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EVALUATION

SWAZILAND-01

Evaluation Conducted
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ABBREVIATIONS

AID -	Agency for International Development
CBD -	Community Based Distribution
CIDA -	Canadian International Development Agency
FLAS -	Family Life Association of Swaziland
FLP -	Family Life Practitioner
FPIA -	Family Planning International Assistance
GOS -	Government of Swaziland
INTRAH -	Program for International Training and Health
IPPF -	International Planned Parenthood Federation
MCH -	Mother and Child Health
MCH/FP -	Maternal and Child Health/Family Planning
MOA -	Ministry of Agriculture
MOE -	Ministry of Education
MOH -	Ministry of Health
NGO -	Non Governmental Organization
PCS -	Population Communication Services
PHC -	Public Health Care
UNDP -	United Nations Development Program
UNFPA -	United Nations Fund for Population Activities

SWAZILAND-01 EVALUATION

I. INTRODUCTION

A. Program Summary

The Swaziland-01 "Temndeni" (Family Matters) project, managed by the Family Life Association of Swaziland (FLAS), has been funded by FPIA since October 1980. Now, four months into its fourth funding period, the project operates out of its clinic in the President Center building, located on Ngwana Street, Manzini. From headquarters, the Project Administrator, one Family Life Practitioner and the Senior Family Life Educator direct the activities of three Family life Practitioners and one Family Life Educator. Family Life services and education activities are conducted in the Manzini, Mbabane and Malkerns clinics. The project reaches the population it serves through lectures, radio broadcasts, home visits and counselling to walk-in clients at the clinics. The project's current catchment area comprises the towns of Manzini, Mbabane and Malkerns, although clients come also from surrounding rural areas. During the first three funding periods, some 5,600 clients were supplied and an additional 6,200 are projected for this year. Having begun as an IEC program, the project continues to place heavy emphasis on promotion of family life education and counselling, through lectures and courses in schools and colleges and to community groups and individual workers throughout the country. The Senior Family Life Educator, assisted by one Family Life Educator and other staff members, plans these activities which to date have reached an audience of over 50,000 persons, 72% of whom were youth. An additional 12,000 persons are expected to be reached this funding period. In addition, individual counselling will be provided at the Manzini, Mbabane and Malkerns clinics.

FLAS has numerous links to government and other private agencies that provide educational and health care services placing it in a leadership role nationwide. Wise utilization of these connections over the years has resulted in integration of activities with those of the Ministry of Health, Ministry of Education, Ministry of Agriculture, as well as with those of several NGOs.

While furthering its own objectives, FLAS is at the same time strengthening other programs in population education, family life education, adolescent and adult counselling and family planning training and service delivery.

FLAS is also well known for its innovative approaches. One of its recent and more popular innovations is a version of monopoly which is played on a board with dice and stones. Each player

throws the dice in turn and moves the indicated number of spaces. ~~The~~ object of the game is to reach Home through a maze of hazards and rewards. The players, for protecting themselves against unwanted pregnancies, go Home... and win the game.

An indicator of FLAS's development as a national leader is the growth in associated institutions. These are institutions that work jointly with FLAS in areas such as client referrals, delivery of family life education presentations, legal advice to women, etc. From three institutions in 1980, the number grew in 1984 to fourteen. This represents a growth of over 450%. Further, as a result of their association with FLAS, several of the associated institutions have initiated or increased their provision of family life and family planning education and services.

FPIA Evaluation Requirements

This project was anticipated to be funded for a five year period. According to FPIA Monitoring and Evaluation Guidelines, when extension of support is being considered beyond the time planned an evaluation must be conducted to ascertain if there is adequate justification for the decision.

In accord with FPIA Guidelines, such an evaluation must determine:

- if the management of the project is efficient;
- if the design of the project is cost effective;
- if resource utilization, time, staff and money is budgeted at maintenance level;
- if the project's significance is recognized by other family planning officials;
- if the plan for redesign of the project is feasible;
- if the management have the capacity to include in their job responsibilities new initiatives; and
- if alternative sources of support are available to allow for an orderly phaseout of FPIA support.

All of these points were considered in the design of the protocol.

Also per FPIA Guidelines, the evaluator selected from New York had not had prior association with the project. Finally, the recommendations in the evaluation must be reviewed by the Regional Director and a recommendation regarding continued funding sent to the Chief Operating Officer.

C. Evaluation Protocol

In addition to the above factors, the protocol took into consideration issues raised by the USAID/Mission regarding the avoidance of possible service duplication, as well as issues related to IPPF requirements for funding and affiliation.

In its final form, the protocol included a statement of purpose, a task outline, with areas to be investigated and questions to be asked, the evaluation methodology to be utilized, the proposed training, and a plan for phasing out FPIA assistance and phasing in IPPF. The statement of purpose follows. The entire protocol is attached in Appendix A.

Statement of Purpose

Based on the project's significance, effectiveness and performance, make recommendations for future direction/expansion including phasing out FPIA assistance and phasing in IPPF.

In conducting the evaluation, every attempt was made to work collaboratively with the grantee and IPPF, to adapt the evaluation design to situations encountered during its conduct, and to incorporate suggestions that could lead to the improvement of the project implementation. The evaluation was conducted November 12-20, 1984 as planned.

II. METHODOLOGY

A. Data Collection and Analysis

All project documents and reports were reviewed prior to arrival in Swaziland. Briefing materials were supplied in New York by Richard Pomeroy, Coordinator of Management Information, Kelvyn Walter, Assistant Director of Grant Management and Gerri Stone, Program Associate. These materials included FPIA's "Table 1" summary of project accomplishments by funding period, quantities and costs of commodities sent to the project, records of disbursements sent by New York and reports and acknowledgements sent by the project, and background data. Reuben Johnson, Jr., Deputy Regional Director and Sahlu Haile, Associate Regional Director from the Africa Regional Office briefed Mas in Nairobi November 9, 1984. Trip reports written by FPIA staff visiting the project since its inception were reviewed, as was project related correspondence between the Regional Office and the grantee and the Regional Office and New York.

Analysis of data on project accomplishments, staffing patterns, budgets and expenditures was carried out prior to arrival as a basis for assessing changes in the project over time. The project staff also provided us with tables summarizing accomplishments for the current funding period, information on employment histories of past and present staff, current statistics on population and family planning aspects; internal records and reporting systems were made available to us and typing and duplicating assistance was provided as needed.

B. Interviews and Meetings

Prior to Jose Mas' arrival in Swaziland, Ben Pekeche, IPPF's Program Officer based in Mbabane, met with FLAS officials and prepared an itinerary. Upon Mas' arrival, Pekeche, Mas, and Diana Gladys Azu, the IPPF Program Officer designated as the evaluation team member, met and discussed the evaluation's parameters, team members' roles and the proposed itinerary. Subsequently, the team members met with FLAS staff to review the itinerary and make final changes. The resulting final itinerary is attached as Appendix B. Interviews were pivotal to the conduct of the evaluation. Interviews were held as follows:

1. At FLAS headquarters two members of the Executive Committee and two volunteers were interviewed, as well as the Executive Director, the Project Administrator, the Administrative Assistant and the Secretary.
2. At the clinics (Manzini, Mbabane and Malkerns) the four Family Life Practitioners and the two General Office Assistants were interviewed.
3. From the IEC section, the Family Life Educator was interviewed. It was not possible to meet with the Senior Life Educator because she was out of the country undergoing a surgical operation.
4. A total of nine clients from the three clinics were also interviewed.

Interviews were conducted following a prepared format for each category of interviewee (Appendix C). However, additional questions were asked of several members on the staff and open-ended discussions held to clarify aspects of the program and the project's management. In addition, meetings arranged by FLAS, during the preparation of the schedule, provided us with the opportunity to look into the context in which family life education and counselling, and the provision of family planning services, takes place throughout the country. A list of persons

we met with is attached (Appendix D). It will be seen that they represent a range of government, international and local private/non-profit organizations with which the project staff maintain working or coordinating relations in their implementation of the project's program.

C. Observations

Many of the interviews took place at the clinics where family planning services are provided and IEC activities are planned and conducted. We attended an IEC session at the Libby's Canning factory in Malkerns where over 600 women of varying ages attended an animated family life/family planning presentation by the Malkerns Family Life Practitioner. Despite the crowded and hot conditions of the room, with many of the women sitting on the floor, the presentation was accompanied by numerous questions and detailed explanations that elicited the close attention of the audience. At the end of the session, pamphlets on family planning, family life, women and the law and sexually transmitted diseases (STDs) were distributed. Many women could be seen reading the pamphlets as they walked out of the room, particularly young ones reading the pamphlet on Sexually Transmitted Diseases (STDs) which have been identified as a problem of epidemic proportions in the country.

We also observed a presentation by the Family Life Educator to a group of young men and women who were attending a course in hotel catering and management. The presentation was given at the request of and in coordination with the Red Cross. The presentation dealt with all the services offered by FLAS, and the question and answer session centered on the reproductive organs, men/women relations and how to get protection against unwanted pregnancies. The most significant observation during the presentation and ensuing discussion was that participants seemed to know little about the subject being discussed. Even though they were aged 20-25, the group as a whole was shy in dealing with the physiology of the reproductive organs, was unsure as to the process of puberty, and did not quite understand how modern methods of contraception work. One young woman stated that she understood the pill was the cause of STDs, at which many in the audience nodded. The Family Life Educator clarified the misconception, partly by allowing participants who were better informed to explain how STDs were acquired. Throughout the presentation, the subjects covered were treated with tact by the Family Life Educator who made visible efforts not to make his audience uncomfortable while covering the materials thoroughly.

D. Planning for the Future

Throughout the evaluation, discussions were held on the desirability to redesign the program and to expand services, consolidating the institutional growth experienced in the last four years,

and FLAS's capability to achieve a balanced expansion/consolidation in the near future. At the conclusion of the evaluation, preliminary findings and recommendations for the current year, and for the FPIA phaseout and IPPF phase-in plan, beginning August 1, 1985, were discussed with Executive Committee members Mrs. Nomsa Hlophe and Mrs. Rozenn Barret, the current Chairman/Executive Director, Mr. David Sibandze, and the Project Administrator, Mrs. Khetsiwe Dlamini. The recommendations were also reviewed briefly with Mr. Robert Heusmann, Mission Director, USAID/Swaziland.

III. FINDINGS

A. Context

1. Country Background and Demographic Data

The Kingdom of Swaziland is one of Africa's smallest countries, with an area of 6,704 square miles and a population of approximately 665,000.^{1/} It is estimated that fifty-seven percent of the population is under age fifteen.

The country is entirely landlocked and is bounded on the North, West, South and South-East by South Africa's Transvel Province and by Mozambique on the North-East.

Swaziland is divided into four districts for modern administrative purposes: Hhohho, Manzini, Shiselwemi and Lubombo. Each of the districts is administered by a district commissioner under the jurisdiction of the Ministry of Home Affairs. The towns of Mbabane (headquarters of the Hhohho district) and Manzini have their own separate councils. Approximately fifteen percent of the population is urban, and agriculture employs about seventy-five percent of the country's work force.

Rural administration in Swaziland reflects the dualism of the central government. Over 150 chiefs across the country act as the agents of both the traditional and modern authorities. The chief-in-council decides who may or may not hold land or live in the chiefdom.

Siswati and English are taught in the schools, although the former is emphasized in the lower years. Since many students drop out in the lower years, literacy among the least educated is mostly in Siswati. Currently, about fifteen percent of the population is literate.

^{1/} FLAS/IPPF Three Year Plan: 1985-1987, page 2.

Over ninety percent of the population is Christian and the remainder is animist. With its per capita GNP of \$844, Swaziland ranks fourth from the bottom of the five South African countries. Its infant mortality rate of 134 is the highest of all other South African countries. Its 6.5% total fertility rate and 3.3% rate of natural growth are significantly higher than all the other countries in the region, except for Botswana.^{2/}

2. Population and Family Planning Programs

To date, the Government of Swaziland (GOS) has no explicit population policy, although in the early 1970's King Sobhuza II was reported to have warned against the danger of overpopulation and its linkage to food shortages.^{3/} Further, the third National Development Plan specified population concerns, and childspacing has been included within current, government, primary health care and maternal and child health (MCH) service programs. These manifestations of concern are the result of the GOS awareness that the 1984 estimated population growth rate of 3.3% is hampering development.

Nonetheless, the absence of a GOS explicit population policy, despite the awareness of the need for family planning services, is an indicator of the still sensitive nature of family planning in Swaziland.

In his speech to FLAS Annual General Meeting on May 28, 1983, the Principal Secretary for Health, Mr. Timothy M.J. Zwane, expressed his concern by stating that family planning in Swaziland is controversial "because it often runs against traditional socio-cultural values and beliefs..."^{4/}

UNFPA and IPPF provide assistance to the Ministry of Health (MOH) for its MCH/FP program. UNFPA-sponsored activities date back to 1973. The Phase II of the UNFPA/MOH plan (1976-1981), "Assistance to Family Planning Programmes," aims to improve and enhance the health and welfare of mothers and children..."^{5/} Specifically, the project's objectives were to

^{2/} 1983 World Population Data Sheet, Population Reference Bureau, Inc.

^{3/} Report on the Evaluation of UNFPA Assistance to the Swaziland Family Planning Programme, page 1.

^{4/} FLAS, Fourth Annual Report April 1983 - March 1984, page 4.

^{5/} UNFPIA Mission Report, page vii.

from different men before they reach twenty.

In conversations held with government officials, representatives of NGOs, project staff and clients, we learned that people are trying to change their reproductive behavior but at the same time are caught between conflicting forces. They are looking for information and services, but are often misinformed, and when ready to take effective actions, do not find adequate vehicles. We learned that young women have children before marriage to prove to their partner that they are fertile, that women had many children to please their husband or partner, and that teenage pregnancy is very extended and is increasing. We also learned that pre-marital sex is increasing and STDs are becoming a serious problem.

In short, although we did not see studies done to document the unmet need for information and service, demographic and economic indicators and our own observation and discussions with the persons we met, indicate that there is great unmet need for family life and family planning information and services in Swaziland. During our interviews of the Family Life Practitioners, all seemed to agree that about 50% of FLAS's clients were first time contraceptors.

B. Significance

The above account of the context in which the program operates indicates that a favorable environment exists for family planning information and services. Further, it demonstrates that there is an unmet need for such services. In attempting to meet those needs, the project has demonstrated innovative approaches to both information and service delivery, has maximized the utilization of a variety of local resources including other educational and health facilities, and has continued to expand its program, bringing those services where they are most needed. GOS officials we spoke to agreed that FLAS's programs meet needs that otherwise would not be met. Mrs. Edith Ntiwane, Matron at the Public Health Division of the MOH, stated that FLAS is playing an important role in key areas. She indicated that FLAS, through its male Family Life Educator, is beginning to motivate the male population, and through its IFC program and the privacy and confidentiality of its clinics, is reaching the sexually active adolescent population. She added that youths are reluctant to avail themselves of MOH services and that GOS programs are not geared to do outreach work. Dr. Rodhes Mwaikambo, the IPPF advisor to the UNFPA project with the MOH, observed that FLAS has done a superb job in reaching the community and gaining its acceptance through its varied IEC activities. This is something that no other government or private agency has been able to do (with FLAS's degree of success). Finally, Dr. Michael Owen, the outgoing Director of Medical Services,

pointed out that the MOH offers family planning as part of MCH, but ~~does~~ not publicize those services because the issue is still very sensitive in Swaziland. Consequently, the MOH downplays the delivery of family planning services and focuses its efforts on strengthening MCH services. But as there is an awareness for the need of such services, the MOH fully supports the activities of FLAS. Swaziland-01's history of innovation and progressive introduction of additional services bears this out. It is noteworthy to see that new activities were added every year. Starting in October 1, 1980 as an IEC program based in Manzini, the project planned to develop family life education materials, provide counselling services to adults and adolescents, and refer those interested in adopting a family planning method to local health facilities. It also planned a family life education training program for educators a course in ante and post-natal care for expectant parents, and the establishment of a Family Life Education Resource Center. All these objectives were accomplished, and in response to unanticipated direct demand for services, 564 new family planning clients were served.

In the second funding period beginning October 1, 1981, a contraceptive service objective service was formally added. To the ongoing IEC activities, a service of radio broadcasts in English and Siswati was added, while a total of 31,267 condom pieces were distributed during IEC sessions. Family life information and education activities were extended to colleges and industry, existing family life pamphlets were reviewed and printed, and new pamphlets were developed. As a result of these efforts, the audience grew considerably both in its size and its diversity. During the latter part of the funding period a new clinic was opened in Mbabane, the Kingdom's capital. A full time Family Life Practitioner, a nurse formerly with the MOH who had received training in MCH/FP in the U.S. in 1977, was hired to provide family planning services. A doctor was also engaged working 100% time to provide medical family planning back-up and to conduct STDs screening and infertility services. A total of 1,800 new and 253 continuing family planning clients were served during this twenty-one month funding period, an impressive achievement for such a new program.

Funding period three, beginning July 1983, experienced a further growth and diversification of activities and services. The Mbabane clinic, staffed with a Family Life Practitioner and a male Family Life Educator, provided a full range of family life and family planning services. A closer working relation with the MOH was initiated that included mutual MOH/FLAS referrals, an agreement by the MOH that FLAS could provide MCH services, and active participation in MOH meetings on MCH/FP and primary health care services coordination. One of the results of these

meetings was that FLAS was designated a practicum site for MOH trainee nurses. A series of newspaper and magazine articles was also initiated during this funding period with the aim of educating the public in a host of family life topics while publicizing FLAS's services. Puppets were made at the MOH workshop and scripts were prepared and recorded for a show at the MOH's pavillion in the Manzini annual Trade Fair. Of major significance during this funding period was a family life seminar conducted with the participation of traditional chiefs as a first step toward gaining their active involvement in FLAS's future programs in the rural areas. Contacts with traditional healers were initiated. Other complementary non-family planning activities were also initiated. Finally, a site for a new clinic was identified and secured in Malkerns. During this twelve-month funding period, a total of 2,100 new and 880 continuing clients were served. And, finally, with the current funding period starting August 1984, the Malkerns clinic became operational providing services to the Malkerns catchment area that includes the Libby's canning factory where up to 1,200 women work in three shifts. A Family Life Practitioner, with the assistance of a General Office Assistant, provide family planning, family life counselling and family planning services at the clinic, and conduct IEC activities at the local schools and at the canning factory. Attempts are also being made to reach the population in the rural and industrial areas. The project continues to expand its provision of services in a multiplicity of areas. These will be discussed below.

The above initiatives and innovations illustrate an important strength of FLAS: staff and volunteers use their personal and professional connections to their benefit to integrate project activities with those of other institutions while reaching segments of the population that would not otherwise be reached. The frequent contacts with representatives of other programs also assure that the project does not duplicate services provided by other agencies. Both Dr. Owen and Dr. Mwaikambo agreed that thus far, FLAS has been complementing the MOH efforts in the provision of family planning services in the country, and discussions are currently underway to ensure that as FLAS initiates activities in the rural areas, coordination between the MOH and FLAS will continue. To this effect, Dr. Owen asserted that the MOH has agreed in principle to identify eight Rural Health Motivators to work part-time with FLAS's proposed CBD program in the Lubombo District.

*These status
and activities
of already
initiated*

C. Resources Utilization and Management

1. Personnel

The present FLAS staff is made up of twelve full-time and three part-time personnel, and a total of five professional volunteers who provide assistance ranging between 2-10 hours per week.

Information provided by the project on dates of employment showed that only two staff, the Executive Director and the Senior Family Life Educator, have been with FLAS from its inception. The other thirteen staff were employed as follows:

- 1981, Administrative Assistant
- 1982, 1 Family Life Practitioner - 1 General Office Assistant - 1 Cleaner
- 1983, 1 Family Life Educator - 1 Family Life Practitioner
2 Secretaries - 1 Cleaner
- 1984, Project Administrator - 2 Family Life Practitioners -
1 General Office Assistant

Except in the cases of the Project Administrator and founder of FLAS, who left in mid-1984, the staffing pattern pretty much reflects the fulfillment of employment requirements as the program expanded. Still unfilled are the positions for one Family Life Educator, the CBD Coordinator and eight part-time CBD workers, all of them included in the Swaziland-01 Project Description and Budget document.

Looked at in terms of full time equivalents (FTE) the present staff is equivalent to 12.85 FTE's. By comparison, funding period one had 4 FTE's. As Table 1 illustrates, the largest growth in staff took place in funding period three, with the establishment of the Mbabane and Malkerns clinics and the expansion of the IEC program.

Funding Period	Full-Time Staff	Part-Time Staff	Full-Time Equivalents	Resource Person Days
1	4	-	4	25
2	5	1 @ 30% 1 @ 20%	5.60	None
3	10	1 @ 10% 2 @ 20%	10.40	112
4	12	2 @ 30% 1 @ 25%	12.85	106

Except for the Executive Director and the male Family Life Educator, all the staff are female.

The project's professional staff have prior experience congruous with the requirements of their respective jobs. For example, the current Project Administrator worked previously as a social worker with the Ministry of the Interior, where she became a supervisor in charge of social workers in the Rhotho District. The Senior Family Life Educator and the male Family Life Educator both came from the teaching profession, and the four Family Life Practitioners are experienced nurses with several years of service with the MOH working on MCH/FP and PHC. They described the satisfaction they receive from work with FLAS as follows:

"I get satisfaction from being able to provide adequate counselling so that the clients can make an informed decision when choosing a method... Then they come back and are very grateful with the results."

"Most people come to FLAS now because they have heard from a satisfied user and immediately they trust us. That makes me feel very good because it confirms that we are providing good services."

"Unlike working experience before FLAS, it is very rewarding to have clients trust us and openly talk about their apprehensions and I can take the time to explain everything."

They believed that the project was helping people understand the concept of family life and its exigencies in a changing society. They felt very good and proud of being perhaps the most important agent in helping the troubled youth in Swaziland. They all felt that through their activities they were helping to restore broken family ties.

Interviews with key project staff indicated that basic responsibilities in most jobs were accurately described in the job descriptions included in the current project proposal, but in some instances staff were doing something else or what they were doing could be realigned. For example, the Family Life Practitioner (who has been employed the longest with FLAS) works daily in the provision of services at the headquarters clinic, monitors the work of the other two clinics, and keeps client and commodity records. She has supervisory and administrative functions whose scope has not been fully anticipated or clearly defined in the job description, as her past responsibilities were primarily service provision. She is still devoting most of her time to this work to the detriment of other responsibilities. It should be noted that she was unsure as to who was her supervisor. However, I must state that

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Executive Director and the Project Administrator were aware of this situation and had already begun formulating ideas for change along the lines described above.

In general, the staff are committed to the goals of the agency and work for FLAS to a great extent because of that. A general weakness is that most of the staff are not fully versed in the specific objectives being pursued, neither are they completely familiar with the program as described in the Swaziland-01 Project Description and Budget document. Further, although they have a sense of FLAS's mission and work hard doing what they do, they do not have a clear idea of how their piece fits in with the whole, and what the communication and supervisory lines are or how they work.

*Communication
Distribute job
description
Organization
Clear*

The staff responsible for IEC activities, the Senior Family Life Educator and the Family Life Educator, currently seem to work fairly independently from the rest of the program. This was apparent only from discussions we held with the Family Life Educator as we were unable to talk with the Senior Life Educator because she had been ill for a while and was convalescing from a recent operation. We also got the impression that, currently, the Family Life Educator was working mostly on his own and was not following closely the objectives set in the project document. As a result, we were unable to obtain a progress report on the IEC activities for the first three months of the current funding period.

*Coordination
between IEC
services*

Hiring of staff has been through a combination of personal contacts and newspaper advertisements. The post of Project Administrator was filled through newspaper advertisements and the vacant position for a Family Life Educator is currently being advertised.

Staff supervision is conducted through informal contacts and through weekly and monthly meetings, but we found no evidence that supervisory patterns and related activities were based on descriptions and workplans in the grant document. Progress on numerical accomplishments was not followed against planned performance indicated in the project grant document.

*Provide TA
in how to utilize
WPC as a
management
tool*

At our request, the (Senior) Family ^{Life} Planning Practitioner compiled the number of new and continuing clients served to date during the current period. For this, she had to travel to Mbabane and Malkerns to count the clients served there during this period. This confirmed that, as we had the occasion to learn during staff interviews, the two Family Life Practitioners in charge of those clinics were not fully versed in client recording and reporting. No staff evaluations are conducted; feedback on individual performance is given through informal individual contacts.

Staff development is encouraged via attendance in training courses, often outside the country. The newly hired Project Administrator attended a Family Planning Managers course at the IPPF/CAFS center in Nairobi during July/August of this year. The Family Life Practitioners have attended training courses in the past (between 1975 and 1979), but have not received formal training in the last five years. The Senior Family Life Educator attended a Women in Management Workshop course in the United States in 1981 and a Planning Management Systems for National MCH/FP Programs in Zimbabwe in 1983. The male Family Life Educator attended a Men and Family Planning course in Nairobi in 1983, a Basic Radio Programme Production course jointly delivered by UNESCO and the Swaziland Broadcasting Service at the Swaziland Institute Management of Public Administration in August 1984, a Theatre for Development course conducted in the University College of Swaziland, and a Youth Managers Workshop in Kenya sponsored by IPPF during October 1984. Finally, on November 17th he left to attend a one-week course on Television and Radio Broadcasting in Kenya. The Administrative Assistant, who was recently given the responsibility of keeping the agency's accounts, has been proposed to attend an accounting course in Nairobi sometime in 1985, sponsored by USAID.

2. Funds

The budget for the current 12 months funding period is E111,392. At the time the award was made, the exchange rate was US\$1 to E1.15; therefore, the dollar obligation was \$96,863. As no significant change in the exchange rate has been experienced, it is anticipated that the dollar obligation will remain the same. Any staff changes affecting the budget that may result from the evaluation could be met from anticipated savings as will be discussed below. A history of FPIA support to the project may be seen in Appendix E.

The project budget began at E24,055 and was increased to E45,483 in funding period two for an anticipated sixteen months of operation. Due to the need to process two extensions of three and two months each, respectively, the total budget for the funding period was E61,899 for an actual twenty-one months of operation. Due to a local currency devaluation against the dollar (from US\$1 = E.82 to US\$1 = E1.14) during the funding period, the additional \$16,416 required only \$8,211 more. The budget for funding period three rose to \$83,533, for thirteen months, an increase of 34% and 347% over the second and first funding periods, respectively. Reference to Table 2 will show that total awards for the 46 month time frame were E169,487, and total expenditures were E159,046, or 93.8% of the total amount budgeted. The corresponding relation budget/expenditure

in dollars is as follows: Total awarded \$172,843 and total expenditures \$133,750, or 77.3% of the total amount budgeted. The difference in the percentages between the local currency and the dollar are due to the devaluation described above.

Funding Period	# Months	E Award	E Expenditures	Approximate \$ Expenditures
1	12	24,055	21,609	22,002
2*	21	61,899	59,674	46,655
3	13	83,533	77,763	65,093
TOTAL	46	169,487	159,046	133,750

During this funding period the exchange rate changed from US\$1 = E.81 to US\$1 = E1.14.

Past financial reports submitted by the project show that FLAS has consistently utilized the funds within the boundaries established in each of the budget's categories, and the FPIA report format has been utilized correctly. As the project started its first four months of the current funding period, in August 1984, there are no financial reports available. However, during the evaluation, a review of actual salaries paid against those budgeted, and the fact that several positions are still vacant as indicated above under Personnel, show that there are potential savings and room for salary adjustments/hiring of new staff as mentioned earlier.

3. Financial Management

During our interview of the Administrative Assistant handling the agencies financial accounts and a brief review of the books, we learned that she had taken over bookkeeping responsibilities from the accountant, a volunteer expatriate who had left the country several months before. The Administrative Assistant told us that the accountant had trained her before she left. Looking at the general ledger for the FPIA account we saw that it consisted of a record of payments based on the check book. Payments are recorded as checks are issued, in chronological order, with a column describing the nature of the payment. Although the ledger was based on the checkbook, it did not include receipts of funds and running balances.

We tracked several payments and saw that bills for purchases made had the initials of the person who received the goods, but there was no actual authorization for payment. We tracked the purchase of some drugs and verified that they had not been charged to the FPIA account. We also tracked the purchase of two office desks and four tables for the Resource Center. We

*He is here
Order books
which can
ours to make
authorization to
purchase/pay?*

looked at the project budget and saw that there was a provision for ~~the~~ of the two desks but not for the tables. When asked why the tables were purchased we were told that they were needed for visitors to the Resource Center and for staff meetings. However, the purchase did not seem to have been made taking into consideration whether tables were included in the budget or if there would be savings within the budget category that would allow for this purchase.

A review of the petty cash ledger showed that petty cash payments are recorded in a book with a date column, a description column, and several columns for the agency's accounts (FPIA, IPPF, INTRAH), etc. The ledger did not specify the source of the money used to issue the payment. The project does keep a separate bank account for FPIA funds, and has acknowledged receipt of all disbursements sent. Due to lack of time, we were unable to further scrutinize the agency's financial record keeping.

The project ran out of funds on two occasions during the period January-April 1983. From the inception, funds to the project were cabled through Citibank in New York. A disbursement sent January 18, 1983, was not received by the grantee and on February 10, FPIA learned through USAID that the project was out of funds. The project ran out of funds early partly because they had increased staff salaries by 25% (effective October 1982 per government decree) but had not notified FPIA. FPIA learned that Citibank could no longer cable monies to Swaziland. An interim disbursement mechanism was established and monies were sent through the USAID pouch. Again, in late April, the project ran out of funds. This time funds did not reach the project due to an inadvertent delay in the pouch system. Again the project ran out of funds, partly because FLAS's Executive Committee had approved a one month salary bonus for all staff and had not advised FPIA promptly. Disbursements were normalized after May 1984 when funds began being sent through International Money Orders. There have been no disbursement troubles since.

4. Commodities

The total value of commodities sent to the project to date is \$25,707. Of these, \$11,125 was contraceptives and \$14,582 was material equipment and supplies, and audio-visual equipment and IEC materials. All commodities sent have been received by the project and promptly acknowledged. A list of commodities by type can be found in Appendix F. Due to problems with the duty free status of FLAS, no contraceptives were included in the current project document for supply by FPIA. The bulk of the contraceptives required have been supplied by IPPF and USAID

through the MOH. In our discussions with project staff we learned that FLAS had experienced difficulties in obtaining a regular supply of contraceptives. In meetings with MOH officials, we learned that their procurement and distribution of contraceptives is impeded by inadequate storage facilities and the lack of properly trained personnel. Dr. Owen indicated that it would be possible for FLAS to arrange for a resumption of shipments of FPIA supplied commodities through the MOH. We estimate that this would be advisable at this time due to the uncertainty of future supplies by IPPF.

*Discuss with
Mabasa &
Mortimer officials*

Although we were unable to conduct a complete inventory of FPIA supplied commodities, we found that, currently, commodities supplied by the MOH, IPPF and FPIA are kept together and no separate inventory is kept. As a result, it was not readily possible to identify commodities from different sources. We found that all contraceptives in FLAS storerooms were unexpired.

The contraceptives at headquarters were stored in an ample, well ventilated room, and most of them were stacked on newly made shelves covering an entire wall. A recent shipment of IPPF supplied pills and condoms were still in boxes as there was no room on the shelves. This storeroom also has a sewing machine and is used as a sewing room. We learned that the room is never locked. The storeroom in the Mbabane clinic is a narrow and long room with shelves covering one entire wall. Contraceptives were kept on the shelves, while some audio-visual equipment and other items were kept on the floor in front of the shelves. This storeroom was also not kept locked. Finally, contraceptives in the Malkerns clinic were kept in a floor shelf-cabinet without doors that acts as a divider between the reception and the consultation room. Clients being seen by the Family Life Practitioner sit on a chair close to the cabinet. We noted that the consultation room had a metal cabinet with doors hanging on the wall opposite to the floor shelf cabinet. The metal cabinet only had a few jugs of sterilizing solution. It would be desirable that contraceptives be transferred to the wall mounted metal cabinet. When we shared this idea with the Family Life Practitioner, she agreed that it made sense, but it had never occurred to her that anybody would take any contraceptives from the shelves.

The inventory of contraceptive supplies at headquarters is kept on a form posted on the wall of the storeroom. This form is a copy of the commodity reporting format FLAS sends monthly to the MOH, attached as Appendix G. No inventory record forms for individual items are kept. We were unable to learn if other type of records are kept showing dates of receipt, issuance, reorder points, etc., but it would be desirable that the inventory record form system be initiated at the three sites, and a format for distribution and usage by the Mbabane and Malkerns clinics be established at headquarters. The

medicines

Family Life Practitioner at the Malkerns clinic keeps a book where ~~she~~ records the inventory at the end of each month. When asked how she would know the reorder point she told us she had not thought in such specific terms. From the inception of the clinic, she has had an adequate supply of contraceptives.

We did a quick reconciliation between the last reordered inventory and the contraceptives on the shelves, and noticed that she had mislabeled the pills in stock. The book showed 55 Noriday cycles and the shelves contained 572 cycles. There were 55 cycles of Norminest.

FLAS has IEC materials on family life, family planning, alcoholism, breastfeeding, STDs, adolescence, and legal aspects. Most of these materials have been developed by FLAS's IEC unit with the help of the MOH, volunteer professionals, and local communication experts. They have an adequate supply of all of them. They are distributed at the end of IEC sessions, sent on demand by educational institutions and other social service agencies, and are kept on display at the clinics' reception areas. All the pamphlets we saw were in English. FLAS plans to approach Population Communications Services (PCS) to explore their funding of the development and production of new IEC materials in English and Siswati.

5. FLAS, other Agencies and FPIA

The Family Life Association was founded in December 1979. Initial funding was provided by USAID and the Unitarian Services Committee of Canada. An Executive Committee of nine constitutes the overseeing body. The Executive Committee meets regularly to make policy on the association's affairs. Income to support the association's projects is generated through fund raising activities, membership subscriptions, donations and contributions from local businesses and other NGOs. Assistance from international donors, other than FPIA, include INTRAH, IPPF, CIDA and others.

FLAS makes excellent use of other agencies in Swaziland which are carrying out related work, as described in the Significance section of this report (see pages 9-11). Project staff provide services and information to ready-made audiences in schools, colleges and factories upon the direct requests of the institutions or in coordination with other NGOs such as the Red Cross. They collaborate with the Ministry of Health, the Ministry of Agriculture, the Ministry of Education and the Institute of Health Sciences in program planning. Collaboration with the different ministries is facilitated by the fact that FLAS' Executive Committee and membership include representatives from these ministries. The project has also been responsive to the requirements and expectations of FPIA, meanwhile developing

ancillary programs that provide much needed assistance to the communities of the project's catchment area and even reaching people in far away rural areas who hear of such services through the radio, newspapers or friends. These services include legal aid to women, counselling on breast-feeding, child psychotherapy, antenatal classes, secondary school scholarships, social welfare counselling, etc. The provision of these services elicits the trust of the community and facilitates the provision of family life and family planning education and services. FPIA requires its projects to submit a financial and a progress report every four months, with supplementary financial and progress reports being submitted also for extensions. The periodic reports must be submitted within two weeks of the end of a four-month long reporting period, and are expected in New York three weeks after mailing. Since the initiation of FPIA funding in October 1980, then, FLAS has submitted 11 financial reports, and 11 progress reports -- all on time.

D. Effectiveness

1. IEC and Counselling

a. Accomplishments

In the first funding period, emphasis was placed on the development of materials and training of school teachers to begin integrating family life education in schools, high schools and colleges. At the same time, a specified number of lectures and counselling sessions on family life and family planning were to be conducted, with an anticipated referral of 240 persons to MOH health facilities. Achievements surpassed expectations. Of an anticipated 300 persons to be counselled, 1,153 were actually counselled. Further, FLAS surpassed its goal of referring 258 persons to local health facilities and directly provided unplanned family planning services to 564 clients. Planned materials were developed and 234 lectures were delivered. Finally, during the first funding period, two workshops with the participation of 34 teachers were conducted with funding and technical assistance provided by INTRAH. Four additional workshops were conducted during funding period three with the participation of a total of 44 additional teachers, also with INTRAH's funding and technical assistance. A "Discussion Guide for Teachers of Family Life Education" was developed. The Introduction/Contents section of the guide is attached as Appendix H.

Over the years, FLAS has continued to provide lectures and counselling on family life education to educational institutions, industry and to clients visiting the clinics. This includes 11,660 individual counselling sessions (mostly in Manzini as the Mbabane clinic was opened in late 1983, and the Malkerns clinic in mid 1984), 659 lectures (delivered in schools, colleges and industries and to community groups) and 172 radio broadcasts (aired in English and Siswati). In

addition, in funding period three, four planned seminars on family life education were conducted with the participation of 64 local traditional chiefs. These seminars were conducted with the assistance of INTRAH staff.

As FLAS' activities are becoming increasingly known throughout the country and it has three clinics in operation, the objectives for funding period four emphasize the provision of services although through the continued implementation of the IEC program, they plan to conduct 120 lectures and deliver 52 radio broadcasts.

b. Procedures for IEC Programming

As indicated above, the Senior Family Life Educator responsible for the IEC activities, was out of the country recovering from a recent operation. Therefore, the information we obtained in this area from the male Family Life Educator may not represent the complete picture. The Project Administrator could not add much as she is relatively new with FLAS and the IEC unit operates from the Mbabane clinic. During the time that the Family Life Educator was available, he informed us that at the beginning of the funding period he had prepared an annual work-plan based on the project document. He did not set monthly objectives, and the lectures he had delivered were done on request of the participating schools and other institutions. We found no evidence that there was a plan to contact or conduct visits to potential sites for the conduct of IEC sessions. He was also busy preparing radio broadcasts and writing newspaper articles, that had previously been written by the former Project Administrator. He had also prepared a curriculum for a course on family life that he was planning to deliver in the near future, but no one else at FLAS had looked at it. It should be noted that the male Family Life Educator was out of the country three times between August-November 1984, attending courses/workshops.

c. Conclusions

These observations raised questions on the intent of and effectiveness of the IEC and counselling program:

1. Is family life information and sex information being integrated into school and college curricula, or are programs solely dependent on FLAS speakers?

In answer to this question we were told that some colleges had already introduced family life education in their curricula. We had the opportunity to verify this when we visited the William Pitches Teacher Training College. This college has a student body of about 500. There we spoke with Mrs. Esness Motsu, who teaches a course on home economics. She informed us that family life education had been introduced in 1982 in the home

economics course. She shared with us the curriculum for the home economics course, which included a section on family life (childcare and development, health education and family relationships). She felt that this was not enough. The family life component needed to be expanded. She also informed us that from time to time, FLAS staff are asked to handle family life topics and provide resource materials. She added that to facilitate further introduction of family life subjects in curricula it would be a good idea to involve the Senior Inspector of Home Economics, who is a member of FLAS. We were unable to learn if FLAS had already approached the College itself at a higher institutional level or if it planned to do so.

At the schools, it appears that FLAS conducts family life sessions, but normally teachers do not participate in the delivery. In our conversation with the Permanent Secretary of the Ministry of Education, he expressed concern as the subject of family life, sexual education and family planning are still very sensitive and controversial subjects in the country and indicated that caution needed to be exercised in approaching them. He agreed that it would be desirable to include family life in the curriculum for teachers, and that a committee was currently discussing changes and family life was on the agenda. He suggested that FLAS should contact members of the committee and give them their input and follow up. He pointed out that as the Inspector of Home Economics is a member of FLAS, staff should work through him.

- ii. Were the expected end results of the IEC program solely numerical, or were behavioral outcomes expected?

A basic concern of FLAS is the seemingly high and increasing rate of adolescent sexual activity and pregnancy in Swaziland. Another related concern of the staff is the increasing incidence of STDS that affect the country's youth, described by many as a problem of epidemic proportions.

When the project set its objectives for reaching adolescents, it did not do it based on available statistics on adolescent sexual activity and pregnancy. The decision to conduct IEC activities and provide services to youth was based on observation of the environment, talks with GOS officials and concerned citizens, and discussions with youth themselves. Two things became apparent: a) youth were becoming increasingly sexually active and at ever younger ages; and b) youth seemed to be ill-prepared to handle potential related problems. Therefore, what FLAS could do, did, and continues to do,

is to set objectives in terms of numbers of meetings and/or numbers of people to reach. This has given it a way to measure levels of activity and to measure the growing level of interest in the community. According to FLAS' Annual Report for the year 1981-1982, 82% of the total number of people reached with IEC activities were under 25 years of age while 46% were under 21.

In relation to the problem of STDs and FLAS role in providing IEC and services in this area, a study conducted by FLAS in cooperation with the Central Pathological laboratories in Manzani showed that for the period September 1983 - March 1984, the FLAS Manzini and Mbabane clinics took a total of 178 cultures. Of those, 127 results were reported showing that 25% of the discharges were due to gonorrhoeal infection. But what was alarming from the study was that "...64% would probably not be cured if treated with penicillin."^{9/} From this it was clear that a large number of individuals had been treated but continued to harbor the disease and infect others. FLAS includes the subject of STDs in all its family life/family planning presentations and, depending on the audience, adjusts the topic to the group. As indicated above, at the end of the presentation at the Libby's factory, many women could be seen leaving the room reading the booklet on STDs. It is important to notice that although the project continues to deliver lectures to schools, colleges and industry, during the last funding period FLAS devoted considerable time and IEC resources to training and evaluation. FLAS reported that during the 1982-1983 year, a total of 209 lectures were given while the number for the 1983-1984 period was 158. As indicated above, FLAS, with the assistance of INTRAH, had provided training for a total of 78 teachers. During funding period three an evaluation and follow up of past trainees was conducted. The results of the evaluation revealed that 42% of the teachers did not know about family life education before attending FLAS training, and while 27% of them knew about it, were not including it in their teaching. After their participation in FLAS training, 69% of the trainees indicated a positive change in their attitude towards family life education. Other relevant findings were, 81% felt that teachers' roles in family life education should include talks with students, and 69% felt teachers should be involved in individual counselling; 81% felt that family life education should be integrated into the teaching curriculum. Finally, 85% of the trainees felt that family life education should be taught in primary school and 15% felt that it should begin in secondary school.

From all the above observations and findings related to the IEC component, we feel thought should be given to developing an IEC strategy that would allow selective focusing on particular groups and following up on results. Some of the ideas discussed with the Project Administrator and the Family Life Educator were:

^{9/} FLAS Annual Report 1983-84, page 24.

- careful planning of IEC activities should be considered including close monitoring of their implementation and ongoing evaluation. This is important at this junction as FLAS becomes fully institutionalized, fills current vacant positions and prepares itself for a challenging future as it becomes national in scope.
- hire a family life educator (provided for in the budget for current funding period) as soon as possible. As the current family life educator has a teaching background, this position should be filled, preferably, with a person with background in journalism, social work or health education.
- efforts should be made to insure the delivery of family life education in school by teachers with FLAS assistance, in their training, in the preparation of presentations as necessary, and the provision of resource materials.
- enlist trained teachers as volunteers or resource people to speak in another school, if not their own.
- efforts should continue so that comprehensive family life education is included in the curricula of teacher training schools.
- fill the currently vacant position of CBD coordinator as soon as possible. This position should be changed from 50% time to full time.
- the IEC unit should be more fully integrated with the rest of FLAS's activities. IEC activities need to be followed closely by the Project Administrator both in terms of planning and for the purpose of coordination with the different universities and agencies associated with FLAS. The integration should take into account that the service delivery and the IEC units can provide reciprocal feedback of mutual benefit. For example, we asked the Family Life Practitioner at the Manzini clinic to provide us with a sampling of how clients heard about FLAS services. We got responses of 300 randomly selected clients. 17 said that they had learned about FLAS passing by the clinic, four through lectures, 36 through health professionals (not FLAS related), 27 through newspapers/radio, and 202 through relatives or friends. Unknown source was 14. It was agreed that this type of information would be very useful to the IEC unit in the preparation of its strategic plan.

- The literacy rate in Swaziland is under 20%, and in the first grades of primary education, where ~~the-highest~~ drop out rate occurs, Siswati is the language used. Therefore, it would be advisable that the pamphlets FLAS gives out during IEC presentations which are currently in English, be translated into Siswati. It was further discussed that since many people cannot read or their reading skills are low, translations (or production of new materials) should be in simple, colloquial language, preferably with pictures/drawings culturally acceptable and communicable.
- As the radio broadcasts have been many thus far, for their continuation it would be desirable that a change in the format be considered. Interviews with satisfied users, with parents of teenagers, community leaders, etc. would probably render the broadcasts more effective.
- Throughout our discussion with the Project Administrator and the Family Life Educator, we learned that the proposed CBD program in the Lubomdo district had not started, primarily due to unforeseen environmental constraints and the slow response from prime movers in the community. Therefore, it was agreed that IEC efforts should be intensified, including the conduct of some kind of feasibility study, prior to the start of contraceptive distribution. Proposed plan of action is included in Appendix I.

2. Family Planning Service Delivery

a. Accomplishments

By referring to Appendix E, it can be seen that the delivery of family planning services has steadily grown since the first funding period, when in an unanticipated outcome, 564 new clients requested and received contraceptives directly from the project. Now, during the first three and one half months into the fourth funding period, the project has served 1,120 new and 1,921 continuing clients, an increase of more than 600% over the entire first funding period.

Table 3 illustrates the growth of the service delivery component of the program. Note that in this table the acceptors reported by the project for funding periods 2 and 3 have been reduced. This, as explained later, resulted from an analysis of the new acceptors served over the life of the project and estimated drop out rates. (See page 26).

Funding Period	Objectives		Reported Acceptors		Adjusted Acceptors	
	New	Continuing	New	Continuing	New	Continuing
1	-	-	564	-	564	-
2	2,500	250	3,480*	1,287	1,800	253
3	2,500	1,500	3,196	889	2,000	889
4	4,000	2,400	1,120**	1,921	1,120	1,921

The chart indicates that the number of acceptors has increased each year. Of the fourth period clients, 49% were served at the Manzini clinic, 24% at the Mbabane clinic, and 27% at the Malkerns clinic. It should be noted that an analysis of the number of contraceptors served in Swaziland during calendar 1983, shows that FLAS served 26.1% of all the clients served in the country. Of an estimated 13,300 clients, 3,477 were served by FLAS. These are estimates based on information provided by the MOH which takes into consideration the fact that figures for continuing clients represent contacts, estimates for incidences of method change, and the practice of "shopping around" i.e., clients registering at several clinics during the year (which we were told by MOH officials is not infrequent). Adjustments were made for both FLAS figures and the totals provided by the MOH, which in turn were analyzed vis-a-vis the anticipated prevalence rate for the country. It is anticipated that the percentage of clients served by FLAS during 1984 will be higher as a result of the opening of the Mbabane and Malkerns clinics.

b. Procedures for Acceptor Recruitment

During each presentation conducted by FLAS staff to a sexually active audience, the services offered by FLAS are publicized. All the pamphlets printed by FLAS include references to FLAS services and addresses. Radio broadcasts and newspaper articles likewise describe FLAS's services. Finally, although the Family Life Practitioners normally work at the clinics providing services, as indicated above in the Introduction, the Malkerns Family Life Practitioner conducts presentations at the Libby's factory. She indicated that, invariably, the clinic was more active two and three days after these

* Note that the objective was originally for a 12 month period, and the actual funding period was 21 months.

Figures for funding period four are only for the first four months approximately.

presentations. Unfortunately, we were not able to verify how the majority of Malkerns clinic clients had learned of the service.

The Family Life Practitioners do not set monthly objectives for the provision of services to clients, and only one of them was familiar with the objectives in the project document. They indicated that they were busy (while we were visiting the clinics most of the time there was at least one client waiting in the reception area), but all admitted they could see more clients. According to data supplied by the project, during the first three and one half months of this funding period, the two Family Life Practitioners in the Manzini clinic saw an average of 21 family planning clients each day, while the Mbabane and Malkerns ones, each saw an average of 7.7 and 3.1 clients respectively.

c. Procedures for Record Keeping

The clinics do not keep uniform recording systems. The headquarters clinic keeps individual client cards that include standard personal data, medical history, date of first and subsequent visits, reason for visits, results of consultation, method adopted, etc. Client cards are filed by number. The client is given his or her number and a smaller card is filed alphabetically. If the client loses his or her number, the record can be found using the back-up alphabetical system. The cards show that the FPIA acceptor recording system has been incorporated, but when we checked some cards at random, several showing that the client had been to the clinic the previous funding period had not been checked as counted. The Mbabane and Malkerns clinics' Family Life Practitioners keep a log book with similar information as that contained in the cards. Each clients' visit is recorded chronologically on the log in black or blue ink, except for first visits which are recorded in red ink. The Family Life Practitioner in Mbabane explained to us that by going through the book and counting all entries in red they determine the number of clients served during a given period. As indicated above, when we requested information on the number of clients served by FLAS since August 1984, one Family Life Practitioner from the Manzini clinic herself compiled the information from her clinic and that of the Mbabane and Malkerns clinics. Although there was no time to conduct a thorough scrutiny of all the client records, an analysis of new clients served during the life of the project vis-a-vis continuation percentages, revealed that the project must have reported duplications in the number of continuing acceptors served during the second funding period while there was under reportage for the third. During the first funding period, a total of 564 new clients were served. When the objectives for the second funding period were formulated, the number of continuing clients was set conservatively at 250 as it was

believed that due to the newness of the program the drop-out rate could be substantial. The number of continuing clients reported during the period was 1,287 or over 200% the number of new clients served during the first year. Then, during the third funding period a total of 929 continuing clients were reported to have been served, from an anticipated objective of 2,400. In this case, it appears that the project underreported the number of continuing clients served. According to the Family Life Practitioners, pill clients are given one to three pill cycles per visit. Therefore, during the first reporting period all continuing pill clients must have visited the project for resupply at least once. Yet, while the objective for continuing pill clients for the funding period was set at 675, the project reported having served only 2 pill clients during the reporting period.

d. Conclusions

The above observations raised questions on the effectiveness of the services delivery of the program.

1. Who are the program clients, and are they receiving services they need? As already indicated above in discussion of the program's IEC activities, FLAS's attention has increasingly focused on youth. We wanted to know then whether there was a corresponding focus on services to young people. In interviews with the Family Life Practitioners, the common response was that most clients were 16-26 years of age, and about 50% of all clients were first time contraceptors. According to FLAS's Annual Report for 1983-84, 69% of all family planning clients were under 25 years of age, while 36% were under 21. The attitude of FLAS staff and others we talked with about this, was that motivated young people seeking services should be treated in such a way as to satisfy their needs and help them solve their problem, be it the provision of family planning services or the identification and treatment of STDs. To obtain a more precise characterization, we utilized a brief client questionnaire (included in Appendix C) and, with the assistance of the Project Administrator and the Family Life Practitioners, interviewed nine clients (six in Malkerns and three in Mbabane). The results were analyzed to characterize clients by sex, age, marital status, method of contraception and reason for contraceptive use. Although the sampling is small with no real statistical validity, the information derived from the analysis was fairly consistent with the information we obtained through observations, interviews and discussions with staff and others. All the clients interviewed, as well as those we saw at different times in the clinics' reception areas, were women.

Eight of them were aged 17-26 while the ninth was 27. Five were unmarried, three married and one was a widow. The contraceptive methods chosen were five pill; one injection, and one IUD, while one was being treated for infertility and the last one for STDs. Finally, the reasons given for contracepting were as follows: Three did not want to have the first child yet, either because they wanted to continue studying or because of a feeling that they could not support a baby yet; three, all of them with two children, were spacing children and intended to have more children, and one who had two children did not want to have any more. It is interesting to note that four of the interviewees were contracepting for the first time, had received counselling from the Family Life Practitioners and were familiar with all modern temporary contraceptive methods.

From the above discussion on the delivery of service it is suggested that the project:

- systematize the collection of identifying data on client cards so as to know who it is serving; and use these data in structuring and measuring end results of IEC programs;
- standardize the client record keeping system, adapting throughout FPIA-acceptor recording so that duplication or underreportage in the reporting of clients served is avoided.
- provide in-house training to the Family Life Practitioners on acceptor recording and reporting.

*Accept. d
Recording*

3. Other Outcomes

FLAS has been instrumental in alerting other organizations to the problems of adolescent pregnancy and the pervasiveness of STDs. The implementation of the programs in the Swaziland-01 project had demonstrated that assertive programs can change the climate so that an agency need not wait until the time is right. FLAS has grown, in only four years, from a small storefront operation with no furniture or equipment, run by two women, to a well-established agency with three service sites, twelve full-time staff and a pool of dedicated volunteers offering information and services in family life/family planning and multiplicity of complementary areas that has gained the respect and support of the community at large. As FLAS enters a new phase of its existence, which includes eventual full affiliation and future support from IPPF and expansion to become national in scope, this seems an opportune time to closely examine its organizational structure, its management and administration systems, its approach to program implementation, and its potential for expansion to meet future challenges. FLAS is called upon

to play a key role in the provision of family life, family planning and related health services in Swaziland. To succeed it will be necessary that FLAS achieve a level of institutional growth, commensurate with the challenges ahead. The recommendations that follow are intended to assist FLAS in achieving such growth.

IV. RECOMMENDATIONS

Recommendations made for the current year and for continued funding are as follows:

A. Current Year Recommendations:

- i. Provide all staff with orientation to FLAS's goals, objectives, structure and organization as soon as possible. This should include the role of donor agencies and their expectations (funding, technical assistance, requirements). This is important not only because FLAS will need to comply with additional requirements as it becomes an IPPF affiliate and becomes national in scope, but also because several key staff are new, and several vacant positions may be filled soon. Orientation should include a review of each individual's job description and his/her relation to the whole, including supervisory structure. Further, structured and updated orientation should be developed for future employees.
- ii. Promote one Family Life Practitioner to Senior Family Life Practitioner, and revise her job description to reflect the supervision of the entire service delivery component. Her responsibilities should include insuring that the clinics have adequate supplies of contraceptives and other needed commodities; monitoring the client record keeping system and commodity usage; compiling regularly clinic statistics and preparing the necessary input for reports to the MOH and donor agencies; providing technical assistance and supervising the work of the three Family Life Practitioners, and providing needed input to the CBD program. Provision should be made for her direct delivery of services only as back-up. Concurrent with this promotion, it is also recommended that the other three Family Life Practitioners receive corresponding salary adjustments in order of seniority, but not exceeding the total amount of the approved budget for these salaries.
- iii. The proposed position of CBD Coordinator, planned as 50% time, should be changed to full time. In addition, it should be upgraded and a revised job description prepared reflecting responsibilities in the preparation and conduct of IEC activities in the CBD program as described in Appendix I.

Senior FLE

- iv. In past discussions held between FLAS and IPPF representatives regarding IPPF eventual affiliation and funding, IPPF recommended that FLAS hire an accountant. Our findings confirmed the need for an accountant. Therefore, it is recommended that FLAS hire an accountant. The proposed terms of employment are found in Appendix J which includes an analysis on how all proposed staff changes affect the budget, and in a memo from Diane Gladys Azu to Jose Mas, attached as Appendix K.
- v. Fill the Family Life Educator position, currently vacant. This position should be filled with a person with a background complementary to skills already available. As the backgrounds of the current Senior Family Life Educator and the Family Life Educator are in teaching, this position should be filled with a person with experience in social work, health education or journalism.
- vi. Hire a driver to take IEC staff and equipment to talks, distribute contraceptives to clinics and future CBD programs, take staff to CBD areas as needed and do deliveries/errands for headquarters office as needed. Currently, driving is done by the Project Administrator or other professional staff and it was considered that this was not appropriate use of their time.
- vii. Train Family Life Practitioners and Family Life Educators in objective setting, planning and scheduling based on the project's document. This will allow them to better understand the project's program, and will help them ensure the program's objectives are met or adjustments made as necessary. Attention is called in this connection to the status of the CBD program at the time the evaluation was conducted.
- viii. The Senior Family Life Practitioner, once she is promoted to this position, should also be trained in clinic management, supervision and reporting.
- ix. Training needs of the Family Life Practitioners should be addressed to determine whether or not refresher training in contraceptive technology and service delivery is warranted. They should be trained in acceptor recording and reporting.
- x. Regional Office staff should continue to work with the Project Administrator to increase her skills in project management and FPIA systems so that these can be adapted as necessary. This will allow for closer project monitoring and will facilitate compliance with FPIA's requirements.
- xi. Both the accountant to be hired and the Administrative Assistant should receive orientation on FPIA's financial reporting and audit requirements.

Original AA

- xii. The Regional Office should continue to work with the Senior Family Life Practitioner, the Family Life Practitioners and the Administrative Assistant in order to increase their skills in commodity management.
- xiii. Revise job descriptions as needed so that they more accurately reflect the work staff do. This should include revision as necessary of the organization chart so that supervisory patterns are more accurately reflected. Also, probation period and annual evaluations should be instituted.
- xiv. The Executive Director, who is also the Executive Committee's Chairman, should occupy only one position. This recommendation is made primarily in preliminary fulfillment of one of IPPF's requirements for affiliation. IPPF's affiliation requires that two positions such as Chairman and Executive Director, with the latter theoretically reporting to the former, be held by two different individuals.
- xv. The IEC unit, that appears as semi-autonomous in the FPIA Project Description and Budget Document, should be fully integrated into the rest of the FLAS management and program structure. In this connection, it is also recommended that the service and IEC components coordinate their activities and share information to insure more efficient planning of activities.
- xvi. Payments for local purchases should be approved in writing by the Project Administrator.
- xvii. Obtain from the MOH a list of health facilities in the country providing MCH/FP services. Locations of these facilities should be indicated on a map of the country for future reference when considering expansion of services throughout the country. This will help avoid possible duplication of services. This list will be of immediate use in the preparations to set up the CBD program in the Lubombo district.
- xviii. Open the Mbabane and Malkerns clinics on Saturday mornings. Many people from the surrounding rural areas come to town to do their shopping on Saturdays and if the clinics are open they can avail themselves of their services.
- xix. The Malkerns clinic is advertised as MCH/FP, but does not provide MCH services for lack of basic supplies. Needed medicines should be secured so that a minimum of curative services can be provided. This is important in view of the fact that the clinic is located on the grounds of a child care center and there are two schools in the immediate vicinity.

xx Translate pamphlets, currently in English, into Siswati. Translations should be in colloquial language and in those cases where the intent is to reach an audience mostly composed of illiterates, the pamphlets should contain pictures/drawings culturally acceptable and communicable, keeping the words to a minimum. FLAS should contact PCS and explore their funding of the production of these materials. A local artist and an appropriate colloquial writer (journalist, radio broadcaster) should be identified.

PCS

xxi. Radio broadcasts should vary the format to include discussions and interviews with teenagers, satisfied clients, parents, prominent members of the community, etc.

xxii. Set up a comprehensive commodity management and control system which should include cards for individual type of commodities based on the FPIA or IPPF models. Also, commodities should be organized per donor agency, if from more than one source, to facilitate inventory. They should be kept secure, and only the person designated to manage them should have access to the store rooms to guarantee better control.

xxiii. Shift efforts to implement the CBD component in the Lubombo district to the Matsapha industrial area. As indicated before, due to unanticipated circumstances the CBD program in the Lubombo district is not being implemented as planned. Therefore, while efforts should be continued to pursue the implementation of this component as described in Appendix K, during the period January-July 1985 (the rest of the current funding period) a CBD program should be initiated in the Matsapha area per the plan prepared by the male Family Life Educator included as Appendix L.

PCS
No 150

B. Continued Funding Recommendation: FPIA Phase-out/IPPF Phase-in

FLAS's expansion plans to become national in scope parallel one of IPPF's prerequisites for affiliation. Since 1972 the MOH has enjoyed partial IPPF membership with non voting rights or other privileges precluded in the IPPF constitution to a governmental agency. FLAS's attempts to become a full fledged affiliate of IPPF date back to mid-1982. Discussions held with IPPF on the subject inevitably gravitated around the MOH readiness to cede membership and acknowledge that FLAS was the most suitable alternative candidate. After lengthy negotiations the issue appears to be settled. The MOH has ceded its IPPF membership and FLAS is being considered for affiliation and is expected to become a full member when its request is approved by IPPF's Regional Council meeting in June 1985. Appendix M includes the last round of correspondence exchanged between FLAS, IPPF and the MOH on this subject.

The following recommendations address FLAS's need for institutional consolidation and a plan to phase out FPIA assistance and phase-in IPPF.

1. For FLAS to become national in scope as it should and as required for IPPF affiliation, it must develop a plan to involve volunteers from the country's districts in policy decisions and in the establishment of permanent branches throughout the country. This plan should be prepared in close coordination with the project's current efforts to develop a CBD component in the Lobombo district and should pave the road for future such efforts. Our findings show that there is still significant potential resistance to family planning in the rural areas. Therefore, the combined efforts to get a foothold in the rural areas should be approached cautiously evaluating on an ongoing basis advances made to ensure success while avoiding possible opposition from local leaders and prominent members of the community.
- ii. Parallel to efforts to become national in scope, it is important that FLAS mobilizes its pool of volunteers, executive committee members and general membership to engage in broader resource development activities. According to FLAS's Annual Report for 1983, E3,817 were generated as a result of varied efforts with individual yields. This represents only 3.4% of the current FPIA funded budget. Towards a goal of some measure of self-sufficiency, it is desirable that FLAS develops specific income generation objectives. There are two immediate needs we feel FLAS should focus on in the immediate future.
 - o In order for FLAS to become fully institutionalized and thus become a permanent presence in Swaziland, a major factor would be the acquisition of an ample building for its headquarters. This would reduce rental costs, would allow for the needed flexibility to incorporate new programs as they are developed, and it could even generate income for FLAS if available unused space could be rented to others. It is recommended that FLAS moves its headquarters to Mbabane, the Kingdom's capital.
 - o The possibility of acquiring laboratory equipment to process client's cultures and provide service to private clinics should be considered. This would allow for speedier processing of its own clients' cultures while generating additional income from services rendered to private clinics.
- iii. Regarding the role expected to play by the donor agencies (FPIA and IPPF) in the future, the following three year plan is being recommended to phase out FPIA and phase in IPPF:

YEAR 1 (August 1, 1985 - July 31, 1986) PHASE 1

- o FPIA and FLAS would negotiate a redesigned project that would include the entire current service component (i.e., Manzini, Mbabane and Malkerns clinics). For budget purposes, the negotiations need to include the apportionment of administrative costs to the donors budgets as necessary.
- o IPPF will fund the IEC and CBD components.

NOTE: The budget of the newly redesigned project will not exceed the current FPIA project's budget of E111,392.

YEAR 2 (August 1, 1986 - July 31, 1987) PHASE 2

- o FPIA to fund 50% of the service delivery component as defined in phase 1, notwithstanding FLAS' expansion in the delivery of services. Any service delivery expansion (e.g., establishment of a clinic in the proposed CBD areas) is to be picked up by IPPF or another donor agency.

YEAR 3 (August 1, 1987 - July 31, 1988) PHASE 3

- o FPIA to fund 25% of the service delivery component as defined in phase 1 with same conditions as in phase 2.

YEAR 4 (4th and Final Phase)

- o IPPF to fund the entire FLAS operations.

NOTE: The Phase-out/Phase-in Plan presumes that FLAS will soon engage in Resource Development efforts to reduce reliance on international donors as indicated above.

Swaziland-01 Evaluation Protocol

Statement of Purpose:

Based on an assessment of the project's significance, effectiveness and performance, make recommendations for future direction/expansion including phasing out FPIA assistance and phasing in IPPF.

Areas and Questions for Investigation:

A. Program Context

What is the context and environment in which the program is operating? How has this changed since the program was initiated?

1. What indications of potential significance, as identified in the continuation proposal, have been met?
2. What are the indications of effectiveness? Have the objectives been based on identifiable needs? What environmental constraints are there on potential effectiveness?

B. Resource Utilization

Are key resources of staff, finance, commodity, other agency assistance being utilized to the maximum extent possible?

How has such usage changed since program inception?

1. Staff Utilization: Was increase in central staff accompanied by corresponding project expansion? What is the current staffing/supervisory pattern on paper? in practice? Are job descriptions accurate? Is time allotted (whether 100% or less) adequate? Is it too much? How are staff evaluated? What are staff characteristics in terms of previous experience, education, sex, age, religion, length of time on job, etc.? How are training needs determined? What evidence is there of staff satisfaction/dissatisfaction (e.g., turnover, promotions, productivity). What is the ratio of staff to clients? How were the CBD workers trained? Are they functioning? Do they understand their jobs?

2. Finance: What is the cost of service provision? Has it increased or decreased over time? What about the cost of the program as a whole? What are other potential schemes for income generation?
3. Commodities: Is commodity usage, especially for contraceptives, in line with reported numbers of acceptors? How much has this added to the cost of the program?
4. Other Agency Assistance: What technical assistance, time, space, financial assistance, communications, public relations or other support is provided by other agencies (other than FPIA). How is this sought/offered? Does the project contribute to a network of supporting agencies?

C. Management

Are current systems for managing finance, commodities data collection and reporting functioning adequately? What problems is the project aware of? How do they handle them? How has FPIA assistance been utilized?

E. Effectiveness

To what extent have the objectives been met, and to what extent has the implementation of the program met identified needs?

1. How is the project conducting its IEC program and counselling in schools and colleges, to community groups and industrial employees, at clinics, through radio broadcasts? What systems are used for planning, scheduling and reporting? Is there a link between IEC and service or referral? What are the characteristics of the persons reached (age, sex, in or out of school, working or not working, children, etc.). Is the curriculum being used in schools? Has it been evaluated?

2. How are clinics' activities carried out? Are clinic staff reports accurate? Can clients be verified? What are the characteristics of clients being served? What are clinics' clients perception of the program? What services are available directly/by referral?
3. How are CBD activities carried out? Are field workers reports accurate? Can clients be verified? Are CBD workers adequately supervised? What are the characteristics of clients being served? What is the client perception of the program? What services are available directly/by referral?
4. What unplanned/unexpected outcomes or side effects have there been in the total program? Have other agencies changed as a result of the program? Has there been a change in school drop out rate?

E. The Future

How do findings on the current program affect plans for continued funding?

1. Expansion: What evidence is there of need for project activities in other geographic area? How will the project have to change in order to expand (nationwide)? What information will need to be collected to plan for expansion? What tools can the project develop and use now to do so? Can the present staff carry out the program and plan for expansion at the same time? What are impediments to expansion both within the agency and in the political, social, physical environment.
2. Other: Can funding for expansion be shared by IPPF? Other Agency? How can FPIA be phased out and IPPF phased in as major funding sources? Can income generation schemes be found to support the program?

Approach:

Prior to Conducting the Evaluation

1. The Regional Office will send the proposed protocol to New York for comments. The Regional Office will be asked to contact the grantee and the IPPF representative so that a schedule is prepared, IPPF's expectation/role in evaluation are defined, and arrangements are made for internal transportation and lodging in accord with the proposed schedule.
2. All the relevant files will be reviewed in New York, background data assembled, and data collection tools developed with Regional Office input.
3. On his way to Swaziland, November 9th, the New York evaluator will stop-over in Nairobi for further briefing with Regional Office staff, and review of proposed schedule and IPPF's input to the evaluation.
4. Upon the New York evaluator's arrival in Swaziland, and prior to the conduct of the evaluation, evaluators will meet to further review the protocol, and make any necessary adjustments/ revisions.

The Evaluation

The protocol will be reviewed with the Project Administrator and the additional concerns of hers addressed as possible. The New York and IPPF evaluators will determine the best means to collaborate on the evaluation so as to utilize the available time most efficiently.

Entry and exit interviews will be conducted with USAID. The evaluation will be conducted through interviews with all staff, a selected number of clients, teachers and, as necessary, and as recommended by Africa Regional Office, officials of the COSL (MOH, MOE) and of other family planning service providers. The interviews will be structured, but will include open-ended questions. Interviews will be conducted at worksites. Records will be examined and data collection systems traced. Visits will be made to at least two schools and two out-of-school sites to observe IEC and counselling. The activities of the Manzini, Mbabane and Malkerns clinics will be observed and activities compared in terms of hours worked, clients seen, methods provided, type of supervision received, etc. As advisable, the new CBD program will also be observed.

The findings of the evaluation of the current program will be shared with ~~the~~ project and a joint assessment made of steps the project will have to take to prepare for expansion, if feasible. As possible, tools will be left with the project to use in the planning process.

Timing:

The current funding period began August 1, 1984. As planned, the evaluation is being conducted in November 1984.

A minimum of seven (7) working days will be needed, ~~to be~~ utilized as follows:

ITINERARY OF VISIT
OF
Jose Mas, Technical Specialist, Family
-Planning International Assistance (FPIA)
New York, and
Mrs. Diane Gladys Azu, Program Officer,
International Planned Parenthood Federation
(IPPF)

FROM
November 11-30, 1984

* * * * *

Sunday November 11	3:00 p.m. 5:30 p.m.	Hotel - Meeting Ben Pekeche, Diane Gladys Azu, Jose Mas
Monday November 12	8:30 a.m. 1:00 p.m.	At FLAS headquarters - Mrs. Ketsiwe Dlamim (Tour premises, review/finalize schedule, evaluation protocol, questionna list of areas of concerns/questions, and confirm appointments)
	1:00 p.m. 6:00 p.m.	At FLAS headquarters - interview staff, review client, financial and commodity record keeping. Meeting with two members of Executive Committee
Tuesday November 13	9:30 a.m. 11:00 a.m.	Courtesy calls MOH - Dr. Michael Owen, Dr. Rodher Mwaicambo, and Matron Edith Ntiwane
	11:30 a.m. 12:00 p.m.	Courtesy call USAID - Ms. Linda Lankenau
	12:15 p.m. 2:15 p.m. 2:30 p.m. 4:00 p.m. 4:15 p.m. 7:00 p.m.	At FLAS Mbabane - tour premises Interview FLE and FLP Courtesy calls: UNFPA, Nosisa Mohamed; UNPP, C.P.C. Metcalf At FLAS Mbabane and Continue staff interviews/discuss IEC/CBD programs with FLE
Wednesday November 14	9:00 a.m. 9:45 a.m. 10:00 a.m. 10:45 a.m.	Courtesy call MOH - Mr. Willard Nxumalo Courtesy call Red Cross - Mrs. Thandi Dlamini

Wednesday November 14 (cont'd.)	11:00 a.m. 12:00 p.m. 12:15 p.m. 4:00 p.m. 4:15 p.m. 6:30 p.m.	At FLAS Mbabane - Continue staff interview/review clinic records At FLAS Mbabane - Interview clients At FLAS Mbabane - Continue discussion IEC program with FLE.
Thursday November 15	8:30 a.m. 10:30 a.m. 11:00 a.m. 11:30 a.m. 12:00 p.m. 3:45 p.m. 4:00 p.m. 5:00 p.m. 6:00 p.m. 7:30 p.m.	At College of Technology - Attend lecture on family life education delivered by the FLE Courtesy call MOE - Permanent Secretary At FLAS Malkerns - Interview staff, review client and commodity record keeping system. At Libby's factory - Attend IEC presentation by the FLP At FLAS Manzini - Meeting with Executive Director and Project Administrator
Friday November 16	9:00 a.m. 10:45 a.m. 11:15 a.m. 12:00 p.m. 12:30 p.m. 4:30 p.m. 4:30 p.m. 6:00 p.m.	At FLAS Malkerns - Finish staff interview and conduct clients interviews Courtesy call at William Pichs Teacher Training College, meeting with Mrs. Esness Motsu At FLAS headquarters - Finish staff interviews and review of record keeping systems At FLAS headquarters - Meeting with Project Administrator to review program of evaluation
Saturday November 17	9:00 a.m. 11:30 a.m. 12:00 p.m. 3:00 p.m.	Team review of findings, start draft of preliminary recommendations At FLAS headquarters - Meeting with Executive Director and Project Administrator to prepare three (3) year FPIA phase-out/IPPF phase-in plan.
Sunday November 18	10:00 a.m. 2:00 p.m.	Continue preparation of preliminary recommendations draft.
Monday November 19	9:00 a.m. 10:45 a.m. 11:00 a.m. 4:00 p.m. 4:00 p.m. 5:30 p.m.	At FLAS headquarters - Complete draft with preliminary recommendations Supervise typing of preliminary recommendations, proof and assemble At FLAS headquarters - Meeting with Executive Committee members and Project Administrator to review/discuss preliminary recommendations.

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Tuesday
November 20

9:30 a.m.
~~11:30~~ a.m.

3:00 p.m.
4:00 p.m.

At IPPF office - Evaluators meeting
to discuss details of three (3) year plan
for presentation to IPPF/London.
IPPF London called and concurrence on
plan obtained
Courtesy call USAID - Mr. Robert Heusmann

Staff Interviews

1. How long had job?
2. How get involved?
3. Look at Job Descriptions. Is this what you do?
4. What else do you do?
5. What is your objective each month?
6. What problems do you face?
7. How many hours/week do you work?
8. What training have you received for your job?
9. Who supervises you? Meetings/report/other
10. Who do you supervise? Meetings/reports/other
11. What training have you received with the project?
12. What is most difficult part of job? Describe a situation and how you overcame it.
13. Greatest success in job? Describe.
14. What do you think is objective of program?
15. Have you been evaluated?
16. Do you have any suggestions that would strengthen the program?

FAMILY LIFE PRACTITIONERS QUESTIONNAIRE

1. How long
2. (Read Job Description)* Is this what you do? (Include discussion of reporting)*
3. Is there anything else you do, not on this job description?
4. What is your objective each month?
How many contraceptives to each?
Do you follow up? How?
How would you characterize your family planning clients?
Age
Married/Unmarried
Religion
Previously used contraceptives
5. What problems do you face?
6. How many hours a week do you work?
7. How have the clinics clients heard about family planning?
8. What obstacles are there to acceptance?
9. Have you had any training for this job?
10. What has been most difficult part of job? Describe a situation and how you overcame it.
11. What has been your most successful experience?
12. Who supervises you? How and how often?
13. Who do you supervise? Meetings/reports/other.
14. Have you been evaluated?
15. What do you see as main objective of this program?
16. Do you have any suggestions that would strengthen the program?

* Job description/Recording-reporting on the back of questionnaire

17. Also
 - a. See record book: count new and continuing clients.
 - b. Ask: What is difference between "new" and a "continuing" client?
 - c. See contraceptives; write down number.
 - d. Ask: How do you account for contraceptives?
18. If possible
 - a. Visit clients.
19. Does Association provide full range of services and supplies to its clients?
20. On average, how much time do clients spend waiting to receive services and supplies?

Job Description

Counsel clients; provide family planning services;
Treat reproductive related illnesses;
Conduct follow-up home visits as assigned.

Recording/reporting

Keep inventories of commodities and provide reports on
contraceptive needs;
Provide monthly reports to MOH and to the PA on family
planning.

CLIENTS QUESTIONNAIRE

CLINIC _____

1. Name _____
2. Age _____
3. Sex _____
4. Married Status: Single/Married/Divorced
5. Number births and sex
6. Number of living children and sex
7. Contraceptive method currently used
8. Began using and how she learned about Family Life Association?
9. Ever used contraceptives before?
10. Type
Source
10. Present source contraceptives
Clinic
Pharmacy
Other
11. Number of children desired
12. Why using contraceptives

13. Can you always get contraceptives when you need them?

Why/Why not?

14. How often do you obtain contraceptive supplies?

15. What methods of family planning do you know about?

16. How did you learn about these methods?

APPENDIX D

Persons Contacted-

USAID

Mr. Robert Heusmann
Ms. Linda L. Lankenau

Mission Director USAID/Swaziland

IPPF

Mr. Ben Pekeche

Program Officer

FLAS

Mr. David Sibandze
Mrs. Edith Ntiwane
Mrs. Nomsa Hlophe
Mrs. Rozenn Barrett
Mrs. Fran Bercube
Mrs. Khetsine Dlamini
Mrs. Juliann Dlamini
Mrs. Grace S. Kunene
Mrs. Martha Nkambule
Mrs. Cynthia Nkosi
Mr. Eric D. Masango
Mrs. Thoko Dlodlu
Ms. Thembi Motsa
Mrs. Dimpho Masuku

Chairman Executive Committee
Member Executive Committee/MOH
Member Executive Committee/MOH
Member Executive Committee/Volunteer
Volunteer
Project Administrator
Family Life Practitioner
Family Life Practitioner
Family Life Practitioner
Family Life Practitioner
Family Life Educator
Administrative Assistant
General Office Assistant
General Office Assistant

Other Agencies

Dr. Michael Owen
Dr. Rhodes Mwaikambo

Director Medical Services, MOH
Head Public Health Unit and the
UNFPA Program
Senior Extension Officer, Ministry
of Agriculture
Permanent Secretary, Ministry of
Education
National Director, Red Cross
Program Assistant, UNFPA
Resident Representative, UNDP
Teacher, William Pitches Teacher
Training College

Mr. Willard Nxumalo

Mr. Alfred Hlatshuyo

Mrs. Thandi Dlamini
Mrs. Nosisa Mohamed
Mrs. C.P.C. Metcalf
Mrs. Esness Motsa

HISTORY OF FPIA SUPPORT TO SWAZILAND-01

FUNDING PERIOD	MODIFICATIONS	TYPE MODIFICATION	FUNDS AWARDED E \$		EFFECTIVE DATES	MOS.
1	0	Original Grant	24,055	29,588	10/01/80-09/30/81	12
	1	Budget Category Adjustment	-0-	-0-	same	
			*T24,055	29,588		
2	2	Continuation	45,483	55,467	10/01/81-01/01/83	21
	3	3-Month Cost Extension	6,732	8,211	10/01/81-04/30/83	
	4	2-Month LC Cost Extension**	T 9,684	-0-	10/01/81-06/30/83	
			T61,899	63,678		
3	5	Continuation	83,533	79,577	07/01/83-06/30/84	13
	7	1-Month No-Cost Extension	-0-	-0-	07/01/83-07/31/84	
			T83,533	79,577		
4	6	Continuation	111,392	96,863	08/01/84-07/31/85	12
		TOTALS	280,879	269,706		58

* Total funds awarded in funding period

** No dollar increase necessary due to devaluation

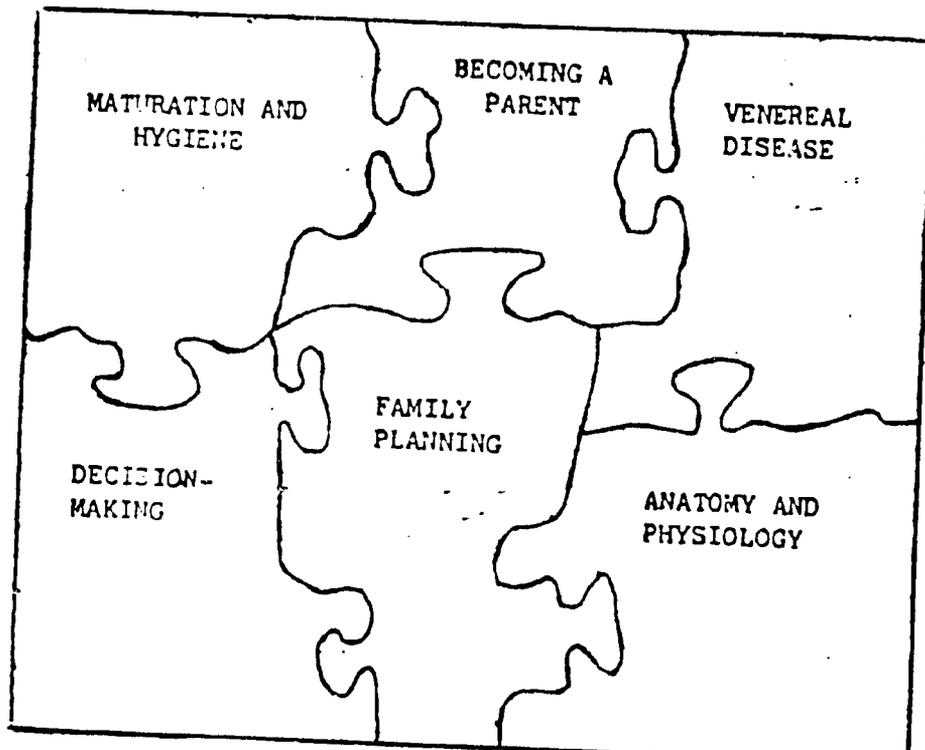
CLINIC: FLAS
 MONTH: OCTOBER 1984

MINISTRY OF HEALTH
 MONTHLY CONTRACEPTIVES USAGE REPORT

SUBMITTED BY: Juliana Namini
 DATE: 19. 11. 1984

	Noriday Cycles	Oral Cycles	Microvium Cycles <i>L. P. 2000</i>	Eugonon Cycle	Neogonon Cycle <i>Neophagen</i>	Normonest Cycle <i>Combined Pill</i>	Depo Provera Dose	Nonestirite Dose	Copper T - unit	Copper 7 - Unit	Lippes Loop A - Unit	Lippes Loop B - Unit	Lippes Loop C - Unit	Lippes Loop D - Unit	Foaming Tablets - tube	Cream/Jelly - tube <i>EXPIRED Oct 7, 84</i>	Foam - Tube - Eukle	Condoms - units <i>100</i>	Diaphragms <i>100</i>	NK - B.I. <i>100</i>	Maximal <i>100</i>	Microvium <i>100</i>	Rigevonon
Opening Balance (1)			180	353	23	60		97	52	15					20	184	446	6308		251	358	511	358
Receipts from IPPF (2)		1200	500	500		400		580							40					864			
Receipts from other Sources (3)																							
Total Available 1 + 2 + 3 (4)		1200	680	853	23	460		677	52	15				39	47	60	484	446	6308		112	358	511
Issues to Acceptors (5)			51	516	10	216		216	23	4				2	2	10	5	13	172		207	297	77
Otherwise Disposed e.g. to other agencies losses, samples (6)								4															167
Total Issues 5 + 6 (7)			51	516	10	216		220	23	4				2	2	10	210	12	172		207	297	244
Closing Balance 4 - 7		1200	629	337	13	244		457	29	11				37	45	50	274	215	1731		309	357	167
Stock Required			100	500	20	100		100	10						10					100	100	100	

Discussion Guide for Teachers of Family Life Education



WHAT THE DISCUSSION LEADER'S GUIDE CONTAINS

Your Discussion Guide contains six units, each dealing with one area of human sexuality. There is no recommended sequence of presentation; each unit is self-contained. Flexibility is the key. Evaluate your students and their needs; then tailor your discussions accordingly. Consideration of age, sex and levels of sophistication will help you structure your content and technique.

Suggested times are just that. Feel free to schedule additional time for topics which your students wish to explore in more detail. You may also combine sections of units if necessary.

TOPIC	SUGGESTED TIME
1. Maturation and Hygiene	One Hour
2. Anatomy and Physiology of the Reproductive System	One Hour
3. Becoming a Parent	One Hour
4. Family Planning	One Hour
5. Venereal Disease	One Hour
6. Decision-Making	One Hour

WHAT EACH STUDY UNIT CONTAINS

Pointers for the Discussion Leader

This section consists of general discussion about the subject matter of the unit. It provides the Discussion Leader with a focus for the discussion of each topic.

Visual Aids

Use these wherever possible. Copy diagrams onto large pieces of card.

Goals and Objective of the Unit

Each unit is preceded by a list of goal statements which outline the rationale and purpose of the discussion unit. Following is a list of objectives which defines specific measurable accomplishments to be mastered by each student participating in the class. The leader is encouraged to carefully study both goals and objectives in order to clarify the focus of discussion and the standards for success. Pre- and post-testing is one method of evaluating the effectiveness of content and methodology. Use the stated objectives as a guide for evaluating the success of your information and discussion sessions.

New Words

This list includes any words and/or phrases which may be technical and foreign to most students in the class. It is suggested that the leader present and define each word so that vocabulary does not inhibit learning or communication.

Content

- Outlines of suggested content to be included in your discussions are presented in this section. Additional material may be included to accommodate the interests and needs of your students. References listed before the unit provide supplemental resources which may be used to expand the scope of each discussion.

COMMUNITY BASED DISTRIBUTION (CBD) PROGRAM
IN THE LUMBOMBO REGION

Plan of Action for the Period January - July 1984

Background

The following has already been done in preparation to the establishment of the CBD program:

Negotiations with Regional Administrator (formerly District Commissioner) informing him and discussing interest in CBD. He agreed. As soon as FLAS is ready, will convene chiefs for meeting.

2. Training preparations (course draft, materials, lectures).
3. Discussions with Ministry of Health and the Ministry of Agriculture to secure cooperation in the identification and recruitment of 4 Rural Health Motivators and Agricultural Extension Workers to become CBD workers.

NOTE: Four seminars have been conducted with the participation of traditional chiefs. The seminars did not specifically deal with the proposed CBD program.

Plan of Action

- look what has been done since evaluation*
- Need to plan actions and conduct further study:
 - Identify communities/population in Region (number of people)
 - Identifying existing health facilities for co-operation on referrals and as contraceptive depots. This to be done dual approach:
 - a) Directly with Ministry of Agriculture headquarters,
 - b) Directly with health facilities.
 - Establish prevalence in the area and receptivity to family planning try communities by
 - a) surveying local leaders
 - b) population
 - c) schools
 - d) health facilities.

Prepare questionnaire: plan general visits. You want to know receptivity.

- Identify Rural Health Motivators and AEW's interview and establish if they will commit/will be accountable.
- Talk to chiefs and inner council propose that they assist in identifying respected community persons who could be trained to become CBD workers. Emphasis on accountability.
- Train CBD Co-ordinator full time.
- Train CBD workers (5 days in central location in region).
- Deploy workers. Initiate program.

Supervise CBD workers, conduct motivational activities, arrange for lectures, liaise/co-ordinate with regions health facilities. Ensure no duplication and guides in this regards the CBD workers.

SALARIES CHANGES FOR CURRENT FUNDING PERIOD

(AUGUST 1, 1984-JULY 31, 1985).

IT IS RECOMMENDED THAT THEY BE IMPLEMENTED EFFECTIVE
1ST JANUARY 1985

It is anticipated that a total of E8,200 will be saved as a result of lower salaries being paid to two Family Life Practitioners the salaries of one Family Life Eduactor and the CBD co-ordinator, both still to be hired, and the compensation to the CBDWs that will not be deployed during this funding period.

It is recommended that these monies be used as follows:

- (a) One Family Life Practitioner promoted to Senior Family Life Practitioner. Salary increase to be in accordance to Ministry of Health scale.
- (b) The other three Family Life Practitioners to receive corresponding salary adjustments in order of seniority.
- (c) An accountant be hired 25% time at E200/monthly.
- (d) In recognition that the Administrative Assistant is doing work beyond and above her current job description, salary to be increased to E400/monthly (currently E362/monthly).
- (e) The CBD co-ordinator's position appears as 50% time commanding a salary of E237/monthly. This position to be upgraded to correspond to that of a Family Life Educator, working 100% and with a salary of E520/monthly (MOH salary scale) for Health Educators.
- (f) Hire a driver 100% time at E250/monthly.

NOTES

- 1. Total increase in salaries and corresponding fringe benefits not exceed currently budget for both categories.
- 2. These require prior FPIA/Nairobi approval.



INTERNATIONAL
**Planned
 Parenthood**
 FEDERATION

Africa Region - Mbabane Field Office

P.O. Box A 30 Mbabane Swaziland
 Telephone 43331

FROM: Diana Gladys Azu
 IPPF Programme Officer

TO: Jose Mas
 FPIA - Technical Specialist

SUBJECT: FLAS EVALUATION

DATE: 20th November, 1984

I have discussed our (MAS/AZU) recommendations on the FLAS phasing out of FPIA and phasing in of IPPF with the Africa Bureau of the IPPF.

Our proposals as set out in attachment 4 are considered satisfactory. It is however recommended that FPIA take over FLAS' commodity budget together with the service delivery during the phasing out process. Furthermore since IPPF is still not too certain of its funding position during this period it is likely that FPIA might be called upon to carry more than the Service Delivery that we have recommended. Since FPIA is prepared to provide a maximum funding level equal to the current budget, I trust that in the event that IPPF cannot meet the full commitment, there will be enough funds.

Employment of Accountant

In the recommendations, we have proposed the employment (from 1st January 1985) of an Accountant on 25% time. We learnt later from FLAS that IPPF is also willing to finance the employment of a full time Accountant from 1st January 1985. Since the Accountant will be dealing with agencies' accounts, including those of FPIA and IPPF, FPIA could as proposed, meet the 25% of the total emolument of the Accountant and IPPF meet the remaining 75%.

FAMILY PLANNING EDUCATION AND SERVICES FOR MEN IN INDUSTRIES

AREA

MATSAPHA INDUSTRIAL SITE (SWAZILAND)

AIMS OF THE PROGRAM:

- (i) To undertake an extensive family planning educational programme for men in industries.
- (ii) To establish an effective family planning Community Based service delivery network in the industries.

OBJECTIVES:

The major objectives of this program will be to:

- (a) Enable the employees to understand and equate family size with their income after being exposed to family planning education.
- (b) Be able to understand, accept and practice family planning as a means towards better living standards for the family.
- (c) To be able to use the condom as a means of preventing sexually transmitted diseases as well as unwanted pregnancies.

IMPLEMENTATION STRATEGIES:

The actual implementation of this program will consist of three distinct but inter-related phases namely:

- (a) Preliminary study/survey
- (b) Project implementation
- (c) Evaluation

Due to its nature it is envisaged that this program could be replicated to other industrial settings within the country.

PHASE 1

During this phase a preliminary study/survey will be undertaken with the view to obtain better information about the employees, their problems and needs, prevalence of and knowledge about family planning, and other related concerns. This will provide a clear base line data and information upon which to implement the project. Again, such base line data and information will be useful in determining a more appropriate and suitable family planning educational programme, that will respond to their immediate needs. Therefore, the strategies and approach to be adopted will be based on the findings of this survey.

The survey will provide among others, the following information: number of industries; types of industries; number of male employees; their qualifications; type of nature of work done; incomes; family size, other dependants; birth rate; death rate; prevalence of teenage pregnancies; Sexually Transmitted Diseases, prevalence; and other relevant information and figures.

*11/1/1971
11/1/1971*
A proper questionnaire will be drawn to be used for extracting such information. Sources of information will be the male employee, the employers (management). Ministry of Industry, Department of Economic Planning and Statistics; the wives of the male employees and other sources deemed relevant.

About 15 university students may be temporarily employed to administer the questionnaire.

The questionnaire will then be analyzed and appropriate strategies be implemented.

PHASE II

This phase will consist of decision making on the appropriate strategy and approach for the family planning educational programme. The findings of the survey will be utilized and discussions with the management of the industries about the findings and intended action will take place. The meetings with the management will be held with the view to get permission and support in implementing the project.

- (a) At least two men from each industry will be selected with the help of the management, to be trained as Community Based Distributors of the family planning services.

Special workshops will have to be conducted for these. After the workshops, they will be expected to provide continuous motivation and the family planning services as well as counselling. They will also make referrals and follow ups where necessary, for example, treatment of Sexually Transmitted Diseases.

- (b) The family planning educational programme will then be undertaken and some of the topics to be covered include:
- (i) Social Change - its effects on (a) family, (b) society
 - (ii) The Family - its importance and functions, size and income, family/home management.
 - (iii) Family Planning - what it is - importance of family planning, the methods of family planning - the relationship between contraception and good living.
 - (iv) Sexually Transmitted Diseases.

During this phase, it is envisaged that the family planning services will be deployed with the CBD Health facilities within the industries or the industrial site - then the services will be deployed there as well. Efforts will be made to ensure that the personnel is qualified to administer the family planning services.

PHASE III

This will be the final phase of the program, and the major activities will be evaluated of the program and reporting to donor agency.

Evaluation procedures and findings will have to be comparable to the base line data gathered in phase I.

The evaluation strategies will vary but will include daily family planning educational programmes, family planning acceptors, Sexually Transmitted Diseases referrals and follow ups, counselling and nature of problems for counselling contribution of educational programmes towards general welfare of male employees as well as its effects on employee production levels.

Management will be briefed on the evaluation findings.

TIME FRAME

Given that the FPIA funding period in relation to this particular program is seven (7) months, i.e., from January 1984 to July 31, 1984, and the fact some 35% time of the educator would be available for implementing the project, a realistic time frame for the project would be:

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PHASE I

Activities: selecting and recruiting of University students
(approximately 15)

- drawing up of suitable questionnaire
- survey administered
- analyzing questionnaire response
- report formulation

Between January to March 15th

PHASE II

- meeting with industries management
- survey findings reporting
- workshop for CBD's
- deploying family planning services
- family planning educational programme

Between March 16 to June 15th

PHASE III

Between June 16 to July 31st and thereafter.

*Check of (orig)
done*

SWAZILAND**GOVERNMENT**

Ministry of Health,
P. O. Box 5,
Mbabane.

Our Ref : MH/1156

8 August, 1984.

The Regional Director,
IPPF Africa Regional Bureau,
IPPF London,
18-20 Lower Regent Street,
London SW1Y 4PW

Dear Mr Sozi,

SWAZILAND MEMBERSHIP OF THE IPPF

Since 1972, the Government of the Kingdom of Swaziland has enjoyed the membership of the IPPF, but only as affiliate members. Whilst we are under no impression that our benefits were limited under this status, we have acknowledged the fact that we do not have a voting right and are not eligible for nomination and may not have any under the current IPPF constitution.

Over the past five years the Government of the Kingdom of Swaziland has been looking for a way in which this situation can be improved or changed, especially because as a government it is very difficult to change our systems to coincide with the IPPF operational systems. In 1979, however, the Swaziland Government has registered a private, non-profit making organization named "The Family Life Association of Swaziland (FLAS)". The association has been in operation since then and it has now developed to a level that the Government recognizes it as a leading organization in family planning activities in Swaziland.

Discussions have been held with FLAS at various levels and as members of the IPPF we are confident that FLAS will adequately satisfy the requirements for IPPF membership and also represent the Swazi view in family planning issues in the Africa Region.

By this letter, I am stating to the IPPF the willingness of the Government of Swaziland to cede its membership of the IPPF provided that the said Family Life Association of Swaziland is considered for associate membership of the IPPF. This decision was taken by Cabinet in a meeting held on 7 July, 1984.

It is my understanding that FLAS is well known to you.

Your assistance in making the change over easy and painless will be highly appreciated.

Yours sincerely,

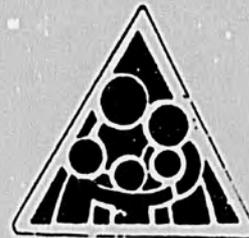
DR Z.M. DLAMINI
FOR : PRINCIPAL SECRETARY

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The Family Life Association of Swaziland
'Temndeni'

Emcozini Building
Ngwane Street
MANZINI

P.O. Box 1651
Tel. 53586
MANZINI



The Director,
International Planned Parenthood Federation,
LONDON

14th September, 1979.

Dear Sir,

RE "APPLICATION FOR INTERNATIONAL PLANNED PARENTHOOD
FEDERATION MEMBERSHIP

Following the ceding of IPPF membership by the Ministry of Health through cabinet in favour of Family Life Association of Swaziland we herewith forward our application for IPPF membership.

Family Life Association of Swaziland is a Non-Governmental Organisation which complements and augments government's activities by providing family planning services, providing information and education to increase the number of family planning adopters and to reduce unwanted pregnancies. In addition, Family Life Association pioneers new areas of services delivery and new educational approaches.

Family Life Association has been in operation since 1973. It started with a staff of two people specialising in injectable and non-prescriptive contraceptives. It has since grown to include a staff of fifteen people and seven professional workers, in providing contraceptives like orals, injectable, IUD, spermicide barriers methods etc.

Family Life Association is a leading organisation in family planning in Swaziland and the Ministry of Health recognises it. Enclosed is a letter from the Ministry of Health in support of the application.



President: Princess Phoina
Vice President: David Sibandze

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2. A constitution guiding Family Life Association in its activities is also enclosed.
3. Names of office bearers are listed hereunder. Their term of office is a period of one year after which elections are held. Most of them have been re-elected every year since the inception of Family Life Association in 1977. They are:-

1. PRESIDENT: Vacant
2. CHAIRMAN: David Sibandze
3. TREASURER: Almon Mkhwanazi
4. SECRETARY: Khetsiwe Dlamini (Mrs)
5. MEMBERS: Elizabeth Nomsa Hlophe (Mrs)
Roserne Barrett (Mrs)
6. MINISTRY REPRESENTATIVES:

MINISTRY OF HEALTH: Edith Mtiwane (Mrs)

MINISTRY OF EDUCATION: Elliot Giniadza

MINISTRY OF AGRICULTURE: Francina Simelane (Mrs)

MINISTRY OF INTERIOR: Maria Dlamini (Mrs)

7. Non-Governmental Organisation Representative:
Sarah Dlamini (Mrs)

Your consideration of our application will be highly appreciated.

Yours faithfully,


DAVID SIBANDE

CHAIRMAN



To Mr. M. K. Sozi

Copies to

From Ben Pakeche

Subject Swaziland - IPPF Membership

Date 20th September 1984.

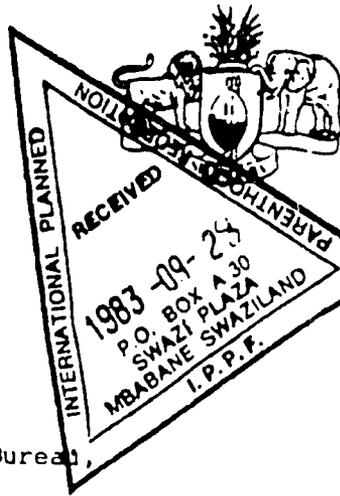
As you will recall, earlier this year the Swaziland Government wrote to the IPPF stating their intention to cede their membership of the IPPF to the Family Life Association of Swaziland (FLAS). The letter was also copied to FLAS. The Government further delegated their seat to FLAS in the 1984 Regional Council meeting. *June 1985 in London*

FLAS have now decided on taking up the membership of the IPPF and have written an application to that effect. I should mention that FLAS have no branches such as would be recognised by IPPF; they call their clinics "branches". They have not enclosed their minutes where the decision was taken. I will ensure that those minutes are sent soonest together with a list of their membership.

May I recommend that FLAS' application for membership be processed with a view to having a definite decision by the next Regional Council meeting.

SWAZILAND

GOVERNMENT



Ministry of Health,
P. O. Box 5,
Mbabane,
Swaziland.

28th September, 1983.

Our Ref : MH/1156

The Regional Director,
IPPF Africa Regional Bureau,
IPPF London,
18-20 Lower Regent Street,
London SW1 Y YPW.

Dear Mr Sozi,

re : SWAZILAND MEMBERSHIP OF THE IPPF

Since 1972, the Government of the Kingdom of Swaziland has enjoyed the membership of IPPF, but only as affiliate member whilst we are under no impression that our benefits were limited under this status, we have acknowledged the fact that we do not have a voting right and are not eligible for nomination and may not have any under the current I.P.F. constitution.

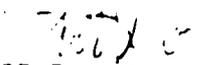
Over the past few years the government of the Kingdom of Swaziland has been looking for a way in which this situation can be improved or changed. It is our considered opinion that the area of family planning is rather complex and delicate and that one National Association may not do the justice deserved. We would rather like to see various non-governmental organizations deal with the programme thus giving the clientele the necessary choice. Moreover the motivation of the providers will vary according to the organization.

Government is therefore, willing to cede its membership of IPPF to a Board or body duly constituted whose responsibility would be to support activities of various non-governmental as well as government organizations in promoting family planning.

Therefore, I write to request your good office to provide the Swaziland Government with an expert who could help organize and establish such a board or body for the purpose already stated.

Your assistance will be highly appreciated.

Yours sincerely,


DR Z.M. DLAMINI
DIRECTOR OF HEALTH SERVICES