

U N C L A S S I F I E D

PD-ABC-038
62917

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

South Pacific Regional
Regional Family Planning
879-0019

Dated: November 9, 1990

U N C L A S S I F I E D

PROJECT DATA SHEET

TRANSACTION CODE

A = Add
 B = Change
 C = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY ENTITY

South Pacific Regional

3. PROJECT NUMBER

879-0019

4. BUREAU OFFICE

ANE

5. PROJECT TITLE (maximum 40 characters)

REGIONAL FAMILY PLANNING PROJECT

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
 0 9 3 0 9 5

7. ESTIMATED DATE OF OBLIGATION

(Under 90% rule, enter 1, 2, 3, or 4)

A. Initial FY 9 0

B. Quarter I

C. Fiscal FY 9 4

8. COSTS \$000 OR EQUIVALENT \$1 =

A. FUNDING SOURCE	FIRST FY 90			LIFE OF PROJECT		
	B. FX	C. L.C.	D. Total	E. FX	F. L.C.	G. Total
AD Appropriated Total						
Grant:	430	340	770	1,050	2,150	3,200
Loan:						
Other:						
U.S.:						
Host Country		20	20		100	100
Other Donors:						
TOTALS	430	360	790	1,000	450	1,450

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROXIMATE PRIMARY PURPOSE CODE	B. PRIMARY TECH. CODE	C. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PH 5440	460					3,200	
(2)							
(3)							
(4)							
TOTALS				3,200		3,200	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

440 420

11. SECONDARY PURPOSE CODE

460

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	B. Amount
RWN	100%
PVOU	75%
PVOH	100%
TMG	30%

13. PROJECT PURPOSE (maximum 480 characters)

To increase promotion of family planning and birth spacing in the South Pacific.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
 0 9 1 0 7 9 4

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 879

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

Clearance: HPH : M Bale
 HPH : P Lowry
 CONT: I Paterson
 PROG: K Dahlgren
 PDA : R Singleton
 ARD : J Osborn

17. APPROVED BY

Signature: *[Signature]*
 Title: John B. Woods
 REGIONAL DIRECTOR

Date Signed MM DD YY
 11 09 89

18. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AMENDMENTS, DATE OF DIS

MM DD Y

PROJECT PAPER

South Pacific Regional Family Planning Project
(Project No. 879-0019)

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Agency for International Development
Washington, D.C. 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, BUREAU FOR ASIA, NEAR EAST AND EUROPE

FROM: ANE/PD: Robert Nachtrieb *Robert Nachtrieb*

SUBJECT: SOUTH PACIFIC REGIONAL Family Planning Project
(879-0019) - Authorization

Action: Your authorization is requested for a grant of \$2.2 million for the South Pacific Regional Family Planning Project (879-0019). It is planned that \$600,000 will be obligated in FY90.

Discussion: The ten countries of the South Pacific range in population size from 3,000 in Niue to 3.3 million in Papua New Guinea (PNG). Fertility rates for most of the islands are high, but exceptionally high in the largest islands: Vanuatu 7.3; Solomon Islands 6.4; PNG 5.3. Female life expectancy averages only in the 50s for most of the population, and Infant Mortality Rates are higher in the larger islands (Vanuatu 100; PNG 72). Lack of birth spacing is considered an important contributing factor. Contraceptive prevalence is very low, averaging only about 25%, and as low as 2.6% in PNG.

To address this issue, the governments and NGOs of the ten island countries have formed an independent non-governmental organization called the South Pacific Alliance for Family Health (SPAFH). The organization provides technical assistance and grants to local private and public groups to undertake policy analysis and design and implement programs. The project proposes to strengthen SPAFH both managerially (to be able to attract additional resources) and technically (in policy development, education and training programs, and service delivery). Contraceptive supplies will not be provided under this project.

The project has been designed as a phased activity. During Phase I of the project, institution building will be concentrated primarily on strengthening the SPAFH so it can become a durable regional resource in population and family planning matters. The Phase I grant will be signed with a PVO which will, in turn, assist the development of SPAFH. Phase I will include limited activities to promote and support national efforts. When SPAFH has made sufficient progress towards sustainability concerns such as staff development and financial diversification (as measured by an in-depth evaluation which

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will be reviewed by AID/W), Phase II of the project would be authorized. Efforts would then commence focusing on strengthening public and private institutions through training, technical assistance, and outreach activities including social marketing, with a much reduced level of inputs directed toward strengthening SPAFH. After the second phase is authorized, a grant would then be signed directly with SPAFH.

Bureau Review: The Project Review Committee reviewed the Project Paper on November 22, 1989. (The authorization has been delayed pending resolution of budget questions). The Committee accepted the basic Project Paper approach of supporting SPAFH to promote adoption of appropriate country policies, information programs, and improved service delivery. However, the review found that some of the design considerations raised at the Project Identification Document review had not been reflected fully in the Project Paper. In further discussion and in order to correct this perceived deficiency, the following set of benchmarks for the initial 36-month phase of the project have been set:

OVERALL STRATEGIC OBJECTIVE

Strengthen community-based private and public sector providers of health products and services.

PHASE I: BENCHMARKS

1. SPAFH operational capability will have been improved
2. At least two additional countries will have established national population policies
3. SPAFH will have the capability to analyze demographic data bases in population policy formulation
4. SPAFH will have assisted at least three countries to establish national guidelines and country strategies for family planning service delivery and social marketing
5. SPAFH will have established ongoing and up-to-date contraceptive usage and inventory information for each of the member countries

The Mission will further reline these benchmarks prior to the signing of the project grant, and develop a draft implementation plan. A Condition Precedent (CP) will require

that, prior to disbursement of funds under the grant, objectively verifiable and measurable indicators will be agreed to by the parties to monitor progress and achievement of these benchmarks, and that an initial Phase I implementation plan will be finalized and agreed to. Toward the completion of Phase I, an indepth evaluation will be conducted to assess the achievement of performance benchmarks and prospects for success in the future. Based on a positive evaluation, which will be reviewed both in the Mission and by the Bureau, you would be requested to authorize Phase II. Phase II activities have been designed as part of the overall effort, and we do not expect significant deviations from the current plans. However, as a result of the experience gained during the first 36 months, some things may change requiring a modification of budgets, implementation schedules, and benchmarks for Phase II. (The exact timing of the evaluation will be set during the first year of implementation. It will be conducted 3-6 months prior to the end of Phase I so that Phase II can be initiated without a gap in funding or services.)

The Project Paper analysis identifies other potential sources of donor and private funding which may be used to sustain financing of family planning activities in the region. However, this analysis is based necessarily on a number of assumptions, and we have suggested that the evaluation verify the economic viability of identified non-governmental funding sources for the program and for SPAFH. The proposed guidance cable (Tab B) includes these points.

Authority: The Regional Director for the South Pacific has not been redelegated standing authority to approve Project Papers and authorize projects, so your approval is required for this authorization.

Congressional Status: The Congressional Notification for this project expired July 13.

Recommendation: That you authorize the Family Planning Project by signing the Attached Project Authorization (Tab A).

Attachments:

- A. Project Authorization
- B. Guidance Cable
- C. Project Paper

Clearances:

ANE/EA:JTennant _____ DRAFT
ANE/DP:PDavis _____ DRAFT
GC/ANE:HMorris _____ DRAFT
ANE/PSD:LMarston _____ DRAFT
ANE/TR/ARD:JSwallow _____ INFO
ANE/TR/HR:SGrant _____ INFO
ANE/PD/ENV:MKux _____ DRAFT
ANE/PD/EA:EMorris _____ DRAFT
ANE/TR/HPN:MJordan _____ DRAFT
PRE:MSinding _____ DRAFT
A/DAA/ANE:BTurner

ANE/PD/EA:EMorris: ^{3A}lsl:rev.7/3/90:WD: rev.JSilver:7/17/90:9268G

Agency for International Development
Washington, D.C. 20523

PROJECT AUTHORIZATION

NAME OF COUNTRY: South Pacific Regional
NAME OF PROJECT: South Pacific Regional Family Planning Project
NUMBER OF PROJECT: 879-0019

1. Pursuant to Section 104(b) of the Foreign Assistance Act of 1961, as amended, I hereby authorize the South Pacific Regional Family Planning Project (the "Project") for the South Pacific Region and certain non-governmental organizations in the United States and the South Pacific Region ("NGOs") involving planned obligations of an amount not to exceed Two Million and Two Hundred Thousand United States Dollars (\$2,200,000) in grant funds over a three year period from the date of authorization, subject to OYB/allotment process, to help finance foreign exchange and local currency costs of the Project. The planned life of the Project is approximately three years from the date of the initial obligation until September 30, 1993.

2. The Project provides training as well as technical, administrative and other assistance to strengthen the family planning capabilities of national, public and private organizations located in the South Pacific Region. Funds for this Project also include matching grants to national, public and private family planning organizations for policy development, information, education and communications, and service delivery activities.

3. The Project Cooperative Grant Agreement (the "Grant"), which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms, covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the South Pacific Region (A.I.D. Geographic Code 879) or in the United States (A.I.D. Geographic Code 000), except as A.I.D. may otherwise agree to in writing.

Except for ocean shipping, the suppliers of commodities or services shall have the South Pacific Region or in the United States as their place of nationality, except as A.I.D. may otherwise agree to in writing. Ocean shipping financed by A.I.D. under the Project, except as A.I.D. shall otherwise agree to in writing, shall be financed only on flag vessels of the United States.

5. Condition Precedent

A Condition Precedent to the following effect shall be included in the Project Grant Agreement:

Prior to disbursement of funds under this agreement, or to incurring expenses pursuant to which funds may be required to be disbursed, other than funds which may be required for services to complete any work needed to comply with this condition precedent, A.I.D. and the Grantee will finalize and agree to an initial implementation plan/schedule for Phase I of the project, and to a set of objectively verifiable and measurable indicators by which to monitor progress and achievement of the project benchmarks.

6. Covenants

(a) None of the funds provided under the Grant, or goods or services financed thereby, may be used for, or in support of, a program that includes the performance of abortion or involuntary sterilization as a method of family planning, or coercion or financial incentives to motivate any person to undergo an abortion or involuntary sterilization.

(b) None of the funds provided under the Grant, or goods or services financed thereby, may be used to finance any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning.

(c) All funds authorized for this Project shall be used in accordance with all applicable provisions of U.S. legislation and A.I.D. policy and regulations governing the provision of population assistance.


Assistant Administrator, Acting
Bureau for Asia, Near East and Europe
Date 7/18/90

BASIC DEMOGRAPHIC CHARACTERISTICS

NATION	POP	DEN	GrR	DUB	CDR	IMR	MMR
Papua New Guinea ¹	3,343	7	2.3%	33	11.8	72	80
Solomon Islands ²	285	7	3.5%	20	10.9	46	65+
Vanuatu ³	140	12	2.7%	26	12.0	100	10
Kiribati ⁴	66	95	2.1%	37	13.9	82	0
Fiji ⁵	716	38	1.7%	43	5.2	20	66
Tonga ⁶	94	139	.5%	139	5.1	10	-
W. Samoa ⁷	163	56	.3%	-	7.0	24	40
Tuvalu ⁸	8	322	1.6%	32	9.6	15	-
Cook Islands ⁹	18	75	.9%	-	6.5	32	-
Niue ¹⁰	3	11	-7.8%	-	7.0	-	-

NATION	FLE	CBR	TFR	CCP	METH
Papua New Guinea	52	35.3	5.3	2.6% ¹¹	OC
Solomon Islands	54	44.6	6.4	-	OC
Vanuatu	54	45.0	7.3	16.3%	OC
Kiribati	55	37.5	4.9	21.5%	Depo
Fiji	65	28.6	3.4	27.2%	TL
Tonga	61	27.4	4.1	30.2%	Depo
W. Samoa	66	29.4	4.9	13.9%	Depo
Tuvalu	70	26.2	2.7	40.3%	OC
Cook Islands	70	23.0	4.1	30.0%	OC
Niue	-	17.4	4.8	8.6%	-

KEY TO ABBREVIATIONS:

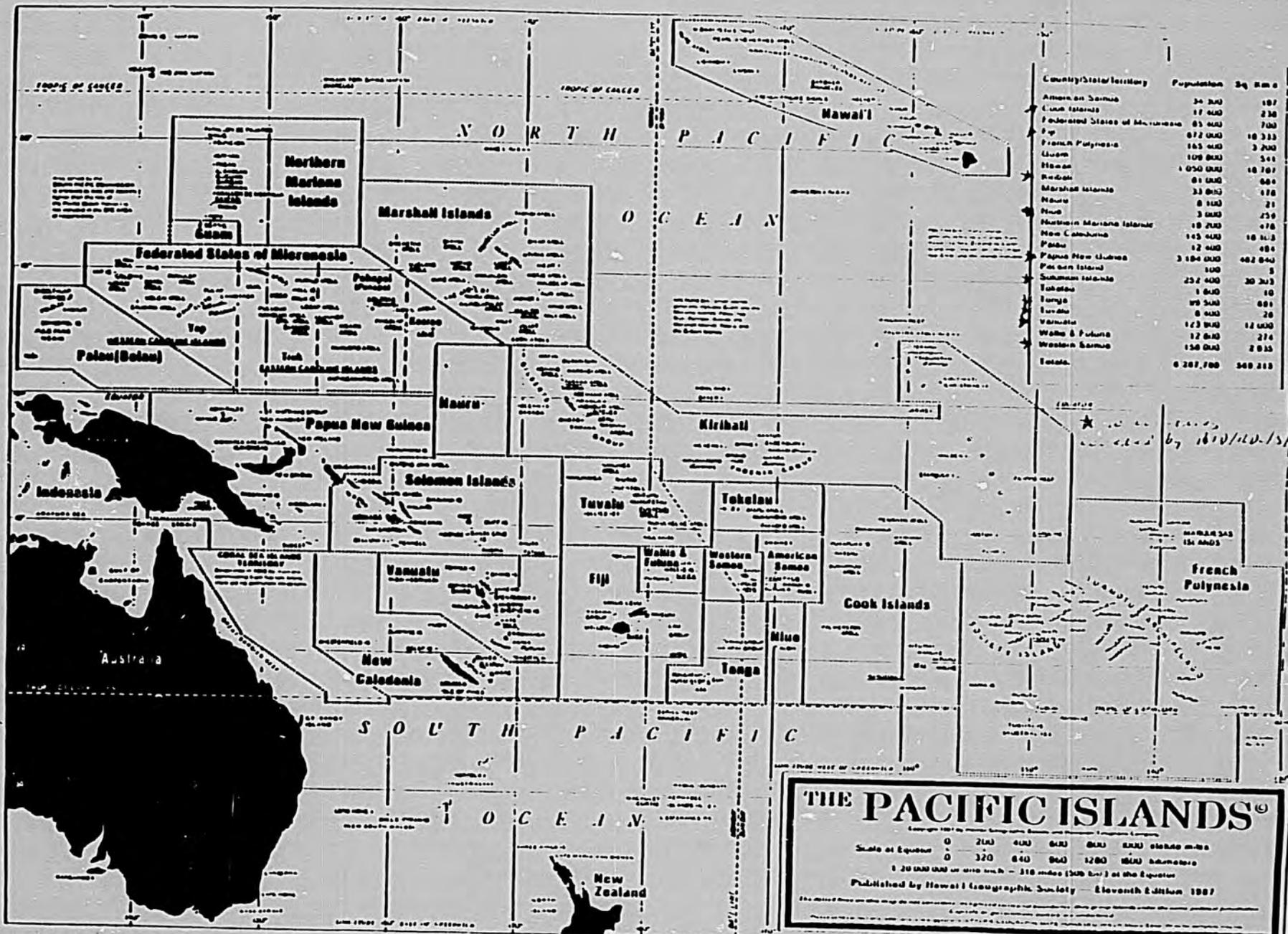
- POP = Total population (in 1,000s)
 DEN = Inhabitants per square kilometer
 GrR = Growth rate
 DUB = Doubling time in years
 CDR = Crude death rate (annual deaths per 1,000 population)
 IMR = Infant mortality rate (annual deaths among infants under 1 per 1,000 live births)
 MMR = Maternal mortality rate (annual deaths due to pregnancy and childbirth per 10,000 live births)
 FLE = Female life expectancy in years
 CBR = Crude birth rate (annual birth per 1,000 population)
 TFR = Total fertility rate (hypothetical number of live births per woman at current birth rates)
 CCP = Contraceptive prevalence
 METH = Principal method used (TL = tubal ligation)

SOURCES:

- 1 Government of Papua New Guinea, Development Plan 1989-91; GPNG National Statistics Office; GPNG Department of Health.
- 2 Government of the Solomon Islands, Solomon Islands Population Policy, 1988; ESCAP Demographic Estimates, 1986.
- 3 Vanuatu Country Report, SPAFH Regional Workshop on Contraceptive Technology, Fiji, June 1989.
- 4 Kiribati 1985 Population Census; GOK 1987 Maternal Child Health/Family Planning Statistics.
- 5 Fiji 1986 Census; ESCAP Population Division, Demographic Indicators: Projections and Estimates, 1986; Fiji Country Report, SPAFH Regional Workshop on Contraceptive Technology, Fiji, 1989.
- 6 Tonga 1986 Census; GOT Ministry of Health, Annual Report, 1986.
- 7 Government of Western Samoa 1981 Census Report; GOWS Department of Health.
- 8 Tuvalu Ministry of Health, Annual Statistics Report, 1986; Tuvalu Country Report, SPAFH Regional Workshop on Contraceptive Technology, Fiji, 1989.
- 9 United Nations Population and Vital Statistics Report, July 1986; Cook Islands Country Report, SPAFH Regional Workshop on Contraceptive Technology, Fiji, 1989.
- 10 Niue 1986 Census; GON Hospital Records, 1986.
- 11 One source has estimated a maximum of 17%. (Ajello, C. Observations on the Reproductive Health Status, Problems, and Needs in Papua New Guinea. Unpublished report, 1988.)

ACRONYMS

A.I.D.	Agency for International Development
AIDAB	Australian International Development and Assistance Bureau
AIDS	Acquired immune deficiency syndrome
AIDSCOM	Communication for AIDS Prevention Project
APO	Aid post orderly
CBD	Community based distribution
CHW	Community health worker
CMR	Child mortality rate
DOH	Department of Health (PNG)
FP	Family planning
FPA	Family planning association
FSP	Foundation for the Peoples of the South Pacific
HEALTHCOM	Health Communication for Child Survival Project
HEO	Health extension officer
IEC	Information, education and communications
ILO	International Labor Organization
IMR	Infant mortality rate
IPPF	International Planned Parenthood Federation
KAP	Knowledge, attitudes and practice
MCH	Maternal and child health
MFP	Ministry of Finance and Planning (PNG)
MHMS	Ministry of Health and Medical Services (SI)
MOET	Ministry of Education and Training
MOH	Ministry of Health
NGO	Non-governmental organization
NTSU	National Training Support Unit
OC	Oral contraceptive
Path	Program for Appropriate Technology in Health
PGR	Population growth rate
PID	Project identification document
PIPPA	Pacific Islands Planned Parenthood Affiliation
PNG	Papua New Guinea
PP	Project Paper
PSC	Personal services contract (or contractor)
PVO	Private voluntary organization
RCO	Regional Contracting Office (Manila)
RDO/SP	Regional Development Office/South Pacific (A.I.D.)
RDSS	Regional Development Strategy Statement
SI	Solomon Islands
SIDT	Solomon Islands Development Trust
SIMRI	Solomon Islands Medical Research Institute
SIPPA	Solomon Islands Planned Parenthood Association
SOMARAC II	Social Marketing for Change Project II
SPAFH	South Pacific Alliance for Family Health
SPC	South Pacific Commission
STD	Sexually transmitted disease



by 18/10/15

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 0 320 640 960 1280 1600 Miles
 1:20,000,000 in area each - 310 miles (500 km) at the Equator
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REGIONAL FAMILY PLANNING PROJECT

I. SUMMARY

A. Recommendations:

Grant: Grant of \$3,200,000 life of project with \$770,000 to be obligated in FY 1990.

Grantee and Implementing Agencies South Pacific Alliance for Family Health (SPAFH) and The Pathfinder Fund on behalf of SPAFH.

Waivers: Waiver of competition to execute cooperative grant agreement with the Pathfinder Fund.

B. Why?

The population growth rate of the ten countries* assisted by the A.I.D. Regional Development Office/South Pacific (RDO/SP) and members of The South Pacific Alliance for Family Health (SPAFH), a regional NGO based in Tonga, ranges from 2.2 percent for the largest country (Papua New Guinea with about 70 percent of the region's population) to 3.5 percent for the third largest country (Solomon Islands) to a negative rate for the smallest (Niue with about 2,500 people). While the population densities are relatively low in comparison with many developing countries, the natural and economic resource bases of some of the South Pacific countries are also very limited. A recent SPAFH staff paper described the situation as follows:

"All of these nations are faced with population pressures influenced variably by high fertility, low mortality, internal and external migration and either poor or underdeveloped human and natural resources...[need to] formulate national development plans and to allocate the resources necessary to provide far-reaching comprehensive family planning programs."

The countries have major weakness in policy planning and execution, information, education and communications (IEC) capabilities and service delivery systems.

*The ten countries are Papua New Guinea, Solomon Islands, Fiji, Vanuatu, Tonga, Kiribati, Western Samoa, Cook Islands, Tuvalu and Niue.



RDO/SP supported the creation of SPAFH through a grant to the Foundation for Peoples of the South Pacific (FSP) in September, 1989 for limited financial management assistance and funds for operations and activities. To date, A.I.D. has provided \$1.2 million to SPAFH through its grant to FSP. SPAFH is non-governmental, but its board is composed of senior government health officials from the ten countries who are nominated by their ministries of foreign affairs. (see Annex E for names and titles) Thus, SPAFH can work with governments as well as PVOs, but is not a government organization itself. It has a staff of six professionals -- all from the region.

Because of its local character, it is in a unique position to work in the critical but politically sensitive field of population policy. It can also work with both the public and private sectors. SPAFH also provides training and technical assistance as well as matching funds to its member countries on information, education and communications (IEC) programs, service delivery activities and policies. It supports both regional and national activities.

To date, SPAFH has made 16 matching grants to eight of its member countries whose matching contributions (\$207,000) represented 42% of the total costs of these activities. In addition, SPAFH has sponsored or supported three regional activities (\$63,356). It has assisted two countries with procurement of contraceptives provided by other donors. Its technical assistance was instrumental in establishment of a population policy in the Solomon Islands.

SPAFH's capacity to fulfill its functions is limited by its small size, small budget (100 percent from A.I.D. at this time), lack of experience and knowledge by its professional staff, and weak management, financial and programming controls and systems. If SPAFH could strengthen its institutional capabilities and capacity, other donors should be willing to channel considerable population funds and other inputs through SPAFH for its member countries. In fact, Great Britain in 1988 made a \$75,000 grant to SPAFH and the Australian aid agency recently invited SPAFH to submit an application for a grant in 1990. SPAFH has the potential of becoming (1) the major provider to its member countries of technical assistance, training, and funding for local population activities; (2) a resource center for IEC, and (3) the coordinator of population activities within the region.

Since SPAFH needs far more technical and management help than FSP is capable of providing, RDO/SP and SPAFH selected through a competitive process the Pathfinder Fund, a U.S. PVO specializing in population matters, to design and assist in implementing this project. Pathfinder was awarded a "bridge" cooperative grant agreement for \$215,000 from the PVO Co-Financing Project in August of 1989 to initiate some pre-implementation actions while awaiting the project's authorization.

C. What?

This project combines institution building and support of family planning activities in the ten countries and the region as a whole. Institution building will be concentrated primarily on strengthening SPAFH so it can become a strong regional resource in population and family planning matters. However, the project will also help strengthen national public and private organizations by training and technical assistance provided by the SPAFH staff or by others under SPAFH's sponsorship.

In Phase I (about 2 1/2 years from authorization), Pathfinder, under a cooperative grant agreement with A.I.D., will provide a resident advisor for two years to SPAFH to assist with strengthening efforts and to coordinate the provision of project inputs. Other inputs will include training in the U.S. and third countries for SPAFH staff, regional training and workshops, short term technical assistance for management and programming improvements, and funds for SPAFH's operations. Funds are also included for matching grants to national public and private family planning for policy development, IEC, and service delivery.

Near the end of Phase I, a formal evaluation will be made to assess whether: (1) SPAFH has reached certain benchmarks of management, technical and programming capabilities; (2) SPAFH has been successful in attracting funds from other donors so as to reduce its financial dependence on A.I.D.; and (3) SPAFH can be registered with A.I.D. as an indigenous PVO and thus become eligible to receive grant funds directly from A.I.D.

During Phase II, RDO/SP should have a cooperative grant agreement directly with SPAFH to provide funds for its operations and matching grants. Pathfinder's role then would become one of providing SPAFH with short term technical assistance and help with training in the U.S. under a new cooperative grant agreement. Thus one of Pathfinder's objectives in Phase I is to work itself out of a job. A major objective of SPAFH during Phase I is to become capable of functioning independently of Pathfinder and to lessen its financial dependence on A.I.D.

Q. L. to do what?

(K)

(D)

*Phase I
2.5 yrs*

Phase II

Summary Budget
(US\$ 000)

SPAFH Operations	1,140
Training	285
Technical Assistance	390
Matching Grants	250
Pathfinder Overhead & Home Office Support	420
Audits and Evaluations	140
RDO/SP Monitoring	375
Contingency	<u>200</u>
Total A.I.D.	3,200
Countries Matching Contributions	100
Other Donors	<u>1,450</u>
Total Project Costs	4,750

D. How?

During Phase I, the project will be implemented through a cooperative grant agreement with the Pathfinder Fund which was selected under modified competitive procedures in May, 1989 to design this project.

All project inputs during Phase I will be provided by Pathfinder, either with its own staff or through sub-contracts because SPAFH at this time is not eligible to receive grants directly from A.I.D. Pathfinder will advance funds periodically to SPAFH for its operations and for matching grants. All matching grants will require the concurrence of the Pathfinder resident advisor and, for grants over \$10,000, RDO/SP concurrence.

Phase II implementation should be carried out mainly by SPAFH under a direct grant from A.I.D. The cooperative grant agreement with Pathfinder would then be extended to provide SPAFH with short term technical assistance and training in the U.S.

The project's financial records will be audited annually by a public accounting firm.

Implementation will be monitoring within RDO/SP by a project advisor, a personal services contractor (PSC) who is a regional public health specialist already on board. Costs of this PSC are included in the budget.

E. Issues:

Several design issues were raised in the PID approval cable (State 376110, November 18, 1988), including the absorptive capacity of SPAFH, recurring costs, reasons for lower than expected effectiveness in family planning in the South Pacific, and need for outputs that go beyond institutional development.



These have all been addressed in the project design and in the text of this PP at various places. Annex A is the PID approval cable plus an amplified discussion of issues and how they were resolved during design.

F. Design Methodology and Conclusions:

The project was designed by a team provided by the Pathfinder Fund in collaboration with the SPAFH staff, some members of SPAFH's board who are senior health officials of their countries, and FSP. Its team leader was a retired senior A.I.D. officer with substantial experience in population, human resources and related fields. Other members included an IEC expert provided by PATH (Program for Appropriate Technology in Health), a policy expert from the Pathfinder field staff, the former Executive Director of SPAFH, and a senior Pathfinder program officer.

They attended part of a SPAFH-sponsored regional workshop where they discussed population matters with SPAFH's staff and representatives of several national organizations. They also attended the SPAFH board of directors annual meeting in June where they discussed the future of SPAFH, including how this project might help SPAFH and the family planning activities in the South Pacific. Two team members visited SPAFH's offices in Tonga while two others visited Papua New Guinea and Solomon Islands to obtain first hand information about the status of population activities, opinions about SPAFH, etc.

The team concluded that an expanded and more effective family planning effort in the South Pacific is greatly needed and that strengthening SPAFH is the most efficient and cost effective way for a donor to have a major impact in the region. The draft PP was reviewed and approved by an ad hoc committee of SPAFH board members and SPAFH staff in October, 1989 after a thorough discussion with representatives from RDO/SP, FSP and Pathfinder. This project is feasible on technical, economic, financial, administrative, and social soundness grounds.

Project Design Team (provided by Pathfinder Fund):

Dr. James Brady, Team Leader
Tupoutu'a Tonoutonu Lindborg, Regional Expert
Nancy Newton, PATH, Media/Communications Expert
Carlos Aramburu, Pathfinder Policy Specialist
Jim Crawford, Pathfinder Home Office Representative

Other Design Participants:

Laufitu Malani, SPAFH Chief Program Officer
Dr. Kerry E. James, University of South Pacific Anthropologist
Dr. Patrick Lowry, RDO/SP HPN Advisor
Ralph Singleton, RDO/SP Project Development Advisor and PP Editor

II. RATIONALE

A. Problem:

1. High Population Rates: Serious and varied population issues face the South Pacific countries. Populations range from about 2,500 in Niue to over 3,300,000 in Papua New Guinea. Estimated annual population growth rates in the region range from a negative rate of -4.3% for Niue (due to emigration) to +3.4% for the Solomon Islands. While population levels are relatively small in comparison with many countries, they create pressures on the limited natural and economic resource bases of most South Pacific countries. A recent SPAFH staff paper described the situation in the following terms:

"All of these nations are faced with population pressures influenced variably by high fertility, lower mortality, internal and external migration and either poor or underdeveloped human and natural resources. In order to reach goals of high quality of life for all citizens and national prosperity, the governments of these countries will have to make decisions in the next few years to formulate national population policies in concert with national development plans and to allocate the resources necessary to provide far-reaching comprehensive family planning programs."

Fertility remains a serious impediment to development throughout the region. The total fertility rate (TFR) of PNG is about 5.4 per woman. The population growth rate in PNG remains low, about 2.2 percent, only because of high infant mortality (IMR = 72/1,000*), maternal mortality (MMR = 80/100,000) and child mortality rates (CMR) = 115/1,000). Life expectancy is about 50 years.

The total fertility rate for Solomon Islands and Vanuatu is greater than six. Growth rates in Solomon Islands and Vanuatu are 3.4% and 2.7% respectively. Life expectancy is 55 and 54 respectively, reflecting somewhat better maternal, infant and child survival in these countries.

The total fertility rate in the remainder of the region is about five per woman, with population growth rates of two for Kiribati, Western Samoa, Tonga, Tuvalu and Fiji. The relatively low growth rate for Kiribati reflects high IMR (82/1,000), CMR (155/1,000) and likely high MMR (unknown).

*A.I.D. Health Sector Assessment reviewed the IMR data and concluded that the IMR is closer to 125 - 130/1,000.

The low growth rates in other countries, despite high TFR's, reflect out-migration to Pacific rim countries such as Australia, New Zealand, Canada and the U.S. However, the rim countries are less willing now than in the past to accept such immigration.

Family planning programs throughout the region except for Fiji have suffered. Without clear policies and strategies, family planning programs have not been focussed. NGOs, interest groups and policy makers, particularly in the Melanesian countries and Kiribati, have begun to make plans for population policies due to increasing awareness of the impact of population growth rates on development. The Polynesian countries will probably not move as fast towards national policy formulation activities.

Population policy in the region needs the support of all service providers, including NGOs and religious groups. Currently, family planning service providers view their work as separate from policy formulation. As their level of awareness on population issues is raised and as they understand that their work is related to the other aspects of development, service providers will play a more important role in policy formulation. Therefore, SPAFH service provider training should include discussions on impact of population growth upon overall development.

National health policies do not include specific guidelines for family planning service delivery programs. Although family planning is considered a priority, government officials and health leaders have been reluctant to set clear policies perhaps due to other aspects of family health considered more important (e.g., immunization and nutrition programs, lack of awareness of the impact of population growth rates on development, family planning sensitivities and personal biases). Nevertheless, family planning donor agencies have responded with sizeable commitments for minimal family planning results.

Constraints to population service delivery include:

- a. Constant leadership turnover in some countries, particularly in Melanesian countries, and lack of government stability to support policy formulation.
- b. Lack of awareness at all levels of government, NGOs, and religious groups of family planning and population issues that affect national development. RAPID?
- c. Lack of awareness that family planning service delivery is related to national development. RAPID?

need more info on just needs social approach

A constraint on service delivery activities has been the lack of information, education and communications (IEC) materials appropriate to local cultures and languages. This shortage has handicapped efforts to increase "demand" for family planning services and products.

2. What South Pacific Countries Are Doing: Family planning/family health is listed as a priority in all the national health plans, with special reference to birth spacing to improve the health of mothers and children. NGO and government service providers visited by the project design team and by the SPAFH needs assessment team in June-September, 1987 expressed the need for more specific family planning policies that provide clear guidelines to follow. Policy statements on family planning/family health throughout the region, except for Fiji, contain objectives which are broad with no clear strategy to achieve the objectives.

While reliable statistics are not available, it appears that the use of modern family planning methods has been gradually increasing in the region. However, progress varies among areas and time periods. (See demographic data table in front of PP for some general information on population levels and contraceptive practice rates) There is still much to be done to:

- a. help couples understand their options for family planning; and
- b. provide them with access to high quality family planning services when needed.

Fiji, with the help of NGOs, has been a leader in the region in supporting family planning activities and the first to recognize that clear policy guidelines and implementation plans are vital for the success of family planning programs. The Fiji Development Plan 9 called for the establishment within the Ministry of Health of the National Family Planning and Population Control Program giving it "top priority". This program began in January 1987 with the installation of a National Family Planning and Population Control Coordinator to manage activities.

The Government of Papua New Guinea (PNG) is making similar plans. The PNG Department of Finance and Planning is currently seeking support from the government for the establishment of a planning unit specifically for population and family planning activities. The PNG Development Plan for 1989 - 1993 notes the increasing importance of population issues and proposes a five-year strategy for the formulation and implementation of a national policy. The policy will address such needs as (a) slowing population growth through reduced fertility, (b) educating leaders and citizens on the implications of population growth, (c) providing information and education on the advantages of child spacing and the means to achieve this, and (d) providing efficient and easily accessible health and family planning services.

Fiji, Kiribati and Tuvalu, have set targets for population growth rates (PGR) in their national development plans. The Government of Tuvalu has set a target of reducing its PGR from 2.01% in 1987 to 0% by the year 2000.

The Solomon Islands is the only country in the region with a specific population policy that promotes the delivery of family planning services. This policy was generated by the need of an NGO, the Solomon Islands Planned Parenthood Association (SIPPA), to have more government support and guidance for its work. In the initial stages of the policy preparation, SPAFH, with assistance from UNFPA, ILO, IPPF and the South Pacific Commission (SPC), collaborated with SIPPA and the Ministry of Health and Medical Services (MHMS) to facilitate awareness raising workshops for high level government and NGO leaders. Since the Solomon Islands initiative, Vanuatu and Kiribati have begun considering population policies. PNG is currently trying to organize its population policy preparation activities, and Tonga expressed interest to the design team in knowing more about the Solomons policy.

There are indications that certain countries in the region are thinking about population policies as vitally important to overall development. However, the process of developing and implementing national population policies will take time. Trained manpower and resources to implement national policies effectively are sometimes not available. Some countries may take longer to formulate and adopt national population policies, particularly Polynesian countries where population growth rates are not high and where immediate population pressures on economic development are not as evident.

3. What Donors Are Doing: UNFPA (United Nations Fund for Population Activities), through WHO (World Health Organization), has been the primary funding agency for the maternal child health/family planning programs in all the countries except Niue. Local family planning associations mainly supported by International Planned Parenthood Federation (IPPF) in Papua New Guinea, Tonga, Western Samoa, and Fiji also provide services independently of health ministries.

There have been sizable commitments of funds and resources in the past decade by UNFPA, and smaller commitments by such donors as Australia, New Zealand, Japan, the United States and multi donor agencies e.g., the South Pacific Commission. Most donor support has been for training or educational activities. The 1987 contributions to the region for "population" activities totalled about \$1.5 million -- a major portion of which supported preparation for a regional census. However, donor assistance for population and family planning activities has had little impact so far upon population growth or fertility rates in any country of the region except Fiji.

At a meeting in Sydney in 1985 of various international and national donors interested in population matters, the consensus was that the practice of flying in short term experts from outside wasn't working as, among other things, there was no involvement of islanders in the planning, programming and policy aspects of the offered aid. As a consequence much of the offered aid was never used. The consensus was that the region needed its own organization, staffed with islanders, to be a channel for aid donors and to provide technical assistance to the countries, especially to government organizations. This led to the creation of SPAFH in late 1986.

B. Alternatives:

1. Bilateral Programs: In family planning, as in other sectors, severe planning and implementation problems result if one tries to provide assistance on a bilateral basis to ten countries encompassing over 1,300 islands over an area of more than 5.6 million square miles. The RDO/SP staff is simply too small to deal directly in an effective manner with the ten countries and the costs of doing this would be prohibitive in many cases. Therefore, a bilateral family planning assistance approach is not attractive or feasible.

2. PIPPA: Outside of SPAFH, the only other regional body focusing on population is the nascent Pacific Islands Planned Parenthood Alliance (PIPPA). PIPPA is basically a paper organization at this time, formed by the International Planned Parenthood Federation (London) as a mechanism for dealing with local associations in the region. At this time, eight of the region's national NGOs are members of PIPPA. Its inaugural meeting was in May, 1988, some 17 months after SPAFH became operational.

PIPPA is not a more suitable mechanism than SPAFH for A.I.D. to assist the ten member countries in family planning activities for several reasons: (a) PIPPA is not full, operational and not in position to provide the technical assistance and other services being provided by SPAFH; (b) It deals only with its affiliated local NGOs -- it does not work with government entities or other NOGs/PVOs; and (c) To date, it is not as quick in responding to requests as is SPAFH.

At this time, it is not clear which way PIPPA will evolve, but it is possible that SPAFH and PIPPA may be working together at some future date.

3. South Pacific Commission (SPC): The South Pacific Commission is another potential channel for providing population assistance, but it has not yet become involved in this sector. The Commission has a membership of 22 developing countries and

territories plus five developed countries (Australia, Great Britain, the United States, New Zealand and France). The A.I.D. Regional Office may work with the Commission as a channel for assistance for regional AIDS prevention. There is also potential for cooperation on demographic data management.

4. SPAFH: At present, The South Pacific Alliance for Family Health (SPAFH) is the preferred channel for population assistance. It has already established cooperation networks in member countries and initiated programs. SPAFH has gained acceptability in the ten member countries because it is a locally-based organization staffed by people from within the region, and is sensitive to local needs and socio-cultural issues. These factors have contributed to its potential for serving as a catalyst or regional coordinating mechanism for further improving population policies and programs in the region.

Therefore, this project will help SPAFH expand its role as a training, advisory and funding agent to improve national population and family planning policies and programs. The Pathfinder Fund will also assist SPAFH to pursue more funding from non-A.I.D. sources during the coming years. However, the project design team was often told by country contacts that there may be more funds available from donors than can be effectively programmed under the current deadlines and systems of donors. Consequently, SPAFH should be discouraged from chasing after large donor grants until it builds up its internal program management capabilities and concentrates its energies on those population tasks where it has a comparative advantage.

C. SPAFH:

1. Organization: SPAFH is a small regional PVO which became operational in January, 1987 in Tonga under A.I.D. auspices to promote population and family planning activities in the ten South Pacific countries served by A.I.D.'s RDO/SP. Funding was provided by a grant to the U.S. PVO, Foundation for the Peoples of the South Pacific (FSP) (\$1,213,477 through September 30, 1989) as SPAFH was and is not yet registered with A.I.D. as an indigenous PVO.

SPAFH's Board of Directors consists of senior health officers from the ten cooperating countries and these persons have been instrumental in helping SPAFH staff to establish contacts and networks for regional cooperation on population issues.

SPAFH has a staff of five professionals: a secretary general from PNG, a chief program officer from Fiji, two other program officers (from Tonga and Solomon Islands), and an accountant (from Fiji but Australian trained). It also has three support persons. An organization chart is in the Administrative Analysis (Annex E).

2. Activities of SPAFH: SPAFH has already made 16 matching grants to countries, totalling \$287,647 and has six applications under review (\$94,794) for a variety of policy, IEC and service delivery activities. Only four of the 22 are over \$20,000. The countries have provided \$207,429 (42%) matching contributions bringing the total value of activities already approved to about \$495,000. In addition, SPAFH has sponsored or supported three regional activities (\$63,356). A list of the matching country grants and regional activities is in the table on the following page. More details of SPAFH's activities are in the Administrative Analysis (Annex E) and discussion of its budget is in the Financial Analysis (Annex F).

SPAFH, in June, 1989, sponsored a regional workshop on contraceptive technology for representatives of the member countries. Earlier, it presented in Solomon Islands a "training of trainers" workshop on contraceptive technology for family planning practitioners from several countries. SPAFH also attempted in 1988, without success, to help Fiji obtain contraceptive supplies on an emergency basis. It was more successful in locating some commodities in Cook Islands to meet a Niue need.

SPAFH has worked closely with other international aid donors, some of whom are beginning to see SPAFH as an effective channel for supporting regional population activities. In 1988, the United Kingdom channeled a grant of \$75,000 for health education through SPAFH. In September, 1989, the Australian aid agency (AIDAB) approached SPAFH about the possibility of making a grant in 1990.

While SPAFH has made significant progress in gaining acceptance and professional creditability in the past two and one half years, much remains to be done to address the serious and varied population issues facing its member countries - especially in policy, IEC (information, education and communications) and services delivery.

3. SPAFH Needs: While SPAFH has provided some training, technical assistance, and project grants to member countries, its capacity has been limited by the staff's size and inexperience in management and technical areas. Most staff have taken short term courses since joining SPAFH, but still need more training in specialized fields of population and family planning.

SPAFH COUNTRY AND REGIONAL GRANTS

I. Matching Grants to Countries - Approved

Country	Date Approved	Type of Activity	Approved* Budget	Status
1. PNG	1/18/87	Medex Training	71,336	Completed
2. Tonga	11/18/87	AIDS Prevention	10,000	On going
3. W. Samoa	11/18/87	Curriculum for Community Nursing	8,351	Completed
4. Solomon Is.	3/2/88	Service Delivery Workers Workshop	**	Completed
5. Solomon Is.	5/2/88	Attend Contraceptive Conference	1,929	Completed
6. Solomon Is.	5/2/88	Prepare IEC Materials	11,235	On going
7. Solomon Is.	7/14/88	Pop. Policies Workshop	15,000	Completed
8. Cook Is.	8/29/88	Prepare Educ. Materials	4,000	On going
9. Fiji	4/10/89	KAP Study	5,200	On going
10. Fiji	4/11/89	2 Nurses Trained in SI	8,538	On-going
11. Vanuatu	4/11/89	2 Nurses Trained in SI	6,648	On-going
12. Vanuatu	4/15/89	Produce IEC Video tapes	1,700	Completed
13. Solomon Is.	5/8/89	TOT & educ. curriculum	75,263	On going
14. W. Samoa	9/25/89	Prepare IEC materials	10,000	Just start
15. Kiribati	9/25/89	Tng & prepare IEC	53,178	Just start
16. Tonga	10/13/89	3 in-country tng. prgm.	<u>5,269</u>	Just start
		Total	\$287,647	

II. Regional Activities - Approved

1. Regional	5/2/88	SPC Regional Census	21,419	Completed
2. Regional	N/A	Support for ILO Regional Workshop	420	Completed
3. Regional	6/1/89	Regional Contraceptive Workshop	41,517	Completed
		Total	<u>\$63,356</u>	

Total Approved Matching Grants & Regional \$351,003

* Actual costs shown for completed grants or activities.

** #4 costs included in #13 as first phase of four phase activity.

III. Matching Grants to Countries - Applications Under Review

A. Fiji	Training of f.p. motivators	12,000
B. PNG	Regional seminar on population	40,000
C. PNG	Prepare f.p. video tapes	20,000
D. Cook Is.	Workshop on family planning	17,037
E. W. Samoa	IEC - update teachers	3,000
F. Tuvalu	Workshop for nurses	<u>2,757</u>

Total \$ 94,794

21'

COUNTRIES MATCHING CONTRIBUTIONS

APPROVED GRANTS 1987-89
(US\$ 000)

COUNTRY	SPAFH GRANT	%	COUNTRY CONTRIBUTION	%	TOTAL
1. PNG	71,336	(100)	-		71,336
2. Tonga	10,000	(44)	12,788	(56)	22,788
3. W. Samoa	8,351	(100)	-		8,351
4. Solomon Is.	*		*		*
5. Solomon Is.	1,929	(100)	-		1,929
6. Solomon Is.	11,235	(48)	12,284	(52)	23,519
7. Solomon Is.	15,000	(45)	18,250	(55)	33,250
8. Cook Is.	4,000	(39)	6,162	(61)	10,162
9. Fiji	5,200	(55)	4,311	(45)	9,511
10. Fiji	8,538	(51)	8,250	(49)	16,788
11. Vanuatu	6,648	(45)	8,250	(55)	14,898
12. Vanuatu	1,700	(90)	190	(10)	1,890
13. Solomon Is.	75,263	(54)	63,157	(46)	138,420
14. W. Samoa	10,000	(52)	9,362	(48)	19,362
15. Kiribati	53,176	(49)	55,996	(51)	109,174
16. Tonga	<u>5,269</u>	<u>(38)</u>	<u>8,429</u>	<u>(62)</u>	<u>13,698</u>
Total	287,647	(58)	207,429	(42)	495,076

*Included in # 13

APPLICATIONS UNDER REVIEW

A. Fiji	12,000	(39)	18,790	(61)	30,790
B. PNG	40,000	(67)	20,000	(33)	60,000
C. PNG	20,000	(67)	10,000	(33)	30,000
D. Cook Is.	17,037	(66)	8,880	(34)	25,917
E. W. Samoa	3,000	(50)	3,055	(50)	6,055
F. Tuvalu	<u>2,757</u>	<u>(55)</u>	<u>2,285</u>	<u>(45)</u>	<u>5,042</u>
Total	94,794	(60)	63,010	(40)	157,804
GRAND TOTAL	382,441	(59)	270,439	(41)	652,880

To realize its potential as a regional policy and program catalyst, SPAFH will need to strengthen its own capabilities to plan, implement, monitor and evaluate programs and projects. This will permit it to help member countries effectively upgrade their program management systems and improve the effectiveness of national population activities.

Similar observations were contained in a December 1988 evaluation Report on SPAFH by Manoa Bale (A.I.D./RDO/Suva) and Willis Eschenbach (FSP/Solomon Islands). That report concluded that SPAFH had done "remarkably well", given its short period of existence. However, the evaluation report noted that SPAFH needed to strengthen staff competencies and design more rigorous criteria for screening and selecting projects to be supported.

SPAFH has already taken steps to address some of the issues discussed in the evaluation report. For example, SPAFH hired a trained accountant in March, 1989, as its accounting and financial management previously was primarily handled by FSP. The accountant is making changes in the accounting system recommended by an FSP-sponsored consultant in early 1989, but more help with financial management is needed. Pathfinder technical assistance was provided in November, 1989 to the SPAFH accountant who will also be going to the U.S. to take a short training course in accounting for non-profit organizations.

An intensive infusion of technical assistance and short term training during the early stage of this project should bring SPAFH's organization and management to the point where it can be a strong, positive force for addressing regional population and family planning issues.

It is important that SPAFH increase the involvement of the more effective private sector groups (profit and nonprofit) in supporting and implementing population programs. This includes providing matching grants to planned parenthood groups with sound organizations and programs. The private sector groups probably have the best resources for getting services out beyond the clinic-based delivery systems of most public health agencies.

The small size of the SPAFH staff also makes it critical for it to have access to qualified local or foreign technical specialists if SPAFH is to maintain credibility with the medical and other professionals in its cooperating countries. Additional expertise will be needed in, inter alia, population policy, data systems development and management, information and education, contraceptive services; and program/project design and management. However, there is general agreement that the SPAFH staff should remain relatively small and that more use should be made of resources available in the private sector and local institutions such as the University of the South Pacific and University of PNG, particularly during the first phase of the project.

Although it might appear that SPAFH would be a logical distribution point for contraceptive materials, the design team recommended that SPAFH not establish a logistical system or become directly involved with the logistics of contraceptives procurement. However, SPAFH could provide a useful service to its member countries by taking on a liaison or middleman role, e.g., by providing information about types, prices and sources of contraceptives; training in logistical planning and operations; reminding countries of order dates with UNFPA and other donors; and putting countries in touch with suppliers.

D. Relationship to A.I.D. Regional Assistance Strategy:

This project is closely related to the concern about high fertility rates expressed in the June 1988 Regional Development Strategy Statement (RDSS). Specifically, it supports the A.I.D. goal of creating local talents and organizational competencies needed to provide information and high quality services to those couples which desire to plan their families. By using an experienced U.S. PVO (The Pathfinder Fund) and a regional population organization (SPAFH), A.I.D. can provide assistance without the burden of trying to manage multiple assistance efforts in ten cooperating countries. This project also supports other A.I.D. assistance in health, population, and nutrition, including the recently authorized Child Survival Project in Papua New Guinea and a proposed regional project for AIDS prevention.

III. DETAILED PROJECT DESCRIPTION

A. Strategy:

1. Focus: This project will strengthen a regional organization (SPAFH) and enable it to support indigenous (national and local) population/~~family planning~~ programs with emphasis on ~~policy, IEC and services delivery~~. The project will have both a regional and a national focus and implemented in two distinct phases.

2. Phase I: This will concentrate primarily on strengthening of SPAFH (regional), but also include some activities to promote and support national efforts. The major inputs in Phase I include: (a) for SPAFH strengthening, a Pathfinder resident advisor working at the SPAFH headquarters, some short term technical assistance, and considerable training of SPAFH staff; and (b) for national activities, some regional and national workshops, and matching grants for local activities - both government and private. During Phase I, all A.I.D.-financed project inputs will be provided through Pathfinder.

The current grant to FSP has sufficient funds to finance SPAFH's operations into early 1990, but FSP is not experienced in providing technical assistance to family planning organizations. Therefore, to enable a smooth transition from between FSP and Pathfinder to be as uninterrupted as possible, a "bridge" grant was made to Pathfinder in September, 1989 to finance some needed pre-implementation technical assistance, mainly in financial management.

In the first months of Phase I, SPAFH will hold a workshop for its board of directors and staff to establish roles, priorities and strategies. The Pathfinder resident advisor will assist with the agenda preparation and discussions. The outcome should influence the first annual work plan and the allocation of inputs.

3. Benchmarks for Phase I and Evaluation: Near the end of Phase I, a formal evaluation will provide information to determine whether (a) SPAFH has made sufficient progress to become registered with A.I.D. as an indigenous PVO, thereby eligible to receive grants directly from A.I.D. and (b) the project can continue into Phase II as planned. Benchmarks or targets for accomplishment during Phase I include:

a. SPAFH is obtaining grants from non-A.I.D. sources at the rate of at least \$100,000 per year to pass on to national family planning organizations, and at least \$25,000 per year for regional and national training activities;

- b. SPAFH is registered with A.I.D. as an indigenous PVO;
- c. At least 10 percent of SPAFH's grants to countries are to NGOs rather than government organizations;
- d. SPAFH has become formally established in Tonga or another South Pacific country;
- e. SPAFH has signed country agreements with at least five member countries, including the three largest countries;
- f. SPAFH has started a roster of regional experts in family planning and population matters; and
- g. SPAFH has evaluated all completed grants to countries.

4. Phase II Focus: Assuming that SPAFH has met these benchmarks and most project funds are provided directly to SPAFH, Phase II efforts will be shifted to the national family planning activities with much reduced level of inputs directed toward SPAFH strengthening. Pathfinder's role should change to one of providing short term technical assistance, arranging training in the United States, as well as serving as a link to U.S. and broader activities in population/family planning matters.

5. Project's Priority Activities: The project will focus on helping SPAFH to provide to its member countries training, technical assistance and limited matching funds for the following:

- a. design and establishment of national population policies;
- b. improvement of population information, education and communications (IEC) activities; and
- c. improvements in the delivery of high quality modern contraceptive services.

Two weaknesses affecting the above are: (1) unreliable and out of date data bases needed to support regional and national policy and program planning; and (2) ineffective organizational systems for design, implementation and evaluation of population projects and programs. Project inputs will include attention to these.

6. Priority Countries: The project will also encourage SPAFH to continue its procedure of prioritizing country groups to avoid overextending its resources. Based on consideration of population size and/or growth rates and policies, SPAFH's current priority groupings are:

First Priority: Papua New Guinea, Solomon Islands, Vanuatu and Kiribati.

Second Priority: Fiji, Tonga, and Western Samoa.

Third Priority: Tuvalu, Cook Islands, and Niue.

Priorities may shift as some countries move faster than others.

7. Fund Raising: SPAFH, with Pathfinder's help, will make efforts during both phases to obtain funds and support from other donors for training and for grants to national family planning programs. In 1987, various donors, mainly UNDP and UNFPA, provided over \$1.5 million in population-related activities in the member countries. Although a substantial amount was for preparation of a 1990 census in the region, funds were also provided for training, IEC, policy planning, and the like.

SPAFH has already received US\$75,000 from Great Britain for development of a health education curriculum through SPC's Community Education and Training Center. Pathfinder is assisting SPAFH with preparing an application to the AIDAB for a 1990 grant. In addition, member countries provide about a 40 percent matching contribution including in-kind contributions for the grants SPAFH makes to them.

As the efforts to strengthen SPAFH progress, it is reasonable to assume that UNDP, UNFPA and bilateral donors will channel a portion of their population assistance through SPAFH. In providing this service, SPAFH should be able to charge a "management fee" for administering donors' funds. This would reduce SPAFH's dependency on A.I.D., give it greater flexibility in its program activities and eventually enable it to invite other South Pacific countries to become members, thereby becoming a wider regional organization.

To the extent that this effort is successful and SPAFH's overhead costs are shared by other donors, some A.I.D. funds that would otherwise be used for SPAFH's operating costs could be redirected to national grants, workshops, etc. The financial plan assumes that SPAFH during the life of the project would attract about \$1,000,000 in matching grants, \$270,000 for regional training activities, and \$180,000 in management fees.

8. Leverage: A.I.D.'s assistance is expected to enable SPAFH to attract increasing amounts of funds from other donors. Therefore, this one time, initial investment in SPAFH's institution building, which builds on the accomplishments of A.I.D.'s \$1.2 million investment over the last three years, should be viewed in the context of SPAFH's potential to attract and manage funds from other bilateral and international donors rather than in the more limited context of amount of project funds going

directly into national family planning activities. For the same reason, SPAFH's operating costs must be viewed in the context of its managing a portfolio of activities financed by many donors. With this in mind, the investments in strengthening SPAFH and supporting its operating costs are justified.

B. Goal and Purpose:

The project's goal is to reduce the economic burden of rapid population growth and improve maternal and child health.

The project's purpose is to increase promotion of family planning and birth spacing in the South Pacific.

C. End of Project Status (end of 5 years):

Regional:

1. SPAFH is recognized within the region and by donors as a valuable source of support for national family planning activities for its member countries.

2. SPAFH has an active fund-raising program and receives funds and support from other donors to channel to the national and local family planning organizations.

3. SPAFH receives at least 20 percent of its operational costs from sources other than A.I.D. and

4. SPAFH provides technical assistance, training, funds and other support to national and local organizations (public and private) in policy, IEC, and delivery services.

National:

1. Policies: Four countries have official population policies and at least four others are actively working to establish policies.

2. IEC: Health educators, community workers and others involved in the dissemination of information and education to the public are providing accurate information on family planning services and population issues through comprehensive IEC programs in three countries and partial programs in all other countries.

3. Service Delivery: In all countries, service delivery to clients is functioning at a more effective, efficient and enlarged level than at the start of the project. Ministries of health provide more training to their personnel in all aspects of family planning service delivery.

In all three fields, SPAFH as well as national (both public and private) family planning organizations, have available and use improved statistical data on population matters.

D. Outputs:

1. SPAFH is strengthened as an effective and responsive regional family planning organization. Some indicators that this has been achieved include:

- a. SPAFH has become registered with A.I.D. as an indigenous PVO and is receiving funds directly from A.I.D.;
- b. SPAFH is receiving funds from non-A.I.D. sources;
- c. SPAFH has effective financial controls installed;
- d. SPAFH's staff's management and administrative skills have been improved;
- e. SPAFH has installed a program management and information system;
- f. SPAFH has established linkages with U.S. and international family planning organizations; and
- g. SPAFH has established and operates an IEC resource center to promote population and family planning.

(THE FOLLOWING THREE CATAGORIES OF OUTPUTS SHOULD RESULT FROM THE EFFORTS OF A STRENGTHENED SPAFH, SUPPORTED BY PATHFINDER'S INPUTS, WORKING WITH THE MEMBER COUNTRIES ORGANIZATIONS ON BOTH A REGIONAL AND NATIONAL BASIS)

2. For population policies, the efforts of SPAFH and Pathfinder directed toward senior government decision makers and supporting technical staff should lead to the following outputs:

- a. An awareness created throughout the region of the importance and need for effective population policies;
- b. The capacity in at least eight countries to establish population policies derived from improved data base, analytical skills, etc.
- c. Improved analytic and population demographic reporting systems in at least four countries; and
- d. Two regional workshop on population policies.

3. The information, education and communications (IEC) outputs include:

a. The IEC capabilities fully institutionalized in at least three countries and some IEC capability in all other countries; and

b. At least one regional and five national workshops on IEC .

4. The family planning services delivery outputs include:

a. National guidelines and standards of practice for service delivery in at least five countries;

b. Expanded national delivery systems for contraceptives in all countries;

c. People with increased knowledge of contraceptive technology;

d. A standard reporting system on contraceptive use in at least five countries; and

e. Design and testing of new and innovative service delivery schemes to increase the accessibility of services to special groups such as youth, men, rural under-served populations, and high-risk women.

E. Inputs:

The following A.I.D.-financed inputs should be of sufficient magnitude to achieve the outputs described above:

1. Technical assistance: One resident advisor for SPAFH for a two year period plus about 10 months of short term technical assistance in such fields as the following: management systems - one month; IEC - two months; population policy - two months ; service delivery - three months; financial systems - one month; commodity logistics - one month.

2. Training: Short term training in the U.S. for all SPAFH professional staff, short term training in third countries for about five participants from national organizations (regional core trainers), and regional and national workshops and short term training programs in the region for participants from SPAFH and national organizations. See the illustrative training plan in Annex L for details.

3. SPAFH Operations: Funds to help finance SPAFH's operating costs, including salaries, office rent and utilities, supplies, travel, etc. The budget includes support for one additional person, an IEC officer, and establishment of an IEC regional resource center within SPAFH. This budget item diminishes over the life of the project as non-A.I.D. support is expected to increase.

4. Commodities: Personal computers, printers, and a limited amount of office furniture and equipment for SPAFH's headquarters for Phase I. Any need for Phase II commodities will be determined by the evaluation at the end of Phase I.

5. Country Grants: Grants to national and local family planning organizations, both government and private, to carry out family planning activities in policy development, IEC and service delivery.

In addition to these project inputs, the project will finance two formal evaluations, audits as needed, and one PSC to serve as RDO/SP's project advisor and regional population expert.

IV. IMPLEMENTATION PLAN

A. Major Implementation Actions:

1. Cooperative Grant Agreements: The project was designed by a team provided by the U.S. PVO, the Pathfinder Fund, under a cooperative grant agreement. The Pathfinder Fund was selected in May, 1989 following a limited competition process involving four U.S. PVOs. Under the collaborative assistance mode employed here, if the design work of the selected PVO was satisfactory, that PVO would be awarded without further competition a follow-on cooperative grant for implementation.

The performance of Pathfinder has been satisfactory so RDO/SP and SPAFH desire to continue the services of Pathfinder for implementation. A PIO/T will be prepared to enable the Regional Contracting Officer in Manila to enter into a cooperative grant agreement with Pathfinder for about a two and one half year period covering placement of a resident advisor in Tonga for two years.

This grant is for Phase I only. The role of Pathfinder should change by the end of Phase I, but the precise nature of Pathfinder's scope of work in Phase II cannot be realistically described now. The expectation is that at the end of Phase I, the grant with Pathfinder would be amended and extended to the end of the project to enable Pathfinder to provide the limited amount of short term technical assistance and U.S. training in Phase II.

The grant will call for Pathfinder to provide all project inputs except evaluations during Phase I. This includes funds for SPAFH to grant to national family planning organizations as well as for SPAFH's operating costs. Pathfinder will procure the limited amount of commodities under the usual procedures for small procurement, will arrange and provide funds for all training in the U.S. and third countries and provide the long term resident advisor and short term technical assistance.

It is anticipated that in Phase II, A.I.D. will enter into a cooperative grant agreement with SPAFH whereby A.I.D. will provide funds directly to SPAFH for some of its operating costs, matching grants and regional training.

2. Annual Work Plans: Within two months of arrival in Tonga, the resident advisor, in collaboration with SPAFH's Secretary General, will prepare for RDO/SP and Pathfinder approval a work plan including budget for the first year's implementation. After approval by RDO/SP, various actions that are within the scope of the approved work plan may then be carried out without further reference to RDO/SP. During the last month of the first year, the resident advisor and the Secretary General will prepare another work plan for the second year of the project for review and approval by RDO/SP.

3. Establishment of SPAFH as an International Organization: SPAFH must act to become fully established as a PVO or NGO (non-governmental organization) as soon as possible, so that it can operate with, and receive funds directly from, both public and private organizations. SPAFH is now operating under the agreements entered into by FSP. SPAFH is "provisionally registered" in the Kingdom of Tonga as a national NGO, but that country's laws do not yet provide for incorporation of regional organizations in Tonga, but do permit registration of regional organizations incorporated in other countries. Efforts are underway in Tonga to amend its law to permit incorporation of international or regional organizations..

4. Pathfinder's Legal Status: Pathfinder and SPAFH must clarify what, if anything, is required before Pathfinder can work as A.I.D.'s intermediary and enter into local agreements or contracts in the region. Unlike most project field situations, there is no basic or bilateral country agreement on economic cooperation between A.I.D. and the countries of the South Pacific and no project agreement will be signed. Such bilateral agreements and project agreements signed with countries normally cover such common legal and financial issues as duty free entry of project commodities and personal effects, tax exemption on salaries, etc.

5. SPAFH Country Agreements: The SPAFH Secretary General and the Board of Directors need to obtain signatures from authorized representatives of all member countries on the pending agreements on cooperation between SPAFH and the countries.

6. Data Bases: SPAFH should establish a statistical baseline which can be used for setting country objectives and measuring progress. This could use the data already being collected by agencies and universities on a limited number of population and family planning issues and would provide a headstart on the project's plans to improve the information bases used to assess needs and carry out activities in member countries. Such data collection should be coordinated with relevant programs of other donors and local institutions (e.g., the UNFPA-funded demographics training program at the University of the South Pacific - Suva campus).

7. Roster of Consultants: The SPAFH Board of Directors indicated that local technical experts should be used as much as possible in implementing the project and SPAFH's grants. Therefore, SPAFH should collaborate with FSP and other donor organizations to build a roster of population and family planning experts and organizations in the region which SPAFH and Pathfinder could use.

8. Evaluation of SPAFH Grants: An external evaluation should be made of the grants already provided by SPAFH to member countries. The evaluation findings and lessons learned could be discussed by all concerned parties and used in planning for new activities. Well documented case studies would be particularly useful in the management training to be conducted during the first year of the project.

B. Responsibilities:

1. SPAFH: SPAFH will provide office space, secretarial support and local, official transportation for the Pathfinder resident advisor and short term advisors provided by Pathfinder. SPAFH will also assist with any customs clearance of the personal effects of the resident advisor and visas/work permits required by the Government of Tonga.

SPAFH will assist Pathfinder in acquiring legal status in Tonga. The Secretary General, working with the country directors, will work toward obtaining country agreements (see A.5 above).

The Secretary General will collaborate with the resident advisor in the preparation of the annual work plan. He will initiate or concur in the nomination of all participants and assignments of any short term advisors by Pathfinder. He will participate fully in the work of the joint project coordinating committee.

SPAFH will be responsible for all arrangements for regional and national workshops which will be conducted under its auspices with such outside assistance as may be needed. Local organizations will work with SPAFH in the presentation of the national workshops.

The Board of Directors and the SPAFH staff will participate in a workshop in about February, 1990 on the policies, roles, priorities and strategies of SPAFH. The resident advisor will also attend. Each individual country director will assist in obtaining government approval of the country agreement with SPAFH.

SPAFH will establish two checking accounts in Tonga for the funds transferred to it from Pathfinder. One account will be for SPAFH's operating expenses and the other for the matching grants program. SPAFH's accounting system will be modified as necessary to meet Pathfinder's fiscal requirements.

Country applications for matching grants will be reviewed and approved by the SPAFH Secretariat and concurred in by the resident advisor. Matching grants over \$10,000 will also require RDO/SP written approval.

2. Pathfinder: Pathfinder will provide all project inputs during the first 2 1/2 years of the project as described in the cooperative grant agreement and other A.I.D. funded

activities. Pathfinder will account for all funds disbursed to it by A.I.D. and report on activities through quarterly progress reports in a format to be provided to its resident advisor. The progress reports, which are to be submitted to RDO/SP within 30 days after the end of each quarter, are to be prepared in a collaborative manner by the resident advisor and the SPAFH Secretariat.

Pathfinder will arrange for all participant training in accordance with the procedures of A.I.D. Handbook 10. All commodity procurement will be in accordance with A.I.D. Handbooks 13 and 15.

A coordinator or backstop officer in Pathfinder's home office will handle the usual support functions. Although the exact division of labor between the resident advisor and the backstop officer is a Pathfinder internal matter, it is not anticipated that much Pathfinder home office support will be needed. The action is in the South Pacific and institution building will be done mainly in Tonga by the resident advisor with the assistance of some short term advisors. Most training will be done in the region under SPAFH's sponsorship. Pathfinder's home office will be especially supportive in arranging the U.S. training of the SPAFH staff and identifying qualified short term consultants requested by SPAFH and the resident advisor from either its own staff or from other sources. About one trip to Tonga by the backstop officer would be useful each year or two.

3. A.I.D.: The A.I.D. Regional Development Office/South Pacific (RDO/SP) will prepare the PIO/T for the Regional Contracting Officer in Manila to use in executing the cooperative grant agreement with the Pathfinder Fund. RDO/SP will designate as Project Advisor the PSC in its Health, Population, Nutrition Office who is to be financed by the project. This individual will be a member of the joint project coordinating committee, obtain all required A.I.D. approvals which will be provided in project implementation letters (PIL), monitor the progress of the project, participate in evaluations as appropriate and otherwise be responsible to A.I.D. for project implementation.

4. Project Coordinating Committee: A joint project coordinating committee should be established as soon as possible after the resident advisor arrives in Tonga. This committee will consider planning and implementation needs and options for addressing them. The regular membership should include the RDO/SP Project Advisor, the SPAFH Secretary General and the Pathfinder resident advisor. As appropriate, representatives could be invited on an ad hoc basis from member countries, other donors or key private sector groups. The committee should meet about quarterly. As a coordinating committee, the group will have no more authority than that of its individuals. Thus any required A.I.D. formal approvals would still have to be obtained through project implementation letters or other means.

C. Implementation Schedule (initial actions):

		<u>Action Agent</u>
Nov., 1989*	ST TA to SPAFH on financial management	P.F. & SPAFH
Dec.	Project authorized.	AID/W
Dec.	Cooperative grant agreement with P.F.	RCO & P.F.
Dec.*	SPAFH accountant to P.F. for training	SPAFH & P.F.
Jan. 1990	1 Letter of credit opened for P.F.	RDO/SP
Jan.	P.F. resident advisor arrives Tonga	P.F.
Jan.	SPAFH 2nd P.O. to IHP for training	P.F.
Jan.	ST TA for IEC design/implementation	P.F.
Feb.	SPAFH board of directors & staff workshop on roles, priorities, strategy	SPAFH & P.F.
Feb.	ST TA on family planning	P.F.
March	First annual work plan prepared	P.F. & SPAFH
March	ST TA for financial mgt. (followup)	SPAFH, P.F.
March	RAPID's program regional workshop	SPAFH, P.F.
April	SPAFH 3rd P.O. to IHP for training; SPAFH General Secretary to U.S. for program management training	P.F. P.F.
June .	Contraceptive regional workshop	SPAFH, P.F.
June	Informal evaluation of progress to date	RDO/SP, SPAFH
Sept	IEC design/impl. regional workshop	SPAFH, P.F.
Jan., 1991	2nd annual work plan prepared	P.F. & SPAFH
Oct., 1991	Formal evaluation	RDO/SP
Dec., 1991	Cooperative grant agreement with SPAFH	RCO & SPAFH
Dec., 1991	New grant agreement with Pathfinder	RCO & P.F.
Jan., 1992	Pathfinder resident advisor leaves	P.F.

*Funding provided by the "bridge" grant to Pathfinder or existing FSP grant.

P.F. = The Pathfinder Fund

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V. COST ESTIMATE AND FINANCIAL PLAN

A. Cost Estimates:

1. Technical Assistance - Resident Advisor (2 years): The detailed cost breakdown is shown in Annex K. It averages about \$125,000 per year. Short term advisors (10 person months): The average monthly cost factor is \$14,000 (including salary, travel per diem, etc.) plus Pathfinder overhead of \$3,000 for a total of \$17,000/month. This is about in line with experience with other contracts.

2. Training: A standard factor for training in the U.S. is \$5,500 per month plus airfare of \$3,000. For planning purposes, most U.S. training is assumed to be of one month's duration. Details on the intra-regional training programs are in Annex L, Illustrative Training Plan. Since it is expected that other donors will provide financing for some of the training activities and some training activities will probably be combined so as to reduce costs, the cost estimates in the training plan are for the total package of training needs. The amount in this budget for training is a lump sum allocation. The national in-country training programs will be budgetted as part of the costs for that country's matching grants

3. SPAFH Operations: The costs are based on actual costs in 1989 of its operations, including present salary levels and fringe benefits of existing staff, etc. It takes into account the plan to move into larger rented office space later in 1989. It does not include any allowance for salary increases or increase in staff other than the addition of an IEC officer. The travel allowance is based on 20 trips per year within the region at an average airfare cost of \$1,500 and per diem of an average of \$107 per day and 21 days per trip.

4. Country Grants: A flat allowance of \$50,000 per year is provided for matching country grants. The amount of grants will not be the same for each country, as there is a large difference in populations (from 3,000 to 3,500,000); nor will the grants be the same on a per capita basis, as some countries are more advanced than others in their population policies and family planning practices.

5. Pathfinder Home Office Support and Overhead: The home office support is based on estimates as to what will be required to backstop the field's program and account for project funds. During Phase II, the home office effort decreases substantially as it no longer would support a resident advisor, would not be responsible for funding of SPAFH's operations or matching grants, and would not have as much training or short term advisors to arrange. The overhead rate of 23.3 percent against all costs is Pathfinder's current A.I.D.-approved rate.

6. Audits and Evaluations: This includes \$5,000 per year for an audit of SPAFH's financial records by a local public accounting firm. Funds are provided for a mid-term formal evaluation near the end of the second year and a final evaluation at the end of the project. It is assumed that the final evaluation will be a larger effort than the mid-term evaluation.

7. RDO/SP Monitoring Efforts: The project will finance the cost of one personal services contractor (PSC), a national of the South Pacific Region, to carry out the functions of a project advisor. The estimate of \$75,000 per year is based on actual contract cost experience with this PSC.

8. Inflation and Contingencies: The project budget includes funds for contingencies, but not for inflation.

9. Budget Tables: A summary budget table is at the end of this section. Detailed supporting tables are in Annex K.

10. Other Donors Contributions: The basis for these amounts is described in III, Detailed Project Description, under the section "Fund Raising."

B. Financial Plan:

1. Phase I: All project activities except audits, evaluations, and RDO/SP monitoring will be financed through a grant to the Pathfinder Fund. Pathfinder will transfer funds to SPAFH on a regular basis as needed to pay directly for operations, the regional and third country training programs and the matching grants. Pathfinder will pay directly the costs of all technical assistance and training in the U.S. Funds will be provided to Pathfinder through letters of credit issued by the Treasury Financial Communications System (LOC-TFCS), in the form of periodic advances. Pathfinder will include details of all financial transactions in its quarterly progress report to RDO/SP.

2. Phase II: It is anticipated that based on the progress made by SPAFH as verified by the mid-term evaluation, SPAFH will be receiving grant funds directly from A.I.D. in Phase II. Therefore A.I.D. will no longer have to use Pathfinder as a financial intermediary. The Phase II grant to SPAFH would include funds for some of SPAFH's operations, regional training programs and matching grants. An amendment to the Phase I grant or a new grant agreement would be executed with Pathfinder to finance Pathfinder-provided short term technical assistance and training

3. Pathfinder's Capability to Manage Funds: The Pathfinder Fund is an experienced and reputable U.S. PVO which receives millions of dollars every year from A.I.D. for overseas projects. It has an established system of accounting, auditing, program and financial management, etc. Its financial records are audited annually by a U.S. public accounting firm.

The Pathfinder Fund is a member of the Association of Private Voluntary Organization Financial Managers, and the Pathfinder's Director of Finance and Administration is on the Association's board of directors. The Association presents training workshops regularly which are attended by the Pathfinder staff.

4. SPAFH's Capabilities to Manage Funds: As a very young organization for which FSP has been managing the financial matters since its start-up, SPAFH does not yet have the capability to receive A.I.D. grant funds directly. Annex E, Administrative Analysis, describes some of the actions being taken or planned to improve SPAFH's financial management capabilities. These include the recent hiring of an Australian-trained accountant, changes in its accounting system as recently recommended by a consultant, and the planned acquisition of additional computer and software equipment. The early short term technical assistance visit by the Pathfinder Director of Internal Audit will assist SPAFH in setting up project-needed accounts and reports. With these actions, plus some planned training for the SPAFH accountant and followup visits Pathfinder and day-by-day assistance from the resident advisor, SPAFH within two years should have sufficient financial management experience and systems to receive, use, and account for A.I.D. project funds and those of other donors in a responsible and effective manner.

5. Audits and Evaluations: Pathfinder, in consultation with SPAFH and concurrence from RDO/SP, will contract for and pay directly for the annual audits of SPAFH's accounts. RDO/SP will contract directly for the two formal evaluations through purchase orders or IQC delivery orders. The cooperative grant agreement will include provisions concerning responsibilities for conducting audits. Pathfinder has standing relationships with U.S. public accounting firms which are used to audit its sub-grantees. An important objective would be to assess whether SPAFH has set up and operates accounting systems which meet professionally acceptable standards. The project is also subject to audits by the A.I.D. Inspector General's Office and the U.S. General Accounting Office.

6. RDO/SP Project Monitoring: RDO/SP will contract directly, using the PSC mode, for a regional public health specialist to serve as project advisor. Payments will be made directly using checks issued by the U.S. Regional Disbursing Officer in Bangkok.

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PROJECT BUDGET
(US\$ 000)

A.	A.I.D.		
1.	SPAFH Operations		1,140
2.	Technical Assistance		390
3.	Training		285
4.	Matching Grants		250
5.	Pathfinder Support Costs		420
6.	Audits and Evaluations		140
7.	RDO/SP Monitoring		<u>375</u>
	Sub-Total		3,000
8.	Contingency		<u>200</u>
	Total A.I.D.		3,200
B.	Countries Matching Contributions		100
	(40% of A. 4 above)		
C.	Estimated Contributions from other Donors:		
1.	Countries Grants	1,000	
2.	Training	270	
3.	SPAFH Management Fees	<u>180</u>	
			<u>1,450</u>
	Total all sources		4,750

VI. MONITORING AND EVALUATION PLANS

A. Monitoring:

The duties of the projects funded FSC project advisor will include monitoring this project as well as obtaining all A.I.D. approvals (generally through project implementation letters) and preparing all A.I.D. project documents.

Monitoring/progress reporting requirements will be specified in the cooperative grant agreement with the Pathfinder Fund. Major monitoring actions of the project advisor will include:

1. meeting with the joint project coordinating committee;
2. reviewing Pathfinder/SPAFH progress reports;
3. reviewing Pathfinder financial reports; and
4. making regular field trips to Tonga and to the other SPAFH countries to review progress of country projects.

Monitoring should be concerned with such questions as:

1. Is the implementation of the annual work plan on schedule and within budget? If not, what corrective actions should be taken?
2. Is progress of project on schedule? If not, what are the problems and who needs to act to resolve them?
4. Are there unforeseen events or obstacles which are significantly retarding progress? If so, does the work plan or cooperative agreement need to be revised to reflect these?
5. If there are special successes or breakthroughs which merit recognition or consideration for replication elsewhere, are these being properly documented and communicated?

B. Evaluations:

An informal evaluation by RDO/SP, Pathfinder and SPAFH will be made at the end of about six months after arrival of the Pathfinder resident advisor. No funds have been budgetted for this evaluation, as the small costs can come from routine operating budgets of the three organizations. This brief and informal evaluation will assess whether personal and organizational linkages have been smoothly established, funds are flowing as needed, and initial work plan activities are not seriously behind schedule.

Two formal evaluations will be made: an interim evaluation about two years after the cooperative grant agreement is signed and the final evaluation at the end of the project. These formal evaluations will examine the same types of questions outlined for monitoring, but go into more depth to assess progress and causative factors.

The interim evaluation should measure whether SPAFH has been successful in meeting its Phase I benchmarks (III above, Project Description). A critical task of the evaluation team will be to determine whether SPAFH's legal status, organization and internal management systems qualify it to operate independently and receive grants directly from A.I.D. and other sources. The evaluation should examine the nature and quality of the country grants made under SPAFH's new systems. The evaluation team would redesign the project and draft a PP supplement if necessary. Further investment in communications and other hardware would be considered at this time.

The final evaluation will provide information on program impact, particularly impact on population issues in SPAFH member countries, e.g., adoption of population policies, and family planning acceptance and continuation rates.

VII. SUMMARY OF ANALYSES

A. Technical Analysis:

1. Background: One of the increasingly serious barriers to socio-economic progress in the region is a population that is growing at a faster rate than physical, social, and other resources can accommodate. The impact is felt not only by national governments - which must finance more public infrastructure to accommodate more people (schools, health services, etc.) - but by families who are trying to make an adequate income from shrinking land parcels and other resources. Many governments are now aware of the seriousness of their population problems and seek ways of addressing them. This project will assist concerned countries in the region to analyze their particular population problems and then design and implement more effective national policies and programs to solve or mitigate them.

The project will focus: (a) on the regional level by improving the capabilities of SPAFH to help national organizations and presenting regional training activities; and (b) on the national level by providing local training under SPAFH's auspices and short term technical assistance from an improved SPAFH staff.

The project will help countries to address three common and urgent needs: (a) the formulation of a national population policy to guide action; (b) the improvement of information and education, and communication (IEC) activities to support policies and programs; and (c) the upgrading of family planning service delivery.

All three of these population activities will reinforce each other. For example, positive and specific national commitments to population policies and goals will provide more motivation to family planning workers. If these activities increase uses of effective family planning methods, that should help to bring down population growth rates over the coming years.

The regional coordinating body for A.I.D.'s inputs will be the relatively young South Pacific Alliance for Family Health (SPAFH). SPAFH will build on and expand its previous population policy work in the countries with the largest populations (Solomon Islands and New Guinea) and initiate policy work in at least two other countries.

The approach chosen responds to ideas and suggestions received during the needs assessments, discussions with other donor organizations, and the governments of the ten countries in the South Pacific region. The majority of these countries are increasingly concerned about rapid population growth and its

impact on their limited resources. Most countries in the region, including PNG, Solomon Islands, Fiji, Kiribati, Tonga, Tuvalu and the Cook Islands, have expressed an interest in creating a demand for family planning services. Virtually all are interested in increasing the motivation and competency of family planning providers. They feel these activities are crucial to the achievement of their development goals.

2. Policy: The formulation of population policy is a process involving a series of discrete activities that must ensure not only a comprehensive formulation but the implementation, monitoring and evaluation of the policy's impact. The formulation and implementation of a policy must reflect country-specific needs, priorities, and the local institutionalization and human resources which are available.

There are four phases to formulating population policy: (a) the collection, analysis and dissemination of reliable and updated information on which to base policy and planning decisions; (b) the appropriate packaging, presentation and diffusion of demographic and other data pertaining to population issues; (c) the drafting of the population policy and its approval by the top policy bodies of each nation; and (d) the implementation, monitoring and evaluation of such policy.

3. IEC: Technical work in IEC will focus on better targeting of IEC campaigns and production of better quality materials which are appropriate for the targeted groups. The improvement of family planning services must first address the prevailing problem of health providers who are not adequately trained in modern contraceptive techniques or the counseling and communications skills needed to explain such techniques to clients or potential clients.

4. Service Delivery: Family planning services are an integral part of maternal and child health services in all countries. Their relationship to decreasing infant and maternal mortality and morbidity rates is clearly understood and as a result, the ten South Pacific nations are supportive of family planning services.

A number of constraints to delivering high quality family planning services have been identified and will be addressed by this project through training of family planning service providers in supervisory positions and educators at the regional and country levels. Efforts will be made to institutionalize family planning service training in pre-service training institutions (schools of nursing, midwifery, etc.) and to improve in-service training capabilities in ministries of health. Improved management of

family planning programs will be addressed by upgrading components of management information systems to insure the data required for effective program management are available and supervisory personnel are skilled in their use.

B. Administrative Analysis:

SPAFH was created under A.I.D. auspices in 1986 and became operational in January 1987. Its organizational goals and priorities had not been completely clarified when this project was designed so its organizational competency is unproven at this point. Its board of directors is composed of senior officials from the health ministries of the ten member countries who have played a rather passive role in providing general leadership for SPAFH. This is understandable given their duties in their own countries and the travel difficulties within the region.

The chief executive officer (Secretary General), recruited from the education faculty of the University of Papua New Guinea, has been with SPAFH about one year. Two of the three program officers have had little program management experience in health or population. Consequently, there will be considerable organizational strengthening needed during the initial phase of the project. Pathfinder will play a critical role in strengthening SPAFH administrative capacity during the early stages of the project.

C. Financial Analysis:

SPAFH has received almost all of its funding from A.I.D. through grants to the Foundation for the Peoples of the South Pacific (\$1,213,477 as of September 30, 1989). Until 1989, FSP also maintained SPAFH's accounting and financial management records, so SPAFH has had little experience in managing its finances, maintaining accounts, or making financial reports. Moreover, SPAFH is not yet legally incorporated as a PVO in any member country. This, plus its lack of a financial management track record, makes it ineligible to receive funds directly from A.I.D..

Pathfinder will assist SPAFH to strengthen its financial management and seek other sources of income. Other donors have expressed interest in channeling funds through SPAFH, so its income should diversify over the life of the project. However, it is unlikely that a regional population PVO such as SPAFH will become financially independent in the near future.

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D. Economic Analysis:

As this is a social sector project and most of the major implementing organizations are government organizations, the focus is on calculating the cost-benefits of the delivered programs and arriving at a least-cost solution.

In this project, a considerable portion of the funds will be used initially for institutional strengthening and this should be seen as longer term investments in organizational or human capital. Since there is currently no regional population organization comparable to SPAFH, it is not feasible to compare its costs to those of similar institutions.

E. Social Soundness Analysis:

The project area includes ten countries and many varied language and cultural groupings, so it is difficult to generalize about the region. However, there are many more or less common beliefs about the roles of families, women, and sexual practices which will be obstacles to increased adoption of family planning practices. Large families are preferred, for social security and other reasons. Many societies stress early marriage and early and continuous production of children. This has serious health implications for mothers and children, but such problems are commonly not publicized. However, some cultures place taboos on post-partum sex and sex while the mother is breast-feeding which leads to longer intervals between births than might otherwise be the case.

There is also a preference for male children, females are socially and legally discriminated against at most stages of their life. Policy makers and family planning workers must understand the cultural mores of their communities if they are to develop acceptance of family planning programs.

There is interest in family planning at both governmental and personal levels. Some people are practicing family planning and others are receptive to family planning ideas when exposed to them. The lack of availability of contraceptive devices and information about family planning and birth spacing are major constraints to increasing the numbers of people who practice family planning.

ACTION: AIR INFO: 8483

ANNEX "A" - PID APPROVAL CABLE

700307AC072
RR RUEHTA
UH RUEHTA #6113 3231133
ZNR UUUUU ZZZ
R 121130Z NOV 88
FM SPOSTATE WASHDC
TO RUEHTA/AMEMBASSY SUVA 5329
INFO RUEEML/AMEMBASSY MANILA 5638
RUEHJA/AMEMBASSY JAKARTA 7299
BT
UNCLAS STATE 375113

LOC: 272
21 NOV 88
CH: 40275

0689

AIDAC MANILA FOR CONTROLLER, JAKARTA FOR RLA

E.O. 12958: N/A

CLASS:

SUBJECT: SOUTH PACIFIC REGIONAL: FAMILY PLANNING
PROJECT (879-0019) - PID APPROVAL

1889

REFERENCE: SUVA 4058

1. AA/ANE HEREBY APPROVES THE PROJECT IDENTIFICATION DOCUMENT (PID) FOR THE FAMILY PLANNING PROJECT. RDO/SP SHOULD PROCEED TO PREPARE A PROJECT PAPER (PP) FOR SUBMISSION TO AID/W IN ACCORDANCE WITH THE GUIDANCE BELOW.

2. A PROJECT REVIEW COMMITTEE (PRC) CHAIRED BY ACTING ANE/PD DIRECTOR JOHN TENNANT REVIEWED THE PID SEPTEMBER 29. RDO/SP HEALTH ADVISER DR. PATRICK LOWRY REPRESENTED RDO/SP. THE PRC ASKS THAT THE PP COVER THE FOLLOWING POINTS.

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3. ABSORPTIVE CAPACITY: PRC RAISED THE ISSUE OF THE ABSORPTIVE CAPACITY OF THE RELATIVELY YOUNG SPAFH TO CARRY OUT THE PROPOSED ACTIVITIES WITHIN FIVE YEARS IN THE GEOGRAPHICALLY DISPERSED AND CULTURALLY DIVERSE SOUTH PACIFIC REGION. AA/ANE ADELMAN CONSIDERS THIS AN

IMPORTANT ISSUE. IT IS ALSO IMPORTANT TO LOOK AT THE RECURRENT COSTS OF SPAFH, ESPECIALLY GIVEN POOR ECONOMIC GROWTH IN THE REGION. WHAT PERCENTAGE OF THE TOTAL SPAFH BUDGET AT PROJECT COMPLETION WILL COME FROM OUR PROJECT? HOW WILL SPAFH CONTINUE TO FUND THESE INCREASED ACTIVITIES, ESPECIALLY SINCE THE PID SAYS A NUMBER OF COUNTRIES ARE UNABLE TO FUND THEIR SHARE OF THE CORE COSTS EVEN NOW?

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THE PP SHOULD CAREFULLY EXPLORE OTHER PUBLIC AND PRIVATE FUNDING SOURCES. THE PP SHOULD ALSO ANALYZE THE INSTITUTIONAL CAPABILITY OF SPAFH TO MEET SOUTH PACIFIC COUNTRY NEEDS TO ASSURE SPAFH IS NOT OVERWHELMED. THE PROJECT SHOULD BE APPROPRIATELY PHASED WITH CLEARLY UNDERSTOOD OBJECTIVES AGREED FOR EACH COUNTRY.

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4. WOMEN'S ROLE IN SOCIETY: THE PP SHOULD EXAMINE

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ATTITUDES TOWARD WOMEN. REFTEL NOTES THIS, AND
DISCUSSION WITH DR. LOWRY SUGGESTS THAT AN
ANTHROPOLOGIST MIGHT CONTRIBUTE TO FP DESIGN IN THIS
RESPECT.

GIVEN PAST INEFFECTIVENESS OF DONOR EFFORTS IN
POPULATION/FAMILY PLANNING PROJECTS AND THE LACK OF AND
DOCUMENTABLE EFFECT ON POPULATION POLICY OR FERTILITY,
AA/ANE ABELMAN ASKS THAT THE FP INCLUDE A VERY THOROUGH
EXAMINATION OF THE REASONS FOR THIS. THE FP SHOULD HAVE
A GOOD UNDERSTANDING OF WHY PAST EFFORTS HAVE FAILED AND
WHETHER/HOW OUR ASSISTANCE CAN CHANGE ALL THIS BEFORE
GOING AHEAD.

5. OBJECTIVES BEYOND INSTITUTIONAL DEVELOPMENT. THE
PRC FELT THAT THE PROJECT SHOULD HAVE SPECIFIC OUTPUTS
IN TERMS OF GOVERNMENTAL POLICY CHANGES AND IMPROVED
SERVICES. STRENGTHENING THE SOUTH PACIFIC ALLIANCE FOR
FAMILY HEALTH (SPACE) MUST BE LINKED TO THESE
OBJECTIVES. S NOTED REFTEL, QUANTIFIABLE BENCHMARKS
FOR OUTPUTS IN SPECIFIC COUNTRIES SHOULD BE SET IN THE
FP. THE INCORPORATION OF FAMILY PLANNING IN BASIC
HEALTH SERVICES SHOULD BE AN OUTPUT WHERE POSSIBLE.

6. BUDGET IMPLICATIONS. RDO WILL HAVE TO LOOK
CAREFULLY AT BUDGET IMPLICATIONS OF THIS REAR-LOADED
ACTIVITY IN CONJUNCTION WITH OTHER BUDGET NEEDS.

7. LEARNING FROM EXPERIENCE: THE PRC ACCEPTED THAT
OTHER DONOR EFFORTS HAVE NOT ALWAYS BEEN AS EFFECTIVE AS

THEY MIGHT BE, BUT THE FP SHOULD EXPLORE WAYS TO MAKE
BETTER USE OF THEIR INPUTS. SIMILARLY, REGIONAL
ORGANIZATIONS SHOULD BE CONSIDERED POTENTIAL COOPERATORS
IN INSTITUTIONALIZING FAMILY PLANNING IN THE REGION.
GIVEN PAST INEFFECTIVENESS OF DONOR EFFORTS AND LACK OF
ANY DOCUMENTABLE EFFECT ON POPULATION POLICY OR
FERTILITY, AA RECOMMENDS THAT FP CAREFULLY EXAMINE
UNDERLYING REASONS AND HOW/WHETHER PROPOSED PROJECT CAN
REALLY MAKE A DIFFERENCE. THESE FINDINGS ARE VITAL IN
DETERMINING HOW WE SHOULD PROCEED. SHUTZ

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STATE 376110

COMMENT ON ISSUES RAISED IN P.I.D. APPROVAL CABLE
(STATE 376110, November 18, 1988)]

A. PROGRAM IMPLEMENTATION CAPACITY OF SPAFH:

Question: Does SPAFH have the organizational capacity to carry out the proposed five year project?

Response: SPAFH should be able to implement the project if the following planned project actions are taken early in the project to improve organizational effectiveness:

1. Concentrate on a few important objectives: SPAFH needs to clarify its basic organizational purpose and focus on a limited number of objectives within the population and family planning area. Stated another way, it needs to avoid trying to be a broad health agency or duplicate other programs. So, it should get out of AIDS and health education activities unless these contribute directly to population and family planning objectives. A.I.D. must also support this effort and not use SPAFH for new unrelated initiatives because it happens to be a convenient regional mechanism. Perhaps SPAFH can branch out in the future, but it should now concentrate on being a catalyst and innovator in the area of population and family planning.

The project design team urged the Board of Directors and staff to concentrate in areas where SPAFH has some comparative advantage (e.g., population policy design and implementation) and/or could serve as a catalyst to upgrade family planning information and services; e.g., building on SPAFH's June 1989 regional workshop on conceptive technologies to update national education/training and service programs. SPAFH staff subsequently worked with the design team to include such an activity in the new project.

SPAFH already has divided member countries into three priority groupings (according to population, population growth rates, and policies). This should continue to be one cost-effective approach to allocating staff time and and other resources.

2. Further strengthen SPAFH's organization and its grants management systems: SPAFH received little systematic technical guidance on getting organized and initiating its training, consulting, and grant-making activities. Its financial affairs were managed by the A.I.D. grantee (the Foundation for the Peoples of the South Pacific) and A.I.D. was to provide technical guidance. SPAFH has done well in establishing working relationships with the ten member countries and in providing grants for what is locally viewed as important needs not being addressed by other regional or international bodies. Countries receiving grants have normally put up a 40 percent matching contribution (cash or in-kind)

There is a need to provide the staff with additional technical and program management training and strengthen project/grant management systems and documentation (both in SPAFH and the member countries). There are significant training and TA inputs to achieve this during Year 1 of the new project. For the first time, SPAFH will receive technical assistance from a PVO with extensive experience in developing family planning institutions and programs (The Pathfinder Fund).

SPAFH will also need to slightly augment its professional staff through direct-hire and or contracting to give it more depth in certain areas of population and family planning (e.g., population policy, data base management, IEC, and modern contraceptive services). Only the Chief Program Officer has had extensive training in health and family planning, while the other program management staff have learned on the job or through short term training taken since joining SPAFH. However, highly specialized technical training is not considered as essential for the program staff as sound training in program and grants management systems. The program officers also have other non-health skills which are useful; e.g., rural development, training and education, and working with community organizations--including womens groups. They do need to know enough about the field to be able to relate to health and family planning specialists in the member countries.

B. REDUCING RECURRING COSTS

Question: How much of SPAFH's recurring costs will A.I.D. be paying at the end of the project?

Response: After strong program design and management capabilities exist in SPAFH and member countries, there should be more effective use of donor funds for population and family planning activities. SPAFH should also be able to diversify its income sources starting in Year 2, so that it is not so dependent on A.I.D.. It already works closely with members of the UN family and there are expressions of interest in using SPAFH to manage some of the UNFPA grants. SPAFH could use management fees to meet some of its recurring costs. Pathfinder will also help SPAFH to seek other sources of income. During the second half of the project, A.I.D. funding should shift so that a greater percentage goes for matching grants to countries and a smaller percentage goes for SPAFH's operational costs. However, SPAFH and all similar regional organizations are likely to remain heavily dependent on foreign donor support for the foreseeable future.

C. EFFECTIVENESS OF PAST DONOR PROGRAMS:

Question: Why have past donor efforts had so little impact on population policies or fertility trends? Why will the new assistance be any different?

Response: The project design team gained the impression from some country interviews that donor funds and programming procedures (including tight obligation deadlines of donors) are often more than many local ministries can effectively manage. This has sometimes resulted in the bad design of projects by (1) flying teams of outside experts who import approaches which do not fit local needs (e.g., using English language IEC posters where few people understand English) or (2) local officials who dream up projects to meet donors' funding targets (there appears to be only limited concern on both sides as to whether the resulting projects directly impact on family planning needs).

On the practical side, donors do not have adequate field staffs to cover the many small countries in the region, so controls cannot be as rigorous as desired. This is why some donor and local ministry personnel welcome the development of indigenous organizations like SPAFH as a intermediary between the various governments and the donors. The new A.I.D. project will better prepare SPAFH to become a catalyst and leader in promoting more effective projects and programs.

However, it is also recognized that some health ministries will not be so eager to give up direct management of donor funds since they have been able to finance their own priority projects and receive personal benefits associated with foreign aid.

While the preceding comments on donors have been rather negative, some joint projects have had positive effects, but not as dramatic or direct as some observers might have desired. For example, many of the donors' investments in training were critical to providing new or updating knowledge and skills, so there are competent and motivated health professionals in many national systems. These are crucial as SPAFH and others now work to add family planning and contraceptive skills to the existing health services. After slow starts, some of the population education programs of UNFPA/UNESCO are being adopted in local schools and will start affecting attitudes toward family planning and population issues during the coming years.

It is also felt that many countries now have a better understanding of their population problems and are more committed to work on them. Until recently, many of the national governments did not believe that population issues (rapid growth rates, large emigration and brain drain, high infant or child mortality rates) were serious enough to worry about. This is changing in some countries and the need for specific national population policies is recognized.

D. GOING BEYOND INSTITUTION BUILDING

Question: What will be done by the project to go beyond institution-building activities? ↓

Response: First, Pathfinder's activities to strengthen the program management systems of SPAFH and selected member countries will focus on the development of specific competencies needed to develop better national policies and action programs. Training in project design and implementation will thus be linked to specific policy efforts or service improvements to be initiated by the participants upon completion of training. In many cases, the training will also be reinforced by technical assistance for graduates back on the job.

Second, SPAFH has already moved into policy and program activities. It has, for example, worked with public officials, local NGOs and the ILO (International Labor Organization) in developing a national population policy in the Solomon Islands and in getting a commitment to move toward a policy in Papua New Guinea. There is also interest in exploring policy development in Tonga and Kiribati.

SPAFH and Pathfinder will also be giving top priority to the development and implementation of population policies under the new project. They will draw on the A.I.D.-supported RAPIDS and other activities which have been effective elsewhere in helping political leaders better understand the importance of population planning.

The project will also be concerned with increasing both the quantity and quality of family planning services. All ten SPAFH member countries have set some types of population or family planning goals in their development plans, although they often do not specify how the goals will be achieved. SPAFH's role will be to help member countries to design and implement better programs to get services out to couples which are to plan their families.

E. CULTURAL FACTORS AFFECTING FAMILY PLANNING ACCEPTANCE

Question: What are the major socio-cultural factors affecting family planning and how will these be addressed in the project? And how will attitudes toward the role of women relate to program effects.

Response: The socio-cultural analysis gives some indication of the wide variety of cultures and beliefs in the ten countries of the region. The analysis, performed by the University of the South Pacific, also gives the impression that there are more negative than positive beliefs regarding family planning, so it will be difficult to expand acceptance rates (e.g., preferences for boys, large families, young marriages, and misinformation about family planning). The project design team accepts the fact that there are many current cultural beliefs and practices which make it difficult to have an impact on fertility rates, but feels that the authors have sometimes made a more negative interpretation than is warranted.

Nonetheless, there are still many things to be done to help make family planning sufficiently widespread to have the desired impact on fertility. The project design team members who visited the Solomon Islands described some of the cultural variables as follows:

"...Women have low status, men desire large families for prestige and power, and misinformation about modern contraceptives is common. The increasing cost of living, changing values..., the growing lack of land, and the desire for children to have an education are considered factors which will eventually lead to more widespread adoption of family planning. Traditionally, birth-spacing was practiced through post-partum taboos on intercourse and prolonged breastfeeding. These practices are being quickly eroded..." (See Annex J, Program Issues and Opportunities in the Solomon Islands)

Some of the same cultural factors which place women in subordinate roles make it difficult to increase contraceptive acceptance rates. The project design team discussed these issues with women professionals in SPAFH and government health institutions and was surprised at the frequent reaction of passivity or fatalism regarding any role that they might play in trying to change some of the prevalent practices and values which disadvantage women.

Nonetheless, SPAFH during project implementation should look for opportunities to make improvements. A few of the new national constitutions at least formally provide for equal rights for women. These new provisions should be linked to population policy and implementation actions. Thus policy conferences and workshops can be used to initiate discussions on legal rights and customs which disadvantage women. SPAFH can help in encouraging policy work to address factors which impact negatively on both the role of women and the acceptance of family planning. Where appropriate SPAFH can do this in collaboration with the ILO's policy work and UNESCO's population education efforts.

In IEC programs, there is some potential for using some values which support family planning and for information programs which address some of the negative beliefs and misinformation about family planning. Special efforts are needed to involve health providers in the IEC efforts since they seem to share some of the bias that negative cultural variables are paramount (or sometimes use cultural arguments as an excuse for low levels of family planning acceptance).

In short, efforts must be made on both the demand and supply sides, so that when couples decide to practice family planning, high quality services are available. SPAFH can use training, technical assistance, and matching funds to support country projects which (1) increase the quality and availability of contraceptive services and (2) promote the IEC and Policy efforts which will increase the demand for these services.

STATUTORY CHECKLIST
REGIONAL FAMILY PLANNING PROJECT

50(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

Not applicable as this is regional project to a regional organization.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 614A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Congressional committees will be notified

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. Is project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
5. FAA Sec. 611(e). Is project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. This is a regional project.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A

9. FAA Secs. 612(b), 616(b). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. Countries receiving grants will meet a portion of costs (about 40%).
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? N/A
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other N/A

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wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A
15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A. Assistance is being provided to SPAFH through U.S. PVO as conduit for implementation.
16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? Yes
17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? ppropriation committees ill be notified.
18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). Project will not involve project agreement.

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B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548
(as interpreted by conference report
for original enactment). If
assistance is for agricultural
development activities (specifically,
any testing or breeding feasibility
study, variety improvement or
introduction, consultancy,
publication, conference, or
training), are such activities (a)
specifically and principally designed
to increase agricultural exports by
the host country to a country other
than the United States, where the
export would lead to direct
competition in that third country
with exports of a similar commodity
grown or produced in the United
States, and can the activities
reasonably be expected to cause
substantial injury to U.S. exporters
of a similar agricultural commodity;
or (b) in support of research that is
intended primarily to benefit U.S.
producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a).
Describe extent to which activity
will (a) effectively involve the poor
in development by extending access to
economy at local level, increasing
labor-intensive production and the
use of appropriate technology,
dispersing investment from cities to
small towns and rural areas, and
insuring wide participation of the
poor in the benefits of development
on a sustained basis, using
appropriate U.S. institutions;
(b) help develop cooperatives,
especially by technical assistance,
assist rural and urban poor to
themselves toward a better life,
otherwise encourage democratic
ate and local governmental

(a) Project is designed to
extend family planning
to rural and poor of
target countries.

(b) N/A

- institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.
- (c) Project supports organization established by regional countries.
- (d) Family planning benefits mainly women.
- (e) Project supports regional organization and cooperation.
- c. FAA Secs. 103, 103A, 104, 105, 106, 106-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used? Yes
- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? Yes
- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes

- g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. Project supports organiza established by government of region to meet their needs. It uses regional expertise as much as possible.
- h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No
- Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No
- Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No
- i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? No
- If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? No

- j. FAA Sec. 602(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? No. Competition used to select PVO for design and implementation using collaborative mode.
- k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? None
- l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase N/A

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production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

- n. FAA Sec. 119(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?
- o. FAA Sec. 119(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?
- p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA;

(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa;

(d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups;

(e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

- g. FY 1989 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified? N/A

2. Development Assistance Project Criteria
(Loans Only)

- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A
- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A
- c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

3. Economic Support Fund Project Criteria

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A

- b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? N/A

- c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

SC(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? No. U.S. PVO to provide all inputs.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? N/A
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

5. FAA Sec. 604(a). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) N/A
6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No
7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes. Through U.S. PVO
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes
9. FY 1989 Appropriations Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Standard cooperative grant agreement to be used.

10. FY 1989 Appropriations Act Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes

B. CONSTRUCTION

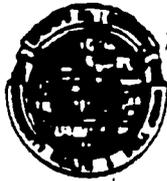
1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress? N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? Yes

3. FAA Sec. 620(b). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes
4. Will arrangements preclude use of financing:
- a. FAA Sec. 134(a); FY 1989
Appropriations Act Secs. 525, 536.
(1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion? Yes
- b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes
- c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes
- d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes
- e. FAA Sec. 662. For CIA activities? Yes

- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes
- g. FY 1989 Appropriations Act Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes
- h. FY 1989 Appropriations Act Sec. 505. To pay U.N. assessments, arrearages or dues? es
- i. FY 1989 Appropriations Act Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes
- j. FY 1989 Appropriations Act Sec. 510. To finance the export of nuclear equipment, fuel, or technology? Yes
- k. FY 1989 Appropriations Act Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes
- l. FY 1989 Appropriations Act Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes
5. FY 1989 Appropriations Act Sec. 584. Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Cooperative grant agreement will contain standard provisions on this subject



South Pacific Alliance for Family Health (SPAFH)

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Our Ref:
Your Ref:

Date:

October 27, 1989

Mr John Woods
Regional Director
Regional development Office/South Pacific
United States Agency For International Development
c/ US Embassy
P O Box 218
Suva
FIJI ISLANDS

Dear Mr Woods,

We wish to inform you that a delegation of USAID Officials ha this week presented and briefed the Sub-Committee of the Board Directors of the South Pacific Alliance For Family Health (SPAFH) the Project Proposal that the Pathfinder Fund has prepared for USAID. Together with officials we had a lively and useful session on the project document.

This Sub-Committee which was authorised by the Board to review and clarify the PP concurs with its present form. Your assistance for the next five years as contained in the PP would be greatly appreciated.

Please convey to the Government and the people of the United States our appreciation for the continued support for family planning activities in the South Pacific.

Yours sincerely,

Dr Supileo Foliaki (Tonga) -----
Chairman
SPAFH Board Of Directors

Dr John Ah Ching (Western Samoa) -----
Member
SPAFH Board of Directors

Dr Asinate Boladuadua (Fiji) -----
Member
SPAFH Board of Directors

Ms Natalie Short (Cook Islands) -----
Member
SPAFH Board of Directors

TECHNICAL ANALYSIS

I. POPULATION POLICIES*

A. Regional Conditions and Needs:

Population policy design and implementation activities under the new project will probably be initially concentrated in three or four of the South Pacific countries. Progress is already being made in the Solomon Islands and Papua New Guinea (PNG). There was interest in the Kingdom of Tonga in moving toward the preparation of a population strategy. One of the first needs in some countries will be to create better data bases on which to make decisions regarding policy and program options and assess progress against the targets which are established.

The total population of the project area is around 4.8 millions (1985), ranging from 3.3 millions in Papua New Guinea (PNG) to around three thousand in Niue. These independent nations consist mainly of small rural islands spread over 530 thousand square kilometers. There is significant cultural diversity within and among the countries. The three major main ethnic groups are Polynesians (predominant in Tuvalu, Tonga, Western Samoa, Cook Islands and Niue), Melanesians (predominant in PNG, Solomon Islands and Vanuatu) and the Micronesians in Kiribati. Fiji combines features of both the Polynesian and Melanesian cultures. There are also over 700 discrete languages which compound problems of relationships and communications.

All ten nations are faced with population problems although the nature of the problem may differ from place to place. Problems thus arise from such such factors as high fertility (the Total Fertility Rate in the Region ranges from 3 to over 7), external migration, and a dropping but still high infant mortality rate. In some areas, the result is a population growing faster than can be supported by the natural or economic resources available. The percent of population classified as rural ranges from a low of 61% in Fiji to over 89% in PNG, Solomon Islands and most of the other countries. Educational levels are generally low and economies are predominantly subsistence level, based on fishing, agriculture and animal husbandry. The main population distribution pattern is dispersed village settlements (except in Fiji and Western Samoa), hindering accessibility to basic health and educational services.

*Based on a report by Carlos Aramburu, Pathfinder Fund Regional Representative for Latin America.

After about two decades of government efforts and foreign donor assistance purportedly directed toward population/family planning problems, the conclusion is that there has been relatively little impact on population growth rates. Some of the poor results have been from poorly designed projects, many of which apparently had little to do with addressing priority population or family needs. This included donor funding of regular government health program and staffs which had little connection with providing better family planning information or services to families who needed these. Our visits suggest that some donors are still so eager to obligate money in the region that they are not asking hard questions about uses and potential impact.

In spite of the lack of past urgency and demonstrated progress, many of the governments and private nongovernmental organizations (NGOs) are increasingly aware of the grave implications of rapid population growth and are moving to formulate population policies and strengthen family planning programs. The next few years are crucial since the population problems are still manageable, but the countries and the donors must take more decisive and concentrated actions to: (1) produce and implement sound population policies and (2) increase the quantity and quality of family planning services.

A.I.D. can take advantage of the existence of a regional population/family planning NGO (SPAFH) with a good local reputation and increasing influence and acceptability to channel and focus its assistance for regional population efforts. This will help A.I.D. avoid the administrative burdens and political sensitivities involved in directly dealing with the several countries on a bilateral basis. This section outlines the strategies and program stages which might be used in carrying out population policy activities in interested countries.

B. General Policy Orientations:

Despite increasing concern on the effects of rapid population growth among most of the South Pacific nations, only the Solomon Islands have an officially approved population policy (November 1988). PNG had earlier approved steps leading to the preparation of a national policy, but the government officers involved are currently moving rather slowly because they are not sure whether there is still top level support for a policy. Nonetheless, the PNG family planning programs

apparently continues to make progress. In both countries, SPAFH support has played a key role in creating awareness on demographic trends and bringing together policy leaders and public officials, mainly from the health sector, to discuss the need for an explicit population policy. The fact that SPAFH's Board of Directors is composed of high ranking public officers from the ten countries has undoubtedly contributed to receptivity among these public opinion leaders.

Despite the lack of an explicit population policy in most of these countries, family planning services are being offered in various degrees by the national health systems. Insufficient support for family planning programs arises basically from the lack of awareness among the population of the health and socio-economic benefits that it may bring, both to their family lives and to the nation. There is very little organized opposition to family planning among the several churches in the region, provided that Natural Family Planning (NFP) methods are included in the programs.

Population policy orientations may thus be based in demographic considerations (mainly reducing the growth rate to a pace more in tune with economic growth and the expansion of basic public services) and in stressing the health and economic benefits of birth spacing and a smaller number of children for the family. The "demographic" approach seems more feasible in the larger, rapidly growing countries such as the Solomon Islands, Vanuatu and PNG; while the "health" approach is valid for all the other countries which face high fertility rates, short birth intervals and less than ideal mother and child health standards. For countries that also face large emigration rates (such as Tonga, Niue, Fiji and the Cook Islands), the population policy must also consider measures to retain their young and more qualified population. A slower population growth rate may facilitate the retention of the young and qualified since employment and educational opportunities may keep a better balance with demand. As a part of population policy, a country may mount programs to promote technical training, government subsidized scholarships, tax incentives and labor intensive investments, as well trying to close the gap between governmental and private pay scales. In fact, these kinds of efforts are being carried out in a number of countries (Tonga and Fiji among others).

C. Goals and Priorities:

As stated in the PID and in SPAFH's five year strategy, program priorities for the project will be:

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- First: Population policy designed and established.
- Second: Information, education/communication (IEC) population issues and family planning services improved.
- Third: Delivery of services improved and expanded.

Country priorities will be:

- First: PNG, Solomon Islands, Vanuatu, Kiribati.
- Second: Fiji, Tonga and Western Samoa.
- Third: Tuvalu, Cook Islands and Niue.

At the end of five years it is expected that the four first priority countries will have sound population policies in place, and two of the second priority countries, (Fiji and Tonga), will be well under way to approving an official population policy. Sound population policies mean that specific measurable goals must be stated and monitored. These will include target reductions in the growth rate and in fertility levels as well as goals on contraceptive prevalence.

D. Overall Strategy:

The formulation of a population policy is a process involving a series of discrete activities that must ensure not only a comprehensive formulation but the implementation, monitoring and evaluation of the policy's impact. The formulation and implementation of a population policy must reflect country-specific needs, priorities, and the local institutional and human resources which are available.

Pathfinder will take advantage of its long experience in population policy formulation in many areas of the developing world in working closely with SPAFH to help interested member countries. Since SPAFH is a regional organization, several policy related activities can be centralized making them more cost-effective and capable of a significant demonstration effect. There are four main phases in the formulation of a population policy. Each phase includes specific activities for which human and institutional resources must be harnessed and specific responsibilities determined.

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1. Information on Population Issues and Family Planning: The first phase of a population policy effort is the collection, analysis and dissemination of reliable and updated information on which to base policy and planning decisions. Several of the countries in the South Pacific region have had a recent census taken, but not all relevant information has been tabulated or analyzed, so wide dissemination of findings has not yet taken place. National expertise in this matter is rather limited, so Pathfinder's policy experts must provide technical assistance to SPAFH to set up a data base of demographic and health indicators. Since SPAFH's capabilities in this area are also limited, it will need to collaborate with appropriate university programs (such as the UNFA-supported demographic training programs at the University of the South Pacific in Fiji). The aim is to process and analyze basic census and survey information related to population issues and family planning, creating a data base that can be stored and handled by microcomputers with comparable information for each country. A copy of such data bases and relevant analyses will be used by SPAFH for dissemination and monitoring purposes. Wherever there are in-country capabilities, training will be supported for the use and update of such data bases.

2. Awareness Creation and Constituency Development: Data becomes information only when it is properly presented and used for policy decisions. Thus the second phase of the policy implementation process is the appropriate packaging, presentation, and diffusion of demographic and other data pertaining to population issues. This information has to reach at least two types of audiences: the policy makers and the general public. The first are important because they will be instrumental in the actual drafting and implementing of the population policy, while the second audience will provide the political support for the policy and make use of the family planning services which are part of the implementation program. SPAFH, with Pathfinder's support, will be mainly responsible for the preparation, organization and diffusion of policy relevant information through regional and national workshops and seminars.

For decision makers, the experience of The Futures Group and the Research Triangle Institute--through the Resources Applied for Population in Development (RAPID) models--can be utilized to illustrate the social and economic consequences in terms of demands on health, education and employment as result of rapid population growth. The experience of PATH-PIACT, for dissemination of population and health related issues, can be used due to their long experience in designing IE&C (information, education, and communication) activities for poorly educated populations.

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SPAFH can bring together policy makers, mainly from the public health sector, to discuss issues and current policies affecting population and family planning programs and their relationship to the formulation of national population policies.

3. Formulation of Population/Family Planning Policy: This third phase is crucial since it involves the actual drafting of the population policy and its approval by the top policy bodies of each nation. It is desirable that the population law or policy statement set specific targets (e.g., reductions in the growth rate and in fertility levels, target under-served groups in contraceptive prevalence, and, wherever pertinent, goals to decelerate external migration). SPAFH has the potential to serve as a catalyst on this task due to its regional character and previous experience in policy formulation in the Solomon Islands and in PNG.

The main activities under this phase include exposing government officials to policy alternatives and draft models of population policies in similar countries, staging study tours to countries with approved population policies (such as Indonesia where Pathfinder has and is playing a major role in forwarding the population and family planning programs), and lobbying to create the momentum required for such decision to be made. A specially favorable circumstance to stage a policy debate is when census results are being presented. SPAFH would stage high level workshops for this purpose.

4. Policy Implementation, Monitoring and Evaluation: A final phase of the policy process deals with the actual implementation, monitoring and evaluation of such policy. National bodies charged with these tasks would be organized, such as the National Population Policy Council (NPPC) in the Solomon Islands. These councils should provide a multi-sectoral support for the policy, and evaluate progress. The action arm of a national population council would be a technical secretariat or advisory unit charged with the technical aspects of monitoring and evaluation.

SPAFH, through its agreements with the regional universities, could provide training and technical assistance in the formation of such technical units. The population and family planning data base would also be managed by the technical units, allowing them to provide information to the national population council for policy improvement and steering. The national population councils would have the main responsibility for a general public awareness campaign (such as the successful campaigns carried out in Mexico). The participation of the

national statistical offices and the Ministry of Health should be obtained to guarantee a coordinated effort in the process of monitoring and evaluation.

Not all SPAFH countries have to pass through all these four stages. In the Solomon Islands, where an official population policy has recently been passed, it will be necessary to concentrate on the activities belonging to phase four. In PNG, where only a preliminary start has been made, it may be necessary to start in phase two, while in Vanuatu it may be necessary to start from phase one.

II. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

A. SPAFH Institutional Capabilities in IEC:

Of the 16 matching grants to countries funded through FSP/SPAFH to date, five are in the area of family planning IEC. One was completed in early 1989, the other four are in progress. One additional project is IEC for AIDS education while others, such as the training-of trainers (TOT) and population policy development in the Solomon Islands, contain IEC components. All family planning and the AIDS IEC projects involve the production of materials. The Health Education Division of the Ministry of Health and Medical Services in Solomon Islands is working with the Solomon Islands Planned Parenthood Association (SIPPA) and the ovulation method clinics (0 clinics) to produce posters. In Vanuatu, the video Healthy Mama, Healthy Pikinini was produced to inform about proper prenatal health practices. The MOH in the Cook Islands has utilized the FSP/SPAFH grant to produce banners for nutrition, anti-smoking, and family health campaigns.

SPAFH has designed and supported these projects on an ad-hoc basis in response to country requests and identified needs. While the IEC component (on-site, interpersonal communication) of the project to support policy development in the Solomon Islands correspond to a planned strategy with defined objectives and outcomes that could be measured, the other family planning IEC projects have been less focused. Evidence of detailed plans for the projects is lacking. Project documents, where available, state the objectives of the IEC projects to "produce IEC materials", with no further elaboration. The purpose, the audiences, the kind and the quantities of the materials have not been specified. Evaluation of the outcome/impact of the projects was not included as part of the project design. The links between the priority needs of the

country family planning programs and IEC efforts are not clear. Plans for distribution of the materials have not been thought out in advance. For example, in planning the video tape for Vanuatu Healthy Mama, Healthy Pikitini, consideration apparently was not given to the fact that there are very few video cassette players and monitors in health in Vanuatu. The SPAFH Board member from this country (also signator of the project agreement between FSP/SPAFH), was unable to identify where the video tape would be used.

SPAFH monitoring of IEC projects is weak. Progress reports from grantees are not submitted regularly and critical project implementation points where SPAFH may have provided technical input, such as prior to printing, were not defined in advance. As a consequence, SPAFH has little control over the expenditure of project funds and the quality of the final products. This lack of oversight results in the production of materials which are not closely tied to the family planning program of the country, as in the case, of the nutrition banners in the Cook Islands. In another case, even the project implementor was unable to identify which materials had been produced with SPAFH funds and what the next steps in the project were. There is little evidence that social marketing principals of audience research and pretesting were applied in the implementation of the projects. The products which were seen by the design team did not appear to reflect local cultural values.

Nevertheless, SPAFH support for IEC projects is aiding to fulfill the need for informational materials, in a region where very few on any topic exist. A 1987 needs assessment by SPAFH and discussions with countries health and planning officials led to the conclusion that population and family planning IEC is a priority program area for SPAFH. Almost every country in the region identified the lack of IEC materials in the local language(s) as a major constraint to stronger family planning development and implementation of population policies. In addition, for SPAFH to attract support from other donor agencies and enhance its credibility as a regional family planning resource, it must improve its "public relations" approach to informing potential funding sources of its institutional capabilities and the region's population and family planning needs.

There are multiple opportunities and needs for IEC activities which can support the population and family planning initiatives of the countries in the regions. In order to ensure adequate planning, implementation, and evaluation of a country and regional IEC projects and decrease dependency on a single donor, SPAFH's technical expertise in IEC needs strengthening. None of the four staff have training or a background in population and family planning IEC. SPAFH needs a staff member with technical expertise in research techniques, audience analysis, design and planning of communication strategies, materials and message design and pretesting, monitoring and evaluation.

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This expertise can be obtained through the upgrading of the skills of one of SPAFH's current staff or the hiring of an additional staff member with the required background and expertise. SPAFH's repertoire and knowledge of population and family planning IEC materials, training tools, resources, and strategies developed and implemented in countries outside the region is limited. Its current public relations efforts are limited to personal contacts and a simple newsletter.

B. Approach to Improving IEC Capabilities:

The immediate target of the IEC technical support provided by the Pathfinder Fund and its subcontractor PATH will be SPAFH's staff and SPAFH as an organization. Capabilities of personnel and programs of public and private sector institutions involved in population and family planning in the countries of the region will be strengthened through the enhanced abilities of SPAFH to assist them in the design, monitoring, and evaluation of IEC activities. The populations of the countries will benefit from the design and implementation of population policies, increased awareness of the benefits of child spacing, and the delivery of quality family planning services, which will result from SPAFH support for IEC.

Due to the large number of identified needs and opportunities in the region and SPAFH's limited technical, financial, and human resources in the area of IEC, support will focus on small-scale, discrete, innovative activities which simultaneously strengthen the capabilities of SPAFH and the priority countries of the region. SPAFH IEC efforts will build upon existing country institutions and fill in the gaps in population and family planning projects supported by other donors.

C. Regional Constraints:

1. Family planning services are not universally available. Increasing access to quality services would occur along with IEC efforts to generate demand. Likewise, logistic and commodity distribution problems exist. This will also affect the distribution of informational and educational materials.

2. The lack of country population policies contributes to the lack of support for and awareness of the importance of IEC for successful family planning programs.

3. The enormous cultural and linguistic diversity within the region (and within individual countries) practically excludes the possibility of using one country's materials, media, and/or approaches regionally or in another country, although the potential for adaptation is high.

4. The status of women, particularly in Melanesia, is extremely low. Traditional IEC approaches which aim family planning promotional messages at women of reproductive age will be ineffective.

5. There are shortage of trained health education staff to implement IEC activities.

6. Myths and rumors about family planning and contraceptives are common, even among service providers. Effectively combatting such misunderstandings is difficult.

7. In some countries, there is a lack of coordination among ministries and between governmental and non-governmental sectors involved in population and family planning.

8. SPAFH's and countries' access to current information and examples of family planning IEC and training resources is limited.

D. Regional Opportunities:

1. Most countries would like to develop family planning IEC materials. There are several proposals for such activities before SPAFH now and other countries have expressed an interest in having IEC activities.

2. There is interest in and a need for family planning counseling and person-to-person communication skills. Strengthening providers' abilities to communicate effectively with clients would improve services.

3. A variety of traditional media (song, dance, drama, custom stories) and contemporary media (video, radio, newspaper) have been used to inform and educate on topics such as nutrition, child health, and sanitation. These media can be drawn upon for disseminating population and family planning messages.

4. Few IEC efforts have been aimed at men. There is a consensus that reaching this population is critical for furthering family planning acceptability.

5. There is a need for materials which easily explain population data and the benefits of family planning to policy makers, technicians, and community leaders.

6. SPAFH staff and countries have expressed a need for up-to-date IEC and training resources.

E. Approach to IEC Activities:

The cultural complexity and diversity of the countries in the region require that IEC programs and activities be guided by an anthropological perspective. An understanding and analysis of traditional cultural values and social systems is needed for the successful introduction of family planning. Review of existing relevant research, where available, and new studies, where needed, will explore issues such as indigenous concepts and practices of birth spacing and health, adoption of 'new/Western' behaviors and technologies and the perceived benefits and disadvantages of such actions, relations between spouses and kin, and community and social networks. These activities will orient the selection of target audiences, messages, and media and ensure that the local communities' perspective is represented in IEC activities.

F. Resource Center:

The design team endorses the recommendation in the December 1988 informal evaluation that SPAFH establish an IEC Resource Center.

1. Goal: To establish SPAFH as a regional population and family planning IEC resource.
2. Purpose:
 - a. To increase the availability of family planning and population IEC materials/media/teaching and training resources to countries in the region.
 - b. To improve access to information on population issues, family planning program strategies, and contraceptive technologies for family planning programs and providers in the region.
 - c. To increase the awareness and credibility of SPAFH among the international population and family planning donor community.
3. Outputs:
 - a. SPAFH resource center that can respond to requests for information/resources from countries in the region.
 - b. A quarterly newsletter with information on SPAFH's resources/capabilities, population and family planning activities in the region, and technical updates on specific aspects of population and family planning for dissemination to regional family planning and population programs and service providers and representatives of the international family planning community.

c. A series of working documents/technical reports for dissemination to regional family planning and population programs and service providers and representatives of the international family planning community.

d. Presentations by SPAFH staff at regional/international conferences. Articles by SPAFH in international journals.

4. Inputs: a. Sample materials, books, teaching tools etc. to be provided by Pathfinder, PATH, other collaborating agencies; e.g., John Hopkins University/Population Communication Services, INTRAH, Development Associates as well as regional family planning and population agencies.

b. Funds for SPAFH subscriptions to family planning and population journals; e.g., Studies in Family Planning, People (IPPF), etc.

c. Technical assistance in establishing and maintaining a library catalog system.

d. Desk-top publishing and data base software programs.

e. Funds for printing and mailing costs.

f. Funds for a SPAFH staff member to attend one regional/international family planning conference annually.

III. FAMILY PLANNING SERVICES DELIVERY

A. Service Delivery Situation in South Pacific:

Family planning services are a part of the integrated maternal and child health (MCH) or primary health care programs in each of the ten South Pacific countries served by SPAFH. Family planning service delivery is mainly provided by the ministries/departments of health and in several countries, (Niue, Cook Islands, Tuvalu, Vanuatu and Kiribati) they are the only family planning service providers. Local FPAs in PNG, Tonga, Western Samoa, Fiji and Solomon Islands also provide family planning services. Natural family planning methods are provided in each country through the Catholic church clinics.

Family planning services are primarily provided by nurses and nurse midwives in most government facilities and FPA clinics. Physicians back up nurses when possible, however, the scarcity of physicians limits their involvement to handling contraceptive complications and the rare surgical contraception procedure. FPA and other NGO service delivery stations refer client complications

to the hospitals. PNG and Fiji private sector service providers usually handle problems in their own clinics or refer them to hospitals. The few private sector service providers in Tonga and Samoa usually refer them to hospitals or they are allowed to use hospital facilities. "O" Clinics (ovulation method) operated by the Catholic Church are also located in each country. The providers at these clinics do refer clients to other family planning clinics, if clients prefer another method.

Internal management problems, lack of systematic training of volunteers, monitoring and evaluation of programs and lack of coordination with MOH have added to the instability of the provision of services by NGO's. NGO's and PPAs have been providing family planning services for a number of years in each country. Despite the long existence of some of them, they have not been stable and efficient family planning service deliverers. Service delivery has been traditionally centered around their clinics, located in national and provincial capitals which probably limited their effectiveness because they are where everyone can see them.

The Fiji FPA in the region has had the longest history of being a stable deliver of family planning services. It has contributed to the success of Fiji's family planning efforts. SIPPA in the Solomon Islands under new leadership is becoming a strong supporter of family planning efforts. In some countries there is very little coordination of activities, sometimes causing ill feelings among MOH and FPA service delivery personnel. UNFPA and IPPF have been known to withhold funding from FPAs in Tonga, PNG, Solomon Islands and Western Samoa due to lack of accountability and reporting systems. SIPPA is the only one in the region that seems to function FPIA and World Vision have ceased to support Lifeline, a PNG family planning service delivery NGO, and which is now supported by MOH.

Many FPAs may be phasing out of service delivery and that their next focus will be on promotional work and IEC. This may also be a trend that all family planning service delivery NGOs will have to take because of the high cost of clinical operations. During the SPAFH needs assessment, both government and NGOs said that perhaps the main role of NGOs working in family planning should be in promotional activities and that they should leave the provision of services to the MOHs. Currently MOH recognizes that it is unable to provide services and do promotional activities or implement effective IEC programs. Later, when demand for services increases, NGOs may also be needed to provide services, particularly to special groups i.e. youth, and working women, etc. However, given the low contraceptive rates throughout the region, it is clear that neither NGOs nor MOH is providing adequate promotional activities through IEC programs nor adequate family planning service delivery.

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Family planning has not been actively promoted. There is a tremendous paucity of family planning service delivery IEC materials and IEC family planning promotional materials throughout the region. WHO has supported the production of IEC materials, but they are usually reproductions of WHO materials from other countries. Little pretesting of these materials if any has been done to assess applicability of the materials prior to reprinting. MOH health education units in each country are responsible for the production of materials. Left on their own to prioritize materials production, health education units have produced very little family planning materials.

A common constraint voiced by FPA, NGO and MOH is the lack of skills of service providers in counselling and interpersonal communication. Evidently, production of family planning IEC materials was not in demand because the service providers do not have the skills to use them.

Many providers have serious doubts concerning the safety of various contraceptive methods. In Vanuatu, movement by women, who found the use of injectables unsatisfactory, pressured the government to ban them. Distribution of oral contraceptives by non-medical personnel is prohibited by MOH for various reasons: fear of problems occurring from untrained service providers, lack of monitoring and evaluation of programs, poor work relationship between NGO and MOH service providers. MOH basically has not wanted lay people to deliver contraceptives other than condoms. They feel that when complications arise they are responsible. A community health worker or volunteer with experiences and training equivalent to nurses training would be qualified to be a distributor of oral contraceptives. In Fiji, Family Planning International Assistance, in a project with an NGO trained a sizeable number of community health workers with family planning service delivery and IEC skills. Despite the need for services and skills acquired by these community health workers, MOH is not comfortable in allowing the NGO to provide anything but condoms.

Commodities for all the countries are provided to MOH by WHO except for Niue, which purchases its supplies from New Zealand. IPPF provides commodities to its local affiliates. Contraceptives are provided free of charge from government and FPA clinics except for Niue and Western Samoa. Small private sectors in PNG and Fiji provide reproductive health including family planning services in all the countries. Due to logistical problems, some countries have an excess of contraceptives, while SPAFH has responded to urgent requests from four countries which had run out of oral contraceptives in the past year. Rural service providers in PNG, Cook Islands, Western Samoa, Solomon Islands and Fiji often report breakdown of supply service for family planning commodities.

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The most commonly used contraceptives in the countries are the pill and deprovera and the least common are condoms and vasectomies. However, in the last two years caused by AID Immune Deficiency Syndrome) awareness campaigns, condoms are becoming more popular throughout the region. Sterilization is not common. Some countries prohibit tubal ligation unless it is for health reasons or the woman is over 35 years old and has had four children. Vasectomy is popular in only one country, Kiribati. Service delivery personnel who attended the Contraceptive Technology Update Workshop felt that IUD would be more popular if more service providers were better informed and trained to promote and provide IUDs. A strong interest was expressed in new technologies especially Norplant. Contraceptive prevalence in the region is slightly higher in the Polynesian countries; e.g., Cook Islands 30%, Tuvalu 40%, Tonga 30.5% than in the Melanesian countries e.g. Vanuatu 16.3% with the lowest 2.6% found in PNG. The higher prevalence in Polynesian countries may be due to increased flexibility in dispensing contraceptives during the past year, because health officials have become concerned about the high rate of teenage pregnancy.

Currently long and short term training has been provided by WHO's overseas and local in-service training programs. IPPF provides training for its FPA affiliates. This training has been largely on project management and other health areas with little time spent on family planning service delivery. Selection of participants for overseas training programs has not been systematic and favoritism has been a part of the selection process. Often personnel who have received training overseas do not return to their countries particularly the Polynesian countries. Those who do return are not monitored to ensure skills are being transferred or utilized.

In-service country training programs for service providers in general have not focused on family planning. Country reports from six countries (Fiji, PNG, Vanuatu, Solomon Islands, Niue and Western Samoa) indicate that service providers lack skills to deliver services and lack of updated information on contraceptive technology.

Officials in PNG and the Solomon Islands are aware that family planning training should be fully covered in the educational curriculum of all health and community health personnel. PNG personnel feel that a family planning practicum with strong emphasis on counselling skills should also be required in the training programs for doctors and nurses. At this point, family planning is often only included in the midwifery training program. The PNG DOH training department is considering the incorporation of family planning into all training programs for its medical and community health workers.

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Accessibility of quality family planning services outside of urban areas and clinics is virtually non-existent, and many provincial communities and rural areas have little or no access to them. Various factors affect the delivery of services. Local FPAs and NGOs are constantly besieged with internal conflicts and funding problems, often disrupting activities. The MOH personnel admit that they are responsible for not making their family planning programs work better. Service delivery in rural areas and provinces is all in the hands of the nurses or nurse midwives and a full range of family planning methods is not given to clients because of lack of time, lack of confidence to provide family planning, lack of counselling skills, or lack of skills and knowledge on new contraceptive technology. In some countries, MOH officials suspect that depo provera and the pill are the most preferred method because that is the easiest for the nurse to dispense.

Countries consisting of island groups scattered over wide distances encounter common obstacles in the provision of services that other bigger land masses such as Vanuatu and the Solomon Islands face. High cost of transport to outlying islands and rural areas, poor communication systems, attrition of trained service delivery staff who do not want to stay in isolated areas, lack of support and monitoring systems cause inaccessibility of family planning services at rural and provincial community areas.

FPAs have tried use of village health auxiliaries on volunteers in CBD type projects. These have been uniformly unsuccessful to date probably due to problems that have plagued the FPAs.

All family planning programs in the South Pacific to date have been aimed at motivating women and targeting women to be the responsible partner. The goal has been to improve the health of mothers and children. However, during the the Project Design Team's visits, a strong argument from service providers and women is that women should not be the main target of family planning programs for they are not the decision makers at home (especially in the Melanesian countries). In fact, a woman in PNG cannot practice family planning without the consent of her husband. It was also argued that the aims of family planning programs should include the social and economic advantages not just the health benefits. After all, concern for the health of the mother and child only happens when they are ill. Male partners are not likely to be concerned about birth spacing when they can still see their women continue to work and take care of the children. Tuvalu, PNG, Solomon Islands and Tonga country reports state that lack of male involvement in family planning is a major constraint to family planning programs.

The impact of family planning programs in the South Pacific countries is difficult to assess because of lack of data. To date, Tonga is the only country that has conducted an assessment and analyzed its findings. (WHO/MOH 1987 KAP Survey). The country reports, together with findings from the SPAFH Needs Assessment Report, indicate that despite the support for training over the years, there is much to be done to upgrade service delivery.

Factors which support family planning service delivery include: realization by governments that national development policies are greatly affected by population issues and governments are making moves to formulate population policies. Increase in level of higher education in some countries might influence couples to seek family planning. Growth in urban population may influence the decision of couples not to have big families. Economic constraints may influence the decision of couples not to have big families. Quick acceptance of family planning methods if they are properly promoted and made popular; e.g., rapid growth of the Kiribati vasectomy program.

B. Constraints and Opportunities in Family Planning Service Delivery:

Constraint # 1: poor accessibility or availability of family planning services.

Opportunities for SPAFH:

- Explore, establish and support CBD projects.
- Provide training support for strengthening provincial and district service provider skills through training of trainers and continuing education courses similar to the one in the Solomon Islands.
- Provide supervisory training for all levels of service delivery personnel to ensure capacity for monitoring and evaluation purposes.
- Provide assistance to support systems for family planning service delivery in each country to ensure regular services and a wide range of methods are offered.

Constraint # 2: inadequate skills of service providers in counselling and IEC skills and lack of service provider skills and knowledge on contraceptive technologies.

Opportunities for SPAFH:

- Support pre-service and in-service training of service delivery personnel at national, provincial and community level to include family planning skill training in contraceptive technologies, counselling and IEC skills.

- Support skills training of a SPAFH core team of regional trainers on family planning and contraceptive technology and provide support system for them to conduct training workshops in each of the ten countries.

- Support preparation of a training manual on family planning and contraceptive technology. Coordinate and assist in use of the manual at all regional and national medical and nursing institutions. Support evaluation and updating of manual.

- Provide assistance for development of IEC materials in the ten countries and training for service delivery personnel in data collection to be used in the design and development of appropriate IEC materials, and skill training on how to use IEC materials.

Constraint # 3: cultural and religious sensitivities.

Opportunities for SPAFH:

- Support awareness raising workshops on population and family planning issues to include national, provincial and community leaders in governments, NGO's and religious groups in each country.

- Support national awareness campaigns in each country to include population and family planning issues.

- Support training workshops held at provincial and community level to include population and family planning component.

- Collaborate with other donor agencies on funding of educational programs at all levels.

- Provide support for analysis and interpretation of census data for the general public in Priority One countries and support distribution of information to be included in SPAFH IEC projects.

Constraint # 4: Lack of male involvement in family planning.

Opportunities for SPAFH:

- Support training programs in youth centers, men's clubs, YMCA , etc. to include family planning and population issues.

- Provide assistance for the design and development of family planning training programs and IEC materials specifically targeting men and youth.

- Collect data on traditionally birth spacing methods and attitudes and beliefs of men toward family planning and utilize information in designing programs for males.

- Assess Kiribati vasectomy program and design vasectomy promotion activities in the ten countries and support vasectomy projects.

- Increase skills of service providers to include men in family planning activities.

- Design and develop IEC family planning materials to include economic and social advantages in practising family planning.

Constraint # 5: lack of data base for programming purposes.

Opportunities for SPAFH:

- Support research and mini KAP surveys.

- Provide assistance for research at universities and other private agencies on traditionally family planning methods, attitudes and beliefs for utilization in program and IEC projects.

- Plan training workshops for service delivery personnel at all levels to include data collection and record keeping skills

- Develop SPAFH staff skills in design and analysis of mini KAP surveys.

- Support and collaborate with other international family planning agencies, universities, research agencies, MOH, etc. in data collection and setting up efficiency well managed accurate data bases in each country.

Constraint # 6: frequent shortages of family planning commodities.

Opportunities for SPAFH:

- include logistics training & record keeping for MOH pharmacists, service providers, supervisors in countries that regularly run out of commodities.

- Identify commodities suppliers within countries or regions so as to be able to respond to urgent needs of countries that run out of supplies as temporary backstop until logistics training has been done.

Constraint # 7: poor planning.

Opportunities for SPAFH:

- Provide training in planning programs to include population and family planning in the ten countries.

- Support training of health planners in each country to utilize data base in family planning and senior family planning service providers program planning in each country.

- Provide skill training in planning for all levels of health and service delivery personnel and to demonstrate use of data base in the ten countries.

Constraint # 8: inadequate facilities.

Opportunities for SPAFH:

- Collaborate with UNFPA and national governments and other family planning donor agencies in assessment of family planning service delivery clinics and collaborate in providing support for facilities where needed.

- Encourage governments to support maintenance of facilities and upkeep of equipment.

Constraint # 9: lack of IEC materials.

Opportunities for SPAFH:

- Support training of health education officers in all the countries to include family planning IEC materials development.

- Support design and production of IEC materials for service providers in all ten countries.

- Collaborate with other agencies in the production of family planning IEC materials for the general public.

Constraint # 10: work overload of family planning service providers.

Opportunities for SPAFH:

- Support training of community health workers to include family planning counselling IEC skills and service delivery skills.

- Support training of volunteers in counselling and IEC skills to assist service delivery personnel to promote family planning.

- Support production of videos, tapes, posters, pamphlets to be used by service providers to provide basic family planning information while clients are waiting for services.

C. Current and Future SPAFH Efforts:

1. Training: SPAFH has already started to address the need to upgrade service delivery at national and regional levels. Support for the training of service providers has been identified as an area that SPAFH will concentrate on for the next five years. SPAFH recently sponsored workshops on family planning to update knowledge on contraceptive technology and counselling skills.

In the Solomon Islands, SPAFH is supporting the new population policy by providing technical and financial assistance to the Ministry of Health and Medical Services for a training of trainers program and the preparation of a curriculum for a continuing education course for provincial and district nurses. Follow up activities to this project will be a series of "echo workshops" in the provinces to be conducted by the participants and supported by SPAFH. This will ensure that there is transfer and use of skills by those trained in the training of trainers program and will help to build up service delivery capacities.

In response to the need to strengthen skills of service providers and to fill a gap where other donor agencies are not working, SPAFH held its first regional Contraceptives Technology Update workshop in Fiji in June 1989. This is the first workshop of this kind to be held at the regional level. Two representatives (doctor and nurse) each from nine of the ten member countries attended the workshop. Four participants were selected to form a core team of regional trainers. They will receive periodic short term training overseas to develop their capabilities and to conduct service delivery training at subregional (Melanesian, Polynesian, Micronesian) and national levels and to produce a family planning service delivery training manual for the region. The aim is to institutionalize the training manual at medical and nursing schools. The other participants will be involved in collecting data for the manual, planning national programs and conducting training at the national and provincial level. The national and provincial training of family planning service providers will be followed by training of community health workers, volunteers and village health workers. They will be trained to conduct group and individual sessions to enlighten the population of the benefits of family planning services and where services are available.

2. Community Based Distribution: SPAFH will commence its plans to develop community based family planning service delivery activities in response to expressed needs to have family planning services more accessible. Priority will be given to strengthening clinical services to insure there is adequate backup referred points for community based activities. As a result, efforts will

focus on clinical services in years one and two. Introducing community based programs requires concurrence from ministries of health and other regulatory bodies in each country. A set of criteria will be developed for choosing countries for the CBD programs. These bodies will require documentation of CBD experiences elsewhere and orientation to on-going efforts to enable them to guide CBD program development. The Pathfinder Fund, which has experience throughout the world introducing and supporting on-going CBD efforts, will provide documentation on CBD experiences to SPAFH.

This information will be shared and discussed with Ministry of Health personnel and others. This will be followed by orientation visits to countries with active CBD programs. Care will be given to selecting countries with similar socio-cultural backgrounds. Two to three countries will be visited by these policy makers who will be accompanied by a member of the SPAFH program staff. Upon their return they will discuss the program and select two program officers from their country or organization to visit countries to learn about CBD programs from an operational perspective particularly training of distributors and supervisory personnel, management information systems, logistics and financing schemes. The selected Program Officers will have received training in project design from SPAFH before the study tour. The Program Officers will return and train CBD programs officers.

At least two community based family planning service projects will be funded as a result of these efforts by the end of year three, four by the end of year five. A specific strategy will be prepared in year two to identify which countries will be supported and when. The first six months of the project will involve establishing the internal systems for support, training of distributors, supervisors, etc. Services will be provided for twelve months before the project will be evaluated. In-service training will be included in each project to respond to needs identified by supervisory personnel. The evaluation will also assess project strengths and weakness. These lessons will be used in designing subsequent training activities.

Operations research will be conducted on two CBD projects with technical support from Pathfinder Fund, the AID contractor for operations research (i.e., Population Council, Columbia University, or Center for Population and Family Health) and either the University of the South Pacific or the University of Papua New Guinea. The results of this research will be used to benefit all CBD projects in the region.

ANNEX E

ADMINISTRATIVE ANALYSIS

I. INTRODUCTION

The South Pacific Alliance for Family Health (SPAFH) is a small regional PVO established in 1986 under A.I.D. auspices to promote population and family planning activities in ten South Pacific countries. A.I.D. asked the project design team to identify actions required to help SPAFH become a stronger organization, so that it can provide positive program leadership in the development and execution of regional population programs. Consequently, this paper analyzes some of SPAFH's basic legal and organizational requirements and suggests steps which can be taken to address some of its needs. Technical assistance and training will be helpful in solving some problems. Other actions are essentially the responsibility of the SPAFH Board of Directors and the Secretary General (formerly Executive Secretary).

One basic problem is that SPAFH has not been legally incorporated as a local PVO, so it essentially operates as an administrative arm of the A.I.D. grantee: the Foundation for the Peoples of the South Pacific (FSP). FSP has been the conduit for SPAFH funding and also managed almost all of its financial affairs until 1989. Therefore, SPAFH cannot receive funds directly from A.I.D. because it has no independent legal status as a PVO and it has no audited financial records to help establish its fiscal accountability.

The SPAFH management/program staff is quite small (five professionals) and only the chief program officer has had any significant experience in managing health or population activities. The Secretary General has been in office since October, 1988 and still seems to be feeling his way. The Board of Directors does not appear to have played a very active role in providing leadership or direction for SPAFH due to the time demands of their senior posts in their own countries which limit the time available for SPAFH combined with the great distances between countries and the difficulties/costs associated with regional air travel.

On the positive side, SPAFH has become generally accepted as a population assistance intermediary by its ten member countries. It has also established ties with international donors involved in health and population. It has conducted needs surveys, funded regional training workshops, and provided matching funds for country health or population projects (predominantly in the area of IEC--Information, Education, and Communication). SPAFH appears to be perceived by member countries as the funding organization which will fill in the gaps when support is not available from the international donors.

To address some of the organizational improvement needs, this project will provide assistance to SPAFH through a cooperative agreement with the Pathfinder Fund--a U.S. PVO which has extensive A.I.D.-related field experience in population and family planning. It is essential that some of the organizational and staff development issues be addressed during the early stages of project implementation. Consequently, a priority task of Pathfinder will be to provide technical assistance and training to help SPAFH improve: (1) its internal programming and management capabilities and (2) the design and impact of country projects funded through SPAFH. Some of this technical assistance is being provided under the Pathfinder "bridge" grant and some training under the existing FSP grant. A resident representative of Pathfinder will work closely with the SPAFH staff during at least the first two years to help make the needed improvements.

II. STATUS OF SPAFH

SPAFH was created in 1986 under an A.I.D. grant to the Foundation for the Peoples of the South Pacific (FSP)--a U.S. PVO. SPAFH became operational in January 1987 with headquarters in Nuku'alofa, Tonga. Under a January 1987 amendment to the Grant Agreement, A.I.D./RDO/SP (Suva) assumed responsibility for providing technical assistance to SPAFH and being "...primarily responsible for design and technical implementation of the project"; FSP was to provide "managerial and administrative oversight". From a legal viewpoint, SPAFH operates under the FSP's agreement with the Government of Tonga. SPAFH is "provisionally registered" as a PVO (charitable institution) in Tonga, but that country's laws do not currently provide for incorporation of international nonprofit organizations.

SPAFH needs to consider incorporating itself in another country and then seeking recognition in Tonga. Discussions by project design team members with the Fiji Government's registrar of records suggest that it should be relatively simple for SPAFH to incorporate as a nonprofit organization ("charitable trust") in Fiji. Registration apparently only requires that SPAFH produce a record of assets/funding, pay a F\$5.00 fee, and provide a contact address in Fiji. However, SPAFH may want to first clarify whether its status as a "charitable organization" under Fiji law would prevent it from carrying out any of its regular activities. (Reference: Laws of Fiji, Chapter 67, Charitable Trusts, Cap. 67, Ed. 1978). In any event, SPAFH needs to get incorporated somewhere so that it becomes an independent legal entity.

Another area needing clarification is the relationship between SPAFH and its member countries. Figure 1 shows the current organization and staffing of SPAFH. The members of SPAFH's Board of Directors are senior officials from the health ministries of the ten member countries and SPAFH activities in these countries are conducted under project agreements signed by ministry officials

and the Secretary General of SPAFH. SPAFH is currently trying to complete general program agreements with each member country covering such matters as local facilitation of SPAFH operations, granting of duty free status of SPAFH equipment, and legal protections for SPAFH staff. (Attachment "A" is a sample copy of the draft agreement.) At the third meeting of the SPAFH Board of Directors, June 20-23, 1989, it was reported that some of these agreements were being processed, but none had been completed.

In summary, SPAFH has no formal or legal agreement as an organization and no formal agreement with member countries covering its operations and staff in those countries. Actions to get incorporated and complete general agreements with member countries should be given top priority by the Board and the Secretary General. SPAFH should consider whether any country unwilling to complete such an agreement should be provided matching funds under the project and be allowed to participate free of charge in SPAFH's training programs.

While not strictly a legal issue, SPAFH needs to clarify its basic organization purposes and priorities and assign clearer responsibilities for achieving these. Otherwise, there will be a tendency to move into too many program areas. After its organizational directions are clarified, the SPAFH staff and the Board need to clarify their respective responsibilities and working relationships, so that they can more effectively cooperate on program implementation. The normal role of a Board of Directors is to approve general policies, help obtain the external resources and support needed by the organization, and provide oversight of the Secretary General's activities. However, the Secretary General should be authorized and encouraged to take the initiative in (a) recommending policies and annual programs for Board approval, (b) making operational decisions, and (c) providing positive supervision and direction for the staff.

III. SPAFH'S ACCOMPLISHMENTS TO DATE

Since SPAFH became operational in January 1987, it has (1) established good working relationships with most of the ten member countries, (2) conducted country needs surveys, (3) financed some training, (4) provided about US\$ 287,000 in 16 grants to fund country projects in health and population, and (5) conducted one regional workshop for key health people from the ten countries. A summary of approved and proposed grants is shown in Table 1.

SPAFH is staffed by people from within the region and is generally seen as being responsive to local needs. At present, SPAFH is the most politically acceptable and operationally active regional institution available for coordinating A.I.D. assistance for health and family planning. It is also being considered by other donors as the logical instrument for coordinating certain types of assistance for family planning programs in the region.

Working with regional groups and foreign donors (ILO, UNESCO, UNFPA), it has helped initiate population policy activities in the Solomon Islands and Papua New Guinea. In June 1989, it sponsored a two-week workshop on "Contraceptive Technology Update" for two supervisory health professionals from each of the ten member countries. The workshop graduates are supposed to follow-up with similar training in their countries.

IV. FUNDING AND FINANCIAL MANAGEMENT

SPAFH's funding comes almost entirely from the A.I.D. grant to FSP. In 1988, SPAFH received a US\$75,000 grant from the Government of Great Britain (ODA) through the initiative of the UK Fund for the Peoples of the South Pacific (FSP/UK). This grant funds the development of a health education curriculum through the South Pacific Commission's Community Education and Training Center in Suva. Some funds and in-kind contributions have also been provided by member countries for joint projects, since SPAFH reportedly requires about a 40% matching contribution. However, these contributions are not fully covered in the current financial reporting system.

Because SPAFH lacks formal status as a PVO, it is not eligible for direct assistance from A.I.D.. A.I.D. funding under this project will thus be provided through the Pathfinder Fund (under a cooperative agreement). Funds may be provided directly to SPAFH after it receives appropriate legal recognition and has achieved sufficient experience in directly managing its financial accounts. Until 1989, most of SPAFH's accounting and financial management were handled by FSP. In March 1989, SPAFH hired an Australian-trained accountant (Mr. Mun Reddy) to help install and operate appropriate accounting systems. A FSP-financed consultant, Mr. Kevin McCumber, studied SPAFH's accounting system in April-May 1989 and suggested that it revise the system to better fit its dual role as a grantee and grantor and to better accommodate its use of different currencies. SPAFH is making some of the suggested changes. Pathfinder is assisting SPAFH by providing short term technical assistance under its "bridge" grant and FSP is arranging some short term training under its existing grant. Pathfinder is also providing assistance, training and software suitable for PVO accounting and budgeting uses.

V. CURRENT ORGANIZATION AND STAFFING OF SPAFH

As suggested above, SPAFH needs to clarify its basic organizational goals and priorities and then create the organizational and staffing capacities needed to work toward these. A primary objective of this project during the first 2 1/2 years is to provide assistance through Pathfinder to strengthen SPAFH's internal organization and its program design and management capacities, so that it can attract and effectively administer funds from regional and international sources. Diversification of income is important for reducing its dependency on one donor (A.I.D.).

The professional staff are program generalists with varied backgrounds (education, rural development, public health). Only the Chief Program Officer (on secondment from the Fiji Ministry of Health) has had extensive experience or training in the health area. The current Secretary General was appointed through a competitive process in October 1988 and is now on a three year secondment from the Faculty of Education, University of Papua New Guinea. One Program Officer was recently promoted to that position after serving as SPAFH's Administrative Officer/Accountant; she has had extensive professional experience in rural development and training (including the role of women in development). The third Program Officer was recently hired through a competitive process; his last assignment was with the Red Cross in the Solomon Islands. Thus, most of the present staff have had little experience in program/project management work of the type performed by SPAFH.

The primary role of SPAFH is to provide training, technical assistance, and financial assistance to member countries. While the main operational focus should be on population and family planning, operations have also included health education and AIDS activities. Representatives of member country government agencies have commended SPAFH for its sensitivity to local needs and its ability to respond quickly, particularly in comparison to the major international donors. SPAFH's grants (ranging from US\$1,700 to US\$75,000) are commonly used by member countries to address special needs or needs not addressed by UNFPA, WHO, or bilateral donors like Australia or New Zealand. Limited technical assistance has been provided by SPAFH staff and consultants recruited from within the region. This has frequently been used to assist in the design of country programs and to assure that SPAFH-supported projects are coordinated with other population projects.

Each program officer is assigned to backstop 3-4 member countries. The program officers see themselves as generalists who need to know enough about population, family planning, and health issues to work effectively with member country specialists in these areas. However, the SPAFH Secretary General has indicated that he is interesting in hiring a medical/health specialist to provide the organization with more in-depth expertise. (note: cost for this position is not in the project budget.) It is recognized that SPAFH will need to increase its use of experienced specialists if it is to effectively provide member countries with training, technical assistance, and guidance on project design and management.

Expertise will be needed in such areas as population policy, family planning services and technologies, information and education, and program/project design and management. It may be necessary to add a few additional regular staff to handle the increasing work load. The project budget does include funds for the addition of an IEC officer and setting up an IEC reference center in SPAFH. However, since there is agreement that SPAFH should keep its direct-hire staff small, some of the needed expertise will have to be obtained through organizational and individual contracts. While priority should be given to using qualified persons available in the region, Pathfinder can also play an important role by bringing in international expertise to help in preparing local knowledge bases and human resources.

VI. PROPOSED ACTIONS FOR A.I.D., SPAFH, AND PATHFINDER

A. Clarifying Implementation Roles:

1. A.I.D.'s Changing Role: A.I.D. has played an active role in the past operations of SPAFH but it now wants to remove itself from this role. It will therefore be critical for A.I.D., Pathfinder, and SPAFH to clarify who does what and to reduce such agreements to writing to avoid future misunderstandings (particularly when new people are appointed to the three organizations). It is suggested that A.I.D. limit itself to approving the cooperative agreement, the annual workplans which would be used to implement the agreement, and the appointment of long term field staff (12 months or over). A.I.D. would naturally continue to play a role in financial oversight, progress monitoring, project evaluations, and audits. But it would not initiate purchase orders or negotiate new project matters with cooperating country personnel; it would refer such country requests for assistance to Pathfinder or SPAFH.

2. Creating Sound Pathfinder-SPAFH Relationships: Pathfinder and SPAFH need to agree on a division of labor, since there is some concern within SPAFH about whether the new A.I.D. cooperative agreement will reduce its operating autonomy which is already perceived as being too limited. There also needs to be a better delineation of responsibilities and authority between the Board of Directors and the Secretary General. At the June 1989 Board meeting, members said that they were unclear about their responsibilities and authorities vis-a-vis A.I.D., FSP, and the SPAFH Secretary General.

Within the Secretariat, there likewise needs to be a better definition of responsibilities and authorities for all staff members. This is especially crucial when the Secretary General is out of country and someone is expected to act in his behalf. SPAFH's relationships with the member countries also need to be clarified, including SPAFH's role in working with both private and governmental groups. Up to now, SPAFH has provided no grants to private family planning organizations or regularly involved them in SPAFH training or other activities.

3. Using a Strategy Workshop to Clarify Directions: One way to work on clarifying goals and division of labor for the various organizations is to run a workshop on organization, goals and strategy using experienced management consultants as facilitators. Pathfinder could draw upon its network and use organizational specialists from such organizations as Management Sciences for Health, Development Associates, or the American Management Associations. Local management talent might also be used in this exercise. The end product should be written agreements on goals and priorities and who does what in achieving them. The workshop and pre-workshop activities will probably not address all the issues, but it can provide a system for continuing to work on them. After organizational directions are clarified, specific training to further upgrade the staff's management and technical skills will also be important.

B. Priority Technical Assistance and Training Needs:

1. SPAFH's Internal Management Systems: After clarification of the program goals and priorities and the responsibility for implementing these, attention should be focused on improving SPAFH's systems for (a) financial management (building on appropriate recommendations in the above-mentioned consultancy report by Kevin McCumber) and (b) project identification, design, financing, monitoring, reporting, and evaluating. Again, one way to approach the second need is to run a two week workshop on project/grants management using the same types of external management training resources mentioned above. The project management workshop should also include staff from selected member countries. The workshop should use completed, ongoing, or proposed SPAFH-funded projects as case materials.

The Secretary General visited Pathfinder's home office and A.I.D./Washington in August, 1989 to become familiar with operating systems and resources which may be tapped for regional programs.

2. Support for Improving Country Programs: SPAFH and Pathfinder need to review the results of past projects and various program planning exercises to identify how SPAFH can best support country programs in population and family planning. Following are some areas where SPAFH can have a positive impact. Again, many of these can be approached through a combination of technical assistance and training. After good action plans are developed, then matching grants might be provided under the project for:

(a) Formulating and implementing national population policies.

(b) Designing and maintaining data management systems to support policy and program/project design and implementation in SPAFH and appropriate member countries. This could be done in cooperation with the UNFPA-supported demography training program at the University of the South Pacific (Suva).

(c) Upgrading population information and education programs and materials (perhaps with initial priority placed on targeting youth and men in some countries).

(d) improving the quality and accessibility of family planning services in member countries through training, technical assistance, and other support; and

(e) developing effective program/project management systems in member countries through training and other assistance which builds on the project management training discussed above.

VII. COLLABORATION WITH OTHER INTERNATIONAL PROGRAMS

SPAFH has already been working with members of the United Nations donor family and has received a grant from the U.K. At AIDAB's request, SPAFH is preparing a proposal for a 1990 grant from the AIDAB. There are also apparently close relationships between SPAFH staff and the IPPF regional representative.

During the preparation of this project paper, proposals for collaboration were received from the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) and the International Planned Parenthood Federation (IPPF) in London. The JHPIEGO Corporation proposed a \$478,476 training program in reproductive health for SPAFH staff members (presumably to be funded by A.I.D.). The project design team felt that the training was targeted on the wrong group, since the SPAFH staff are not health specialists and probably will not become training specialists in reproductive health. However, this type of training may be appropriate for government health trainers or university staff, but it should be available at a lower cost. Consequently, such proposals could be considered later after Pathfinder and SPAFH have initiated project implementation and reviewed the current training needs of country programs.

The IPPF five year project proposal is being sent to donors to attract funds (\$2.47 million) for supporting family planning associations through PIPPA--the Pacific Islands Planned Parenthood Affiliation. PIPPA would apparently become the regional arm of IPPF, so some country associations are reportedly not eager to endorse it because they would lose their direct link to IPPF headquarters in London. PIPPA is still in a formative stage and it is not clear how SPAFH and PIPPA would work together. The project design team did recommend that SPAFH work closer with those local family planning associations which are effective.

VIII. EXPECTED OUTPUTS

By the middle of Year 3, SPAFH should have an effective organizational structure and management system in place which is producing good projects in most of the ten cooperating countries. Progress would be measured by such things as:

1. A clear written statement of basic goals and priorities for SPAFH which is accepted by all member countries and supporters (such as financiers and donors). This should limit SPAFH's involvement to population and family planning issues and within these to areas where it can play a role as innovator and catalyst. SPAFH currently has the potential to serve as a source of support to (a) produce better national population policies and implementing programs and (b) raise the quality of information and services provided by national programs to families desiring to plan their families.

SPAFH should normally not get involved in the provision of such services or the contraceptive commodities needed to support them since other donors have this responsibility. However, SPAFH could serve as a catalyst to bring together the donors and member countries to discuss ways of improving logistical systems.

2. Excellent project management/grants systems in SPAFH and member countries which are producing innovative and high quality family planning policies and projects in member countries. This means that SPAFH should have effectively assisted local family planning organizations to develop the ability to (a) plan and implement projects and (b) attract funds.

3. A competent and motivated SPAFH staff/consultant team which works well with its Board and clients in the cooperating countries. This will require a system of staff recruitment, reward, and retention to prevent the loss of competent people.

4. SPAFH receiving funds from member countries and new donors, but not taking on so many new projects that its small staff is overextended.

5. A SPAFH data base and management information system which will provide current information on population issues and program impact in the region. This could be achieved through a contract with a local university which has skills in demography and data collection and management.

SPAFH COUNTRY AND REGIONAL GRANTS

I. Matching Grants to Countries - Approved

Country	Date Approved	Type of Activity	Approved* Budget	Status
1. PNG	1/18/87	Medex Training	71,336	Completed
2. Tonga	11/18/87	AIDS Prevention	10,000	On going
3. W. Samoa	11/18/87	Curriculum for Community Nursing	8,351	Completed
4. Solomon Is.	3/2/88	Service Delivery Workers Workshop	**	Completed
5. Solomon Is.	5/2/88	Attend Contraceptive Conference	1,929	Completed
6. Solomon Is.	5/2/88	Prepare IEC Materials	11,235	On going
7. Solomon Is.	7/14/88	Pop. Policies Workshop	15,000	Completed
8. Cook Is.	8/29/88	Prepare Educ. Materials	4,000	On going
9. Fiji	4/10/89	KAP Study	5,200	On going
10. Fiji	4/11/89	2 Nurses Trained in SI	8,538	On-going
11. Vanuatu	4/11/89	2 Nurses Trained in SI	6,648	On-going
12. Vanuatu	4/15/89	Produce IEC Video tapes	1,700	Completed
13. Solomon Is.	5/8/89	TOT & educ. curriculum	75,263	On going
14. W. Samoa	9/25/89	Prepare IEC materials	10,000	Just start
15. Kiribati	9/25/89	Tng & prepare IEC	53,178	Just start
16. Tonga	10/13/89	3 in-country tng. prgm.	5,269	Just start
		Total	\$287,647	

II. Regional Activities - Approved

1. Regional	5/2/88	SPC Regional Census	21,419	Completed
2. Regional	N/A	Support for ILO Regional Workshop	420	Completed
3. Regional	6/1/89	Regional Contraceptive Workshop	41,517	Completed
		Total	\$63,356	

Total Approved Matching Grants & Regional \$351,003

* Actual costs shown for completed grants or activities.

** #4 costs included in #13 as first phase of four phase activity.

III. Matching Grants to Countries - Applications Under Review

A. Fiji	Training of f.p. motivators	12,000
B. PNG	Regional seminar on population	40,000
C. PNG	Prepare f.p. video tapes	20,000
D. Cook Is.	Workshop on family planning	17,037
E. W. Samoa	IEC - update teachers	3,000
F. Tuvalu	Workshop for nurses	2,757
	Total	\$ 94,794

COUNTRIES MATCHING CONTRIBUTIONS

APPROVED GRANTS
(US\$ 000)

COUNTRY	SPAFH GRANT	%	COUNTRY CONTRIBUTION	%	TOTAL
1. PNG	71,336	(100)	-		71,336
2. Tonga	10,000	(44)	12,788	(56)	22,788
3. W. Samoa	8,351	(100)	-		8,351
4. Solomon Is.	*		*		*
5. Solomon Is.	1,929	(100)	-		1,929
6. Solomon Is.	11,235	(48)	12,284	(52)	23,519
7. Solomon Is.	15,000	(45)	18,250	(55)	33,250
8. Cook Is.	4,000	(39)	6,162	(61)	10,162
9. Fiji	5,200	(55)	4,311	(45)	9,511
10. Fiji	8,538	(51)	8,250	(49)	16,788
11. Vanuatu	6,648	(45)	8,250	(55)	14,898
12. Vanuatu	1,700	(90)	190	(10)	1,890
13. Solomon Is.	75,263	(54)	63,157	(46)	138,420
14. W. Samoa	10,000	(52)	9,362	(48)	19,362
15. Kiribati	53,176	(49)	55,996	(51)	109,174
16. Tonga	<u>5,269</u>	<u>(38)</u>	<u>8,429</u>	<u>(62)</u>	<u>13,698</u>
Total	287,647	(58)	207,429	(42)	495,076

*Included in # 13

APPLICATIONS UNDER REVIEW

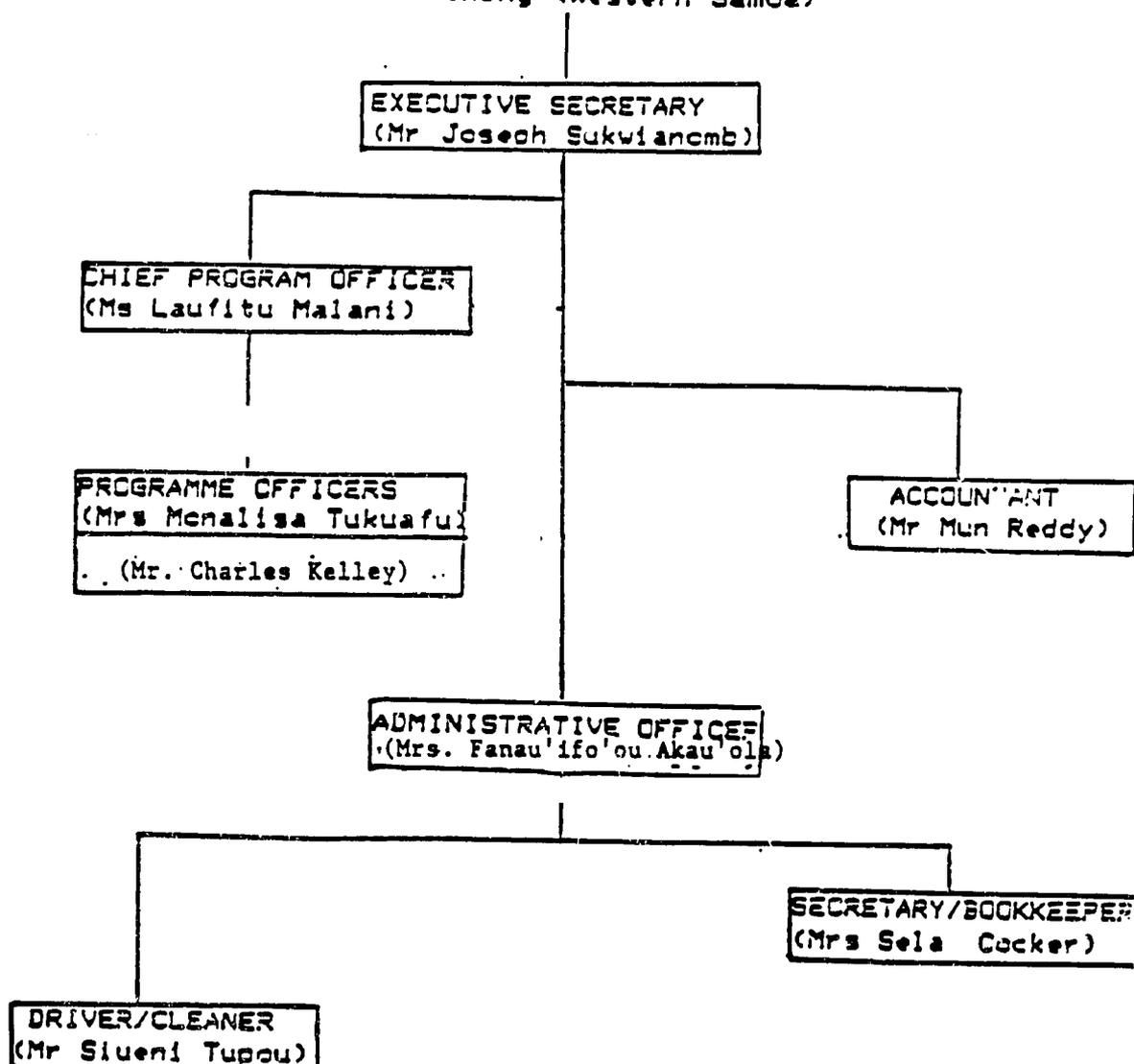
A. Fiji	12,000		18,790		30,790
B. PNG	40,000		20,000		60,000
C. PNG	20,000		10,000		30,000
D. Cook Is.	17,037		8,880		25,917
E. W. Samoa	3,000		3,055		6,055
F. Tuvalu	<u>2,757</u>		<u>2,285</u>		<u>5,042</u>
Total	94,794	(60)	63,010	(40)	157,804
GRAND TOTAL	382,441	(59)	270,439	(41)	652,880

FIGURE 1

SPAFH ORGANISATIONAL CHART
PATRON: HIS MAJESTY KING TAUFA'AHAU TUPOU IV

BOARD OF DIRECTORS

- Dr T Teariki (Cook Islands)
- Dr A Boladuadua (Fiji)
- Dr T Taitai (Kiribati)
- Dr A Mitukulena (Niue)
- Dr D Johns (Papua New Guinea)
- Mr A Lovi (Solomon Islands)
- Dr S Foliaki (Tonga, Board Chairman)
- Dr F Salesa (Tuvalu)
- Dr T Vocor (Vanuatu)
- Dr J Ah Ching (Western Samoa)



OPERATIONAL AGREEMENT BETWEEN THE GOVERNMENT OF COOK ISLANDS
AND THE
SOUTH PACIFIC ALLIANCE FOR FAMILY HEALTH

ARTICLE I:

The Government of Cook Islands welcomes the proposal which the South Pacific Alliance for Family Health (SPAFH) has put forward to establish formal relationship in order for the latter to provide "Family Planning/Family Health Assistance Programme" in accordance with the(refer to Development Plan, other documents, and meetings that have major issues of concern directly related to maternal and child health care)

The SPAFH proposes to assist through its program:

1. Support of family planning/family health programs and manpower development in coordination with the health policies and objectives of the Ministry of Health as expressed in various.....(eg. Cook Islands National Development Plans and Strategies)
2. Provision of technical and financial assistance to approved government departments and established non-governmental organisations for family planning/family health projects in accordance with the goals of the(eg. Ministry of Health, including the most important areas of maternal and child health concern reflected in the aforementioned Reports)
3. Assistance for training of personnel in health management and service deliver systems in accordance with the(eg. objectives of the future Government decision on Population Policy and Implementation)

ARTICLE II:

The South Pacific Alliance for Family Health shall consult with the Government of Cook Islands and keep it informed of its major areas of programming interest and its project activities.

- A. The details of future SPAFH assistance programs to Cook Islands shall be laid down in separate Agreements which shall be entered into between SPAFH on the one hand, and the Government of Cook Islands agencies or non-government organisations, institutions, or associations on the other hand.

- B. Such assistance shall derive in the first instance from programs and project discussions between SPAFH and potential grantees, but review and approval by the Government of Cook Islands shall be required through the AID Co-ordinating Committee, some other body or agency or the relevant government Ministries as appropriate and as agreed upon between SPAFH and the Government of Cook Islands prior to any grant Agreement being entered into or any project implementation work being undertake.

ARTICLE III:

The Government of Cook Islands shall:

- A. Permit the dispatch to Cook Islands of staff members of the South Pacific Alliance for Family Health in order to facilitate the implementation of this Agreement and to enable them to enter or leave Cook Islands at any time, grant them gratis, work and other permits as required, and to provide similar assistance to technical experts and other contract personal as may be required for implementation of the activities within the framework of this agreement.
- Provided that for any foreign (regional) staff members involved in a court proceedings, his right to leave Cook Islands shall be subject to the consent of that court with such conditions as the court deems appropriate.
- Provided also that it is understood that such staff member is immune from suit and legal process in respect of things done or omitted to be done in the course of performance of official SPAFH duties.
- B. Exempt the SPAFH foreign (regional) staff members, including Cook Island nationals who are employed on regional positions, or technical experts and contract personnel from taxes on their income.
- C. Exempt bond requirements from certain qualified and experienced Cook Island nationals by the Government of Cook Islands in order for them to work for SPAFH for a term of contractvd period.
- D. Exempt the personal and household effects of the SPAFH foreign staff, technical experts and contract personnel from import and export duties and port and service tax within the first six months of the staff members arrival.
- E. Exempt equipment, supplies and a motor vehicle required for office purposes from import and export duties, port and service tax and sales of such goods.

F. Exempt the articles supplied by or on behalf of SPAFH from import and export duties, port and service tax, providing if these are sold in the Cook Islands at any time full duties must be paid, on the value at date of sales of such goods.

G. Technical experts and contract personnel will be assisted by the Cook Island authorities in the performance of their tasks and in the implementation of this Agreement, and that the Cook Island authorities will provide adequate protection for their persons and property.

H. Exempt donations of funds or equipment for office and project purposes from income tax, import and export duties, port and services tax and sales tax.

--- If any of the above goods are sold in the Cook Islands at any time, full duties must be paid by the individual or SPAFH on the value at date of sale of such goods.

ARTICLE IV:

This Agreement shall enter into force on the date of signature hereon.

ARTICLE V:

This Agreement may be terminated by either Party by written notice at least six months in advance of such termination.

FOR THE GOVERNMENT OF COOK ISLANDS:

.....
(Signature)

.....
(Place)

.....
(Date)

FOR THE SOUTH PACIFIC ALLIANCE FOR FAMILY HEALTH:

.....
(Signature)

.....
(Place)

.....
(Date)

FINANCIAL ANALYSIS

I. GENERAL FINANCIAL MANAGEMENT OBJECTIVES

This project continues A.I.D. financial support to population and family planning policy and program activities in ten cooperating countries in the South Pacific Region. The primary organization for channeling assistance to the countries will be the South Pacific Alliance For Family Health (SPAFH).

Until early 1989, most of SPAFH's financial management and accounting systems were managed by FSP. In March 1989, SPAFH hired its own professionally trained accountant and FSP then brought in a short term U.S. consultant to make suggestions on the organization of SPAFH's accounts. A basic objective of this project is to help SPAFH become more financially independent by strengthening its program and financial capabilities. For these purposes, technical assistance and financial support will be provided to SPAFH and member countries through a cooperative agreement between A.I.D. and The Pathfinder Fund.

Pathfinder is familiar with A.I.D. financial regulations and can assist the SPAFH staff to understand these. Pathfinder also has contractual arrangements with U.S. CPA (Certified Public Accounting) firms which operate in the region, so this can facilitate the completion of necessary audits. An intensive infusion of technical assistance and short term training during the early stage of the project should bring SPAFH's management and financial/accounting systems to the point where it can qualify for direct assistance from A.I.D. and other donors.

The Pathfinder Fund will also assist SPAFH to actively pursue funding from non-A.I.D. sources. However, the project design team was told by country contacts that there may be more funds available from donors than can be effectively programmed under the current deadlines and systems of donors. Consequently, SPAFH should be discouraged from pursuing large grants from other donors until it builds up its internal management capabilities.

While SPAFH has provided some training, technical assistance, and project grants to member countries, its capacity has been limited by both staff size (3-4 professionals) and the limited training of some program staff in management and technical areas. Most staff have taken short term courses since joining SPAFH, but still feel that they need more training in certain areas of population and family planning.

Consequently, during the first year of the project, Pathfinder will provide considerable short term TA and training, including personalized assistance for the SPAFH accountant. SPAFH needs such assistance to strengthen its financial management and grant management systems, both for the funds it dispenses to member countries and those it receives. Sound program and financial management systems will be important factors in attracting additional sources of income and reducing SPAFH's current dependence on a single donor.

II. ASSESSING SPAFH'S FINANCIAL VIABILITY

A. SPAFH's Potential for Increasing Its Income:

This project will fund population and family planning programs in ten countries and most activities will probably be carried out by government agencies as part of their national economic development or social services programs. The primary investors in population programs in the South Pacific Region will probably continue to be national governments and international donors. While the private sector is expected to play a larger role over time, such participation is likely to be relatively small in financial terms.

SPAFH's matching grants to member countries (mostly government but some to private organizations) for country projects have been supported by about \$200,000 in matching funds as cash or in-kind contributions from member countries. However, it is unlikely that the member governments will be able to fund a significant share of SPAFH's administrative costs in the near future. In short, SPAFH's ability to earn profit or other income is now somewhat limited. Special efforts will be made by Pathfinder and A.I.D. to seek other income sources including the charging of reasonable administrative fees for coordinating grants from other donors. One objective of these efforts will be to reduce the percentage of administrative costs paid from A.I.D. funds.

B. SPAFH's Current Funding and Expenditure Levels:

SPAFH has received almost all of its income from A.I.D. through a grant to the Foundation for the People of the South Pacific (FSP). That grant budget totals US\$ 1,213,477 for the period January 1, 1987 through March 30, 1989 (39 months). The budget is divided into three major categories:

SPAFH Admin. & Activities	657,875	(54%)
Grants to Country Programs*	345,739	(29%)
FSP Costs/Fees	209,863	(17%)

*Includes some regional programs.

SPAFH had expended 75% of its operating budget and 66% of the country program matching grants to countries as of September 30, 1989:

	Budget (39 mos.)	Expended (33 mos.)
SPAFH Admin. & Activities ...	\$ 657,875 (54%)	\$491,647 (75%)
Grants to Country Programs...	345,739 (29%)	\$228,316 (66%)

However, the infusion of funds by A.I.D. was relatively heavy during the last budget year. Two large country grants were approved in the last few months and several other applications are under review by the SPAFH staff and may be committed during the coming months if funds are available.

There are sufficient funds in the existing grant to FSP to finance SPAFH's administrative costs and some training for SPAFH's staff through March, 1990. The "bridge" grant to Pathfinder will fund the initial technical assistance, some commodities and some SPAFH administrative costs until the new project and grant to Pathfinder is in place.

It was difficult for the design team to make judgments on whether SPAFH's internal costs are within acceptable limits for an organization of its kind. They appear high as a share of total budget, but contacts advise the team that individual line items do not appear excessive in comparison with other regional organizations. Regional staff normally receive higher salaries and benefits (such as relocation/housing allowances) than national public agencies. Travel and per diem costs are necessarily a significant budget item because the member countries are located so far apart and airfares are not inexpensive.

Rental and staff costs will increase in FY 1990. SPAFH in September, 1989 leased larger quarters near the current office location in Nuku-alofa, Tonga. The organization's old office space was rather small, particularly when all of the 8-person staff were at home base. The larger space is necessary since SPAFH may need to hire/contract a few more full-time/part-time professional staff and it is essential for the Pathfinder residential representative to be in the SPAFH office.

III. CONCLUSIONS

SPAFH should be viewed as a nonprofit PVO which acts as an intermediary for A.I.D. in channeling population and family planning assistance to ten cooperating countries in the region. SPAFH is likely to remain heavily dependent on funding from A.I.D. and other donors during the life of the project. However, efforts

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should be taken to attract income from other donors and private sources to reduce the organization's almost complete reliance on A.I.D.. One of the most likely source of income may be "fees" charged for administering specific population programs for other donors. The technical assistance and training provided through Pathfinder will help SPAFH attract such resources by upgrading its (1) internal organization and operation, (2) systems for designing and managing programs/grants, and (3) accounting and financial procedures and reports.

SPAFH and Pathfinder also need to continuously review and monitor administrative costs to keep these as low as possible, consistent with achieving project objectives. Some of the budget items now shown as overhead or administrative costs might be treated as part of the funding for "matching grants" (e.g., staff's travel and per diem to help countries on joint projects).

Attachment: List of FSP Grant Agreement and Amendments

Attachment to Annex F

FSP GRANT AGREEMENT AND AMENDMENTS

- Sept. 30, 1986 - Original grant 879-0001-G-SS-6026-00 to FSP for \$446,000 for "the development of a regional family health federation. PACD Sept. 29, 1988.
- Jan. 13, 1987 - Amendment No. 1 revised the budget and FSP's responsibilities. Added that RDO/SP would provide TA and be primarily responsible for design and technical implementation.
- Sept. 8, 1987 - Amendment No. 2 added \$90,701 (total \$536,701).
- Sept. 18, 1987 - Amendment No. 3 added \$60,500 (total \$597,201).
- May 16, 1988 - Amendment No. 4 added \$70,000 (total \$667,201); Changed name to South Pacific Alliance for Family Health (SPAFH); new PACD Dec. 31, 1988.
- Sept. 1, 1988 - Amendment No. 5 added \$297,580 (total \$964,781) Extended PACD to Sept. 30, 1989. Revised FSP's responsibilities.
- Sept. 30, 1988 - Amendment No. 6 added \$193,696 (total \$1,158,477).
- March 7, 1989 - Amendment No. 7 revised the budget.
- June 30, 1989 - Amendment No. 8 revised the budget and extended the PACD to December 31, 1989.
- Sept. 30, 1989 - Amendment No. 9 added \$55,000 (total \$1,213,477 and extended PACD to March 31, 1989.

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ANNEX G

ECONOMIC ANALYSIS

I. THE ECONOMIC BENEFITS OF SLOWING POPULATION GROWTH RATES

This social sector project is concerned with helping individual countries produce outputs which are difficult to value, except over a long time period. The project has two major objectives: (1) the strengthening of a young regional population organization to provide technical assistance, training, and matching funds to cooperating countries in the region and (2) the design and implementation of more effective population policies and programs by the ten countries being assisted by this regional organization. The regional organization is also the mechanism through which A.I.D. population funds will flow to the ten countries.

We assume that investments made in national population and family planning programs will contribute to lower birthrates and thereby produce significant social, economic, and health benefits over the long term. From a national government's viewpoint, one of the greatest benefits is the decreased demand for public investments in social infrastructure (e.g., schools, health services, etc.) because the population is growing less rapidly. There are also personal economic benefits as families with fewer children normally can spend less of their budget on food, education, health, and other costs.

It is difficult to reliably track progress and assign monetary values to the direct and indirect effects of national population efforts. Nonetheless, countries frequently measure the cost-effectiveness of such programs in the short and medium term by tracking such factors as: the increase of family planning service outlets, the number of people using modern contraceptive methods, or declines in annual birthrates. The cost per acceptor or cost per birth averted is one measure for making estimates of program costs. However, drawing conclusions about the relationship between such variables is often a tricky proposition. For example, the decline in births may be due other factors besides the government's family planning program; e.g., U.S. birthrates declined significantly during the 1930's economic depression and this was a long time before government family planning programs even existed.

Similarly, in comparing costs between programs delivering the same service in a given year, there must be some way to treat (amortize) costs of training or institution-building as when younger organizations are compared with older ones. In spite of the limitations of such cost-effectiveness measures, we will undoubtedly continue using them, since program managers feel that limited data is better than nothing in making decisions about the relative benefits of alternative investments. Consequently, the program and financial management organizations supported under this project will be encouraged to collect and analyze cost and output data to help in the process of assessing the cost-benefits of relative approaches to providing population and family planning information and services. At present, such data is not available

II. OPTIONS FOR ACHIEVING PROJECT OBJECTIVES

A.I.D. desires to support the design and implementation of effective population and family planning policies and programs in as many of the ten regional countries as possible. Given A.I.D. Regional Office staff constraints and the expense and difficulty of dealing with ten widely dispersed countries, it is not economically or administratively feasible to use a bilateral approach to support population programs in the region.

Consequently, A.I.D., in 1986, supported the establishment of a regional organization - SPAFH - to (1) facilitate cooperation on population issues among the ten cooperating countries and between various countries and the donors and (2) become a regional influence to promote awareness of the economic, health, and other cost of unwanted population growth. Since it began operations in 1987, SPAFH has (1) become a forum for regional discussions on population issues and (2) provided technical assistance, training and financial support to countries interested in developing new policies and programs.

We can then ask whether there are other more cost-effective alternatives to SPAFH for implementing the project. The project design team looked at two other regional bodies to ascertain if they might be more suitable as A.I.D. intermediaries: (1) the South Pacific Commission or (2) PIPPA--the Pacific Islands Planned Parenthood Alliance. At present the South Pacific Commission is doing limited work in health, but not in family planning. It is being proposed as the implementing agent for A.I.D. planned project to help address AIDS.

PIPPA is sponsored by the International Planned Parenthood Federation (IPPF) in London as its regional intermediary to deal with the local Planned Parenthood Associations. However, PIPPA is still not yet completely organized or staffed to function as a regional program coordination mechanism. Moreover, IPPF affiliates have traditionally worked rather exclusively in the non-government sector. Since the government health agencies are the dominant service providers in most countries in the region, the intermediary should be able to work with and fund both private and public organizations. SPAFH has this ability, although it has primarily funded public programs up to now. It will be encouraged to broaden private sector participation and support under the new project.

SPAFH has now developed credibility as a population organization, initiated regional training activities, and provided matching funds to most of its ten member countries. These countries have normally provided at least 40% of the project costs (cash or in-kind contribution). SPAFH still has some organization weaknesses, but has already made good use of past A.I.D. funds. For the present, SPAFH has relatively stronger family planning and population program coordinating abilities than PIPPA or the South Pacific Commission, so A.I.D. finds that it is the best organizational alternative for continuing our support for regional population policy and family planning efforts.

Other donors have indicated an interest in providing some of their family planning funds through SPAFH for essentially the same economic and administrative reasons as A.I.D.. As SPAFH develops stronger program design and management capabilities it should increase the return on both donor and country investments in population and family planning by developing better projects which get better results for given amount of input.

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SOCIAL SOUNDNESS ANALYSIS

PURPOSE

This paper analyses some of the socio-cultural factors which will influence efforts to improve family planning and population efforts in the region. The South Pacific Alliance for Family Health (SPAFH) is to be the center for providing technical assistance and funds to national family planning organizations in ten South Pacific countries: Papua New Guinea, Fiji, Solomon Islands, Vanuatu, Tonga, Tuvalu, Kiribati, the Cook Islands, Niue, and Western Samoa.

I. BACKGROUND

A. History:

All countries share a colonial history except Tonga, which remained independent although very much influenced by European people and ways. Papua New Guinea was under the trusteeship of Australia after the Second World War until its independence in 1975. Fiji was granted independence from Great Britain in 1970 and became an independent republic but left the Commonwealth following two military coups d'etat in 1987. Western Samoa was a United Nations trusteeship administered by New Zealand until its independence in 1962. Tonga is a constitutional monarchy, by no means democratic, and the sole remaining Pacific kingdom. Niue and the Cook Islands were New Zealand dependencies which are now self-governing (Cook Islands 1965; Niue 1974); but people have New Zealand citizenship. Solomon Islands gained independence from Great Britain in 1978 and is a Westminster-style parliamentary democracy. Kiribati became independent of Britain in 1979 as a republic. Nauru, after 1945, was governed by Australia on behalf of Australia, Britain and New Zealand under a trusteeship agreement with the United Nations, and became an independent republic in 1968.

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B. Terrain:

The islands of Melanesia (Papua New Guinea, Solomon Islands and Vanuatu) are continental islands, the largest and most complex geologically, rich in resources, including forests and minerals, rugged of terrain, mountainous in the hinterland, swampy around area on the coast, and often hard to traverse. Solomon Islands and Vanuatu are of the same type as PNG but are smaller, and have small outlying islands that are either volcanic islands or coral atolls. Micronesia and Polynesia are made up of the two other types of islands being either raised coral islands (such as Tongatapu or Niue), or coral atolls such as Kiribati and Tuvalu, which are all only a few hundred meters above the sea; or high volcanic islands such as Western Samoa's Savai'i. The islands are separated from one another by large tracts of ocean in many cases.

C. Human Geography:

The early colonists in New Guinea eventually occupied most of that huge island as well as most larger islands farther east and south east as far as New Caledonia (settled about 4,000 years ago). In the course of the many millennia required for all the movements, the many separate bands of migrating people evolved into numerous pockets of distinctive physical types, in consequence of their mutual isolation over very long periods of time, isolation fostered by geographical barriers and reinforced by attitudes of ethnocentricity (which have continued to prevail until modern times).

D. Ethnic Groups and Languages:

Beginning about 5,500 years ago, peoples with mongoloid genes began moving into the Pacific through the Solomons, New Hebrides, and beyond, to western Micronesia. This served to introduce a family of languages called Austronesian which differ from Papuan languages in fundamental respects. There are now 700-800 Austronesian languages in the area stretching from South East Asia to Hawaii and Easter Island.

It would seem that the pioneers who introduced Austronesian languages into the Gilberts (Kiribati) and who populated much of Polynesia were mainly mongoloid in physical type. Elsewhere the link between physical type and language is not so close. Many coastal and off-shore people of Papua New Guinea and most of those of the rest of Melanesia, of Fiji and even parts of Polynesia are dark-skinned and curly to frizzy-haired, yet spoke Austronesian languages, which demonstrated that new (that is, mongoloid) genes and new (Austronesian) speech patterns in the Pacific Islands did

not always travel together or remain together ever after. Evidence bearing on genetic (that is, racial) relations is so patchy, or so ambiguous, or, (in the case of present-day populations) so clouded by recent interbreeding, that there are almost as many theories as theorists.

Present day Polynesians are the descendants, mainly, of mongoloid-featured, Austronesian-speaking peoples, who established pioneer settlements in Fiji (probably from the central New Hebrides) and, then, in Tonga and Samoa some 3,500-3,300 years ago. During the first few centuries of their residence in and around the archipelagoes, they underwent enough of a distinctive differentiation in their languages and in some other domains of their common culture to set them off from their culture "cousins" in the west. Subsequent to the colonising of Tonga and Samoa, other more physically "Melanesian" people migrated to Fiji from the west and interbred with Polynesians still there, thereby differentiating later Fijians from the Tongans and Samoans both genetically and culturally (but not so widely as Europeans once believed). From this, some Polynesians remained in Tonga and Samoa, while others moved on, over centuries, east, north and south; and, a few of them, moved back west. The movements of people and ideas and artefacts among these far-flung islands will be found to be much more numerous and complex than is now known.

E. Regionalism:

A Pacific-wide consciousness, such as suggested in "the Pacific way" or other ideologies, is an artefact of modern times, and not an always convincing one. It should be remembered that when the Europeans arrived on the scene -- from 1521, when the Spanish landed at Guam, to a few years ago, when some bands of New Guinea natives were "contacted" for the first time -- there were hundreds of sharply distinguished cultures in place. Differences among them are so numerous and, in many instances, so wide, that any attempt to classify them, in order to generalize about them, is fraught with difficulties. The usual, anthropologically standard, classification is into three major divisions: Polynesia (meaning "many islands"), Micronesia ("small islands") and Melanesia ("black islands").

As implied above, the first of these labels is the least arbitrary; the twenty or so societies of people who occupied the widely scattered islands of this division (including, the modern nations of Western Samoa, Tonga, the Cook Islands, Tuvalu and Niue) spoke closely related languages, shared many cosmological beliefs and religious practices, and ordered their social relationships in similar ways, all as a result of their relatively recent derivation from a single cultural source. On the other hand, the no less relevant subsistence technologies of the

Polynesians were widely diverse, ranging from total dependence on fishing and one or two tree crops to cultivation of a wide variety of vegetables, fruits and nuts.

The islands of Micronesia which lie mainly north of the equator include only about 320,000 people in Kiribati, Nauru, the Marshall Islands, the FSM, Belau (or Palau), Guam, and the Mariana Islands. The islands are indeed small, as are many of the islands of Polynesia and Melanesia, but four of the languages spoken in this division were only very distantly related to the many other, more closely interrelated ones. Moreover, although several of the societies of central Micronesia had similar cosmologies, social institutions, and subsistence technologies, those of the western and southeastern ends of this division differed markedly in many cultural respects from those of the centre and from each other.

For Melanesia, diversity of terrain and of people is the keynote. It comprises New Guinea (Papua New Guinea with about 3,500,000 people who speak more than 700 languages), Solomon Islands with 230,000 people and 83 languages, and Vanuatu with about 146,000 people but 108 languages, and New Caledonia with 145,000.

Fiji stands as a "bridge" between Polynesia and Melanesia: physically the Fijian people are similar to other Melanesian people but their culture has more in common with Polynesia. For centuries, Fiji has been the region of contact between Pacific peoples. Indians, mostly third and fourth generation Fijian-born, comprise about half the population and constitute a deep social cleavage in terms of languages, religion and culture. Small numbers of Europeans, Chinese and other Pacific Islanders make up about 5 per cent of this culturally diverse and challenging nation.

The cultural diversity that prevailed among the hundreds of societies lumped together under this label was of a scale large enough to accommodate forty or fifty subdivisions comparable with Polynesia in terms of homogeneity. It is reflected in the fact that the five million people of Melanesia speak over one thousand languages. Linguistic fragmentation is greater in Melanesia than anywhere else in the world; nearly one quarter of all the world's languages are in Melanesia. In other words, the usual three-fold division of the Pacific Islands and their cultures is even less discriminating than would result from dividing the United States into, say, Maine, the rest of New England, and all the other states. Thus, the concept of Pacific regionalism, or even Poly-, Micro-, or Melanesian regionalism, is a vexed one.

There is more internal differentiation in Pacific cultures than in most others. The main lines of cleavage between the diverse tribes of New Guinea, Solomon Islands, and Vanuatu are linguistic and cultural and, to a lesser extent, physical (pockets of

Polynesian and Micronesian peoples live in Melanesia also). In New Caledonia and Fiji, the deep divisions are racial -- between Asians, Europeans, and Melanesians -- although there is also considerable division within each racial group. In Samoa, Tonga, and the Marshall Islands, the major social divisions are those of rank.

The three cultural divisions do not form viable bases for regional organisation, although significant parts of each area do. The concept of these areas rests on notions of similarity of cultures, not on past interaction within them, which was limited. Nevertheless, members of particular areas do "pull together" at times within larger regional bodies, and in ad hoc decision making. There tends also to be more interaction within culture areas than between them. The specific studies of family planning which were surveyed for this study, however, continuously stress the need to consider the specific local regional differences and for family planning teams to cultivate sensitivities towards local cultural values and avoidances.

II. SOCIO-CULTURAL CONTEXT

A. Technology:

People had pottery, stone technology, and could make barkcloth. Polynesians were the finest navigators and mariners in the world before the time of European contact. Nowadays, the small island nation states are trying to approximate in many ways modern western technology. Some may even think that science and technology will solve their problems. Sir Paul Hasluck, in opening the 1971 Pacific Science Congress, noted a growing "disillusionment with science" and its overemphasis on material goals. Unique identification provides a significant satisfaction for Pacific Islanders and elements of their value system have continuing utility. While each nation has produced some highly educated individuals, most people in the Pacific have only rudimentary notions of western education (which is only one generation old in some cases) and that rural education is generally poorer than urban.

B. Social Structure:

Social organization in most places is based on the extended household in which the two principles of kinship and locality are the most important, together with participation and contribution to the welfare and activities of the unit. Kinship based units are the primary landowning units. Melanesian societies are, in general, "egalitarian" while those of Polynesia are hierarchical. Another specific and crucial distinction is that Polynesian social systems recognise what English speakers call cousins, i.e.,

children of brothers and sisters are regarded as brothers and sisters. But, in parts of Melanesia, including Fiji, persons who are parallel cousins (the children of two brothers or of two sisters) are regarded as markedly different from those who are cross cousins (the children of a brother and of a sister). These two categories form the two basic divisions in many Melanesian societies. In a general way, parallel cousins are like brother and sister, but cross cousins are like husband and wife (which is not true in Polynesia, where sisters and their children are generally regarded as being of higher rank in the hierarchy than the brother and his children). A stranger moving into this kind of system can be very confused if not aware of the rules.

C. Subsistence Strategies:

The subsistence economies were household-based and comprised agriculture, fishing, and textile making. In Melanesia and, to a somewhat lesser extent, in Micronesia, women were employed extensively in agriculture, and also fishing and gleaning, within the reef area, as well as being primarily responsible for household activities. Women care for pigs in Papua New Guinea cultures although the men gain the prestige from the exchanges. In Polynesia, women of rank were excluded from hard outdoors work, but were solely responsible for the manufacture of household textiles; mats and barkcloth.

In all societies, land ownership was vested in kinship-based units. Settlement patterns are primarily nucleated, that is, village structures are today the most important local units even in countries that once had patterns of dispersed settlement in hamlets or household clusters, such as Tonga. In lowland, sago-growing areas of Papua New Guinea, however, the dispersed pattern may still to be found among shifting cultivators together with, in other areas, what might be called a pattern of shifting village sites, due to quarrels and beliefs in contamination or threat by witchcraft.

The nucleation or dispersal of a community's household buildings was not necessarily correlative with its degree of social unity, nevertheless, the nature of its public buildings and areas provides useful clues about many of its institutions. An example from the Solomon Islands will serve to illustrate. The 2,200 or so Baegu-speakers occupied a 61-square-mile mountainous area of north Malaita. Baegu territory was divided into lolo (communities) and these into fera (hamlets). Each lolo was identified with one or other of the Baegu's clans and contained within its territorial boundaries that clan's ancestral shrine; it was thus, a religious as well as a kin-based residential unit. Each fera consisted of two or more nuclear family households (i.e. one consisting of a husband, his wife or wives, and their

offspring), and each household had its own house, called a luma, used by all the family members. Also, the men and youths of a fera had houses (bisi) of their own where they spent much of their time and which were off-limits to females. In addition, the senior man of a fera had a house of his own, also denied to females, where he represented the fera's residents in petitions to the spirits of their recently deceased kinsfolk. Women as well had houses of their own, in isolated and hidden places; one for giving birth and one for residence during menstruation. Both of these places were avoided by males, mainly because of beliefs about the pollutive condition of women during menstruation and childbirth. In fact, a male Baegu's fear of the pollutive influence of women carried over into the topographic layouts of both luma and fera. Thus, when a household's youths and men slept in their separate houses, their females customarily slept at the downhill, back end of the aluma. And in laying out a fera, the part of it associated with men was always located uphill (because, it was believed, women's "pollution" flowed downhill).

The prevailing national pattern is of a central town or city to which more remote dwellers are migrating in search of wage employment, excitement or release from the constraints of traditional community social control. The resultant overcrowding and pressure brought to bear upon limited urban resources, including land, is leading to a host of problems such as squatter settlements, homelessness, illegitimate births, and crime.

Countries of the Pacific differ markedly in their road patterns and in the ease with which the interior of the island may be reached. At one extreme is Tongatapu in Tonga which is traversed by a network of fairly good roads; the other extreme may be illustrated by the least developed areas of PNG which have poor road networks that, in undeveloped provinces, may only reach less than an estimated 20 per cent of the people. About a quarter of the nations's communities are reachable only by difficult walking tracks. All Pacific Islands rely heavily on light aircraft and boats for communication, which are fuel-expensive.

D. Leadership and Community Government:

Traditionally male (and to an extent gerontocratic), there were, nevertheless, marked differences of emphasis between Polynesia and Melanesia in terms of the balance between achievement and ascription in acquiring leadership positions. Melanesia had an egalitarian bias whereas, in Polynesia, Fiji, and most of Micronesia, social classes and hierarchical systems of chieftainship predominated. Still, today, one is born a chief or commoner and can do little in one's lifetime to change one's status. Parts of Polynesia, notably Tonga, and Fiji still have structures of this general type.

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In most of Melanesia, however, a man with ability and ambition could climb socially by successful economic activity, especially by trade, manufacture, or the accumulation and distribution of wealth. A person who gained economic power usually also gained political power.

There is need to transfer at least some of the respect that attached to earlier forms of authority (e.g., community councils, chiefs, or churches) to the newer forms (e.g., central government, new political institutions, and police). Otherwise, as respect for old forms disappears, the new forms are not treated with respect, and those in power may use crude force to get obedience, conformity, and even submission. This is a poor substitute for respect based on mutual understanding and an appreciation of the various roles in society.

E. Authority: Government vs. Non-Government Approach:

This is one of the main issues concerning population policy in the Pacific islands as in other countries in the world. The rationale for making the government responsible for family planning activities is that only a government body has the power to enforce measures. This enforcement can take the form, at one end of the scale, of mild encouragement through the educational system and, at the other, of a strict population control program using economic and social sanctions such as tax advantages for small families to heavy penalties - heavy fines, or compulsory sterilization -- on large families. Private institutions and individuals can only advise. It is not always clear to the recipients or, sometimes, the donors themselves, precisely what their purposes for population activities are, or whether they are acting in agreement with what the majority of the population wants. It is also often impossible to monitor their activities.

F. Law and Order:

While the problems of rapid population growth tend to be seen almost exclusively in economic and social terms, laws may also serve to frustrate or encourage the objectives of population policies. The age of consent, the legal age for marriage, abortion and contraception legislation, influence population trends to a greater or lesser extent. Despite their political, economic and cultural diversity, the countries (Tonga excepted) share a colonial heritage. Tongan law, however, is also deeply influenced by English models.

This common background has resulted in broad legal similarities: English law in Fiji, Kiribati, and Solomon Islands; English and New Zealand law in Western Samoa, Tokelau, Niue, and the Cook Islands; English and Australian law in Nauru; and, in

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There is now a growing awareness of local custom and traditional values upon which Pacific law might be based, especially in Fiji, Kiribati, Papua New Guinea, Vanuatu and Western Samoa, which are making an effort to preserve local customs and traditional institutions within the legal system. For example, Solomon Islands has given recognition to customary law in its constitution to take precedence over English common law and equity. Other countries leave matters such as customary adoption to be dealt with by appropriate statutes. For example, customary adoption in Kiribati is codified under the Gilbert and Phoenix Islands Land Code. By contrast, other countries give no recognition to widely-practised customs: Fijian customary adoption is not recognised in law; its Adoption of Infants Act is based on English law.

The effect of these various sources, legal provisions, and plurality of legal systems on the family and the community needs to be considered because little attention is given to law as a prime instrument of social change. Similarly, family planning policies need to be examined in the light of changes taking place in the structure of the Pacific family today.

G. Education:

Most learning is carried out informally in the Pacific islands. Generally, parents and elders, the "teachers", do not encourage their children to ask questions, to participate in conversations, to express ideas, or to undertake creative activity. The child finds that the best way to handle its environment is to put on a pleasant front, and face everybody with a friendly, accepting, agreeable image, without disclosing too much of its true feelings.

Formal education does not reach many rural people and that which they do receive is often of a low quality. In general, the education levels of women are far below those of their male counterparts and grow lower as one moves from east to west in the Pacific. Another notable contrast is that, whereas Tonga and Samoa

once had the highest proportions of highly educated manpower in the Pacific, they now have lower ratios than PNG; once they were the most productive and had the highest standards of living but now they are among the lowest on both counts.

It has been suggested that this difference reflects the difference between societies where heredity is emphasized and those where leadership is achieved by the younger and more energetic. This shows up too in the ages of cabinet ministers; the average age of the ministers in Solomon Islands, Papua New Guinea, and Vanuatu, for example, is probably about ten to twenty years younger than that for Fiji, Tonga, or Samoa.

In many societies and in rural areas, women are less likely than men to know any lingua franca such as English, or the various forms of Pidgin or Police Motu in PNG.

H. The Status of Women:

As in the case of the education of women, the status of women can be conceived as growing progressively lower, in relation to that of men, as one moves from east to west in the Pacific. In Melanesia and Micronesia the status of women is below that of men. Women do hard physical work outdoors and are under the authority of male brothers, father, and husband. In Polynesia, women's status as sisters is high in ceremonial terms but as wives, women are under the authority of the husband and his family and it is considered their duty to produce children for the group they have married into.

I. The Value of Children and Family Size:

All Pacific islanders today value children and families tend to be large by western standards.

Fiji: Preference for sons, and large families. See appendix: Sociocultural Factors Affecting Family Planning in Fiji.

Papua New Guinea: Large numbers of children were not necessarily desired in PNG and, throughout the country, traditional methods of controlling the population (abortion, infanticide, medicinal and ritual means as well as post partum taboos of considerable duration) were widely used. As these practices have been discouraged, perhaps, people are having larger families in order to acquire much valued sons (particularly valued in the highlands where gardening is relatively intensive and clan rivalry and even warfare is endemic). Due to improved conditions, despite a bias towards the males, more girls may be surviving and, thus, increasing total family size.

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Solomon Islands: In most of the diverse cultures of Solomon Islands, marriage and children are synonymous. The ideal family size is probably between 6 and 8 children although there is some evidence for a tendency particularly in Honiara for couples to begin to think of planning after five children.

Kiribati: Various factors affect family size here. As elsewhere in the Pacific, sons are valued because of their role as family protectors (and continuers of the 'name'), and as remittance earners. In the outer islands where the mortality rate is higher than in Tarawa, people want more rather than fewer children. Ideal family size is still over four children in urban areas whereas in outer islands it could be about six.

Western Samoa: In rural and remote areas, preference is for sons and many children; fertility is higher than in urban areas. The shortage of trained personnel, a restricted budget and the focus of family planning programmes mainly on women are factors primarily responsible for the failure to meet National Development Plan objectives. The 1981 census reveals a significant reduction in levels of fertility in all but the oldest age groups. Greatest decline in the 25-34 age group; women aged 30-34 had an average of 3.8 children compared with 4.5 and 5.0 for women of the same ages in 1976 and 1971 respectively. Reduction in marital fertility has resulted from reduced proportions of women having 7 or more children (dropped from 49 per cent in 1971 to 40 per cent among women 35-39 years).

Tonga: The people value a mix of sexes because of socio-economic coordinates of the sibling relationship: brothers and sisters are to care for each other throughout life, more particularly the brother for the sister and her offspring. Many sons are wanted to work the land. Large families are desired since the children can emigrate to earn money to send home, work at home, or provide security in other ways.

J. Traditional Medicine: Traditional medicine is still used freely throughout the Pacific, including the use of abortifacients and herbal preparations believed to encourage fertility. Special foods are either encouraged or tabooed (forbidden) to women who wish to conceive, are pregnant, or are nursing children.

III. PROJECT BENEFICIARIES

The notion of beneficiaries of the project brings to the fore issues of the public good versus the private interest which is one of the most important issues in development today. Individual men and women, families, and communities are the ultimate target group for the thrust of family planning efforts, but they may not see themselves as benefitting, at least, not in the short term, from limiting their numbers of family members.

The main immediate, perceived beneficiaries of the planned project will be (1) governments, which perceive an "explosive" population growth as detrimental to their national developmental goals; (2) environmentalists who perceive the detrimental effects that overpopulation is having and will increasingly have upon the delicately-balanced ecosystems of Pacific islands (indeed, some development plans now include environmental provisions), and (3) the advocates of family planning, who aim, in part, to curtail population growth by means of birth control measures.

While the focus of the project remains family planning in relation to family health, it also bears directly on the more general question of population control. At the individual or local level, the issues involve families and decisions made by them in relation to fertility control; while, at a national level, and from the point of view of governments, the issues are those of controlling population numbers. However, family planning is by no means the major move of Pacific Islands governments to control population. Relatively few governments have made a truly concerted attempt to confront the domestic and personal issues involved in family planning.

Some countries have controlled population pressures in many cases primarily through the migration of their people. Thus, more Tokelauans, Cook Islanders and Niueans live in New Zealand, whose citizenship they hold jointly with that of their country of origin, than live in Tokelau, the Cook Islands or Niue. The same trend applies also to Western Samoa, large numbers of whose people stay for long periods of time in New Zealand or reside there permanently. An estimated 93,000 Tongans live at present in Tonga but another estimated 40,000 live overseas, predominantly in New Zealand, Australia, and the United States. Migration from the northern island states of Micronesia and Polynesia, especially the Samoas, to America is also very great. Although much of the immigration is illegal and unrecorded, we could hypothesize further that people in the fertile age range are more likely to emigrate and, thus, further limit population numbers in their home countries.

IV. PARTICIPATION

It has not been possible with the resources and time available to make accurate estimates of the actual participation in family planning programmes, although some rates are suggested elsewhere in this PP. Some general observations can be made, however. First, we should not say that Pacific Islanders do not plan their families; they plan to have large families. For this and many other reasons to do with cultural nuances and semantics, it is essential to have people of the "target group" as participants in

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the planning stages and also to encourage them to diagnose and suggest solutions to their own problems; that is, to use the resources and initiative they have.

Also, it seems that most potential recipients of family planning program see family health (and prosperity) as an entity (for example, comprising nutrition, hygiene, MCH, and family planning) and have little understanding of the fragmented special parts offered them by this or that agency.

A pilot study in Tonga some years ago produced visual materials to illustrate the notions common to western family planners: small happy families compared to large poor unhappy ones; close spaced (as compared to widely-spaced) pregnancies leading to overcrowding of people and also fragmentation of land, and the like. The workshop found that the Tongans' response was that, owing to the land tenure system, and subsistence horticulture, large families were believed often to fare better than small ones, and that the unfavorable comparison between family size was thought to be uncharitable, it aroused resentment and promoted a lack of confidence in the message as a whole. There was very little the researchers did find to motivate the Tongan sample group, except perhaps a tenuous link between family size (i.e. fewer children) and a high desire for educational attainment and wage employment for their children, which was exploited to the full with later materials.

One general note: Basic data concerning family planning results and population control in general is too often poor, badly collected, and unreliable. Record-keeping needs to be upgraded in importance and quality. Too often also, questionnaire survey methods have been used to elicit attitudes or responses, presumably because they are quantifiable. The Pacific cultural heritage does not favor quick repartee about these matters or snap answers. Assessment of procedures and the time it takes require more thought. If a woman is asked as an individual, and out of the context of her group relations, whether she has more than the number of children she desires, she may well answer yes, to be agreeable. But it should not be inferred from her answer that she is a ready candidate for family planning for she will want also to please her husband and his relatives, who can make life very hard for her if they find she is using family planning against their desire for family, and she may also at the same time be pressuring her brothers' wives to have children for her group.

Other ways of eliciting responses should not be overlooked, such as (1) song and dance, which incorporate segments of culture meaningful to the people involved, (2) plays, as have been used in Tuvalu, or (3) concert skits that convey messages in the words people actually use in the way they speak. These activities come

second only to gardening and housework in involving all ages and groups of people.

Many commonly held stereotypes exist concerning the relations between a number of factors, such as the education of women, socio-economic situation, urbanization, capitalism and wage-employment, and the acceptance of family planning techniques. The relation is usually conceived as a positive one; for example, it has been thought that the higher the woman's educational attainment level, the more likely she is to accept family planning. However, studies exist to show that, even if a positive relationship may be shown between these factors in one social context, it cannot be inferred that the relation is inflexible, or is a causal one that will obtain in all places and under all circumstances. It may be merely that a high level of acceptance and a high level of women's education has been found together in some survey but that, rather than one being caused by the other, both are due to extraneous factors, such as location, economic aspirations, or social caste, which were not precisely identified in the survey.

For example, an analysis of data obtained from the 1980 National Population Census in PNG showed some interesting results. Fertility of women with some or completed primary education was far higher than that of either women with some or completed secondary or tertiary education and women with no formal education at all. Clearly, in the case of education, we are dealing with a problem of threshold of a certain level of education above which fertility again begins to decline.

Similarly, women belonging to different churches have in a few cases significantly different levels of fertility. There is also a very significant variation in trends of fertility among women of different (Christian) religious denominations. In some areas, Roman Catholics had higher levels of fertility than other denominations but, it would be wrong merely to assume that this is because of the Catholic church's well known dicta on birth control. Equally, or more, it could be because all of one very remote, isolated, money poor and ill-educated group were converted by a Catholic mission and any one or combination of the other factors could be responsible for the "RC" group's fertility rates.

Economic activity of women in PNG does not as yet seem to be an important determinant of fertility in PNG but that of the head of the household is more strongly correlated. Women living in households where the head has money income have significantly higher fertility than women living in households where the head has no money income. Again, women in the urban sector living in low cost houses have in most cases significantly higher fertility

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than women living in high cost houses or in makeshift, squatter housing. It must be stressed that these relationships are functional and are not necessarily also causal. Multivariate analysis is imperative to assess the impact of various other characteristics of women and households on the level and pattern of and trends in fertility. The FPA, the Health Department records, and the Provincial Data System (PDS) could be helpful. Depending on how they are defined, probably in the order of upwards of 100 factors could be adduced as relevant in the acceptance and continuance with family planning. The relationship between them is complex and needs to be examined empirically in each field site.

One further note: family planning programs are almost always largely aimed at women; yet, women are under the immediate sway of their husbands and other male relatives and usually have to receive permission from them to participate. Emphasis must shift from women to men equally and from the individual male and female to the extended family and the community since it is within these units that decisions affecting fertility are primarily made. Indications of participation for those countries for which data could be obtained have been included below under Impact.

V. SOCIO-CULTURAL FEASIBILITY

Whereas one could live off a tenth of a hectare of crop in the subsistence society, more was needed to earn an equivalent living from cash cropping. There was no shortage of land for the first few generations after Western contact, because the populations of the Pacific were drastically reduced by introduced diseases and by warfare with more lethal weapons. The populations declined from the first half of last century until the turn of this one, which created an apparent surplus of land. It was assumed the population decline would continue but in this century populations have regained their former levels and are now increasing rapidly. The underlying sense of having to breed to survive as a people may still persist at some level within populations despite the growing figures and evidence of overpopulation.

Although direct or causal links should not be made too readily between the predominance of particular religious beliefs, their leaders' attitudes to family planning, and the practices of their adherents in this regard; nevertheless, Christianity, even when not ostensibly opposed to family planning, has introduced to the islands, or strengthened already existing, beliefs about the sanctity of human life. All people are equal in the sight of God, and all have souls (in some precontact beliefs, by contrast, some very low-born people were not believed to have an after life, or one only as a very low creature such as a worm). Thus, there is definitely a fear of retribution for stopping human life occurring

in any form, even if the belief is poorly articulated among many sections of the population.

Children are regarded as blessings reflecting the "will of God", a sign of prosperity and of His favour. Pregnancies contracted while a woman is practising birth control are also regarded as being particularly the "will of God". In developing countries, which lack social services to a significant degree, large extended families are still the best security. Some offspring stay at home to garden and care for the household while others go overseas to work and send back remittances. These people would have to be convinced that it was in their own best interests to limit their families. Observers have noted the Pacific ideas of time, which are usually confined to the present or immediate future, and what has been called an "optimistic outlook" which, at best, is a simple view that "things will be OK" and, at worst, is a notion, bred of years of increasing dependence on aid, that the nations of the Pacific rim will pick up the tab for unrestrained rates of birth. To outsiders, this attitude, that other nations will take care of one's children, is completely and wantonly irresponsible, but it is one that has served Pacific Islanders' interests and of which most of them have yet to be convinced otherwise.

Many people with things to sell realise the validity of the idea that in a situation of rapid social and economic change, people "respond most easily to stimuli which have some continuity with, or analogy to, their traditional values and forms of organization", and many family planning organizations encourage spacing rather than birth control as such. One feels that if they could arrange for a couple of boy babies to be born to each family, their job would also be easier.

VI. IMPACT

Papua New Guinea: In 1987, 3 per cent of all women 15-44 years of age were new family planning acceptors, and the Health Department estimates that the overall utilisation rate is only about 7 per cent. Constraints are political, due to ignorance or negative attitudes and lack of motivation, the economic importance of large families in subsistence farming, a high infant mortality and the problem of manpower in the delivery service, management and financial difficulties.

Fiji: High impact of family planning program, although ambiguous, due to extraneous factors.

Solomon Islands: Customary practices are beginning to die out as knowledge of 'western' methods of contraception grow. The director of SIPPA believes the SI community is adopting a positive

attitude toward family planning. Despite the lack of intensive health and family planning education, the situation has improved significantly in recent years.

Western Samoa: The ready availability of contraceptives now seems to have caused little change to traditional ideas about family size. Great fluctuation of numbers of new acceptors and current users. The fertility level of women still higher than FPA expecting.

Vanuatu: 3,706 persons used some form of contraception in 1987 but may be the same people swapping methods. 12% of women use some form of family planning, but few men.

Tonga: More work needs to be done especially on motivation and re-motivation. Indications are that only 15.2 per cent of family planning acceptors continue to use after one year. A WHO/MOH survey in 1988 showed 15.4% of females and 11.7% of males surveyed used contraceptives. FPA could increase cooperation with government measures and intends also to broaden scope from family involvement to include youth.

Kiribati: Most acceptors are found on South Tarawa where land is scarce. About 3,380 users out of a population of about 63,496.

The Cook Islands: Family planning services confined mainly to area around Rarotonga. Population has negative growth due to out-migration.

Tuvalu: Estimated family planning coverage of women in fertile group 40.3% and the population's natural growth rate dropped from 2.0 in 1987 to 1.6 in 1988.

Niue: Population negative growth due to out-migration. Family planning emphasis on spacing for healthy children rather than on birth control.

VII. SOCIAL ISSUES

A. Reproductive health care knowledge, attitudes and practice at the community level and approaches to raising awareness of health and family planning issues:

Papua New Guinea: Without a clear government policy or resources devoted to family planning, acceptance rates are not likely to rise. Availability of contraceptives in the private sector offers additional modes of access to urban populations whose fertility rates are higher than those in the rural areas. In two small rural areas, the FPA, a private organisation, has been experimenting with community-based distribution of contraceptives

with some success. The opportunity to obtain contraceptives privately and conveniently would appear to have considerable potential in rural areas.

Family planning delivery services at present tend to be part of the MCH services which operate from government-run health centers. Because of the other difficulties the centers and nurses have, family planning comes low on their list of priorities. Difficulties include the terrain and great distances to be covered; breakdown in transport and delays in repairs; violence by gangs of young men (especially nearer to major urban centers); and the resistance from nurses' husbands to their staying away overnight. The practical constraints of providing service has meant often that male nurses or young unmarried nurses are sent to the aid posts in rural areas. Neither provider nor consumer is likely to welcome discussions on family planning under such constraints.

Even female nurses do not often relate well to village people because of the social distance between them and because training is oriented to fixed-location, urban, work and not to the constant, arduous, and frequently dangerous, travel needed to provide a service to rural women. Rural women themselves often move about, from garden house to pig house or sago and fishing camps, so they do not always know when the clinic is coming to their area.

However, the need for family planning services is indicated by, among other factors, an apparent rise in artificial abortions. Despite many difficulties with the reporting of maternal mortality statistics, a recent report placed abortion fourth in a list of causes of death between 1976 and 1986.

Fiji: This country has a long history of family planning activities compared to most Pacific countries due, in part, to an early concern of Fijians and Europeans for the rapidly growing Indian population and, since about 1950, to a more general concern with the "explosive" growth rate of the total population. Whereas the debates on restriction of population date back to the beginning of the century, in the early 1950s the debate started to concentrate on the use of contraceptive devices and birth control programmes in order to reach the goal of limiting population growth.

In 1951, the first family planning facilities were established and, in 1957, the first family planning clinics. The history of family planning activities in Fiji can be found in the publications of the Medical Department and Family Planning Association. The emphasis was on family spacing. After the results of the 1956 Census were known, and the Burns Commission

into natural resources and population trends stated that the "Government should provide additional family planning clinics and contraceptives should be provided free of charge to married persons", the debate flared again.

The debates on government vs non-government control have been moderate. Until about 1950 the government policy was that family planning should be up to the individual. Fijian people tended to allocate responsibility for a birth control program to the government, whereas some of the Indian leaders favored voluntary planned parenthood organizations with an emphasis on regulating the size of families, spacing births, and having healthier families. Since 1963, a full-scale family planning program (National Family Planning Service) has been in force. From the outset, the link between the official government policy and the FPA has been strong and clear: the FPA as a voluntary organization takes care of the promotion, advertizing, and advisory activities, while the Medical Department is responsible for the clinic services. This division of labour serves as a check of the one upon the other.

In assessing the results of the combined effort, one encounters the same kinds of problems as in most demographic assessment procedures in Fiji; namely, the lack of basic data, measurement problems, and the lack of profound analysis of the available data. Success is measured in terms of registered births, without taking underregistration of births into account, the number of people attending family planning clinics etc. There certainly was a downturn in fertility in a short space of time which is strongly correlated with the activities of the Medical Department and the FPA.

However, it should be noted that Indians were the ones who wanted family planning. We have noted that, in the past, Fijians, normally assisted by Europeans, stressed the necessity of a check on population growth whereas the Indians emphasized that birth control was not necessary but that, on the contrary, more people were needed to develop the resources of the country. However, rather paradoxically, the early preachers of birth control accepted family planning quite late themselves, and have not made much progress yet towards a decline in fertility, whereas the early opponents were not only first in accepting the family planning program but also have been successful in reducing their fertility.

In the late 1970s, and still today, most official resistance to family planning activities comes from some of the churches. Most Christian communities do not officially interfere with their members' attitudes toward family planning (eg., the Anglicans, the Seventh Day Adventists, and Jehcvah's Witnesses. The Methodist

Church seems to be by far the most broad-minded although there are different opinions within this church. Particular groups are strongly opposed to birth control. The Roman Catholic position is well-known; control is self-control, restricted to the rhythm method. The Mormon Church is totally against any form of birth control as it teaches the earth's resources are abundant and that God will look after everyone's needs. No group, furthermore, with the possible exception of some Methodists are willing to revise Fiji's rather strict Abortion Law.

Hindu leaders especially from the two main groups, the Arya Samaj and the Sanatanis, are totally against family planning activities. If there is no wish for a child, there must be no sexual intercourse. The Sikhs are officially against any form of family planning. The same view is held by the Muslims, although the calendar method is practised. None of the non-Christian communities would consider abortion.

Hence, it is all the more surprising that family planning program appears to have been so successful and, especially, in the case of the Indian community. One explanation could be a large discrepancy between the official stand of the leaders of the religious communities and the practice of their members. Another, more potent, explanation is that falling fertility was assisted by the family planning program but was due also to a consistent balance of out-migration (around 0.7 per cent of the population per year during the 1970s). Migration, particularly by Indians has increased markedly since the coups d'etat of 1987, although it is predicted that these rates of outmigration will decrease to those of 1986 level.

Solomon Islands: This country is beginning to adopt a positive attitude towards family planning. Despite the lack of intensive health and family planning education in the past, the situation is improving significantly. The Government's family health program, with the Ministry of Health and Medical Services, began in 1975 and was funded by UK aid until 1980. The emphasis was on MCH, reducing infant mortality and improving the quality of life through family planning education and services, rather than on population control as such.

WHO began to develop training for family planning nurses and UNFPA also supported this from 1977-9, mainly by supplying contraceptives. In 1975, the SI Nurses and Midwives Board allowed registered nurses with special training and authorised by the medical officer, to insert IUDs, prescribe the pill, using a check-list as guideline, give Depo-Provera injections, and distribute condoms. This meant that over 300 nurses working from over 100 clinics would be able to provide family planning services to all, including people outside Honiara and in the outer

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Solomon Islands Ministry of Health instituted a population policy after the 1986 Census, drafted and passed by cabinet in 1988. An MCH/FP unit was established earlier this year to coordinate activities between MHMS and NGOs, and to implement programs. The government now considers family planning a priority to promote and maintain a population growth rate that the country can afford, and to improve quality of life. S.I people need to be educated so that couples can decide for themselves the number and spacing of children. The intersectoral approach is positive as there is so much work to be done in this culturally diverse country where traditionally emphasis has been placed on large families for security in old age, to provide bride price, and the like.

Western Samoa: The Ministry of Health administers the family planning programme through the Family Welfare Centre, which was established in 1971, with responsibility for a national program embracing MCH, family planning, and health education. Located in Apia, it serves the rural areas and outer islands.

A number of people believe the churches, the local community and the government could give much more support to the program. Outside Apia, women's health committees located in almost every village play a vital role in community health care. Based on local customary precedent, they were set up by the Ministry of Health in 1929 and number 439 in all. Despite linkage with government, the committees have a history of independence. Generally, they cooperate closely with doctors, nurses, and other field health personnel in developing, implementing, promoting, and monitoring health services especially MCH and family planning. The committees supplement the programs of the Family Welfare Centre and the district hospitals and help compensate for the shortage of doctors and nurses in rural areas. Like district nurses, the women's committees are engaged in family planning motivation and preventative medicine but their responsibilities also include building health centers and making provision for water tanks.

In addition to ten government-staffed health sub-centers and fourteen district hospitals there are almost 300 health centers operated by women's committees. There are free government training programs for committee members and traditional birth attendants.

Family planning has had a greater impact in and around Apia than elsewhere, perhaps because the Family Welfare Centre is adjacent to the national hospital there, and because certain contraceptives, like Depo-Provera, are unavailable elsewhere.

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Gradually, the numbers of family planning acceptor are increasing. Western Samoa does not have a FPA but there is the Samoa Planned Parenthood Association (SPPA) formed in 1971 under the presidency of the Minister of Health with the long-term aim of developing and strengthening MCH services. SPPA's activities complement the government's family planning program but have been curtailed through lack of financial support (IPPF support was withdrawn in 1977, and a fire in 1979 destroyed a newly established office and equipment). There was no budget at all to run the program in 1988 as the UNFPA aid was between agreements. It suffers from lack of adequately trained personnel and equipment to deliver services in rural areas.

Vanuatu: Since the government conducts no program, the newly-restarted FPA (1987) is facing the cultural and geographical constraints outlined for other countries, unameliorated by official backing though government has lately encouraged family planning. The NGO workers are mainly from the National Council of Women.

Tonga: Awareness and knowledge of family planning is still very low. Parents do not discuss sex freely with their children because it is a taboo subject. Girls are highly valued if they are virgins when they marry. There is very little family life education in the school curriculum. Yet, an illegitimate birth, after the initial parental fury has died down, is quickly accepted and the child fitted into the mother's family. Males have a very limited involvement in family planning; their attitude is that such affairs are women's business, and generally males are ignorant of existing techniques. Prospective unmarried users of contraceptives are on the increase in Tonga as in other Pacific countries but are reluctant to approach clinics because of cultural, religious and social norms.

Government Health Department, Tonga FPA, and other NGOs deliver family planning services but have yet to make headway against traditional ideas and modern desire for large families.

Government family planning activities are organized mainly by the Health Department and include service deliveries of different types of contraceptives through its 16 clinic or health centers located throughout Tongatapu, the most densely populated island in the archipelago. District nurses give non-clinical services. The Tonga FPA is active. It runs a mobile clinic in the outer islands. The RC church advocates the natural method only and is strongly against its members using contraceptives as is the rapidly growing Mormon church.

Lack of acceptance today is due markedly to: refusal of husbands, religious reasons, fear and ignorance, rumours of side effects, lack of accessibility in remote islands, lack of training, supervision and follow-up in the field, lack of supplies and equipment.

Kiribati: There is a discrepancy between attitudes to family planning and practice, largely because of inadequate medical back-up although family planning information has been disseminated through medical personnel, village women's committees, and Radio Kiribati. One family planner considers the Kiribati attitude to family planning is influenced by the shortage of land. The highest number of acceptors are found on South Tarawa, where land is scarce and the people are dependent on a cash economy. The islands are scattered over five million square kilometers of ocean which makes communications a problem.

All health care services are provided by the Ministry of Health and Family Planning (MHFP) with the close cooperation of WHO. There is no private practice and all family planning methods except condoms and the natural method are dispensed with medical prescription. The ministry has implemented a very soft fertility intervention program supported by special natural family spacing program run by the RC church. Abortion is illegal except on medical grounds where two doctors certify separately. Female sterilization is legal only with the consent of the husband; male sterilization is legally carried out by medical officers only. The constraints on family planning are said to be: religion, jealousy of husbands (perhaps that contraception will allow wives to be unfaithful with impunity), rumours of side effects, and the isolation and lack of transport.

The Cook Islands: Spacing is practised for health of child. This is likely now to be accomplished through family planning measures, available especially around Rarotonga, rather than sexual abstinence after birth.

Tuvalu: Family planning has been earmarked as the top priority in National Primary Health Care Programme established through the Ministry of Social Services in 1985. Its goals is to decrease NGR from 2.01% per year. Motivation is usually by female nurses to women visiting clinics or training programs. Efforts have been made to reach men through Sanitation Aides but was not successful because, as nonmedical people, men do not accept the information from them. Knowledge seems to be increasing but is hampered by transportation, management of health systems, and cultural barriers to getting information past the clinics to the people. Female sterilisation can be done only at the hospital.

Niue: Large families are wanted and strong healthy children are considered a blessing. Abstinence after birth has lessened with families migrating overseas, and the subsequent adoption of other values and practices of child-rearing to suit the family economy. The prevention of conception, like abortion, is frowned upon. Emphasis in family planning is on spacing of births and MCH rather than on birth control.

B. Knowledge, attitude and practices of the people of the different countries towards specific contraceptive methods:

Papua New Guinea: Over 60% of new acceptors in 1987 received, in order of preference, a pill, then injection (all other methods in small minority).

Fiji: Reliance on traditional methods of family planning continues together with use of modern contraceptives. A small minority rely on the rhythm, ovulation or coitus interruptus. Earlier programs relied on oral contraceptives which are still inexpensive, but their popularity waned with the introduction of intra-uterine devices and Depo-Provera, the latter becoming increasingly popular although it may eventually be superceded. A 1965 campaign promoting IUDs lost ground when rumours of side-effects grew, and the pill was preferred. However, in recent years, proper follow-up care and better understanding have reversed the trend. Female sterilization has increased (21,832 women protected by this as of December, 1983).

All family planning methods except sterilization, loops and injection have dropped in popularity. Vasectomies are not popular with either Fijian or Indian men, due to cultural obligations, hence the figures are low and impact of this method is negligible. Despite the ready availability of contraceptives, Fijians in particular are still hesitant, even a little ashamed of buying them in case other think they are preoccupied with sex.

Solomon Islands: The overall situation is unclear because, as in other cases, reviews and records are not flawless. Since the family planning program began in 1975, the pill appears to be the most popular method especially among the younger age groups. Ovulation methods widely used in Honiara and Makula where actively promoted by RC church. Depo-Provera shows signs of becoming increasingly popular especially among the multigravida.

Western Samoa: All contraceptive methods are available through the family planning program. The IUD and injectable contraceptive are the most popular methods for acceptors through the Family Welfare Centre. In 1973 the Fiaola clinic was started by the R.C. church to promote the Billings method of family planning, but the Apia clinic and smaller clinics attached to missions around the islands do not appear to have many acceptors, nor does the Family Welfare Centre which also teaches this method.

Tonga: Condom and diaphragm were the first contraceptives to be used. The loop and the pill were introduced later. The pill is not so popular because it is easy to forget to take it. New

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acceptors appear to be using more effective methods: IUD, Depo-Provera, or sterilization, but more research needs to be done on this question and several other aspects of the family planning activities in Tonga.

The Cook Islands: Oral contraceptive was the most popular in 1976, followed by IUD, and Depo-Provera. More research is needed, however, as a review in 1980 showed the pill was not generally favourably accepted among the population.

Niue: Depo-Provera has been the most popular method since 1973. The small charge made for oral contraceptives and the need to visit hospital more frequently make the other methods more popular.

C. Pregnancy and Childbirth Practices and the Role of Women in Family Health:

Pregnancy was usually accompanied by eating restrictions. Childbirth was attended by midwives, generally female (in some cases, for example, Kiribati, men were excluded from seeing a female's genitalia and the belief that family planning practices will today somehow involve breaking this taboo may prove to be a barrier to their introduction).

D. Traditional Birth Spacing Practices:

Generally (in Niue, Tonga, Fiji, Samoa, PNG, the Cook Islands) spacing was accomplished by post-partum taboos on sexual relations on the part of the mother if not both parents (to prevent the child from becoming ill), which continued for 2 to 3 years in Fiji, Tonga, Samoa and parts of PNG, or until the child was weaned. This was primarily for the sake of the health of the existing child. Spacing could also be accomplished by abortion.

In all parts of the Pacific, these taboos were broken down by Christian beliefs and western medicine, and also by the idea of sexual activity for pleasure rather than primarily for reproduction. These changes have led to soaring population growth, since infant mortality has been greatly reduced by western medicine and methods of care for infants (MCH), but also to neglected and undernourished children since, in most parts of the Pacific, they follow so closely upon one another during a woman's fertile years.

In the Solomon Islands, spacing is not a universal practice. The most common method, post-partum abstinence, survives in Malaita, one of the areas where husband and wife sleep apart at times of feasting as well. Also, the number of eligible men in Malaita has been reduced considerably by migration to Honiara.

Rural mothers tend to breast-feed longer but pregnancy can still occur before the child is weaned.

E. Community Access to Methods of Family Planning:

Fiji: ready availability of contraceptives. Papua New Guinea: outlets comprise hospitals (100%), health centres (94%), health subcentres (60%), and aid posts (23%). Solomon Islands: delivery improving but far from "readily available". Tonga: through Health Department clinics, district nurses, mobile clinics in outer areas. Services appear fairly readily available in Tongatapu but much less so in other islands. Western Samoa: fairly readily available through village women's committees as well as other agencies.

VIII. CONCLUSION

Clearly, there is a need for family planning activities in the Pacific to be strengthened based on a deeper understanding of the complex cultural process involved. Such efforts will have to take into account the many practical and ideological constraints which have been touched on in this analysis.

Attachment: Fiji - Sociocultural Factors Affecting Family Planning

FIJI SOCIOCULTURAL FACTORS AFFECTING FAMILY PLANNING

Fiji is politically independent. It has the status of a republic and is currently without a constitution. At the end of 1988 Fiji was made up of the native Fijian people (342,965), Indian population (340,121) and other races (35,033). This was the first time in 42 years that the Fijian population had outnumbered the Indian population. A total of 8920 Fijians were born last year compared to 8902 Indians and 1002 people of other races (Fiji Times 17/1/89). In 1963 the crude birth rate of the Indian population began to decline because of the rising age in marriage and the use of family planning (1).

Fijian traditional society is kinship based and there is an organized hierarchical structure within each kinship unit. The authority within this structure is believed to be God ordained.

Traditional Indian society is not as tightly structured as traditional Fijian society, although rural areas are more conservative in outlook than urban areas.

Most of the people making up the other races in Fiji are of Pacific Island extraction, and the rest are of Anglo-Saxon, European extraction or from other parts of the world.

This section concentrates on the factors affecting the Fijian outlook mainly because it is the Fijian people who are not as protected by family planning as the other races. Below are some of the sociocultural factors affecting family planning in Fiji.

Religion

The will of God is an important concept of Fijian life. Things that happen whether good or bad are attributed to the will of God. Both Fijian and Indian societies traditionally regard children as God-given.

The Methodist official policy supports family planning where family planning is taken to mean "the exercise of judgement on the question of how many children to have, that a couple can afford to look after, and the spacing of births for health and economic reasons ... and the use of medical contraception for this purpose" (2). The emphasis by the church is on the personal freedom of the members of the congregation to make their own decisions led by Christ's Spirit. Many believers who do not use medical contraception fear its use and some believe that if their heart is right with God then He will regulate the spacing of their children. Where this worked for women in the older generation

then they will try to pass this belief and practice on to their daughters. Abortion is forbidden by the Roman Catholic church but the Methodist church will make exceptions where the physical and social welfare of the mother and child is at risk. One observation was made at a religious seminar - "We became deeply convinced about the importance of the work of the Family Planning Clinics. Yet in many communities the churches have given only half-hearted support to this service and even opposed it. The same has been true of sex education" (3).

Where family planning and birth control methods comes to be viewed as encouraging pre-marital and extra-marital activities, rather than for spacing and controlling family size for the economic, social and emotional well-being then only half-hearted or very little support will be given by religious organizations. The success of the family planning campaign is indirectly a measure of the success of the Church's teachings among its congregations and others it is hoping to convert.

The Unwanted Child

"While tradition accepts that cohabitation may result in conception, modern ideas emphasize that cohabitation need not result in conception but must be enjoyed for the sake of satisfying the sexual drive. This 'modern' concept has been given undue emphasis. Any child born accidentally during the satisfaction of the sexual urge is labeled as an 'unwanted child' and is quite disliked. Before, there was no such thing. The concept of the 'unwanted child' is spreading fast, sooner or later many more children will be 'unwanted'. An unintended outcome of such family planning is the loss of the human value which emphasizes the love and care of other human beings" (4).

The Sociological Need In Fijian Communities For A Son

Although nowadays both sons and daughters are valued the traditional emphasis on the male to carry on the family and mataqali (sub-clan) name and to carry out the family obligations still exists. "The more children a couple have, especially male children, the more honored and proud they are. As it is through the male members that the group will continue, men are considered important - the continuation of the family group in its larger sections, the tokatoka (lineage), mataqali (sub-clan), yavusa (the larger clan)" (4).

Individual and Group Thinking

Although individuals make up the group it is usually somebody else who bears the responsibility for the personal group happiness that family planning programs envisage. These may be parents,

chiefs, ancestors, supernatural beings and above all the 'will of God'. "In the Fijian context, personal or individual gratification and happiness can be enjoyed only in relation to other human beings. Happiness or self-gratification is never an individual quality, but it is a much shared entity in the Fijian culture if the individual is to achieve meaning and satisfaction" (4).

Economic

There is a belief that large families mean economic security, more children, more helpers and protectors. "Economic tasks of gardening, house building, clearing new sites, and carrying out social obligations to other kin become light when shared. The efficiency of such a household is not impaired by the removal of one child at marriage or through sickness and death. The individual within an extended family feels much more secure when life crises and economic deprivation affect the family. Thus death or divorce may not be as serious as in a small family. There is more fellowship, providing social and recreational functions within the family. Parents also receive much assistance of the family in rearing their children" (4). Only when family size does grow do couples show a greater persistence in the use of birth control methods at other times this use is "indifferent or intermittent." Indian husbands support family planning in the early stages of marriage, while Fijian husbands became more favorable in their attitude as family size grew (5). Overall the involvement of males both Indian and Fijian is very low.

Urbanization

Most of the kinship units in rural areas rely greatly on subsistence agriculture but there is a growing need for access to the cash economy as there is much traveling from rural to urban areas, education and other needs. In urban areas there is much interaction with people outside one's kin or ethnic groups and greater reliance and need to be part of the cash economy. Where absence from the subsistence based economy is greater, people begin to experience new relationships with a wider variety of people and over time they develop other obligations and do not readily meet traditionally based kinship obligations.

Conservatism in Discussing Sex Related Topics.

This is a feature that is not common to Fiji only. Most of the island communities are kinship based and there already exists a cultural taboo on talking about sex related topics in front of close relatives of the opposite sex especially brothers and sisters and their parallel cousins. In more traditional oriented communities this carries over into married life where the man makes the decision and full discussion on birth control related topics is difficult.

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Use of Young Unmarried Motivators

They are viewed as lacking in experience to speak on family planning matters (1). In the villages, health workers (those who have undergone about six weeks training in basic health workers) help out in preventive health care.

Racial Differences

Family planning among the Fijians is lower than that of the Indians as Fijian men who make the decisions regard "large numbers of children as a means of counter-balancing the Indian population" (5). Fiji's Development Plan Nine (1986-1990) aims to increase the family planning protection rate. Indian women had the highest protection rate of women in the 15-44 years age group between 1978-1984.

Protection Rates (%)

<u>Race</u>	<u>1978</u>	<u>1980</u>	<u>1982</u>	<u>1984</u>
Fijian	16.9	16.0	16.0	16.4
Indian	31.9	31.5	34.3	33.3
Others	22.2	19.3	15.3	15.3

From National Planning Protection Protection Rate
DP9, Pg143

Education

One survey conducted on post natal care and family planning practices among Fijian women in Suva who had given birth in 1972, found that more women with lower primary school education than secondary educated women were protected at the time of the interview a year later. This was attributed to the practice of abstinence as well as the interest of the younger women who had secondary education in the spacing of their children. But this did not mean that family size would be limited. Among the Indian women in the same survey it was found that education does have a bearing on the practice of family planning. Women with more education were more likely be using a birth control method at the time of the survey but they were also the ones who had a higher rate of discontinuation after some time. (6).

Reproductive Health Care Knowledge

Mass media, relatives and friends, medical personnel are the sources of knowledge in the community. Health institutions and hospitals, dispensaries and clinics have nurses are specially trained in family planning and contraceptive advice. There is a

high correlation between age and education - younger people who have more education have more knowledge of modern contraceptives. A finding in a family planning report for the Pacific Islands' Trust Territories could also apply to the Fiji situation. Potential interest in those who want to learn more is more likely to be with women who have more children more education and live in large households and aged 25-34 years. (7).

Attitudes and Practices at the Community Level

Long periods of breast-feeding and post-parturition sexual abstinence was the traditional Fijian means of birth control spacing in the early 1900's at a time when infant mortality was high. This was intended to give the new born baby a better chance to survive. There was also the traditional belief that sexual intercourse while breast-feeding would cause the milk to go bad (6). On average, Fijian mothers' practices of abstinence and breast-feeding in the 1974 Fiji Fertility Survey lasted for ten months, while Indian mothers breast-feeding span was half of that time - five months. Traditional spacing of two to three years between births is still practiced today.

Natural birth control was ensured by built-in pressures within the community. The continued health of an unweaned child would be seen to be neglected and the parents obsessed with sex if children were born too close together. Now many husbands leave home for job opportunities, some go overseas, and fear of pregnancy outside marriage can act as such a control and helped maintained family stability. (1).

Use of contraceptives can be associated with both pre-marital and extra-marital activities in both Indian and Fijian communities. In the Indian community female chastity before marriage was traditionally valued. Availability of contraceptives contributes to the gradual erosion of this value. Some think others will think they are preoccupied with sex and are hesitant about buying or asking for contraceptives despite it being widely available. (1). It is not known as to how much of the non-use of contraceptives can be attributed to infertility, pregnancy, menopause, no sexual relations, want children, religious objection, fear, not yet, don't to don't know, or no reason. (7). To effectively increase the protection rate, perhaps this could be ascertained if a study of a sociological nature by non-medical personnel were carried out.

Approaches to Raising Awareness of Health and Family Planning Issues

In 1962 government's policy of population control through family planning was established to "create healthier families and enhance the quality of life to benefit the entire community" (1).

District nurses carry out family planning responsibilities in the rural areas as well as pre and post natal contact with mothers. The objective during the Development Plan Nine period (1986-1990) (9) is to reduce the birth rate to 25/1000 live birth by 1990 and the annual population growth rate to below 1.9% through public education campaigns and provision of additional financial and human resources.

Attempts at educating the public have been through the tri-lingual use of mass media, particularly radio because of the listening habits of people and the wide coverage it receives, newspaper advertising and articles, films, matchboxes, illustrated lectures, distribution of leaflets, and booklets. The Family Planning Association had also appealed to the Ministry of Education to introduce sex education at the 12 and 13 year old level. This has come about due to the noticeable trend of mothers getting much younger. In the early 1980's 75% of those who gave birth for the first time were between 15 and 24 years. Family Life Education of the Ministry of Education which seeks to raise the awareness in secondary schools of family life and sex education issues, came about as a response to this.

The Responsible Parenthood Council of the Catholic Church encourages the use of natural methods of family planning - the ovulation or Billings method in particular. They have counseling centers in the urban areas and chosen centers in out-lying islands. Counseling sessions include premarital talks to young couples about their moral and spiritual responsibilities as parents.

Knowledge, Attitude and Practices of the People Toward Different Specific Contraceptive Methods

One survey conducted by a health team in the early 1980's found that respondents agreed that family planning was good because of family health, high cost of living, land, education, and food needs. Men requested more information while women had sufficient information from the nurse.

Negative feedback included family planning not being right because it disagreed with biblical teachings (teachings not specified), side effects, rumors that family planning causes many diseases and the belief that when a woman practiced family planning and then stops and becomes pregnant the previous child becomes sickly. Population control, some men pointed out, meant that there were not enough men to carry out the work. Men generally, preferred at least 5 or 6 children. Sometimes people were just tired of using it and some reported difficulty in conceiving when they wanted to conceive again. (8).

Mixed reactions included children being the will of God so to prevent conception would not be right but that it was a sin to not be able to care for children's needs. Elders opposed it because they saw there was not enough children to fill the schools. Male groups were generally opposed but accepted it when their wives were favorable as they saw spacing reduced financial burdens. The trend between 1978 and 1984 showed a gradual reduction in the use of the pills and condoms and the injection by contraceptive acceptors. In 1978 23.2% of acceptors were using the pills and 17.4% were using condoms. The injection was used by 5.6%. In 1984 there were only 14.9% pill users and 12.3% condom users and 4.9% injection users respectively. Acceptance of loops increased from 11.6% in 1978 to 15.7% in 1984. Sterilization stood at 42.2% in 1978 and this increased to 52.3% in 1984.

Despite increases or decreases in acceptance of the different methods the protection rate is not as high as planners would like it to be. Cleland's survey (6) interviewed mothers in Suva who gave birth during 1972 about post-natal and contraceptive practices. Interesting practices between Fijian and Indian women came to light. Women feared the loop and the pills because of possible harmful effects and this was a decisive factor in the use by Fijian women of birth control acceptance but Indian women tended to be more ready to accept family planning methods. Opposition by their husbands was cited by both Indian and Fijian women. For Indian women this was a decisive factor in determining its use, with Fijian women this was not necessarily so. One third of the Indian women interviewed and only 12% of the Fijian women were not using any method because they wanted another child. The author of the survey concluded that Fijian women are more concerned about spacing. Use of condoms was more prevalent among Indians in this survey while withdrawal was used by more Fijian couples despite the fact that it requires the co-operation of the husband. The author also noted that the use of the rhythm was not limited to women of Roman Catholic background but that Fijian and Indian women also used that method. Trying different methods was a more common practice amongst women.

Pregnancy and Child Birth Practices and the Role of Women in Family Planning Health

Poor weaning practices, poor nutrition of mothers and babies and other socio-economic factors contribute to maternal and child health problems. The Fiji Red Cross Society's volunteers and motivators advise mothers about maternal and child care at ante-natal clinics. The traditional women's organisation, the Soqosoqo Vakamarama has family planning educators among its members and they work at village and community level (9).

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ANNEX I

PROGRAM ISSUES AND OPPORTUNITIES IN PAPUA NEW GUINEA

I. BACKGROUND

The country agreement between the Government of PNG and SPAFH is about to be signed, giving recognition to SPAFH as an international NGO and allowing it to operate in PNG. The Minister of Finance and Planning (MFP) has no objection to NGO assistance, but asks that all requests for assistance to an international NGO go through the Foreign Aid Management Office. A copy of the request is sufficient for NGO-to-NGO relations. A letter of support from the MOH, or relevant government body would be helpful. The MFP prepares a "Public Investment Strategy" every year, which indicates how much foreign assistance is expected to come in so it would prefer that assistance to PNG be in line with this strategy. However, SPAFH's role in complementing other programs is welcomed. The soon-to-be-approved A.I.D. Child Survival Project has been listed as a priority in the 1989 PNG Investment Strategy.

Discussions and document review revealed a consensus on priorities for SPAFH involvement in PNG over the next three to five years. These include policy development work, research on cultural constraints to family planning, IEC skills training and outreach to men and youth, and training for service providers in family planning counseling, interpersonal communication, and contraceptive technologies. Several of these areas overlap, such as IEC and interpersonal communication skills training and outreach to men.

Within the DOH there is a strong interest in support for family planning IEC and services. Little information is available on the family planning services that are provided (estimates of prevalence range from 2.6% to 17%) and on the cultural factors influencing family planning acceptability.

There is a dearth of personnel trained in family planning IEC skills; information and education activities and materials are limited. Men and youth are considered two key target audiences that have not been reached. Providers need training in family planning counseling, interpersonal communication, and contraceptive technologies. Any efforts at demand generation must be closely coordinated with the availability and upgrading of services.

Note: The findings and recommendations in this paper were discussed with PNG contacts during the SPAFH Regional Workshop on Updating Contraceptive Knowledge (Fiji), held June 5 - 16 in Fiji, and the SPAFH Board of Directors meeting, held June 20 -23 in Fiji. Priority recommendations for SPAFH activities were focused on where there seems to be a potential for impact. Equally promising opportunities may be identified during project implementation.

II. ISSUES AND OPPORTUNITIES FOR POLICY

A. Background and Current Status:

In early 1988, the MFP established a National Advisory Committee on Population Policy in collaboration with the International Labor Organization (ILO), UNFPA, and A.I.D. This committee drafted guidelines towards the formulation of a national population policy. Goals to be met in three phases were set. The first goal called for drafting a policy and obtaining Cabinet and National Executive Council approval. The second phase aimed to increase public awareness of population issues through IEC materials and to train staff in population policy and program development. The third and last phase included establishing a functioning Population Policy Unit to review and evaluate goals, improving the technical capacity of the provinces to integrate population programs into their services, establishing a regional resource center on population issues, and strengthening the IEC program at sub-national levels. In the intervening period, the status of population policy development has changed.

The 1989 - 1993 "Development Plan: Sector Policies and Strategies" calls for a "sound population policy". The task to develop and implement the population policy was given to the MFP. While there seems to be a consensus that there is a demand for a population policy, there are two views as to how to best approach policy development and implementation. One, which was expressed mainly by mid-level technical/managerial staff and expatriate technical advisors, holds that the MFP's statement is a sufficient basis for moving ahead without making it a controversial issue. The other view holds that population policy must be approached in a systematic, academic manner with a clear government endorsement (via the establishment of a population policy unit). The latter view feels that in order to avoid controversy, a concrete policy (the Solomon Islands was cited as an example) should be established before public support is sought.

In either case, little action has been taken since this statement and none of the high-level government representatives appear to want to take the leadership. Assignment of population policy to the MFP (rather than to the Department of Health (DOH) from where previous initiatives for a population policy have come) could mean a side-tracking of the issue. However, the Acting Secretary of Health stated that the DOH does not want to be responsible for a population policy because doing so "might spoil our family planning program." The DOH has been involved in population policy work, lead by the Assistant Secretary of Family Health, however little concrete action has taken place. Some provincial ministers are said to be supportive of birth spacing, but are hesitant to raise the issue in the national parliament.

A plan to establish a Human Resource Planning Branch within the Planning Division of the MFP has been submitted to the Personnel Office within the Office of the Prime Minister. It calls for establishing a Population and Development Unit and an Employment and Manpower Unit within the Branch. A draft project document, prepared with assistance from Mr. Krisnamurti of Lactech of Bangkok, has been submitted to UNFPA for funding for the Population and Development Unit and to ILO for funding for the Employment Unit. (The document was not made available to the team.) A technical advisor will be placed within the Population and Development Unit to train three proposed staff and assist in establishing the unit.

To date, no response has been received from the Personnel Office and it is believed that the Personnel Office thinks this Branch should not be located in the MFP-- perhaps the Ministry of Labor and Employment is a more appropriate place. The Acting Assistant Secretary for Planning, who is responsible for submission of the project, is taking a very cautious stand in light of this lack of approval. She feels adamantly that no government-level action on a population policy, including SPAFH facilitation or coordination, can or should be taken until the Population and Development Unit is established. The project document calls for a phased approach to population policy development; activities would start in two provinces with the goal of incorporating population factors into development planning. The overall approach to population policy in the project is comprehensive taking into account family health as well as demographic factors.

The Assistant Secretary expressed doubt about the extent to which "public input" into the policy is wanted. The one area in which SPAFH might get involved is IEC, as this responsibility is not fully established, but not until there is government endorsement for a policy. SPAFH work with NGOs and support for DOH programs was suggested.

Demand for family planning standards of practice, guidelines and protocols also exists. For example, when DepoProvera was first introduced, it was indicated only for women with four or more children. Although this "policy" no longer holds, providers are reluctant to administer it to women with less than four children, even if it is requested. One of the few family planning posters available states "Depo: for women with four or five children." In some areas, service providers require written permission from the husband before prescribing oral contraceptives (OCs) for women, although this is not a formal policy.

In August, 1989 the senior nursing staff of the DOH are holding a workshop to design standards of practice for family planning, with support from the DOH. The FPA is involved in the planning committee. SPAFH support for followup workshops to refine policy/review policy implementation would be welcome. This kind of support would be needed at both the national and provincial levels.

Support should be pursued for the proposed 1991 post-census workshop/meeting which is described in the SPAFH annual progress report to the Board of Directors, but was not mentioned by any one in PNG.

B. Human Resources:

There are no PNG national demographers. Two professors in the Geography Department at UPNG teach demography and the Department of Community Medicine in the Medical School has a demographer, Dr. A. Muthiah, who is one of the participants in the "Friends of the Census" ad hoc group at UPNG. All staff in the National Statistics Office of the Census Division have some background in demography, but need training in demographic data analysis, particularly in dealing with the 1990 census data. All demographic data/projections are based on the 1980 census. Birth/death registration and health service delivery data are unreliable.

The Institute for Applied Social and Economic Research, affiliated with UPNG, is capable of social science research, although its reputation is not strong. The Institute of National Affairs is a private sector research body involved in studies of employment and migration for the private sector. The Institute for PNG Studies at UPNG is anthropologically oriented. The Institute of Medical Research, based in Goroka, focuses on epidemiological studies. The MFP's population project document calls for the MFP to subcontract UPNG to do certain studies, but currently links between the MFP and UPNG are weak.

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UNESCO is working with the GPNG on a project with the Curriculum Unit of the Department of Education to incorporate population education into schools.

C. Policy Constraints and Opportunities for SPAFH:

Constraint # 1: lack of leadership and political will in initiating policy development within the public sector.

Opportunities for SPAFH:

a) Establish good work relationships with MFP to share SPAFH staff experiences in policy work from the Solomon Islands; to assess level of interest in high level awareness raising workshop for national and provincial government leaders, NGO and church leader etc; to discuss census data and the MFP 1989-1993 development plan; and to identify whether there is demand, rationale, support and leadership for the preparation of a national population policy.

b) Assist, support and facilitate high level awareness raising workshop if there is interest and need and follow-up activities to ensure population policy plans from high level workshop are carried out.

c) Assess its own capabilities and make accessible the best available resources such as Futures' Rapid Programs and Solomon Islands resources that would be useful to PNG, in its policy preparations.

Constraint # 2: high level public sector directive which restricts SPAFH to support policy by working with NGOs only at this point.

Opportunities for SPAFH:

a) Work with the PNG Family Planning Association (FPA) and other NGOs to determine the extent and sources of support for a population policy and/or family planning within the NGO sector and disseminate easily interpreted population data for awareness and consensus building. A 1988 needs assessment by IPPF recommended to the interim Pacific Island Planned Parenthood Alliance (PIPPA) Executive Council that it support consensus building for population policy development. Any FPA activities towards this goal can be funded as separate projects, outside the FPA's annual budgets.

b) Collaborate with the "Friends of the Census" ad-hoc group to identify ways in which the 1990 census data can be best used and disseminated for population awareness and planning purposes.

c) Involve the press and the non-governmental research groups in disseminating population data for awareness raising.

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Constraint # 3: limited capabilities for population-related research.

Opportunities for SPAFH:

a) Work with "Friends of the Census" groups and the statistics department to suggest the inclusion of family planning related questions in 1990 census.

b) Support the proposed 1991 post census workshop meeting which plans to hold national awareness campaign on population issues.

c) Identify and support mechanisms for including family planning on population-related research at UPNG, Institute for Applied Social and Economic Research, DOH Kap Surveys.

d) Explore ways in which it can support the analysis and dissemination of the data for population planning purposes.

Constraint # 4: lack of family planning standards of practice, guidelines and protocols for service delivery programs.

Opportunities for SPAFH:

a) Support the DOH Nursing Council and Family Planning Association efforts in designing standards of practice for family planning.

b) Support follow-up workshops to refine policy/review policy implementation at national and provincial levels.

III. ISSUES AND OPPORTUNITIES FOR IEC PROGRAMS

A. Background and Current Status:

Within the DOH there is a strong interest in support for family planning IEC and services. The National Health Plan includes family planning as one of its four priority areas. When the A.I.D. project Communication for Child Survival (HEALTHCOM) first approached DOH officials about two years ago, family planning promotion and services were the first priority expressed. Family planning services are outside the mandate of HEALTHCOM; this project is working with control of diarrheal diseases in Central Province, with plans to expand to additional provinces.

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Health providers and others make a number of broad generalizations about attitudes and practices regarding the value of children, the role of women, birth spacing, and modern family planning methods. There seems to be little culture- or region-specific data that provides in-depth understandings of current trends or practices, or under which circumstances they occur. Sex and sexuality are said not to be subjects of conversation. PNG is commonly divided into two "cultural zones"--the highlands and the lowlands, although hundreds of distinct cultures exist within each. In both areas, women have a subservient role. Bride prices are reported to be as high as K 40,000 (\$US 48,000). Polygamy is common, and the out-migration of men to urban areas contributes to perpetuating this system. Incidence of sexually transmitted diseases [STDs] among women is reported to be high. Children and wives are a means by which a man builds power and status within his clan and community.

Birth spacing has been widely practiced through a variety of traditional mechanisms--taboos on post-partum intercourse and prolonged breastfeeding (intercourse with a woman who is breastfeeding is believed to impair a man's virility). Although these traditions are now breaking down, particularly in urban areas, it is not known how strongly they still hold in rural areas. (Note: breastfeeding is strongly promoted in PNG. A physician's prescription is required for purchase of a baby bottle.) Herbal and other traditional contraceptive methods are thought to be used, but no study has been done about the extent to which they are employed or their effectiveness.

The public which has heard of family planning interprets the term to mean fertility limitation, two children only, etc. and there is little awareness of family planning as a health intervention. There are so few contraceptive users in PNG (estimates of prevalence vary from 2.6% to a high of 17%) that a profile of the "typical user" is difficult to obtain. Urban women who wish to avoid pregnancy prefer the rhythm method, so they can tell their partners that their bodies are pure, untainted by chemicals such as those in the pill. There appears to be little interest in vaginal barrier methods, as women are adverse to touching their genitals.

Among young urban men, it is a social stigma not to have fathered a child. Both urban and rural men are reported to complain that the women don't want to get pregnant any more, which may indicate a demand for family planning on the part of women. In addition, inquiries about and sales of condoms in Port Moresby pharmacies have increased, but it is not clear if this increase is due to interest in contraception or AIDS/STD prevention. "Delaying cream" to maintain erection is a popular product in urban areas. Positioning condoms as "delayers" may be a feasible marketing approach to condom promotion.

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The UNFPA-funded MCH/family planning project (the DOH's primary externally-supported family planning project), executed through WHO, in Central, Enga, and Morobe provinces was a "significant failure," with only a minor increase in prevalence in the targeted provinces being reported. It is hypothesized that this failure was due to two factors: the wrong group was targeted (health workers), and administrative support at the national level was weak. A knowledge, attitude, and practice (KAP) survey in the three provinces was conducted near the end of the project. The data, now with the Assistant Secretary for Family Health, has yet to be analyzed. Preliminary results indicate that there was an increase in knowledge of modern contraceptive methods (women are aware of the options) but no change in practice was achieved. (Note: there is some doubt as to whether UNFPA will fund a follow-up project to this one, given its failure.)

In many areas, it is culturally unacceptable for male health workers (the majority of the APOs and many of the nurses) to discuss family planning with women. The decision to use a family planning method rests with male partners. In spite of the general recognition of the key role that men play in family planning decision making, no efforts have been made to target men with family planning awareness/benefit information and education.

More than two-thirds of the women undergo childbirth without trained assistance. There is no recognized traditional birth attendant role, and many women deliver alone. About two-thirds of women receive prenatal care, but less than half of the women make more than one pre-natal visit before delivery. Utilizing TBAs and prenatal care as mechanisms for family planning awareness is practically excluded. Although family planning education is supposed to be offered from Aid Posts up to hospitals and services provided from sub-health centers up, no one seems to know if this really occurs.

Men and youth are the two target groups most often mentioned as needing relevant information about family planning, population and health. UNFPA is funding a family life project with the Department of Women's Affairs.

The A.I.D. Child Survival project contains a few components, such as training in reproductive health education and midwifery, and in nursing administration which should offer opportunities for increasing family planning/birth spacing awareness and services.

B. Resources for IEC:

Several years ago, the Health Education Section at the national level was downgraded and phased out at the provincial level with the rationale that all health workers are health educators. Not only were health workers not trained in health education/IEC, but this task was generally moved to the bottom of

the priority list. The current Minister of Health is very supportive of health education mainly as a result of the need for AIDS education and has approved funding for seven health educator positions at the national level and the reestablishment of a Health Education Coordination within the DOH. (The current section has one health educator and a graphic artist as well as a WHO Advisor for Health Education.

Plans call for establishing three units: health education research and evaluation (with a social scientist), IEC, and administrative services. Health education is currently under the Division of Primary Health Services; the plan is to place it directly under the DOH so that it can support all divisions. A request has been submitted to make health education a nationally delegated function until the provinces have the financial capabilities (political support) to implement health education activities on their own.

At the same time that the health education function was abolished, the Institute for Health Education, which provided post secondary, diploma level training was abolished. There are plans to reestablish the Institute at the Goroka Teaching College. The goal is for PNG to become a regional health education training resource. Qualified faculty will be needed initially. The new health educators will be drawn from among service providers previously trained as health educators (now working as Health Extension Officers, etc.) and "promising young people." Provincial health education sections will be set up.

WHO is supporting the first national health education workshops to be held in June and July of this year. WHO is also sending eight provincial health educators to Thailand for a 12-week training and observation visit to learn community health organizing and educational skills. Planning and evaluating health education activities in line with community beliefs, attitudes, and practices are needed skills. Plans do not call for developing personnel with speciality skills in family planning IEC, but support for this is welcome.

There are few available family planning-related materials and those that do exist are several years old, in limited quantities, and/or highly textual. There are numerous resources which can be built upon. No systematic outreach efforts have been undertaken. The National Training Support Unit (NTSU), which is responsible for in service training and health education materials design and production, has good printing capabilities. 50,000 copies of PNG Health News are printed and circulated monthly with Wontok (Pidgin) and The Courier (English) newspapers. (Printing is done by the newspapers.) Each issue focuses on general interest news around a specific health topic (modern family planning methods and the ovulation method have been included). The DOH, with funds from WHO, then buys and distributes an additional 12,000 copies at 12 copies/US\$ 1.20 and has a special section printed that includes "how-to" information for health workers.

A series of radio spots on health, including child spacing, are under preparation. Radio listenership is high. The DOH has ready access to free TV time. Talking about Health is broadcast on TV in Pidgin three hours a week.

There are a number of provincial touring theater groups, which bring health messages to rural areas. Some of these have included family planning messages and there is a history of DOH support for these groups. Walkabout Marketing, a theater group of First Market Research, has been very successful in using drama and demonstration to market consumer products such as laundry soap, instant soup, and toothpaste to villagers.

Videos are increasingly popular in rural areas and large numbers of VCRs and monitors exist. WHO is providing VCRs and monitors to every province. There are talented local video production agencies. Corporations have provided funding and in-kind support for health activities. Johnson and Johnson produced the video on prenatal care, Baby and You, in three languages with technical advice from the Health Education Section and Colgate Palmolive has donated soap bars as incentives for immunization.

The Health Education Section has worked with churches, women's groups, and other NGOs on immunization and diarrheal disease campaigns.

The New Guinea Collection of the UPNG library has a computerized catalog and copies of all research done by both nationals and foreigners. Several studies on the meaning of children were conducted around the time of the 1980 census. Proposals to do research related to sexuality and fertility have usually not been approved. In order to do research, a proposal must be submitted and clearance must be obtained from both the national and provincial authorities. The Department of Community Medicine of UPNG has an anthropologist on its staff, Kerry Pataki-Schweitzer. Community Medicine students are required to do field research.

C. IEC Constraints and Opportunities for SPAFH:

Constraint # 1: current lack of trained IEC personnel, at provincial and national levels. Information on community attitudes and practices regarding reproductive health beliefs and practices (including attitudes toward modern contraceptives) is either not available or not being shared with personnel involved in family planning programs. Availability of family planning services to meet current demand and any increased demand generated by IEC efforts is not known.

Opportunities for SPAFH:

- a. Support initiatives for strengthening the health education program.
- b. Support a review and analysis of studies in the PNG, collection at UNPG. Should these not provide sufficient background, it may be possible to contact anthropologists/social scientists doing research in the field and request that they provide information (via a questionnaire) on reproductive health beliefs and practices etc.
- c. Support the Family Health Department in the analysis of the KAP data from the UNFPA project in three provinces. This could additionally serve as baseline data for evaluating any IEC efforts in that region.
- d. Support mini-KAP studies (for rapid feedback) to identify who is interested in family planning, why, and in which methods in order to develop IEC efforts. This may be an area of mutual collaboration with the SOMARC II Project.

Constraint # 2: lack of IEC materials to encourage involvement of men in family planning programs

Opportunities for SPAFH:

- a. Support the design and implementation of a multi-media campaign aimed at men (perhaps beginning in a few targetted provinces) utilizing the print and other media.
- b. Support research on studies on men's attitudes and beliefs to develop appealing, credible messages that convince men that use of modern family planning methods by their wives will be beneficial. The approach should build upon traditional birth spacing practices and beliefs and economic and social advantages.
- c. Assist the DOH to draw upon the cadre of male health workers as resources in a "man to man" family planning awareness campaign. All health workers would need training in contraceptive technologies and interpersonal communication for the success of such a project.
- . Explore collaboration with the Department of Women's Affairs/UNFPA Family Life Project and/on other organizations (churches, women's organizations) to evaluate gaps in these existing projects which SPAFH could effectively fill. Suggested activities for SPAFH support may be films, videos, leaflets and counselling for youths.

Constraint # 3: family planning information has not been readily made available to the general public.

Opportunities for SPAFH:

a. Explore the many existing media (Theater, Radio, T.V. Newspapers) with broad reach including rural communities and support the inclusion of family planning information.

b. Support the development pictorial print materials which reinforce family planning messages and distribution of materials as reminders.

c. Pursue the history of public/private sector collaboration in health education and expand these experiences with health topics to include family planning e.g. work with NGOs to seek corporate support for materials.

IV. ISSUES AND OPPORTUNITIES FOR IMPROVING FAMILY PLANNING SERVICES

A. Background and Current Status:

The extent to which family planning information/services are effectively being offered at the various levels of services in the provinces is not known. (Anecdotes of the APO who was in residence in his village 3 weeks of the year were told.) The DOH is aiming to have APOs provide OCs and condoms, in a CBD-type program. This will require policy changes as OCs are now provided by prescription only. Service delivery data is not routinely collected. Lack of transport and the difficulties female community health nurses encounter in travel to rural areas impede regular supervision of aid posts.

A key weakness in family planning service delivery is the inability of service providers to appropriately communicate with the community about family planning. The need to train health workers at all levels on "how to deal with people" and communicate family planning messages clearly was expressed by all officials. Many health workers, particularly, but not exclusively, male health workers (Health Extensions Officers, nurses, APOs) hold erroneous notions about contraceptive methods and/or share beliefs about cultural inappropriateness of family planning. Teaching aids are distributed from the national level to the provincial level to the district and community levels. It is not clear to what extent materials do reach the community level, and if so, whether or not health workers are trained to use them. Family planning reference manuals for health workers are also lacking. Understaffing, especially at urban health centers, leads to overburdened health workers with little or no time to talk to clients.

B. Resources for Service Provider Training:

Pre-service training is mainly the responsibility of the Training Branch, under the Division of Administration of the DOH. Currently, this branch is primarily concerned with training of nurses. (The School of Nursing operates under the Training Branch. Nurses consider MCH/family planning to be "nursing centered activities.") The NTSU was established as a resource for pre-service and in-service training and curriculum/media development, with a focus on in-service training for both nurses and other categories of health workers. Provincial schools and teaching colleges are also involved in health worker training. The amount of family planning (technical, IEC, supervisory, and data collection skills) that is/was included in pre-service training for all categories of health workers is unknown. Family planning as part of the medical school curriculum seems to depend on the individual professor, although both ob/gyns and internists (general medicine) are required to do practicums in ob/gyn which are supposed to include family planning. UPNG is graduating only about five ob/gyns per year.

Relationships and division of responsibilities between the NTSU and the Training Branch are not clear. Comprehensive, coordinated training strategies are lacking. Recently, about 200 of a new category of health worker, the Community Health Worker (CHW), were trained, with support from A.I.D. via MEDEX of the University of Hawaii. The intention is to eventually have these CHWs replace APOs. CHWs have more education than APOs and were trained in provincial schools (both church- and government-affiliated.) The Nursing Council, which operates under the DOH, is dissatisfied with this approach, claiming that they were not consulted about the incorporation of this new cadre into the health system, yet are being asked to supervise the CHWs. The Nursing Council plans to recommend that training of CHWs be stopped, the curriculum be revised, and a policy on the CHW role be developed. It's not clear whether this is a real training/service delivery issue or an expression of nurses' fear of professional encroachment. The Health Education section of the DOH has worked with the NTSU to develop in-service training strategies and materials for health workers on interpersonal communication for diarrheal disease control.

The A.I.D. projects, Social Marketing for Change (SOMARC II) and Communication for AIDS Prevention (AIDSCOM) made a joint project exploration visit to PNG in July, 1989. Social marketing of condoms (as contraceptives and STD preventive measures) and OCs will be explored. Over-the-counter OC sales will require policy changes. Although it is premature to indicate potential relationships between SPAFH and these projects, collaboration should be kept in mind. SPAFH staff may be able to participate in training provided through these projects, when appropriate.

C. Constraints and Opportunities for Service Delivery:

Constraint # 1: lack of skills of service providers in inter-personal communication and knowledge and skills on contraceptive technology.

Opportunities for SPAFH:

a. Support pre-service and in-service training to include contraceptive technology and family planning counselling and interpersonal communication in conjunction with family planning IEC skills training.

b. Support follow-up workshops to the Contraceptive Technology Update Workshop held in Lautoka, Fiji in June 1989 at national and provincial and community level. Follow up could include interpersonal communication and counselling design of simple health education tools, and a review of contraceptive methods.

c. Support DOH.Nursing Council and DOH/Training Department to require family planning training and practicing in the medical and nursing curriculum and incorporate family planning IEC (including inter-personal communication and family planning counseling).

d. Encourage and support health education training programs to include family planning.

e. Explore possibilities of adapting Solomon Islands continuing education courses for provincial and district family planning service providers in PNG, and support activities.

f. Support production training ideas which gives simple explanation of modern contraceptive methods and which describes and discusses "how to talk to clients". (Note: The Health Education Section, with assistance from HEALTHCOM, has produced a training video Speaking Clearly which has been successfully used to train health workers to communicate with clients about diarrheal diseases.

Constraint # 2: lack of comprehensive, coordinated training policies and assigned responsibilities for pre-service and in-service training.

Opportunities for SPAFH:

a. Support DOH/Nursing Council and FPA in the formulation of family planning standards of practice for service providers and support any plans for training policies to include family planning.

b. Work with WHO & DOH to coordinate training and assistance for training and support initiatives to formulate training policies for pre-service and in-service training.

c. Encourage a change in national policy to allow trained paramedical staff to dispense oral contraceptives.

Constraint # 3: lack of information on actual family planning service delivery (who is doing it and where)

Opportunities for SPAFH:

a. Support analysis of DOH surveys and other research groups' data.

b. Support training of health educators, nurses etc to include research methodologies.

Constraint # 4: lack of trained health workers, to provide family planning service delivery.

Opportunities for SPAFH:

a. Carry out research and support model CBD program in a few provinces in collaboration with NGOs and PNG FPA, and DOH aid post orderlies and community health workers.

b. Incorporate breast feeding into service delivery as a contraceptive method as well as health intervention. This also builds on traditional approaches to birth spacing. This is an area in which the A.I.D. Child Survival Project might be involved.

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ANNEX J

PROGRAM ISSUES AND OPPORTUNITIES IN THE SOLOMON ISLANDS

I. BACKGROUND

A. Political Setting:

Elections were held in February 1989 and a new government is in place. This is the first one-party government in the history of SI. The Prime Minister's Office directed that all projects with NGO, bilateral, and multilateral assistance must be reviewed. All programs must correspond to the "People's Alliance Manifesto" The manifesto is still being designed and therefore is not available to the public.

The GSI has put a moratorium on the hiring or placing of expatriate personnel within the government. NGOs are coming under particular scrutiny. NGO coordination is now under the newly created Ministry of Provincial Governments, which is currently operating jointly with the Ministry of Home Affairs.

The Peace Corps program has been stopped. The Foundation for the Peoples of the South Pacific (FSP) and the Solomon Islands Development Trust (SIDT) have been asked to submit all financial reports and audits for review. However, none of the discussions indicated that SPAFH and SPAFH's support for SI projects was being questioned.

The Planning Unit of the Ministry of Health and Medical Services (MHMS) is drafting the 1988 annual report and the 1990-1994 Plan of Action, which will be reviewed by the Prime Minister's Office and possibly changed. MHMS staff were hesitant to specify particular areas for SPAFH assistance until these strategies have been approved. At the same time, it was clear that SPAFH is welcome and respected in the SI.

All project proposals for outside funding must be first reviewed by the Planning and Evaluation Unit of the Prime Minister's Office, then they go to the Ministry of Foreign Affairs for approval.

The WHO Country Liaison Officer suggested that SPAFH might be requested to work with WHO in providing assistance for the family planning component of the WHO Family Welfare project that is currently being planned.

B. Health Services Setting:

Health service delivery and administration is decentralized. Provincial governments manage and make decisions about health matters. The MHMS (Ministry of Health and Medical Services) is responsible for staffing, training, supplies, and facilities. At the provincial level, the provincial health department is under an Assistant Secretary of Health. Health centers and other peripheral units are under the supervision of a Health Extension Officer. In Honiara, MHMS services are provided through the Honiara Town Council clinics.

Village health workers (VHWs) are volunteers from the community who provide preventive, educational, and basic first aid services. They are supervised by nurse aids. Nurse aid posts are village-level health services, supervised by clinic staff. Clinics are staffed ideally by two nurses (one female and one male) and are supposed to provide family planning services. Area health centers are staffed by nurses and medical officers and supervised by Health Extension Officers. Family planning services are said to be provided. Provincial hospitals are also staffed by nurses and physicians and offer family planning services. The Solomon Islands Planned Parenthood Association (SIPPA) provides family planning services at their own clinics and supplement services provided by the Honiara Town Council and the services offered by government health centers.

II. ISSUES AND OPPORTUNITIES FOR POPULATION POLICIES

A. Background and Current Status:

SPAFH is recognized for having set the ground work for the promulgation in 1988 of the National Population Policy. Although the current Prime Minister was opposed to family planning during his previous term as Prime Minister, nothing thus far indicates that the new government is opposed to the policy or family planning. Workshops as outlined in the policy (pp. 27-28) have been moving ahead. Because of the review of all externally funded projects, the appointment of the proposed Senior Administrative Officer for Population Planning and Coordinator in the MHMS is on hold (p.29) although ILO has promised to fund it. The Acting Undersecretary for Health Improvement is coordinating policy implementation activities, as per the policy statement, although the Chief Medical Officer for Health Care was the "mover and shaker" behind policy development. The two family planning nursing positions, which were to be funded by the GSI, have also not been approved. The MCH/family planning Unit has been created, as planned (p. 23).

All but two of the SPAFH supported Phase I workshops have been held. These workshops are focused on briefing health workers on the population policy and producing related IEC materials. SIPPA is carrying out the workshops in collaboration with the Health Education Section of the MHMS. The first three workshops were funded by UNFPA via WHO; the others have been funded by IPPF. Plans are under way for the second year of Phase I workshops. UNFPA has indicated a willingness to continue funding for these workshops. Regular radio programs in English and in Pidgin on population issues complement the workshop awareness efforts. There is only one radio station in SI and no TV--radio listenership is high.

The initial UNESCO support for a community population awareness project through the Community Education Division of the Ministry of Education and Training (MOET) has just ended. SIPPA and MHMS also assisted on population education issues. An organizational infrastructure of a national coordinating committee and provincial coordinating committees still exists and a new UNESCO-supported project is at the Ministry of Economic Planning for approval. "Bridge support" from SPAFH to continue activities until the UNESCO project is approved would be welcomed.

B. Resources for Population Policy Implementation:

Population-related research capabilities are known. There appears to be an infrastructure of community level networks that could be tapped for awareness and educational purposes. (See also SIDT and SIMRI below.)

C. Constraints to Population Policy Implementation:

1. The new Government's position on the population policy is not clear.

2. The new Government is looking closely at NGO activities in SI.

3. National capabilities in demography, statistical analysis etc. are unknown, but seem quite limited. SIMRI (see below) may have the capability to do some research.

D. Opportunities for SPAFH to Explore:

Policy implementation is moving ahead as planned. SPAFH can work with MHMS and SIPPA to "fill in the gaps" in the activities supported by UNFPA. ILO will be working in the Solomon Islands in July 1989 to assess the status of population policy implementation and to draw up suggested plans of action for all international agencies to ensure coordination on policy implementation.

Possible areas of SPAFH involvement include: evaluation of the effect of the Phase I workshops to determine future directions and design of Phase II workshops; translation of the demographic goals into family planning service delivery objectives; production of IEC materials for the Phase II workshops at the village level; and continued support for family planning service delivery and IEC.

SPAFH should also evaluate the feasibility of providing bridge support to the MOET's community population awareness program and assisting in the production of IEC materials for this program.

III. ISSUES AND OPPORUTNITIES FOR IEC PROGRAMS

A. Background:

SI is a nation of villages. About 85% of the population live in rural areas. Many of the same cultural conditions that contribute to a lack of awaress/resistance to family planning in PNG also exist in SI. Women have low status, men desire large families for prestige and power, and misinformation about modern contraceptives is common. Some factors which will eventually lead to more widespread adoption of family planning include the increasing cost of living, changing values (imported, canned fish is perceived as a better food than fresh fish), the growing lack of land, and the desire for children to have an education. Traditionally, birth spacing was practiced through post-partum taboos on intercourse and prolonged breastfeeding. These practices are quickly being eroded. Approximately one half of pregnant women receive prenatal care and deliver under professional supervision.

The terms "birth spacing" or "family spacing" are preferred by officials over family planning. The latter has a negative connotation. However, two of the MHMS posters used the term family planning in Pidgin. Contraceptive prevalence is unknown, but assumed to be very low. The total fertility rate is 6.1 (per the 1986 census), the second highest rate in the region.

B. Resources for IEC:

The MHMS Health Education Office has a staff of about seven. There are provincial Health Education Sections. The provincial sections do not produce their own materials for which they rely on the national section. WHO is supporting a five-month training course for 15 health education assistants who will be posted to the provinces to work within the health education sections.

The MHMS Health Education Office has produced a series of family planning posters (about six--half are in English, the other half in Pidgin). Two of the posters were produced under the SPAFH IEC project. There is a SPAFH/SIPPA ovulation method clinic (O clinic) coordinating committee for the IEC project. The MHMS posters are made available to clinics and to schools and other organizations who request them. The MHMS plans to produce a family planning flipchart and brochures on methods. These will be used by nurses who are participants in the SPAFH sponsored Training of Trainers program. They had requested materials for counselling purposes, therefore SPAFH has included these materials in the current IEC project.

SIPPA has also produced a calendar, several posters, and a series of brochures on each contraceptive method and one on all methods. Two of the posters were produced under the SPAFH project. The brochures and posters are all in English. Adult literacy in English is 15%. SIPPA did not produce the brochures in Pidgin because there are no standard terms for the methods in that language. (Oral contraceptives [OCs] are known as "quinin," the word for all pills, tablets.) The SIPPA brochures are given to the public who request them in writing or by phone and to users in the SIPPA service delivery sites. Most of the posters are adaptations of familiar images in family planning posters from other countries. None have an indication of where or how someone might get more information and/or services if so inspired by the posters.

In sum, the approach seems to be materials production for the sake of materials. There is not a clear sense of the purpose of the materials, nor how they can be best used. While the materials were said to be pretested, it is not clear with whom or how.

SIPPA does a 15 minute radio session on family planning and population in Pidgin three times a week. Air time is purchased. "Custom stories" (traditional tales, legends) are very popular on the radio. Other outreach efforts using traditional media have not been tried.

An NGO, the Solomon Islands Development Trust (SIDT), has a well established network of 115 trained village workers divided into mobile teams of three throughout the SI. The teams are involved in conducting group meetings/workshops with villagers regarding population related issues: land, logging, reforestation, etc.; e.g., the workers conduct an exercise which gets people to think about food, housing, education etc. in terms of the past, the present, and the future.

The Young Women's Christian Association (YWCA) focuses its programs on its priority areas of health, education, and human rights. They would like IEC materials for policy makers, technical people, and the community level along with accompanying information on how to use the materials in their programs. The materials should focus on why family planning is both a woman's and a man's responsibility.

C. Constraints to IEC Activities:

1. Family planning service delivery is concentrated in the Honiara city area (see below). Outreach/awareness efforts must be carefully coordinated with expansion/upgrading of service delivery so that supply can meet demand.

2. The uncertainty about the new government's support for family planning probably hinders more aggressive outreach efforts.

D. Opportunities for SPAFH to Explore:

1. Health education personnel at both national and provincial levels exist. Working relationships between the MHMS, SIPPA, and the O'clinics (Ovulation method) are good. The SI representative to the SPAFH Board of Directors also sits on the SIPPA Board of Directors.

SPAFH can work with MHMS/SIPPA/O Clinic IEC committee to improve the quality of the current IEC project, with a focus on Honiara, where services are available now. Over time, these efforts can expand to the provinces as services become available. SPAFH could support/assist in the determination and diffusion of Pidgin terms for birth spacing and each of the contraceptive methods.

SPAFH should look into the health education assistant training program and determine if family planning IEC is included. If not, the possibility of including it should be explored.

2. NGOs are interested in incorporating family planning awareness into their programs. Depending on the outcome of government inquiries into SIDT, SPAFH should explore working with their network of village teams for family planning awareness, rather than recreating such a program. SPAFH should also ensure that any materials on family planning that are developed are shared with other NGOs such as the YWCA.

IV. ISSUES AND OPPORTUNITIES FOR IMPROVING FAMILY PLANNING SERVICES

A. Current Situation and Background:

Family planning service delivery is concentrated in Honiara. SIPPA provides family planning services in its clinic and in 10 satellite clinics and the Honiara Town Council provides services in seven clinics in squatter settlements. SIPPA does not operate in the provinces, although they plan to form provincial core groups as a result of the Phase I population awareness workshops. These groups could eventually become SIPPA provincial branches.

On Ysabel island there is a retired physician who receives contraceptive supplies from SIPPA. SIPPA has a "CBD" (community based distribution) Family Health Project in the area west of Honiara. Village counselors provide information on family planning and identify clients. Every 14 days a SIPPA nurse visits the area and screens OC and Depo-Provera clients for side effects.

Depo-Provera can only be administered by the nurse. OCs (after screening) and condoms are supplied by the village counselor. The latter two are the most popular methods. Currently, SIPPA has no supplies of condoms. SIPPA would like to expand their "CBD" program to the area east of Honiara, but there have been protests by the Catholic Church.

In theory, family planning is offered by the community health nursing team at the sub-provincial level. However, MHMS expressed a need for SIPPA to expand service delivery to the provinces as "very little family planning is done in hospitals." There is no family planning education at prenatal and postnatal clinics, although services are now offered two times a week at Central Hospital in Honiara. Provincial level health services lack trained managerial and administrative personnel.

The O clinics offer the ovulation method at three sites in Honiara. Recently, eight O method teachers in the provinces were trained with funding by SPAFH. Since 1973, 1,600 couples have been instructed in this method. The O clinics do not oppose the use of other methods and refer women who desire OCs (or for whom the method is "too hard" because the husband is an alcoholic and won't collaborate with abstinence) to SIPPA. Likewise, SIPPA refers clients requesting natural family planning to the O clinics. The central O clinic would like to establish a site outside the Catholic church where it is now located, so people will not say "this method is only for Catholics." They would also like to train more teachers.

B. Training Resources:

The SIMRI, also known as the Malaria Center, has just been opened. All training (pre-service and in-service) for health personnel, including nurses, will be conducted at SIMRI. Currently each division of the MHMS develops its own training plans. Coordination of training and training needs will be done through a Senior Health Resources Development Officer, a new position. Family planning is currently not included in the nursing curriculum, although in theory nurses have an opportunity to learn family planning skills through a six-month practicum. A need for in-service, post-basic training for nurses was expressed.

SPAFH is currently supporting a family planning training-of-trainers (TOT) course for nurses. It consists of three one-week theoretical sessions over a nine-month period, with practical assignments in between. The first session was conducted in March 1989. The second is scheduled for August and the third for December. Provincial nurses from SI are attending, as well as two nurses from Vanuatu and two from Fiji.

SPAFH contracted with consultants to design the curriculum and carry out the training. Following training, the nurses are supposed to return to their provinces and conduct "echo workshops," e.g., train other nurses. The curriculum is a series of modules on technical aspects of contraceptives and one on motivation. Family planning counseling and interpersonal communication are not included, and, more importantly, neither are training techniques or information on how to conduct these echo workshops. It appears that these trainers will be trained, but then not provided with materials or skills to train others. Nevertheless, there is some evidence of a positive impact.

The SIPPA nurse who is participating in the course is now more willing to go out into the community and talk to people. Two of the TCC participants from the SI, who also attended the Contraceptive Technology Update workshop in Lautoka, Fiji, scored higher on the Lautoka workshop pretest than any of the other workshop participants. The Nursing Superintendent is currently working on getting the nurses and midwives board to recognize this training as a post basic training on family planning, in order to provide incentive for the Solomon Islands nurses to pass their tests and to do all their assignments.

C. Constraints to Service Delivery:

Again, the uncertainty about the new government's support for family planning probably impedes expansion of training efforts. The MHMS also appears to be waiting for SIPPA to expand its services.

D. Opportunities for SPAFH to Explore:

1. Establish a SIMRI and a MHMS training coordination position. SPAFH can facilitate the inclusion of family planning into pre service and in-service training curricula for all levels of health personnel.

2. Follow-up and evaluate SPAFH TOT course. SPAFH should support an assessment of this course and work with the head of Maternal and Child Health Division who is supervising the participants to determine if the echo workshops are conducted, if skills learned are being used, and how the curriculum can be adjusted. Follow-up could also include skill training in counseling, interpersonal communication, and outreach.

3. Support SIPPA's desire to expand service delivery to provinces. Given that SIPPA is the major family planning service provider and the MHMS would like them to offer more services, SPAFH should explore ways to support the establishment of branch offices in the provinces. The executive director of SIPPA has recently completed training in management at the University of Connecticut and appears to be capable of handling such expansion.

4. Support O Clinics desire to expand. Until trained family planning service providers and the infrastructure to support them are in place in the provinces, SPAFH could consider supporting the training of more O method teachers. This method seems to be acceptable and does not rely on commodities for adequate delivery. Users of this method are often the first to request "modern" contraceptive methods, unfortunately, after a failure, but also as it becomes inconvenient.

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ANNEX K

TABLE 1

Total Project Costs
(US\$ 000)

	Calendar Year					Total
	1990	1991	1992	1993	1994	
1. SPAFH Operations*	200	280	240	220	200	1,140
2. Technical Assistance	196	180	14	-	-	390
a. (long term)	(126)	(124)	-	-	-	(250)
b. (short term)	(70)	(56)	(14)	-	-	(140)
3. Training	55	65	100	45	20	285
4. Matching Grants	50	50	50	50	50	250
5. Pathfinder Costs	189	173	35	18	5	420
a. (H.O. Support)	(68)	(41)	(7)	(7)	(2)	(125)
b. (Overhead)	(121)	(132)	(28)	(11)	(3)	(295)
6. Audits & Evaluations	5	60	5	5	65	140
7. RDO/SP Monitoring	<u>75</u>	<u>75</u>	<u>75</u>	<u>75</u>	<u>75</u>	<u>375</u>
Sub-Total	770	883	519	413	415	3,000
8. Contingency	<u> </u>	<u>82</u>	<u>41</u>	<u>37</u>	<u>40</u>	<u>200</u>
Total A.I.D.	770	965	560	450	455	3,200
<u>Other Sources</u>						
1. Country matching grant contributions (40% of 4 above)	20	20	20	20	20	100
2. Contributions from other donors for:						
a. Countries grants		100	200	300	400	1,000
b. Training		20	50	100	100	270
c. SPAFH Mgt. Fees (20% of 2a)*			<u>40</u>	<u>60</u>	<u>80</u>	<u>180</u>
Total Other Sources.	20	140	310	480	600	1,550

Notes: 1. Overhead is 23.3% of all costs 1 - 5a for first 2 years and for training and technical assistance thereafter.

2. Contingency is about 10% per year except for CY 1990 which has no contingency amount.

3.* Assumption is that in 1992 SPAFH has proven itself so that donors are now willing to pay "fees" of 20% to SPAFH to manage their contributions. A.I.D. project payments for SPAFH operations have been reduced by corresponding amounts beginning in FY 1992.

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TABLE 2

SPAFH's Operating Costs
(US\$ 000)

	Calendar Year					
	. 1990 .	. 1991 .	. 1992 .	. 1993 .	. 1994 .	
1. Salaries:						
Secretary General	13	26	26	26	26	117
Chief Program Officer	9	18	18	18	18	81
Program Officer #1	7	15	15	15	15	67
Program Officer #2	7	15	15	15	15	67
IEC Officer *	7	18	18	18	18	79
Accountant	9	18	18	18	18	81
Adm. Officer	3	6	6	6	6	27
Secy/Typist	2	4	4	4	4	18
Driver/Clerk	<u>1</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>9</u>
Sub-Total:Salaries	58	122	122	122	122	546
Payroll Fringe 25%	<u>15</u>	<u>30</u>	<u>30</u>	<u>30</u>	<u>30</u>	<u>135</u>
Total Salary Costs	73	152	152	152	152	681
2. Travel in Region	40	75	75	75	75	340
3. Communications, Misc.	10	20	20	20	20	90
4. Rent	6	12	12	12	12	54
5. Utilities	1	1	1	1	1	5
6. Board of Directors Annual Meetings	20	20	20	20	20	.00
7. Office Equipment & Furniture	25	-	-	-	-	25
8. IEC Center Setup	<u>25</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>25</u>
9. Sub-Total 2-8	127	128	128	128	128	639
10. Sub-Total 1 + 9	200	280	280	280	280	1,320
11. Less Mgt Fees Rec'd From Other Donors	---	---	<u>40</u>	<u>60</u>	<u>80</u>	<u>180</u>
12. Sub-Total (10 - 11)	200	280	240	220	200	1,140
13. Plus Pathfinder Over-Head - 23.3%	<u>47</u>	<u>65</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>112</u>
11. Total Project Costs. Financed By AID	247 .	345 .	240 .	220 .	200 .	1,252 .

Notes: 1990 costs are for 6 months rather than 12 months as first six months costs will be covered by the existing grants to FSP and Pathfinder. Pathfinder overhead ceases after CY 1991.

* New Position to be filled in 1990.

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TABLE 3
 Long Term Advisor
 (US\$ 000)

	Calendar Year					Total
	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	
Salary	58	58				116
Fringe Benefits 25%	15	14				28
Int'l Travel/Per Diem	25	25				50
Trans./Storage HKE	10	10				20
Housing	6	6				12
Temp. Lodging	2	-				2
Education Allowance	3	3				6
Misc. Expenses	<u>8</u>	<u>8</u>				<u>16</u>
Sub-Total	126	124				250
Pathfinder Overhead	<u>29</u>	<u>29</u>				<u>58</u>
Total	155	153				308

TABLE 4
 Short Term Advisors
 (US\$ 000)

	Calendar Year					Total
	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	
Cost (salary, travel, per diem, etc.) at \$14,000/month-10 PM	70	56	14			140
Pathfinder Overhead	<u>16</u>	<u>13</u>	<u>3</u>			<u>32</u>
Total	86	69	17			172

TABLE 5

Pathfinder Home Office Support
(US\$ 000)

	Calendar Year					Total
	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	
Salaries	25	15	4	4	-	48
Fringe Benefits - 25%	6	4	1	1	-	12
Travel & Per Diem	27	12	-	-	-	39
Communications, Misc.	<u>10</u>	<u>10</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>26</u>
Sub-Total	68	41	7	7	2	125
Pathfinder Overhead	<u>16</u>	<u>10</u>	<u>2</u>	<u>1</u>	<u>-</u>	<u>29</u>
Total	84 .	51 .	9 .	8 .	2 .	154

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ANNEX L

ILLUSTRATIVE TRAINING PLAN

Some 14 specific training activities which might be presented by this project or by other donors are described on the following pages. These represent the minimum needs for training in the ten countries and SPAFH in the following subject areas:

- SPAFH Strengthening (4 courses)
- Population Policies (3 courses and workshops)
- Information, Education and Communications (IEC) (2 courses and workshops)
- Services Delivery (5 workshops and courses)

The training program is balanced between SPAFH strengthening, regional objectives, and national needs. The SPAFH staff, by having their skills upgraded through selective training programs in the U.S., on-the-job training by the resident advisor, and attendance at the regional workshops, should be able to conduct the national training activities with assistance from the local personnel who attend the regional workshops.

The regional workshops and courses would be followed by country-specific workshops and courses. For example, the regional course in the preparation and use of the RAPID's program would be given for two demographers and statisticians from each country. This would be followed by a RAPID's presentation in each country for the senior decision makers of that country. The country's presentation would use data prepared by and assistance of the two participants to the regional course. The regional IEC design and implementation workshop would be followed by national workshops on IEC.

While the regional workshops and training courses will require outside technical assistance, the national workshops should be presented by the local officials who attended the regional course and the SPAFH staff. Little to no outside assistance should be needed for the national programs with the possible exception of the RAPID's program.

The total cost of this illustrative training plan is far greater than the budgeted amount as this plan represents the magnitude of training needs over the next five years without regard to source of funding. It is anticipated that WHO, UNFPA and perhaps other donors active in family planning and population matters in the South Pacific will finance some of these or similar training activities.

Due to lack of time, it was not possible for the design team to visit all ten countries so as to identify the extent of need, appropriate subject matter, and interest in training. However, it might be possible to combine some workshops and training so as to reduce costs.

For simplicity of budget presentation and due to lack of sufficient information to describe otherwise, this illustrative training plan assumes that national training activities will be conducted in each of the ten countries with the same cost in each country. Obviously, the cost and magnitude of an activity in PNG with 3.5 million people will be far greater than in Niue with about 2,500 people. Several of the smaller countries might combine forces for their national training activities and thereby reduce costs (e.g., Niue, Western Samoa and Cook Islands).

One of the early tasks of the resident adviser will be to prepare a training action plan based on a more precise identification of training needs, survey of other donors regarding their training plans, and discussions with SPAFH's country directors regarding their priorities and views about training needs of their countries.

1. Program Mgt. & Fundraising	SPAFH Strengthening
2. Financial Management*	" "
3. Project Monitoring & Evaluation	" "
4. Program Management*	" "
5. RAPID's Program (regional)	Population Policy
6. RAPID's Program (national)	" "
7. Planning Policy (national)	" "
8. IEC Design & Impl. (regional)	IEC
9. IEC Design & Impl. (national)	"
10. Contraceptive Workshops (regional)	Services Delivery
11. Contraceptive Workshops (national)	" "
12. Training Skills in Delivery	" "
13. Supervising CBD (regional)	" "
14. Training of CBD Workers (national)	" "

*Being provided during transition period by funds in the FSP grant or in the Pathfinder "bridge" grant.

TRAINING ACTIVITY 1 : PROJECT COMPONENT: SPAFH Strengthening

- a. SUBJECT AREA: Program Management & Fundraising Skills
- b. OBJECTIVE: Improve program management and fundraising skills
- c. OUTCOME: SPAFH's programs are better managed and SPAFH obtains funds from other sources than AID.
- d. WHO SHOULD ATTEND: SPAFH Secretary General
- e. WHEN & LENGTH OF TRAINING: Year 1, 2-4 weeks
- f. PROBABLE PROVIDER & LOCATION: Pathfinder, Watertown, Mass.
- g. RESPONSIBLE FOR ARRANGEMENTS: Pathfinder
- h. RESOURCES NEEDED: None
- i. ESTIMATED COSTS: \$5,000
- j. LINKAGE TO OTHER ACTIVITIES: Training for SPAFH program officers.

TRAINING ACTIVITY 2 : PROJECT COMPONENT: SPAFH Strengthening

- a. SUBJECT AREA: Financial Management
- b. OBJECTIVE: Familiarize accountant with Pathfinder financial management system
- c. OUTCOME: Better financial management of project accounts and financial reports
- d. WHO SHOULD ATTEND: SPAFH Accountant
- e. WHEN & LENGTH OF TRAINING: Year 1, 2 weeks
- f. PROBABLE PROVIDER & LOCATION: Pathfinder, Watertown, Mass.
- g. RESPONSIBLE FOR ARRANGEMENTS: Pathfinder
- h. RESOURCES NEEDED: None
- i. ESTIMATED COSTS: \$5,000
- j. LINKAGE TO OTHER ACTIVITIES: To help phase out FSP system.

TRAINING ACTIVITY 3 : PROJECT COMPONENT: SPAFH Strengthening

- a. SUBJECT AREA: Project Monitoring and Evaluation
- b. OBJECTIVE: Increase monitoring and evaluation capabilities in all program staff
- c. OUTCOME: Have capability to prepare indicators and monitoring tools for projects designed or approved by SPAFH
- d. WHO SHOULD ATTEND: All SPAFH program officers (3)
- e. WHEN & LENGTH OF TRAINING: Years 2 & 4; two weeks
- f. PROBABLE PROVIDER & LOCATION: IHP, Bangkok or Philippines
- g. RESPONSIBLE FOR ARRANGEMENTS: Pathfinder and SPAFH
- h. RESOURCES NEEDED: None
- i. ESTIMATED COSTS: \$10,000 each - total \$30,000
- j. LINKAGE TO OTHER ACTIVITIES: Supplements program management training

TRAINING ACTIVITY 4 : PROJECT COMPONENT: SPAFH Strengthening

- a. SUBJECT AREA: Program Management (Family Planning)
- b. OBJECTIVE: Increase skills in (1) preparing program goals and objectives, (2) planning and problem solving, (3) making needs assessments and (4) evaluating problems
- c. OUTCOME: Have capability to prepare "sound" project documents addressing all project components
- d. WHO SHOULD ATTEND: All SPAFH Program Officers (3)
- e. WHEN & LENGTH OF TRAINING: Year 1, Five weeks each
- f. PROBABLE PROVIDER & LOCATION: IHP, Santa Cruz, CA
- g. RESPONSIBLE FOR ARRANGEMENTS: Pathfinder
- h. RESOURCES NEEDED: None
- i. ESTIMATED COSTS: \$10,000 each - total \$30,000
- j. LINKAGE TO OTHER ACTIVITIES: Other training for SPAFH

TRAINING ACTIVITY 5 : PROJECT COMPONENT: Population Policy

- a. SUBJECT AREA: RAPID's Program Training (Regional)
- b. OBJECTIVE: Expand skills in RAPID's presentation and use of statistics in development planning
- c. OUTCOME: Trained personnel can prepare and present RAPID's program for their countries
- d. WHO SHOULD ATTEND: National demographers and statisticians
- e. WHEN & LENGTH OF TRAINING: Year 1, 4 weeks
- f. PROBABLE PROVIDER & LOCATION: Future's Group; Fiji
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH, Pathfinder and Future's Group
- h. RESOURCES NEEDED: Consultant from Future's Group; suitable site
- i. ESTIMATED COSTS: \$50,000
- j. LINKAGE TO OTHER ACTIVITIES: Strengthen data bases in countries needed for policy makers and IEC activities

TRAINING ACTIVITY 6 : PROJECT COMPONENT: Population Policy

- a. SUBJECT AREA: RAPID's Program Training (National)
- b. OBJECTIVE: Increase awareness of country-specific policy issues
- c. OUTCOME: Population policies established in some countries
- d. WHO SHOULD ATTEND: Government ministers and senior secretaries
- e. WHEN & LENGTH OF TRAINING: Year 2, 1 week in each country
- f. PROBABLE PROVIDER & LOCATION: Future's Group, all countries
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH, Future's Group
- h. RESOURCES NEEDED: Consultant from Future's Group
- i. ESTIMATED COSTS: \$50,000 (\$5,000 each country)
- j. LINKAGE TO OTHER ACTIVITIES: Supplement UNFPA/ILO program on population policy development; follow up to regional training program.

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TRAINING ACTIVITY 7 : PROJECT COMPONENT: Population Policy

- a. SUBJECT AREA: Planning and Preparation of Population Policy Workshop (National)
- b. OBJECTIVE: Advance skills in planning and creating population policy
- c. OUTCOME: Policies established in PNG, SI and Vanuatu; underway in Kiribati and Tonga
- d. WHO SHOULD ATTEND: High level government and NGO officials (20 each country)
- e. WHEN & LENGTH OF TRAINING: Years 3-5, 2 weeks each country
- f. PROBABLE PROVIDER & LOCATION: SPAFH and Pathfinder; 5 countries
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH, Pathfinder and local organizations
- h. RESOURCES NEEDED: Pathfinder ST consultant
- i. ESTIMATED COSTS: \$100,000 (\$20,000 each country)
- j. LINKAGE TO OTHER ACTIVITIES: RAPID's training programs

TRAINING ACTIVITY 8 : PROJECT COMPONENT: IEC

- a. SUBJECT AREA: IEC Design and Implementation (Regional)
- b. OBJECTIVE: Provide skills in designing IEC activities
- c. OUTCOME: Participants able to design prototype materials, pretest and adapt to local needs
- d. WHO SHOULD ATTEND: IEC health educators (2 from each country - 20)
- e. WHEN & LENGTH OF TRAINING: Year 1, 4 weeks
- f. PROBABLE PROVIDER & LOCATION: SPAFH, Pathfinder; Fiji
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH and Pathfinder
- h. RESOURCES NEEDED: ST Consultant from PATH, SPC Audio-Visual Center
- i. ESTIMATED COSTS: \$100,000
- j. LINKAGE TO OTHER ACTIVITIES: Supports all population policies and service delivery activities

TRAINING ACTIVITY 9: PROJECT COMPONENT: IEC

- a. SUBJECT AREA: IEC design and implementation (National)
- b. OBJECTIVE: Provide skills in designing IEC activities
- c. OUTCOME: Participants able to prepare materials for people with limited or no reading skills
- d. WHO SHOULD ATTEND: People active in IEC or FP programs
- e. WHEN & LENGTH OF TRAINING: Years 2-5; 2 weeks in each country
- f. PROBABLE PROVIDER & LOCATION: SPAFH; each country
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH and local organizations
- h. RESOURCES NEEDED: ST Consultant from PATH for first one; personnel who took regional course
- i. ESTIMATED COSTS: \$100,000 (\$10,000 for each country)
- j. LINKAGE TO OTHER ACTIVITIES: Supports all population policies and service delivery activities; follow up to regional training program.

TRAINING ACTIVITY 10: PROJECT COMPONENT: Services Delivery

- a. SUBJECT AREA: Contraceptive Services Workshop [2] (Regional)
- b. OBJECTIVE: Review and update awareness of contraceptive technologies
- c. OUTCOME: Increased use of latest contraceptive technologies
- d. WHO SHOULD ATTEND: Service delivery supervisors and planning (20 at each, 2 from each country)
- e. WHEN & LENGTH OF TRAINING: Years 1 & 2; 2 weeks each
- f. PROBABLE PROVIDER & LOCATION: SPAFH and Pathfinder; Fiji
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH
- h. RESOURCES NEEDED: Pathfinder ST Consultant
- i. ESTIMATED COSTS: \$120,000 (\$60,000 each year)
- j. LINKAGE TO OTHER ACTIVITIES: Complements UNFPA/WHO country program training of family planning providers

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TRAINING ACTIVITY 11: PROJECT COMPONENT: Services Delivery

- a. SUBJECT AREA: Improving Contraceptives Services (National)
- b. OBJECTIVE: Expand knowledge of contraceptive services; including counseling and inter-personal communications
- c. OUTCOME: At least 20 people in each country aware of latest services. Knowledge spread beyond capital cities
- d. WHO SHOULD ATTEND: Senior nursing supervisors from each province or island (20 each workshop)
- e. WHEN & LENGTH OF TRAINING: Years 2-5; 2 weeks each; one in each country during this time
- f. PROBABLE PROVIDER & LOCATION: SPAFH and Pathfinder
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH and national organizations
- h. RESOURCES NEEDED: Pathfinder ST consultant (for first one); local personnel who attend regional workshops
- i. ESTIMATED COSTS: \$50,000 (\$5,000 for each country)
- j. LINKAGE TO OTHER ACTIVITIES: Complements regional workshops.

TRAINING ACTIVITY 12: PROJECT COMPONENT: Services Delivery

- a. SUBJECT AREA: Training skills in contraceptive technology
- b. OBJECTIVE: Create core group of regional trainers in contraceptive technology
- c. OUTCOME: People in 5 countries with skills and knowledge to train others in their countries and region
- d. WHO SHOULD ATTEND: 5 who attended SPAFH June, 1989 Workshop
- e. WHEN & LENGTH OF TRAINING: Year 2; 6 weeks
- f. PROBABLE PROVIDER & LOCATION: Manila or Bangkok
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH and Pathfinder
- h. RESOURCES NEEDED: None
- i. ESTIMATED COSTS: \$30,000
- j. LINKAGE TO OTHER ACTIVITIES: Related to regional and national workshops on same subject.

TRAINING ACTIVITY 13: PROJECT COMPONENT: Services Delivery

- a. SUBJECT AREA: Supervising Community Based Distributors (Regional)
- b. OBJECTIVE: Improve skills of people who supervise CBD
- c. OUTCOME: Improved CBD activities in each country
- d. WHO SHOULD ATTEND: Supervisors of FP services at different levels (20 - 2 from each country)
- e. WHEN & LENGTH OF TRAINING: Year 2, 4 weeks
- f. PROBABLE PROVIDER & LOCATION: SPAFH and Pathfinder; Solomon Islands
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH
- h. RESOURCES NEEDED: Pathfinder ST consultant
- i. ESTIMATED COSTS: \$30,000
- j. LINKAGE TO OTHER ACTIVITIES: Improve delivery of contraceptives provided by other donors

TRAINING ACTIVITY 14: PROJECT COMPONENT: Services Delivery

- a. SUBJECT AREA: Training of CBD Workers (National)
- b. OBJECTIVE: Improve skills of CBD workers
- c. OUTCOME: More efficient delivery of contraceptives
- d. WHO SHOULD ATTEND: Well accepted community workers
- e. WHEN & LENGTH OF TRAINING: Years 3-5; 1 week each
- f. PROBABLE PROVIDER & LOCATION: SPAFH and trained supervisors; in each country
- g. RESPONSIBLE FOR ARRANGEMENTS: SPAFH and national organizations
- h. RESOURCES NEEDED: Assistance of supervisors who attended Regional course
- i. ESTIMATED COSTS: \$50,000 (\$5,000 each country)
- j. LINKAGE TO OTHER ACTIVITIES: Regional Workshop of CBD supervisors and other service delivery programs.

ANNEX M

JOB DESCRIPTION

Resident Advisor

PURPOSE:

Responsible for providing technical assistance and coordinating project-financed inputs to the South Pacific Alliance for Family Health (SPAFH) in the design and upgrade of their management, program, and financial systems and staff capabilities. Serves as the Pathfinder representative for project implementation.

DUTIES & RESPONSIBILITIES:

1. Assists the Secretary General (SPAFH) to review, revise and install systems for family planning project planning, implementation, monitoring, reporting and evaluation.
2. Assists the Secretary General (SPAFH) to design and install financial management systems to accomodate growth and expansion of SPAFH programs.
3. Assists SPAFH to prepare and implement a strategy for its organizational growth.
4. Prepares for approval by SPAFH and RDO/SP a training plan for SPAFH staff and for national family planning organizations to facilitate the strategic plan for SPAFH's program growth.
5. Reviews and comments on all reports to be submitted to A.I.D.'s RDO/SP and/or Pathfinder/Watertown.
6. Assists SPAFH prepare quarterly project progress reports for submission to RDO/SP.
7. Coordinates the provision of technical assistance and training required to support SPAFH and projects funded by SPAFH.
8. Prepares an annual detailed work plan for the project for review and approval by the Board of Directors and RDO/SP.
9. Serves as the Pathfinder representative to SPAFH and RDO/SP for all aspects of project implementation.
10. Reviews all applications for SPAFH grants and submits his comments to the Secretary General.

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QUALIFICATIONS:

1. Has a graduate degree in public health, public health administration, or related area.
2. Has a minimum of ten years working experience - five in a developing country - in family planning and population subjects.
3. Has knowledge and ability to use computers for program planning, budgeting, monitoring and evaluation.
4. Has at least two years experience in supervisory or managerial roles overseas.
5. Has good training/teaching capabilities.

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SPAFH IEC Technical Officer

PURPOSE:

To provide SPAFH staff and national family planning organizations with expertise in family planning/population IEC (information, education and communications).

REPORTS TO:

The SPAFH Secretary General or Chief Program Officer.

DUTIES AND QUALIFICATIONS:

1. Identifies IEC materials and activities to meet family planning program needs of SPAFH and the national organizations.
2. Assists countries family planning organizations and SPAFH program officers in the design of IEC projects to support national family planning programs in policy and service delivery.
3. Provides technical assistance to country and regional IEC projects in the areas of research techniques, audience analysis, design and planning of communication strategies, materials and message design and pretesting, interpersonal communication and counseling, monitoring and evaluation.
4. Identifies and coordinates outside technical assistance in the area of IEC.
5. Assists SPAFH program officers to monitor the implementation of IEC activities.
6. Designs and conducts IEC skills training within and outside SPAFH.
7. Identifies and obtains population and family planning IEC materials, training tools, and resources for SPAFH and the countries.
8. Overseas the production of the SPAFH newsletter and SPAFH promotional materials.

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9. Prepares, in consultation with the Secretary General and the Chief Program Officer, proposals and reports to donors.

10. Assists with the planning, installation and operation of an IEC Resource Center within SPAFH if one should be approved and funded.

QUALIFICATIONS:

1. Some university-level training in IEC.
2. At least three years experience in development communications or marketing/advertising.
3. Demonstrated abilities in: formative research (focus group discussions, pretesting, qualitative methodologies); project planning and management; message and materials preparation (most print and radio, but video and/or traditional media helpful).
4. Strong written and oral communication skills in English.
5. Knowledge of the countries in the region, particularly socio-cultural factors affecting health and development.
6. Willingness to travel at least 35% of the time and locate in Nuka'alofa, Tonga.
7. Although not required, the following will be important plus factors: (a) background/experience in population and family planning; (b) background/experience in evaluation, design of KAP studies for baseline and summative evaluation, and data analysis; and (c) training experience.

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ANNEX N

SELECTED REFERENCES

Foundation for the Peoples of the South Pacific. SPAFH - Consultant's Report Regarding Financial Management [Kevin McCumber, May 11, 1989]

International Planned Parenthood Federation. Report of the Needs Assessment Mission to the South Pacific, February 1988. (London, May 1988)

Papua New Guinea. Ministry of Finance and Planning. Development Plan 1989-1993 - Vol. 1, Sector Policies and Strategies [1988]

South Pacific Alliance for Family Health (SPAFH). (Various internal documents, including country assessment reports, country situation reports, draft strategies, and budgets.)

South Pacific Commission. South Pacific Epidemiological and Health Information Services. Annual Report for the Year 1987

Tonga (Kingdom of). Ministry of Finance. Budget Statement for the Year 1989-90.

Tonga Family Planning Association. Work Programme and Budget for 1990.

U. S. Agency for International Development. South Pacific Regional Development Office (Suva, Fiji). Project Paper - PNG Child Survival Support, May 1989 and Regional Development Strategy Statement, FY 1990 - 1994, June, 1988.

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LOGICAL FRAMEWORK

REGIONAL FAMILY PLANNING PROJECT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATIONS	MEANS OF VERIFICATION	ASSUMPTIONS
<u>GOAL:</u>			
1. Reduce economic burden of rapid population growth.	- Population Growth rate for region reduced.	National population statistics.	- Reduced birth rates will promote economic growth and improve maternal and child health. - Birth rates are reduced
2. Improve maternal and child health.	- IMR decreased. - Childbirth deaths decreased.		

END OF PROJECT STATUS

<u>PURPOSE:</u>			
Increase promotion of family planning and birth spacing.	<u>Regional:</u>	- SPAFH Records. - SPAFH reports to AID. - Evaluations.	- SPAFH reputation grows. - SPAFH able to retain qualified personnel. - Countries level of interest and activities in F.P. increases.
	- SPAFH receiving increased funds from donors. - SPAFH providing increased technical support to F.P. organizations.		
	<u>National:</u>		
	- 4 countries carrying out population policies. - 4 countries working to establish pop. policies.		

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- 3 countries operating IEC programs.
- 3 countries operating provider training programs.
- nat'l public & private F.P. organizations have & use improved statistical data on population.

OUTPUTS:

Regional:

SPAFH strengthened.

- | | | |
|--|--|---|
| <ul style="list-style-type: none">- Registered AID PVO.- Financial controls established.- Mgt. & adm. systems installed.- Staff increased.- Grants MIS installed.- Funds received from non-AID sources.- Linkages to U.S. and int'l F.P. organizations established.- IEC Resource Center est. in SPAFH. | <p>SPAFH progress reports.
Evaluations.
Project Officer Field trips.</p> | <ul style="list-style-type: none">- SPAFH retains qualified people.- Project funds sufficient to provide planned level of inputs.- Other donors channel F.P. resources to region thru SPAFH and pay mtg. fees.- Board of Directors continues its interest & involvement with SPAFH.- Inputs are of sufficient magnitude to achieve outputs. |
|--|--|---|

National:

1. National population policies promoted.

- Awareness of need for population policies created in region.
- Capabilities to create policies mobilized in 6 countries.

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- Improved, relevant analysis & pop. demographic data available.
- 2. IEC established.
 - IEC capabilities institutionalized in 3 countries.
 - Workshops on IEC held.
- 3. Family planning services delivery improved.
 - National guidelines in 5 countries with standards of service created.
 - Expanded national delivery systems for contraceptives.
 - Increased knowledge of contraceptive technology.
 - Standard reporting system on contraceptive use installed in 5 countries.

INPUTS:

- Technical assistance LT - 2 years
- Technical assistance ST - 10 PM
- Overseas training - 8 participants
- Regional training - 3-5 workshops
- Commodities - Miscellaneous
- Countries grants - About 20 sub-grants
- Project monitoring - 1 PSC, 5 years
- Audits & evaluations - up to 5 audits and 2 evaluations.

RDO/SP Records

Project authorized as designed and annual OYB adequate to provide funding as planned.

Total \$3.2 million.
See PP budget for details