. The CPAIMC component, funded since 1979, provides family planning services through one central clinic and over 40 community sites. Negotiations are underway to phase out funding to this component at the end of the funding period. The ABEPF component was added in May 1984 to fund family planning clinics throughout Brazil. This component may split off and be funded as a separate program.

Peru-06 (\$58,322) Located in Lima. This project has been funded since November 1973, and is due to be taken over by the USAID Mission as of January 1986. Through its physician training component, emphasizing training in sterilization, the project assures that physicians can provide family planning services in rural/marginal areas. The grantee agency has been influential in promoting acceptance of family planning by individuals and government officials in Peru.

Developing Project

Peru-18 (\$40,330) Located in Lima. This project, funded since July 1981, recently expanded its CBD services to include distribution in three cities outside Lima using techniques developed and found to be effective in the "pueblos jovenes."

New Projects

Brazil-09 (\$153,295) Located in Belo Horizonte, this project has been funded since February 1983. The project provides services in health posts and is exploring the possibility of expanding services throughout Minas Gerais State.

Mexico-25 (\$730,939) Located in Ciudad Juarez, this project has been funded since October 1983. This innovative "umbrella" project is becoming a model for the transfer of family planning technology from nationals to other nationals. Each of the agencies funded by the project provides family planning services through a CBD program supported by the clinic.

Elizabeth Prehle

AFRICA

Mature Projects

Kenya-09 (\$47,559) Located in Chogoria, Meru Province. This project, funded since May 1983, is well known as one of the most effective family planning service providers in Kenya. Services are provided through 25 static service delivery points and six mobile clinics, a young adult program, and CBD activities. Based on preliminary results of a recent CDC Evaluation, approximately 30% of all eligible women in the area are now active users. The project is currently conducting a community survey to pinpoint areas of highest unmet need.

Kenya-06 (\$128,647) Located in Mombasa, this project has been funded since February 1981. Because of the high quality services and the culturally appropriate approach to family planning the demand for services, including voluntary sterilizations, has greatly increased.

Developing Projects

Zambia-02 (\$56,110) Located in Lusaka. The grantee agency was established ten years ago and FPIA funds have been provided since January 1981. This project's success has been partly attributed to the willingness of the staff to utilize innovative approaches in program implementation. An aggressive IEC campaign was conducted through the mass media and clinic staff visited both private and government clinics in the area to provide IEC and family planning services. Currently CBD services are provided in four peri-urban areas of Lusaka and Kabwe Rural through 22 service delivery points and training centers.

New Projects

Zambia-04 (\$134,508) Located in Lusaka, this project has been funded since December 1984. This project is expected to upgrade and complement the MOH's efforts to provide MOH/FP services by providing training to doctors, registered nurses and nurse midwives and by strengthening the contraceptive logistics system.

Zambia-05 (\$80,584) Located in Lusaka, this project has been funded since May 1985. It is expected that through this project the Pharmaceutical Society of Zambia will ensure the continuous availability of condoms in private and parastatal pharmacies at a lower cost to the consumer. Condoms will be distributed through 40 retail outlets in Lusaka and Kitwe.

Barbara Janowitz

AFRICA (cont'd)

Mature Projects

Sierra Leone-05 (\$51,420) Located in Freetown, this project has been funded since December 1978. This project has an extensive IEC and counselling program in Freetown and five provincial towns, reaching educational institutions and community associations, and a CBD component which introduced community-based distribution of oral contraceptives for the first time in Sierra Leone.

Developing Projects

Nigeria-10 (\$50,249) Located in Oyo State, this project has been funded since October 1982. IEC and family planning services, including voluntary sterilization, are provided in a hospital in Ogbomosho and in six villages. Project activities also include sexuality education courses in secondary schools and teacher training colleges. The state government has informed the project it will not be able to provide the expected financial assistance.

New Projects

Nigeria-13 (\$60,096) Located in Lagos State. This project has been funded since March 1985. This one-year project will enhance the grantee agency's capability to provide family planning services by training health professionals and village health workers. The expansion of services will be facilitated by a pilot CBD program.

Nigeria-18 (\$45,049) Located in Lagos. This project has been funded since June 1985. The chronic shortages of pills and condoms in Nigeria will be additionally alleviated through the distribution of pills and condoms through retail pharmaceutical outlets in eleven states of Southern Nigeria. Contraceptives will be distributed through the established Sterling Products logistics network. This project will also introduce family planning services in several company clinics.

Katherine Cameron

AFRICA (cont'd)

Mature Projects

Egypt-02 (\$97,984) Located in Cairo, this project has been funded since September 1975. This project continues to provide family planning services through its community development program. The villages where FP services have been established have become quasi-self-supporting in a period of three years, allowing the project to begin services in new villages. The project's records indicate that close monitoring of the village activities has produced continuation rates of approximately 80%.

Egypt-07 (\$428,883) Located in Cairo, this project has been funded since October 1975. This project has successfully incorporated family planning services into the diocese programs. Services, which were initially provided through a CBD program and later through a network of clinics, are utilized by both Christian and Muslim clients.

Developing Projects

Sudan-02 (\$60,141) Located in Khartoum, this project has been funded since February 1982. In spite of the extreme poverty of the Hag Yousif area served, the local community provides a clinic at low costs. Combined IEC, clinic, and CBD activities have overcome many of the cultural, educational, and religious barriers to accepting family planning.

New Projects

Sudan-03 (\$105,312) Located in Omdurman, this project has been funded since August 1984. The project has been designed to improve commodities distribution and management through a more effective distribution and inventory system and through the training of MOH logistics staff. Services will begin in four provinces and additional provinces will be added each succeeding year. An FPIA consultant assisted the project with the development of a logistics system and storekeepers handbook.

Dr. Hugh R. Holtrop

ASIA

Mature Projects

Bangladesh-28 (\$496,120) Located in Dhaka, this project has been funded since May 1979. The project's field workers provide family planning services through CBD in various districts of Bangladesh. They have effectively implemented a system to phase out of some areas, turning them over to the Government of Bangladesh field workers, so as to initiate services in new areas.

Bangladesh-18 (\$128,345) Located in Dhaka, this project has been funded since February 1979. This project provides subgrants and training to indigenous PVOs in Bangladesh, enabling them to provide CBD family planning services. The projects has oriented staff of other projects in the Asia Region, contributing to the establishment of similar "umbrella" projects in Sri Lanka and Thailand.

Bangladesh-24 (\$91,043) Located in Dhaka. This project has been funded since October 1980 (FPIA funded this grantee previously from January 1976 to September 1980 as Bangladesh-04). Concerned Women for Family Planning (CWFP) provides family planning and MCH services through CBD (door-to-door) visits in Dhaka and surrounding slum areas, through family planning in health centers, and through branches throughout Bangladesh. Its training center trains field workers from several organizations. Support comes primarily from three donors: FPIA, the Ford Foundation, and The Asia Foundation.

Thailand-08 (\$363,586) Based in Bangkok, this project has been funded since October 1977. Continuing its subsidy reimbursement scheme for voluntary sterilizations carried out at private medical institutions, this project is testing a new micro-project concept this year to enable selected clinics to manage the provision of sterilization services in a larger area.

Developing Projects

Indonesia-18 (\$177,521) Located in Jakarta, this project has been funded since December 1981. The project, which administers and provides subsidy payments for hospitals that provide sterilization services, has developed management systems that will enable them to absorb and oversee the implementation of FPIA's other sterilization programs in Indonesia.

Indonesia-22 (\$78,725) Located in Jakarta. This project has been funded since January 1984, supporting the provision of family planning services in five universities in Indonesia. It is currently in the process of decentralization in moving towards establishing each university program as a separate sub-project.

New Projects

Thailand-19 (\$86,967) Based in Bangkok, this project has been funded since February 1985. This "umbrella" project is overseeing the implementation of eight CBD projects with indigenous community organizations in 10 provinces in Southern Thailand. The design of this project was based on Bangladesh-18.

APPENDIX C
FPIA EVALUATION -- GENERAL QUESTIONS

APPENDIX C

FPIA EVALUATION - GENERAL QUESTIONS

1. In selecting projects does FPIA seek out innovative pioneering programs in challenging settings? By contrast, what proportion of projects are easily executed: for example, those in middle income countries and/or metropolitan areas?
2. Is the technical assistance provided by FPIA appropriate to host country project needs? Do family planning services receive adequate technical assistance? Or are they overshadowed by a concern with management? Is there enough medical backstopping provided to the field?
3. What is the nature of FPIA's own evaluation system? How much is needed? How much effort goes into it? Are outside consultants used? Is it adequately quantitative? Should measures of program input involve, for example, couple years of protection, commodity data, etc.?
4. How well does FPIA use staff in New York and regional offices? Are their qualifications appropriate for project development, management technical assistance, and service delivery techniques?
5. Does the FPIA system make adequate provision to enhance the chances of projects to remain in existence after FPIA support has ended? Does FPIA provide any technical assistance, commodities or evaluation to terminated projects?
6. How does the FPIA commodity assistance program fit in with the larger commodity objectives of AID and the needs of the field?
7. How is the existence of buy-ins to the basic project affecting FPIA's program?
8. What is FPIA's role in supporting family planning associations that are part of IPPF's system?
9. What are the policy implications of FPIA-supported programs, including commodity systems? How are lessons learned communicated to the population community? How much coordination is there with other programs?
10. What progress has there been since previous evaluations?

APPENDIX D

FPIA EVALUATION -- QUESTIONS FOR SITE VISITS

APPENDIX D

FPIA EVALUATION - QUESTIONS FOR SITE VISITS

I. Broad Issues

1. How and why was this project selected?
2. What are the objectives of this project?
3. Are the objectives of this project appropriate to host country needs?
4. Are the objectives of this project appropriate to AID objectives and strategy (discuss with AID)?
5. Is this project breaking new ground and if so, what are the policy implications?
6. What plans exist for continuation of the project when FPIA support ceases?
7. Does this project include income generating activities and if so what are their nature?

II. Issues Relating to Implementations

Please make observations on the following topics:

1. Project Design - is there evidence of long term advance planning and/or regions/coordination.
2. Number and Quality of Staff
3. Information Services Including Outreach Activities
4. Are Training and Technical Assistance needs for Administration/Management and Program delivery being met?
5. Administration and Management - are there problems?
6. Quality of Services - do staff have up-to-date information on service delivery techniques, contraceptive technology, etc. If sterilization is included is PD-3 adhered to?
7. Evaluation Activities Including Use of Service Statistics and Feedback to Implement Needed Improvements
8. Cost Data Including Calculations of Cost Per Client Served
9. Income Generating Components
10. Commodities and Logistics
11. Progress in meeting objectives: e.g., Contraceptive Prevalence - how much results from the project?

APPENDIX E
PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: 1981 to 1982
Family: A1
Total US Funding: \$73,150,000
Date Prepared: 7/25/82

Planned Parenthood Federation of America/

Project Title & Number: Family Planning International Assistance (PFIA/PIA) - 110-0155

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The immediate objective to which this project contributes:</p> <p>Reduce the freedom of individuals to decrease voluntarily the number and spacing of children and encourage population growth consistent with the growth of economic resources/productivity</p>	<p>Measures of Goal Achievement:</p> <p>Change in age-specific fertility rates in developing countries</p>	<p>1) Family Planning Program data 2) Census data 3) Sample Surveys 4) Vital Registration data</p>	<p>Assumptions for achieving goal target:</p> <p>Individuals and couples should be able to decide freely the size of their families and, Voluntary Family Planning Programs are needed and wanted by citizens of the Third World</p>
<p>Project Purpose:</p> <p>Introduce and/or extend the availability of family planning services throughout existing medical social and welfare programs in less developed countries</p>	<p>Conditions that will indicate purpose has been achieved: End of project status:</p> <ul style="list-style-type: none"> ■ LDC organizations/institutions have assumed increased leadership and financial responsibility for their own Population/FP Programs. ■ Family Planning information and services being provided by indigenous organizations/institutions in 70-100 LDC's. 	<p>1) Subproject Reports/Evaluations 2) On-site inspections of sub-grantee projects 3) Verification of contraceptive availability and prevalence</p>	<p>Assumptions for achieving purpose:</p> <p>Provision of limited commodity, financial and/or technical assistance to LDC agencies/institutions will stimulate development of family planning leadership, FP infrastructure and efficient and effective service programs in the developing countries.</p>
<p>Outputs:</p> <p>1) FP commodities distributed to men and women in 50 to 60 LDC's. 2) FP Clinic (CB), and VS projects undertaken in 30-40 LDC's. 3) Womens and adolescents project in 18 to 24 LDC's 4) FP training projects in 5 LDC's 5) I.E.C projects in 3-5 LDC's 6) Management and program-related technical assistance provided to LDC subgrantees</p>	<p>Measures of Outputs:</p> <p>1) 120,000,000 oral contraceptives; 375,000,000 pieces of condoms and 45.5 million of related FP equipment distributed thru local FP agencies. 2) 25 FP/HPH clinics; 35 CB and 10 VS Service projects. 3) 5-15 I.E.C projects implemented thru womens organizations 4) 1-5 adolescent projects 5) 10 training projects for 200 physicians; 1000 paraprofessionals and 15 managers of FP projects. 6) 5,000 person days TA provided mostly by Third World Consult.</p>	<p>1) Grantee financial, commodity and program reports 2) On-site inspections by independent evaluators, USAID and Embassy Population Officers and/or AID/W staff.</p>	<p>Assumptions for achieving outputs:</p> <p>Host governments/US country Missions will sanction project activities. Host country institutions & agencies will develop leadership and management for sustaining FP services after phase-out of Grantee funding assistance</p>
		<p>1) P/O/T's 2) Evaluations 3) Financial and Program reports 4) Vouchers 5) Travel records</p>	<p>Assumptions for providing inputs:</p> <p>Grantee has demonstrated capacity to carry out work Funds will be available for project implementation Other donor support not available for project activity</p>

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APPENDIX F
STRATEGIC PLAN SUMMARY OF PROGRESS

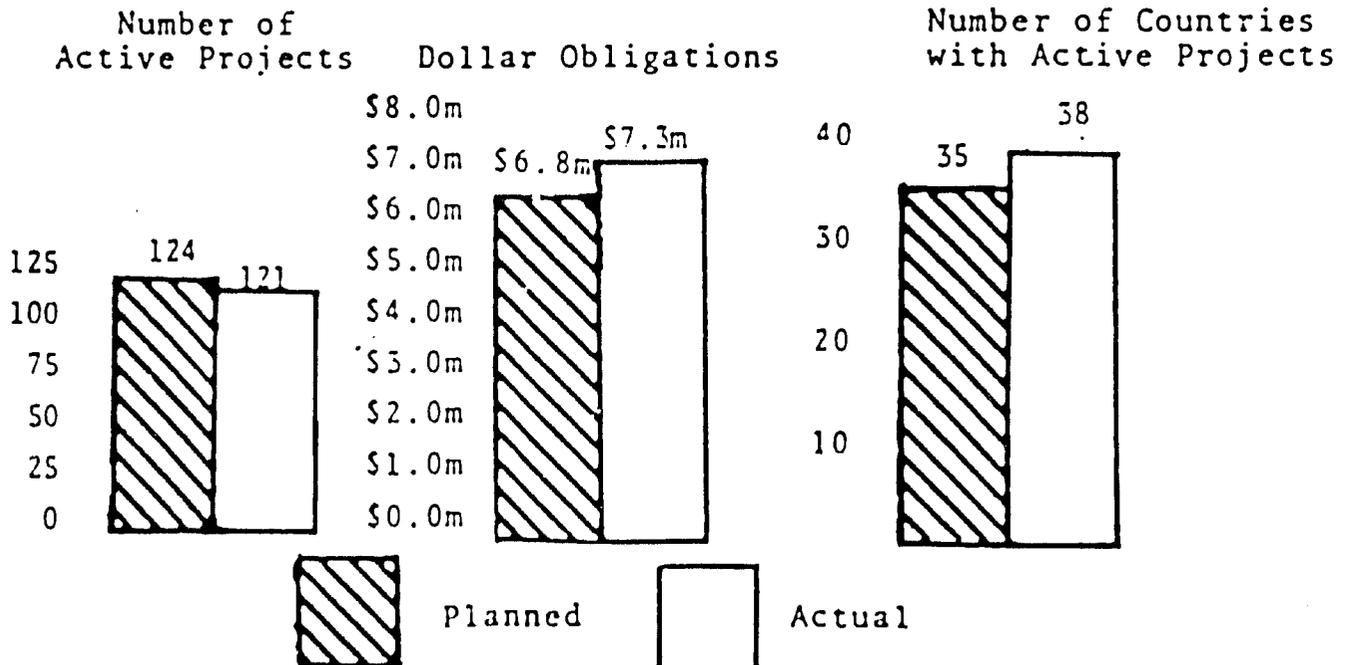
II. STRATEGIC PLAN SUMMARY OF PROGRESS

The objectives in the FPIA 1984-1986 strategic plan relate to the planned stage of development as of 31 December 1986. Most are three year, cumulative objectives. With some exceptions, annual objectives for each of the three years involved were not shown. Nevertheless, each FPIA region developed annual objectives which, in aggregate, contributed to the whole.

Subsequent to the publication of the strategic plan, and in accordance with the development of PPFA's 1984 national headquarters plan, FPIA staff used base data from the strategic plan to develop annual benchmarks of performance. Performance data described in this section of the report are based on preliminary computer runs. Final data, which will be included in FPIA's Annual Report, however, are not expected to differ significantly.

A. Project Development: FPIA generally met or surpassed its planned performance in three key areas (number of active projects, dollar obligations, countries with active projects). As can be seen in Chart 1, 124 active projects were planned for 1984; 121 actually were implemented. Against planned project obligations of \$6,803,186, a total of \$7,305,862 actually was obligated. There were 38 countries with active, FPIA-assisted projects against a planned total of 35.

Chart 1. Project Development: Planned Vs. Actual Performance



It is of interest to note that as of 31 December 1984, an additional \$50,954 of projects had been approved by AID but not yet been obligated by FPIA. More significant, AID was processing approvals for an additional \$1,375,834 of project proposals previously submitted by FPIA, and FPIA was processing \$1,494,568 of proposals for submission to AID. Had some or all of these proposals been approved, 1984 dollar obligations would have been significantly higher. Additionally, the lack of such approvals, and subsequent obligations during 1984, affected the regional geographic distribution of project obligations.

Funding distribution by geographic region is affected by the timing of proposal submission and approval, duration of projects and fluctuations of local currencies against the U.S. dollar. FPIA's objective, during 1984-1986, is to decrease the percentage of funding going to Asia, and to increase the percentage going to Africa and Latin America. More important than the actual percentages themselves, however, are the directions they represent. As can be seen from the following table, FPIA followed its general plan. Furthermore, had the proposals previously mentioned (approved/not obligated, at AID/Washington, being processed in New York) been obligated during 1984, the actual percent distribution by geographic region would have been much closer to the planned percentages.

Table 1. Geographic Distribution of Project Obligations
Planned Vs. Actual Performance*

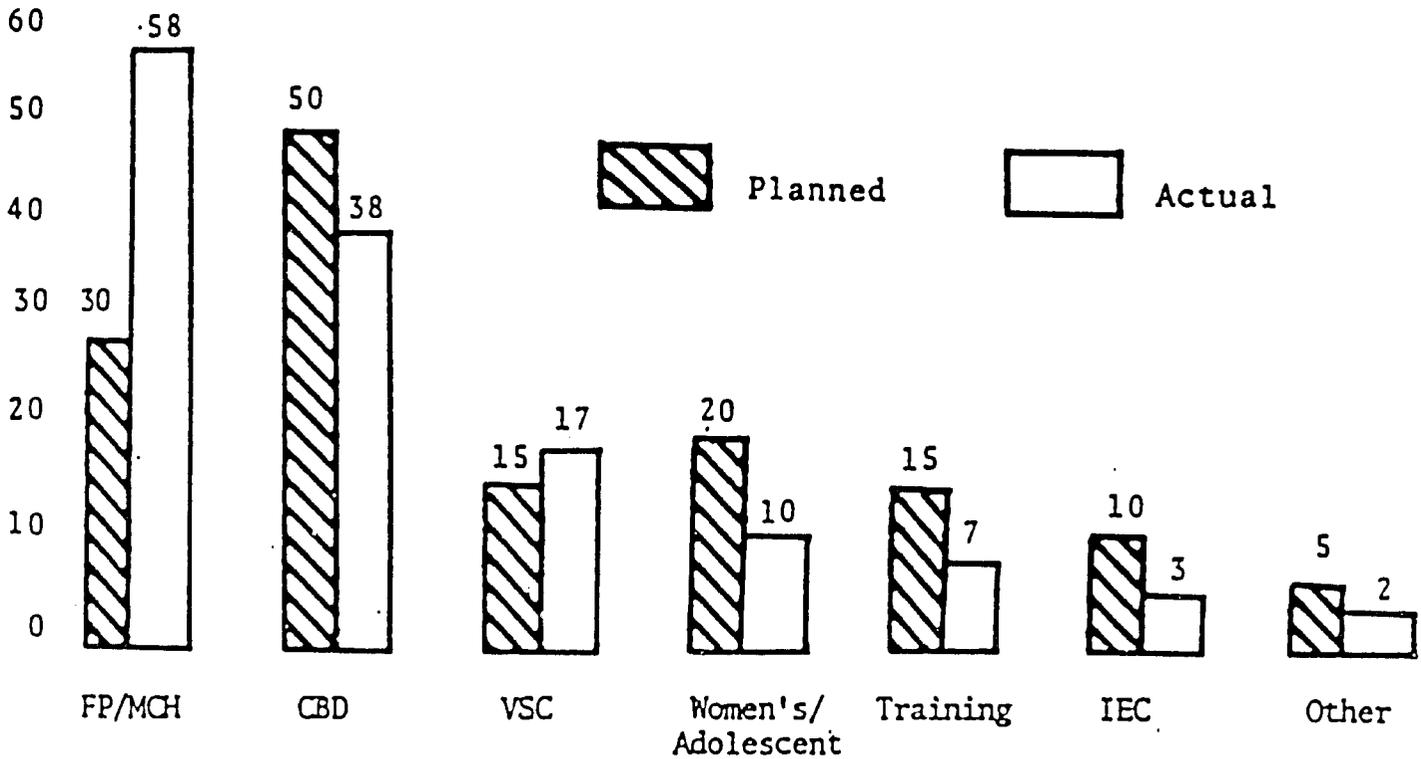
	1984 Dollar Obligations		Percent Distribution	
	<u>Planned</u>	<u>Actual</u>	<u>Planned</u>	<u>Actual</u>
Africa (ARO)	\$2,076,342	\$2,539,667 (+22.3%)	31	36
Asia & Pacific (APRO)	2,328,228	1,418,908 (-39.1%)	34	20
Latin America (LARO)	2,398,636	3,072,805 (+28.1%)	35	44
FPIA/Headquarters	-	266,613	--	--

FPIA's strategic plan calls for the development, by 31 December 1986, of 30 family planning/maternal child health (FP/MCH) clinic projects, 50 community-based distribution (CBD) and 15 voluntary surgical contraception (VSC) projects, 20 adolescent and/or women's projects, 15 training projects, 10 information, education and communication (IEC) projects and 5 other, including commodity logistics, natural family planning and other types of projects. The actual 1984 numbers, in some cases, already exceed the cumulative objective totals. In other cases, they indicate numbers/types of projects that still need to be developed in 1985-1986. The following chart shows 1984 actual against 1984-1986 planned performance. Because many projects can be classified in more than one category, the total exceeds the number of active projects during 1984.

* Percent distributions exclude headquarters obligations.

JK

Chart 2. Type of Project: Planned Vs. Actual Performance



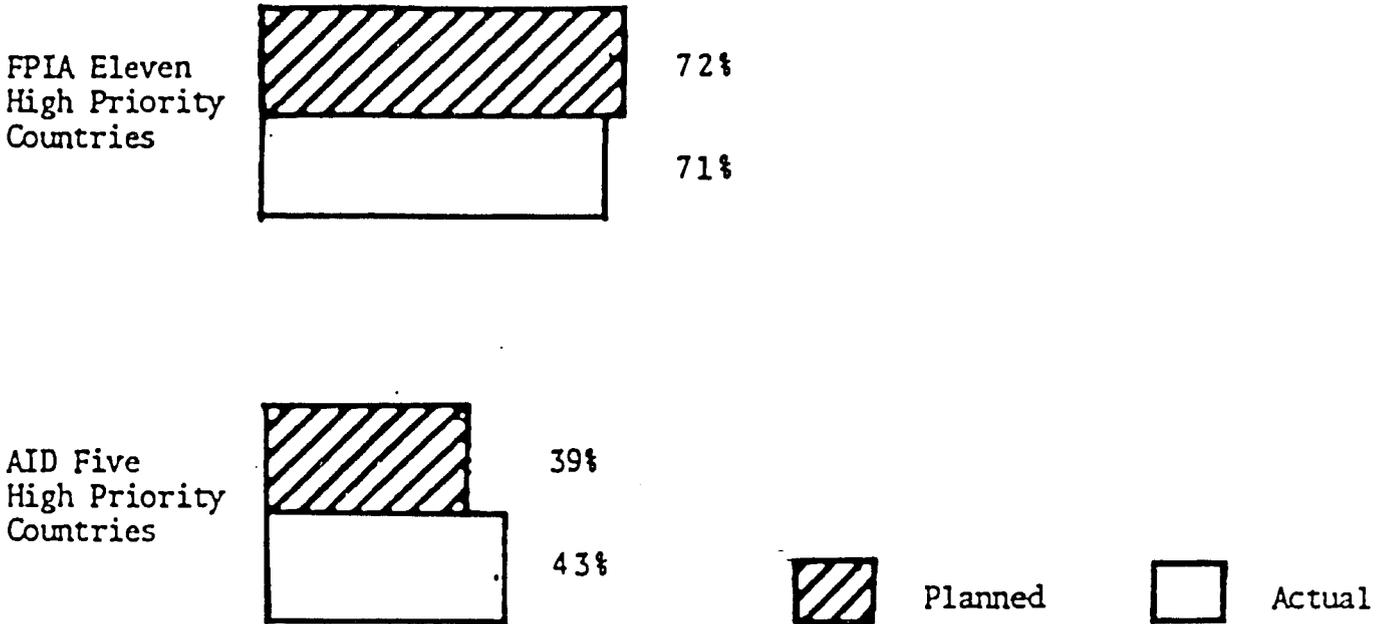
The FPIA strategic plan prioritized countries as high, medium or low. Goals were set for high priority countries and monitored as follows:

- 72% of 1984 subgrant obligations were to go to 11 high priority countries (Bangladesh, Brazil, Egypt, India, Indonesia, Kenya, Mexico, Nepal, Nigeria, Thailand and Turkey)
- 39% of 1984 subgrant obligations were to go to five countries in which AID does not have a bilateral program (Brazil, Colombia, Mexico, Nigeria and Turkey).

As can be seen in the following chart, FPIA generally met or exceeded its planned objective.

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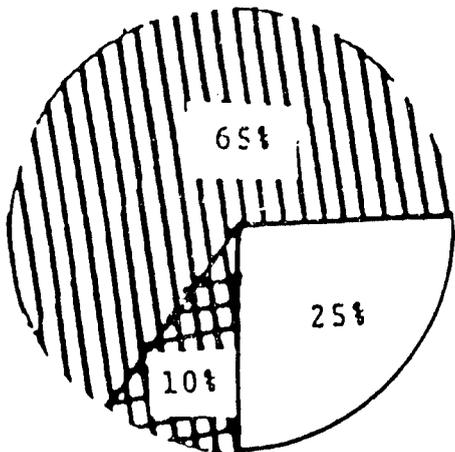
Chart 3. Priority Country Obligations: Planned Vs. Actual Performance



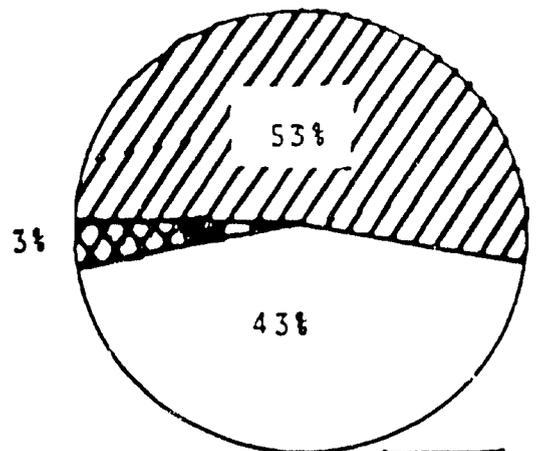
The FPIA strategic plan calls for allocation of project funds by size of obligation. The objective, by the end of 1986, is to have 25% of projects funded at less than \$50,000, 65% at \$50,000-\$299,999 and 10% at \$300,000 or more. Actual 1984 percentages, shown in the following chart, show a higher than called for percentage of smaller projects, and lower than called for percentages of medium-sized and larger projects.

Chart 4. Project Obligations by Project Size: Actual Vs. Planned Performance

Planned 1984-1986 Percentage Distribution



Actual 1984 Percentage Distribution



small

medium

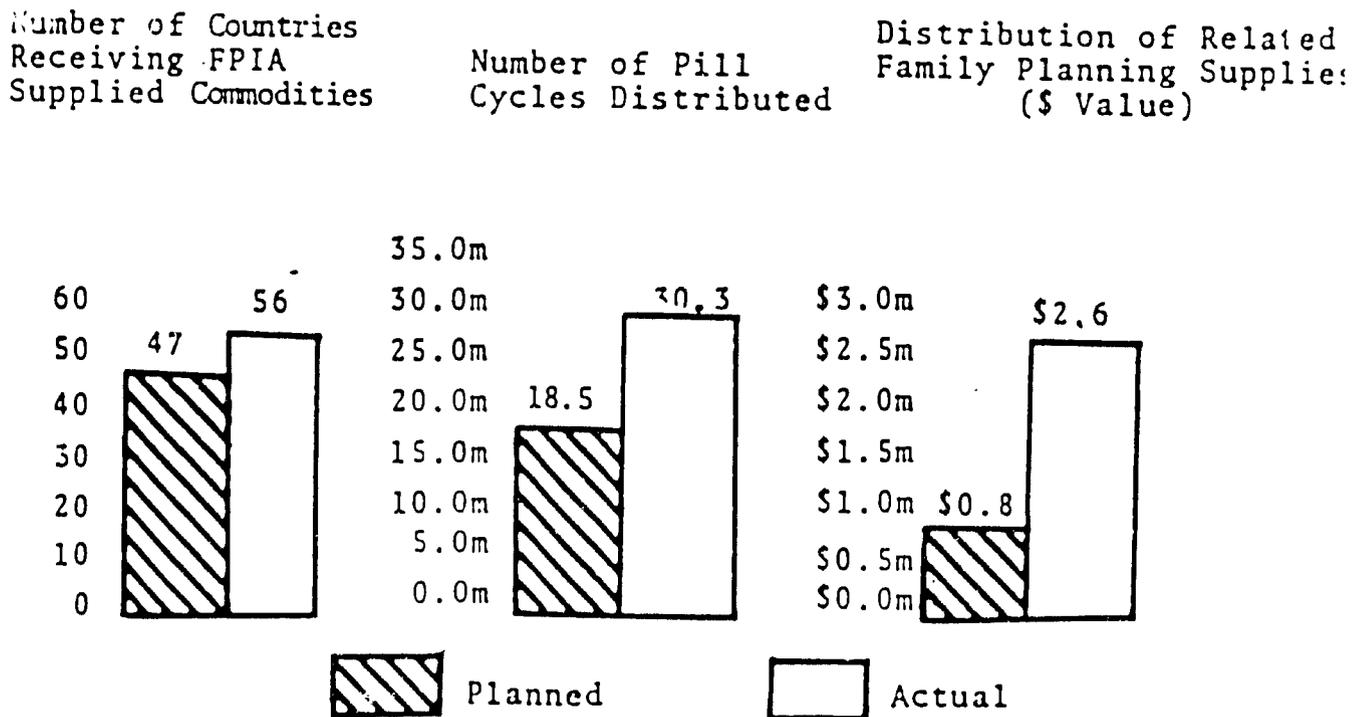
large

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FPIA's strategic plan called for service to 1,100,000 contraceptive clients in 1984. Actual service data, obtained through a survey and comparison with project progress reports, will not be available until late 1985. Based on active project objectives (taken from project proposals), however, a total of 1,218,258 clients were expected to be served during 1984. The performance of projects funded by FPIA during 1983, according to the recently published results of the 1984 survey, included 1,058,266 contraceptive clients.

B. Commodities: As can be seen from the following chart, FPIA surpassed its planned performance in three key areas (number of countries receiving FPIA commodities, distribution of oral contraceptives and distribution of related family planning supplies). The actual number of countries in which FPIA distributed commodities during 1984 totaled 56 against a planned total of 47. Oral contraceptive distribution in 1984 totaled 30,268,200 pill cycles and the dollar value of the distribution of related family planning commodities (contraceptives excluding pills and condoms, medical kits/equipment, films/literature, audiovisual equipment, other) equalled \$2,631,599. The 1984 planned totals were 18.5 million pill cycles and \$825,000, respectively.

Chart 5. Commodity Distribution: Planned Vs. Actual Performance



With regard to the distribution of condoms, the 1984 objective was 68.0 million pieces. Actual distribution totaled 57,222,400, about 16 percent lower than planned. The strategic plan also called for the distribution of contraceptive commodities to 75 new institutions (excluding FPIA-funded projects and AID-initiated shipments). The actual number of new institutions receiving contraceptives from FPIA during 1984 was 63.

- C. Technical Assistance: The strategic plan called for FPIA to increase its capacity to provide a minimum of 1,000 days of technical assistance to its subgrantees during 1984. This was to be accomplished by: a) hiring a New York-based Technical Specialist to provide assistance to projects; b) using New York staff to provide technical assistance in areas of their expertise; and c) disseminating, from FPIA/New York, improved management information. The actual number of technical assistance days provided by FPIA staff to projects during 1984 totaled 1,674, 67.4% higher than the planned total. New York staff provided technical assistance in commodity logistics, management, medical review, project development, audit and evaluation. A New York-based Technical Specialist was hired, and the purchase of personal computers began to result in significantly improved management information.

The strategic plan also called for the production, by 31 December 1986, of three manuals (Grantee Technical Assistance, Medical Practices, Income Generation). During 1984, a two volume medical practices manual was produced. Preliminary work also began with regard to the other manuals.

Finally, the strategic plan called for the use of consultants (U.S. and Third World) and the provision of training to regional office staff. During 1984, six consultants (four U.S. and two Third World) were used. These consultants evaluated private sector agencies in Lagos (Nigeria), evaluated Bangladesh-18, Egypt-03, Kenya-04 and Liberia-04, and assisted in the Sudan-03 training. Seven FPIA staff, from the New York and regional offices, attended training courses dealing with supervisory management skills, financial management, project management and communications. Regional office training was conducted by a number of New York-based staff, both in New York and overseas. Training subjects in regional offices included: terms and conditions, reporting instructions, acceptor recording, start-up visits, proposal preparation, RIT procedures, consultant procedures, income generation, disbursements, checklisting and report analysis. Additionally, 10 regional FPIA staff received training/orientation at FPIA/New York.

- D. Evaluation: The FPIA 1984-1986 strategic plan calls for 13 project evaluations. Seven actually were conducted during 1984. The evaluations included Peru-09, Swaziland-01, Bangladesh-19 and Sudan-03 (community-based distribution), Kenya-04 and Liberia-04 (clinic/maternal child health) and Egypt-03 (training/information, education, communication).
- E. Other: Over the three year period, the strategic plan calls for the development of strategies which will result in grants for project activities from sources other than AID/Washington. During 1984, FPIA successfully negotiated, with USAID/Bangladesh, a \$600,000 add-on to its Cooperative Agreement.

A proposal was drafted (but not submitted) to NORAD. Proposals also were submitted to a number of foundations and corporations. As a result, PPFA/FPIA was able to obtain an in-kind donation (valued at \$850,000) of pregnancy test kits. Additionally, for 1985, FPIA's non-AID budget was increased by \$100,000. PPFA's Resource Division will assign a full-time fundraiser to international programs and an international sub-committee of the PPFA Board Resources Committee is being formed. Discussions also were held with regard to further add-ons to the Cooperative Agreement (e.g., Zambia, Sahel and Egypt).

APPENDIX G

**ISSUES HANDLED BY FPIA MEDICAL DIRECTOR
17 MAY 1983-31 OCTOBER 1985**

APPENDIX G

Issues Handled by FPIA Medical Director
17 May 1983 - 31 October 1985

Africa Regional Office

- 1) Cameroun-01
 - Physician CV approved for VS, June 1983.

- 2) Kenya-06
 - Laprocator policy of FPIA, and reason for difference in FPIA and JHPIEGO policy, explained in letter to Dr. Rajahyaksha/JHPIEGO October 1983.
 - Physicians CVs approved July 1984, June 1985.
 - Sterilization complication report analyzed.

- 3) Kenya-08
 - Physicians' CVs approved for VS, July 1983, January 1984, February 1985, May 1985, June 1985.

- 4) Kenya-09
 - Responded to grantee questions on pregnancies and infection with IUD and X-ray evaluation of IUD; responded to grantee question on injectable contraceptives. November 1984.
 - Sterilization complication report (pregnancy) analyzed, July 1985.
 - Physician CVs approved June 1985

- 5) Lesotho-02
 - Sterilization Protocol approved August 1983
 - Bulletin on Anesthesia, AVS, sent October 1983

- 6) Nigeria-04
 - Responded to grantee question on IUD 'fittings', May 10.
 - Approved physician and protocol for sterilization, June 1985.
 - IUD Training protocol approved October 1985.
 - Sent information on Chlamydia and AIDS.

- 7) Nigeria-10
 - Sterilization protocol reviewed and questioned; revised based on additional information, July 1983.
 - Physician CVs approved, with additional information, July 1983.
 - Information on health benefits of oral contraceptives and increased risk of infertility and PID with use of IUD sent, Sept. 1985.

Africa Regional Office (cont'd)

- 8) Senegal-02
 - IUD Training protocol approved, October 1985.

- 9) Sierra Leone-04
 - Sterilization Protocol approved, August 1983.

- 10) Tanzania-05
 - Sterilization protocol, revised according to FPIA requirements, approved, October 1983.
 - Physician CVs approved, April 1984.

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Asia and Pacific Regional Office

- 1) Bangladesh-25
 - Sterilization protocol approved, June 1983.
- 2) India-02
 - Sterilization protocol reviewed, approved, based on additional requested information, November 1983.
 - IUD training protocol approved, June 1984
- 3) Indonesia-12
 - Sterilization protocol reviewed; revised protocol approved, July 1983.
 - Bethesda Hospital prohibited from receiving reimbursements for vasectomies due to non compliance, October 1984.
- 4) Indonesia-18
 - Sterilization protocol discussed with project physicians, November 1984; protocol approved, March 1985.
 - Documentation on sterilization related death analyzed, February 1985.
 - Documentation on sterilization complications (pregnancy) analyzed, August 1985.
- 5) Indonesia-19
 - Sterilization protocol approved, March 1985.
- 6) Indonesia-20
 - Sterilization protocol approved, March 1985.
- 7) Nepal-05
 - Documentation on sterilization related death (referral project) analyzed, August 1985.
- 8) Philippines-34
 - Sterilization protocol reviewed and required changes transmitted to grantee, 1984.
- 9) Sri Lanka-09
 - Vasectomy protocol revisions received and approved, February 1985.
 - Sterilization complication report (referral project) analyzed, June 1985.

Asia and Pacific Regional Office (cont'd)

10) Thailand-08

- Follow up criteria required for special one-day vasectomy program, September 1983.
- Sterilization protocol reviewed; revised protocol approved.

11) Thailand-14

- Sterilization protocol reviewed, approved, based on additional information, August 1983.

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Regional Offices

1. Supplies and Equipment List for minilap procedures, as approved by Dr. Tyrer, the PPFA National Medical Committee, Dr. Douglas Huber, AVS, and the AVS Science Committee, sent to all Regional Offices, June 1983.
2. New information from AID on Copper containing IUDs sent to all Regional Offices, June 1983.
3. IUD Management articles in French and Spanish forwarded to ARO and LARO, June 1983.
4. Revised standardized CV format for physicians doing sterilization sent to all regions; September 1983, May 1984.
5. Meeting held in NY with all Regional Directors to review FPIA medical standards and guidelines, November 1983. Topics discussed: Sterilization protocols; Fifth International Conference on VSC, Dominican Republic; IUD training requirements; meeting with grantees and AID Mission personnel. Information distributed: Facts about Female Sterilization; Facts about Vasectomy; Memo of October 31, 1983 covering (1) Lancet Articles on the Pill and Cancer; (2) NICHD Bulletin on the Pill and Cancer; (3) Removal of Dalkon Shield; (4) FDA Drug Bulletin; Memo of October 26, 1983 on National Medical Committee Comments on Lancet Studies on the Pill and Cancer.
6. Memo sent to regional offices recommending size B Lippes Loops for Nursing Women, March 1984.
7. FPIA Medical Manual distributed to all regional offices, June 1984.
8. Information on TCU 380A sent to all Regional Offices, December 1984.
9. Voluntary Surgical Sterilization and Training pamphlet sent to all regional offices. Distributed by regional offices to projects with sterilization components.
10. Responded to Government of Kenya and USAID concern about safety of Noriday 1/50 oral contraceptives; February 1985. Letter on same subject sent to W.H.O. advisor.

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Latin America Regional Office

- 1) Brazil-04
 - CVs approved, April 1984.
 - Sterilization protocol approved.

- 2) Brazil-05
 - IUD Training Protocol reviewed; revised protocol approved, October 1985.

- 3) Brazil-10
 - IUD Training Protocol approved, June 1985.

- 4) Brazil-13
 - IUD Training Protocol approved, October 1985.
 - Sterilization protocol reviewed; revised protocol approved, October 1985.
 - Physician CVs approved.

- 5) Dominican Republic-04
 - IUD Training Protocol, revised to meet FPIA standards, approved for use with Resident Physicians and Nurses Aides, October 1983.
 - Required changes in Training Manual for Auxiliaries incorporated and manual approved, March 1985.

- 6) Ecuador-05
 - Responded (affirmatively) to question on greater efficacy of IUD when used with foam, March 1985.
 - IUD Training Protocol approved, February 1985.

- 7) Mexico-23
 - Physician CVs approved, May 1985.

- 8) Peru-06
 - Sterilization protocol reviewed and questioned; revised protocol approved, January 1984.
 - IUD Training Protocol, based on required changes approved, February 1985.

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APPENDIX H

MEDICAL PERSONNEL FROM FPIA PROJECTS ATTENDING
MEDICAL CONFERENCES AND TRAINING PROGRAMS
17 MAY 1983-31 OCTOBER 1985

APPENDIX H

Medical Personnel from FPIA Projects
attending
Medical Conferences and Training Programs
17 May 1983 - 31 October 1985

Conferences

1) IFFIP Third International Congress and Third General Assembly,
Hongkong, 11/83

Dr. James Ferguson
Lifeline (Papua New Guinea-04)

Dr. Somsak Varakamin
MOH (Thailand-15)

Fifth International Conference on Voluntary Surgical Contraception,
Santo Domingo, Dominican Republic, 12/83

Included meeting with Dr. Louise B. Tyrer, PPFA
Vice President for Medical Affairs, to review FPIA
requirements and guidelines for sterilization projects.

Dr. Helio Aguinaga
CPALMC (Brazil-03)

Dr. Walter Rodriguez
BEMFAM (Brazil-05)

Dr. Jean Calvin Debong
Hospital de Djoungolo (Cameroun-01)

Dr. Miguel Trais
PROFAMILIA (Colombia-05)

Dr. Ramon Portes Carrasco
CONAPOFA (Dominican Republic-04)

Dr. Sukant Singh
CMAI (India-02)

Dr. Azrul Azwar
PKMI (Indonesia-18)

Dr. Oilly Mesach
DGI (Indonesia-12)

- Dr. Guno Samekto
Bethesda Hospital (Indonesia-18)
- Dr. Sudraji Sumapraja
PKMI (Indonesia-18)
- Dr. Mohamed H. Mohamed
Mkomani Clinic (Kenya-06)
- Dr. Manual Urbina Fuentes
Dr. Carlos Gonzales Westerman (Mexico-22)
- Dr. Christopher Adeoye
University of Ife (Nigeria-04)
- Dr. Sudesh Kapuria
Baptist Hospital (Nigeria-10)
- Dr. Carlos Munoz
National University of Trujillo (Peru-06)
- Dr. Carolina Gabriel
Ron-Carmel Hospital (Philippines-34)
- Dr. Yooth Bodharamik
ASIN (Thailand-08)
- Dr. Apichart Nirapathpongporn
PDA (Thailand-11)
- Dr. Vitoon Osathanondh
ASIN (Thailand-08)

XI Latin America Ob/Gyn Congress
Caracas, Venezuela, 10/84

- Dr. Maria Limailo
- Dr. Galo Calero
- Dr. Pilar Loor
- All from CEMOPLAF (Ecuador-04)

Sub-Sahara Africa Conference on Reproductive Health Management,
Freetown, Sierra Leone, 11/84 (Included meeting with
Dr. Louise B. Tyrer, PPFA)

Dr. Anjien Conteh
Nixon Methodist Hospital (Sierra Leone-04)

Mrs. Moola Mufaya
MOH (Zambia-04)

Mrs. Brigitte Thiombiano (Nurse - midwife)
Association of Nurse-Midwives (Burkina-01)

Courses/Training Programs

Management of Family Planning Training Programs,
University of California

Mrs. Brigitte Thiombiano, State Certified Nurse Midwife
Association of Nurse Midwives (Burkina-01)

Planning Management Systems for Program Coordination and
Control, University of North Carolina

Dr. Mohammed Ezzat Sakr
Al Azhar University (Egypt-05)

Family Planning and Reproductive Health Workshop,
Emory University, Atlanta, Georgia

Dr. S. O. Ayangade
Mrs. A.O. Oyetosho

both from Department of Ob/Gyn and Perinatology,
University of Ife, (Nigeria-04)

Nurse Practitioner Training Program,
Margaret Sanger Center, New York

Ms. Princess Nicole, Nurse
Sierra Leone Home Economics Association (Sierra Leone-01 and 05)

Ms. Mary Mwamba
Ms. Gilda C. Ngoma
Ms. M. Luhanga
Ms. A. Ngenda

All from MOH (Zambia-04)

APPENDIX I
MEDICAL TECHNICAL ASSISTANCE PROVIDED TO PROJECTS
EVALUATED

APPENDIX I

MEDICAL TECHNICAL ASSISTANCE PROVIDED TO PROJECTS
EVALUATED

Medical Technical Assistance Provided to Projects to be Evaluated (includes conferences, workshops, seminars attended by medical personal; on-site technical assistance; and materials provided).

NOTE: All projects receive direct mailing of the Population Report (Johns Hopkins University) and International Perspectives (Alan Guttmacher Institute).

1. Bangladesh-17 (-28):
 - CBD program. New position of Public Health Coordinator, requiring a physician, began 11/85.
 - 25 copies of Family Planning for Nurses and Midwives.
 - 25 copies of Procedure Manual for Nurs_s and Midwives.
2. Bangladesh-18:
 - No medical personnel. This umbrella project funds CBD subgrants.
 - 1 copy of Vasectomy Techniques (film).
3. Indonesia-18:
 - Five physicians, one nurse and two paramedics trained to perform VSS procedures.
 - Project Director attended BKKBN National Workshop.
 - Three physicians attended Fifth International Conference on Voluntary Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
 - On-site technical assistance visit made by Dr. Tyrer.
4. Indonesia-22:
 - Project Director, project manager and project coordinator attended: seminar on long acting progestins; annual meeting of the Society for the Advancement of Contraception.
 - Project Director attended seminar on infertility.
 - 5 Copies Intrauterine Contraception.
 - 5 copies IUDs: Current Perspectives.

5. Thailand-08:

- Project Director attended: W.H.O. Study Tour (Geneva); World Population Conference (Mexico City); Meeting on Thailand Contraceptive Prevalence Survey (Bangkok); and Ninth Asian and Oceanic Congress of Ob/Gyns (Secul, Korea).
- Project Director, deputy director, medical director and chief of public relations attended Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- Medical director attended meeting of the Expert Committee on Voluntary Surgical Contraception (Manila).
- 2 copies Minilaparotomy Techniques (film).
- 22 copies Minilaparotomy Techniques.
- 1 copy Training Manual for Surgical Sterilization.
- 75 copies Family Planning Handbook for Doctors.
- 1 copy Insertion and Removal of an IUD (film).

6. Thailand-19:

- This umbrella project, for development of subgrants, has one medical director, at 2.5% time.

7. Kenya-06:

- Project physician attended: Course on Management in Family Health and Family Planning (JHPIEGO, Baltimore); mini-lap training course; reproductive health courses; and Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- In-service mini-lap training lecture given by Dr. Tyrer.
- 1 copy Managing Contraceptive Pill Patients.
- 1 copy Managing Patients with IUDs.
- 2 copies Cervical and Vaginal Cytology.
- 2 copies Family Planning Handbook for Doctors.
- 2 copies Oral Contraceptives: A Guide for Programs & Clinics.
- 2 copies Intrauterine Contraception.
- 2 copies IUDs: Current Perspectives.
- 2 copies Vasectomy.
- 2 copies Minilaparotomy Techniques (film).

10. Zambia-04:

- Four nurse midwives attended Margaret Sanger Nurse Practitioner Course (New York).

11. Zambia-05:

- This condom distribution project has no medical staff.

12. Egypt-02:

- Eight midwives attended a training conference.
- 3 copies Casebook for Intrauterine Device.
- 5 copies Family Planning Handbook for Doctors.
- 2 copies Family Planning for Nurses and Midwives.
- 2 copies Cervical and Vaginal Cytology.
- 3 copies Intrauterine Contraception.
- 11 copies Contraceptive Technology.
- 3 copies Intrauterine Devices in Clinical Practice.
- 1 copy Managing Patients with IUDs.
- 1 copy Managing Contraceptive Pill Patients.

13. Egypt-01 (-07):

- Project Director attended seminar at Syracuse University (New York).
- Physicians and nurses attended training course.
- 1 copy Contraception Techniques (film).
- 5 copies Family Planning: A Teaching Guide for Nurses.
- 5 copies Casebook for Intrauterine Device.
- 5 copies Family Planning Handbook for Doctors.
- 5 copies Family Planning for Nurses and Midwives.
- 5 copies Cervical and Vaginal Cytology.
- 6 copies Intrauterine Contraception.
- 2 copies Contraceptive Technology.
- 1 copy Choosing a Contraceptive Method (slides).
- 5 copies Contraceptives (film).
- 1 copy Managing Patients with IUDs.
- 1 copy Managing Contraceptive Pill Patients.

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10. Zambia-04:
 - Four nurse midwives attended Margaret Sanger Nurse Practitioner Course (New York).
11. Zambia-05:
 - This condom distribution project has no medical staff.
12. Egypt-02:
 - Eight midwives attended a training conference.
 - 3 copies Casebook for Intrauterine Device.
 - 5 copies Family Planning Handbook for Doctors.
 - 2 copies Family Planning for Nurses and Midwives.
 - 2 copies Cervical and Vaginal Cytology.
 - 3 copies Intrauterine Contraception.
 - 11 copies Contraceptive Technology.
 - 3 copies Intrauterine Devices in Clinical Practice.
 - 1 copy Managing Patients with IUDs.
 - 1 copy Managing Contraceptive Pill Patients.
13. Egypt-01 (-07):
 - Project Director attended seminar at Syracuse University (New York).
 - Physicians and nurses attended training course.
 - 1 copy Contraception Techniques (film).
 - 5 copies Family Planning: A Teaching Guide for Nurses.
 - 5 copies Casebook for Intrauterine Device.
 - 5 copies Family Planning Handbook for Doctors.
 - 5 copies Family Planning for Nurses and Midwives.
 - 5 copies Cervical and Vaginal Cytology.
 - 6 copies Intrauterine Contraception.
 - 2 copies Contraceptive Technology.
 - 1 copy Choosing a Contraceptive Method (slides).
 - 5 copies Contraceptives (film).
 - 1 copy Managing Patients with IUDs.
 - 1 copy Managing Contraceptive Pill Patients.

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14. Sudan-02:

- Chairman attended Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- 1 copy Managing Patterns with IUDs.
- 1 copy Managing Contraceptive Pill Patients.
- 1 copy Contraceptive Technology.
- 1 copy How to Organize a Basic Study of the Infertile Couple.
- 1 copy Family Planning Handbook for Doctors.
- 1 copy Oral Contraceptives: A Guide for Programs and Clinics.
- 1 copy Intrauterine Contraception.
- 1 copy IUDs: Current Perspectives.
- 1 copy Male and Female Sterilization.
- 1 copy Vasectomy.
- 1 copy Family Planning for Nurses and Midwives.
- 1 copy Procedure Manual for Nurses and Midwives.

15. Sudan-03:

- Assistant Project Coordinator attended Primary Health Care Workshop.
- 10 copies Contraceptive Technology.
- 4 copies Insertion and Removal of an IUD (film).

16. Sierra Leone-01 (-05):

- Field Assistant attended Margaret Sanger Center Nurse Practitioner Training Course (New York).
- On-site technical assistance provided by Dr. Tyrer.
- 10 copies Contraceptive Technology.
- 1 copy Family Planning for Nurses and Midwives.
- 1 copy Procedure Manual for Nurses and Midwives.
- 1 copy Contraceptives (film).
- 1 copy Managing Patients with IUDs.
- 1 copy Managing Contraceptive Pill Patients.

17. Nigeria-10:

- On-site technical assistance provided by Dr. Tyrer.
- Nurse-midwife attended course on Family Planning Service Delivery at University College Hospital (Ibadan).
- Physician attended Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- 6 copies Oral Contraceptives: A Guide for Programs and Clinics.
- 5 copies Contraceptive Technology.
- 11 copies Family Planning for Nurses and Midwives.
- 2 copies Procedure Manual for Nurses and Midwives.
- 1 copy Insertion and Removal of an IUD (film).

18. Nigeria-13:

- This project trains medical personnel. Project began 3/85.
- 20 copies Procedures Manual for Nurses and Midwives.
- 20 copies Intrauterine Contraception.
- 5 copies Managing Contraceptive Pill Patients.
- 1 copy Minilaparotomy Techniques (film).

19. Nigeria-18:

- No training for medical personnel. Project began 6/85.

20. Brazil-03:

- Staff attended conference on High Risk Ob/Gyn Management and Prevention by the Brazilian Ob/Gyn Society.
- Nurse-supervisor attended a practical course in family planning (Santiago, Chile).
- Chief registered nurse attended training course in Nursing Attendance.
- Staff attended conference on Teaching of Ob/Gyn.
- Physician attended Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- 1 copy Family Planning Handbook for Doctors.
- 1 copy Medical Manual
- 1 copy Procedure Manual for Nurses and Midwives.

Brazil-03 cont'd.

- 1 copy Intrauterine Contraception.
- 1 copy Fertility Control and the Physician (film)
- 1 copy Contraceptive Methods (slides)
- 1 copy Minilaparotomy Techniques (film)

21. Brazil-09:

- Project Director and project coordinator attended an Ob/Gyn seminar in Belo Horizonte.
- Project coordinator attended an NFP seminar in Cali, Colombia.
- Two staff members attended a course on contraceptive implants.
- 1 copy Minilaparotomy Techniques (film).

22. Peru-06:

- Two physicians attended a family planning orientation seminar sponsored by Planned Parenthood of Metropolitan Washington, D.C. (U.S.A.).
- Project Director attended: JHPIEGO conference in Rio (Brazil); sterilization forum at the Medical College of Peru; Latin America Ob/Gyn Congress (Venezuela); International Ob/Gyn Congress (Ecuador); seminar on high risk pregnancy; Fifth International Conference on Voluntary Surgical Sterilization (Dominican Republic), including workshop with Dr. Tyrer to review FPIA requirements and guidelines for sterilization projects.
- Technical assistance provided by JHPIEGO.
- On-site technical assistance provided by Dr. Tyrer.
- One physician attended a mini-lap course at JHPIEGO, Colombia.
- Two physicians attended medical seminars in Peru.
- 2 copies Family Planning: A Teaching Guide for Nurses.
- 125 copies Family Planning Handbook for Doctors.
- 2 copies Comments on Steroidal Contraceptives.
- 102 copies Vasectomy.
- 2 copies Family Planning for Nurses and Midwives.
- 12 copies Cervical and Vaginal Cytology.
- 122 copies Intrauterine Contraception.
- 61 copies Casebook for the Intrauterine Device.
- 1 copy Male and Female Sterilization.
- 151 copies Systemic Contraception.

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Peru-06 cont'd.

- 1 copy Fertility Control and the Physician (film).
- 1 copy Insertion and Removal of an IUD (film).
- 1 copy Minilaparotomy Techniques (film).

23. Peru-18:

- Project Director attended a course in reproductive health at JHPIEGO (Baltimore, U.S.A.).
- On-site technical assistance provided by Dr. Tyrer.
- 2 copies Insertion and Removal of an IUD (film).
- 2 copies Contraceptives (film).
- 2 copies Choosing a Contraceptive Method.
- 12 copies Intrauterine Contraception.
- 1 copy Contraceptives (film).
- 1 copy Insertion and Removal of an IUD (film).
- 1 copy Choosing a Contraceptive Method (slides).

24. Mexico-25:

- Subproject physicians attended a physician workshop sponsored by DA.
- Technical assistance provided by AVS.
- Plans underway for a second physician workshop.
- 5 copies Insertion and Removal of an IUD (film).

APPENDIX J

**MEDICAL PUBLICATIONS AND FILMS
FOUND AT SITES VISITED**

APPENDIX J

Medical Publications and Films Found At Sites Visited

PUBLICATIONS

<u>Qty</u>	<u>Title</u>	<u>Project</u>
5	Intrauterine Contraception	Indo-22
5	IUD's Current Persepectives	
2	Contraceptive Technology	Sri Lanka-10
2	Family Planning Handbook For Doctors	
2	Oral Contraceptives: A Guide For Programs And Clinics	
10	Intrauterine Contraception	Burkina-Faso-01
5	Oral Contraceptives: A Guide For Programs And Clinics	
4	Procedures Manual For Nurses & Midwives	
100	Oral Contraceptives: A Guide For Programs And Clinics	Egypt-06
100	Intrauterine Contraception	Ivory-Coast-01
5	How To Organize A Basic Study Of The In-Fertile Couple	
10	Intrauterine Contraception	Ivory-Coast-01
7	Cervical & Vaginal Cytology	
10	Oral Contraceptives: A Guide For Programs And Clinics	
4	Oral Contraceptives: A Guide For Programs And Clinics	Kenya-04
4	IUD's Current Perspectives	
2	Procedure Manual For Nurses & Midwives	
215	Procedure Manual For Nurses & Midwives	Malawi-01
15	Managing Patients With IUD's	
15	Managing Contraceptives Pill Patients	
15	Handbook On Infertility	
15	Periodic Abstinence	
5	Oral Contraceptives: A Guide For Programs And Clinics	Mauritius-02
11	Intrauterine Contraception	Nigeria-10
5	Procedures Manual For Nurses & Midwives	
5	Contraceptive Technology	Nigeria-10
5	Family Planning Nurses & Midwives	
2	Procedure Manual For Nurses & Midwives	

PUBLICATIONS

<u>Qty</u>	<u>Title</u>	<u>Project</u>
13	Procedures Manual For Nurses & Midwives	Nigeria-13
20	Intrauterine Contraception	
5	Managing Contraceptive Pill Patients	
30	Managing Contraceptive Pill Patients	Nigeria-16
30	Managing Patients With IUD's	
30	Procedures Manual For Nurses & Midwives	
1	Contraceptive Technology	Sudan-02
1	How To Organize A Basic Study Of The Infertile Couple	
1	Family Planning Handbook For Doctors	
1	Oral Contraceptives: A Guide For Programs And Clinics	
1	Intrauterine Contraception	
1	IUD's: Current Perspectives	
1	Male & Female Sterilization	
1	Vasectomy	
1	Family Planning Nurses & Midwives	
1	Procedure Manual For Nurses & Midwives	
10	Contraceptive Technology	Sudan-03
1	Cervical & Vaginal Cytology	Swaziland-01
20	Intrauterine Contraception	Zambia-06
1	Family Planning Handbook For Nurses & Midwives	Ecuador-05
3	Intrauterine Contraception	Mexico-24
4	Handbook On Infertility	
4	Periodic Abstinence	
20	Intrauterine Contraception	Mexico-29
50	Intrauterine Contraception	Peru-22

4, V

FILMS & SLIDES

<u>Oty</u>	<u>Title</u>	<u>Project</u>
2	Insertion & Removal Of An IUD (film)	Burkina-Faso-01
1	Contraception (film)	Ivory Coast-01
2	Insertion & Removal Of An IUD (film)	
1	Choosing A Contraceptive Method (slide)	
1	Choosing A Contraceptive Method (slide)	Kenya-04
4	Minilaparotomy Techniques (film)	Malawi-01
1	Insertion & Removal Of An IUD (film)	
1	Insertion & Removal Of An IUD (film)	Nigeria-17
4	Insertion & Removal Of An IUD (film)	Sudan-03
1	Contraceptive (film)	Togo-02
1	Insertion & Removal Of An IUD (film)	
1	Insertion & Removal Of An IUD (film)	Zambia-02
1	Insertion & Removal Of An IUD (film)	Bolivia-02
1	Minilaparotomy Techniques (film)	
2	Insertion & Removal Of An IUD (film)	Brazil-08
1	Choosing A Contraception Method (slide)	
1	Minilaparotomy Techniques	Brazil-09
1	Choosing A Contraceptive Method (slide)	Mexico-18
1	Insertion & Removal Of An IUD (film)	Mexico-22
5	Insertion & Removal Of An IUD (film)	Mexico-25
1	Minilaparotomy Techniques (film)	Mexico-29
1	Insertion & Removal Of An IUD (film)	
1	Insertion & Removal Of An IUD (film)	Peru-22
1	Contraceptive (film)	Mauritius-02
1	Insertion & Removal Of An IUD (film)	
1	Choosing A Contraceptive Method (slide)	
1	Minilaparotomy Techniques (film)	Nigeria-13
1	Insertion & Removal Of An IUD (film)	Nigeria-16

APPENDIX K

LIST OF RECENT PROJECT ASSESSMENTS

APPENDIX K

List of Recent Project Assessments

EVALREPORT/TEXT198/FPIA

10/01/85

<u>Project #</u>	<u>Evaluator(s)</u>	<u>Date</u>
Bangladesh-11	Shanti R. Conly	Apr. 1980
Bangladesh-18	Dr. Alimullah Miyan	Apr. 1980
Egypt-01	Samiha El Katscha	Feb. 1982
Egypt-02	Connie O'Connor	Nov. 1980
FPIA-07	Charles Cortese	Jun. 1977
Kenya-03	Abby Krystall, Richard Pomeroy	Nov. 1978
Kenya-04	Joseph Popp	Jun. 1984
Liberia-01	Dr. Hans Groot	Aug. 1982
Mexico-03	Neal Munch	Jun. 1981
Philippines-27, 28, 29, 30, 32, 33, 34	Neal Munch	Feb. 1982
Sierra Leone-01	Carol Klein, Jean Karabizi	Sep. 1983
Sudan-01	Dr. Louise Tyrer, Richard Pomeroy	Aug. 1982
Thailand-11	Dr. Hans Groot	Mar. 1982
Nigeria	Khadijat L. Mojidi	Sep. 1984
Egypt-03	Dr. A. Zaki	Jul. 1984
Bangladesh-18	Sharon Epstein	Apr. 1984
Liberia-04	Nicholas M. Dondi Khadijat L. Mojidi	Nov. 1984
Peru-02	Miriam Inocencio	Nov. 1984
Swaziland-01	Jose Mas Diane Gladys Azu	Nov 12-20 1984
Colombia-05	Enrique Suarez	Jun 17-20 1985
Nigeria-04	Habil Younis	Jun 20 - Jul 2 1985
Peru-06	Alcides Estrada	Apr 27 - Jun 15 1985
Kenya-07	Evelyn Njeroge	May 6-17 1985

APPENDIX L
FPIA STAFF CAPABILITIES

APPENDIX L

FPIA STAFF CAPABILITIES

A total of 42 FPIA professional staff speak and/or read at least one foreign language other than English. These languages include Spanish, Tagalog, French, Portuguese, German, Nepali, Dutch, Swahili, Fulani, Russian, Thai, Amharic, Rwandan, Ewe, Ga, Luganda, Twi, Chinese, Wolof, Diola, Krio/Pidgin, Mandarin, Indonesia, Bengali, Italian and Arabic. A total of 16 professional staff speak Spanish, 18 speak French, 6 speak Portuguese, 5 speak Thai, 5 speak Swahili and 3 speak Bengali.

Among the 10 FPIA Senior Staff:

- there are 3 doctorates, 2 masters and 5 bachelor degrees.
- there is a total of 154 person/years of family planning experience. The average (mean) number of years of family planning experience is 15.4 with a range of 0 to 42 years.
- there is a total of 97 person/years of employment with PPFA. The average (mean) number of years with PPFA is 9.7, with a range of 0 to 17 years.
- a total of 9 staff have overseas working experience. For these staff, the average (mean) number of years of overseas experience is 4.7, with a range of 1 to 11 years.
- a total of 7 speak a foreign language. These languages include Spanish, Tagalog, French, German and Portuguese.

A comparison of FPIA regions follows:

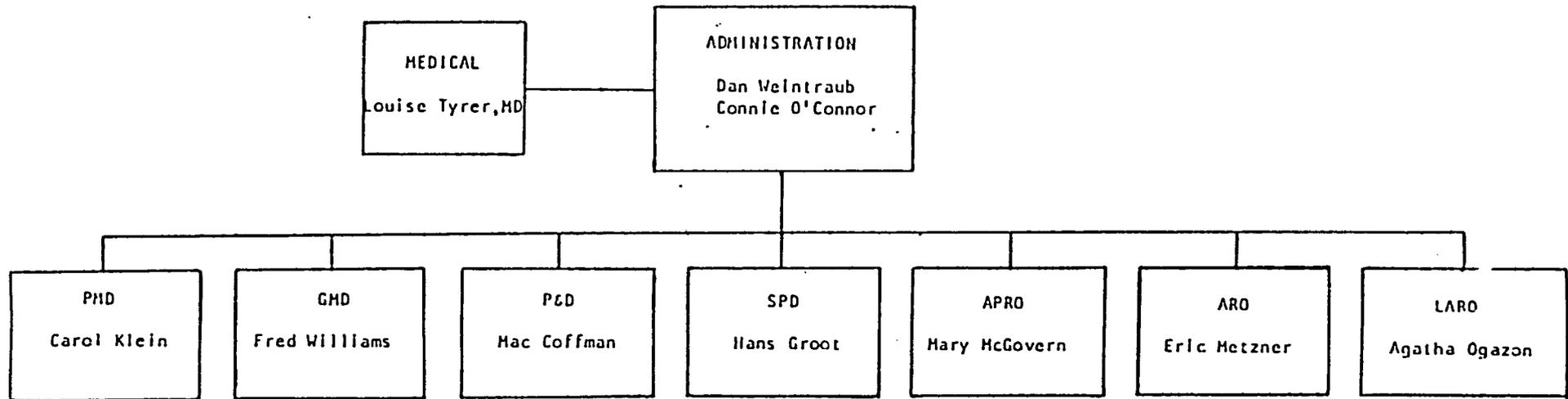
<u>Educational Degree</u>	<u>Number of Staff</u>		
	<u>ARO</u>	<u>APRO</u>	<u>LARO</u>
None	0	0	1
AA	0	0	0
Bachelors	2	4	0
Masters	8	11	7
Doctorate	1	1	0
<u>Years in FP</u>	45.3	39.0	34.5
<u>Years with PPFA</u>	34.0	34.0	22.5
<u>Years of Overseas Exp.</u>	87.5	80.0	11.0

APPENDIX M
FAMILY PLANNING INTERNATIONAL ASSISTANCE
ORGANIZATIONAL CHART

APPENDIX M

FAMILY PLANNING INTERNATIONAL ASSISTANCE

Organizational Chart



PHD Project Management Department
GMD Grant Management Department
P&D Procurement and Distribution
SPD Special Projects Department

APRO Asia and Pacific Regional Office
ARO Africa Regional Office
LARO Latin America Regional Office

10/85

APPENDIX N

FAMILY PLANNING INTERNATIONAL STAFF

FAMILY PLANNING INTERNATIONAL ASSISTANCE STAFF

as of 10/22/85

INTERNATIONAL DIVISION (FPIA)ADMINISTRATION (New York)

Daniel R. Weintraub	V-President for Int'l. Programs
	FPIA Chief Operating Officer
Connie O'Connor	FPIA Deputy Chief Operating Officer
Rosalie Marlowe	Coordinator for Administration
Maryann Walker	Senior Administrative Assistant
Valerie Giunta	Administrative Assistant
Deborah Collazo	Administrative Secretary
Kindel Davis	Administrative Secretary

PROJECT MANAGEMENT (New York)

Carol Klein	Director of Project Management
Miriam Inocencio	Deputy Director of Project Management
Polly Mott	Program Management Specialist
Susan Asonaning	Program Associate
Catherine Brokenshire	Program Associate
Hedy Kalikoff	Program Associate
(Vacant)	Program Associate
Marcia Presky	Program Associate
Toni White	Special Asst. to Director of Project Management
Effie Robinson	Administrative Assistant
Joseph Brown	Senior Project Secretary
Margaret Alston-Prince	Project Secretary
Ruby Price	Project Secretary

GRANTS MANAGEMENT (New York)

Fred D. Williams	Director of Grants Management
(Vacant)	Deputy Director of Grants Management
Kelvyn Walter	Audit Specialist
Gail Gauthier	Fiscal Associate
Jami Long	Senior Administrative Secretary
Janette Volz	Senior Secretary/Bookkeeper

PROCUREMENT & DISTRIBUTION (New York)

H. McKinley Coffman	Director of Logistical Services
Carmela Ferguson	Associate Director, Logistical Services
(Vacant)	Assistant Director, Logistical Services
Lucie Klein	Assistant Logistical Supervisor
Maritza Pacheco	Material Resources Coordinator

SPECIAL PROJECTS (NEW YORK)

Hans C. Groot	Director of Special Projects
Richard Pomeroy	Coordinator of Management Information
Michael Chaplan	Senior Program Assistant
Ralph Elliott	Junior Program Assistant
Ava Edwin	Administrative Assistant

AFRICA REGIONAL OFFICE (Nairobi, Kenya)

Eric Metzner	Regional Director (Eff. 4 Nov.)
Reuben Johnson, Jr.	Deputy Regional Director
Andrew Franklin	Associate Regional Director
Sahlu Haile	Associate Regional Director
Altrena Mukuria	Associate Regional Director
Jean Karambizi	Assistant Regional Director
Cecilia Nöeti	Assistant Regional Director
Wisdom K. Amenyah	Program Officer
Margaret Joy Awori	Program Officer
Gayi Kwame Bedou	Program Officer
Tewodros Melesse	Program Officer
(Vacant)	Commodities Program Officer
Wambui Chegeh	Senior Administrative Assistant
Willie Mutwota	Senior Administrative Assistant
Chantal Bunyenyezi	Secretary
Margaret Njuki	Secretary
Tarulata Shah	Secretary
(Vacant)	Secretary
Jidraph Gathanga	Driver/Messenger
John Mwangi	Office Messenger

ASIA & PACIFIC REGIONAL OFFICE (Bangkok, Thailand)

Mary L. McGovern	Regional Director
Peter Foley	Deputy Regional Director
Kim DeRidder	Associate Regional Director
Abul Hashem	Associate Regional Director
Promboon Panitchpakdi	Associate Regional Director
Evelyn Paolangeli	Associate Regional Director
Sajjad Hussain	Program Management Specialist
Shyanoden Lara	Assistant Regional Director
Pimsuda Tiandum	Administrator
Kritsada Bronruang	Program Officer
Mukarram Chowdhury	Program Officer
Suchai Kasaisaevae	Program Officer
Alex Sumarauw	Program Officer
Supaporn Tiraprasert	Program Officer (Eff. 4 Nov.)
(Vacant)	Program Officer
(Vacant)	Commodities Program Officer
Duantip Bunphapong	Administrative Assistant
Milton D'Silva	Administrative Assistant
Jaruwan Nanna	Secretary (Eff. 27 Oct.)
Pattra Panprung	Secretary
Sittinee Prempre	Secretary
Sirilak Vipadaputi	Secretary
Sekander Ali	Messenger/Office Assistant
Abul Hassan	Messenger/Driver
Cachapon Ngasong	Messenger/Driver

LATIN AMERICA REGIONAL OFFICE (Miami, Florida)

Agueda Ogazon	Regional Director
Carla Schworer	Deputy Regional Director
Isaac Berezdivin	Associate Regional Director
Albert Costales	Associate Regional Director
Teresa Mansfield	Associate Regional Director
Lydia Medrano	Assistant Regional Director
Reed Thorndahl	Assistant Regional Director
Marta Aulet	Senior Commodities Assistant
Maria Gonzalez	Administrative Assistant
Esther Forget	Jr. Administrative Assistant
Rose Baccallao	Administrative Secretary
Victoria Rodriguez	Administrative Secretary
Magda Vidiella	Administrative Secretary

APPENDIX 0
ASSISTANCE TO OTHER ORGANIZATIONS

APPENDIX O

ASSISTANCE TO OTHER AGENCIES

Agency & Representative	Date	Assistance Provided By	Means	End Result
<u>PCS</u> Ron Magarick	4/24/85	PHD	Mail	FPIA Project Report Format, report instructions and sample report sent to PCS.
<u>PCS</u> Maxwell Senior	10/24/85	PHD	Mail	Information sent on Ghana projects for PCS reference in needs assessment.
<u>Pathfinder</u> Yvonne Dunn	Spring 1985	Mac Coffman P&D	2 day meeting in NY 1 day meeting at New Windsor extensive telephone follow up.	FPIA Commodity Logistics system described in detail; technical assistance given to Pathfinder to develop similar system.
<u>Pathfinder</u> Steve Smith - Consultant	November 1985	Carmela Ferguson P&D	Meeting scheduled in NY, November 1985	FPIA to assist Pathfinder with development of a commodity catalogue.
<u>Pathfinder</u>	1985	Carmela Ferguson P&D	Telephone	Assistance provided in identifying IEC resources.
<u>AVS</u>	1985	Carmela Ferguson P&D	Telephone	Assistance provided in identifying IEC resources.
<u>International Federation for Family Life Promotion</u> Charles Obold Finance Officer	October 1985	Fred Williams GMD	Half day meeting in NY.	Comprehensive orientation on receiving and handling AID agreements. Requested forms to be sent.

Agency & Representative	Date	Assistance Provided by	Means	End Result
<u>Population Communication Services (PCS)</u>				
Linda Donhauser Vera Ford	12/19/83 10 am - 3 pm	C. Klein } M. Inocencio } R. Marlowe, Admin.	Meeting in NY at PCS request to discuss internal monitoring and disbursement procedures.	FPIA systems described, including PMDs monthly status report, weekly cables, application of disbursement system. Monitoring procedures and report forms described.
<u>PCS</u>				
Cynthia Green, Project Director	6/7/84 1:30-4:30 pm	C. Klein } J. Mas } M. Coffman } C. Ferguson } P&D	Meeting in NY at request of PCS to discuss FPIA Africa program, IEC materials, planning/budgeting process, access to African countries, shipping AV equipment.	Items were discussed with emphasis on FPIA project planning, and budget preparation, monitoring and TA. Recommended PCS contact ARO directly for IEC linkages with on-going programs with PVOs and MOU's. FPIA agreed to ship limited quantity projectors with PCS paying shipping and indirect cost. Received list of current PCS activities.
<u>Pathfinder</u>				
Carol Gibbs David Wood	4/13/84 4:00-5:00 pm	C. Klein } J. Mas } A. Ogazon } LARO	Meeting in NY at suggestion of Joe Loudis to discuss FPIA's local currency grant procedures.	FPIA's local currency budgetting, award and disbursement procedures described to Pathfinder representatives.
<u>Pathfinder</u>				
Sylvia Virisendrop (Consultant)	6/18/84 1:00-3:00 pm	J. Mas } P. Mott }	Meeting in NY at Virisendrop request to provide information on FPIA income generating projects for Pathfinder internal report on income generating projects.	Verbal briefing provided. Virisendrop sent follow up letter summarizing meeting. FPIA responded with clarifications and additional material.

Agency & Representative	Date	Assistance Provided By	Means & Purpose	End Result
<u>Pathfinder</u> Deirdre Strachan Donna R.	9/21/84 10 am - 4 pm	L.B. Tyrer, M.D. C. Klein, PMD	Meeting in Chestnut Hill at Pathfinder's request to share information on training, monitoring and standardization, and AID requirements for sterilization projects.	Medical issues emphasized, with Pathfinder especially interested in physician comments on certifi- cate of competence, sterilization site visitors report, grantee qualification form. FPIA Medical Practices Manual/Sterilization distributed and used as resource material.
<u>AVS</u> Douglas Huber, M.D.				
<u>JUPIEGO</u> Robert Costabot, M.D.				

APPENDIX P

FPIA PROGRAMS IN AFRICA:
TRIP REPORTS

(Kenya, Zambia, Egypt, Sudan, Nigeria, and Sierra Leone)

APPENDIX F1

AFRICA GENERAL: FPIA REGIONAL OFFICE

APPENDIX P1

AFRICA GENERAL: FPIA REGIONAL OFFICE

FPIA's Africa Regional Office, located in Nairobi, serves both Francophone and Anglophone Africa country projects. The 20-person office includes a Regional Director (recently appointed); a Deputy Regional Director; five Assistant Regional Directors; four Program Officers; and nine support staff. The staff were recruited almost exclusively from the region. All brought extensive experience from many different disciplines, and an abundance of enthusiasm and commitment. However, many lacked the broad family planning experience that contributes to the technical quality of country projects. Such input is critical from the Regional Office, since FPIA does not post its own staff in country offices (in Africa). Despite this lack of depth in family planning, staff has worked effectively and expediently to expand FPIA assistance throughout Africa, in keeping with AID's mandate.

Program officers have neither firm country nor sectoral responsibilities, resulting in lack of continuity in repeat visits to project sites. The rationale for such seemingly random travel schedules was to permit all staff to become familiar with all country programs to enhance their flexibility, and to economize by sending staff who happen to be in the geographical area to troubleshoot, as necessary, in a particular country.

FPIA has done a remarkable job of expanding its assistance in Africa in response to AID's increasing emphasis. In a climate in which it is difficult to initiate high quality services, FPIA has progressed in a timely and effective manner.

FPIA has performed admirably in selecting projects. Its subgrantees' projects are of high quality, innovative, and have potential for serving as successful models for alternative and intensified service delivery. Subproject staff are excellent, and the terms and conditions negotiated with FPIA staff ensure effective and tight management and adherence to FPIA and AID guidelines. The FPIA Regional Office is planning a regional meeting for all relevant Anglophone project personnel to discuss clinical and program management (Africa-02). This should facilitate an exchange on the administrative and management issues common to FPIA programs in different countries.

FPIA's projects could, however, benefit greatly from higher quality and more intensive technical assistance or guidance in

the substantive aspects of program design, implementation, and evaluation. In addition, the flow of materials from headquarters could be handled more effectively. Copies of a simplified version of the FPIA Medical Standards Manual are supposed to be sent to most project directors, but they were not always found during site visits. In addition, although medical recommendations are passed along, sometimes verbally, to project directors, this dissemination of recommendations does not appear to be handled in any regularized fashion. Both FPIA medical standards and recommendations, however, are reviewed and explained when a project is developed. Compliance is monitored during visits by assessing how the pill/IUD questionnaire is being used, reviewing the training curriculum, etc.

Regional Office staff are aware of the need for further technical assistance in the medical area. A project is being developed with American University in Cairo to identify needs, develop a training curriculum and conduct training in clinical management for project medical staff.

APPENDIX P2

KENYA: TRIP REPORT

KENYA: TRIP REPORT

GLOSSARY

AVS	Association for Voluntary Sterilization
CBD	Community-based distribution
CDC	Centers for Disease Control
Cu-T	Copper-T (type of IUD)
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
IWHC	International Women's Health Coalition
NORAD	Norwegian Agency for International Development
MCH/FP	Maternal and child health/family planning
SIDA	Swedish International Development Agency
STD	Sexually transmitted disease

APPENDIX P2

KENYA: TRIP REPORT

Projects Visited: Kenya-09: Community Health Department,
Chogoria Hospital, Merv District
Kenya-06: Family Planning Programme of the
Mkomani Harambee Health Centre, Mombasa

1.1 Introductory Remarks

1.1.1 Country Background

Kenya is known in the population field for one of the world's highest birth rates, estimated at nearly 50/1,000, a population growth rate close to 4 percent, and a total fertility rate of over 7. While the demand for family planning is thought to be high, the average desired family size and incidence of premarital fertility are also high. In spite of this, most family planning projects only serve married women, and only after they have given birth to at least one child.

The Kenyan government was the first sub-Saharan country to express concern about the effect of population growth on social and economic development, especially employment. It was also one of the first to establish an official national family planning program for achieving a lower rate of population increase. The present Vice President, Mr. Mwai Kibaki, is a vocal advocate for family planning.

In addition to the usual difficulties in delivery of maternal and child health/family planning (MCH/FP) services, Kenya faces the additional obstacles of religious opposition, high family size norms, and low status of women.

1.1.2 Summary of Assignment Visits

Two of six Kenya FPIA projects were visited during the evaluation: KENYA-09, the Community Health Department of Chogoria Hospital in Meru Province, and Kenya-06, the "SHANNI" Family Planning Programme of Mkomani Harambee Health Center in Mombasa. Both are mature projects. Of the remaining four projects, one has been terminated and turned over to the Association for Voluntary Sterilization (AVS) and the other three are in their final FPIA funding periods.

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2. Kenya-09: Community Health Department, Chogoria Hospital, Meru District

Current Funding Period: 1 August 1985 - 31 July 1986

Level of FPIA funding: \$47,559

2.1 History and Objectives

The Community Health Department of the private Chogoria Hospital began family planning services in 1969 and has been assisted by FPIA in various forms since 1976. It is presently co-funded with the Swedish International Development Agency (SIDA.) It services a population of over 200,000 in a 560 square mile area.

The present highly respected project, "Health for the Family," is considered a model in Kenya. It continues to maintain its objective: to utilize innovative and cost-effective methods of delivering quality services to the underserved population of Chogoria, especially in the areas of ante-natal care, child welfare and family planning.

FPIA phased out of clinic services support in 1982, and salaries for clinic staff will be totally phased out within two years. The present FPIA funding represents only 15 percent of the total project budget, with SIDA and the hospital sharing the major costs.

2.2 Family Planning Service Delivery

The clinic offers all family planning methods each day, in conjunction with ante-natal and child welfare services, rather than different services on different days. This approach is expensive, but is credited with attracting and maintaining clients, who find this system convenient.

The sterilization component of the project has recently been turned over to AVS. There has been an enormous increase in female sterilization acceptors, but still very few male acceptors. Women and their husbands sign the appropriate consent forms. No incentives or payments are made to motivators or clients. Age and parity of acceptors are reported to be dropping slowly.

Depo-Provera is given in only five sites where nurses have been trained, but this service will be expanded. Foam, jelly, and the diaphragm are offered, but are not popular. The oral contraceptive is increasingly popular, particularly since the initiation of the CBD program and the introduction of a lower-dose pill. Condoms are popular initially, but have a low

continuation rate. The IUD is popular, but the clinic is concerned that satisfied users do not come in regularly to have the device checked, or to have it removed after the recommended duration of use. Natural family planning clients are referred to other providers, but very few request this method.

Finally, infertility services are also offered. The project takes this problem seriously, resorting to diagnostic laparoscopy if necessary. Penicillin-resistant sexually transmitted diseases (STD) are a major cause of sterility (due in part to medical providers having repeatedly diluted doses for treatment of earlier attacks).

The breakdown of methods provided is as follows:

IUD	44%
Oral Contraceptive	36%
Foam/jelly	9%
Condoms	8%
Sterilization	3%
	100%

Project defaulters are identified and followed up by field educators and volunteers. The present manual system is seriously overloaded, however, and the introduction of a computer (donated by AID and presently being installed with the assistance of Thunder Associates) promises to revolutionize the process. According to a 1983 Centers for Disease Control (CDC) Survey (see Section 2.8) volunteers followed up 60 to 70 percent of project defaulters.

CBD activities, for Kenya a fairly new approach to providing family planning services, are apparently proceeding well. Volunteers are still unpaid, but remain motivated by the incentive of semi-annual residential training courses. They are supervised by Area Health Committees, which, according to the CDC study, could benefit from strengthening.

2.3 Service Statistics

Service data are available, but require abstracting from a number of different tables, reports, and client records. At present the situation is extremely confusing. New data being analyzed by CDC in Atlanta will yield additional, up-to-date data on new and continuing acceptors. The 1983 CDC survey indicated that 30 percent of eligible women with one or more children in the Chogoria area were using family planning and 25 percent of all eligible women. This is considerably higher than the prevalence rate quoted for all of Kenya, 14 percent (which is

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widely thought to be inflated). The prevalence rates for Chogoria, cited above, are consistent with a 1979 CDC survey.

The present FPIA record-keeping system is problematic:

- o Family planning staff must complete different forms for the national government program, the individual clinic, the individual client, and for FPIA.
- o The definition of new and continuing acceptors, and the recording of these by FPIA funding period and year, is confusing and imprecise.
- o The present system does not lend itself to determining continuation rates.
- o Age and parity are tabulated regularly only for sterilization clients.

Despite the problems mentioned above, the clinic keeps meticulous records, according to the system prescribed for them.

The new computer will permit the following: processing of the vast amounts of acceptor data generated by the project, consolidation of the presently numerous reporting systems, a reduction of staff work load on record-keeping, and an increase in accuracy.

2.4 Cost and Income-Generating Considerations

A 1983 CDC survey assessed the cost to the clinic per family planning client per year at \$1.00 (for pill, condom and foam users) and \$0.55 for IUD users. The clinic charges a modest client fee. Other government services are free at present (although inferior in quality) although charges may be introduced soon to help overcome the government budget deficit. The costs of the Chogoria services are unusually low, in part because the higher level staff are expatriate missionaries whose local salaries are modest even by Kenyan standards and because the costs of the buildings, contraceptives, supplies, and equipment are not factored in.

The most striking financial element of this project is that the family planning services are totally self-supporting, since they are subsidized by the fees received from curative and other preventive services.

In an innovative move, the Project has recently appointed an income-generating officer (with half of his salary supported by

FPIA). His role at this point is unclear, and few income-generating ideas have been forthcoming.

Recommendation. It is recommended that FPIA monitor income-generating initiatives closely.

2.5 Administration, Management and Staffing

Administration of the project is excellent, in part due to a strong, committed expatriate director, and in part due to FPIA's insistence on stringent financial management and reporting. For a multitude of reasons, Kenyanization of the project's leadership posts does not appear to be taking place.

2.6 Commodities and Logistics

Family planning commodities are provided by SIDA through the Ministry of Health. Supply is irregular and unreliable.

2.7 Youth Program

The Youth Program was begun in 1981, and although quite unusual in the Kenya setting, has been pursued vigorously. It presently represents FPIA's major input into the project. The Program was started because of concern about unmarried, pregnant teens (who account for over 20 percent of total births in Kenya). The target groups to be reached are in-school youth, out-of-school youth, and church-going youth. The impact is likely to be long-range and difficult to measure. This Program is fully Kenyanized, and has served as a model for the Protestant Churches Medical Association and a Methodist group in Kenya. It is indeed remarkable that it has been able to overcome initial community resistance so successfully. The program is scheduled to become self-sufficient in 1988, when a local community group will take it over.

Recommendation: An external evaluation, commissioned by FPIA, should be undertaken before 1988.

2.8 Evaluation

The information yielded by the service statistics system (see Section 2.3) does not lend itself to program analysis. Chogoria officials, however, are concerned about self-evaluation and external evaluation. CDC has undertaken two major analyses of this project: the first in November 1983, and the second in August 1985. (Data from the second evaluation are now being

analyzed.) The second survey will attempt to verify acceptor data and compare them to the data for the rest of Kenya, as well as to establish baseline data for the lower altitude, poorer catchment areas to which Chogoria plans to spread its services. CDC's inputs in the evaluation are another excellent example of Chogoria's effective use of technical assistance (see Section 2.2).

2.9 Future

The future prospects for this project are encouraging, particularly in view of the continually declining quality of government services. Chogoria staff take a long-range view of the program, recognizing that it takes at least two years of work in any given area to win community acceptance and family planning acceptors. The eventual withdrawal of FPIA support should not unduly affect program operation.

2.10 Role of FPIA

By choosing and supporting this project, although at a minimal financial level, FPIA has lent important legitimacy and moral support to its development. FPIA has also contributed to discipline in planning, monitoring and has supported innovation (i.e., use of volunteers in CBD, new efforts of income-generating and youth projects).

Recommendations: The income-generating components need increased direction. FPIA should therefore offer technical assistance in this area to ensure that its investment results in sound programming.

FPIA should continue to keep in touch with this project after it withdraws financial support, to ensure that Chogoria continues to have access to the international family planning information exchange network.

3. Kenya-06: "SHAANI" Family Planning Programme of the Mkomani Harambee Health Centre, Mombasa

Present Funding Period: 1 November 1984 - 30 April 1986
Level of FPIA Funding: \$128,647

3.1 History and Objectives

This project has been assisted by FPIA since 1981. Objectives are to provide family planning information and family life information to the local population through home visits, village meetings, film shows at beach hotels and school lectures; and to

provide family planning services to new and continuing clients through CBD activities and clinic-based services. The objectives are appropriate to Kenya's population situation and policies.

Mkomani was the first group in Kenya given government approval to experiment with delivery of oral contraceptives through CBD. Field workers recruit new acceptors, resupply clients, and find program defaulters. FPIA's support of these efforts are another instance of its commitment to being involved with the innovative and experimental family planning service delivery.

3.2 Family Planning Services

To judge from the quality of staff, clinic conditions, and high number of acceptors, the quality of family planning service delivery was impressive.

The oral contraceptive is the most popular method. Cycles are given after an examination at the clinic, and are resupplied by a local field worker, who does continual screening of pill clients upon resupply, using the FPIA checklist. Depo-Provera is in high demand but short supply. The Ministry of Health supplies are insufficient and irregular (FPIA cannot supply it without FDA approval). The sterilization caseload has been increasing, and this aspect of the program is scheduled to be turned over to AVS in April 1986. At present, the sterilization clinic operates three days per week. Consent forms are strictly required, including signatures from both the husband and wife. These forms are often distributed by the fieldworkers and signed long before the client appears for the procedure. Forms are kept for five years. In cases where the woman has no husband present, or in psychiatric cases, the mother or sister can sign instead. The IUD, foaming tablets, diaphragm, and condoms are also offered. The quality of service delivery appears high and the protocols established by FPIA headquarters for each method are closely followed.

3.3 Infertility Services

The clinic has made a serious attempt recently to address infertility by offering a clinic each Saturday. The main cause of sterility in this area, however, is repeated incidence of STD, as opposed to anovulatory problems, and therefore is more difficult, if not impossible, to treat. In this setting the cost-effectiveness of the infertility service is questioned, as is the danger of raising false expectations among clients about the reversibility of their infertility. The clinic conducts a thorough pelvic examination of the woman, and semen analysis of

her husband. If indicated, she is then referred to a local hospital for a hysterosalpingogram. If blocked tubes are found, Mkomani will perform a diagnostic laparoscopy to confirm this diagnosis. If only minimal adhesions are identified, the patient is then referred to a hospital for a laparotomy. The entire procedure, however, is probably beyond the financial reach of most of the clients.

3.4 Service Statistics

FPIA's system for keeping service statistics is closely followed. In addition to the serious shortcomings noted in Section 2.3, the vast numbers of acceptors at this point are making manual record-keeping increasingly difficult. FPIA does random spot checks from client records of age and parity, but these data are not tabulated routinely and are not easily available. For injectables, the clinic also keeps Ministry of Health records.

3.5 Income-Generating Potential

Project personnel have been aware from the inception of that FPIA assistance will eventually be phased out, but still are hopeful of continuing support after the 1986 funding period ends. The major support at present is for salaries and is critical to the project's operation. The clinic is continually approaching alternative donors and is attempting to make wise investments of private contributions. Other major donors have included The Rotary Club, The Norwegian Agency for International Development (NORAD,) AVS, Johns Hopkins Program for International Development in Gynecology and Obstetrics (JHPIEGO), and International Women's Health Coalition (IWHC.) FPIA has, to its credit, facilitated the clinic's contact with other donors.

Attempts to generate significant income from client fees and/or other projects seem unreasonable in this environment (over 90 percent of Mkomani's clients have a monthly income of under 600 KS, or \$36.00 per month). Focus on income generation could also detract from the present high quality of service delivery. At present, there is a minimal charge for some family planning services (oral contraceptives, sterilization and IUDs), but no client is turned away for inability to pay.

In the event FPIA withdraws and the clinic cannot raise other funds, the project's plan is to reduce the number of field workers.

3.6 Cost Issues

The cost to the Project of a tubal ligation is \$11 per client, down from the earlier cost of \$21.00. The change is due to reduction in doctors' fees. The costs may be reduced further when FPIA headquarters approves a full-time physician to perform sterilizations; at present these are done by a consulting physician.

Unlike the Chogoria project, the clinic does not have a large curative patient load and resulting financial base from which to subsidize its family planning and MCH services.

3.7 Administration, Management and Staffing

The management appears effective. The Compliance Officer from FPIA Nairobi keeps a tight rein on compliance with subcontract terms and conditions, and the project closely adheres to FPIA terms and conditions. The quality of staff is high, although the number may be insufficient.

3.8 Information and Outreach

An evening film show/discussion in the village and home visits were observed. The former appeared to have limited impact (the audience was primarily children), but the latter appeared very successful.

Recommendation: The IEC approach to the project is very traditional, and could benefit from new suggestions in this field by FPIA.

Field workers were clearly well-acquainted with the neighborhood and with acceptors and were well-respected, persistent, yet caring in their approach. The project's physician has also visited other private doctors in the area to invite them to refer family planning clients to Mkomani if they do not offer the services themselves. The physicians are reported to be receptive.

3.9 Evaluation

A project evaluation scheduled by FPIA for April 1985 was postponed until 1986, due to the workload of the Nairobi office.

3.10 FPIA's Role

Support of this program represents a good choice by FPIA. Its innovative approach to CBD, its solid leadership, and its record of successful service delivery together make it a candidate worthy of support.

Recommendation: FPIA could increase its impact on the project by offering technical assistance in the design of new services (i.e. the new infertility services) to ensure their appropriateness and cost-effectiveness.

KENYA: PERSONS MET

USAID/REDSO	Ms. Rosilyn Waithaka
USAID/Nairobi	Mr. Gary Merritt, Population Officer
UNFPA/Nairobi	Mr. Michael Heyn, Deputy Representative
Kenya-06	Mrs. Hayati S. Anjarwalla, Chairperson, Mkomani Harambee Clinic
	Dr. Rafique Parkar, Project Physician
	Mr. Prafull Mehta, Project Assistant
	Ms. Mary Edwards, Sr. Field Worker
	Ms. Margaret Awino, Field Worker
	Ms. Theresa Jembe, Field Worker
	Mr. Dickens Martin, Field Worker
	Mr. McDonald Mvoo, Field Worker
Kenya-09	Mr. Malcolm McNeil, Project Director
	Mrs. Olwen McNeil, Nurse
	Dr. C.N. (Kees) de Boer, Medical Adviser
	Mrs. Lydia de Boer, Nurse
	Mr. Justus Waboyo, Income-Generating Officer
	Rev. Geoffrey K. Bundi, Youth Officer
	Mrs. Jane M. Njeru, Assist. Youth Officer
	Mrs. Enid Miriti, Clinic Supervisor
	Mr. E.B. Mpungu, Hospital Administrator
	Mrs. Helen K. Raini, Hospital Matron
	Dr. Geoffrey Lachlan, Acting Medical Officer in Charge

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Mrs. Y.M. Rinngu, Clinic Nurse (Kiereni
Clinic)

Mr. Daniel Mburia, Key Teacher Youth Program
(Kiri ani Primary School)

Mr. Japhet Miriti, Headmaster

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APPENDIX P3

ZAMBIA: TRIP REPORT

ZAMBIA: TRIP REPORT

GLOSSARY ·

ESAMI	Eastern and Southern Africa Management Institute
MEC	Makeni Ecumenical Center
MOH	Ministry of Health
NGO	Non-governmental organization
PPAZ	Planned Parenthood Association of Zambia
PSZ	Pharmaceutical Society of Zambia
UTH	University Teaching Hospital
ZEN/ZEM	Zambia Enrollee Nurse/Zambia Enrolled Midwife

APPENDIX P3
ZAMBIA: TRIP REPORT

Projects Visited: Zambia-02: The Lusaka Responsible Parenthood Project

Zambia-04: The Ministry of Health/University Teaching Hospital Family Planning Project

Zambia-05: Private Enterprise Family Planning Project

1. General Introduction

1.1 General Climate for Family Planning

Child-spacing services have been offered as an explicit part of primary health care by the Ministry of Health (MOH) since 1980 and with the assistance of the Planned Parenthood Association of Zambia (PPAZ) since 1972. Although an official program commitment exists, the many restrictions and conditions for service delivery imposed by the MOH definitely impede the rate of program acceptance.

At present, the government of Zambia does not have an official family planning or population policy, although it is hoped that one may be formulated and officially announced after a December 1985 UNFPA-sponsored policy seminar is completed. Government interest in such a policy has increased recently due to the severe national economic problems, (including further devaluation of the Kwacha and reduction in copper prices), and could lead to an intensified interest in family planning.

The government's firm policy that medical services and drugs must be offered free makes any income-generating potential for family planning projects largely unfeasible at this time. The government feels it is too soon to introduce CBD on a large scale, but does permit some small non-governmental organizations (NGO) (such as the Makeni Ecumenical Center [MEC]) to use CBD on a small scale.

FPIA's constructive, continuing presence in Zambia will be increasingly important (by supporting successful family planning project models) if family planning does assume a higher priority in the future.

Recommendation: In the meantime, it is recommended that FPIA consider increased invitational travel for MOH officials as a potential means of acquainting Zambians with other, more intensive, less conservative models of service delivery in the region.

1.2 Relationship of FPIA with USAID/Lusaka

The relationship with FPIA/Nairobi staff and the USAID mission is mutually respectful but remote due to USAID/Zambia's bilateral program being focused on agriculture without any activities in family planning, population, and health. At present, FPIA is the only U.S. cooperating agency working in Zambia. In the Zambia-04 project, which serves the MOH rather than the usual private sector channels, FPIA is functioning much like an AID bilateral program.

FPIA's projects in Zambia are in keeping with overall AID policies and also with the recommendations of a recent AID assessment team to concentrate in Zambia, on "focused areas for support to service delivery through non-governmental channels...to meet of some of the country's most urgent needs and at the same time build a base -- in improved management, in information collection and use, and in tested models for service delivery -- for later, large scale donor assistance". 1/

1.3 Contraceptive Methods

A wide range of methods is available, in theory, to married women who have obtained their husband's consent. Oral contraceptives are one of the most popular methods. IUDs have a potential, but at present are limited in part because they can only be inserted by physicians. Sterilization is legal for health reasons but rarely undertaken for limiting family size. Depo-Provera is banned by the Government. Diaphragms are not popular. Foam is often given as an interim method while the client awaits a clinic visit. Natural family planning efforts are supported by other local groups and with AID funds. Condoms are reputed to be extremely popular in Zambia, and are being widely distributed by FPIA. The actual demographic impact of condom distribution and use is unclear, however, as many men apparently use condoms in extra-marital relations for contraception and to prevent sexually transmitted diseases, rather than using them at home to space or limit family size.

1/ U.S. Agency for International Development, "Pre-assessment of Population, Maternal and Child Health and Family Planning in Zambia," January, 1984.

Overall, however, contraceptive prevalence in Zambia is estimated to be only 2-3 percent. 2/

Abortion has been legal in Zambia since 1972 but is difficult to obtain due to the many conditions which must be satisfied: an approved institution, signature of three physicians, etc. The large number of incomplete, septic abortions (according to hospital admissions records) indicates unsafe abortion is a major problem. FPIA regional staff and grantee staff are well aware of AID restrictions in this area, and strictly avoided any involvement in this area.

2. Zambia-02: Lusaka Responsible Parenthood Project
Current Funding Period: 1 July 1984 - 31 December 1985
Level of FPIA Funding: \$56,110

2.1 History and Objectives

The Makeni Ecumenical Center (MEC), the grantee agency, has offered family planning in Zambia since 1971, and has received FPIA assistance since 1981. The present funding period ends December 1985 and an extension proposal (for an additional 16 months) is awaiting FPIA headquarters approval. The project seeks to expand family planning service delivery by initiating CBD in four peri-urban areas of Lusaka and in the Kebwe Rural area, and by conducting family planning IEC activities at 22 service delivery points and training centers.

2.2 Community-Based Distribution Outreach Approach

CBD is the major thrust of this project, and it could serve as a model for further replication. While the quality of services offered at the static MEC clinic is excellent and a sincere and dedicated effort is being made in the CBD area, there are some serious shortcomings. The system operates at three levels: the field workers (four at present) who conduct home visits primarily for motivational purposes; the Mercedes mobile clinic van donated by FPIA and staffed by qualified nurses, which visits selected sites twice a month; and the static MEC clinic that serves as the clinical back-up. The project interprets informal MOH guidelines for service delivery conservatively, resulting in service delivery limitations. (Even getting approval for field workers to deliver foam through the CBD channel was a major obstacle initially.) A field trip with the mobile team revealed demand for family planning was extremely

2/ Ibid.

high, even on a day when the visit was unscheduled, but the large majority of women did not receive services during their visit because:

1. The mobile van, a major FPIA investment fully equipped with clinical facilities, is functioning as a normal vehicle and grossly underutilized. The project does not intend to use the van for IUD insertion, voluntary sterilization, or even pelvic examinations, because the lights have ceased functioning, cleanliness cannot be ensured, and clean water is not available for the water tank.

2. Family planning clients interested in receiving oral contraceptives for the first time must satisfy the standard FPIA medical checklist, and these additional conditions as well:

- a) Have a pelvic examination by project staff (in most cases), a procedure only done at the MEC clinic. This is to ensure that the client is not pregnant, has no cervical problems, vaginal infections, or cancerous growths, etc.; and
- b) Appear for her first supply (in most cases) on the fifth day of her menstrual period. Patients who appear for oral contraceptives mid-cycle are given foam (and sometimes condoms) and often told to return to the clinic during her next menstrual period.

The implications of these restrictions on satisfying the potential for increasing demand for contraceptive acceptors and on ensuring that clients continue with a method need not be elaborated. The large number of new acceptors which the Project has actually recruited, however, (7,820 since 1981), is testament to many women's determination to limit family size.

A positive addition to the mobile clinic team is the male driver, who distributes condoms and discusses family planning with male villagers while the female field workers work with women. He finds demand high, and distributes a large number of condoms through this forum.

The MEC plans in future to distribute condoms to shops as an income-generating venture, similar to the approach being tried by the Pharmaceutical Society of Zambia, under FPIA support.

2.3 Service Statistics

As noted in other FPIA-supported projects, the records are kept scrupulously but the system design could be improved. Field

workers now keep records of their house visits (primarily as a tool to evaluate their performance), but these records only indicate condom distribution, not the client's interest in other methods, contraceptive resupply needs, etc.

2.4 Cost and Income-Generating Implications

In compliance with government policy, the Project must offer all services free of charge. However, it has recently added a membership fee of 2 Kwacha (\$0.30) per year for initial acceptors, as an income generating venture. The fee will be reduced for continuing acceptors in subsequent years. Cost per client figures are not available.

The plan to sell condoms to neighboring shops may also generate income (see Section 2.2).

2.5 Commodities and Logistics

FPIA provides contraceptive commodities directly to the project, rather than through the stocks it normally provides to the MOH. This system ensures speedy import clearance and more reliable reporting, storage and utilization of the supplies. In fact, MEC has occasionally supplied the MOH with contraceptives when their stocks have run short.

2.6 Administration, Management and Staffing

The project, administered by expatriate missionaries, appears well managed at present. FPIA should seek to ensure that a national counterpart for the overall MEC is eventually trained to ensure continuing high quality management. The Responsible Parenthood Project itself is run by a highly qualified Zambian woman with many years of earlier government experience.

2.7 Role of FPIA

This is another example of FPIA's effectiveness in project selection; FPIA has made a large contribution in promoting one of Zambia's few ongoing family planning projects.

Improved technical assistance by FPIA in project design and implementation would have helped avoid such mistakes as the purchase of the expensive mobile van, inappropriate for the needs of the project.

3. Zambia-04: Ministry of Health University Teaching Hospital (UTH) Family Planning Project

Funding Period: December 1, 1984 - March 31, 1986

Level of FPIA Funding: \$134,508

3.1 Objectives

The prime objective of this project is to assist the government of Zambia strengthen the delivery of family planning services by training doctors and nurses in family planning service delivery, training and supervision, and by strengthening the contraceptive distribution and logistics system. FPIA identified these areas as gaps in the government system and areas which UNFPA ceased funding due to budget limitations. During this funding period the nursing supervisors are scheduled to complete their 12-week training course in December 1985; the Zambia Enrolled Nurses/Zambia Enrolled Midwife (ZEN/ZEM) training is scheduled for January 1986. No acceptors are yet reported specifically through these trained nurses, but acceptors who receive FPIA-provided contraceptives through normal government channels are recorded in the overall government service statistics system.

3.2 Service Statistics, Commodities and Logistics

An FPIA Regional Office staff member, on a recent visit to the Project, indicated that additional technical support might be appropriate for commodities and logistics. The government expressed a frequently heard complaint about AID-provided oral contraceptives in Africa: that the brands provided by AID (which must be produced in the United States) are not popular with African women.

The government views the FPIA service statistics system as an improvement over the former government system and plans to adopt it nationally. A seminar to be sponsored by the Eastern and Southern Africa Management Institute (ESAMI) in January 1986 will train additional staff in the FPIA record-keeping system.

3.3 Role of FPIA

Because of its direct assistance to a government effort, FPIA, in this project, is functioning much like an AID bilateral program. As the only AID cooperating agency working in Zambia, FPIA can fill an increasingly useful role in supporting the government as it moves from a limited child-spacing-only program to a broader family planning program. With limited funding and no in-country staff, however, FPIA has less influence over this

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government program (including issues of direction, innovation or quality), than it does with smaller, private sector projects. Within these limits, it could make an important contribution in advocating less conservative, more effective modes of service delivery to the government.

4. Zambia-05: Private Enterprise Family Planning Project
Funding Period: February 1, 1985 - January 31, 1986
Level of FPIA Funding: \$80,584

4.1 History and Objectives

This is a new, highly innovative project incorporating the concepts of commodity provision, income generation, social marketing and private enterprise. Its objectives are to distribute 4.8 million condoms through 40 retail pharmaceutical outlets and to hold two seminars for the 40 members of the Pharmaceutical Society of Zambia (PSZ) (which will be selling the condoms) on family planning methods.

The Project is based on two premises: that condoms are popular in Zambia and that there has been a serious shortage of this imported commodity due to increasingly scarce foreign exchange.

4.2 Cost and Income-Generating Consideration

FPIA estimates the Project cost at \$1.26 per year per client served, based on the assumption of 66,000 males served per year. The amount of income generated will be directly related to numbers of condoms sold to and through the pharmacies.

Condoms are to be provided free to the PSZ by FPIA, and then sold by the PSZ to individual affiliated pharmacies for .10 Kwacha each (\$.016). The pharmacies will then sell condoms to their customers for .15 Kwacha each (\$.025), representing a 50 percent profit.

During the first 12 months of the project, revenue to the Society is expected to be approximately 480,000 Kwacha (\$79,000). As revenue accrues, the PSZ will reduce condom prices; reduce its dependency on FPIA for salary support, etc., purchase a Project vehicle, build a warehouse, and initiate other family planning activities. At present exchange rates, if the PSZ meets its target, it could effectively pay for its second year of activity.

Central issues, not yet adequately addressed by the PSZ or FPIA are the rate and timeliness of reduction in condom prices,

and the potential uses of the revenue for family planning activities.

Recommendation: FPIA should monitor the situation closely to lend technical assistance in planning these activities.

4.3 Information/Outreach Component

Effective information efforts are needed for

- o promotion of the condom in general;
- o promotion of the FPIA-supplied condom (to overcome the opinion that since it is the least expensive brand available, it is inferior); and
- o to display the product prominently and attractively in pharmacies where it is sold (through "point of sale" materials).

FPIA/Nairobi has promised to send sample materials from other countries to assist in this design, and an advertising firm has been contracted locally.

The first of two seminars planned to acquaint pharmacists with the project, and with family planning methods in general, will begin November 18, 1985.

Political considerations may restrict IEC activities, as some conservative groups in the country are averse to public advertising of contraception (although natural family planning is apparently advertised freely in the press by the Catholic church).

4.4 Administration, Management and Staffing

The bookkeeping system in use follows that prescribed by FPIA's terms and conditions for accounting for income generated, and for commodity management. This system, however, may prove too unwieldy if and when sales reach the expected volume.

Recommendation: It is suggested that the Compliance Officer from FPIA/Nairobi or another consultant visit regularly and offer technical assistance in bookkeeping, since the volume of funds involved will present a major challenge and a potential for errors in financial management.

All posts except that of storekeeper are filled, and staff appear adequately qualified.

4.5 Coverage and Impact

The population coverage could be substantial, since all 40 recognized pharmacies in the country will participate.

The project is restricted to pharmacies at present to assure control over pricing (to avoid price-hiking, etc), but if it is successful, it will be expanded to regular drug stores and other supply points.

The project will certainly increase the availability of condoms and should, to some extent, reduce the incidence of STDs, a serious problem in Zambia. Actual impact on the number and spacing of births will depend on how consistently the condoms are used and the extent to which they are used within, as well as outside marriage.

In the first four months of the project alone, over 40,000 condoms were sold to pharmacies.

4.6 Role of FPIA

This project is an excellent example of FPIA's capacity to support innovation and to take risks in creative programming. With continuing follow-through of technical support by FPIA, it could become a highly successful bridge in the gap of condom services in Zambia, and a model for other similar efforts. FPIA has combined a careful country needs assessment with AID priorities in the areas of social marketing and private enterprise.

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ZAMBIA
Persons Met

USAID Mr. J. Patterson, USAID Representative

UNFPA Mr. Teferi Seyoum, Deputy Representative
Mr. Hugo Mpamba, Programme Assistant

ZAMBIA-05 Mr. Ceasar Mudondo, Chairman, Pharmaceutical Society of Zambia
Mr. Mark Musonda, Project Administrator
Mr. Chilufya Lundamo, Bookkeeper
Two participating pharmacists

ZAMBIA-02 Rev. Pierre J. Dil - Part time Project Director
Mrs. Elizabeth Kapambwe - Senior State Registered Nurse
Mrs. Maggie Chiwuswa - Zambia Enrolled Nurse/Midwife
Mrs. Alice Mutinta - ZEN/Midwife
Mr. Patson Chibambo - Male Instructor/Driver
Miss Mirriam Nyironge - Instructor/Cleaner

Fieldworkers:

Mrs. Faustina Ndonga - Chipwili
Mrs. Irene Nyirenda - Mimosa/Linda
Mrs. Jessie Katongo - Shantumbu
Mr. Lupenga Sakala - Kamaila

ZAMBIA-04 Dr. E.K. Njalesani, Director of Medical Service, Ministry of Health
Mrs. Therasa Mwinga, Nurse Tutor, Ministry of Health
Mrs. Chikunga - Nurse Educator, Ministry of Health
Miss W. Chisha, Clinical Services Coordinator, Ministry of Health

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APPENDIX P4
EGYPT: TRIP REPORT

EGYPT: TRIP REPORT

GLOSSARY

AMM	Assistant Medical Manager
ARO	Africa Regional Office
CABU	Coptic Orthodox Association for the Brothers of the Underprivileged
CEOSS	Coptic Evangelical Organization for Social Services
Cu-T	Copper-T
FHCC	Family Health Care Centers
FOF	Family of the Future
GOE	Government of Egypt
MM	Medical Manager
NFP	Natural family planning
NPC	National Population Council
OC	Oral contraceptive
PVO	Private voluntary organization

Appendix P4

EGYPT: TRIP REPORT

Projects Visited: Egypt 02 "Community Based Family Planning in Rural Egypt." Coptic Evangelical Organization for Social Services (CEOSS)

Egypt-07 "Population and Family Welfare Project". Coptic Orthodox Association for the Brothers of the Underprivileged (CABU)

1. General Assessment

1.1 Significance of Projects vis-a-vis Host Country Needs

Mr. Effat Ramadan, Director of the National Family Planning Project, was aware of the FPIA-supported CBD projects. He observed that the projects were of great interest to the National Population Council (NPC) for two reasons. First, because they are implemented by the Coptic Church, their political impact is significant. Second, because the government program plans to emphasize the CBD approach, Ramadan feels the NPC can benefit from the experience of the projects. He was particularly interested in the training of CBD workers and the possibility of basing national-level training on the curriculum already developed by the projects. He asked that FPIA Regional Office staff determine if project heads would be willing to cooperate with the NPC.

In sum, Mr. Ramadan felt that the projects had a political and programmatic significance far beyond actual numbers served and urged continued support for these activities.

1.2 Appropriateness of the Projects vis-a-vis AID/Cairo Country Strategy

Given the ambivalent attitude toward family planning within the Government of Egypt (GOE) bureaucracy, USAID/Cairo's strategy has been to attach high priority to private sector projects, primarily to contraceptive retail sales and, to a lesser extent, to projects implemented through private voluntary organizations (PVOs). AID consciously endorses pluralism in the provision of family planning services, and therefore welcomes FPIA support in this effort. FPIA's ability to identify and support demonstration projects is viewed as a strength, as is its management style. USAID agrees with Ramadan's assessment of the political

importance of the project's association with the Coptic Church.

AID/Cairo urges that FPIA projects adopt the use of CYP as a measure of program performance. (Note: USAID/Cairo wants AID/Washington to amend FPIA's Cooperative Agreement to allow subgrantees to purchase contraceptives from revenue. The African Regional Office (ARO), which does not think this will work, has arranged for NPC to clear commodities for FPIA projects.)

2. Egypt-02: "Community Based Family Planning in Rural Egypt"

FPIA has been supporting this CBD project, implemented by the Coptic Evangelical Organization for Social Services (CEOSS), since 1975. The general aim of the project, which operates in 38 villages in Upper Egypt and in selected slum areas of Cairo, is to introduce family planning services in areas currently underserved, and to develop local leadership. These services are provided by CEOSS as part of its integrated community development program, which has been operating since 1952.

2.1 Long-range plan

The Project Head reported that her ultimate goal was to extend project activities throughout El Minya and Assuit provinces. She was aware that this would require a significant increase in funding level, but is not currently approaching other potential donors.

FPIA Regional Office staff plans to work with the Project Head to develop a more realistic long-range plan, based in part on a phasing out of support for the "maintenance" (quasi-self-sufficient) villages (see Section 2.7). This revised strategy will provide the basis for the continuation of FPIA support beyond the current funding period, which terminates in July 1986.

2.2 Staffing

The project is managed by a part-time Project Director (based in Cairo), and a full-time Project Head (based in Minya).

The Project Head, with a degree in Social Work, has been with the project since its inception. She is assisted by four field assistants, an accountant, a storekeeper, 68 field workers and 65 village leaders. The field workers are young graduates of El Minya University, both male and female, who are assigned to work in "new" villages (as opposed to "maintenance" villages--see Section 2.1). They receive initial training before being posted to the field as well as continuing training during weekly staff

meetings. Village leaders are carefully selected during the two to three years of intensive CEOSS support in a village. The leaders are all literate, married women who are currently using family planning and are highly respected in their communities. CEOSS has recruited both Moslem and Christian leaders and the fact that not a single leader has ever left the program is indicative of the effectiveness of CEOSS' careful selection process.

Medical services are provided by 14 physicians who work part-time for the project. A weakness in the project is the lack of a staff physician or medical advisor to provide central leadership and to oversee quality of medical services.

Recommendation: A part-time medical consultant should be hired to supervise project physicians and village leaders and provide technical assistance in contraceptive service delivery.

2.3 IEC Program

The core of the IEC program is the monthly or bimonthly village meetings organized by the village leaders. These meetings are conducted by CEOSS staff and a guest speaker (such as a religious leader), and focus on the importance of family planning in the context of community development. Meetings are followed by a film or slide show and discussion period.

CEOSS has also developed posters and a series of pamphlets on various contraceptive methods, family life, breastfeeding, etc. These pamphlets are not designed for illiterate or semi-literate women and therefore are usually read to clients during counseling sessions. Few, if any, acceptors are given materials to take home. In addition, information on family planning is provided by the field workers/village leaders during home visits.

Recommendation: CEOSS should obtain or adapt materials for semi-literate or illiterate users developed by Family of the Future (FOF) 1/ for distribution to acceptors.

2.4 Technical Assistance

The FPIA regional office staff conducts monitoring visits once or twice a year to assess project performance and provide technical assistance, principally in program and commodity management. The Project Head felt this was adequate. When asked about programmatic problems, however, she expressed concern that an error in judgment on the part of the physicians working in the

1/ A contraceptive social marketing operation in Egypt.

project would have serious repercussions. Symptomatic of this cautious attitude is the practice of distributing oral contraceptives (OC) one cycle at a time and removing Cu-Ts after two years, at which time the acceptor is switched to another method so her body can "rest" for a while. She did not appear to see this as a need for technical assistance, however. The addition of a part-time medical consultant would address this issue (see recommendation under 2.2).

2.5 Quality of Services

a) Project: The Project Head reported that she had not received any information on recommended medical practices/standards from FPIA. She did receive various publications such as Contraceptive Technology and Population Reports, but felt these were of little value since none of the project staff speaks English. Of more use were publications issued by the Egypt Fertility Care Society, which were distributed to appropriate staff. All new acceptors are required to have a doctor's examination before receiving oral contraceptives (OC). Physicians also insert IUDs and fit diaphragms. 2/ Field staff village leaders may distribute foam and condoms, and provide pills to continuing users. Physician services are subsidized by CEOSS. Clients in new villages may visit the doctor as often as they wish. New IUD or pill acceptors in the maintenance villages may see the physician as often as they wish during the first three months of use. Continuing users are permitted only two subsidized visits a year.

Recommendation:

- 1) CEOSS should evaluate the actual need for frequent subsidized clinic visits.
- 2) The medical consultant should train the village leaders in the use of the Pill Checklist for screening to cut down on the need for routine physician examinations for new pill acceptors. Village leaders should also receive training in the identification of problems requiring referral to a physician and those requiring mere counseling/reassurance.

b. Regional Office: None of the Project Directors of projects visited in Egypt and the Sudan had received a copy of the simplified FPIA Medical Standards Manual.

2/ Natural Family Planning (NFP) is theoretically offered, but the Project Head reports few requests and many pregnancies.

There are plans for the Project Head from Egypt-02 and the Project Director and Medical Director from Egypt-07 to attend the planned Nairobi meeting on clinical and program management.

2.6 Evaluation Activities

a. Program: The ARO evaluates project progress by means of progress reports and site visits. Given the frequency of both, they are felt to be sufficient to identify any problems in project implementation.

The Project Head monitors the project through the monthly service statistics submitted by the Village Leaders/Field Workers. These are carefully reviewed with a focus on the number of new clients recruited and the number of dropouts. If the Project Head finds a problem, she or one of her assistants visits the village to discuss the situation. In addition, project staff periodically conduct random checks to verify reported acceptors.

Selected statistics (such as new acceptors, number of dropouts and continuing users) are periodically summarized for FPIA or CEOS reports. Data on age and parity, although reported in the individual worker report, are not summarized or reported. Nor are comparisons made between villages, or progress charted over time. The focus is almost entirely at the individual village or worker level. While this appears to be adequate for routine monitoring, it does not permit monitoring of overall trends or project progress.

Recommendation: Periodic summaries of use, broken down by method accepted and by age distribution, as well as number and type of contraceptives issued (to calculate CYP) should be used to track trends/growth of the program and verify that it is reaching the appropriate population. This information can also be used to verify the number of active users and to plan for the resupply of commodities to village distribution parts.

b. Commodities: Regional Office staff routinely check and verify stock during site visits and check reorders for commodities against reports on numbers of acceptors.

The Project Head reported that she was in desperate need of Norminest and Copper-T (Cu-T) IUDs, having submitted an order to the ARO eight months earlier. Since the ARO had not received the order, and she had not followed up, she was now completely out of IUDs. New acceptors were apparently going to the government clinic to obtain an IUD and seeing a project physician to have it inserted. Village Leaders were buying Norminest from pharmacies and selling it to clients at cost.

2.7 Income-Generation

Approximately five percent of total project costs are covered by revenue generated through clinic fees and the sale of contraceptives (with the exception of the IUD). No client, however, is refused service because of inability to pay.

Under the current structure, there appears to be no possibility of self-sufficiency for this project. Villages labeled quasi self-supporting ("maintenance villages") are in fact quasi self-sufficient only in terms of technical assistance. All services, commodities, and the salary of the village leader are totally subsidized by the project. Even with economies of scale, further expansion of activities will require ever-increasing financial and commodity support.

Recommendation: Long-range strategy should focus on identifying means of reducing the dependence of the maintenance villages on project funding through a gradual phasing out of support for subsidized clinic visits and Leaders' salaries. Commodity support may have to continue for some time.

2.8 Project Impact

Information on project impact, other than the reports on new and continuing acceptors submitted to FPIA, was not readily available.

An attempt was made to calculate CYP based on issues from the central storehouse to the distribution points, but not all the requested data was transmitted from El Minya to Cairo prior to the consultant's departure due to a problem in the phone lines. CYP was calculated for 1984 and 1985. In 1984, the project achieved 3,595 CYP, compared to a projected 2,266 in 1985 (Table 1). The apparent reduction in coverage for 1985 can be traced primarily to the shortage of Norminest and Cu-T IUDs (see Section 2.6b). (Note: Calculations cover only FPIA-supplied contraceptives)

Although information on the age and parity of individual clients is collected at the village level and submitted in monthly reports, it is not summarized. Given the lack of time available, a sample of March statistics (considered an average month) was collected for 1981-1985. The results are presented in Table 2. With regard to age of acceptors, there appears to have been a gradual shift to the lower age groups, with the bulk falling into the 20-29 years category. The parity of the acceptors also appears to be falling, particularly the proportion with five or more children. Approximately one-third of new

clients in March 1981 had five-plus children, compared to less than 20 percent in March 1985.

According to the CEOS's annual reports, whose figures are based on FPIA's definitions of new and continuing acceptors, the program has produced average continuation rates around 74 percent of total acceptors. Due to problems in the FPIA recording system, however, which tends to inflate the number of continuing users, these data are not completely reliable. The same caveat holds for cost per acceptor calculations, (not including commodities), which range from a low of \$5.16 in 1982/83 to \$9.77 in 1984/85 (see Table 3). This compares favorably to an estimated cost per acceptor in the GOE program of \$25-30.

Table 1

CYP Achievement Based on Contraceptives
Distributed to CBD Workers 1/

CBD Program of Contraceptives

Contraceptive	Quantities Distributed		Conversion Factor	CYP	
	1984	1985 <u>2/</u>		1984	1985 <u>3/</u>
Pill	21,700	18,413	.0769	1,669	1,416
Condom	23,400	24,933	.01	234	249
IUD	640	220	2.5	1,600	550
Foam	98	119	.25	25	30
Diaphragm	67	21	1	<u>67</u>	<u>21</u>
				3,595	2,266

1/ FPIA-supplied contraceptives only

2/ projected, based on nine months experience

3/ Does not include Norminest, which is more popular and will be supplied by FPIA in future.

Table 2

Age and Parity Distribution of New Acceptors: 1981-1985
(Percentages and Total Numbers)

(Sample of March Records Only)

<u>Age</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
20	3.3%(6)	8%(22)	5.3%(6)	10.4%(23)	8.7%(18)
20-29	40%(73)	53%(144)	49.6%(56)	42.5%(94)	46.3%(94)
30-49	42.8%(78)	36.5%(99)	41.6%(47)	38.9%(86)	39.9%(81)
40+	13.7%(25)	2.2%(6)	3.5%(1)	8.1%(18)	4.9%(10)
	(182)	(271)	(113)	(221)	(203)
<u>Parity</u>					
1	9.1%(17)	10.9%(30)	14.5%(16)	12.3%(28)	8.7%(18)
2	16%(30)	20.4(56)	20.9(23)	17.6(40)	24.1(50)
3	22.5%(42)	22.2(58)	22.7(25)	25.9(59)	28.0(43)
4	19.3%(36)	23.7(65)	20.0(22)	19.4(44)	20.8(43)
5+	33.2%(62)	23.7(65)	21.8(24)	24.6(56)	18.4(38)
	(181)	(274)	(110)	(227)	(207)

Table 3

Cost Per Acceptor: 1981 - 1985

<u>Funding Period</u>	<u>Budget</u>	<u>#Users (new & cont)</u>	<u>Cost per Acceptor</u>
4/1/81-5/31/82	\$81,533	10,649	\$7.66
6/1/82-6/30/83	78,986	15,307	\$5.16
7/1/83-7/31/84	104,543	11,689	\$8.94
8/30/84-7/31/85	97,984*	10,032	\$9.77

Average Cost: \$7.88

*obligated value

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3. Egypt-07: Population and Family Welfare Project

This project is a redesign of an earlier project (Egypt 01) that has been receiving FPIA support since 1975. The overall objective of the project, which is implemented through the Coptic Orthodox Association for the Brothers of the Underprivileged (CABU), is to continue and expand the provision of family planning services through a network of Family Health Care Centers (FHCC) in Upper Egypt and in the slum areas of Cairo.

3.1 Long-range Plan

Over the next five years, the project will gradually phase out support for FHCCs, starting with five during the first 16 months. It takes approximately four years for an FHCC to become independent, although the project continues to supply commodities and supervision.

As CABU reduces activities in one area, however, it initiates activities in a new one, so the base of support required is more or less the same from year to year. The Project Chairman noted that it was time to look ahead to the period of post-FPIA funding. He felt it was possible for at least some of the activities to be absorbed under the Church's health program.

3.2 Staffing

The Project is directed by a Project Chairman (75 percent time) and a full time Project Director. Key staff include the Medical Manager (MM), the Field Manager and a Training/Evaluation/Materials Manager. The FHCCs are staffed by a full-time supervisor (under a regional supervisor), and part-time doctors, nurses, educators and field workers.

A new position under this project is the part-time Data Analyst. The person currently occupying this position was found to have no formal training in statistical data analysis. It appears that the MM is doing most of the work.

The MM, who has been with the program for five years, and the Assistant Medical Manager (AMM), with the program for three years, have backgrounds in pediatrics. The AMM indicated a desire for more specialized training, a view seconded by the Project Chairman. It was not possible to assess the qualifications of the MM.

CABU has prepared and distributed a "Guide for FHCCs" that explains what an FHCC does and identifies the responsibilities of and qualifications required for each staff member. For example,

the fieldworkers, the majority of whom are female, must have a secondary school degree (or equivalent), be a church worker, and complete an orientation course (as well as receive ongoing training). They are selected through the local Church Committee.

Recommendation: Identify new staff member, with background in statistics, for Data Analyst position, or provide formal training in family planning program data analysis for current incumbent. (The Project Chairman plans to increase the position from 30 percent to 50 percent of the time). Identify need and provide specialized training in family planning for key medical staff.

3.3 IEC

The current IEC program consists of pamphlets for trainers, a poster developed by CABU, films and slides. In addition, the Project Chairman feels that the project benefits from the publicity campaign of FOF. No materials have been developed specifically for clients. IEC sessions are held at the FHCCs and in the communities, and consist of talks on family life/family planning, followed by film/slide shows.

In one of the two clinics visited, no family planning materials or posters were in evidence. The Project Chairman promised to look into this.

Recommendation: CABU should obtain or adopt materials for semi-literate or illiterate users developed by FOF for distribution to acceptors.

3.4 Technical Assistance

The Project Chairman had recently responded to a Needs Assessment questionnaire developed by the ARO in preparation for the Nairobi meeting on clinic and program management (see Appendix P1). He identified the following as areas where technical assistance is required:

- o evaluating workers' performance and defining specific training needs;
- o setting measurable and attainable objectives;
- o developing functional job descriptions for different cadres of workers;
- o motivating workers;

- o managing CBD programs;
- o evaluating the quality of services; and
- o recruitment of trainees and evaluation of training

Recommendation: ARO staff should follow up to determine if these specific needs have been met during the November meeting. If not, TA should be provided, where still needed, either by staff or by outside consultants.

3.5 Quality of Services

The Medical Manager said he had not received the simplified Medical Procedures Manual from the ARO. Information on latest techniques is obtained through publications of the Egypt Fertility Care Society, Population Reports, and attendance at conferences such as the annual meeting. The AMM felt that Depo-Provera caused cancer and was unfamiliar with the mode of operation of NORPLANTR. (It was not possible to evaluate the MM's knowledge of contraceptive technology.)

All new clients must see a physician, although continuing pill clients can be resupplied, at least in theory, by fieldworkers. Apparently women living close to a clinic are only given one cycle at a time and are examined by a physician at each visit. Both Lippes-Loops and Cu-Ts are offered. Women using the latter are told to have it removed after two years, take oral contraceptives for one month, and have a new IUD inserted. Loop acceptors are told to return after five years.

NFP is offered, but the clinic staff reported few requests and many failures.

Recommendation: Needs for additional training of project medical staff should be assessed, as should fieldworkers' knowledge regarding use of the pill checklist. While it is understood that frequent visits to the physician are reassuring to the client, this may place an unnecessary burden on medical staff. The protocol of removing Cu-Ts after 2 years should be modified.

3.6 Evaluation

Project progress is monitored through monthly statistical reports, which are reviewed by the Data Analyst and the Medical Manager. Feedback is provided during staff meeting attended by the Regional Supervisors. If there are any problems, the appropriate member of the central staff reviews them with the Regional Supervisor and/or visits the FHCC. The key indicators

appear to be the number of new and continuing acceptors by method. There is apparently no data on the size of the target population. Data on age and parity of acceptors is collected at the FHCC, but is not reported in summary form at the central level.

3.7 Income Generation

The most important source of revenue is client fees, which average LE1 per visit. Services are free to those who cannot afford to pay. There is a charge for OCs (Noriday: 10 piasters per cycle; Norminest, purchased from FOF, 3 cycles for 10 piasters). There are no data available on the proportion of total costs covered by fees and commodity sales.

3.8 Impact

Beyond reports of new and continuing acceptors, data on impact were not readily available. Table 1, which summarizes data on new acceptors by year and by method, shows a gradual growth in the proportion of women using IUDs. The vast majority are using pills or IUDs, ranging from 82 percent in 1982-83 to nearly 96 percent from December 1984 to July 1985 (the first-07 funding period). The third most popular method is condoms, followed by negligible amounts of foaming tablets, diaphragm, or NFP use.

An attempt was made to calculate CYP based on issues from central stores. Unfortunately, data were not available on the number of cycles of Norminest distributed, since these were not furnished by FPIA until recently. However, Table 2 does give an indication of the substantial growth of the program, particularly following the introduction of FHCCs in 1983. (Prior to that, the program was clinic-based, with an emphasis on IEC rather than service delivery.)

As in the Egypt-02 project, client records record the age and parity of acceptors, but that information is not summarized. An attempt was made to take a sample of records, but due to a breakdown in communications, the data were obtained only for a small number of IUD acceptors.

EGYPT

PERSONS CONTACTED

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Egypt-02:

Mrs. Saud Fam, Project Head
Mrs. Nariman Abedallah, Project Assistant
Accountant
Storekeeper
Village Leaders (2), Samarot East Village
Fieldworkers

Egypt-03:

Bishop Seraphaim	Resp. Official
Dr. Maurice Assad	Project Chairman
Mrs. Hedy Assad	Training Materials/ Evaluation Manager
Dr. Alfred Yassa	Medical Manager
Dr. Ceale Naguib	Assistant Medical Manager
Fr. Antonios	Data Analyst/Field Training
Sisters Batul & Tabiza	Halwal Clinic Regional Supervisors (6)

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Table 1

New Acceptors by Year and by Method

Funding Period	OC	IUD	Condom	Foam Tabs	Diaphragms	NFP	Total
<u>01</u>							
8/80-7/81	11,334 (88%)	488 (4%)	709 (5%)	376 (3%)	-	-	12,907
8/81-7/82	8,411 (90%)	550 (6%)	266 (3%)	110 (1%)	-	-	9,337
8/82-7/83	8,513 (69.7%)	1,505 (11.4%)	1,403 (11.4%)	643 (5.3%)	31 (.3%)	113 (.9%)	12,208
8/83-7/84	7,873 (66.1%)	2,101 (17.6%)	1,268 (10.6%)	595 (5%)	34 (.2%)	42 (.4%)	11,913
<u>07</u>							
12/84-7/85 (6 mos)	7,186 (73.4%)	2,199 (22.5%)	397 (4.1%)	3 (-)	1 (-)	1 (-)	9,787

Note: Data for the period August-November 1984 were not provided

TABLE 2

CYP Achievement Based on Commodities

Issued in Distribution Points 1982, 1983, and 1984

Method	Quantities Distributed ¹			Conversion Factor	CYP Achievement		
	1982	1983	1984		1982	1983 ²	1984
OC	15,000	40,920	51,000	.0769	1,154	3,147	3,922
IUDs	505	370	1,845	2.5	1,263	925	3,613
Condoms	1,400	24,900	6,700	.01	14	249	67
Diaphragm	--	--	32	1	--	--	32
TOTAL					2,341	4,321	8,634

¹ Norminest not included--now provided by FPIA. Prior to 1985, it was procured from FOF.

² FHCC's introduced.

APPENDIX P5
SUDAN: TRIP REPORT

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SUDAN: TRIP REPORT

GLOSSARY

FIFO	First-in first-out
FPE	Family Planning Educator
SFPA	Sudan Family Planning Association
SFCA	Sudan Fertility Control Association
SIC	Sister-in-Charge
SOMARC	Social Marketing of Contraceptives

Appendix P5

SUDAN: TRIP REPORT

Projects Visited: Sudan-02 "Project Hag Yousif"
Sudan-03: "National Commodities Distribution Project"

1. Sudan 02 "Project Hag Yousif"

1.1 General Assessment

1.1.1 Significance of the Project in Relation to Host Country Needs

The Government of the Sudan does not have an explicit policy on population growth/family planning. It has, however, indicated an interest in improving maternal and child health and creating a rational balance between population and resources. The recent change in government has raised hopes that the environment for family planning activities will improve.

Project Hag Yousif is a clinic-based MCH/FP service delivery project in a slum area north of Khartoum, attached to the Sudan Fertility Control Association (SFCA), a research institution founded in 1976. The results of the fertility management study conducted by the SFCA are used in planning health care services throughout the country, so the service link supported by the project is appropriate and logical. Moreover, the integration of family planning with MCH services is in keeping with the national level approach.

1.1.2 Significance of the Project in Terms of USAID/Khartoum Objectives/Country Strategy

USAID staff believes that the Hag Yousif project is particularly important as it has demonstrated that family planning is acceptable. AID has recently (September, 1985) signed an agreement (\$1,796,000 over seven years) with the SFCA to establish a model family planning project. As in Hag Yousif, family planning services will be integrated with MCH services. (USAID/Khartoum has also earmarked approximately \$2 million in grants to assist the Sudan Family Planning Association strengthen its activities).

USAID/Khartoum could possibly assume eventual support for the -02 project. It would be better, however, if the Khartoum

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Regional MOH were to absorb it. According to USAID staff, FPIA has done a good job of coordinating with the Mission. Both Sudan-02 and Sudan-03 were discussed at an early stage to ensure that they complemented the Mission's strategy. Drafts of proposals, trip reports, etc. are all shared with the Mission, so it is generally well informed about FPIA's activities in-country. In USAID's view, it would be better if FPIA staff made more monitoring visits, preferably using the same person(s). This approach would ensure continuity and consistency in project oversight and help develop programmatic expertise in the project staff.

1.2 Long-range Plan

The Project Director feels there are several options, when and if FPIA support ceases. The optimum solution would be for the Hag Yousif Project to be absorbed by the AID-funded Model Clinic project, also with the SFCA. Less desirable options would be for the project to move into the government hospital being built in the Hag Yousif area and/or to obtain commodities through the National MCH/FP Project. The Project Director says the project will never die, but efficiency would be compromised should external support terminate. He feels confident that FPIA assistance will continue for a long time. According to the draft refunding proposal, a total of seven years of assistance is visualized. This is two years beyond the original cycle proposed, in order to give the SFCA time to identify alternative funding sources.

As noted previously, while no formal mechanism has been developed to link the new Model Clinic project with the Hag Yousif project, the AID Population Advisor felt the latter could become a subproject of the Model Clinic. This would be a logical step, allowing the new project to benefit from the considerable expertise developed in the Hag Yousif project.

1.3 Staffing

The project is managed by a part-time (30 percent) Project Director, who is a member of the Board of the SFCA and an obstetrician attached to North Khartoum hospital. He has been with the project since its inception.

The Sister-in-Charge (SIC), who manages the day to day project activities, has been promoted to Project Coordinator in the draft refunding proposal. She is a nurse-midwife and has received specialized training at the Margaret Sanger Family Planning Nurse Practitioner Course. She oversees all medical services at the center, including prescription of OCs and

insertion of IUDs. In addition, she supervises support staff and handles administrative matters such as the preparation of routine reports. She appeared knowledgeable and extremely competent.

She is assisted by two full-time nurses (one is a nurse-midwife) and four family planning educators (FPEs). The FPEs are high secondary school graduates who have completed an intensive two-week MCH/FP course offered by the National MCH/FP Project, as well as on-the-job training by the SIC. The FPEs conduct home visits, follow up clients, and counsel and educate women in the community about MCH/FP. A male FPE had been hired at FPIA's insistence during this funding period. Experience showed this was ineffective given the cultural setting, and he has been terminated.

Five physicians from Khartoum North Hospital offer services to the clinic on a part-time basis. They see only the more complicated obstetric, gynecologic, and pediatric cases.

The project is also assisted by a part-time statistician, who is the Chief of Health and Vital Statistics at Khartoum North Hospital. She has a post-graduate degree in statistics and medical record-keeping. She visits the clinic about once a month to review records and assemble data on new and continuing acceptors. She summarizes these data every four months for the project progress report that is submitted to FPIA.

NOTE: SIC and Nurses are deputed from the MOH.

Recommendations: The Project Director's request to attend an FP program Management/Evaluation course in the United States should receive serious consideration from FPIA.

1.4 IEC

Education about MCH/FP is provided at the clinic, through films and individual and group counseling sessions, and through the outreach work of the FPEs. In addition, the Project has erected six large signboards around Hag Yousof to inform the inhabitants about the location and nature of the services offered.

As in the rest of Sudan, there is a paucity of IEC materials such as posters, informational pamphlets, etc. The SIC said that clients are bored with the films, and that although FPIA has promised additional materials, none have materialized.

Recommendation: FPIA should assist the Project staff in identifying suitable films, slides, etc. from external sources. In

addition, materials being prepared by the SFPA for the logistics project (Sudan-03) should be made available to this project.

1.5 Technical Assistance

The Project Director cited several instances in which he feels FPIA had provided less than adequate response to problems identified during project implementation:

a. During the preparation of the original proposal, the FPIA definition of new clients was not made clear, so the target was radically overestimated. When this target was not met, the Project Director indicated that he met criticism from USAID and that he felt the project's future was jeopardized.

b. The project is desperately in need of a new vehicle. Staff transportation is currently provided by an old Land Rover, which consumes an inordinate amount of petrol. Although FPIA provides funds for petrol, it allows a ration of only six gallons/week. The project site is 20 km outside of Khartoum, and the allotment permits one trip a week at best.

This situation has resulted in problems of coordination/communication between Hag Yousif, Khartoum North Hospital and the SFCA. In addition, because the Hag Yousif catchment area is so large, the FPEs are not able to follow up clients living in the outer areas.

c. While project progress reports are routinely acknowledged by the ARO, the Project Director would like feedback, comments, questions etc. Computation errors found when trying to collect data on new and continuing clients corroborate a need for more scrupulous ARO review.

d. The staff also felt pressured by FPIA to initiate CBD activities that they felt were inappropriate in the Sudan, where women like to be seen by a doctor or senior nurse midwife. e. The Project Director complained that the ARO seemed always to send a new individual for each monitoring visit. Not only did this require extensive briefing each time; no one staff person at Africa Regional headquarters could be counted upon for expert knowledge of this project (see 1.1.2).

Recommendations:

1. The request for a new project vehicle should be presented to FPIA for consideration, as the absence of adequate transport is hampering project activities.

2. ARO staff should carefully review and provide routine feedback on all progress reports.

3. FPIA should provide TA in CBD activities by a knowledgeable and enthusiastic consultant. The SPFA is said to be running a successful pilot CBD project, and the Sudan-02 Project Director and SIC should be encouraged to visit that project.

4. FPIA should consider the pros and cons of sending the same individual on project monitoring visits.

1.6 Quality of Services

The SIC and the Project Director stated that they had received no information on recommended medical standards and practices from FPIA. Because of her training at Margaret Sanger, the SIC is on several mailing lists and routinely receives publications from the Population Crisis Committee, Johns Hopkins, etc. as well as the SFCA newsletter. She also had two copies of a book on contraception published in Arabic by IPPF.

The SIC prescribes OCs and inserts IUDs, but resupply is handled by the nurses. New clients are first carefully examined before a method is finally selected. The staff tries to give the woman her method of choice, unless there are contraindications.

New pill clients are given one cycle; continuing clients can receive up to six cycles. OCs are selling for LS 6-7 in pharmacies, and since the clients are very poor there is a possibility that some of them may be reselling the pills to drug stores.

All clients are given information and counseling about the range of available methods, including NFP (women who wish to try NFP are also given foam). Clients seeking sterilization are referred to Khartoum North Hospital. The number of requests for this method during the earlier funding periods has fallen off to virtually none--probably due to a procedure failure leading to pregnancy in one of the sterilization clients.

Recommendations: The FPEs should ask to see pill packets during home visits not only to verify that the client is taking the pills properly but also to ensure that she is actually using the method.

1.7 Evaluation Activities

Project progress is monitored in terms of progress in reaching the targets of new and continuing acceptors set forth in the project proposal. These data are summarized every four months. In the interim, the SIC routinely reviews individual records to identify any problems, such as a large number of missed appointments. Feedback is given to the FPEs as appropriate.

The Project Director noted that the project used to collect information on the age/parity of acceptors, but has stopped, since this is no longer required by FPIA. Both he and the SIC seemed interested in looking at additional indicators of project progress, such as CYP.

1.8 Income Generation

The Project Director and SIC feel they have been pressured by FPIA to charge a fee for service, something they feel is difficult to implement in a slum area. The project is currently charging 25 piasters per family planning visit, and 10 piasters for MCH visit.

The draft refunding document proposes charging 50 piasters per visit for all services, but the SIC thinks this is unrealistic, as only about half of the clients can afford the current charge of 25 piasters. Project staff plan to discuss this further with FPIA.

1.9 Program Impact

Data on program impact, beyond reported numbers of new and continuing clients, were not readily available. The program has exhibited fairly steady growth, rising from a reported 757 new acceptors in the first funding period to 1,342 in the third. If similar periods are examined (see Table 1), the program appears to be leveling off. From April 1982 - March 1983, 757 new clients were reported; 862 between April 1983 - April 1984, and 833 between May 1984 - April 1985. However, 509 new clients were reported between May - October 1985 (seven months), which may indicate the program is picking up. These data should be monitored more carefully to determine any trend.

CYP was calculated on the basis of issues of commodities. The results indicate that project output has been growing steadily, from 174 CYP in 1982 (April-December) to 936 CYP in 1985 (January-October) (see Table 2).

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Analysis of method mix reveals that while the majority of new clients are using OCs, the proportion has dropped steadily, from 76.6 percent of all new clients in the first funding period, to 58.1 percent in the third funding period. The proportion of new clients using foam has increased proportionately, from 11.6 percent to 31.7 percent, while the proportion of clients using other methods has remained fairly constant. Since foam is somewhat less effective than OCs, the reasons behind this trend should be examined.

Table 1

New and Continuing Acceptors, by Method
 April 1982 - August 1985
 Sudan-02: Project Hag Yousif

Method	1st Funding Period			2nd Funding Period			3rd Funding Period								
	4/82-3/83			4/83-4/84			5/84-10/85								
	New	Cont		New	Cont		New	Cont							
Orals	580	76.6%	-	550	63.8%	469	780	58.17%	355						
IUD	39	5.1%	-	65	7.5%	21	72	5.4%	24						
Foam	88	11.6%	-	192	22.3%	75	426	31.7%	61						
Condoms	39	5.1%	-	37	4.3%	9	58	4.3%	3						
Diaphragm	11	1.5%	-	-	-	-	2	1.5%	-						
Sterilization	-	-	-	18	2.1%	-	4	2.9%	-						
Total	757			862			601			1,342			499		

Note: Approximately 36 infertility cases have been reported to FPIA as "new" clients. These were not included in the calculations.

Table 2

Estimated CYP: 1982-1985
Sudan-02: Project Hag Yousif

<u>Method</u>	<u>Quantity Distributed</u>	<u>CYP Achievement</u>
1982 (April-December)		
Pill	1,150 cycles	88
Condom	310 pieces	3
IUD	24	60
Cream/Foam	80	20
Foaming Tablets	320 tablets	3
	Total	174
1983		
Pill	2,595 cycles	200
Condom	2,870 pieces	287
IUD	69	173
Cream/Foam	278	70
Foaming Tablets	280 tablets	2
	Total	732
1984		
Pill	3,953 cycles	304
Condom	2,390 pieces	239
IUD	109	273
Foam/Cream	465	116
Foaming Tablets	240 tablets	2
	Total	934
1985		
Pill	3,382 cycles	260
Condom	3,152 pieces	315
IUD	83	208
Foam/Cream	341	85
Foaming Tablets	8,012 tablets	68
	Total	936

The impact of the project cannot be assessed in purely demographic terms, however, even if sufficient data were available. This project, though modest, is considered by USAID/Khartoum to be the best family planning project in the country. In addition, it is serving as a field training station for health and social workers at the Community Department, Faculty of Medicine, and for nursing students at Khartoum High Nursing College. The impact of the integrated service approach has already been documented. Before the initiation of project activities, the majority of maternal deaths at Khartoum North Hospital were among residents of Hag Yousif. This is no longer true.

Recommendation

Since this and other FPIA projects are called demonstration projects, however, there should be a careful attempt to document the impact/effectiveness of project activities in order to justify replication.

2. Sudan-03: "National Commodities Distribution Project"

2.1 General Assessment

2.1.1 Significance of the Project in Terms of Host Country Needs

The National MCH/FP Project of the Sudan Ministry of Health (MOH) was established in 1979 with assistance from UNFPA/WHO. The principal focus of the project is the training of Health Visitors. Sudan-03 is designed to overcome deficiencies in the National Project's handling of contraceptive logistics, a key factor in the successful implementation of any service delivery program. The project has been designed to correct deficiencies in staffing and supervision, levels of commodity supply and expertise in logistics in four pilot provinces. Additional provinces will be brought into the system during an anticipated five years of support.

Recommendation: Project staff/FPIA should attempt to keep UNFPA staff informed as to project activities and progress. Although this project is an important part of the UNFPA program support, the UNFPA Program Officer in Khartoum knew little about it.

2.1.2 Significance of the Project in Terms of USAID/Khartoum Objectives/Country Strategy

The USAID staff observed that the National MCH/FP project is weak, and that improvement in the logistics system should have a beneficial effect on the entire government program. She expects/hopes that the MOH will absorb support for the project when FPIA funding terminates.

2.2 Long-range Plan

Since the logistics project is designed to support the national program, its expansion depends on the success of the National MCH/FP Project in introducing services to new areas. FPIA ARO staff and the Project Coordinator have prepared the refunding document for the second funding period, January 1, 1986 - April 1987. According to the draft proposal, a total of six years of support is anticipated. The Project Coordinator assumes that the project will have reached all provinces after six years, and will be absorbed by the MOH. Since the Project Director was out of the country at the time of the assessment, it was not possible to determine if this was a realistic expectation. It is anticipated, however, that the institutional capacity to continue the program will have been created by the time FPIA support ceases.

2.3 Staffing

The Project Director, who is also the Director of the National MCH/FP Project, is supposed to spend 30 percent of his time on the FPIA project. The UNFPA Programme Officer expressed dissatisfaction with this arrangement, since the Director's time is already spread thinly across several projects. Since the logistics project is a key component of the national program, however, this arrangement makes sense from a management point of view.

Day-to-day program activities are managed by a full-time Project Coordinator. This position is filled by an individual who was previously in charge of Central Medical Stores and seems admirably qualified for his current position.

He is assisted by a full-time Assistant Project Coordinator who has a degree in nursing. Although she has received no formal training in logistics, she seems fully conversant with the various procedures.

The Headquarters Storekeeper, who was only assigned to the project on a part-time (25 percent) basis, will be full-time in

the second funding period. This individual previously worked in Central Medical stores and was handpicked by the Project Coordinator for his present post. He is a Standard School graduate and is studying accounting in night school. The storehouse was well organized (in spite of the cramped quarters), and the various reporting forms were filled out well. He follows first-in first-out (FIFO) procedures, was well aware of minimum-maximum supply and reorder points, etc. His abilities are key, as he is responsible for training the Provincial level storekeepers.

2.4 IEC

Although IEC was not intended to be part of the logistics project, it soon became apparent that there was less demand for contraceptives than had been assumed when commodity requirements were projected in the original proposal. One reason is assumed to be the lack of a strong IEC program to support the national project and inform potential clients about the availability of services. According to the draft refunding proposal, support will be provided to the Sudan Family Planning Association (SFPA) for the production of pamphlets and posters in the target provinces.

Recommendation: Since UNFPA is supporting an IEC project with the Ministry of Culture and Information as an adjunct to the national project, FPIA and the Project staff should try to coordinate input with these efforts. UNFPA plans to assign an expatriate advisor to this project in the near future.

2.5 Technical Assistance

FPIA has conducted/supported a number of TA visits to this project. An external Logistics/Supply Consultant visited the Sudan in late 1984 to review the needs assessment prepared by the Project Coordinator and to assist in the design of the revised commodities distribution system, the Storekeepers Handbook, and the follow-up and evaluation scheme.

In addition to various administrative visits, a team composed of an ARO Program Officer, a representative from USAID/Sudan, and the Project Coordinator spent two weeks in September 1985 assessing the training program. The team visited two of the four targeted provinces, identified several problem areas, and made recommendations for improving provincial-level training, logistics management, the need to reassess assumptions regarding service levels, improved supervision, and rescheduling expansion to new provinces. All of these are reflected in the draft refunding document. Perhaps most important, because the

Project Coordinator was a member of this team, he is well aware of which areas need improvement.

The Project Coordinator expressed complete satisfaction with the level of FPIA's technical assistance. He pointed out that many of the problems are systemic--arising out of the national program. Other problems, such as inadequate supervision due to transportation difficulties, have been identified and are being addressed.

2.6 Income Generation

Although the original proposal contained plans to introduce the sale of contraceptives, this phase of activities was not carried out. Project staff feel contraceptive sales represented a major administrative burden and should only be introduced after careful testing. In addition, the Project Coordinator doubted that Provincial Directors would be willing to pass along revenues from sales to the Central level, as would be required by FPIA. A pilot project will be initiated in one of the original four provinces during the second funding period.

Recommendation: Since the AID-funded Social Marketing of Contraceptives (SOMARC) team recently completed an assessment visit to Sudan, FPIA may want to coordinate activities/information.

2.7 Training

The project fell short of some training objectives in the first period, training only 3-5 storekeepers (reports vary) out of a targeted 35, and 6 paramedical staff out of a targeted 100. It exceeded its target with regard to administrative staff, training 12 to 13 instead of the 11 planned. The shortfalls were due in part to poor communication between Headquarters and the Provinces, and in part to inadequate per diem allotted to the trainees (an issue raised in the draft refunding proposal).

Provincial-level personnel (Provincial Directors, storekeepers and senior nurse-midwives) are trained in Khartoum at the Management Development Center. They, in turn, train district-level nurse-midwives, district storekeepers, and health visitors. The recent assessment visit identified some inadequacies in the training of district-level staff (see Table 3). Responsible Provincial staff will receive retraining.

During the second funding period, the Project Coordinator will concentrate on reaching the target number of trainees. In addition, he has prepared a circular for all six provinces, which will inform Provincial Directors about the project, identify

personnel to be trained, and propose a training schedule. These steps should overcome the problems encountered in the first funding period.

Table 3
Number of People Trained in
the Provinces as of July 31, 1985

Sudan-03: National Commodity Distribution Project

<u>TYPE</u>	<u>NORTHERN</u>	<u>N.KORDAFAN</u>	<u>RED SEA</u>	<u>E. EQUATORIA</u>	<u>TOTAL</u>
PMCH/FPD	1	1	-	1	3
S.N.M.	1	-	1	1	3
P. Storekeeper	1	1	1	1	4
Storekeepers	-	-	2	3	5
H. Visitors	11	14	14	2	41
M. Assistants	6	-	3	1	10
Nursing Sister	-	-	-	1	1
Midwife	-	-	-	2	2
C.H.W.	1	-	-	-	1
Senior Midwife	-	-	3	-	3
Chief M.A.	-	-	3	-	3
Total	21	16	27	12	76

Source: Trip Report, J. Karambizi, Assistant Regional Director, September, 1985

2.8 Supplies Distribution and Logistics Management

Among the main problems faced by the Project Coordinator are delays in acknowledgement of receipt of commodity shipments. The Coordinator is currently addressing this by sending messengers to the Provincial offices to collect the information. In the long run, he feels that better follow-up and supervision from

the Central level are required. In the first funding period, only six of a planned 12 monitoring visits were carried out. Twenty-seven are planned in the refunding period.

A complete system for requisition, distribution, and control of stock has been designed and is set forth in the Storekeepers Handbook (available in Arabic and English). Forms for requisition and distribution have been printed and distributed to every level. Maximum-minimum stock levels and reorder points have been established. As noted previously, the biggest problem is ensuring that responsible staff at each level complete the forms and submit them on schedule.

The proposal for the current funding period overestimated commodity requirements.^{1/} (It was based on an estimate of 15 percent of total eligible women in participating centers.) The Project Coordinator is now basing projected needs on the actual consumption at the health unit level as recorded on the individual client card. (These data are summarized at each level and sent to Headquarters.) It should be noted, however, that the project is also serving 60 centers in Khartoum as well as other provinces on an informal basis, so the supplies are moving.

2.9 Project Monitoring

Only 50 percent of the scheduled monitoring visits were actually carried out--three by the Project Coordinator and three by the Assistant Project Coordinator. During the second refunding period, the number of supervisory visits will be increased. The addition of a project vehicle will facilitate access to those sites that can be reached by road. More remote areas will be reached by plane.

The Project Director has designed extensive and well thought-out checklists for supervisory visits. Separate checklists have been developed for different categories of personnel. The checklists cover such matters as compliance with requisition/supply procedures, use of training materials, and recording of acceptors. Such a system provides a complete and consistent mechanism to evaluate performance in the field.

2.10 Project Impact

While demographic impact is an underlying, long-range objective of FPFA assistance to this project, it is not an

^{1/} The excess stock is being used to supply centers in Khartoum and a few other provinces.

immediate objective. Moreover, given the youth of the project, it would be premature to attempt to assess demographic impact, by whatever measure, at this stage.

It is clear, however, that no national program will succeed without a well-organized, well-managed logistics system to support services in the field, particularly in the more remote areas of the country. It is also clear that this project is proceeding in the right direction and that, with continued support, it can make a significant contribution to the total government MCH/FP service delivery program.

Sudan

Persons Contacted

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APPENDIX P6
NIGERIA: TRIP REPORT

NIGERIA: TRIP REPORT

GLOSSARY

SDA **Seventh Day Adventists**

VHW **Village Health Worker**

APPENDIX P6

NIGERIA: TRIP REPORT

Projects visited: Nigeria-10: Baptist Hospital, Ogbomoso:
Clinic CBD project

Nigeria-13: Seventh Day Adventist: Family
Planning Service Delivery

Nigeria-18: Retail Commodity Distribution

1. USAID's View

USAID considers FPIA the most effective cooperating agency operating in Nigeria, particularly its experimental approach with a variety of methods of delivering family planning services. The mission supports large FPIA projects, perhaps even on a statewide basis.

2. Nigeria-10: Baptist Hospital, Ogbomoso

2.1 Background

This project is carried out by the Baptist Hospital in Ogbomoshu in Oyo State. Before its inception, the community had almost no information about family planning and few services were available. Poor economic conditions have spurred the demand for both, and this project aims to meet these needs.

The project started as an IUD clinic, complemented by IEC activities. It has expanded to provide contraceptives through dispensaries (one day a week) and barrier methods in markets, IEC sessions etc. A CBD program, also recently started, provides barrier methods but refers women to the clinic for pills, even resupplies. An attempt to distribute barrier methods through home visits, a natural part of CBD in other countries, was not successful in this project.

In USAID's view, this program is the least effective of those visited. Fairly traditional, it has a poor record in supplying pills. Outreach efforts, while improving, are still unsatisfactory.

2.2 Staff

The project is run by a physician and is backed up by a consultant Ob/Gyn. The project director is a nurse/midwife trained in family planning. She is assisted by two other nurse/midwives, one of whom has been trained in family planning. Four fieldworkers who distribute condoms and foam have a school certificate (11 years education). The CBD workers are village health workers. They attend a three-week training course in primary health care and family planning.

The hospital absorbs the salaries of the family planning workers at the clinic. CBD workers receive a 40 percent commission on sales. This payment not only serves as an incentive but enables the CBD portion of the program to cover the cost of all workers.

2.3 IEC

The IEC program includes films on sex education, conception and contraception. It has posters and flip charts, but no booklets for clients. Since clients are illiterate, PIACT booklets might be suitable.

2.4 Technical Assistance

2.4.1 Service Delivery. FPIA has sent regional staff to help with the record-keeping system. It has not, however, been successful in meeting the important need in this project for program support. The project director has had no experience or training in CBD. Rather than dispatch a staff member knowledgeable about CBD to assist project implementation, FPIA suggested the project director attend a CBD workshop being held in Nairobi. She did not make the necessary efforts to get help from FPIA to attend the conference, and thus the problem of how to upgrade the CBD activities of this project remains unsolved. The issue of pill resupply is one where appropriate technical assistance might be particularly useful. If the project director were to learn about programs with fewer strictures, she might be less adamant about referring women to clinics for resupplies.

2.4.2 Medical Services. The project director is personally responsible for assuming compliance with medical standards. Although Regional Office staff talk to her about medical practices and standards and their experience in other countries, they do not provide FPIA medical standards sections on IUDs and sterilization. The publication Voluntary Sterilization was also not available. The Regional Office staff, however, send Population Reports when it covers subjects germane to the project and

furnish project staff with FPIA's medical questionnaires on contraindications to pill and IUD use. Women are given instructions concerning what to do if they have problems with either type of contraception. To minimize pelvic inflammatory disease, the use of IUDs is not recommended for women in polygamous unions.

Consent for sterilization is required of the woman and her husband or close relation. There is a waiting time but only because of scheduling. Sterilization is free.

2.5 Evaluation

2.5.1 Objectives. Objectives are set after discussions with Regional Office staff. FPIA exerts some pressure to increase goals, even when project staff know that they cannot be met (as in the last funding period). Efforts are being made to increase the number of new clients by giving barrier methods to women who request IUDs between menstrual periods and asking them to return for an IUD during their menstrual periods, when IUDs can be inserted. Monthly meetings are held to talk about progress in meeting objectives.

Acceptor records are completed as required, but these are used only to track individuals, not to examine the demographic profile of clients, changes in method selection, drop-out rates, etc. Attention would seem to be paid only to meeting the targets specified in FPIA documents, not to gain more understanding of how the project works.

2.5.2 Program Impact. Data from the FPIA reporting sheet allows only the most imprecise determination of program impact. The data give clinic-specific information on numbers of new and continuing clients by method but none on the amount of contraceptives delivered there. In the marketplace, (theaters, markets etc.) however, there are data on the amounts of contraceptives delivered but none on the number of acceptors.

More serious is the way FPIA counts new and continuing users (see Appendix P7, Section 8.2.1). The technique described above of providing barrier methods on an interim basis to would-be IUD users tends to distort the picture of method users, because when these women return for IUDs, they are not counted as new IUD acceptors. They are instead still listed in the barrier category, thus inflating the number of new barrier method users. On the other hand, if they receive the IUD as requested on their first visit, they will be counted as new acceptors of IUDs. If they do not return in the next funding period, however, they are not transferred into the continuing category, although most

probably they are continuing to use the IUD. 1/ In fact, the only IUD users who tend to return are those who are having problems. Women with problems, moreover, may cease to use contraceptives altogether or perhaps, may switch to barrier methods. Since an IUD provides an average 2.5 CYPs, the system of counting distorts analysis of CYPs provided through this program.

Table 3 illustrates some problems that result from this illogical system of counting. For example, continuing users of IUDs are shown as declining precipitously, while new users of barrier methods are rising almost as rapidly. The decline in continuing IUD users must certainly reflect in part the practice of not keeping these women listed as continuing users of IUDs if they do not return six months after the IUD is inserted, while the rise in new barrier method users may reflect the practice of urging would-be IUD users to adopt barrier methods on an interim basis. A decline in new IUD users can also be explained in terms of the counting methods: i.e., perhaps those who have switched from barrier methods to IUDs are still being listed as barrier method users. In short, the system of counting new and continuing clients of various methods provides overall program figures that at best mask the true situation and at worst must be discarded as impossible to substantiate.

The unreliability of Table 3 becomes even more apparent when it is compared with Table 4. Here, for instance, IUD users have been tabulated at 77 percent of all users, compared with 52 percent in Table 3. Furthermore, Table 4, while a random sample of 100 new acceptors, gives a better picture of current contraceptive use of clients of this program than do the FPIA data. Another example of problematic counting practices appeared in the two most recent funding period documents, in which distribution of new and continuing acceptors by method were identical. Clearly this scenario could not reflect reality.

1/ A check of a sample of 100 first visit patients between April 1984 and July 1985 indicates that a high percentage of IUD acceptors do not regularly return for the recommended six-month check-ups.

Table 3

New and Continuing Acceptors by Funding Period
Nigeria-10: Baptist Hospital, Ogbomosho

Method	Total		May-Aug 1984		Sept-Dec 1984		Jan-Apr 1985		May-Aug 1985	
	N*	%	N	C**	N	C	N	C	N	C
IUD	805	52.0	222	514	234	249	177	89	172	53
Foam/ condoms/ diaphragm	694	44.8	49	6	83	6	221	0	341	0
Pills	49	3.2	9	20	12	11	17	1	11	1
Total	1548	100	280	540	329	266	415	90	524	54

* N = New

** C = Continuing

Table 4
 Characteristics and Method Used by Clients Making
 First Visits from October 1984 - July 1985
 (N = 100)

Nigeria-10: Baptist Hospital, Ogbomosho

<u>Characteristics</u>	<u>%</u>
<u>Age</u>	
< 20	2
20-24	11
25-29	19
30-34	24
35-39	17
40+	13
Unknown	14
Total	100
 <u>Living children</u>	
1-2	21
3	14
4	23
5	17
6+	21
Unknown	4
	100
 <u>Method</u>	
IUD	77
Barrier	22
OCs	1
Total	100

If the sole problem were that these figures distort the CYP, there would be justifiable cause for attempting to improve the situation. More immediately critical, however, is the need for reliable figures on which to base contraceptive supply orders. Clearly, if barrier method purchases are based on

artificially inflated figures, the project will be purchasing an oversupply of condoms and foam.

Pill acceptors are not numerous. Preference for IUDs seems to be common in Nigeria, but in this case the proportion is extreme. Table 4 indicates that 56 percent of women clients are 34 or under, many of whom would normally be acceptable pill clients. It is possible that the merits of the IUD have been oversold and the demerits of the pill oversold. Health professionals in Nigeria insist on close monitoring of pill users, the kind of monitoring that is incompatible with a CBD program. If contraceptive use is to increase in rural areas, it is hard to imagine how it will do so unless some relaxation in the "medicalization" of the pill takes place.

Table 5 shows that the number of sterilizations performed has increased over the previous 15 months. Whether this trend will continue is unknown.

Table 5

Number of Sterilizations by Funding Period

Nigeria-10: Baptist Hospital, Ogbomoso

Time Period	No.
May - August 1984	74
Sept. - Dec. 1984	72
Jan. - April 1985	81
May - Aug. 1985	95

Distribution of condoms, jelly and most recently foam is shown in Table 6. These commodities are distributed in the marketplace, at film shows, etc. or other place at which new acceptors are recruited. Recently, prices have been instituted, but it is too early to assess the impact of charging for supplies. The impact of this part of the program is difficult to assess; there is no information on the number of acceptors, supplies distributed per person or on resupply. It is possible that some acceptors do not use all or part of the supplies they receive. With prices being charged, there will be greater assurance that what is purchased will be used.

Table 6

Distribution of Foam, Jelly, and Condoms
by Funding Period

Nigeria-10: Baptist Hospital, Ogbomoso

Period	Condoms	Jelly	Foam
Feb. - April 1984	3725	-	-
May - August 1984	1736	106	-
Sept. - Dec. 1984	4522	66	-
Jan. - April 1985	3747	47	-
May - August 1985	6048	123	295

3. Nigeria-13: Seventh Day Adventists

3.1 Summary

This project, first funded in January 1985, will enable the Seventh Day Adventist (SDA) Health Services in Nigeria to expand family planning through training of health professionals at clinics and health centers, and village health workers (VHWs) at community-based locations. The project also includes the provision of family planning methods: VHWs provide condoms and foam and refer women for orals. Health centers provide orals and IUDs.

3.1 Broad Issues

This project introduces family planning into the existing SDA health program and should allow for the spread of family planning services through the entire SDA network. In areas where services are already provided by the MOH, the SDA is attempting to choose locations where no other services are available. Even when there is overlap, the SDA believes the efficiency of its operations will serve the public interest.

The main objectives of the project are to create an awareness of the need for family planning and to motivate grass roots staff (health professionals [nurses, midwives], community health aids, and VHWs) to promote family planning. The long-range objective is to increase service provision.

The project coincides with an increase in public interest in family planning, which stems in turn partly from poor economic conditions.

The long-term future of the project is promising, as the SDAs have money and can eventually run the project. The need is for technical assistance to help establish an infrastructure.

Income is generated through sales of contraceptives. VHWS receive 50 percent of the value of what they sell.

USAID supports FPIA's involving itself with other projects like this one, which incorporates family planning into existing infrastructure and whose costs eventually can be absorbed by the system.

3.3 Implementation

Short-term goals in project implementation are to develop staff competence in advising on family planning and to integrate family planning into the health program.

The staff includes physicians at hospitals, community health aids or nurse/midwives at health centers and CED workers. The CBD staff include housewives, traders, etc. They are instructed in both basic primary health care and family planning, with an emphasis on foam and condoms.

Pill clients are regularly followed up. They are seen at one, three and six month intervals and told to return if they have severe symptoms. Orals are provided only at health centers and VHWS do not resupply pills.

IUD patients are followed up at one and four weeks. They are told they may initially have painful and heavy periods and are told to feel for the string.

Natural family planning is also taught in depth to anyone interested.

3.4 IEC

IEC materials include films and slide shows, and drama teams provide presentations on family planning. Project staff give talks to women's groups, at information sessions at clinics, and at ante- and post-natal visits.

3.5 Technical Assistance

FPIA provides very little written literature. Project staff have made a request for booklets and have been trying to design their own material. They were unaware of the PIACT booklets.

Technical assistance is also minimal in regard to training, design of a syllabus, curriculum development, and the setting up of record-keeping systems. One curriculum was sent to Margaret Sanger for review, but comments were received too late to make major changes.

An attempt has been made to design record-keeping systems but further help is needed.

The Regional Office forwards reports on contraceptives and other medical material from FPIA, and Population Reports is received regularly.

3.6 Evaluation

Objectives are set in consultation with FPIA staff. Estimates are based on location of clinics, education, cultural factors, staff strength, patient load, and transport. All agree it is important that goals should be achievable. Unrealistic goals are demoralizing to staff and FPIA alike.

Nonetheless, objectives have not always been met, in part due to lack of motivation of some health professionals, in part due to loss of some strong personnel, and in part due to staff being overloaded with non-family planning activities. The solution may be to hire people specifically to do family planning. Another path may be through better promotion of program activities.

The performance of clinic staff is monitored through periodic visits and that of CBD workers by sales. Staff are trying to work out a service statistics system. Although FPIA record forms include information on numbers of clinic clients, project staff also collect data on supplies distributed to clinic clients and disaggregate them according to whether the client is making a first or subsequent visit. This system thus is superior than that of FPIA's.

It is too early to measure project impact.

4.1 Nigeria-18: Retail Commodity Distribution

This project seeks to expand the availability of family planning commodities. Commodities will be distributed through an existing system of 115 distributors to 5700 pharmaceutical retail outlets. This includes 9,000,000 condom pieces and 4,050,000 pill cycles in eleven states. To stimulate the distribution, a program campaign will be launched.

The commodities are now in place. The program will be launched with radio and TV spots, newspaper inserts and talks in market places and factories. Posters will be display in depots. The program will begin as soon as the posters are ready. Over the long term, it could vastly expand access to family planning.

Start-up financial help from FPIA will be needed. After three years, the program should be able to stand on its own. The project is viewed very favorably by USAID.

Nigeria

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APPENDIX P7

SIERRA LEONE: TRIP REPORT

SIERRA LEONE: TRIP REPORT

GLOSSARY

CFWEC	Centre for Family Welfare, Education and Counselling
SLHEA	Sierra Leone Home Economics Association

APPENDIX P7

SIERRA LEONE: TRIP REPORT

Project Visited: Sierra Leone-05: The "Family Welfare Education and Counselling Project"

1. History

Managed by the Sierra Leone Home Economics Association (SLHEA), the Family Education and Counselling Project has been funded since December 1976. The project operates out of SLHEA's Centre for Family Welfare Education and Counselling (CFWEC). It includes a CBD program in Freetown and six towns. Fieldworkers distribute condoms and foam and refer women to the center in Freetown or centers in the other towns for oral contraceptives. Women who wish to use other methods are referred. There is a small charge for contraceptives. The project began as an IEC project and continues to place a heavy emphasis on these activities. Staff members give talks in schools and in the community with the emphasis on adolescent problems, especially unwanted pregnancy.

Fieldworkers talk to clients in their homes, in the marketplace and at places of business. They sell condoms and foam and refer women who wish to purchase orals to the Center. Purchases of orals require a medical exam. Although there is no population policy stating the requirement, it is the rule followed in all programs and is the interim policy of the MOH until the country announces its policy.

Adolescents attending school who are under 18 are not sold contraceptives without parental consent. This, too, is MOH policy and is followed in all programs.

2. Objectives

The project was developed because of growing concern on the part of SLHEA about the problem of female drop-outs from school because of pregnancy. It was thought that an educational program emphasizing reproductive health and the negative consequences of early pregnancy could help alleviate this problem. As a consequence of the program, there is more acceptance of the teaching of sexual education among school principals. Some schools now include family life education in their curricula.

While other organizations were concerned with problems of adults, this organization was the first to address the needs of

young adults. Over time, SLHEA became concerned with other needs and addressed itself to the problems of pregnancy for married women including spacing and unwanted pregnancy.

USAID and the MOH agree that the communication aspect of the project, and particularly its focus on youth, fill a major gap in the government program, which is still relatively new. CFWEC is currently viewed as the main provider of family life education to young people.

The project's objectives, as stated in a project handout, include the following:

1. To provide youths with a forum for discussion of adolescence problems;
2. To guide youths in the development of the right attitude towards sexual relationship;
3. To enable young adults to understand the health hazards of adolescent pregnancies;
4. To assist young adults in developing positive attitudes towards responsible parenthood and family life planning; and
5. To help parents develop an awareness of the importance of good parent/adolescent relationships and communications.

In addition to these objectives is the goal of providing family planning to couples for spacing in order to improve the mother's and child's health and the quality of life.

The long-range plan of the organization is to provide classes for pregnant unmarried young women in income generating activities, school counseling and newborn care. Plans include establishment of a day care center and acquisition of a separate building for the new activities. These plans have been discussed The Pathfinder Fund and will be presented to FPIA. USAID considers these goals appropriate to Sierra Leone's needs.

3. Cost Data/Future Funding

The project includes income generating activities through the sale of contraceptives and through the running of a day care center. Some fund raising is also undertaken.

Costs include salaries of CBD workers, who receive a salary of 128 Leones per month (which totals roughly \$24). CBD workers are employed four hours per week. They also receive 18 Leones

for transport. FPIA support currently enables the project to exist. The economic situation in Sierra Leone is poor and getting worse, and it is extremely unlikely that the government, with its currently limited resources, can support this program alone. Project staff expressed the hope that, if FPIA funding ceases, money from other cooperating agencies might become available to cover at least core costs.

4. Staff Qualifications

The project staff are well prepared for their jobs. The project also has a medical consultant who is extremely well qualified for her role.

The part-time staff, mostly field workers, have a variety of backgrounds including teacher, nurse, housewife, clerk, etc. They appear to be enthusiastic about their work in the program.

Because the staff has background and experience in handling problems of adolescents, there seems to be no call for technical assistance from FPIA in this area. Likewise, with no medical problems associated with the condom or foam, there is no need for assistance in this area. The need for a medical consultant arose when the pill was introduced into the program. The individual in this position was trained at the Margaret Sanger Center in New York.

As the government debates the issues of the medical exams and the pill and contraceptive sales to under-18s (see Section 1), FPIA should be encouraged to send staff to visit successful programs, especially in Africa, which do not have these requirements. One possibility is Zimbabwe, which has a successful CBD program and a more advanced adolescent program. Another possibility is an FPIA-funded adolescent counseling program in Mexico, where a good prototype exists.

5. Information Services

The IEC program includes material on various contraceptives including material for non-literates. Fact sheets giving information on condoms and foam and on the pill are provided. There are booklets on adolescent problems, venereal disease, counseling services available, the problems of a large family, etc. Some, for example the method fact sheets, are in short supply. Some material is provided by other organizations. PIACT provides booklets for illiterates.

6. Quality of Services/Medical Backstopping

Because the program includes only referrals for IUDs and sterilization, much FPIA material is not relevant. The methods poster designed by the Population Crisis Community on methods, however, is available. On the other hand, no material has been provided on aspects of service delivery important in this project: IEC and CBD (although Population Reports, which is received, covers these topics from time to time).

Moreover, staff have not been given the opportunity to visit other CBD programs, although such technical assistance has proved effective in other settings.

To assist in making referrals, CBD workers are provided with a checklist to screen women for contraindications of the pill. If a woman has no contraindications, she is sent to the center where her blood pressure is taken, a pelvic exam given and specimens are provided for a lab test. The woman is told about early symptoms and told to come back to the clinic if she is concerned about them. If she has severe symptoms, she is instructed to return to the clinic.

Clients are provided with instructions on how to take the pill and what to do if a pill is missed. This is covered in PIACT's pictorial booklets.

7. Evaluation Activities

7.1 Data Gathering/Acceptor Cards

The basic data for the program is collected on acceptor cards, which contain information only on sex, date of sale, type of contraceptive and number sold. This information is designed to provide outsiders with information about the program, particularly its growth in specific areas. The cards are kept in locations convenient to distribution points, not in a central file. On the basis of these cards, reports are prepared which are forwarded to FPIA for central tabulation (tables 1 and 2). Local staff, however, cannot check, compare or analyze work at different sites because of the wide dispersion of the records.

Recommendation: Some consideration should be given to establishing central files for acceptor records.

Recommendation: Age and number of children should be recorded on acceptor records. With this information, the program would have data on the characteristics of clients.

7.2 Data Assessment

7.2.1 Program Performance. Table 1, compiled by FPIA, presents information on client load over the course of the program, percentage of clients who purchased condoms (almost all of the remainder purchased foam, as pill sales are very low) and mean number of cans of foam and condoms purchased per contact by reporting period (four months) for the last two years of the program. The number of new clients has grown fairly steadily, whereas only in the beginning and in the last period has the number of continuing users increased.

Definitions of new and continuing clients are not satisfactory. To be counted as continuing, a user need return only once in a new funding period. A client who buys condoms twice in a funding period (usually a year) is counted as a new user in that funding period whereas a person who buys condoms in one period and buys again in the next period is counted as a new user in the first period and a continuing user in the next. Furthermore, the indexes do not allow determination of how much protection the average client receives. The last two columns of Table 1 show the average amount of condoms and foam purchased but not how often the purchase was made. Thus, although the average number of condoms purchased (8-9) is about enough for a year if

Table 1

Number of new and continuing clients, percent purchasing condoms and mean number of supplies purchased: Sierra Leone-05

<u>Time Period</u>	<u>Total</u>	<u>New</u>	<u>Continuing</u>	<u>% Clients purchasing Condoms</u>	<u>Mean # Condoms</u>	<u>Mean # Foam</u>
6/1-9/30/85	5892	3858	2034	77%	9.4	1.8
2/1-5/31/85	5134	2712	1522	65%	9.5	1.8
10/1-1/31/85	3834	2409	1425	99%	7.7	1.0
6/1-9/30/84	3587	2059	1528	78%	8.4	1.2
1/1-5/31/84*	5073	2826	2247	-	-	-
9/1-12/31/83	3992	2490	1502	-	-	-

* 5 months

purchased monthly, it is not known if condoms were purchased that often. The same problem arises with purchases of foam. The problem was pointed out in the 1983 evaluation.

There is one additional point to be made about the recording of client data. Some clients purchase both foam and condoms; if a man does the purchasing, the buyer is considered to be a condom client, if a woman, a foam client.

Recommendation: Creation of a new category--foam/condom client--should be considered.

Recommendation: Average number of visits per client per year or per funding period should be included in reports to FPIA. This would allow determination of the average amount purchased per client and on the average CYP provided per client. This information could be separately tabulated for those making their first visit in the funding period and those who made a visit in the previous period.

7.2.2 Couple Years of Protection. Information on couple years of protection (CYP) is provided in Table 2. Since the fourth funding period, the number of CYPs has been about the same. The fluctuations in the relative importance of condoms to foam are explainable in part by a foam shortage starting in mid-1984.

Table 2

Couple Years of Protection Provided
Sierra Leone-05

<u>Funding Period/Time Period</u>	<u>Total</u>	<u>Condoms</u>	<u>Foam</u>
1	43	25	18
2	598	283	315
3	1881	1330	551
4	2109	1301	808
5/1-8/31/83	582	181	401
9/1/83-9/30/84*	2068	623	1440
9/1/83-12/31/83	(793)	(182)	(611)
1/1/84-5/31/84**	(803)	(210)	(593)
6/1/84-9/30/84	(472)	(236)	(236)
10/1/84-9/30/85	1967	1040	927
10/1/84-1/31/85	(307)	(299)	(8)
2/1-5/31, 85	(717)	(319)	(398)
6/1-9/30/85	(943)	(422)	(521)

* normalized to 12 months

** normalized to 4 months

A number of relevant factors have been omitted in Table 2. For example, in this last period, the program had expanded into two new towns, but figures are not disaggregated by area, so it is not possible to make an exact comparison with the preceding time periods in the original project area. Also, in the last two periods, the program has expanded to include sales of pills. In the last period, there were 218 pill clients; sales to these clients would have added at least 16.75 CYPs (218 divided by 13), more if clients had purchased more than one cycle. Because of the impact of supply problems affecting the number of clients and CYPs, it is not possible to determine the impact of the program on contraceptive use.

7.3 Evaluation Activities

7.3.1 Simple Evaluations. Some simple evaluations could be carried out by staff. For example, 21 schools have been targeted for special attention. Pre- and post-information on drop-out rates at these schools and a comparison group could provide some indication of the impact of educational programs on the retention rate.

7.3.2 Evaluation of Overall Program. It is much more difficult to evaluate the impact of the project as a whole. Not only are many statistics open to question, it is not clear what system is used to set project objectives.

The project manager's theory does not reflect the system set out in the original funding document and there seems very little discussion among staff members and between the project manager and the Regional Office on how objectives should be arrived at. Thus, the project manager apparently sets objectives with reference mainly to the distributors and their areas of coverage, while the project's original funding document indicates the goals should be expressed in terms of the clientele served. An attempt to execute the FPIA principle of management-by-objective must break down, however, if there is no clear perception about how objectives are and should be set. This lack represents a critical shortcoming in this project.

Recommendation: Discussion of how to set objectives should be clarified and these should be discussed with project staff. Regional Office staff should work more closely with project staff in interpreting reports sent to FPIA. Better collaboration might help project staff view these reports as a tool to be used for program evaluation, not just an FPIA requirement.

Sierra Leone

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APPENDIX Q

FPIA PROGRAMS IN LATIN AMERICA: TRIP REPORTS
(Brazil, Peru, and Mexico)

APPENDIX Q1

FPIA PROGRAMS IN BRAZIL, PERU, AND MEXICO:
TRIP REPORT SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

APPENDIX Q1

FPIA PROGRAMS IN BRAZIL, PERU, AND MEXICO:

TRIP REPORT SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. Overall Performance

The projects visited in Brazil, Peru and Mexico demonstrate that FPIA is succeeding extremely well in achieving a major objective--to extend family planning information and services to socio-economic classes which have previously had limited access to them. Though often including other maternal and child health services, the predominant health intervention provided in these projects has been family planning. As confirmed by USAID population officers, FPIA has developed projects that fit USAID population strategies and are supportive of U.S. and host country objectives.

Institutions have been selected for FPIA support that have made a policy impact and have extended significant family planning services. The successful experimentation with networking of institutions through The Brazilian Association of Family Planning Agencies (ABEPF) and The Mexican Federation of Private Associations for Family Planning (FEMAP) suggests a good potential for building national institutional capability and multiplying the effectiveness of FPIA support. Five out of the six projects visited were led by women, and women were actively involved at all levels of project implementation.

2. Community Links

Although most successful in involving community leaders in service delivery in Peru and Mexico, FPIA has also made progress in this direction in Brazil. The conservative policy approach of political, medical and religious leaders in Brazil, however, constrains the organized programs from more expansive, community-based approaches. The widespread availability of contraceptives in the pharmacies at reasonable prices suggests that closer linkages with these channels would be desirable. Unlike many physician-dominated projects, the Center for Research and Studies Clovis Selgado (CEPCS) was doing very well, at least in the initial stages close to Belo Horizonte.

3. Reporting, Monitoring and Evaluating

FPIA has developed a system and a manual of instruction for counting and reporting family planning service clients. The system, however, is not uniformly well understood and compliance is uneven. The system more effectively serves FPIA's reporting purposes than the local project management needs.

FPIA's project development system and monitoring of projects is impressive. Measurable objectives are stated, a time-phased plan of action is developed, and monitoring of progress is accomplished through regular reports and project visits by FPIA personnel.

Calculating impact of projects on contraceptive prevalence, however, is fraught with difficulties, not the least of which is the task of estimating the population of the project catchment area. Some tentative estimates were made suggesting a range of from two percent to 13 percent prevalence related to these projects. In any event the provision of some 70,000 couple years of protection and service to approximately 100,000 new users in this project period is a significant contribution to expanding the availability of family planning services.

Recommendation: AID and FPIA, together with other organizations, should review the service statistics system and make appropriate modifications. Consideration should be given to including a measure of couple years of protection. Project managers should also be encouraged to make more analysis of the relation between clients reported and the quantities of contraceptives distributed.

4. Cost Factors

4.1 Self-Sufficiency

Projects demonstrate efforts at income generation and encouragement of institutions to work toward self-sufficiency. Attention is paid to seeking low-cost approaches to service delivery--in most instances with considerable success. Three of the projects had costs to FPIA of less than \$9 per new user and \$12 or less per couple year of protection. Two of the higher cost projects, ABEPF and FEMAP, had considerable administrative overhead as new subprojects in the networks continued to be initiated. Future productivity should reduce the costs per client. The higher cost with the Center for Research and Integrated Attention to Mothers and Children (CPAIMEC) in Brazil appeared related to its higher cost supervisory system and reduced client numbers.

The emphasis on income generation and encouragement for projects to become self-sufficient is positive. In some cases, however, this concern may have been carried to an extreme. For example, several of FEMAP's subprojects express their long-range plans solely in terms of reducing FPIA/FEMAP input and increasing local input.

Recommendation: The emphasis on self-sufficiency and income generation should be continued; realistic expectations should be

developed of how much can be expected from client charges without interfering with client use; and plans for self-sufficiency should not divert attention from other elements of long-range planning. Greater linkages with the commercial sector should be explored, especially in Brazil, both as a means to extending services and to developing approaches more likely to be self-sustaining.

4.2 Budgeting

The rapid inflation in Latin America puts in question FPIA's system of budgeting in current value local currency. Staff complained that much time was wasted in repeated readjustments of the budget to bring it in line with new financial situations. The perception in the field was that FPIA was adamant on the issue. The field, however, does not see as a solution that projects should be paid in dollars, although both AID/W and FPIA headquarters in New York impute this point of view to the field.

Recommendation: AID and FPIA should continue to review the practice of budgeting in current value local currency and initiate increased communication with USAIDs and project directors to develop a mutually satisfactory approach.

5. Program Considerations

5.1 Logistics

By and large, commodity logistics are handled very well; commodities are warehoused carefully and appropriate systems are used to document shipments, receipts and distribution. Problems of shipment delays associated with customs regulations have been encountered in Brazil and Mexico.

5.2 Information, Education and Communication (IEC)

The FEMAP project has a strong emphasis on information, education and communication (IEC), using a combination of media, client informational materials and person-to-person approaches. The other projects, however, especially those in Brazil, could profit from a stronger emphasis on IEC.

Recommendation: Increased attention should be given to IEC.

5.3 Invitational Travel

FPIA has used travel grants for project managers especially in Mexico to provide training opportunities and exposure to project approaches in other countries. More emphasis on invitational travel would also strengthen other projects.

Recommendation: Greater use should be made of invitational travel.

6. Relations with USAID

FPIA has done well in aligning its projects with USAID and host country priorities and strategies. It appears, however, that this has been accomplished with little dialogue with USAID and other institutions.

Recommendation: FPIA representatives should consult more actively with USAIDs and other agencies in developing their plans and strategies.

7. Summary Recommendation

In summary, these effective projects are a good indication of the substantial contribution FPIA makes to extending family planning services. Problems encountered were relatively minor in comparison to the positive results being obtained.

Recommendation: AID should continue a substantial level of support to these activities.

1972

APPENDIX Q2
BRAZIL: TRIP REPORT

BRAZIL: TRIP REPORT

GLOSSARY

ABEPF	Brazilian Association of Family Planning Agencies
BEMFAM	Sociedade Civil de Bem-Estar no Brasil
CPAIMC	Center for Research and Integrated Attention to Mothers and Children
CEPECS	Center for Research and Studies Clovis Salgado
CLAM	Centro Londrinense de Assistencia a Mulher (family planning agency in the south of Brazil)
FEMAP	Mexican Federation of Private Associations for Family Planning
PROFAMILIA	Colombian Family Welfare Association
ob/gyn	obstetrics/gynecology
WIFA	Women in fertile age

APPENDIX Q2

BRAZIL: TRIP REPORT

Projects Visited: Brazil-03: Center for Research and Integrated Attention to Mothers and Children (CPAIME)

Brazil-03: Subproject: Brazilian Association of Family Planning Organizations (ABEPF)

Brazil-09: Center for Research and Studies Clovis Salgado (CEPECS)

1. Brazil-03: Center for Research and Integrated Attention to Mothers and Children (CPAIME)

1.1 Background

This project supports the Center for Research and Integrated Attention to Mothers and Children (CPAIME), a Brazilian non-profit institution headquartered in Rio de Janeiro. As implied by the name, CPAIME provides a broad range of maternal and child health (MCH) care. Family planning is by far the major activity (85 percent of visits on one given day at the central clinic). Research, particularly of an operational nature, is also part of CPAIME's program, but the main focus has been on training of medical and paramedical personnel throughout Brazil and on service delivery in metropolitan Rio de Janeiro. CPAIME was founded in 1975 and began receiving FPIA assistance October 1, 1979. FPIA assistance since 1979 has totaled \$3,042,764 plus contraceptives, including \$768,000 for this funding period (July 1, 1984 to December 31, 1985).

A component of this project, which will be dealt with separately, is with the Brazilian Association of Family Planning Agencies (ABEPF). This institution, begun in 1981 by the association of various organizations throughout Brazil, was strongly assisted in its foundation by CPAIME and received its first funding from FPIA under the CPAIME Brazil-03 grant.

1.2 Broad Issues (CPAIME)

1) How and why was this project selected?

The project was selected by FPIA in consultation with Brazilian private sector health and family planning institutions, USAID Brazil and in consideration of FPIA's strategic plan

and resource availability. The importance of the project lay in the status of this institution in health delivery circles, the importance of its contribution to family planning policy development, the significance of its experimentation in the Brazilian setting with delegation of service delivery functions to paramedical personnel and with outreach to the community, the value of its training activities, its capacity to import and distribute contraceptives to other agencies, and the significant amount of service CPAIMC could provide.

2) What are the objectives of this project?

Quantitative objectives are to provide family planning services to 44,000 new users, 23,000 continuing users and 4,500 sterilization referrals through a network of one central and 44 community clinics and service agreements with 20 industries. Through ABEPF, the objective is to develop 20 service delivery programs throughout Brazil providing service to 32,000 new clients. Implied additional objectives, in many cases supported by organizations other than FPIA, were to continue the sterilization, commodity distribution and training efforts, and legitimize the concept of delegation of functions.

3) Are the objectives of this project appropriate to host country needs?

Especially at the stage of political attitude change in Brazil and the growing openness but continuing sensitivity toward family planning, the approach, relying on a highly respected organization and including a strong MCH element, is appropriate.

4) Are the objectives of this project appropriate to AID objectives and strategy?

As part of an effort to focus on the private sector, emphasize service delivery to the poor, institutionalize assistance to organizations that can serve a broader network and to call attention to the need to develop self-sufficiency, this project fits AID's strategy very well. USAID expressed some concern that FPIA's administrative vigilance may be excessive in view of USAID's effort to deal with Brazilian agencies as mature development partners. There was also a concern expressed that FPIA at times sends more individuals than necessary to do discrete parts of a task that perhaps could be handled by fewer persons with broader responsibility and capability.

5) Is this project breaking new ground, and if so, what are the policy implications?

Although not new in family planning circles around the world, CPAIMC's delegation of functions to nurses and paraprofes-

sional personnel and development of simplified service delivery protocols is new ground for its own organization and for many family planning providers in Brazil. Delivering well-supervised family planning services in a relatively low-cost fashion in poor urban communities is also innovative in the Brazilian context. The attempt to involve industry in a fee-for-service plan would have been new ground had it been successful.

- 6) What plans exist for continuation of the project when FPIA support ceases?

CPAIMEC has developed a long-term strategy that calls for reduction of service delivery points to the number needed for training and operational research. This ties in with its ultimate aim of becoming a national center of excellence for training and research, which may also attract trainees from other countries in Latin America and Africa. As it moves out of provision of family planning services, CPAIMEC expects the government to expand in this area. In addition, CPAIMEC hopes to be successful in its long-standing negotiation for contracts with Social Security for major funding and to reopen discussions with industry for financial support as economic conditions improve. Client financial contributions will play a minor role as will charitable donations. CPAIMEC has been working with FPIA in analysis of fund generation possibilities through training and clinical laboratory services. FPIA states its intention to consider additional discrete project support to CPAIMEC for innovative proposals and will continue commodity support.

- 7) Does this project include income generation activities, and if so what are their nature?

As noted above, fees for services to clients are being tried. To date they coincide with declines in clinic attendance, but CPAIMEC personnel believe this will reverse as it becomes clear that no clients will be denied service for inability to pay. The general feeling is that some client payment is positive in the long run. It is hardly likely that more than 25 percent of program costs, however, can be generated in this way. In 1985, although double in dollar value from 1984, client fees were only 24 percent of the total local contribution and less than 9 percent of the total budget. As noted above, other national sources are being explored. As a result of these efforts, local contributions have increased from 25 percent of the budget in 1983 to 33 percent in 1985.

1.3 Issues Relating to Implementation (CPAIMEC)

- 1) Project Design - is there evidence of long-term advance planning and/or regional coordination?

It is clear from the project document that the future (although changing) role of CPAIMC was considered. Plans were made for phase out of FPIA assistance and linkages were fostered within Brazil through the assistance to ABEPF, which will take on a regional coordinating and technical assistance role. CPAIMC's founding role and early support of ABEPF is a major contribution to the spread of family planning service delivery in Brazil.

2) Number and Quality of Staff.

CPAIMC is well staffed with highly qualified personnel as demonstrated by the following breakdown of its 264 personnel (see Table 1). Women play a prominent role in top management and in service delivery. The high percentage in health services (see Table 2) is in keeping with the service delivery emphasis of the project. Because client numbers are relatively low in centers serviced, however, there is some question whether the medical staff is perhaps unjustifiably large. The number of physicians is also relatively high, in part because CPAIMC provides (outside the FPIA grant) a substantial surgical service and significant gynecological attention in its integrated MCH activities. The low emphasis on training personnel and information and evaluation shown in Table 2 does not seem fully appropriate. In time the research component may grow to require more professionals.

Table 1
CPAIMC

Number of Employees by Professional Category
 1985

<u>Professional Category</u>	<u>Number of Employees</u>
Physicians	41
Registered Nurses	20
Technical Nurses	33
Auxiliary Nurses	62
Other Health Auxiliaries	25
Public Health Specialist	1
Social Workers	2
Psychologist	1
Social Scientists	1
Educator	1
Pharmacist	1
Nutritionist	1
Laboratory Technicians	3
Programmer/Statistician	5
Administrator	1
Administrative Assistants	10
Secretary/Typists	6
Receptionists	4
General Administrative Support Personnel	45
Total	<u>264</u>

Tables 2 and 3 demonstrate the allocation of personnel within the organization by functional area and the level of FPIA support to CPAIMC.

Table 2
CPAIMC

Number of Employees by Functional Area
1985

<u>Functional Area</u>	<u>Number of Employees</u>
Executive Management	9
Health Services	176
Administration	64
Training	6
Research	4
Information and Evaluation	5
TOTAL	<u>264</u>

Table 3

Level of FPIA Support to CPAIMC
Staff Full-time Equivalent
1985

<u>Functional Area</u>	<u>CPAIMC</u>	<u>FPIA</u>
Executive Management	9	1-1/2
Health Services	176	147
Administration	64	18
Training	6	-
Research	4	-
Information and Evaluation	5	4-1/2
Total	<u>264</u>	<u>174</u>

3) Information Services Including Outreach Activities.

Possibly in keeping with the low profile still required for family planning in Brazil, CPAIMC's information and outreach activities are relatively modest. No use is made of mass media. Although rather attractive "home made" posters on various aspects of maternal and child health are used, family planning materials in clinics are conspicuous by their absence. CPAIMC's claim that it focuses on community participation has some justification. It has taken its services outside the Saint Francis of Assisi hospital to some 44 peripheral health units and community posts, most of which have been made available by community organizations. With the exception of talks to clubs and organizations by social workers, however, the penetration into the community seems to stop at the post. The participation of community leaders in information or service delivery activities is not noticeable. This may be part of the reason why the number of clients (even for gynecology, pre-natal, and other services as well as for family planning) is low in relation to the capacity of the staff and the quality of the service being provided.

4) Are training and technical assistance needs for administration/management and program delivery being met?

FPIA has been responsive to needs and requests for this type of assistance. Taking care not to duplicate assistance being provided by other agencies (AVS, JHPIEGO etc.), FPIA has developed admirable management systems. It either produces or helps the grantee to produce documentation that can be easily tracked and evaluated for management purposes. If anything, the procedures call for a level of attention to administrative matters that overshadows the programmatic needs (see 5 below).

5) Administration and management--are there problems?

The two most problematic areas of management are budget and client counting. Budgeting in local currency in a highly inflationary situation is extremely difficult. All predictions of inflation are open to doubt, but not making them results in a budget that becomes rapidly obsolete. Financing through a system of advances ameliorates the problem but does not solve the time-consuming bureaucratic process of budget modifications. (Brazil-03 is now operating on modification 18, 11 of which are related to local currency modifications.) To pay in dollars is not an acceptable approach, but to budget in dollars to be paid in cruzeiros might be. To budget with inflated cruzeiros is difficult but not impossible. At any rate, disbursing on time is of the essence. A related problem, AID's requirement that project funds must be held in non-interest bearing accounts,

while benefiting Brazilian bankers, only compounds the problems of inflation for project staff.

The system of counting acceptors remains unsatisfactory, despite FPIA's admirable efforts to clarify the process. Definitions are confusing: subsequent visits of "continuing users" are not taken into account and therefore client load may be underreported. The system provides little idea of the continuity of the "new" or "continuing user." Neither does it lead project managers to make an analysis of the number of contraceptives distributed as compared to the users involved. Couple years of protection admittedly also leaves some aspects obscure but it is an objective measure which could be introduced. A final technical problem is that FPIA's project years do not coincide with CPAIMC's.

- 6) Quality of Services--do staff have up-to-date information on service delivery techniques, contraceptive technology, etc.?

The quality of services as viewed in the central clinic (hospital) and three community posts was very good. There was appropriate delegation of functions to paramedical personnel. Important ancillary health measures, examinations, and tests were available but did not stand in the way of clients' receiving contraceptives on the first visit (orals [three cycles] and condoms [about 10]). Processing time for new clients (said to be about 2-1/2 hours in the central clinic) seems long but in the community posts with much less activity is probably only the 1/2 hour stated. Informational materials were lacking or poor in quality and the availability of only English materials on the pill seems questionable. Although sterilization is not part of the FPIA project, the procedures for referral were reviewed. A one-month waiting list seems long but the procedures were appropriate--good informational materials, complete (and completed) voluntary consent forms, provision for ambulatory procedures with local anesthesia and increasing use of mini-laparotomy.

- 7) Evaluation Activities Including Use of Service Statistics and Feedback to Implement Needed Improvements.

Despite problems (see para 5 above), service statistics are kept meticulously under careful supervision and collected by the central unit. Comparisons are made of clinics' outputs, and cost figures are used for effectiveness comparisons. Feedback goes at least to the supervisor but clinic personnel visited seemed unsure of what they were getting back. Review of clinic records to ascertain the relationship between clients and contraceptives

distributed turned up some odd relationships.^{1/} CPAIMC, however, does not make such comparisons as yet.

8) Cost Data

Table 4 contains CPAIMC's calculations of cost per client served and couple years of protection in its central clinic, community units and mini posts.

Table 4

CPAIMC Cost Data

<u>Place of Service</u>	<u>Per Client</u>	<u>Per couple year of protection</u>
Central Clinic	\$4	\$4
Community Unit	\$9	\$22
Mini post	\$12	\$64

Calculated in dollars at a change rate of 19,000 cruzeiros to \$1.

Although the figures must be viewed with caution, given the problems described in paragraph 7 above, CPAIMC contends that they prove that the larger the facility, the more efficient the service. CPAIMC is using the figures to justify pulling out from smaller community centers except those needed for training. The organization rejects the argument that better outreach might increase the client load and thus the efficiency of the smaller units. Another factor in the high costs are the large supervisory and medical staffs, but again CPAIMC seems wedded to this approach. CPAIMC also seemed reluctant to use such alternative approaches as cooperating with pharmacies for contraceptive provision.

^{1/} For example, numbers of contraceptives distributed was very low (especially orals) in relation to the number of clients seen. Discussion and review of records suggested the causes included a variety of factors: some clients were referred for sterilization, some were provided orals other than those supplied by FP1A, and some were using CPAIMC for clinic backup when purchasing orals from the pharmacy.

It is impossible to calculate cost-effectiveness of all the FPIA-supported efforts undertaken by CPAIMC. There seems only to be agreement on how to count new clients. Here, the prediction is that the project will likely produce approximately 27,000 new clients (23,000 through September and 3,700 October through December). Dividing this total by the \$422,000 received by CPAIMC during the project period yields a cost per new client of \$16. ^{1/} Projected to the end of the period, this figure suggests a contraceptive distribution sufficient for 17,500 couple years of protection at a cost of \$24/couple year.

9) Commodities and Logistics

CPAIMC does an effective, well-supervised job of maintaining appropriate stocks of contraceptives in its service outlets. All units visited were well supplied, stocks carefully stored and up-to-date records maintained. The location of contraceptive stores in the central warehouse was being changed at the time of the visit so disorder was to be expected. Other CPAIMC stocks are generally carefully maintained, so expectations are for good procedures after the move. The warehouseman understands "first in - first out" and keeps FPIA informed of stocks getting older. He apparently was not aware of the possible problem of heat damage, as he was preparing storage space close to the ceiling.

In addition to supplies for its own centers, CPAIMC serves as an importation/distribution center for more than 30 other organizations and institutions throughout Brazil including the Center for Research and Studies Clovis Salgado (CEPECS), ABEFF, and CLAM, a family planning agency in the south of Brazil.

With the change in government, there have been delays in importation, with no new shipments having been received for nine months to a year. FPIA and CPAIMC are trying various means of reopening the import process. A review of stocks on hand suggests no need for immediate alarm. If the importation does not resume this year, however, the problem will become serious. A conservative estimate of the new and continuing clients to be served by CPAIMC, ABEFF, CEPECS, CLAM and a few others suggests:

^{1/} Certainly to apply all costs against this one measure of productivity is questionable as it does not take into account the increasing effort spent on continuing users and subsequent visits, on referrals for sterilization, developing a service that provides a training ground for others, providing contraceptives for other organizations, etc.

Table 5
Annual Contraceptive Requirements

<u>Types</u>	<u>New User</u>	<u>Continuing User</u>	<u>Requirement</u>
Orals	31,000	16,000	410,000 cycles
IUD	20,000	10,000	25,000 IUDs
Condom	15,000	8,000	2,200,000 condoms

A November 4 warehouse inventory report shows 700,000 cycles of pills on hand (140,000 manufactured as long ago as September 1980) and 2,225,000 condoms (311,000 also old, manufactured in April 1980). The foam supply of 3,773 units is short of requirements. IUDs were not in the report, but since quantities and bulk are small, they can be imported as required.

An issue of concern was that the pills are all with English markings and pamphlets, limiting their informational value and increasing sensitivity to U.S. involvement.

10. Contraceptive prevalence - how much results from the project? What are other measures of project performance?

The project operated in one clinic and roughly 44 community sites as planned, but was unsuccessful in developing service agreements with industries primarily because of poor economic conditions. Clinic operations provided the backdrop for important training ^{1/}, contraceptives for other family planning institutions and important insights into delegation of functions to paraprofessionals.

The project, however, did not reach its stated objectives in client service. Despite time extensions, it is likely to reach only 61 percent of its new user target--27,000 rather than 44,000--and only 77 percent of its goal for sterilization referrals (3,500). The number of new users has in fact steadily

^{1/} Since 1979 CPAIMC has trained 2,400 personnel for 322 institutions; in this funding period courses were given to 153 medical professionals and paraprofessionals and seminars were held for 152 health and community leaders.

declined throughout this funding period, from 7,695 new users and 915 surgical referrals in the first four months to approximately 5,000 new users and 680 sterilization referrals in the most recent four months. CPAIMC attributes part of this decline to its increasing focus on training. Furthermore, the increasingly liberal access to contraceptives in the pharmacies in Rio at prices relatively moderate compared to other developing countries (\$0.30 to 0.50/cycle) reduced the comparative advantage of the CPAIMC post in meeting community needs. CPAIMC has documented a correlation between a drop in new family planning clientele attendance in the central clinics (of 25 percent) and community posts (47 percent) with a substantial increase (in excess of inflation) in the average funds generated per new client visit (45 percent in the central clinic and 1,600 percent in the community units). In truth, however, it probably was not realistic to expect a relatively mature program operating out of fixed locations to continue to increase the number of new acceptors unless it instituted more outreach.

Little meaningful can be said about changes in contraceptive prevalence rates, since little accurate information is available about previous levels, other sources and characteristics of users. Some attempt was made by CPAIMC to relate users to population in the immediate area of the posts, which of course is also an easily questioned figure. In any event CPAIMC went to considerable effort to break down its program performance by the 48 locations where it worked from 1980 until the present. CPAIMC estimated the population to be approximately 1,063,450 in these areas. In these areas from 1980 to 1985, 135,834 new users of family planning were served. Using these figures, if one were to estimate 24 percent of the population as women in fertile age (WIFA), 255,228 might be the target population. Assuming a continuance rate of 25 percent of these new users (continuation with family planning and living within the area), it might be concluded that this project is at this time serving as many as 34,000 1/ women in the area or about 13 percent of the total WIFA.

One aspect of importance in evaluating the significance of these numbers is the age and parity of users. In a 1979 survey

1/ As with the other figures, this number must be used with caution. Apparently significant numbers of clients use CPAIMC for medical service associated with family planning but get their contraceptives, especially Brazilian-made pills, at the pharmacy. As many as 25 percent of the recent new clients chose natural family planning. This, however, does not fully explain the level of contraceptive distribution for July 1984 to September 1985, which only provides approximately 15,000 couple years of protection.

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it was found that the average age of the new accepters was 29 with a parity of 4.4. In a sample of new clients in December 1984, the average age had dropped to 26.8 years and parity to 2.3.

2. Brazilian Association of Family Planning Organizations (ABEPF) (Part of Brazil-03)

2.1 Background

In 1981, a group of family planning organizations came together to form the Brazilian Association of Family Planning Organizations (ABEPF). ^{1/} Many of these organizations had received their impetus from training and experience gained in CPAIMC. By 1984, when ABEPF had grown to 120 members, it entered into a service delivery project supported by FPIA. By November 1985, ABEPF had reached a membership of 152.

For FPIA and AID bureaucratic purposes, the project was included in the third funding period of CPAIMC. This arrangement has been convenient for both, as CPAIMC provided ABEPF considerable initial support, including office space, and the two groups continue to work closely and harmoniously together. Due to the importance of the ABEPF activity, however, it is being handled separately from CPAIMC in this report. However, since it is part of Brazil-03, it will not be discussed in detail.

2.2 Broad Issues

This project responds to the expressed need of many Brazilian institutions, which have recognized the need for extending family planning services to the poor both as a health measure and a response to human rights considerations. It was chosen as a natural outgrowth of work with CPAIMC and responds well to USAID strategy of networking, working in the private sector, emphasizing self-sufficiency and focusing on service delivery. In addition to direct support for family planning service delivery, ABEPF is involved in policy development, training, operational and biomedical research, and development of informational materials. The major thrust of the FPIA-supported project, however, is family planning service delivery.

This project is breaking new ground in the sense of supporting a nationwide network of already existing family planning organizations and bringing them the training, technical assistance, informational materials, commodities and financial resources necessary to help them more effectively achieve their

^{1/} The use of the word organization in this title may imply a stronger institutional infrastructure than presently exists in many cases. Some units may be only a point of contact: a trained person involved in family planning, with potential for organizational growth and expansion.

goals. Although like CPAIMC, ABEPF emphasizes delegation to paraprofessional personnel, it emphasizes the medical/social nature of family planning and at this time is opposed to community distribution of any contraceptives requiring medical involvement (i.e., oral contraceptives) on the grounds that medical prescriptions are required by law. 1/

ABEPF is engaged in strategic planning, with a staff retreat for this purpose planned for early November. At this time the directors state their future plans primarily in terms of continuing to respond to a rapidly growing number of requests for affiliation or for assistance. Since they do not see the government developing effective service delivery programs in the near future, they believe they should help their affiliates develop the capacity to respond to the needs of the population. Over the long run, they envision ABEPF members and the government providing complementary services.

ABEPF is particularly interested in promoting self-sufficiency among its members. Its individual subprojects are developed on the premise of a decreasing percentage of assistance. ABEPF has held several seminars on this issue, brought in technical consultation from the Colombian Family Welfare Association (PROFAMILIA) and Colombia's finance director and has developed a manual and an audio-visual presentation. Emphasis is given to developing a client fee system, but attention is also given to seeking government and private sector support. Although the latter effort has been largely unsuccessful to date, the directors are moderately optimistic for the future. Church efforts to head off this kind of support were noted. The director of one hospital visited, reputed to be particularly imaginative in gaining community participation, was quite skeptical of the ability of subgrantee organizations to become self-sufficient in the expected three years, even if FPIA continues to provide contraceptives.

2.3 Issues Relating to Implementation

A relatively young organization, ABEPF has brought together an enthusiastic staff of capable professionals. The full staff complement of 32 in Rio includes a physician, professional nurse, social worker, sociologist, biologist, administrative economist,

1/ While ABEPF states the law requires a medical prescription for oral, CPAIMC disagrees: A moot question in a sense since all agree that the common practice is for complete freedom in the pharmacy, but all the medically oriented organized programs visited insist on the need for medical supervision.

and professor. Of these, the FPIA-supported project provides the following full-time equivalents:

Table 6

Level of FPIA Support to ABEPF Staff

<u>Functional Area</u>	<u>Full-time equivalents</u>
Executive	1.2
Health services	2.0
Administration	4.75
Evaluation	<u>.50</u>
	8.45

Few of these individuals have experience in family planning (one has five years), and few have been provided the opportunity for additional training or observational travel. The director was sent by FPIA to Mexico and Colombia and others may go in 1986.

ABEPF is involved in the development and distribution of IEC materials, with both FPIA and Johns Hopkins assistance. Examples of their posters and pamphlets were seen in CEPECS and ABEPF clinics in Belo Horizonte.

FPIA has carefully monitored the development of this project and has provided considerable assistance in program planning, management, and monitoring. Some of the systems developed both by FPIA and ABEPF for this project may in fact be more complex than necessary for the size and nature of the subactivities. The project experienced early the implementation difficulties typical of new programs. In its first assessment report, FPIA drew attention to some problems and suggested solutions. ABEPF took steps to resolve the administrative issues raised, including increasing field supervisory staff, and is currently still attempting to do a more effective job in reaching clients. Brazilian cultural/political sensitivities and medical policy, however, may continue to inhibit the increased outreach and participation by community leaders recommended by FPIA. Although the evaluation report included many positive comments, ABEPF found it overly negative and even six months later was still distressed at its tone.

In the one location visited, delegation of functions was limited. Professional nurses took a very active role but lower level paraprofessionals were only beginning to deal with clients and a community leader had mainly a custodial role for a minipost

nearby, maintaining the facilities until the professionals came at stated times.

The doctor in charge was complimentary about the technical assistance (programmatic and administrative) received from ABEPF, as well as the feedback on monthly service statistics reports. He also appreciated the good working relationship with CEPECS.

ABEPF uses reasonably simple but adequate reporting forms for family planning clients and contraceptives. Those reviewed were complete and the tally comparing clients seen and contraceptives distributed was done well. The ratio of orals to IUDs distributed (3.5 to 1) reflects a situation in which clients apparently rely primarily on the clinic (not pharmacies) for their orals and in which physicians, who often tend to promote IUDs, do not seem to dominate the contraceptive distribution process.

ABEPF has a computerized system of service statistics analysis. It is principally used for routine reporting of clients by method, by doctor or nurse, and contraceptives distributed. Some efforts have also been made to analyze results for management purposes.

Cruzerio cost figures were not yet being analyzed in a detailed fashion, so a cost comparison of FPIA support compared to new users may be the best available.

FPIA support to ABEPF within the Brazil-03 project was approximately \$345,000. By the end of August, ABEPF had registered 16,445 new acceptors. If the trend continues, the total will be 24,000 by the end of December, and the project will have reached about 75 percent of its stated goal for this funding period at a cost of about \$4/new acceptor. Enough contraceptives will have been distributed for approximately 8,000 1/ couple years of protection at about \$43 per couple year of protection. In looking at these costs, it should be recognized that ABEPF's exclusive function is not service delivery. Although in these calculations all FPIA costs were charged to users and couple years of protection, in fact, much of ABEPF's role is technical assistance and organizational development with applicants, development of manuals and IEC materials. Contraceptive logistics are handled effectively by CPAIMC (see Section 1.3 question 9).

The numbers of population in the catchment areas were not readily available. Considering the early stage of this project,

1/ This seems low, but most of the users are new acceptors and distribution to each would thus be lower.

it hardly seemed useful to spend the time to make a questionable estimate of impact on prevalence.

3. Brazil-09: Center for Research and Studies Clovis Salgado (CEPECS)

3.1 Background

The Center for Research and Studies Clovis Salgado (CEPECS) was founded in 1980 as a non-profit organization to carry out training and research in the field of gynecology and family planning. It has its base in the University medical faculty in Belo Horizonte, capital of the state of Minas Gerais. It is closely associated with the Red Cross where it rents its office space. CEPECS also has leading community members (non-physicians) on its board. While expressing its objectives in terms of gynecology, maternal and child health and prevention of cancer, CEPECS focuses much of its attention on family planning. It receives assistance from Development Associates, JHPIEGO, and AVS, and began to receive FPIA assistance in February 1983.

3.2 Broad Issues

1) How and why was this project selected?

The project was selected in recognition of the status of physicians in Minas Gerais, the previous years of work in family planning by Professor Rocha of the medical faculty, and the substantial corps of medical personnel trained in family planning at the medical faculty in Belo Horizonte.

2) What are the objectives of this project?

The objectives are to initiate family planning clinic activities in 15 family planning posts and one distribution post in Minas Gerais, and over the long term, to provide statewide services. The goal for the second funding period (7/1/84 to 10/31/85) is to serve 24,000 new and 8,000 continuing users. CEPECS's president emphasizes the social justice aspect of the work: to provide the poor the same access to family planning that is now available to the rich and middle class through private physicians and pharmacies. The project represents 80 percent of CEPECS' work. It also is involved in research with NORPLANT (not with FPIA funds) and has published some articles.

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- 3) Are the objectives of this project appropriate to host country needs?

There is no question but that the need exists for extension of family planning services to the poor classes. The growing number of requests from mayors and community organizations certainly suggests the acceptability of this approach. Involvement of the medical community may be the best approach at this initial stage. Young physicians have become enthusiastically involved in the project, and with 1,800 new physicians graduating yearly in the state, there should be no lack of medical manpower in the near future. There is also room for medical involvement. IUDs represent 35 percent of modern methods, and oral contraceptives are increasingly available from pharmacies, with an accompanying need for medical backup. Only time and further expansion will tell if this physician-dominated, clinical approach can be sustained in the less accessible small towns in the interior. There is enough discussion among the physicians of their interest in looking at how other programs operate elsewhere to suggest that some more expansive approaches may be tried out. At present they are committed to making this clinic system operate effectively at the community level.

- 4) Is this project breaking new ground and if so, what are the policy implications?

The new ground is largely geographic. Also significant, however, is the securing of elite acceptance of organized family planning programs.

- 5) What plans exist for continuation of the project when FPIA support ceases?

CEPECS looks primarily to university, society, industry and local government support for its continuance and expects to get 35 percent of its support from these sources by the end of 16 months and be self-sufficient at the end of five years.

- 6) Does this project include income-generation activities and if so what are their nature?

With a long tradition of free clinical services provided by the university, it is proving difficult to develop a client-supported system. Some effort has been made in this direction but the results are disappointing.

As the project expands into smaller communities, CEPECS usually looks to the county government (prefeitura) or to a local organization to provide a building and upkeep, with the hope that within three years, the service will be sufficiently

well established that the local group will take it over completely.

3.3 Issues Relating to Implementation

- 1) Project Design -- is there evidence of long-term advance planning and/or regional coordination?

The project was launched as an experiment to test the capacity of the local physicians and the efficiency of the clinical approach and its capacity to involve the community. Its growth, according to CEPECS, has been in response to the growing number of requests and has been determined by the resources available.

- 2) Number and Quality of Staff.

The project is staffed with young, well-trained competent personnel. With the exception of the social worker, the leadership is all male. Auxiliary nurses and social workers have been trained by the project at the university or by CPAIMC. The physicians receive family planning training at the university in Belo Horizonte and many of those in leadership positions have been to JHPIEGO headquarters in Baltimore, Maryland.

The project has a director, coordinator, two medical supervisors, a social worker, 14 gynecologists, 21 auxiliary nurses and two secretaries. The plan is to add another social worker to develop community information programs and personnel to visit community leaders. As the program develops, more personnel will be needed for medical supervision and coordination. An important element of its success in the community is CEPECS's emphasis on staffing each clinic with an auxiliary nurse who lives in the community. FPIA support provides the following personnel:

Table 7

Level of FPIA Support to CEPECS Staff

<u>Functional Area</u>	<u>Full-time equivalent</u>
Executive	1-1/2
Health Services	25
Administration (including commodity management)	12
Training	-
IE&C	-
	38-1/2

3) Information Services including Outreach Activities.

The project makes considerable use of the posters and pamphlets bought from ABEPF, as well as 10,000 produced by CEPECS itself. Negotiations are under way with the Sociedade Civil de Bem-Estar no Brasil (BEMFAM--the IPPF affiliate) for the production of additional materials. Social workers expect to increase visits to community groups, industry and schools. Mass media campaigns are not considered appropriate at this time, although there are reported to be several substantial television campaigns noting the danger of using pills bought at the pharmacy without medical supervision. CEPECS believes this and the poor economic conditions of the lower class may be an important reason for the demand at CEPECS clinics.

4) Are training and technical assistance needs for administration/management and program delivery being met?

Between what FPIA and other organizations have provided, these needs are largely met. CEPECS expressed interest in having a greater opportunity to observe programs and exchange ideas with other projects in Brazil and Latin America.

5) Administration and management - are there problems?

CEPECS is experiencing some of the same budgetary/administrative problems as is CPAIMC, but apparently to a lesser degree. CEPECS's spectrum of service is less complex than CPAIMC's, and it appears to have developed a simple service statistics system that can respond easily to FPIA's needs and

definitions. Even if problems arise between CEPECS and FPIA, it appears they are easily resolved. Physician-dominated, CEPECS fears that as the project expands, it may need to acquire a staff member with administrative experience to satisfy FPIA's management demands.

- 6) Quality of services - do staff have up-to-date information on service delivery techniques, contraceptive technology, etc?

The condition of the clinics and the quality of the services appeared very good. At community posts, physicians are available several days a week for two-hour stretches and clients crowd up at the appointed time for consultations. Apparently, however, clients deal with the situation reasonably well. CEPECS maintains a library of family planning information and makes use of materials available from various sources.

- 7) Evaluation Activities including Use of Service Statistics and Feedback to Implement Needed Improvements.

Services statistics on clients and contraceptives are collected and collated each month for analysis by doctors. The analysis of contraceptive distribution appears to be more to assure logistic control than to match clients with contraceptives or observe trends. CEPECS has had little experience with these latter types of analyses or their use for management purposes. The medical audit performed by the medical supervisor, however, is effective for clinic supervision at this stage. The supervisory system is unexpectedly streamlined.

- 8) Cost Data including Calculations of Cost-per-Client Served.

Cost accounting for individual clinics was not immediately available at CEPECS. A superficial review of clients served and FPIA costs of couple years of protection with modern contraceptives was made.

From August 1984 to September 1985, 23,151 new users were provided contraceptives, a level representing approximately 9,000 couple years of protection. FPIA disbursements during that time were \$110,000, or a cost to FPIA of \$4.75/new user and \$12/couple year of protection. In comparing these costs to other projects, it should be noted that at this stage, CEPECS is almost exclusively a service delivery project without the training, organizational development and technical assistance costs of some others. Rather, other projects operating in Brazil provide these types of services to CEPECS.

9) Commodities and Logistics.

Commodities are well stored in a central warehouse in the Red Cross building. Supplies provided by FPIA come through CPAIMC. (Comments for Brazil 03 apply here. See Section 1.3 question 9.) Additionally, there is the concern for clinical equipment to be sent from the United States for the expected expansion of this project. A simple, effective system of commodity requests and dispatches are used and the warehouseman efficiently tracks quantities, date of manufacture and first in/first out principles.

Review of contraceptives at the posts showed appropriate quantities available, well stored. Amounts distributed matched reasonably with clients served. An exception was the large clinic at the Red Cross building where far fewer orals were distributed than the client load would have suggested. This discrepancy may reflect a clientele that can afford to purchase oral contraceptives at the pharmacy. The global client and distribution records show a considerably closer correlation between distribution and requirements than did other projects.

- 10) Contraceptive prevalence - how much results from the project? What are other measures of project performance?

With the same caveats noted in discussing Brazil 03 (see Section 1.3 question 10), some effort was made to calculate the prevalence impact. CEPECS' impact population estimate was probably larger than that used by CPAIMC.

The results suggest the influence population of these various modules to be very approximately 1,350,000 (this is about 1/3 the population of the state), with WIFA at 340,000. New users in this project totaled 23,000. Discounting them 50 percent to get continuing users is consistent with other projects at this stage. This may even be a conservative approach in light of 9,000 CYP of contraceptives distributed. The 11,500 translate into a 3.4 percent prevalence rate that can be attributed to the project.

**APPENDIX Q3
PERU: TRIP REPORT**

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PERU: TRIP REPORT

GLOSSARY

ADIM	Association for Women's Development
APROSAMI	Peruvian non-profit organization for health mothers and children

APPENDIX Q3

PERU: TRIP REPORT

Projects Visited Peru-06: Fertility Regulation--Obstetrics and Gynecology Department, Cayetano Heredia University

Peru-18: Community Distribution by the Carmen de la Legua Clinic - APROSAMI

1. Peru-06: Fertility Regulation--Obstetrics and Gynecology (ob/gyn) Department, Cayetano Heredia University

1.1 Background

The fertility regulation project of the Cayetano Heredia University has been in operation continuously under the direction of the same person (Dr. Carlos Munoz) since its inception in 1964. It has always had various in-kind support from the University and international support initially from the Ford Foundation, then The Pathfinder Fund and for the past 12 years from FPIA. The project is essentially a training program for physicians and some paramedical personnel, with a service delivery capability at the Loayza Hospital to assure practical training opportunities in family planning. There is an outreach component to communities, schools and industry through talks and seminars; more important is the outreach to the rest of the country through courses and seminars given in cities in the interior for physicians, public health personnel and community elders. Over the 12-year period, this project has received approximately \$428,000 from FPIA; the budget for the period January 1, 1984 to December 31, 1985 is \$65,000.

1.2 Broad Issues

1) How and why was this project selected?

FPIA long-term continuous support for this project, with USAID encouragement, reflects a high regard for the importance and autonomy of Cayetano Heredia University. The status of the project director has given respectability to family planning even during periods when this subject was extremely sensitive in Peru.

2) What are the objectives of this project?

The director views the objectives of this project in demographic terms. He believed early on that a demand would grow for family planning services, and he sought to develop the health personnel expertise that would be necessary to meet the demand. Project staff view themselves as a technology base for the Ministry of Health and see their role expanding to support the growth of family planning throughout the country through training of health personnel outside Lima.

3) Are the objectives of this project appropriate to host country needs?

Project objectives--providing training and some service delivery and contributing to policy development--are appropriate.

4) Are the objectives of this project appropriate to AID objectives and strategy?

AID views this project as important to its strategy and has consistently requested FPIA to extend its support.

5) Is this project breaking new ground and if so, what are the policy implications?

In its initial stages, this project was one of the pioneers in family planning. Others may have provided service more widely, particularly at the community level. In its training of health personnel in interior cities, however, especially in minilaparotomy, the project continues to provide new avenues of service.

As this project continues to deal directly with physician, who presumably will remain a dominant force in population and family planning policy development, the project will maintain an important policy role.

6) What plans exist for continuation of the project when FPIA support ceases?

University and hospital in-kind contribution now cover about 25 percent of project costs. If external support were no longer available, very likely the extension service to the community and to the interior cities would be lost. AID, however, intends to include the project, perhaps in an expanded role, in its forthcoming bilateral project.

7) Does this project include income-generation activities and if so what are their nature?

Tuition payments by participants in the interior cities are

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the only income-generating activity in this project. These payments may help cover some of the costs of project promotion.

1.3 Issues Related to Implementation

- 1) Project Design - is there evidence of long term advance planning and/or regional coordination?

Even though FPIA has intended to phase out its participation for some time, the project has shown evidence of long-range planning and slow but steady growth in reaching changing objectives. While remaining conservative, training has evolved to meet the needs of community medicine: doctors are being trained to head health teams; paramedical personnel are being trained; the concepts of high reproductive risk are noted; training for surgical contraception is expanding; and more linkages and follow-up are being developed with physicians and institutions in the interior.

- 2) Number and Quality of Staff.

There are three physicians in executive positions and five gynecologists who supervise and participate in the practical training and service delivery. Two social workers, one auxiliary nurse, two secretaries and one messenger complete this staff, which is well qualified and certainly knowledgeable about and dedicated to the project.

- 3) Information Services Including Outreach Activities.

The project makes considerable use of posters from the National Population Council, client informational material from AID and flip charts from FPIA. The project director expects to request more.

Additionally, the project assisted Expresso, a weekly photo and news journal, to publish 17 issues largely on family planning. This publication, said to reach 400,000 readers, was reported to have increased attendance considerably at the family planning clinic in the hospital.

Although social workers give talks and seminars in the community, industries and schools, this appears to have had little influence on clinic attendance. On the other hand, talks

and interviews by hospital personnel with obstetric patients seems to be an effective approach. 1/

- 4) Are training and technical assistance needs for administration/management and program delivery being met?

The project director has felt little need for technical assistance in service delivery, and, backed by university and hospital administration, has requested little from FPIA in management. The project seems to have had little difficulty in managing its affairs and reporting to FPIA.

- 5) Administration and Management - are there problems?

Budgeting in an inflationary environment presents the same kind of problems in this project as are being experienced elsewhere in Latin America (see e.g., Appendix Q2, Brazil-03, Section 1.3, question 5). FPIA regional staff turnover is another problem area. The project director indicated that comments received from the Regional Office on his quarterly report did not reflect the kind of long-term understanding of the issues that could be expected if staff remained in place over a long period of time. Finally, there are always problems with importation of commodities, but the project director feels that these are being solved.

- 6) Quality of Services - do staff have up to-date information on service delivery techniques, contraceptive technology, etc.?

Through other organizations with which the project has ties, such as JHPIEGO and AVS, adequate technical information is available.

Services are provided in rather crowded circumstances (two examining tables to a room, for example, not allowing much privacy). The sign-up procedure for family planning services is time-consuming, involving long waits and crowds in the outpatient department. The building is old and not too well maintained, but there is evidence of effort at maintaining cleanliness and order. All the personnel give the appearance of providing helpful and efficient service.

Surgical procedures are by minilap or laparoscopy in a well-refurbished operating room supported by AVS. Procedures

1/ This and various other comments in this section are based on an outside evaluation undertaken in 1985 by Dr. Estrada of Colombia.

are performed under general anesthesia and patients remain for 24 hours. For sterilization, a couple must make an application to the hospital, and approval is given by the project director based on medical rationale (some are turned down; the example given: a woman of 23 years of age with only one child). The director says the approval process only takes about 48 hours, whereupon the sterilization can be done immediately. No major problems have been reported. The informed consent form being used is as important for relations with the government as it is to AID, so is kept permanently in the main hospital files. The form contains all the AID requirements except those which pertain to non-literate persons (i.e., regarding explanations and witnessing).

The course outlines and syllabus of the department of obstetrics indicate some family planning is taught. The project director identified several additional courses where family planning is included. With the dedication of the three top project staff, it is likely that indeed more is being taught than might appear. Provision of practical training at the hospital clinic is a further guarantee of the quality of training. The need to provide this practical training to a considerable number of physicians may be one of the reasons why relatively less attention has been given to training and using paramedical personnel.

7) Evaluation Activities Including Use of Service Statistics and Feedback to Implement Needed Improvements.

A complete (fairly simple, but adequate) set of client history, registration cards, etc. has been developed and maintained. Presumably considerable use is made of the client history in evaluation of individual health needs. Enough information is drawn from these records to report in a timely fashion to FPIA on client levels. Contraceptive use figures were available, but it did not appear that they were as up-to-date or that they were being used other than to report to FPIA. Attention was being given to recording age and parity for student research.

A knowledge and attitude survey is being carried out by the social worker, who is interviewing every twentieth client and comparing the knowledge of those who heard family planning talks with those who did not. Only 100 interviews have been carried out and no analysis has been completed as yet.

8) Cost Data Including Calculations of Cost per Client Served.

No cost data was immediately available. The project director says what cost accounting is done is done by the

university accountant and is not available to him on a regular basis. He did not cite any examples of cost comparisons being made.

Calculating the cost per user to FPIA in this project is misleading, since a substantial portion of the project is training. Nevertheless some estimates are interesting. The cost to FPIA this period through August 1985 equaled approximately \$55,000.

Table 1

Estimates of Cost Data: Cayetano Heredia University

New users	6735	cost per new user	\$8.16
Continuing users	9828		
Sterilization clients	515		
Total persons attended	<u>17,078</u>	cost per person	\$3.22
CYP Provided	18,194	cost per CYP	\$3.02

These figures compare with those calculated by an outside evaluator engaged by the project for the period 1973 to 1985 as follows:

Table 2

Outside Evaluation 1/

Total Period

Cost per new user	N.A.
Cost per person attended	\$12.65
Cost per CYP	\$ 3.35

9) Income Generating Components

Not significant.

1/ Dr. Estrada's: see previous footnote.

10) Commodities and Logistics.

The material is stored in the general warehouse of the University, which is reported to have adequate control. Problems of outages and of products' reaching expiration dates are being addressed.

11) Contraceptive prevalence - how much results from the project? What are other measures of project performance?

In conjunction with an extension of project funding, targets were increased as follows: for new users, from 6,000 to 9,000, for continuing users, from 9,100 to 13,650, and for sterilizations from 335-465 to 503-698. Through August, the project had served 6,735 new users (75 percent of the goal), 9,828 continuing (72 percent), and had provided 515 sterilizations (85 percent). It is most likely that all the goals will be met by the end of this funding period.

The geographic spread and numbers of institutions assisted by training in the interior was remarkable.

The only goal that may not be met are planned interviews with women recovering from a septic abortion, who are to be interviewed and be provided family planning information. Fewer women are experiencing this problem than expected and thus probably only about 70 percent of the interview goal will be achieved.

Nine and 9/10ths cycles of pills were provided each to 768 new and 849 continuing pill users, or 1,617 clients over a 20-month period for a total of 16,050. This ratio is rational. Foam is given to each IUD user initially; IUDs and foam numbers approximately matched the 5,754 new users, as expected.

Couple years of protection provided through August are calculated at:

16,050 cycles / 13 =	1,234
5,754 IUDs x 2.5 =	14,385
515 sterilization x 5 =	2,575
Total	<u>18,194 CYP</u>

Prevalence impact calculations are particularly problematic for this institution, which until recently was one of the few if not the only institution providing IUD insertions in the city. Loayza Hospital's radius of impact is larger than its immediate surroundings, but the program essentially only deals with those women seeking IUDs or surgical contraception.

If one were to consider the impact area 1/3 of Lima or 2,000,000 persons, 400,000 of whom were WIFA, a very tentative estimate of prevalence might indicate the following:

There were 7,200 new users in this period most of whom chose a longer acting method. Discounting only 40 percent for drop-out, the users at this time might be 4,320 or possibly one percent of the WIFA in one-third of Lima.

2. Peru-18: Distribution Comunitaria de Carmen de la Legua

2.1 Background

This project under the auspices of APROSAMI, a Peruvian non-profit organization for health for mothers and children, has received PPIA assistance since 7/1/81. It is now finishing its fourth funding period (budgeted at approximately \$53,000) for a total of approximately \$153,000 since its inception. The project operates out of a modest headquarters in a lower middle class area. The headquarters building includes the project's central clinic (Centro Medico Carmen de la Legua). The program has urban CBD activities in nine lower socio-economic level sectors carried out by 225 volunteers (distributors) under the supervision of 14 promoters and coordinators.

2.2 Broad Issues

1) How and why was this project selected?

This project was selected to support the efforts of a small but active medically oriented Peruvian institution seeking to extend CBD of family planning information and methods to the urban poor, especially those living in the new urban settlements, hereafter referred to as "pueblos juvenes."

2) What are the objectives of this project?

APROSAMI's overall objective is to improve health of mothers and children. Family planning, however, is acknowledged to play an important role in health. Initial activities were centered in the clinic at Carmen de la Legua. As the demand and support grew, APROSAMI has experimented successfully with CBD and now sees possibilities of expansion to other activities and other areas of the country. Complementary to the project are the support of AVS to equip an outpatient operating room at the clinic and that of FHI to undertake limited biomedical research on the use of the mini-pill for lactating women. APROSAMI has begun to emphasize adolescents through the development of a

comprehensive sex education manual. While the original objectives of this project were to offer reversible family planning methods in the central clinic, urban CBD distribution points in Lima and a few points in other cities, with AVS involvement and continued funding, the project may start to provide voluntary sterilization and to expand into new geographic areas.

- 3) Are the objectives of this project appropriate to host country needs?

The unsatisfied demand for family planning in Peru has been documented by several surveys. Neither the growing facility-based program of the MOH, clinics of several private organizations, nor pharmacy sales adequately meet the demand. The CBD approach appears to respond well to the needs of the underprivileged people living in the "pueblos juvenes" of Lima.

- 4) Are the objectives of this project appropriate to AID objectives and strategy?

The objectives of this project fit very well AID's overall objectives and strategy, specifically: the project's focus on the provision of a wide spectrum of contraceptives, a low-cost, public health-oriented approach using appropriate technology, community participation, and plans for self-sufficiency. Further work must be done to refine both USAID's and this project's strategy for coordination with other organizations. Nonetheless, the project should fit well with USAID's future bilateral project.

- 5) Is this project breaking new ground and if so, what are the policy implications?

This project, together with several others in Lima, is breaking new ground in the area of community participation in the distribution of contraceptives and in user participation in the financing. Although neither of these approaches at present is part of the government (Ministry of Health) program, their existence and the documentation of their success can contribute to policy development.

- 6) What plans exist for continuation of the project when FPIA support ceases?

Although client payments presently provide approximately 25 percent of the budget, this level of contribution represents some hardship to the very poor whom the project serves. Without more external support, however, there is no other option. Meanwhile, plans for expansion in Lima and other cities and for inclusion of sterilization will require a higher level of additional funding than will be available locally. While

continuing to seek support in-country assistance, APROSAMI will look to international support for its future. USAID expects to provide bilateral assistance of a substantial level.

- 7) Does this project include income generation activities and if so what are their nature?

Income generation is almost exclusively from client charges for services, which range from \$0.04 for a cycle of orals to \$0.50 for a consultation or IUD insertion at the central clinic. Volunteer distributors are "compensated" for their services by keeping approximately \$0.02/cycle for pills and a fraction of a cent for a condom.

2. Issues Relating to Implementation

- 1) Project Design - is there evidence of long-term advance planning and/or regional coordination?

This project has been in the forefront of efforts in Peru to distribute contraceptives among the urban poor. It has expanded only gradually, however, at a pace commensurate with its resources. FPIA, while sharpening the focus on strategic planning, has not provided enough funds to allow the project to expand as rapidly as it might have. More funds would have permitted the promotion and additional supervision that would have resulted in improvement and expansion of delivery of family planning services.

- 2) Number and Quality of Staff

The project is implemented by a small but well-qualified staff of enthusiastic personnel. It includes five physicians, nine non-physician professionals (nurses, nurse-midwives, social worker, engineer, accountant, teacher, etc.) two secretaries, ten CBD promoters, two auxiliary nurses, a driver and a guard. The physicians are part-time and most of the others full-time.

- 3) Information Services Including Outreach Activities.

One of the strengths of this project has been its use of informational materials provided by the Peruvian National Population Council, Development Associates, Johns Hopkins Population Communication Services project, USAID and others. The project has also developed some of its own materials, mostly motivational. The project looks to FPIA for audio-visual equipment and materials.

- 4) Are training and technical assistance needs for administration/management and program delivery being met?

Some provision has been made for staff training, but relatively few staff members have been sent for visits to other projects either in Peru or elsewhere in Latin America. Arrangements exist for training of new personnel and for periodic refresher courses and seminars. Promoters exhibited some confusion as to the use of contraceptive methods, suggesting weakness in on-the-job follow-up.

FPIA's recent work to help plan the service delivery strategy for future CBD activities is a good example of effective assistance in this area. It would be more fruitful if done with more consultation with USAID and other institutions.

- 5) Administration and management - are there problems?

As in Brazil, FPIA is providing well-managed, closely supervised administrative assistance to this project. The amount of paperwork required, however, seems disproportionate, given the level of assistance (\$17,000 for the eight months [February - September, 1985] to date in this funding period). In particular, both USAID and APROSAMI staff expressed concern that the need to rebudget repeatedly to adjust for inflation took a considerable toll on both staff time and enthusiasm. (see Appendix Q2: Brazil-03, Section 1.3, question 5 for a fuller discussion of this problem). A representative of the Association for Women's Development even refused to work with FPIA because of the budgeting complications.

The FPIA system of counting clients proved unsatisfactory throughout this project. Although the system was designed for use in the clinic setting, even here the director misunderstood FPIA's distinctions between "new" and "continuing" clients. More understandably, the system is proving inappropriate for the CBD program. In fact, even if distinguishing among clients in a CBD setting were possible, it might detract from the simplicity and community leadership which otherwise distinguish this approach.

The project ran out of condoms in June, after demand for them had been particularly heavy. The problem was partially resolved by borrowing from other programs but will continue to be a deterrent to project expansion until new shipments arrive in December. With the change in governments, there may be port delays.

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- 6) Quality of Services - do staff have up-to-date information on services delivery techniques, contraceptive technology, etc.?

The clinic procedures seem appropriate. While information and printed material at headquarters are adequate, there was a shortage at the field level for both distributors and clients (who are said to be largely literate).

- 7) Evaluation Activities including Use of Service Statistics and Feedback to Implement Needed Improvements.

Despite the problems noted in para 5. above, reports are prepared regularly on new and continuing users (results of which are questionable), contraceptives distributed, and money collected. The reporting chain goes from the distributor, who keeps a rudimentary system of notebooks and hand-lettered report forms, to the promoter (who collates weekly), to the coordinator (who collates), to the directors of the IEC and community service who report to the project director at least monthly.

These data are compared with progress in meeting the project goal. There is little evidence of analysis of how contraceptives distributed and money collected correlate with users, or how users correlate with population numbers in the service area or near a distributor's home. Cost factors do not appear to be analyzed in relation to project components. The project director expressed an interest in a microcomputer, presumably so some of this analysis could be done. It would appear that priority should be given to developing a more systematic approach to data collection and simple analysis before there is a need for more sophisticated data analysis capability.

- 8) Cost Data including Calculations of Cost per Client Served.

APROSAMI's system of inventory control includes a monthly report on receipts, distribution, and balance, as well as a figure for sales received, expressed in quantities of contraceptives. This makes calculation of contraceptive distribution reasonably easy, with a cross check. The figures check out well, with sales receipts running about 20 percent behind warehouse distribution in any given month. On the basis of this information, it is possible to calculate the cost/user and couple years of protection.

From the beginning of this funding period, February 1985 through September 1985, the project served clients and distributed contraceptives as follows:

Table 3

Estimates of Cost Data: APROSAMI

	<u>Quantities Distributed</u>	<u>New Users</u>	<u>Continuing Users</u>
Orals	50,000 cycles	2,223	1,250
Condoms	1,174,200 units	10,160	3,862
Jelly & foam	5,328 units	1,066	12
IUDs	588 units	588	---
Total		<u>14,042</u>	<u>5,124</u>

The couple years of protection provided using 13 cycles/year for orals, 144 condoms/per year, 3.5/year for foam and 0.4/year for IUDs = 14,983 CYP.

Costs to FPIA in this period (actual disbursements to APROSAMI not including commodities) = \$17,000

Funds generated by APROSAMI U.S. \$ equivalent \$6,330
Total - \$23,330

$$\text{cost/new user} = \frac{\$23,330}{14,042} = \$1.66/\text{new user}$$

$$\text{cost/CYP} = \frac{\$23,330}{14,983} = \$1.55/\text{CYP}$$

9) Income Generating Components

A small but neatly arranged warehouse is located in the central headquarters. Inventory is taken every several months, records of arrivals and dispatch are well maintained and supplies are distributed in the appropriate order. As noted above, condom supplies are very low; pill supplies are adequate and all were manufactured in 1982. IUD supplies are adequate. Foam and jellies, which are increasingly popular, are out of stock. More attention is now being given to ordering ahead.

10) Commodities and Logistics

The project is well on its way to meeting its targets, having reached 80 percent of new and 65 percent of continuing user targets in 50 percent of the project period. If barrier methods had been available in full supply, the numbers would

probably be even better. The distribution of contraceptives per capita has been surprisingly high: 13.5 cycles of pills, 4.8 units of foam or jelly, or 83 condoms distributed per person. The reasons for this high count are not clear but probably reflect in part an undercount of person served, in part the practice of not identifying subsequent visits of continuing users, and in part the practice of volunteers who distribute as many as 10 cycles at a time to a user who is said to be supplying her sisters, cousins and neighbors. This is not necessarily bad, but it can result in use without proper instruction and follow-up, and it makes the record keeping more problematic.

In any event, even taking the most conservative estimate of users for this period--that of new users only--it appears that some impact on prevalence has been made. Again, with all the caveats in the Brazil report, an expansive estimate was made of the impact areas of the nine zones where CBD was functioning. The total population in those zones was 3,100,000, with roughly 620,000 WIFA in union. The 14,000 new users discounted by 25 percent for dropout (over the eight-month period) make approximately 10,500 users at present. This is considered conservative as 14,000 CYP were provided. Thus, the percentage points of prevalence currently being provided by the project in these areas would be approximately two percent.

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**APPENDIX Q4
MEXICO: TRIP REPORT**

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MEXICO: TRIP REPORT

GLOSSARY

FEMAP

**Mexican Federation of Private Family Planning
Associations**

APPENDIX Q4

MEXICO: TRIP REPORT

Project Visited: Mexico-25: Mexican Federation of Private Family Planning Associations (FEMAP)

1. Background

This project with the Mexican Federation of Private Family Planning Associations (FEMAP) is in its second funding period, 1/1/85-4/30/86. The initial period was 10/1/83-12/31/84.

The specific stated objectives of this project period are to initiate seven new CBD projects in various cities in Mexico and to maintain support for the five subprojects begun in the initial period. A combined total of 21,000 - 27,000 new and 6,100 continuing clients is expected.

FEMAP is a non-profit federation which was organized in 1981 largely due to the success of the pioneering efforts of the Program of Maternal and Child Health and Family Planning, initiated in 1973 in Juarez, Mexico and replicated later in several other cities. From six member association, which served 0.5 percent of Mexico's family planning users, FEMAP has grown to include 22 affiliates operating in 32 cities in 14 states and serving six percent of the country's total users.

The Juarez experience and the subsequent FEMAP model are noted for their program of maternal/child health with a strong emphasis on family planning (all methods), community participation, leadership of women and the dependence on volunteers.

2. Broad Issues

1) How and why was this project selected?

This project was selected to support the expansion of the FEMAP model. Although there is a strong government policy and reasonably strong government health institutions providing family planning services in Mexico, a significant percent of the poor population is outside their reach. The contribution of the private sector, particularly as it involves volunteers and community leaders, adds an important qualitative dimension to the service provided. The high level of continuity of users in the program, (said to be up to 85 percent for one year and 65 percent for five years as compared to less than 50 percent for other

programs), is an indication of the quality of the program. The results of a recent study of users in the Juarez project, showing that 75 percent of the users had never used contraceptives before, indicates that this model represents a previously unmet need. FEMAP considers the program the highest quality in Mexico in retention of clients, impact on prevalence in the target area, and involvement of volunteers.

- 2) What are the objectives of this project?

FEMAP's goals are to extend its program to more cities of Mexico. This objective is consistent with its efforts to secure funding from other donors for the same purpose.

- 3) Are the objectives of this project appropriate to host country needs?

FEMAP's objectives are consistent with the Mexican government's strong policy to reduce the population growth rate and to extend health and family planning services beyond the population reached by the government program.

- 4) Are the objectives of this project appropriate to AID objectives and strategy?

With its private sector, expansive, service delivery emphasis, and its involvement of volunteers, women's leadership, community participation, and focus on self-sufficiency, the project is consistent with AID strategy. USAID is very supportive of FPIA assistance to this project.

- 5) Is this project breaking new ground and if so, what are the policy implications?

Both the creation of a network of FPIA-supported projects and the development of an administrative center which uses FPIA procedures represent new approaches in Mexico. The mutually supportive FEMAP-FPIA partnership which has evolved for developing, funding and monitoring subprojects is said to be excellent by both FEMAP and FPIA personnel. Some of the lessons learned in this relationship in Mexico should be examined in Brazil and Peru.

Programatically, the project is demonstrating how a reasonably broad concern for maternal and child health can be maintained while emphasis is placed on family planning. Those who have become doctrinaire on either side of the MCH/FP issue can learn from this project. The CBD approach backed by medical services providing IUDs and surgical contraception is not particularly new. On the other hand, the organization to

coordinate all these elements and the strong emphasis on volunteers and community participation are unique.

- 6) What plans exist for continuation of the project when FPIA support ceases?

This project has placed considerable emphasis on self-sufficiency and the generation of local support (see question 7 below). Indeed, the clinic in the Juarez project is now self-sufficient, thanks in part to client fees. Nevertheless, it is apparent that expansion to meet the needs of a growing number of WIFA, a higher percentage of whom are seeking family planning, cannot be financed by user fees alone. FEMAP is not at all sanguine about its ability to meet increased demand, and at the same time to become self-sufficient.

- 7) Does this project include income generation activities and if so what are their nature?

FEMAP is trying a variety of income-generating activities including campaigns, fairs, and bazaars. Initial experimentation with commercial sales of contraceptives indicates some potential in this area. Each subproject document emphasizes the need for local participation in the provision of land and buildings and in the development of a plan for phased down FEMAP support. Client fees are used to defray some of the costs. Information on the actual funds generated is limited, but it was estimated at about 25 percent of program costs.

3. Issues Relating to Implementation

- 1) Project Design--is there evidence of long-term advance planning and/or regional coordination?

At the subproject level, the issue of long-range planning is inextricably linked to that of self-sufficiency, and most subproject long-range plans are stated in financial phase down terms, rather than expressions of programmatic interest or strategy. At headquarters level, FEMAP states that its long-range plan is to cover all the major population centers of the country, depending on the availability of resources. Although FEMAP does strategic planning to identify the most critical areas requiring additional services, its expansion is conditioned primarily by leadership interest and organizational capability in particular cities.

FEMAP leaders note a growth in public awareness of FEMAP and the importance of its program. They feel this may eventually result in governmental or industry subsidies but cite economic conditions in the country as making this unlikely in the near

future. They cite examples of positive results from their efforts to collaborate with state and city governments or with the Ministry of Health. With continued government in-kind contributions and more frequent clinic referrals to public facilities, FEMAP will be able to expand its operations to some degree. Only with sustained international support, however, can it hope to achieve significant growth.

2) Number and Quality of Staff

FEMAP has an excellent 19-person staff of enthusiastic, well-qualified personnel, including physicians, economists, psychologists, social scientists, accountants, administration and support personnel. Of these, FPIA supports six professionals and two secretaries. Field staff have been developed with help from both FEMAP and FPIA. FPIA funds are used to pay salaries of 95 field staff: 12 administrative, 15 physicians, four nursing, 18 social worker supervisors of CBD, 20 CBD coordinators and the rest support staff.

Although all subproject directors and most other staff are women, male staff predominate in the central office. The national director, however, is female.

Management style is personal and informal. There is a great deal of interaction and interpersonal communication perfectly suitable for an organization that is growing and developing. As the program becomes more complex, however, it may be necessary to formalize some of the communication and working relationships and to narrow the span of control of top management. Efforts, however, should be made to retain the current level of enthusiasm, spontaneity and initiative in the growing process.

3) Information Services including Outreach Activities

IEC and outreach are hallmarks of the FEMAP approach. Interpersonal communication at the community level through CDB distributors backed by coordinators is combined with printed community and client informational materials provided by FPIA/PPFA, Spanish-language materials, and materials published by FEMAP. FEMAP is convinced that a strong IEC component is essential to its success among clients.

4) Are training and technical assistance needs for administration/management and program delivery being met?

FPIA, Development Associates and other institutions have been effective in assisting FEMAP in this area. FEMAP employs the FPIA style of management-by-objectives in all subprojects,

adapted and simplified as appropriate. A noteworthy accomplishment has been the development of a series of procedural manuals, including an adapted project proposal form, a modified report form, a complete manual describing the FEMAP model and the steps required to put it into operation, and an administrative manual providing step-by-step directions for project proposals and administrative procedures. FPIA's assistance, provided mostly through training site visits, is obvious, especially in the administrative manual, proposal and report forms.

A substantial number of the FEMAP staff have had training at Columbia University, JHPIEGO, and in other stateside training programs. Several indicated they profited greatly from observation travel to Brazil, Colombia and India.

5) Administration and management - are there problems?

Of the organizations examined, FEMAP demonstrated the clearest understanding of the FPIA client-counting procedures. It has a clear and adequate system of internal reports on clients which counts new users, eliminates dropouts and thus measures "active" users. A special review of records will be required to produce the FPIA designated "continuing users," a process FEMAP staff say they are willing and able to accomplish. They see it, however, only as something useful for FPIA with no value for program management purposes.

Perhaps because of a lower rate of inflation, more overall resources and a very capable administrator, FEMAP expressed little of the concern regarding the budget process that was evident in Brazil and Peru. On the other hand, the USAID Population Officer found the currency issue a problem, and also expressed concern regarding turnover of FPIA staff and delays in project documentation. FPIA delegates considerable authority to FEMAP for subproject approval and budget modification. This appears to be a key element in the remarkable progress FEMAP has made in developing its procedures and subprojects.

From a review of subproject proposals, trip reports and the review and feedback made by FEMAP staff on subproject reports, it is apparent that FEMAP staff are handling their responsibilities in a professional and competent fashion. It is not uncommon to see in a subproject quarterly report mention of a much appreciated technical assistance visit from FEMAP personnel.

A significant problem exists in the importation of commodities. The procedure is that each subproject must order contraceptives direct from FPIA New York through the appropriate coordinating office. This is a cumbersome approach and one which leaves FEMAP little control. FPIA, FEMAP and the national (government) coordination officer for family planning (who has

the main responsibility) are working to develop alternative approaches.

- 6) Quality of Services - do staff have up-to-date information on service delivery techniques, contraceptive technology, etc.?

Considerable attention is given to circulating pertinent information by mail and through personal visits. In one subproject visited, there was good evidence of appropriate medical supervision and a knowledgeable coordinator and supervisors. Careful follow-up was provided to clients. In the maternity and MCH clinic visited in Juarez, (not part of this FEMAP project but closely related to it), the attention to appropriate quality care was apparent. The voluntary nature of sterilization is emphasized and the provisions of PD-3 are followed.

- 7) Evaluation Activities including Use of Service Statistics and Feedback to Implement Needed Improvements.

Appropriate service statistics forms have been developed, and recent modification of the quarterly report form from the subprojects will provide even better information. The need remains for a way to estimate continuing users. The local coordinator's monthly report provides information on users by method and by promoter but none on contraceptives distributed. The quarterly report to FEMAP does have contraceptive distribution amounts, but there is little indication of analysis of user numbers compared with amounts distributed.

The FEMAP evaluator, with his recently hired assistant, does a careful analysis of user figures and provides feedback to each project. Partially because projects operate on different trimesters, there has been little comparative analysis among projects, and no consolidated reports are issued. Subproject personnel, however, confer on major problems. As the number of subprojects increases, additional analysis and reporting techniques will be needed.

Staff visits to subprojects are an important element in evaluation, and several trip reports reviewed indicate careful analysis and attention to relevant issues including staff and client verification through interviews.

From time to time, FEMAP engages in ad hoc studies of client and staff characteristics and performance. Those that were reviewed, (a profile of Juarez users, characteristics of coordinators and distributors, and a study of adolescents), provide useful information for program guidance.

8) Cost Data including Calculations of Cost per Client Served.

FEMAP has an effective accounting system which can quickly provide current information on central office expenditures and disbursements to subprojects. There has been an attempt in subproject development to predict costs per user and this issue is followed in regular quarterly analyses. The use of different fiscal periods for FPIA and for various subprojects complicates analysis, but FEMAP will be able to do more complex analysis as experience is gained. A preliminary analysis was made as part of this evaluation of total users, new users, contraceptives distributed, couple years of protection and costs (see Table 1).

There is considerable variation in subproject performance, particularly between projects in their first period and those in their second. Start-up time required high overhead (central office) expenditures, with the central office having used 43 percent of the budget in the first fiscal period compared to 32 percent in the second. This reduction was apparently accomplished by increasing efficiency, since the second period was also an expansion period. Cost (central and subproject) of total users went down from about \$30 in the first period to \$18 in the second, with the cost of new users remaining about the same, between \$25 and \$30.

It is too early to draw conclusions about costs per user compared to other projects. FEMAP's high retention rate should be taken into consideration when comparing the cost of new users. Trends appear to be moving in the right direction, and the Juarez experience suggests that the policy of starting slowly to build capability and quality performance can result in greater productivity. Nevertheless it is apparent that the present level of output is not particularly low cost.

The cost (and quality) issue is also affected by the amount of contraceptives distributed per client. Although the orals per user months and the IUDs per new user are about what are to be expected, the condom levels are significantly low. The cost of new users (at the project level--not including central costs) ranges from \$11 to \$23 and that of total users from \$6 to \$19. The cost of a CYP, however, ranges from \$14 to \$40 without central costs among projects operational for at least six months. (Global project calculation of FPIA investment indicate \$30/new user, \$18/active user and \$45/CYP).

9) Income Generating Components.

Many approaches are being considered to gain community and government support. Significant in-kind contributions have been provided both at the local and central level, but financial

contributions have been minimal. There is considerable reluctance to charge clients for service, except for specialized functions like pap smears, pregnancy testing, some medical exams and maternity services. An effort to begin charging clients a nominal (\$0.10/cycle) fee for contraceptives resulted in a dramatic drop in clients in Chihuahua and a strong negative reaction from the community distributors. This is still being explored as are several retail commercialization of contraceptive schemes.

10) Commodities and Logistics.

The handling of commodities was the only significantly weak administrative spot noted in this otherwise well-supported network. Due to the import requirements of the Mexican government, FPIA supplies can be delayed in Brownsville for eight months or more before arriving in Mexico, under the direction of the National Family Planning Commission, for delivery to the various projects. Delivery is not regular, and fully adequate procedures have not been developed to monitor the process. Nevertheless, with good relations among project directors and with government officials, loans and transfers are worked out and supplies of contraceptives seem to be generally moving in appropriate quantities. Other items on the commodity list are a more critical problem at this time.

11) Contraceptive prevalence--how much results from the project?

In developing its subprojects, FEMAP has used a simple but effective process of identifying the potential size of the target population. Based on census and various survey data, total population of the area is estimated, married WIFA calculated and an estimate made of those women not served by the official programs. These unprotected married WIFA are considered FEMAP's target group. The number totals about 588,000 in the subproject areas now operating. FEMAP reports 13,463 total users in these areas--a number that probably is closer to being "active" users than in most projects. Thus the contribution to prevalence is about two percent overall, with as much as 15 percent in a smaller target population where the project has operated for two years.

The project is meeting its goals of beginning new sub-projects and developing the management system necessary to service them. Its service delivery goals are lagging somewhat at this stage of the second project period. With 10 months or 62 percent completed, the project has met 25 percent of its 15,500 new user goal from new projects. (Several of the new projects are just now beginning and momentum should pick up.) The project has met 52 percent of its 8,500 new user goal from

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old projects and has met 86 percent of its 6,100 continuing user goal.

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PERSONS CONTACTED

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Mrs. Lia Kropsch	Project Director
Ms. Estela Goncalves	Project Coordinator

Medical, nursing and auxiliary personnel at the central clinic and at community units in Vasco, Prazeres and Parque Union. Warehouseman at central headquarters.

ABEPF - Rio de Janeiro and Belo Horizonte

Ms. Denise Das Chagas Leite	Project Director
Ms. Rosele Paschoalick	Project Coordinator
Dr. Ivo de Oliveira Lopes	Project Director at Sofia Feldman Hospital

Nursing and auxiliary personnel at Sofia Feldman and community leaders at mini-post in Monte Azul.

CEPECS - Belo Horizonte

Dr. Delzio de Moura	President
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Community Distribution
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APPENDIX R
FPIA PROGRAMS IN ASIA: TRIP REPORTS
(Bangladesh, Indonesia, Thailand)

APPENDIX R1
BANGLADESH: TRIP REPORT

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GLOSSARY -- BANGLADESH

BAVS	Bangladesh Association for Voluntary Sterilization
CWFPP	Concerned Women for Family Planning Project
DSS	Department of Social Services
FC	Field Coordinator
FPSTC	Family Planning Services and Training Center
IUCW	International Union of Child Welfare
RFCWP	Rural Family and Child Welfare Project
TI	Trade instructors
USSO	Upazilla Social Services Officers
USW	Union Social Workers

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APPENDIX R1

BANGLADESH: TRIP REPORT

- Projects Visited: Bangladesh-28: Rural Family and Child Welfare Project (RFCWP): Rural Social Service Program of the Department of Social Services (DSS)
- Bangladesh-18: Family Planning Services and Training Center (FPSTC)
- Bangladesh-24: Concerned Women for Family Planning Project (CWFPF)

1. USAID's Views

The relationship between USAID and FPIA, viewed from USAID's perspective, is very good. USAID finds both FPIA's Asia Regional Office and its Bangladesh Country Office most responsive and cooperative. USAID's one serious misgiving is the inability or unwillingness of FPIA/PPFA to get involved with the procurement and distribution of injectable contraceptives, for which USAID sees a great need in Bangladesh.

There is close congruity between USAID's plans for the future and FPIA's program emphasis.¹ Because the issue of voluntary sterilization is currently very delicate in Bangladesh, special mention should be made of FPIA's activities in this realm. While FPIA carries out no sterilization activities, it is active in voluntary sterilization referrals in both projects reviewed below. Specifically, a "helper's" fee is ordinarily paid to the field worker who refers the patient for voluntary sterilization. The "helper's" fee is paid to the field worker because he or she incurs

¹FPIA activities are not expected to be congruent with USAID/Bangladesh Population Sector NGO strategy, which will be carried out by six CAs. A comparison of FPIA's record and the USAID/Bangladesh Population Sector NGO Strategy for 1985-88 indicates only three exceptions. Page 6, Paragraph C (Medical Standards), of the Strategy is not appropriate to FPIA activities in Bangladesh since these are exclusively nonclinical. On Page 7, Paragraph E (Commodities and Logistics), the difficulties in maintaining contraceptive supplies in the CBD projects seemed to be difficulties initiated in USAID, not by FPIA or the subgrantees. Paragraph F of Page 7 (Voluntary Sterilization Voluntariness) is also inappropriate because FPIA is carrying out no sterilization activities in Bangladesh.

expenses in transporting the patient to the clinic and devotes extra time to this effort, sometimes a full day for a client. Patients are also compensated for lost wages and food and transport expenses incurred when obtaining sterilization. This latter client compensation does not seem to be a matter of FPIA concern, since FPIA is not doing the sterilization operation.

2. Bangladesh-28: Rural Family and Child Welfare Project (RFCWP)--International Union for Child Welfare (IUCW)

2.1 Background

The Rural Family and Child Welfare Project (RFCWP) started operations in March 1974. It is administered by the Rural Social Service Program of the Department of Social Services (DSS) and grew from collaborative efforts in the early 1970s of the International Union for Child Welfare (IUCW) and the DSS. The RFCWP was initiated in five pilot villages and has been expanded into 916 villages in 86 upazillas throughout the country.

RFCWP's main objectives are as follows:

- (1) Improve the socioeconomic conditions of the most needy families and children in the villages by loaning them materials, livestock, etc., with which to start individual or group employment schemes, such as rice husking, animal husbandry, jute handicrafts, training, etc. A revolving fund is thus established, designed to assist other needy families for the continuation of the project once the IUCW withdraws.
- (2) Improve the general welfare of children and families by organizing community-oriented activities and projects, such as nutrition and health education for mothers, adult education, the provision of drinking water tubewells, sanitary latrines, the clearance of fish tanks for the benefit of the total community, the improvement of school facilities, etc.
- (3) To sustain economic uplift of the poor families through income-generating schemes.

2.2 Personnel

IUCW employs 93 staff members to run this project. Core field-level program staff include 44 Field Coordinators (FC)

stationed at upazilla level. They assist the Upazilla Social Services Officers (USSO) in implementing and administering the project.

Project implementation task forces operate at the grassroots level and include Union Social Workers (USW), Trade Instructors (TI), and grassroots workers who work with target families/communities and the village committee. The task forces are supervised by USSOs and FCs in cooperation with the District Social Services Officers and the Division Field Coordinators of IUCW. At the national level, the chief Field Coordinator coordinates and supervises the field program. A Project Coordinator is in charge of family planning services and a Public Health Coordinator is responsible for MCH, health and nutrition services. Each is assisted by a Deputy Coordinator. Except for the project chief and two volunteers for handicraft activities, all the staff members are Bangladeshi.

2.3 Funding

At present, IUCW receives funds from two sources:

- (1) Swiss Development Corporation (Swiss Government), and
- (2) FPIA, which is financing 16 percent of the total project fund. Current funding by FPIA is budgeted at \$115,000 per year.

The government has been so pleased with the project that it decreed it should be instituted in every village in the land. Although this was obviously an impossibility, IUCW and DSS have undertaken a modest expansion. Initial selection of the new villages was accomplished by a new social-economic baseline survey of 276 villages and 46 upazillas in Bangladesh, which was published in October 1985. The survey included minute data on every family in the village, including their socioeconomic potential. Criteria for selecting villages for the program included a demonstrated need, necessary infrastructure and a requisite distance from the next village. In each village, a 7-9 member council has been organized to administer the subgrant.

2.4 Family Planning Services

Between 1979-1984, when it was known as "Bangladesh-17," the project provided family planning, MCH and health services in 40 upazillas. In April 1984, FPIA withdrew its financial support from 19 upazillas. DSS will continue to provide family planning services to acceptors of conventional methods in these areas.

As of October 1984, FPIA entered into its second five-year funding period. The project expanded to an additional 46 upazillas, totaling 67 upazillas of the IUCW-DSS joint project, and covering 612 villages.

The project includes the following family planning activities and services:

- (a) Motivates and recruits new acceptors for conventional birth control (foam, condoms, IUDs and pills);
- (b) Provides contraceptive services to continuing and new acceptors through visits made by the USWs, TIs, and volunteers;
- (c) Refers clients to the Upazilla Health Complex or the Union Family Welfare Center for clinical methods (sterilization and IUD insertion);
- (d) Organizes contraceptive depot holders (i.e., neighborhood suppliers) at village level to help ensure a regular supply of contraceptives to the clients once FPIA withdraws its financial support.
- (e) Organizes village-level group meetings and educational film shows;
- (f) Procures and distributes contraceptives for temporary methods to project villages;
- (g) Immunizes persons referred by USWs, TIs and volunteers;
- (h) Trains women (using workers in (g) above) in MCH and health to increase their sensitivity to family health problems;
- (i) Trains women in oral rehydration preparation;
- (j) Treats children with Vitamin A capsules;
- (k) Enhances nutritional balance by encouraging kitchen gardens and providing seeds; and
- (l) Monitors children's growth to improve mothers' nutritional and hygiene practices.

A major objective of the IUCW is to coordinate, strengthen and facilitate service efforts with local organizations, including the government's Family Planning and Population Control Division;

Family Planning Advisory Board; Family Planning Services and Training Center; UNFPA, and USAID.

3. Bangladesh-18 (Modification #10): Family Planning Services and Training Center (FPSTC)

3.1 General

This project funds the Family Planning Services and Training Center (FPSTC). It was designed to provide a model to link NGOs with government policy and to stimulate the participation of small community-based organizations in MCH/FP.

The project has been operating for approximately six years. In the past year, 43 subgrants have been supported, 20 by FPIA and 23 by USAID. In addition, the project receives support from the Ford Foundation.

This project appears to have been appropriately selected; its objectives have been well designed and are appropriate to host country needs. The project clearly is congruent with AID objectives and strategy. The project has broken significant new ground, but has not yet succeeded in its income-generation goals.

3.2 Service Statistics and Cost Considerations

FPIA reports that as of June 30, 1985, FPSTC-funded subgrants were serving 110,000 active users. In calendar year 1984, the FPIA segment of the project served 25,000 new acceptors and 68,000 continuing users and referred 30,000 patients for voluntary sterilizations. Training was provided to 277 project-related persons and to 23 non-project related persons. Immunizations and other MCH services were also provided to some degree, but figures for these MCH services are very difficult to understand and do not have a high degree of credibility. The cost-per-acceptor figures are extremely confusing because the costs of three funding organizations are involved and their reporting periods differ.

Because neighborhood surveys were conducted at the inception of each subproject, good baseline data on contraceptive prevalence could be available in each of the subproject areas. Excellent data on current usage of preference and contraceptive prevalence could also be obtained from the subproject records. Although statistical evaluation of these results has been neither done nor budgeted for, it is probable that, if carried out, it would yield data showing a very favorable impact.

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3.3 Subproject Management

The grantee, FPSTC, funds the subgrants. Each subgrant is directed by a project coordinator, two field supervisors, a part-time medical officer (four hours per week), 12 field workers, 1 office assistant, and 1 peon. The two subprojects visited function almost identically. The project coordinator establishes a management plan and delegates some supervisory authority over field workers to the field supervisor. The field workers have discrete geographic areas and are familiar with every household in their assigned territories. They keep records of the family planning use and preference of each household. To check field workers records, the supervisors make sample visits to 100 percent of the new acceptors. The field workers meet with their supervisors for a daily group meeting, which includes a report of activities and a problem-solving session.

Field workers are conceived as adequate for their present roles. Projects with MCH components appoint paramedics. FPSTC is planning to replace part-time physicians with full-time paramedics.

Each subproject has four hours a week of physician services. The physicians' primary tasks are management of contraceptive side effects and provision of MCH and other primary health care services for the community.

Requests for sterilizations and injectable contraceptives are referred to government clinics or, in the case of sterilizations, to the Bangladesh Association for Voluntary Sterilization (BAVS) or the Pathfinder clinic, depending on which is nearer. Field workers who make sterilization referrals often accompany the client to the clinic. In the case of BAVS, the field worker receives a helper's fee as reimbursement for transportation expenses and the diversion of her time. At government clinics, however, the referral fee is occasionally not forthcoming because of insufficient funds. Field workers are expected to generate a minimum of two sterilization referrals per month. Only couples with two children or more are supposed to apply for voluntary sterilization.

Shortages of commodities, both pills and condoms, were reported at one site. Because the government clinic at this same site was refusing to provide IUDs due to a recent medical complication, the field workers were experiencing serious frustrations in their attempts to provide family planning services to their clients.

Both subprojects have started income-generation schemes, one for fabric dyeing and the other for garment manufacturing. These will operate as cooperatives, with revenues divided between

the women and the organization to meet operating expenses. In both cases, these schemes are at an embryonic stage. They clearly will require more thought and additional field trials.

3.4 The Future

FPIA support for this project was scheduled to end in August 1985. Plans for continuation of the project when FPIA support ceases, however, do not appear to be coherently structured, particularly the income-generation scheme. The USAID mission (according to FPIA) has requested that FPIA continue support after that date with mission funds.

2/2/85

ATTACHMENT I
Bangladesh-18

Site Visit to Bandar Subproject

The Bandar subproject began with the organization of a local Family Planning and Child Welfare Agency in Bandar, probably stimulated by the known availability of support within FPSTC. The goal was to address the lack of family planning services in Bandar, to create a demand for those services, and to market them. The project coordinator now believes that these original objectives have been largely met, and two new foci have been added: maternal and child health activities and income generation. Commensurate with this expansion comes a need for new staff skills, particularly in contraceptive technology, entrepreneurial skills, and paramedical skills in maternal and child health. The income-generation scheme is a garment manufacturing cooperative, with a 25 percent commission on manufactured garments to go to the organization and the remaining 75 percent to the producer. While some income-generation activities along this model have developed, the total income in the first year of operation has been only 17,000 taka.

Client satisfaction appears to be high, with no complaints about field workers' behavior or relationship with clients.

The part-time doctor is available only four hours a week. His primary task is the management of contraceptive side effects. He will, however, do immunizations for the community's children if the child is brought to the office at a set time. If expansion of the MCH role takes place, trained paramedics will need to be used, not the medical officer. There is a wish to provide better coverage, including immunization, prenatal and postnatal visits, and treatment of the acute illness of sick children.

Sterilization referrals from this clinic go to the BAVS clinic. When referrals are made, the procedure is usually done on the same day. The field worker who finds the client requesting sterilization also transports her to the BAVS clinic. For this transport, and the diversion of her time, the field worker receives a helper's fee. A government fee is also paid to the doctor who does the sterilization, to the clinic that provides the facilities, and to the client, as compensation for lost wages and other costs incurred. This four-way reimbursement does not work with universal smoothness, on occasion because of the government's shortage of funds.

Requests for injectable contraceptives are referred to government clinics and abortion requests are "not entertained."

ATTACHMENT 2
Bangladesh-18

Site Visits to Naranganj Subproject

The Naranganj subproject has been in operation for three years. It is currently bilaterally funded by USAID. The community survey that preceded project inception showed a catchment-area population of 75,000 people, with 11,000 eligible couples. The project was designed as a social services motivation of a group of local women, with the ambitious objective of achieving a zero population growth rate in the community within five years. A technique of group meetings with local leaders in each subzone is used. These meetings are designed to pique interest in family planning and to meet the need for services. The hope is that services can include contraceptive distribution, side-effect management, child health (health education, medical services through the medical officer in the project, and dispensing of medicines for treatment), and income-generation for clients. There are also plans for a cooperative income generation scheme, perhaps fabric dyeing, with a percentage of revenues to be retained by the organization to meet operating expenses. It is not at all clear that project organizers as yet have either the technical expertise or the management skills to achieve all parts of this plan.

Staff participation and staff discipline at Naranganj appear to be excellent. The supervisors have close contact with their field workers, card visit audits are clearly carried out, and records are well kept. Only two field workers have been replaced in the last three years. The only complaints from clients relate to shortages of pills and a rather severe condom shortage in the past year. Field workers are evaluated on the basis of a daily report. The coordinator feels that their skills are adequate for their present role, but that the future will require paramedics in addition to the field workers. The staff counts on the government to provide the requisite staff training when expanded services are ready to be initiated.

The Naranganj Center is reasonably satisfied with its four hours a week of physician services. Sterilizations and injectable contraceptives are referred to the Pathfinder clinic or to the government health center, both in Naranganj. Sterilizations are only provided for couples with two or more children, but couples with fewer children will be referred at the "patient's insistence." Nonetheless, it is evident that each field worker is expected to generate a minimum of two sterilization referrals per month. The field workers at this site complain that the government clinic is chronically short of money and does not pay the helper's fee. They further state that the government has even stopped the use of the IUD here because of recent side effects and complications with two perforations in September when a paramedic inserted the Copper T200.

In regard to injectables, field workers feel they have insufficient knowledge to counsel clients about this method, and the number of referrals for injectables is indeed minimal. As far as abortion is concerned, staff simply do not offer advice or support to abortion seekers out of respect for the requirements of FPIA.

4. Bangladesh-24: Concerned Women for Family Planning Project (CWFPF)

The Concerned Women for Family Planning Project was initiated in 1976. It pioneered contraceptive distribution through CBD in Bangladesh, and it pioneered the women-to-women approach. Perhaps even more important, the project opened the door for NGO involvement in family planning programs in Bangladesh. Subsequently, a clear policy evolved that gives NGOs a definite role to play in the total picture of Bangladesh family planning. This role has recently been expanded to include village and rural areas. These represent a significant series of accomplishments in a nine-year experience. The project's executive director credits FPIA with having had the courage to assist a core group of concerned women with their revolutionary ideas.

Originally, the objectives of this group of rather elitist women were modest. They simply wanted to do something to help mitigate the miserable conditions of social and family health that prevailed in Bangladesh in the mid-1970s. As these women exercised their skills, they developed new ones and they expanded their horizons. Their objectives now have evolved to include staff development. They are offering training programs for staff from other NGOs and they are engaging in increasing amounts of economic activity and income generation. They have had a very significant influence on the development of governmental policy and on the development of significant new roles for women in the country. The successful projects of the IUCW (see Section 2 of this appendix) attest to the influence exerted through these efforts.

Recommendation: The CWFPF will be celebrating its tenth anniversary in 1986. Although FPIA funding will have terminated by then, it would certainly seem an appropriate gesture if FPIA involvement in the project's evolution was observed in some significant way.

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APPENDIX R2
INDONESIA: TRIP REPORT

GLOSSARY -- INDONESIA

BKKBN	National Family Planning Coordinating Board
FHI	Family Health International
POGI	Indonesian Association of Obstetrics and Gynecology
PKMI	Indonesian Society for Secure Contraception
SAFE	Secure, Appropriate, Fast, Effective

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APPENDIX R2

INDONESIA: TRIP REPORT

Projects Visited: Indonesia-22: Indonesian Association of Obstetrics and Gynecology (POGI)
 Indonesia-18: Indonesian Association for Secure Contraception (PKMI): Project SAFE

1. USAID's Views

FPIA's overall performance in Indonesia with a few exceptions received strong support from USAID staff. On the plus side, staff found the organization responsive to its program suggestions, particularly as these related to the Council of Churches Program and to initiatives in the areas of private sector service delivery, institutionalization of fee-for-service and sterilization. USAID also cited FPIA's creativity, specifically in terms of the Catholic Social Services Program's success in reaching a large group of clients. On the negative side, USAID would appreciate better communication among all USAID grantees and NGO donors, including FPIA. USAID also views FPIA project management systems, as in the case of other project reporting, as needing to provide better information about local support, project fund generation, recruitment of new acceptors, active users, and costs.

2. Indonesia-22: Indonesian Association of Obstetrics and Gynecology (POGI)

The project was initiated in February 1984 to provide family planning and primary health services at outpatient clinics of five Indonesian universities. The grantee is the Indonesian Association of Obstetrics and Gynecology (POGI). The project was proposed by Dr. Haryano Suyano, the long-term Director of the National Family Planning Coordinating Board (BKKBN). The idea was to serve university faculty, university staff, people from surrounding neighborhoods, and students, using the students and faculty wives as peer counselors and physicians as providers.

The five universities originally selected all had medical schools. Six more have been added, three with medical schools and three without. Multiservice clinics offer immunizations, primary health care for simple illnesses, and dental services as well as family planning, which is emphasized. IUDs are inserted and oral contraceptives dispensed at the clinic. IUDs are usually Copper Multilode devices. Sterilization referrals are made after counseling is done by the POGI staff. This counseling meets the standards of the PKMI, and is provided by some 600 counselors. If

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the client elects to use injectables, she must buy the medication elsewhere and return to have it injected by the clinic staff.

In the initial phase of this project, an outside consultant provided technical assistance for development of a curriculum for the counseling staff. The POGI staff feels that this curriculum material was very much needed and was very well done. The material is now being used as the basis of the information services in the outreach activities of this project.

This project, with its focus on the university community, can certainly be described as innovative. Since it is targeting students in part, it also addresses a major Indonesian population problem: young age at first birth. Cognizant of a national suspicion of providing contraceptives to unmarried individuals, however, USAID makes the point that the project should not in any way be equated with an adolescent outreach program.

There are plans eventually to incorporate all the services into the University Health Services. A strong university constituency is being developed, and self-support on a fee-for-service basis can be foreseen.

3. Indonesia-18: Indonesian Association for Secure Contraception (PKMI)

3.1 Project Background

Indonesia 18, known as "Project SAFE" (Secure, Appropriate, Fast, Effective), is run by the Indonesian Association for Secure Contraception (PKMI). PKMI was established as a private professional organization whose goal was to increase the health and welfare of the Indonesian population through sterilization programs. It has 16 regional chapters throughout Indonesia operating sterilization services at more than 100 clinic sites. The FPJA contribution to this effort provides, through Indonesia-18, technical and management support to 16 clinic facilities through four PKMI branch offices. It also gives supplemental payments to institutions (but not the doctors) that perform sterilization operations. Reimbursement amounts to 10,000 rupiah for female sterilization and 7,500 for male sterilization. (The rate of exchange at this writing is 11,030 to \$1.)

The FPJA segment of the project is relatively small. The PKMI also receives direct support from AVS, the Pathfinder Fund, the USAID mission, JHPIEGO, and PIACT. There is evidently also funding for research efforts in the training center from Family Health International (FHI). PKMI has received no direct support from the Indonesian government.

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The project has two segments: training and service delivery (see Sections 3.2 and 3.3 below). In addition, there is some attempt at IEC, but the religious climate in the country rules out the use of mass media, and the effort now is restricted to some bland message posters on clinic walls. Some minimal research is also under way, including studies on culdoscopy as an option and on the Filshie clips. These studies are meant only for the staff's education. PKMI also has a mandate from the government to coordinate and collect data on sterilization activity in the country. Overall, the administrative and management aspects of the project are clearly of the highest quality.

3.2 Training Program

PKMI's policy is that sterilization procedures should be carried out by trained personnel. Therefore, it has established nine training centers throughout the country. One physician is trained for every two paramedics--the doctors to perform the procedure and the paramedics to provide support services and surgical assistance.

The training program began in West Java in 1979, funded by IPPF. Fifty physicians were trained. In 1982, another 50 physicians were trained in a program supported by AVS. In 1984, a third program was initiated to train general practitioners and specialists in laparoscopy using falope rings. In addition, interns and some medical students are being trained in the medical school curriculum. Ideally, project staff would like to train all medical students, but funds are not available, and the clinical material is not sufficient to provide 10 or more cases for 120 medical students in the senior classes. On the other hand, it is planned to have every resident be a certified specialist, able to do all types of sterilization and able to teach it to others.

3.3 Service Delivery

PKMI also has a large service program, which currently provides about 120,000 surgical sterilization procedures a year. While from an administrative point of view, the project appeared to be running smoothly, considerably more attention appeared needed in regard to medical aspects.

The quality of service appeared somewhat deficient at the site visited (Hasan Sidikin Hospital). A visit to the operating theater took place while a postpartum minilaparotomy sterilization was in progress on a woman who was at least three days postpartum. A midline incision had been made, which was half-way between the umbilicus and the symphysis and was fairly bloody. It was apparent that this was going to be a somewhat difficult procedure. The usual caveat of either doing the procedure in the first postpartum day, or delaying it until an interval

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sterilization with the appropriate lower abdominal mini-lap incision could be carried out, did not seem to be appreciated by the staff. Patients normally receive Demerol, Valium, and local anesthesia. Although appropriate resuscitation equipment was available, there was no dedicated attendant at the patient's head watching the vital signs. It appears that this precaution is taken only when the patient is under genuine general anesthesia.

FPIA's director, in an October 1984 review of 14 FPIA-funded sterilization sites, had identified several deficiencies in operative sterile and anesthesia techniques. Among sites observed, this was one of the best. It is apparent, however, that the patient monitoring standards and the anesthesia regimen suggested by the Fishburn report have been not absorbed in this institution.

Other than retraining of some physicians, FPIA has not provided any additional technical assistance in the past year. AVS has recently made a site visit, but involvement of multiple donors, each responsible for separate segments of this sterilization funding, does not seem to lead to a suitable degree of accountability for standards.

Recommendation: If multiple agencies are to continue the funding effort of PKMI, they should develop and adopt uniform monitoring standards and medical policies.

Actual medical supervision of the PKMI project is carried out by a regional medical supervisor in each of the 16 districts. The medical supervisor is a volunteer and unpaid. He is supposed to visit each of the projects every four months and submit a written report to PKMI.

Recommendation: FPIA, in one of its internal project evaluations, should evaluate the adequacy of this quality assurance system. Salaried staff making more frequent visits, sharing their reports with the funding agencies, and seeking more frequent consultation might be more productive than distantly spaced volunteer visits.

3.4 Counseling

Efforts have recently begun to train family planning field workers to discuss sterilization during home visits.

Counseling takes place, but its specific content is somewhat unclear. Doctors sometimes question whether the patient understands the nature of the operation, although all agree that patients understand the purpose of the operation and the permanence of the procedure. Counselors are instructed in the application of various formulas, currently a "Formula of 75." This means that a woman's

age multiplied by the number of her living children should at least equal 75 or the sterilization may be inappropriate. All agree that health should be an overriding consideration. Although physician paternalism is an important factor, it seems clear that the program is voluntary, that there is no coercive sterilization taking place, and that there are no patient or provider incentives that would promote coercion.

NOTE: AVS has been providing technical assistance and support for a pilot counselor training program.

3.5 Costs

Costs represent a substantial obstacle to long-term prospects for sterilization. PKMI's goal is that sterilization services become self-supporting, i.e., that fees cover all costs. There has been no cost accounting done on the true costs of providing sterilization services, however, and the current reimbursement schedule comes nowhere near meeting the costs. Hospital superintendents are becoming reluctant to support or expand programs when they are losing money. The GOI/BKKBN is currently expanding a reimbursement program for sterilization services provided at hospital sites.

3.6 The Future

The objectives of this project appear to be appropriate to the USAID objectives and strategy and USAID favors its continuation. The project certainly is breaking new ground and the policy implications may be profound if the project can continue for a sufficient period of time.

Three years, perhaps even five years, may not be enough. A 10-year strategy might be more appropriate. No realistic contingency plan has been developed for continuing this project without some form of USAID support. While there appears to be no objection to bilateral funding, there are obviously multiple opportunities for this organization to seek funding through USAID intermediaries.

APPENDIX R3

THAILAND: TRIP REPORT

GLOSSARY: THAILAND

ASIN	Association for Strengthening Information on National Family Planning Program
PDA	Population and Community Development Association
STARTS	Southern Thailand Appropriate Resources and Technical Support

APPENDIX R3

THAILAND: TRIP REPORT

- Projects Visited: Thailand-08: Voluntary Sterilization in Private Institutions -- The Association for Strengthening Information on National Family Planning Program (ASIN)
- Thailand-19: Southern Thailand Appropriate Resources and Technical Support (STARTS) -- Population and Community Development Association (PDA)

1. Thailand-08: Voluntary Sterilization in Private Institutions

1.1 Summary of Program

The Association for Strengthening Information on National Family Planning Program (ASIN), headquartered just outside Bangkok, is the grantee for the Voluntary Sterilization in Private Institutions project. This project reimburses private medical institutions (clinics and hospitals) for carrying out voluntary sterilizations. An estimated 85 percent of the institutions in the country capable of providing sterilization operations (male or female) are private and the rest are governmental. Since its start in 1977, the project has enlisted some 1,300 member institutions covering about one-third of the country. The project provided reimbursement for 180,000 procedures. Initially, ASIN's goal was to provide 20 percent of the sterilization procedures in the country. It currently has achieved 18 percent.

During the first two to three years, memberships grew rapidly, accompanied by an equally swift increase in the number of sterilizations performed. Since then, the number of sterilizations has begun to drop. The decline continues at present. The ASIN Medical Director attributes this drop both to a national loss of momentum in use of voluntary sterilization and to inadequacy of the reimbursement payment to the institution.

Member institutions report about one male sterilization for every two female sterilizations, while the national figures show a ratio more like 1:5. ASIN staff interprets the high proportion of male sterilization as a technical advantage, but it is more likely because most of these "institutions" are really private doctors' offices where female sterilizations cannot be done because of technical inadequacies.

ASIN provides professional and technical communications support, including annual national seminars, bimonthly bulletins, which are mainly social and statistical in nature, and reviews of complication reports.

The issue of whether participating institutions provide adequate counseling on informed consent needs further investigation. The standards on counseling are the government's and a review of compliance with those standards evidently does not take place. Credentialing, likewise, is very informal, both for the institutions and the physician providers; it depends primarily on the Medical Director's wide knowledge of the physicians in the field and his impressions of their abilities and knowledge. No problems were encountered regarding the administration or the management, and there was no objective evidence of there being any poor quality service.

1.2 Site Visits

Site visits to three medical facilities (two in Bangkok and one in a town in southern Thailand) where voluntary sterilizations were available cast further light on issues of counseling and equipment and a new perspective on reporting of complications and adequacy of the ASIN reimbursement practices.

The frequency with which the sterilizations were reported to be performed varied according to the institution. The small storefront clinic doctor in Bangkok claimed to do only vasectomies, and to refer females to a nearby hospital (the second site visit), where it was reported that "frequent" postpartum sterilizations were performed, as well as "occasional" interval sterilizations. The third institution, a rural hospital, reported a minimal case load of 3-4 patients a month.

The government consent form appeared to be consistent with AID requirements. Doctors differed in their views about AID-supplied equipment. One said it was of such poor quality that he had resorted to using his older instruments, while another had no complaints. The doctor who found fault with the USAID-supplied instruments uses Ketamine for anesthesia, clearly not in accord with the Fishburn protocol.

The requirement that complications be reported to ASIN does not seem to be widely recognized. Both physicians interviewed denied that any complications had occurred, and one said that he knew of no obligation to report complications, but would not object if asked to do so. In no case was there evidence of poor quality service.

The major finding was that the so-called reimbursements, which range from \$6 in the country to \$10 in the city, do not meet the costs of sterilizations. What the women are charged for the procedure, however, more than meets these costs. The women pay a flat fee of 2,000 bhat (approximately \$20) or more for the surgeon and hospital in Bangkok, while in rural hospitals, costs are as high as 1,000 bhat (\$10) for the procedure. The project mandates no ceiling prices for these procedures. Thus, the reimbursement represents a supplement and incentive for the performance, not a reimbursement.

1.3 The Future

The objectives of the project are evidently appropriate to the host country needs and it is evident that they are congruent with the USAID strategy. While innovative at its start, this project now is no longer breaking new ground. There is no evidence of real long-term advance planning for withdrawal of funding. While project staff claim that contingency plans exist, the overriding thought seems to be that, since the project is clearly doing such an excellent job, some other agency of USAID will assume funding if FPIA funding ceases. The site visits, however, provided no convincing evidence that there would be any change in the behavior or the performance of the participating institutions (most of which are probably private doctors), when and if supplemental funding is discontinued. USAID staff share this view.

The project has very little information about the number and the quality of the staff involved in direct patient care. FPIA, with the cooperation of USAID, will be conducting a comprehensive evaluation of this project in 1986. The evaluation team is expected to include USAID and Government of Thailand officials and they will address the issues surrounding future funding and/or continuation of this project. USAID policy relative to this project will probably be determined by the results of the evaluation.

2. Thailand-19: Southern Thailand Appropriate Resources and Technical Support (STARTS)

The Southern Thailand Appropriate Resources and Technical Support (STARTS) project has been funded since February 1985. The grantee is the Population and Community Development Association (PDA). The goal is to deliver family planning services to the southern region of Thailand, which, according to government statistical records, has the lowest contraceptive prevalence rate in the country. The area is relatively remote, and is mainly Muslim. The Government of Thailand has had a priority to develop family planning service systems and educational facilities in this region.

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The project was designed as an "umbrella" to incorporate eight subgrant proposals to be developed by indigenous community organizations. These organizations were to be provided with technical, commodity and financial resources in order to provide family planning education and services. With the hope that in time they would become small, viable, grassroots community organizations implementing family planning programs, the long-term goal is for PDA to raise funds from other donor agencies to continue and expand this work. It is early to evaluate the project's overall effectiveness and its ability to reach its ultimate goal of replicability and multilateral support.

FPIA, developing the project jointly with PDA, drew on the experience of Bangladesh-18 for the project's design. It began with three subprojects selected from 11 applicants. One of these subprojects, "Rural Population Development for Quality Project," run by the Faculty of Management Sciences at Songkhla Nakrintr University, is particularly impressive. It aims to deliver family planning as a basic, essential ingredient for socioeconomic development to a rural area, where dissipation of forest resources and building of new roads are ushering in a new economic and social era. This project is seen as a means to help preserve the quality of life for people in this community.

The two projects have a social marketing component for income generation. This is being done by early identification of depot holders, where barrier methods can be sold both during and after the project.

Among projects being recruited for future funding is one that will include some PDA distributors. No microprojects will have any salary components since this is a PDA policy and none with traditional birth attendant groups has been identified.

In summary, the FPIA Asia office is to be commended for its splendid work on development at this exciting project.

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