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**EVALUATION OF THE
ZAIRE FAMILY PLANNING SERVICES PROJECT
(Project No. 660-0094)**

FINAL REPORT

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ACRONYMS

A.I.D./W	Agency for International Development/Washington
AIDS (SIDA)	Acquired Immune Deficiency Syndrome
AIZA	Zaire Nurses Association
AORP	Africa Operations Research Project
AVSC	Association for Voluntary Surgical Contraception
AZBEF	Zairian Association of Family Well-Being, formerly CNND
BCZ	Zaire Commercial Bank
BOM	Catholic Medical Office
BRH	Basic Rural Health Project
BUPROF	Female Workers Union
CBD (DCC)	Community-Based Distribution
CDC	Centers for Disease Control
CECAP	Cellule de Coordination des Activités en Matière de Population
CIP	Commodity Import Program
CNND	National Committee for Desired Births, now AZBEF
CONAPO	Comité National de la Population (Zairian National Population Committee)
CPF	Counterpart Funds
CPS	Contraceptive Prevalence Survey
CSM	Contraceptive Social Marketing
CTIP	Interdepartmental Technical Advisory Committee of CONAPO
CYP	Couple Year of Protection, a measurement of contraceptive use
ECZ	Eglise du Christ au Zaire
FCNAMES	National Medical and Health Fund (Zairian parastatal affiliated with MOH)
FP	Family Planning
FPIA	Family Planning International Assistance
FPSP	Family Planning Services Project
GOZ	Government of Zaire
HZ (ZS)	Health Zone (Zone de Santé)
IEC	Information, Education and Communication
IFFLP	International Federation for Family Life Promotion
ILO	International Labour Organization
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
JHPIEGO	Johns Hopkins Program for Training in Gynecology and Obstetrics
LOP	Life of Project
MCH	Maternal and Child Health
MIS	Management Information System
MOH	GOZ Ministry of Health
MSH	Management Sciences for Health
MSU	Management Support Unit
NFP (PFN)	Natural Family Planning
NPP	National Population Policy
NGO	Non Governmental Organization
OPG	Operation Program Grant

OPTIONS	Options for Population Policy Project
OR	Operations Research
PACD	Project Activity Completion Date
PEV	Expanded Program on Immunizations
PMU (UACP)	PSND Project Management Unit
PP	Project Paper
PCS	Population Communication Services
PHC	Primary Health Care
PRODEF	Programme d'Education Familiale (Bas Zaire CBD project)
PSI	Population Services International
PSND	Projet de Services des Naissances Désirables (GOZ family planning agency)
PVO	Private Voluntary Organization
RAPID	Resources for the Awareness of Population Impacts on Development
RHC	Reference Health Center
SANRU	Projet des Soins de Santé Primaires en Milieu Rural
TIPPS	Technical Information on Population for the Private Sector
UNTZA	Zaire Workers Union
UND	Unite de Naissances Desirables (family planning service unit)
UNFPA	United Nations Family Planning Agency
UNTZA	Union National des Travailleurs du Zaire (labor union)
USAID Zaire	U.S. Agency for International Development Mission in Zaire
VSC (CCV)	Voluntary Surgical Contraception
WHO	World Health Organization

French acronyms shown in parentheses, where applicable.

EXECUTIVE SUMMARY

I. Introduction

USAID Zaire has reaffirmed its commitment to support Zaire's population and family planning efforts in its FY 1990 - FY 1993 Action Plan, issued in March 1990. While recent political and other changes may lead to revisions in this plan, Family Planning (FP) will continue to have a high priority within the USAID Zaire portfolio. The Action Plan's strategic objective in the health and population sector is to improve health status, with emphasis on increasing the rate of child survival and reducing fertility. The key program performance indicator in support of this strategic objective for population/family planning efforts is to increase contraceptive prevalence from two percent in 1988 to seven percent in 1995. Prior to taking further steps in its commitment, USAID arranged for Checchi and Company Consulting, Inc. to evaluate the ongoing Family Planning Services Project (660-0094).

Field work for the evaluation was carried out during late October and November 1990 by a three-person team consisting of a Senior Family Planning Specialist/Team Leader, a Management/ Organizational Development Specialist with experience in family planning, and a Zairian Clinical Family Planning Specialist. The evaluation Scope of Work called for the team to provide USAID with a set of recommendations as to: 1) the most effective mix and levels of FPSP activities, given available resources, that would contribute to the project goal in the remaining two years of the project; 2) any outstanding issues or opportunities which would require additional analysis or study before the design of a follow-on A.I.D. assistance package in FY 1992 that may enhance the design and implementation of the follow-on project, and 3) future orientations for population/family planning activities for consideration during the design process. Recommendations were to be based on analysis of:

1. The project's technical accomplishments/outputs.
2. The institutional framework of the project.
3. The internal management of PSND.
4. The management organization of PSI Zaire.
5. The specific management problems and issues identified by USAID.

The team's findings, conclusions, and recommendations are based on review of project-related documents; interviews in Kinshasa with USAID mission staff, GOZ and NGO project implementation personnel, and potential "actors" in future population/family planning assistance programs; and field visits to project activity sites in Bas Zaire and Shaba. Field work was greatly facilitated by USAID's HPN staff who prepared for the team's arrival by assembling an exhaustive set of documents, producing an annotated bibliography of key documents, and conducting an internal review which helped to focus the team's investigations.

The major emphasis of this evaluation is on those activities and organizations now receiving direct assistance from USAID under FPSP: (a) CONAPO/CECAP in the area of

population policy; (b) PSND for support to clinical and community based distribution activities; (c) PSI for contraceptive social marketing; and (d) the Population Council for management and operations research advisory services. Brief assessments were also made of several private sector entities, including SANRU and AZBEF, in terms of the roles they might play in any future population/family planning program.

II. Principal Findings and Recommendations

At the outset, the team wishes to note some important accomplishments and positive attributes of FPSP observed in the course of the evaluation:

- the project has exceeded expectations in terms of the number of family planning units (Unites des Naissances Desirables or UNDs) that have been established and are providing varying degrees of service;
- some staff are well-trained and highly qualified;
- financial accountability has been improved;
- the GOZ has begun to contribute through its investment budget;
- two of the three regional training centers established are currently operational, and large numbers of people have received training;
- a population policy has been crafted and approved by CONAPO;
- compared with some other French-speaking African countries, Zaire's family planning program is well advanced in terms of numbers of delivery points, mid-level management talent, and systems codification.

It is within the context of these considerable accomplishments that the team offers the following observations and related recommendations.

A. CONAPO/CECAP (Policy)

Observations:

- A population policy has recently been adopted by CONAPO.
- The GOZ Minister of Plan has indicated that this policy will be made an integral part of the next five-year development plan.

B. PSND (Support to Clinical Services; Operations Research)

1. Technical Outputs

Observations:

- A.I.D.-supplied commodities are appropriate; no evidence of outdated contraceptives was found.
- The logistics systems is functioning poorly; frequent interruptions in supply are partly due to the linking of reporting and resupply, and partly to unclear responsibility for reordering.
- 140 family planning units (UNDs) are operating to varying degrees, compared with the planning target of 125 UNDs. Units in parastatals are better equipped and generally better managed than others. Equipment and supplies are insufficient, incomplete, or not functioning at many sites.
- Three regional training centers were opened and two are still functioning.
- 849 people have received in-country training and 148 people have participated in overseas training programs since 1984. Training has ranged from courses in the basics of family planning to full MPH degree programs.
- Although 148 individuals have completed a basic course in family planning, there is widespread recognition of the urgent need for in-service retraining programs.
- Family planning has been integrated into the curricula of several nursing schools at the secondary school level, but not at university-level nursing schools and at medical schools.
- A 1989 evaluation found that the post-training performance of service providers was "satisfactory" in only 80 percent of the cases assessed, and that training in supervision did not result in better on-the-job supervisory performance.
- There are no codified medical standards or referral guidelines for service providers that have been approved for use in family planning units.

Recommendations:

1. A full-scale training needs assessment should be conducted, as has been planned by INTRAH for 1991. Needs for pre-service basic training should be distinguished from in-service retraining needs.
2. Training, especially management training which is not topic-specific, should be planned and carried out jointly with other health programs such as PEV. Other

health care providers should be encouraged to use the FP regional training centers in order to minimize costs.

3. A standard supervisory protocol should be used to help select providers in need of training.
4. Family planning should be integrated into the curricula at all levels of nursing schools. In medical schools, family planning should be covered in courses in obstetrics and gynecology, rather than introduced as a separate course. The MPH curriculum at the School of Public Health should also incorporate family planning.
5. The 20 percent of trainees receiving unsatisfactory performance scores in the INTRAH evaluation should be followed up for retraining or reassignment.
6. In-country training should gradually replace overseas training. In selecting trainees, attention should be paid to equity in terms of gender and staff position.
7. A standardized referral system should be included in a module of medical standards which should be prepared in writing and taught to FP service providers.
8. A study of whether and how the referral system works in practice should be conducted.
9. A Medical Director with extensive knowledge of the clinical aspects of family planning should be hired by PSND.
10. Medical guidelines and standards (protocols) for family planning service providers should be prepared, approved, and integrated into training curricula. PSND should be given formal notice that all USAID support will be terminated unless these guidelines and standards are in force by a specified date.

2. Management Issues

a. Planning and Setting Objectives

Observations:

- National and regional planning objectives sometimes are unreasonable and unattainable.
- Planning is not based on proper analysis of past performance; for example, the relationship between numbers of new acceptors and Couple Years of Protection (CYP) is dramatically different in fact than in the plan.

- The planning process is essentially ad hoc and top down; although there are some sub-national objectives, service providers had no role in setting them and are not aware of their existence.
- There is no reward for innovation.

Recommendations:

11. USAID (together with the major "actors" in family planning) should clarify the goals and specific objectives of the U.S. family planning assistance program in Zaire.
12. Annual service delivery objectives should be realistic and based on a consistent set of assumptions from year to year.
13. Objectives for sub-national units (regions, zones, clinics, CBD sites) must be transmitted to, and understood by, those who are expected to attain them. Preferably, the planning process should begin with the setting of field-level objectives in the field, with assistance from Kinshasa.
14. The planning process should be more participatory and "bottom up." If funding is not available for regional coordinators to spend time in Kinshasa, inputs from these coordinators should be solicited by other means.
15. Training needs should be linked to realistic objectives, however these objectives may be stated (in terms of prevalence, continuing clients, new acceptors, or CYP).

b. Organization and Staffing

Observations:

- PSND's organization of human resources in headquarters-heavy rather than field-oriented.
- Individuals are moved often from post to post for no documented reason; the organigram itself is frequently changed.
- There has been a proliferation of divisions and bureaus within PSND, and the number of staff positions has grown from 41 to 89 between 1984 and 1990.
- PSND has become dependent on counterpart funds for the payment of some staff salaries and salary supplements.

Recommendations:

16. There is no clear organigram for PSND which reflects current relationships and is not subject to continuous change. There is need for an organigram which leaves

key personnel in place for a minimum period of time (at least six months) and eliminates the constant reshuffling.

17. The Director should abide by the organigram and rely on her subordinates to play their respective intermediary roles rather than bypassing layers of supervisory structure. There should be one person to whom the Director can delegate daily management responsibilities, while she focuses on external relations.
18. No new headquarters staff positions should be created (other than the position of obstetrics/gynecology specialist) until the future of PSND has been clarified.
19. A complete overhaul of PSND staffing should follow the agreement on new roles and relationships among the various agencies participating in FPSP.
20. The role of the Project Management Unit should be reinforced, and decisions made by this management body should be adhered to.
21. MOH should begin paying all salaries and salary supplements by September 1991.

c. Supervision

Observations:

- There are too many supervisors at headquarters and inadequate supervision at the regional level.
- There is inadequate back-up support to the field with respect to vehicles, training, supplies, and operating funds.

Recommendations:

22. As there appear to be too many layers of nominal "supervision" at PSND, consideration should be given either to eliminating the bureau level, or to consolidating it into one position of Assistant to the Division Director.
23. The placement of PSND regional coordinators should be considered a short-term, albeit necessary, arrangement; the long-term objective is to ensure that MOH personnel (Medecins Chefs du Zones, Superviseurs Protection Maternelle) take on supervision of family planning services along with other health services.
24. Until this happens, the role of the PSND Regional Coordinator should be expanded beyond supply coordination and report collection to include such tasks as:

ensuring the accuracy, consistency, and timely submission of reports;

- identifying staff retraining needs and ensuring that staff are enrolled in the appropriate courses;
 - providing technical assistance on improving quality of services (based on the supervisory checklist) including IEC/outreach and medical care, and achieving site specific objectives; and
 - trouble-shooting and problem-solving.
25. PSND's regional coordinators should be retrained as necessary to carry out the above tasks and should be equipped with adequate tools, including transportation (vehicles, fuel, parts, maintenance); radio communication; supervisory checklist; contraceptive MIS and logistics system; and sufficient supplies (contraceptives, IEC materials, forms).
26. A plan should be drawn up now for the phaseover of the above tasks to MOH personnel by 1995 in "better" regions, and by 1998 in other regions.

d. Data Collection and Analysis

Observations:

- The definitions for terms used for reporting of service statistics to PSND headquarters are not understood in the field.
- Appropriate approaches to the recovery of drop-outs are not used.
- Reporting forms are unnecessarily complex and are not consistent with forms used by SANRU.
- There is no information "loop" providing feedback to service providers; many field personnel are unaware of where they stand relative to previous years or relative to the performance of other units.
- Analysis of existing data is minimal and does not constitute a basis for sound decision-making.

Recommendations:

27. The various terms used for collecting and reporting of service statistics (new clients, old clients, visits, active, inactive, dropouts, etc. need to be reexamined. To ensure that the data collected are useful as a management tool at the service delivery level, service providers should be involved in developing the definitions and in designing new reporting forms. All providers should be thoroughly trained to use the forms and forms should be distributed and resupplied in sufficient quantities.

28. Since the national objective of 60 percent recovery of dropouts has not been operationalized in field activity, the objective should be either dropped or reformulated. Constructive suggestions should be compiled and distributed to service providers on how to keep track of inactive clients and encourage them to return.
29. Supply forms should be separate from client reporting forms and should include space for requisitioning. Responsibility for replenishment of supplies should be clarified.
30. Non-reporting units should not be penalized by withholding contraceptive supplies. Other sanctions (or preferably incentives) should be devised to encourage prompt reporting of service statistics.
31. A system should be developed to feedback program service data and trend information to the field level. Service providers should be involved in defining what type of information they need and with what frequency. Making data useful to those who collect it is one way of minimizing data falsification.
32. As SANRU's data are incorporated in a national scheme, differences in the reporting formats used by SANRU and PSND will have to be resolved.
33. Basic training in data analysis for managers should be provided at headquarters and regional levels.
34. A nationwide contraceptive prevalence survey should be conducted as soon as possible, using the same methodology as the 1982-84 Westinghouse survey. Sentinel point mini-surveys should be carried out frequently thereafter to ensure accuracy of service statistics.
35. Couple years of protection (CYP) should continue to be used as a measure of program success; however, conversion factors should be refined to reflect prevailing conditions in Zaire with respect to age at sterilization, the use of condoms for family planning as distinct from AIDS prevention, and numbers of couples who actually practice natural family planning (NFP) methods. Couple months of protection (CMP) should be reconsidered as a rough indicator of the number of active contraceptors.
36. Priority should be given to installing the PSND national radio communications system.

e. IEC/Outreach

Observations:

- Outreach materials developed at PSND headquarters are virtually unavailable in the field.
- The IEC Division appears to be overstaffed in view of its apparent output and results.
- A revitalized AZBEF would be a more appropriate locus for IEC activities than PSND.
- Service providers see their role as responding to existing demand rather than stimulating new demand through IEC outreach activities.
- In general, family planning services offered in clinics are greatly underutilized, suggesting a need to build these clinics' client base through outreach activities that are effective in informing the uninformed, motivating the informed, and turning the already-motivated into service-seekers.

Recommendations:

37. PSND should not have responsibility for IEC production and distribution. The IEC function should be handled by AZBEF as the lead agency, with input from other groups. Opportunities for integrating family planning IEC into IEC of other projects should be explored.
38. In taking over the IEC function, AZBEF can draw on the ILO technical advisor and the U.N. volunteer as well as on the extensive community contacts and materials development expertise of HEALTHCOM, now housed at FONAMES.
39. Consideration should be given to reallocating resources so as to put more emphasis on the production, distribution, and imaginative utilization of appropriate high-quality IEC materials. Greater use of video, not only for training but also for community outreach, should receive high priority.
40. FP clinic staff should not be expected to perform community outreach activities.

f. Community-based Distribution (CBD)

Observations:

- CBD has been found, in Zaire and elsewhere, to be a useful and cost-effective way to supplement clinic-based services; however, CBD activities in Zaire have been greatly curtailed due to cutbacks in counterpart funding and the termination

of Tulane's operations research support to PHODEF.

- CBD workers sometimes focus exclusively on sales at the expense of the education component of their work.

Recommendations:

41. Since this service delivery mechanism has been shown -- in Zaire and elsewhere - to be a valuable adjunct to clinic-based FP services, CBD should be revitalized, based on the lessons learned from the Tulane studies, and made a major part of Zaire's overall family planning program. Budget allocations must be made to accommodate this recommendation.
42. AZBEF should be the lead agency for CBD, since its focus is on close relationships with communities. SANRU should also be included in measures to strengthen this component in rural areas. Linkages between CBD and CSM should be explored.
43. CBD workers in need of retraining should be identified and retrained.

C. PSI (Contraceptive Social Marketing)

Observations:

- Sales of condoms have soared from less than one million in 1988 to a projected nine million in 1990.
- Most condoms (75-80 percent) are purchased for prevention of sexually-transmitted diseases, including AIDS.
- Objectives are unclear with respect to both target markets and program self-sustainability.

Recommendations:

44. A market segmentation strategy should be devised with the long-term objective of offering two brands of condoms priced and promoted to reach separate target audiences: (a) the existing middle-class market for PRUDENCE; and (b) poorer, less well-educated potential customers. A two-tiered price structure could also enhance cost recovery in that the brand being marketed to middle-class consumers could be sold at a higher price.
45. PSI should continue to investigate the feasibility of creating a local legal entity with which USAID could contract for CSM.

46. **Constructive dialogue between all entities involved in family planning should be encouraged while maintaining PSI's semi-autonomous status with respect to other health providers.**
47. **PSI should continue to explore the possibilities for introducing oral contraceptives, oral rehydration salts, and other medications to its product line. However, given the uncertainties of the marketplace and USAID funding, the emphasis during 1991 should be on team building, market research, and recruitment and training of top level local talent, with only modest growth in sales projections and geographic coverage.**

D. Population Council (Advisory Services)

Observations:

- **The Management Technical Advisor has provided valuable services to both CONAPO/CECAP and PSND.**
- **The background and skills of the Operations Research/Family Planning Advisor are better suited to dealing with the medical/clinical aspects of family planning than with research.**

Recommendations:

48. **The Management Technical Advisor should remain in place for the term of the Population Council project. The incumbent should become increasingly involved in activities associated with the design of future USAID assistance to the population sector and with tasks for family planning groups that appreciate his skills and utilize his advice. He should give somewhat lower priority to working with CECAP than was envisioned in this job description so as to devote more time to family planning management issues.**
49. **Full advantage should be taken of the Operations Research/Family Planning Advisor's expertise in the medical/clinical aspects of family planning, since PSND PSND has no physician on staff with this type of expertise.**
50. **The Population Council should consider developing stronger links with other indigenous groups and organizations (SANRU, AZBEF) which may wish to institute operations research.**
51. **PSND's Operations Research unit should be integrated into a new "Research and Evaluation" unit. Consideration should be given to having operations research unit funded entirely by PSND by 1992.**
52. **The Population Council and USAID should consider funding an operations research project on the promotion of family planning, breastfeeding, and child nutrition with**

low parity women. This project, which has been suggested by the OR/FP Advisor, would examine the impact of an early post-partum intervention on birth spacing, child survival, and experience with contraceptives.

III. Future Directions

A. Short-range Measures

In addition to the short-range measures recommended in Section II above, which concern FPSP entities now receiving USAID support, short-run actions are recommended in the following areas.

1. SANRU

With its extensive infrastructure, dedicated staff, and interest in strengthening the integration of family planning with health services, SANRU represents the most logical private sector mechanism for stimulating demand for family planning services and for providing contraceptive supplies in rural and many semi-urban areas. To lay the groundwork for SANRU to play an expanded role in any long-range family planning program, it is recommended that SANRU's current family planning activities be reinforced through training and provision of IEC equipment. It is also recommended that SANRU collaborate with AZBEF and PSND on a study to test the feasibility of a decentralized contraceptive supply system.

2. AZBEF

In order to play the prominent role envisioned for it in the long-range future, AZBEF needs to be revitalized. It is recommended that the initial focus of this revitalization be on equipping AZBEF to take on the role of lead agency in the production, dissemination, and creative utilization of IEC materials. The team envisages a phased program of activities in collaboration with IPPF. Phase I would involve recruitment, institutional development, staff training, and the placement of an expatriate advisor at the Deputy Director level. During Phase II, a major IEC activity would be initiated. During Phase III, a program to assist the GOZ in establishing "centers of excellence" in each region would be instituted.

3. Health and Contraceptive Prevalence Survey

A health survey which would generate data on contraceptive prevalence should be undertaken by USAID prior to termination of the current Family Planning Services Project.

4. Other Private Sector Activities

Annexed to the body of this report are several concept papers that suggest way to involve the private sector in family planning activities. Suggestions include:

- postpartum family planning and adolescent sex education through the Nurses Association of Zaire (Annex E);
- initiation of urban family planning activities through "for profit" industrial and commercial companies in Kinshasa (Annex F);
- family planning services for the families of plantation and mine workers through Medecins sans Frontieres (Annex G);
- birth spacing outreach activities in urban areas through the Medical Department of Eglise du Christ au Zaire (ECZ) and local parish churches Annex H); and
- family planning outreach activities with female labor union members of Union National des Travailleurs du Zaire (Annex I).

B. Long-range Measures

The team's vision of the long-range future of family planning activities in Zaire is best expressed by the matrix on the following page, which indicates major activities or focus areas, by responsible entity.

As the matrix suggests, USAID assistance to CONAPO would be phased out and responsibility for population policy would rest with the Ministry of Plan. It is possible that UNFPA may continue to provide support with policy analysis.

The MOH would eventually take over the supervisory functions of PSND's regional coordinators. In the interim, the role of these regional coordinators would be expanded and strengthened.

PSND would be responsible for establishing and maintaining a nationwide data bank, and for analyzing and disseminating the data to interested parties including service providers and policymakers. It would continue to supply contraceptive commodities to some health units and would be the lead agency for training of family planning personnel.

PSI would handle contraceptive social marketing and any related CBD activities, including provision of supervision and supplies.

AZBEF would play a central role in private sector family planning activities, first taking on the responsibility of lead agency for IEC, then revitalizing CBD in urban and periurban areas. AZBEF would collaborate with PSND in establishing one "center of excellence" in

each region and producing a video on the essential elements of IEC and FP service delivery for training and public relations purposes.

SANRU would provide support and advice to AZBEF on IEC in rural areas and would incorporate CBD into its rural programs. SANRU would also take the lead in any decentralized depot system that may be adopted, working with AZBEF and PSND.

The for-profit sector (parastatals and private practitioners and clinics) would be encouraged to provide family planning along with other health services in hospital and clinic settings.

Linkages with women's organizations, professional nursing associations, UNFPA, UNICEF, other GOZ ministries (i.e. Agriculture and Education), and other USAID programs (i.e. agricultural extension) would be explored and developed as conditions warrant.

The School of Public Health would house the Operations Research unit which would provide services to all entities involved in family planning. The School would also collaborate with PSND on training activities.

All service entities (PSND, PSI, AZBEF, SANRU, for-profit hospitals and clinics) would be responsible for their own supervision, supplies, and internal monitoring.

Periodic external monitoring and contraceptive prevalence surveys would be carried out by USAID.

Section 1

INTRODUCTION AND BACKGROUND

1.1. Family Planning In Sub-Saharan Africa

Africa's population, now over 800 million, will exceed one billion by the year 2000. Population growth rates for sub-Saharan Africa average three percent per year. Mortality rates, while still high, are declining, yet birth rates remain very high. Women have an average of six to seven children during their reproductive lives. With 45 percent of the population under the age of 15, population momentum will continue to drive insupportable growth well beyond the turn of the century. Such rapid rates of population growth have the potential to seriously hinder socio-economic development throughout Africa. The figures are sobering when one considers the substantial monetary investments that governments will be required to make in health care, employment, housing, infrastructure, agriculture, education, and water and sanitation to support the burgeoning population in the face of rampant inflation, increasing urbanization, environmental degradation, substantial long-term debt, insufficient government revenues, and falling prices for cash crops on world markets. African governments simply do not have the resources to provide for their existing populations, much less populations that will double in less than 25 years.

In the interest of the future, it is critical that increased attention and resources be devoted to family planning by the governments of sub-Saharan African countries and by donors such as A.I.D. Latent demand for family planning has been demonstrated in some countries, particularly among women and men in urban areas where norms and values towards family size are gradually changing. It is anticipated that the specter of AIDS will increase demand for condoms. However, it is also evident that the public sector is severely limited in its ability to provide family planning services. Currently, health expenditures emphasize curative, physician-oriented, clinic or hospital-based care, and preventive services, such as family planning, are often neglected. Where family planning services do exist, they are generally integrated into maternal and child health programs, and thus may not reach young women who are unmarried and have not yet had children.

Many African countries have articulated explicit population policies, but few countries have implemented successful programs and none of these have resulted in any noticeable fertility decline. Of 35 sub-Saharan African countries for which family planning program effort scores were determined by Lapham and Mauldin (1985), eight were categorized as "weak", and 27 as "very weak" or "none". For a variety of cultural, religious, political and other reasons, and despite policy commitments on the part of many African governments, few local resources have been allocated to national family planning programs and it seems unlikely that this will change despite major international donor interest in such programs.

This difficult situation is particularly true of the French-speaking countries of tropical Africa. The table which follows shows the difference in contraceptive prevalence rates between low per capita income (often French-speaking) countries, such as Zaire, and the English-speaking middle income countries of Africa. Among the low income countries contraceptive prevalence is rarely above one or two percent. With the exception of Zimbabwe, the middle income countries all have less than six percent prevalence. Among the French speaking countries two of the most prosperous (Senegal and Cote d'Ivoire) appear to have 4 and 3 percent prevalence, respectively.

Estimated Contraceptive Prevalence Rates in Selected African Countries

<u>Country</u>	<u>Year</u>	<u>Prevalence</u>
Mali	1977	1 (%)
Burkina	1977	1
Niger	1977	1
Somalia	1982	2
Gambia	1977	5
Chad	1977	1
Ethiopia	1982	2
Zaire	1982	3
Malawi	1977	1
Uganda	1983	1
Burundi	1977	1
Tanzania	1977	1
Rwanda	1982	2
Guinea	1977	1
Senegal	1978	4
Lesotho	1977	5
Zambia	1977	1
Cote d'Ivoire	1980-81	3
Zimbabwe	1984	27
Nigeria	1983	6

(World Bank Figures)

It should be noted that the low prevalence rates are not necessarily due to the absence of donor interest. The United Nations and IPPF, for example, have been funding integrated maternal/child health and family planning programs in many French speaking tropical African countries for up to eight years with no noticeable impact on contraceptive prevalence rates. It is in this context of concern and lack of success that one must examine the "Programme des Naissances Désirables" in Zaire.

It is evident from the experience of other African countries that there are no quick fixes for family planning. Demographic transition theory only roughly applies. Indeed it appears that family planning programs will only be effective to the extent that weakened motivations for large families push couples towards the use of contraception. The mere

availability of contraceptives does not bring about reduced fertility - rather it merely helps translate other social forces into fertility decline. Where there is urbanization, industrial development, salaried labor force participation of women, reduction in mortality levels (among other factors) there appears to be greater prospect for the successful initiation of family planning. Where those conditions do not exist - as in Zaire and most other Francophone African countries - it is naive to expect major changes in contraceptive prevalence levels.

It should be noted that in a number of sub-Saharan African countries where the public sector has been either unwilling or unable to provide adequate, accessible family planning services, NGOs and international donors have become interested in promoting involvement by the private sector in family planning service delivery. Encouraging the private sector to help "fill the gaps" has the potential to reduce the cost burden on the public sector, facilitate more cost-effective service delivery, and allow for cost recovery by tapping the financial resources of clients who are willing to pay for services. Private sector involvement in family planning in sub-Saharan Africa, while limited, has taken a number of different forms. This evaluation examines the potential of (continuing) to work with non-profit groups and initiating activities with profit-making groups, such as mines, plantations and factories.

1.2. Family Planning in Zaire

Zaire has historically assumed a pro-natalist stance, which was reinforced by the colonial powers and the Catholic Church. In 1972, however, the Government of Zaire (GOZ) officially endorsed the concept of "child spacing", and in 1973 the Comité National des Naissances Désirables (CNND) was created to promote family planning services. CNND helped establish a "desirable births" component in the pilot health zones of the 1970s.

In 1978, IPPF offered to support a non-governmental family planning entity and AZBEF (the Zairian Association of Family Well-being) was created with many of the CNND members. By 1980, AZBEF was concentrating almost entirely on Information, Education, and Communication (IEC) with only limited programs in the area of service delivery. The first USAID-supported family planning project in Zaire, developed in 1981-1982, has involved a tripartite relationship among SANRU (Church of Christ), AZBEF, and the Projet des Services des Naissances Désirables (PSND), which is now the family planning agency of the Government of Zaire, Ministry of Health (MOH).

1.3 The Current Institutional Framework

The health sector in Zaire is complicated in that health services are provided by a variety of organizations: MOH, private voluntary organizations (PVOs), private practitioners (both traditional and licensed), company medical programs etc. The totality is coordinated or sanctioned by MOH.

At the national level, MOH is divided into seven Directorates: 1) general services; 2) hospital administration; 3) pharmaceuticals and traditional medicine; 4) epidemiology and preventive medicine; 5) primary health care (PHC) policy and health zone strategy; 6) nursing school administration and curricula development; and 7) water and sanitation. Also under MOH management, but parallel to the Directorates and with separate administrative and management offices, are special programs for immunizations, trypanosomiasis control, tuberculosis control, leprosy control, onchocerciasis control, nutrition activities, AIDS coordination, and family planning services.

Two public health entities falling under the jurisdiction of MOH are important to note:

The *Projet de Services des Naissances Désirables (PSND)*, the organization officially designated to promote GOZ family planning activities.

FONAMES, a parastatal organization established to coordinate PHC activities at the zonal level.

The Ministry's administration is decentralized to the regional level where there are 11 Regional Directorates headed by Regional Inspectors. The Regional Directorates were designed to correspond in structure to the seven central Directorates. The regions are further sub-divided into 36 sub-regions, each with a sub-regional chief physician.

The basic building block of the entire health care delivery system is the Health Zone, the system's smallest functional unit. A health zone serves a population of 60,000 -150,000 people and consists of a central office, a general hospital, 1-3 reference health centers (RHCs), and 10-20 health centers (HCs), each with a catchment of 3,000-10,000 people. The RHCs are established as intermediate facilities in areas of a health zone that are relatively far from the general hospital.

The health zone central office team generally includes a chief medical officer, an administrator, one or more nurse supervisors, a water and sanitation coordinator, and a person responsible for coordinating drug distribution.

The Health Center (HC) is the key unit in the health zone structure and is where much of the family planning activity takes place. Health centers are generally staffed by one nurse and several aides who are responsible for providing PHC services, including curative care, prenatal and preschool clinics, vaccinations, growth monitoring and counseling, and basic laboratory testing. HC staff also supervise community-based activities. Theoretically, approximately 90 percent of health problems can be treated at the HC; the remaining 10 percent are to be referred to the RHC or the general hospital.

To ensure community involvement in the management of health services, the Health Zone administrative approach includes a HC committee composed of the HC staff and elected members representing the surrounding communities. The objective of the committee is to involve the community in HC management decisions.

As previously noted, a large percentage of primary health care (particularly in the rural areas) is provided by PVOs, many of which are religious missions. Major groups involved in PHC are the Church of Christ in Zaire (Eglise du Christ au Zaire, or ECZ), an indigenous umbrella PVO for all Protestant groups; the Catholic Medical Projects Office (Bureau des Oeuvres Medicales Catholiques, or BOM); the Kimbanguist Church, the Salvation Army, and others.

An important characteristic of Zaire's approach to health care delivery is the emphasis on cost recovery from the public. With the establishment of the decentralized health zone system in the 1980s, health zones were permitted to develop cost recovery schemes to generate operating costs to fit local conditions. Contraceptives are among the items sold.

Assistance for zonal level investment costs has been arranged primarily through external donors and the extensive system of church-related PVOs mentioned above. The GOZ pays base salaries for some zone, sub-regional, and regional personnel, and provides limited supervision and some rehabilitation subsidies. The zones themselves are responsible for operating and maintenance costs.

Zaire also has a thriving private health sector. Large enterprises, such as Gecamines, the parastatal copper conglomerate, have in-house medical services. Some of the wealthier firms provide family planning services in their clinics, although many firms do not. Smaller businesses contract with outside private or public facilities for curative care.

In addition to the health infrastructure mentioned above there is an extensive network of private pharmacies. It is common practice for a physician to direct his or her patient to bring drugs from the local pharmacy for a specific procedure and many drugs including oral contraceptives are sold without prescription.

The private practice of medicine, although not entirely legally sanctioned in Zaire, is widespread. Services vary from sophisticated facilities in Kinshasa such as those found at the Kinshasa Medical Center to small dispensaries and health posts in rural areas operated by independent physicians and nurses. The type of care provided by these centers is normally curative.

Most family planning services in Zaire are delivered by nurses. The nurses are trained at three levels. There are about eighteen thousand in the country. There are also approximately 2,000 physicians who are trained in three medical faculties. Doctors, and to a lesser extent nurses, are concentrated in the larger cities.

Lastly it should be noted that under a USAID grant, Tulane University has helped set up a Masters of Public Health (MPH) program at the University of Kinshasa, the first of its kind in Central Africa. About 20 MPH students graduate each year and return to work in rural areas. Short-term technical training and research in public health areas are also conducted under this program.

1.4. The Family Planning Services Project

The Family Planning Services Project (FPSP, 660-0094) was authorized on September 14, 1982 and has been amended three times. Current life-of-project (LOP) funding is \$13.8 million and the project assistance completion date (PACD) is September 30, 1991. Bilateral dollar funding has been supplemented through Mission buy-ins with various U.S. contractors, through cost-sharing with centrally-funded A.I.D. projects, and through an estimated \$2.47 million equivalent in local currency counterpart funds (CPF), which have been used for salary supplements and other soft-currency expenditures.

According to the Project Paper (PP), the "goal" of FPSP is to increase the use of voluntary family planning services among Zairian families, assisting them to space their children and to have the number of children they desire. The project "purpose" is to increase contraceptive use in selected urban areas by strengthening and expanding efforts to include family planning in on-going government and private health care programs. By the end of the project, it is expected that seven percent of couples of fertile age in 17 targeted urban areas will be using modern contraception. The estimated 1990 population of these 17 urban areas is 7.4 million people, or about 20 percent of the total population of Zaire.

The initial implementing agencies for FPSP were SANRU, AZBEF, and PSND. An evaluation of FPSP undertaken in 1985 found that SANRU had performed relatively well but that AZBEF was starting to experience problems of mismanagement and weak leadership. As time went by, these problems intensified and AZBEF increasingly was left behind by PSND in the areas of IEC (where it had initially shown strength) and service delivery. This further weakened AZBEF as did the creation of a variety of new organizations and approaches to service delivery.

A major Project Paper Amendment (No. 2) in August 1988 changed the project's assumptions and design. Significantly, this amendment included funding for population policy and for a new project component, Contraceptive Social Marketing (CMS), which has since become a key service delivery mechanism for AIDS prevention and family planning in Zaire.

The amended FPSP has six major components: (1) integrated service delivery through MOH, parastatals, and PVO clinics or hospitals and vertical services through Population Services International (PSI); (2) IEC through PSND and AZBEF and through buy-ins to the Population Communication Services (PCS) Project; (3) operations research, through Tulane University and the Population Council; (4) training and supervision, through three PSND training centers, selected other training venues, and seven newly established PSND regional offices; (5) population policy and planning, with CECAP and CONAPO; and (6) management assistance, currently through a contract with the Population Council for a Management Support Unit (MSU) which provides assistance to PSND and the other organizations involved in family planning in Zaire. Comments on some of the major FPSP components follow.

1.4.1. CONAPO/CECAP - Population Policy and Planning

The population policies of national governments (as well as international assistance agencies) can play an important part in identifying problems and opportunities for interventions in the population arena. It is widely believed that favorable policy settings can facilitate the effective implementation of population programs and projects; conversely, unfavorable policies can clearly obstruct work in this area.

In Zaire, major constraints to family planning program implementation stem from the ideologies and outlook of some of the political elite and the great mass of the population; the tendency of some to view population efforts as a diversion from fundamental structural changes; the hostility to all policies affecting women's traditional roles; (religious) opposition to family planning; competing claims by government ministries and departments over the allocation of scant resources; and the lack of motivation, probity and skills needed to undertake agreed upon programs effectively. To address these constraints, USAID and United Nations agencies have sought to reinforce a strong policy commitment to population planning and population policy formulation.

The two Government agencies which have the major responsibility for activities in the policy area are the National Population Committee (Comité National de Population - CONAPO) and the Secretariat for Population Activities (Cellule de Coordination des Activites en Matiere de Population - CECAP).

CONAPO was created by the GOZ in 1986 to serve as the principal mechanism for the "conception, coordination and pursuit of activities and studies in the area of population to enhance the use of human resources". The Committee consists of representatives of various organizations and government ministries and is chaired by the Secretary General for Plan.

CECAP is the secretariat of CONAPO's Interdepartmental Technical Advisory Committee (CITIP), which was set up by the GOZ to review population issues with all the technical departments. CECAP's mission is to: a) promote, coordinate and monitor all population-related activities, in both the public and private sectors; b) conduct, in collaboration with the National Statistical Institute (INS), an inventory of existing demographic data and future research and surveys as needed; c) serve as a population data bank for government departments, social service agencies, and institutions in both the public and private sectors; and d) contribute to the extension and development plan, ensuring that population activities are systematically incorporated into all sectoral development activities. (Further detail on CONAPO/CECAP is provided in Section 3.1.)

1.4.2. PSND - Services

The primary implementing agency for FPSP is the Projet de Services des Naissances Désirables (PSND), an agency of MOH. PSND has had a relatively secure base within MOH due to its ability to secure external (largely USAID) funding. Its Director has been in place since the inception of FPSP. It has over 60 core staff in Kinshasa and many

PSND senior managers have received professional training in the U.S. While the PSND organization chart changes frequently, the major functional units have been Training, Administration, Supervision, Operations Research, IEC, and Program or Field Operations. The organization has its own warehouse and model clinic. (Further detail on PSND is provided in Section 3.2.)

1.4.3. PSI - Contraceptive Social Marketing

In most of Africa, family planning services are considered a health intervention to be provided in conjunction with Maternal and Child Health (MCH) and Primary Health Care (PCH) services. Thus they are often given inadequate attention by service providers. The use of supposedly "integrated" services as the sole delivery channel for family planning often severely constrains the speed with which contraceptives can be made available and fertility can be reduced. The clinical approach can also neglect key population groups, i.e., males and teenagers, among whom both the demand and need for contraception are high in urban areas. If the pace and scope of family planning are to improve in countries such as Zaire, innovative approaches for service delivery are called for. One such approach is social marketing, a public health service which utilizes private sector distribution channels to provide primary health care products at affordable prices to the general public, and promotes their correct use through private sector management techniques and mass-marketing efforts.

In 1987, Population Services International (PSI) designed and inaugurated a pilot condom social marketing project in Kinshasa. Previously condoms had been distributed mainly through government clinics which, compared to consumer oriented commercial outlets, are often inadequately stocked; moreover, clinics usually are visited by clients for curative, rather than preventive purposes. Condoms could rarely be found in private pharmacies and when available were often out of economic reach of the average person. PSI has since undertaken an expanded social marketing program which includes both spermicides and condoms and has been successful. Nine million condoms will be sold during 1990. (Analysis of the PSI Contraceptive Social Marketing program is included in Section 3.3.)

1.5. Population Contractors

There has been a large number of activities carried out by contractors that are directly related to or associated with FPSP. Of particular interest are:

Community-Based Distribution, carried out through over 200 distributors in various locations throughout Zaire. Support was provided until December 1989 through centrally-funded contracts with Tulane University and at an earlier stage by Family Planning International Assistance (FPIA);

Information-Education-Communication (IEC). In late 1986, with assistance through FPSP from the centrally-funded Population Communication Services (PCS) Project, the GOZ developed a Five Year Comprehensive IEC strategy. The key executing agency for IEC was to have been PSND but work has also been carried out by AZBEF, PSI, and

FONAMES. USAID continues to provide long and short-term technical assistance and related support to PSND for IEC through an FPSP buy-in to PCS.

Training and Supervision. Cooperating agencies have been the Program for International Training in Health (INTRAH), Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), Management Sciences for Health (MSH), and International Health Programs, University of California, Santa Cruz. Three training centers have been established, two of which are currently operational.

Management/Operations Research. Two long-term advisors (a Management Technical Advisor and an Operations Research/Family Planning Advisor) and a bilingual secretary, provided through a buy-in to the Population Council, comprise a Management Support Unit (MSU) for FPSP. The MSU works with various divisions of PSND to improve overall internal management capabilities (information, operations research, finance, logistics, personnel, decision-making) and PSND's external image as the lead GOZ family planning agency. (Analysis of the Population Council's activity is included in Section 3.4.)

Private Sector Support. Technical assistance and related support has been provided through the centrally-funded Technical Information on Population for the Private Sector (TIPPS) project to three private companies: UTEXCO (the largest textile company), the Banque Commerciale du Zaire (BCZ), and Compagnie Sucrière in Kwilu Ngongo.

1.6. Related Projects

1.6.1 SANRU

The Basic Rural Health II Project (660-0107) known locally as SANRU II (Projet des Soins de Santé Primaires en Milieu Rural), is the successor to the Basic Rural Health Project (660-0086), known as SANRU I. SANRU I assisted in establishing a sustainable community-supported PHC system in 50 rural zones to combat the ten most prevalent public health problems in Zaire. Project assistance was provided in the form of basic equipment and medicines needed to transform 250 dispensaries into full-service health centers, technical assistance, educational materials, and training for health personnel, as well as office equipment and vehicles to establish supervisory capacity for the rural health zones.

SANRU II planned to expand SANRU I activities into 50 new rural health zones, while continuing support to further strengthen the 50 zones assisted by SANRU I. In addition, important new activities were to be initiated, including support for national and regional coordination of public health activities by the Ministry of Health, national planning of water systems, intensification of water and sanitation activities and provision of essential equipment needed to upgrade RHCs and hospitals. SANRU I's project life basically coincided with the GOZ's first five-year National Health Care Plan; SANRU II's project life will coincide with the second five-year plan. Like SANRU I, the successor project was to be a collaborative effort between the GOZ, the Eglise du Christ au Zaire (ECZ), participating rural health zones, Peace Corps, and USAID. The ECZ is the implementing

agent for the rural health activities; the National Rural Water Service (SNHR) was to be the implementing organization for national and regional water activities.

SANRU (as opposed to PSND) is the rural program of choice in terms of integrated family planning. SANRU staff have noted that the following activities are presently under way or are planned to reinforce their family planning activities in the existing SANRU zones:

- Emphasizing family planning components in the training of health zone personnel. These include:
 1. Health center supervisors
 2. Traditional birth attendant trainers
 3. Village health worker trainers
 4. Management personnel
- Continuing national level training of family planning specialists (four week course which includes training in IUD insertion),
- Promoting conferences and lectures. Publications through the SANRU documentation center put emphasis on dissemination of family planning information.
- Placing a new order for audio-visual equipment and film-strips (including several on family planning). These will be used for the village level seminars.
- Initiating new Operations Research projects (large and small). One extraordinary piece of SANRU-associated research has been undertaken in Kananga by the Institut Medical Chretien du Kasai, with support from the Population Council. The results deserve wide dissemination. Another study will shortly be undertaken in collaboration with PSND and AZBEF to determine if there are more effective regional methods of storing and distributing contraceptives.

An analysis of SANRU family planning services statistics shows that access to family planning services within the zones covered by SANRU increased from an estimated 30 percent in 1985 to 40 percent in 1989. Over 75% of the zones reporting on family planning activities in 1989 are carry-over zones from SANRU I, which included most of the Protestant-affiliated zones. Although the volume of contraceptive commodities distributed has varied widely by year and type of supplies, there appears to be a generally increasing trend in the average number of contraceptives distributed over the last five years. Figures on commodities distributed during 1989 are:

Depo-provera	5,907 injections
Pills	50,483 cycles
Condoms	105,054 units
Sterilizations	697 procedures
Spermicide	2,518 tubes

1.6.2 AZBEF

AZBEF, formerly the "Comité National des Naissances Désirables," was established with GOZ permission in 1973 and became operational in 1979 providing family planning services integrated within units run by or through the MOH. In the mid-1980's, after AZBEF began to experience management and organizational problems, PSND moved into many areas, such as IEC and service delivery, which AZBEF had previously monopolized. In spite of its pioneering role, AZBEF is no longer as active as it once was. The AZBEF 1989 Annual Report shows that the organization earned a modest income from the sale of contraceptives plus minor income from volunteer dues and occasional special projects. It received technical assistance in the form of a short-term (seven months) advisor to help prepare plans, and this objective was achieved. AZBEF's 1991 Work Plan speaks of 126 AZBEF members (26 staff and the rest volunteers). Nonetheless, in spite of excellent plans and ideas, AZBEF is operating under serious constraints, the most important of which appears to be a chronic lack of funds. As a result, many planned activities have not taken place and most of the central level staff have been placed on "administrative leave." (Further analyses of AZBEF is contained in Section 4.1.)

Section 2

EVALUATION PURPOSE AND METHODOLOGY

2.1. Purpose of this Evaluation

USAID Zaire has reaffirmed its commitment to support Zaire's population and family planning efforts in its FY 1990 - FY 1993 Action Plan, issued in March 1990. While recent political and other changes may lead to revisions in this plan, Family Planning (FP) will continue to have a high priority within the USAID Zaire portfolio. The Action Plan's strategic objective in the health and population sector is to improve health status, with emphasis on increasing the rate of child survival and reducing fertility. The key program performance indicator in support of this strategic objective for population/family planning efforts is to increase contraceptive prevalence from two percent in 1988 to seven percent in 1995. Prior to taking further steps in its commitment, USAID arranged for an evaluation of the ongoing Family Planning Services Project (660-0094).

2.2. Team Composition

The evaluation was conducted by a three-person team. Checchi and Company Consulting, Inc. provided two team members under the terms of its IQC for Development Information and Evaluation Services: a Senior Family Planning Specialist/Team Leader (Joel Montague), and a Management/Organizational Development Specialist with experience in family planning (Emily Moore). The third team member, a Zairian Clinical Specialist (Dr. Lusembe), was contracted directly by USAID Zaire.

2.3. Scope of Work

The evaluation was carried out over a five week period from October 25 to December 1, 1990. The Scope of Work called for the team to provide USAID with a set of recommendations as to: 1) the most effective mix and levels of FPSP activities, given available resources, that would contribute to the project goal in the remaining two years of the project; 2) any outstanding issues or opportunities which would require additional analysis or study before the design of a follow-on A.I.D. assistance package in FY 1992 that may enhance the design/implementation of the follow-on project, and 3) future orientations for population/family planning activities for consideration during the design process. Recommendations were to be based on analysis of:

1. The project's technical accomplishments/outputs.
2. The institutional framework of the project.
3. The internal management of PSND.
4. The management organization of PSI Zaire.
5. The specific management problems and issues identified by USAID.

The team carried out the required analyses through extensive interviews with local professionals, field visits, and discussion among themselves and with USAID staff. Following one day of preparation work in Washington, D.C. which included a meeting with cognizant A.I.D./W personnel, these activities were carried out in Kinshasa and through field trips to Bas Zaire and Shaba. Annex A provides a list of persons contacted and places visited.

Section 3

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

3.1 CONAPO/CECAP

In 1987, following a visit to Zaire by "Options" personnel and preparation of a strategy paper, \$680,000 was allocated to an ambitious effort by Futures/JS and A in the area of population policy involving 9 major activities and 22 objectives. A Resident Advisor arrived in 1988. As of May 1989, 12 of the 22 most important tasks had been implemented.

By 1990 a National Population Policy (NPP) had been drafted; some action plans for the policy had been drawn up; 60 workshops had been held which trained some 70 high and middle level technicians in planning and budgeting; computers had been installed at CECAP and ten persons had received micro-computer training; and permanent communication links had been established between sectoral actors (CTIP members) and sectoral planners. Perhaps most significantly, PSND (and SANRU) in 1989 were able to obtain some small sums (\$75,472 in the case of PSND) from the GOZ Investment budget as the result of a new budgeting process.

Nonetheless, a National Population Policy has not been approved by the GOZ and "Options" efforts have repeatedly been delayed and frustrated in the area of population policy formation. As part of the overall effort (Task I), the RAPID model was brought in and a simplified story-board version was developed for Zaire. At a CONAPO meeting in May 1990, a population policy was accepted. Subsequently the Minister of Plan indicated that the policy was to be an integral part of the next Five Year Development Plan.

Although progress has been made, the overall results are somewhat disappointing and it is doubtful that the significant financial investment made by USAID in the population policy area has been entirely cost effective. It should be noted that recent A.I.D. inputs into population policy formation have taken place at the same time as the UNFPA has been providing significant funds and human resources to achieve the same objectives.

3.2 PSND

3.2.1 Technical Outputs

3.2.1.1 Contraceptive Commodities and Logistics System

Selection of Contraceptives. Major contraceptive suppliers to family planning programs in Zaire are USAID (to PSND and PSI) and IPPF (to AZBEF). PSND and AZBEF are responsible for the distribution of contraceptives to service providers. They have made arrangements allowing them to exchange contraceptive commodities in order to complete each other's contraceptive mix. For example, PSND does not receive Depo-provera from

USAID, but can obtain it from AZBEF. Similarly, AZBEF can obtain condoms and other types of contraceptives from PSND.

The USAID-supplied contraceptives appear to be appropriate. The range of contraceptives distributed by PSND clinics includes condoms, pills, foam tablets, and IUD's.

Pills: Lo-femenal is the standard dose USAID-supplied pill.
Ovrette is the progesterone only pill for nursing mothers.

Condoms: Non colored Sultan is the public sector condom.
Non colored Panther is used in the PSI program.

IUD: USAID now provides the copper T 380 A.

Foam tablets: Conceptrol is the USAID supplied foaming tablet.

Other donors supply other brands, the most important of which is Depo-provera.

Logistics System. The logistics system has not worked efficiently resulting in "stock-outs" and major re-supply delays. The most important reason for these problems has been the "pull system".

Until recently family planning clinics could not receive contraceptives unless they had submitted their quarterly reports. Inasmuch as only slightly over 50 percent of the units reported, this resulted in major delays. In addition, even when reports were submitted, it appears that headquarters bureaucracy was exceedingly slow in approving re-supply. A CDC study of "turn around time" found an average of two months from first request to shipment. Our study showed it took a month from the departure from the central warehouse until arrival (by air) at peripheral units in Lubumbashi. Moreover, some decisions on whether or not units should receive contraceptives may have also been flawed in that units that did not appear to be using a particular type of contraceptive were not resupplied when in fact they may not have used them because they did not have them.

USAID has now requested that this system be reviewed and that supplies at the central level be pushed out - presumably against a requisition. The old system, which is well described in "Système de gestion des stocks/magasin/PSND" (Kinshasa, June 1990), needs to be revised to reflect this new approach. Four individuals have been sent to MSH for logistics training, which appears to have been useful. The CDC Contraceptive Commodities Management Information System (CCMIS) is a computerized system used to monitor the contraceptive commodities supply system.

Inventory. Inventory records for the period 31 August to 31 October 1990 show that very substantial quantities of many items are in stock. During our visit to the central warehouse in Kinshasa we found no evidence of the presence of expired stock.

**Warehouse Inventory for Period from
August 31 to October 31, 1990.**

<u>Product</u>	<u>Quantity</u>
Lo-Femenal	102,900 cycles
Ovrette	45,850 cycles
Ovral	7,458 cycles
Ovostat	46,800 cycles
Depo-provera	1,479 doses
Neo-Simpoon	702 tubes
Conceptrol	1,317,800 tablets
Condom	3,119,580 units
IUD	2,286 units

3.2.1.2 Facilities and Equipment

Facilities. The FPSP Project Paper planned for 125 FP clinics. As of June 1990, 140 clinics of varying functional status had been opened. PSND directly operates only one of these clinics, the Libota Lilamu Clinic of Kintambo, which is located at PSND headquarters in Kinshasa and is used both for service delivery and demonstration purposes. In the field, FP shares clinical facilities with other primary health care activities (immunization, prenatal care, pre-school clinics and curative care). In hospitals, FP services are generally delivered in the maternity or in the gynecology and obstetrics department. However, there is almost no post-partum education.

The quality of facilities directly depends on the resources of the clinic owner. Parastatal companies and churches generally have spacious, clean, and well equipped facilities while government clinics tend to be smaller, poorly equipped, and unclean. A typical rural clinic visited was the Centre de santé de Mvululu (NGO) near Sona Baia, not far from the main highway to Matadi. This rural health center is assisted by SANRU. The facility had almost no supplies, few contraceptives, no health education materials, and is rarely supervised. Newly delivered women with their babies are not separated from other in-patients. Another clinic visited was the Centre de santé Stop in urban Matadi. This large, busy, government-owned clinic has no contraceptive supplies in some months and has had repeated stock-outs. The facility is crowded, dirty, and juxtaposed to what appears to be a garbage dump. The "cafeteria method" and "follow-up" of clients seem to be alien concepts.

Equipment. The clinics usually have their own equipment. No evidence of PSND-provided equipment was found in clinics visited by the evaluation team, although a limited number of clinics have received laparoscopes used for surgical contraception from JHPIEGO. The quality of equipment observed in clinics varied according to ownership. Clinics owned by parastatal companies and churches were often well equipped while government clinics were poorly equipped. For example, at the University Clinic Mama Mobutu in Lubumbashi, which is ranked as a high performance FP clinic offering

sterilization procedures, the team observed during a visit to the sterilization room that the laparoscope, while working, was missing a few parts and was not suitable for teaching purposes. The respirator was not in working order due to the lack of some spare parts, the light source was weak, and there was no air conditioning. Another high performance unit visited at the Gecamines Hospital in Likasi, by contrast, was very well equipped. In general, it can be stated that most small facilities lack both equipment and supplies.

3.2.1.3 Training

Expected outcomes for FPSP with respect to training included the establishment of three training centers, the training of 250 FP service providers and the introduction of FP into formal nursing school and medical school curricula. Short-term training was supposed to provide opportunities for project leadership and for those engaged in training and supervision to visit FP programs in other countries and attend courses and seminars on management, FP delivery, curriculum development and training methodology, evaluation, communication skills and special concerns. Long-term training would allow candidates certain to continue employment related to FP to be trained at the MPH level in appropriate African or U.S. institutions.

PSND first received training-related assistance in 1986 from MSH. INTRAH training effectively started in 1987. Training has been carried out both in country and abroad. A wide range of subjects have been covered. From the breakdowns in Table 1 and Table 2 on the following pages it appears that basic training has been a priority for in-country training while management has been the most frequent type of external training.

Regional training centers were opened in Kinshasa, Lubumbashi, and Kisangani but the Kisangani center is no longer operational. The evaluation team had the opportunity to visit the Rwashi Training Center in Lubumbashi, which has trained 10 trainers, 23 doctors, 60 nurses, and 10 IEC specialists since it opened in 1987. Training modules at Rwashi cover primary health care, FP clinical aspects, IEC, management, and FP philosophy. The training is conducted through group work, discussions, supervised practice, problem solving and lectures (less than 10 percent of time allocation). Basic training lasts four weeks. From our discussions with the Director, it appeared that the center was also being used for training in other aspects of primary health care since training in FP alone would result in under-utilization of the center's facilities.

Reportedly, no standard procedures are used to select training program participants. The training staff at Rwashi has had to deny admittance to training sessions to a few participants who did not have the appropriate backgrounds. The intent is to train teams of service providers by offering similar curricula to participants with different backgrounds

¹Service providers include physicians, nurses, midwives, IEC specialists, and community-based distributors. PSND staff is limited to the central staff in Kinshasa and to one or two persons in each regional coordination office. Service providers generally are not hired by PSND.

(for instance, to both doctors and nurses.) As a result, the level of training may be too high for some participants and too low for others. Re-training does not receive adequate attention, nor does management-by-objectives in the "management module". It is worth noting that the Director was unable to show the team any training modules.

Problems raised by the head of the training division at PSND headquarters included the increased training costs associated with the decentralization of training in regional centers; logistics; too much material in the training modules; the reluctance of many health care institutions to free their best personnel for FP training; and a certain degree of loss of trained personnel.

An INTRAH evaluation team (1989) found that FP had been integrated into the curricula of several nursing schools at the secondary school level but not into the curricula of medical schools or university-level nursing schools.

It appears that significant numbers of trainers and service providers have received FP-related training. The INTRAH evaluators noted that the performance of service providers was satisfactory in the case of 80 percent of providers assessed. They also noted that training in supervision did not result in better supervisory performance in the field.

Recommendations:

1. A full-scale training needs assessment should be conducted, as has been planned by INTRAH for 1991. Needs for pre-service basic training should be distinguished from in-service retraining needs.
2. Training, especially management training which is not topic-specific, should be planned and carried out jointly with other health programs such as PEV. Other health care providers should be encouraged to use the FP regional training centers in order to minimize costs.
3. A standard supervisory protocol should be used to help select providers in need of training.
4. Family planning should be integrated into the curricula at all levels of nursing schools. In medical schools, family planning should be covered in courses in obstetrics and gynecology, rather than introduced as a separate course. The MPH curriculum at the School of Public Health should also incorporate family planning.
5. The 20 percent of trainees receiving unsatisfactory performance scores in the INTRAH evaluation should be followed up for retraining or reassignment.
6. In-country training should gradually replace overseas training. In selecting trainees, attention should be paid to equity in terms of gender and staff position.

Table 1: FPSP TRAINEES BY SUBJECT AND BY YEAR: IN COUNTRY

Subject/Year	1984	1985	1986	1987	1988	1989	1990	Total
FP Basics	56	62	69	26	61	96	*	370
VSC/CCV Counseling	0	0	0	23	0	0	*	23
IEC (Radio/TV)	0	0	0	18	0	0	*	18
IEC (Newspapers)	0	0	0	0	0	16	*	16
Animateurs	0	0	0	0	0	68	46	114
Provider Retraining	0	0	0	0	0	0	18	18
Training of Trainers	0	0	0	3	0	0	31	34
Supervisors	0	0	0	22	0	0	*	22
CBD/DCC	0	0	0	115	119	0	*	234
Total	56	62	69	207	180	180	95	849

* = not available

Table 2: FPSP TRAINEES BY SUBJECT AND BY YEAR: OUT OF COUNTRY

Subject/Year	1984	1985	1986	1987	1988	1989	1990	Total
Management	2	10	8	6	7	5	0	38
IEC	2	2	4	6	7	0	0	21
Nutrition	3	3	2	0	0	0	0	8
Nursing	1	0	30	0	0	0	0	4
Operating Room	1	1	1	2	2	1	0	8
Evaluation	0	4	4	0	1	0	0	9
Microcomputers	0	0	4	0	0	0	0	4
Supervision	0	0	0	4	0	0	4	8
VSC/CCV	1	3	2	4	1	0	3	14
VSC/CCV Counseling	0	0	0	0	1	1	0	2
Natural FP	0	1	0	0	0	0	0	1
CBD/DCC	0	0	4	0	1	0	0	5
Fecundity Regulation	0	0	0	2	2	0	0	4
Reproductive Health	4	2	7	5	1	0	0	19
MPH	0	0	1	0	1	0	0	2
Operations Research	0	0	0	0	0	0	1	1
Total	14	26	40	29	24	7	8	148

Source: PSND files

3.2.1.4. Referral Systems

FP services are delivered either through the health care system or through community-based distribution (CBD) workers. CBD workers are taught to use a simple checklist of signs and symptoms (written in the local language) before selling contraceptives to their clients. In theory, they are supervised by the CBD nurse supervisor who reports to the CBD program director (who is also the *médecin chef de zone*). Clients needing IUDs, Depo-provera or sterilization are supposed to be referred to the nurse supervisor and to the program director, as are patients having problems related to the use of contraceptives. In practice, CBD workers receive little supervision and it is unlikely that referrals actually take place in rural settings.

Within the health care system, the FP service provider at the clinic level (usually an A3 or A2 nurse) is supposed to refer clients with problems and clients needing IUD or sterilization procedures to the medical doctor who supervises the clinic. This physician may be the head of the department under which the FP clinic functions, the head of the hospital, or the *médecin chef de zone*. He may or may not be trained in family planning.

Another referral path is from one service clinic to the FP clinic. For example, a client may be referred by the pre-natal or pre-school clinic to the FP clinic in the same institution.

During our field visits we found no evidence of standardized instructions (algorithms) for service providers. Similarly, there is no standardized referral system for FP, reflecting the absence of medical standards of which referral procedures are a part.

Recommendations:

1. A standardized referral system should be included in a module of medical standards which should be prepared in writing and taught to FP service providers.
2. A study of whether and how the referral system works in practice should be conducted.

3.2.1.5. Medical Direction and Standards

At one time there was a Medical Director at PSND. While he did not provide written clinical guidelines for the staff at any level, his presence was at least reassuring in that he was knowledgeable of the clinical aspects of family planning. Currently, there is no physician at PSND headquarters who has medical training in contraceptive technology, obstetrics, and gynecology. Nor, apparently, are there any codified medical standards or guidelines for family planning service providers that have been approved for use in the FP units. In the judgment of the evaluation team, this situation is cause for the gravest possible concern.

Recommendations:

1. A Medical Director with extensive knowledge of the clinical aspects of family planning should be hired by PSND.
2. Medical guidelines and standards (protocols) for family planning service providers should be prepared, approved, and integrated into training curricula. PSND should be given formal notice that all USAID support will be terminated unless these guidelines and standards are in force by a specified date.

3.2.1.6 Service Delivery

Life of project (LOP) service delivery outputs projected for FPSP, as amended, include 150,000 new users in 137 clinics and CBD sites, and 440,000 couple years of protection (CYP's).² To date, PSND estimates show that the project has reached 77,478 new users at 140 clinics and 11 CBD sites and has achieved 75,037 CYP. While the number of clinics has exceeded expectations, service utilization remains low as indicated by the number of CYP.

3.2.2 Management Issues

3.2.2.1 Planning and Setting Objectives

The logical framework for the amended FPSP calls for goal and purpose level achievements to be measured by the following verifiable indicators:

- An increase in contraceptive prevalence from approximately 1-2 percent in 1982 to 6 percent by 1990 and thereafter to achieve the GOZ goal of approximately 30 percent by 2000 (goal-level indicator);
- 7 percent of couples of fertile age in 17 urban areas will be using modern contraception by project completion (purpose-level indicator);
- At least 50 percent of couples will know about one or more modern methods and where to obtain supplies by project completion (purpose-level indicator).

Measures of service delivery outputs include number of new clients (users), CYP, and number of cities reached by CSM activities.

²CYP is a composite measure of total protection provided by all contraceptive methods, to all users, during a period expressed in couple-years. It is calculated by multiplying the quantity used for each contraceptive method by a conversion factor equivalent to the average duration of protection provided to one couple by one unit of that contraceptive method.

While USAID covers all bases by including contraceptive prevalence, number of new users, and couple years of protection among its achievement indicators, PSND Action Plan objectives for 1989 and 1990 make no reference to prevalence rates or CSM acceptor figures:

Service Category	<u>1989 Plan Objectives</u>		<u>1990 Plan Objectives</u>	
	CYPs	New Clients	CYPs	New Clients
Clinics	45,000	13,000	41,667	30,912
CSM	60,000	/a	/a	/a
CBD	15,000	6,667	13,167	12,460
VSC	4,000	337	17,308	672
NFP	/a	/a	11,000	/a
Total	124,000	20,004	83,142	44,044

CYP objectives for natural family planning (NFP) were added in 1990. Although new client objectives are not given for this category, the team was told that 41,000 new NFP acceptors were expected, which would indicate that the anticipated protection rate is very low.

CSM objectives were deleted after PSI's contraceptive social marketing program achieved semi-autonomy from PSND in 1989. However, the team could find no reason why CYPs associated with the CSM program should not still be included in the total figure.

According to PSND's 1989 Plan of Action, objectives for the Program Division were established assuming that each of 104 FP units would achieve at least 430 CYPs and serve 150 new clients. The plan set similar objectives for the CBD sites. The ratio of clinic CYPs to new clients is more than three to one (45,000:13,000) for 1989, while for 1990 it drops to less than 1.5:1 (42,000:31,000). This difference suggests that there has been a dramatic change in the set of assumptions underlying the two plans, for which the team could find no justification. If the expectation were for a significant number of carryovers (of continuing active contraceptive users) from prior years, then the ratio of CYPs to new clients would have increased, not decreased, in 1990.

Similarly, the team questioned how PSND could expect, for the Voluntary Surgical Contraception (VSC) category, to achieve a two-fold increase in the number of women sterilized (from 337 to 672) and a four-fold increase in the corresponding number of CYPs (from 4,000 to 17,308) from 1989 to 1990. These comparisons also suggest that planning from year to year may not be based on a consistent set of assumptions concerning contraceptive mix, continuation rates, etc.

It is understood that PSND regional coordinators normally are called to Kinshasa for a week at the end of the calendar year to work with program staff on plans for the following year; however, lack of counterpart funding precluded the regional coordinators from participating in preparation of PSND's 1990 annual plan.

Inquiries were made at PSND headquarters about whether the planning process is goal-driven or resource-driven, i.e. do planners start by formulating goals and objectives, then determine necessary inputs, or do they start with available resources, then decide what goals and objectives can be achieved? The response was reasoned and balanced: the process begins with the definition of goals, objectives, and activities, but planners are mindful of resource constraints and try to be realistic. Unforeseen circumstances, such as a sudden drop in CPF, can create a need for major modifications in mid-course.

None of the service providers interviewed by the team in the field had any knowledge of PSND's national or sub-national objectives. Nor were these providers able to articulate their own objectives beyond stating that they hoped to achieve an increase in the number of acceptors. The physician in charge at Likasi SNCZ Hospital told the team that he was thinking in terms of setting annual objectives but had not decided what measures to use.

In the absence of explicit goals and objectives, field units tend to operate on an ad hoc basis, adjusting their schedules of activities to respond to the peaks and valleys of demand. Since no complaints were heard about overwork or excessive client caseloads, the absence of goal-directed work plans does not appear to hinder service providers in the conduct of their day-to-day activities.

PSND does not appear to have any reward system to encourage innovation, risk-taking, and increased outreach at the service delivery level. This is in striking contrast to the CSM program where sales goals and profit motives drive the PSI representatives as much as altruism and "coverage" objectives. (See Annex C, "Beyond Problem Identification and Lamentation," for a suggestion on dealing with this issue.)

There is also the broader question of whether USAID, PSND or any of the other "actors" in FPSP have sufficiently defined the goals and objectives of family planning assistance in terms of target group (the whole population or the poor majority?) and expected outcomes. Is the intention to create channels for service delivery wherever they may work and at whatever cost, or is it to develop a system that can be self-sustainable in the short- or long-run? Is the intention to provide models so that the GOZ can eventually build a nationwide service network, or is it to support a variety of service delivery mechanisms with no expectation that they will be institutionalized in the long-run by a central government agency?

Recommendations:

- 1. USAID (together with the major "actors" in family planning) should clarify the goals and specific objectives of the U.S. family planning assistance program in Zaire.**
- 2. Annual service delivery objectives should be realistic and based on a consistent set of assumptions from year to year.**
- 3. Objectives for sub-national units (regions, zones, clinics, CBD sites) must be transmitted to, and understood by, those who are expected to attain them.**

Preferably, the planning process should begin with the setting of field-level objectives in the field, with assistance from Kinshasa.

4. The planning process should be more participatory and "bottom up." If funding is not available for regional coordinators to spend time in Kinshasa, inputs from these coordinators should be solicited by other means.
5. Training needs should be linked to realistic objectives, however these objectives may be stated (in terms of prevalence, continuing clients, new acceptors, or CYP).

3.2.2.2 Organization and Staffing

Organigrams. The team was given several versions of PSND's organigram, including a "final" version which subsequently was altered by the Director of PSND in the presence of the team. After our interviews, we learned that at least two other changes in this organigram had been made, one adding the position of Assistant to the Supervisor for Sterilization, and the other hiring a Medical Advisor who, while paid as an advisor, holds the title of Associate Director.

Since the 1985 evaluation was conducted, top positions in PSND's organigram have changed frequently, as have the people holding them. Divisions and bureaus have proliferated, and the size of the headquarters staff has increased to an extent that does not seem to be justified by increases in program activity.

The 1985 evaluation recommended that PSND's Project Management Unit (PMU), consisting of the Director and Division Chiefs, play a strong role in daily management. This recommendation was accepted and the group now meets on a weekly basis. However, the decisions reached by this body are reported to be less-than-firm and are often overruled by the Director. The Director's frequent and lengthy absences from Zaire render daily management decision-making extremely difficult for those to whom responsibility is only weakly delegated.

Roles and Responsibilities. The Director of PSND serves as medical advisor to the Ministry of Health on all matters concerning contraception, safe motherhood, and infecundity. Technically, she could advise MOH to "correct" AZBEF, SANRU, or even autonomous PSI if she felt they were undertaking medically unsound activities. Conceivably, she would be in a position to block a decision by PSI to promote and sell oral contraceptives.

At the field level, staffing is the responsibility of the service into which family planning activities are integrated. The goal is to have at least two nurses in each unit who are trained in family planning. The relationship between PSND and AZBEF regional coordinators and MOH supervisory personnel is discussed in Section 3.2.2.3.

Personnel Issues. Responsibility for personnel rests with the Chief of PSND's Administration Division, who also directs finance and public relations. The term "personnel" refers only to PSND's Kinshasa-based staff, whether direct employees of the

Project (49) or civil servants employed by the Ministry of Health (25). It does not include service providers at clinics or CBD sites.

Personnel needs within PSND are determined at the division level. New positions are created based on the level of activities planned. The team observed that PSND had become dependent on counterpart funds for the payment of some staff salaries and salary supplements.

There have been no personnel performance evaluations carried out to date. , but they will be in the future. In the future, the Administration Division, not the division chiefs, will have responsibility for these evaluations which will also identify needs for training and retraining. The Division of Training will develop the necessary courses and hire the trainers. The purpose of the training is to fill gaps identified by the workers themselves, not to correct problems. [Note: staff sometimes do not recognize their needs for training; their supervisors or co-workers may be in a better position to identify additional training needs.]

Other personnel problems mentioned to the evaluation team were lack of transport; budget restrictions precluding staff promotions (but not, apparently, the addition of new staff), and high turnover. However, the team was not able to obtain any data on turnover rates.

Recommendations:

- 1. There is no clear organigram for PSND which reflects current relationships and is not subject to continuous change. There is need for an organigram which leaves key personnel in place for a minimum period of time (at least six months) and eliminates the constant reshuffling.**
- 2. The Director should abide by the organigram and rely on her subordinates to play their respective intermediary roles rather than bypassing layers of supervisory structure. There should be one person to whom the Director can delegate daily management responsibilities, while she focuses on external relations.**
- 3. No new headquarters staff positions should be created (other than the position of obstetrics/gynecology specialist) until the future of PSND has been clarified.**
- 4. A complete overhaul of PSND staffing should follow the agreement on new roles and relationships among the various agencies participating in FPSP.**
- 5. The role of the Project Management Unit should be reinforced, and decisions made by this management body should be adhered to.**
- 6. MOH should begin paying all salaries and salary supplements by September 1991.**

3.2.2.3 Supervision

It should be reiterated that PSND, SANRU, and AZBEF do not run their own clinics, but rather provide contraceptive supplies, training, technical assistance, and supervision of staff who are employed by MOH, various PVOs, and other organizations. The one exception is the model Libota Lilamu Clinic in Kinshasa, which is operated directly by PSND.

The supervisory structure in place at PSND headquarters in Kinshasa is often bypassed or ignored. For example, the Director indicated that she tries to remain in direct contact with the regional coordinators by asking that their reports come first to her for review and only then be passed down the line to the Director of the Division of Supervision (who also directs the Program Division). Under the Director of the Division of Supervision there are five other supervisors: three for clinic services, one for sterilization, and one for CBD. The role of these individuals is not at all clear, since it appears that they do not go into the field more than once a year. Since the Director of the Division wears two hats, it makes sense to have someone under him who is concerned solely with supervision; however, the team questions why it is necessary for him to have so many assistants.

There is one PSND regional coordinator in each of the 11 regions whose task is loosely described as "supervision". In the two regions visited by the team, these coordinators seemed to be concerned almost exclusively with collecting reports and ensuring that contraceptive supplies are received.

Service providers working in sterilization centers, in FP clinics, or as CBD outreach workers at the zone level also have MOH supervisors -- usually the Superviseur Protection Maternelle -- who in turn answer to the Medecin Chef du Zone and the Regional Medical Inspector.

A similar situation prevails in zones where FP activities are supported by AZBEF rather than by PSND. The AZBEF regional coordinator acts as a supply depot, as a report collector, and sometimes, depending on his or her personal relationship with the provider, as an advisor. For example, the nurse providing family planning education and services at the Gecamines hospital in the outskirts of Lubumbashi said that the AZBEF coordinator had helped her in a dispute with her Gecamines supervisor. Neither she nor other providers interviewed saw any conflict in having both a direct supervisor and a second supervisor in the form of an AZBEF or PSND coordinator.

The team attributes this apparent lack of conflict to the fact that the regional coordinators do not play a real supervisory role. Lacking vehicles, it is not possible for them to spend time in the field observing providers in the course of their day-to-day activities with an eye toward correcting weaknesses. Moreover, the wide variations noted by the team in the reporting and interpretation of field data by these regional coordinators (see Section 3.2.2.4 below) suggest that they may not be properly trained to identify data discrepancies nor be in a position to correct them.

The Population Council's Management Advisor, in collaboration with PSND's Operations Research team and the Division of Supervision, has designed and is currently pretesting a detailed supervisory checklist which will enable a nurse/regional coordinator to:

- assess the level of integration of the FP unit into the public health structure;
- determine the equipment level of the FP unit;
- evaluate the level of operations of the FP unit;
- assess the performance of service providers in certain important tasks; and
- obtain a follow-up table of FP unit performance on a semiweekly basis.

A supervisory manual will be prepared after the checklist has been pretested.

Recommendations:

1. As there appear to be too many layers of nominal "supervision" at PSND, consideration should be given either to eliminating the bureau level, or to consolidating it into one position of Assistant to the Division Director.
2. The placement of PSND regional coordinators should be considered a short-term, albeit necessary, arrangement; the long-term objective is to ensure that MOH personnel (Medecins Chefs du Zones, Superviseurs Protection Maternelle) take on supervision of family planning services along with other health services.
3. Until this happens, the role of the PSND Regional Coordinator should be expanded beyond supply coordination and report collection to include such tasks as:
 - ensuring the accuracy, consistency, and timely submission of reports;
 - identifying staff retraining needs and ensuring that staff are enrolled in the appropriate courses;
 - providing technical assistance on improving quality of services (based on the supervisory checklist) including IEC/outreach and medical care, and achieving site specific objectives; and
 - trouble-shooting and problem-solving.
4. PSND's regional coordinators should be retrained as necessary to carry out the above tasks and should be equipped with adequate tools, including transportation (vehicles, fuel, parts, maintenance); radio communication; supervisory checklist; contraceptive MIS and logistics system; and sufficient supplies (contraceptives, IEC materials, forms).

5. A plan should be drawn up now for the phaseover of the above tasks to MOH personnel by 1995 in "better" regions, and by 1998 in other regions.

3.2.2.4 Data Collection and Analysis

Monitoring and Evaluation Responsibilities. There is no single unit within the PSND structure that is responsible for monitoring and evaluation. The evaluation function is spread among the various divisions, and each division is expected to evaluate activities within its sphere. In fact, the oversight exercised by each division is confined to routine monitoring and does not extend to evaluation per se. The Operations Research Division is separate from the other divisions and does not view its role as serving these divisions in any specific way.

It is the responsibility of the Program Division to prepare a consolidated monthly report that compares plans with achievements. This report is presented to the PMU.

Definition of Terms. The basic tools used in the collection and compilation of service statistics for incorporation in quarterly reports to PSND headquarters are a manual, a personal card (fiche) for each client, and a daily register. Each new client is assigned a file number. If she moves to another center, she is supposed to carry her card with her and the remainder of her file is supposed to be sent by her old center to her new center; however, field clinic staff state that such file transfers rarely if ever occur in practice.

The reporting form has five columns: (1) new clients; (2) old clients; (3) total clients; (4) visits; and (5) total clients and visits. Although these terms are defined in the manual, the team found that they were being interpreted in the field in many different ways. For example, at some FP sites a person who is recorded as a "new client" in January is counted as a "visit" if she comes back later in the same quarter for supplies or a medical check-up; if she returns again in May (the second quarter), she is entered as an "old client" and all subsequent returns in that calendar year are marked as "visits". At other sites, a new client is recorded as a "visit" every time she returns to the clinic during the first calendar year but is listed as an "old client" only once a year thereafter. At still other sites, a client is counted as a "visit" anytime she appears. At one clinic visited by the team, the numbers in column (4) are simply repeated in column (5).

Although there are national objectives with respect to recovery of drop-outs, the team could find no evidence of efforts being made at FP sites to recover clients lost to follow-up. No one could provide a clear definition of what a drop-out was. Nor was any distinction made between a client who was inactive because she had failed to keep her last appointment, and one who had abandoned the clinic and/or contraception practices.

Reporting of Service Statistics. The following data on the percentage of required quarterly reports that were received at PSND/Kinshasa each year suggest continuing compliance problems:

<u>Year</u>	<u>% Received</u>
1984	62%
1985	81%
1986	66%
1987	59%
1988	74%
1989	79%
1990 (1st 6 months)	51%

Since information on supplies of contraceptives is entered at the bottom of the reporting form, rather than on a separate requisition form, there is no way for headquarters to know which supplies are running low if the form is not received. This de facto sanction for non-reporting may be circumvented if the regional coordinator is aware that a clinic needs more supplies and is able to furnish them from the regional inventory. The practice of withholding contraceptives from clinics that do not comply with reporting requirements is, in the team's judgment, inappropriate.

At one site visited by the team the staff had run out of reporting forms and said they were too costly to replenish. Since no carbon paper was available, service providers wanting to retain a copy for their files had to complete a duplicate form. That many of them failed to do so may reflect the fact that the form is designed to meet the information needs of PSND headquarters and may be of no immediate use in the field.

The team also found the forms to be unnecessarily complex, as evidenced by the wide variety of different ways they were completed. It is worth noting that SANRU uses an entirely different data collection instrument that calls for data on catchment area population, number of registered clients this year (both new and old) by contraceptive method, and number of consultations for sterility and for contraception. SANRU's form also provides for reporting of data on quantities of contraceptives distributed by type.

Data Analysis and Feedback. The service statistics received at PSND headquarters from the regions are used mainly for descriptive purposes rather than for data analysis. The reports go first to the chief of PSND's Statistics Bureau in the Division of Administration, who is concerned with data collection and the improvement of data quality, but not with data analysis. From there they are sent to the Director and on to the PMU for its quarterly review. If questions arise, the Director may take them to the Program or Supervision Division (both now headed by the same person) or write a letter to the regional coordinator. The data may also be used to respond to inquiries by MOH, the Department of Plan, USAID, or local politicians (commissaires du zone).

The chief of the Statistics Bureau apparently plays no role in the formulation of PSND's annual Action Plan objectives which, based on our comparison of the 1989 and 1990 plans (see Section 3.2.2.1 above), contain a number of inconsistencies.

There does not appear to be any information "loop" providing feedback to service providers on the performance of their unit relative to other units in their region, to other

regions, and to regional or zonal objectives. Nor do they receive any feedback on trends in demand for specific contraceptive methods.

It should be noted that the equipment for a national radio communications system remains in the PSND warehouse. If installed, the system would facilitate feedback to and from the field.

Performance Measures. An important indicator of the performance of USAID's FP program in Zaire is couple years of protection, or CYPs, which is calculated based on the following conversion factors:

<u>Method</u>	<u>Factor</u>
Oral Contraceptives	0.0769
Condoms	0.01
Injections (i.e. Depo-provera)	0.25
Foam, Cream	0.2
Spermicide Tablets	0.01
IUD	2.5
Sterilization	12.5

Some of these conversion factors may not be appropriate in the context of Zaire. For example, the 12.5 years of CYP counted for each sterilization is based on an average age at sterilization of 31.5 (from the IPPF manual which assumes fertility lasts until age 44), whereas the average age at sterilization in Zaire is much higher. Nor does it seem appropriate to count a year of protection for every 100 condoms sold when the comparable figure in Bangladesh, for example, is 150; the lower figure tends to inflate the amount of protection afforded and should be adjusted upward based on some reasonable estimate of coital frequency in Zaire. Moreover, it should not be assumed that condoms sold for AIDS prevention in casual sex prevent as many births as the same number of condoms sold for family planning by marital partners. Finally, CYP estimates for natural family planning (NFP) methods should reflect the number of actual acceptors.

The measure CMP (couple month's of protection) was introduced as a rough indicator of the number of active contraceptors. It is the team's judgment that this measure should be reconsidered.

It may be helpful to compare family planning with some other type of health program in order to determine the most useful and realistic progress measure. If reduction in mortality of a particular disease is the goal of a given national health intervention, and mortality data are routinely collected in vital statistics and are of reasonable quality, then an appropriate measure of the intervention's success would be a reduction in mortality rates. A comparable measure for a population intervention would be a reduction in general fertility rates.

One step removed from the mortality rate measure would be the incidence of the disease which accounts for the mortality. This may be even more difficult to capture since it is

harder to count sick people than dead people. In population terms, the equivalent of disease incidence is the number of births relative to the population base (crude birth rate). Again, if vital statistics are routinely collected and are accurate, and if the age structure of the population is not undergoing dramatic change, this can be a reasonable measure of the success of a family planning program -- other possible causes being equal.

Yet another step removed is to measure coverage, i.e. the proportion of the eligible population that has been covered by immunizations against the disease in question. In population terms, coverage is contraceptive prevalence. However, while a person once inoculated remains immune for the duration of the particular vaccine, a person who accepts contraception may discontinue contraceptive practices. This "dropout" problem complicates the relationship between provision of services and coverage, making it necessary to conduct period contraceptive prevalence surveys.

Recommendations:

1. The various terms used for collecting and reporting of service statistics (new clients, old clients, visits, active, inactive, dropouts, etc. need to be reexamined. To ensure that the data collected are useful as a management tool at the service delivery level, service providers should be involved in developing the definitions and in designing new reporting forms. All providers should be thoroughly trained to use the forms and forms should be distributed and resupplied in sufficient quantities.
2. Since the national objective of 60 percent recovery of dropouts has not been operationalized in field activity, the objective should be either dropped or reformulated. Constructive suggestions should be compiled and distributed to service providers on how to keep track of inactive clients and encourage them to return.
3. Supply forms should be separate from client reporting forms and should include space for requisitioning. Responsibility for replenishment of supplies should be clarified.
4. Non-reporting units should not be penalized by withholding contraceptive supplies. Other sanctions (or preferably incentives) should be devised to encourage prompt reporting of service statistics.
5. A system should be developed to feedback program service data and trend information to the field level. Service providers should be involved in defining what type of information they need and with what frequency. Making data useful to those who collect it is one way of minimizing data falsification.
6. As SANRU's data are incorporated in a national scheme, differences in the reporting formats used by SANRU and PSND will have to be resolved.
7. Basic training in data analysis for managers should be provided at headquarters and regional levels.

8. A nationwide contraceptive prevalence survey should be conducted as soon as possible, using the same methodology as the 1982-84 Westinghouse survey. Sentinel point mini-surveys should be carried out frequently thereafter to ensure accuracy of service statistics.
9. Couple years of protection (CYP) should continue to be used as a measure of program success; however, conversion factors should be refined to reflect prevailing conditions in Zaire with respect to age at sterilization, the use of condoms for family planning as distinct from AIDS prevention, and numbers of couples who actually practice natural family planning (NFP) methods. Couple months of protection (CMP) should be reconsidered as a rough indicator of the number of active contraceptors.
10. Priority should be given to installing the PSND national radio communications system.

3.2.2.5 IEC/Outreach

In 1986, a workshop, involving PSND, SANRU, AZBEF, FONAMES, Radio-TV Scolaire, and other concerned agencies, was held to design an IEC strategy for family planning. Three specific sets of objectives (knowledge, attitudes, and practice) were drawn up and target groups were identified for IEC activities; men headed the priority list of target groups, followed by women delivering in Kinshasa and health personnel not trained in family planning. IEC message strategies for each target group were then specified, along with appropriate channels for each message and group. Coordination responsibilities for IEC activities were assigned to FONAMES, and a technical advisory group was set up consisting of representatives from PSND and other workshop participants.

In the intervening years since the workshop was conducted, PSND has taken over the function of producing and distributing IEC materials, while AZBEF remains involved -- on a reduced scale -- with promotion, motivation, and referral activities.

The IEC Division of PSND currently shares its chief with the Administration Division. It consists of three bureaus: mass media; print materials; and interpersonal communication, with a total of nine full-time staff. Although IEC staff are physically located in FONAMES offices, they are paid and managed by PSND.

Technical assistance with IEC activities has been provided through buy-ins to Johns Hopkins' PCS Project and through United Nations agencies. UNFPA is currently funding an ILO resident advisor to work on IEC at FONAMES. There is also a United Nations volunteer who is compiling inventories of IEC/FP materials and who will be assisting PSND with the focus group component of a planned IEC impact evaluation.

PSND's 1989 Plan of Action listed no fewer than 11 IEC objectives and 55 activities expressed in terms of numbers of target persons to be "sensitized" and items to be printed and distributed. These conformed in general to the activities listed in the 1986

workshop strategy, and were based on research and a set of assumptions linking activities with desired outcomes. However, no reference was made to the broader objectives of changing knowledge, attitudes, and practices which were intended to give purpose to IEC activities.

Although the IEC Division of PSND is producing some materials, the team found an almost total lack of IEC materials in the field, even in otherwise well-equipped parastatal facilities. The AZBEF Director in Matadi had a few hand-out brochures which were written in French, even though the team was informed that the AIDS and family planning brochures have been translated into Kikongo and other local languages. Other materials observed were wall posters (some of which were in English); a few flip charts suitable for very small groups; and the Prudence wall calendar distributed by CSM.

The two education sessions that the team was able to observe were both conducted in Swahili at parastatal clinics among well-motivated middle class women. In one case, a well-trained, dynamic SNCZ nurse deftly handled a group of 25 women, passing contraceptives among them talking for about 10 minutes while making do with only a small flip chart, then responding well to animated questioning. At the other site, an equally dynamic Gecamines nurse spent 45 minutes educating two women who had returned from a maternal/child health care session.

The team found no evidence that clinic staff leave the premises of their health facilities to engage in "outreach" activities. At one site, we were told that there used to be worker assigned to the task of motivating maternity patients to return a month later for family planning services, but that this individual had left and was not replaced.

At the Gecamines hospital in Likasi, systematic efforts are made to recruit maternity patients; the dynamic nurse there was the only one interviewed by the team to mention using songs and playlets in stimulate interest in prenatal and other services. No mention was made of such routine recruitment techniques as bedside visits to abortion patients or talks with patients recovering from spontaneous abortions concerning contraception for child spacing purposes.

We were informed that new clients typically learn about the clinic through word of mouth or through referral by prenatal, preschool, or other health services. Some clinic-based procedures (i.e. IUD insertions and sterilizations) are also performed on clients referred by community-based distributors.

AZBEF staff and volunteers also provide community outreach services. The team was impressed with the two AZBEF coordinators they met in Matadi and Lubumbashi. In both cases, the coordinators were personally conducting a full schedule of outreach activities with a variety of church-based women's and mixed groups, in addition to training and coordinating outreach/educational activities by volunteers. However, volunteer activities have been severely curtailed in recent years due to shortages of funds for transportation.

A general observation of the evaluation team is that services offered in FP clinics are greatly underutilized; service providers do not appear to be overburdened and say they would have no difficulty accommodating additional contraceptive clients. This suggests an urgent need to stimulate demand through IEC outreach activities that are effective in informing the uninformed, motivating the informed, and turning the already-motivated into service-seekers.

Recommendations:

- 1. PSND should not have responsibility for IEC production and distribution. The IEC function should be handled by AZBEF as the lead agency, with input from other groups. Opportunities for integrating family planning IEC into IEC of other projects should be explored.**
- 2. In taking over the IEC function, AZBEF can draw on the ILO technical advisor and the U.N. volunteer as well as on the extensive community contacts and materials development expertise of HEALTHCOM, now housed at FONAMES.**
- 3. Consideration should be given to reallocating resources so as to put more emphasis on the production, distribution, and imaginative utilization of appropriate high-quality IEC materials. Greater use of video, not only for training but also for community outreach, should receive high priority.**
- 3. FP clinic staff should not be expected to perform community outreach activities.**

3.2.3 Community-based Distribution (CBD)

Until December 1989, Tulane University was providing operations research support to PRODEF (Projet Education Familiale), a CBD project in Bas Zaire, in testing the effectiveness and cultural acceptability of this mechanism for FP service delivery. Among the findings of Tulane's research were the following:

- AIDS education can be incorporated among the tasks of CBD workers; this approach is preferable to training separate AIDS education outreach workers.**
- CBD can be highly successful; the contraceptive prevalence rate in Matadi, where several approaches, including CBD, are functioning simultaneously, is estimated to be 23 percent.**
- CBD is culturally acceptable; CBD workers "become valued members of communities."**
- Acceptability of CBD is enhanced by including sale of medications for children under 5 (along with contraceptive sales).**
- Both males and females are effective as CBD workers.**

- **Opposition from one regional medical director can badly damage a CBD program, even one that is significantly underway.**
- **CBD is more costly in rural areas than in urban areas.**

Tulane's research in Zaire did not compare the costs of CBD as a service delivery mechanism with the full costs (including staff time, facilities, and other overhead) of delivering family planning services through clinics. The evaluation team was unable to find service providers who could estimate the proportion of their time devoted to family planning within the integrated health services program. Nevertheless, research from other countries indicates that when full costs are included, clinic-based services are considerably more expensive than CBD.

The generally positive findings of Tulane's operations research notwithstanding, when counterpart funds were cut back in 1990, it was the CBD program which experienced the most dramatic cuts by PSND. The PRODEF project had been administratively separate and was viewed primarily as an operations research undertaking. Its rapid decline at the conclusion of the Tulane intervention has resulted in a greatly curtailed program; in 1989 there were a total of 280 CBD workers (119 in Bas Zaire, 37 in Haut Zaire, 48 in Kinshasa, 76 in Kivu) whereas in 1990 there are about 125 such workers. However, PSND has indicated its intention to resurrect what is left of this struggling program.

The PRODEF formula was to begin with awareness raising in a village (or city quarter) by a nurse. The community would then select a matronne to receive training in the basics of primary health care, reproductive anatomy, how to sell a few medicines and contraceptives (spermicides, pills, and condoms) and make referrals for other methods), pricing, and filling in forms. To be selected, a woman had to be literate and have had six years of schooling; those chosen were typically single or married women between 25 and 35 years old.

Although turnover figures are impossible to estimate, turnover reportedly is high among CBD workers, sometimes because the worker's husband moves and sometimes because she becomes frustrated with supply interruptions.

Some CBD workers make home visits, while others wait for customers to come to them. They retain a percentage of the proceeds from their sales; one worker interviewed by the team said she kept 50 percent of the price she receives for contraceptives and 40 percent of the price for medications.

We were told that four years after training, some CBD workers "get into bad habits" and focus on sales, neglecting the education component of their work. Though there is much talk of retraining, there appear to be no real retraining plans.

In some zones, a distinction is made between matronnes and commercantes. One of the city-based commercantes said that her sales were very slow since there is so much competition from pharmacies, and recommended that CBD be focussed on rural communities.

Recent cutbacks have precluded funding of training activities and created a number of other problems, including vehicle and staffing shortages. At the PRODEF office in Sona Bata, the staff had been reduced from ten to three, including a physician director (who is also Medecin Chef du Zone), a supervising nurse, and a male secretary/administrator.

None of the CBD workers interviewed by the team appeared to be working towards achievement of any particular objectives beyond a vaguely stated "increased number of acceptors." No reference was made to satisfied users, continuing users, coverage, and other performance indicators.

Recommendations:

1. Since this service delivery mechanism has been shown -- in Zaire and elsewhere - - to be a valuable adjunct to clinic-based FP services, CBD should be revitalized, based on the lessons learned from the Tulane studies, and made a major part of Zaire's overall family planning program. Budget allocations must be made to accommodate this recommendation.
2. AZBEF should be the lead agency for CBD, since its focus is on close relationships with communities. SANRU should also be included in measures to strengthen this component in rural areas. Linkages between CBD and CSM should be explored.
3. CBD workers in need of retraining should be identified and retrained.

3.2.4 Finance and Cost Effectiveness

The evaluation team did not review the budgeting or financial aspects of PSND's program. They were, however, assured by USAID that:

- Considerable improvement had been made in PSND bookkeeping and accounting procedures during the last two years;
- It was likely that PSND would be "certified" by USAID as having met USAID's stringent bookkeeping and financial procedures by the end of 1990.

The cost effectiveness of family planning programs is a controversial but important subject. Given the paucity of data and diverse settings for such programs, cross-national comparisons may not be particularly instructive. Sirageldin in Evaluating Population Programs (New York, 1983) put the cost range at U.S. \$28 to \$66 per acceptor for the DANFA project in Ghana. Speidel (Ibid), while noting many possible sources of error, set out the following rough order of magnitude cost per user estimates for various African countries in U.S. \$:

Burundi	33.2
Ghana	38.1
Guinea	10.6
Kenya	71.6
Liberia	76.1
Mauritius	23.8
Sierra Leone	48.8
Swaziland	435.8
Tanzania	35.0

The evaluation team arrived at an estimated cost per user for Zaire of U.S.\$ 118 by dividing total USAID bilateral assistance to PSND during 1989 (exclusive of PSI and policy inputs) by the total number of new acceptors for that year. This estimate does not include GOZ inputs. However, care should be taken in comparing this estimate with Speidel's data, which date from an era when family planning programs were made up largely of NGO and/or demonstration projects rather than large (PSND-type) efforts.

3.3 PSI Contraceptive Social Marketing

Following what was considered a successful 1987 pilot project, Population Services International (PSI) received additional funding from USAID in 1989 to expand contraceptive social marketing (CSM) to other urban areas of Zaire toward the long-term goal of nationwide coverage. Additional financial and technical support from Family Health International/AIDSTECH was provided to extend the client base for CSM through sales of PRUDENCE³ in bars, hotels, and traditional medical outlets.

As an alternative to mass-media advertising on radio and television, which is prohibited for brand-name condoms in Zaire, the PSI project relies heavily on point-of-purchase advertising and special promotions. Emphasis is put on publicity materials with high visibility potential for target consumers and on promotional items that have utilitarian value. Special promotions at fairs, nightclubs, etc. combine dissemination of AIDS information with distribution and demonstration of proper use of condoms.

As the result of serious marketing efforts PRUDENCE sales rose from just over 900,000 in 1988 to over four million in 1989. 1990 sales had exceeded six million through September and were expected to top nine million by the end of the year.

It is estimated that PRUDENCE now accounts for 90 percent of all condoms distributed through both public and private channels in Zaire. Furthermore, increased sales of other brands indicates that CSM promotional campaigns are contributing to growth of the total condom market.

³PRUDENCE is the local brand name for USAID-donated condoms. The name and product pricing strategy were based on the results of market research.

A recent (July 1990) intercept study found that PRUDENCE consumers were largely middle class (by Zairian standards) and relatively well educated. This points to the need to expand current educational and sales efforts beyond the existing channels in order to better reach the lower socio-economic strata of the population.

Most condoms sold are for AIDS and other sexually transmitted disease (STD) prevention rather than for family planning purposes. In intercept studies conducted in 1988 and 1990 only 20-25 percent of condom purchasers stated that contraception was the primary motivation behind their purchase. However, some respondents citing AIDS and/or STD prevention also said that family planning was another reason they used condoms.

It is reasonable to assume that condoms sold through medical outlets are more likely to be used for pregnancy prevention than those sold through other channels. Thus it is reassuring to note from the following figures that condom sales to medical outlets have been increasing not only in absolute numbers but also relative to total condom sales. In 1988 they comprised only 3.9 percent of total sales whereas in 1989 they accounted for 14.9 percent. The modest reduction to 11.3 percent of total sales for the first nine months of 1990 may be partially explained by the fact that PSI has added new distribution outlets (bars and hotels).

<u>Year</u>	<u>Medical Ctrs</u>	<u>Pharmacies</u>	<u>Other</u>	<u>Total</u>
1988	35,370	870,390	-	905,760
1989	594,779	3,399,427	5,940	4,000,146
1990	711,885	5,426,108	148,431	6,286,424

Some USAID documents reviewed by the team make a direct correlation between the volume of condoms distributed and CYP's without taking account of the fact that only a minority of condom users purchase them for family planning purposes. It is difficult to develop sound assumptions about the effectiveness of CSM activities in terms of contraceptive prevalence, especially in the absence of data on continuous use and/or coital frequency. However, assuming that 20 percent of all purchasers are using condoms for contraception and that there is no interruption in such use, it may be inferred from sales figures that CYP's rose from 9,058 in 1988 to 40,001 in 1989 to 75,467 for the first nine months of 1990.

PSI also markets spermicide tablets called GRAINE. Intercept studies have shown that 100 percent of project brand spermicide users purchase them for family planning. Sales figures show a growth from 253,258 units in 1988, to 450,264 in 1989, to 1,447,576 through October 1990. This sales figure for the first ten months of 1990 is equivalent to 17,378 CYP.

PSI's 1991 Annual Marketing Plan forecasts sales of 15.2 million condoms and 3.6 million spermicide tablets. In addition, a new activity will be initiated to market oral contraceptive pills through retail level pharmacies. Although contraceptive pills are now readily available at pharmacies without prescription, the introduction of a USAID-funded activity which in effect sanctions this approach poses some legal, and perhaps even ethical, problems. While PSI intends to release the pills only after training the participating pharmacists and with the blessing of appropriate professional organizations, it may be prudent for PSI to also obtain written permission to undertake this experimental program from the MOH.

One of the major issues that face evaluators is whether CSM programs create new demand for contraceptives or merely satisfy existing demand that is not being met through other delivery systems. In the case of Zaire where PSND's service delivery efforts have been weak, it seems likely that the program is meeting some amount of latent demand for family planning services. However, new demand is also being created for the AIDS and STD prevention aspects of the program.

Although the project has experienced growing pains resulting in an overextension of credit and poor cost efficiency in some zones, it is the team's conclusion that PSI, USAID, and the GOZ should be very pleased with the success to date of the CSM project, which is a worthy continuation of PSI's pioneering CSM work in Kenya in the 1970's. The first three years of project activity clearly demonstrate that private sector marketing and management methods can be used to achieve socially responsible objectives. Nevertheless, it is the team's judgment that the objectives of PSI's CSM project should be clarified with respect to its target audience and expectations for financial sustainability. Although CSM activities typically require ongoing subsidy of at least donated contraceptives, the PSI project is almost entirely supported by donor funds and cost recovery in local currency appears to be negligible.

Related sustainability concerns are PSI's status as a USAID contractor and its dependence on expatriate staff for project management. Although the MOH allowed the project to establish a semi-autonomous status from other existing health projects in August 1989, PSI remains in a state of legal limbo. However, even if an appropriate indigenous legal entity is created to carry out CSM activities, it will be important to encourage collaboration and information sharing with GOZ-sponsored family planning efforts at the national and local levels. This collaboration and information sharing will be of paramount importance if the CSM project becomes involved as planned in the marketing of oral contraceptives.

Recommendations:

1. A market segmentation strategy should be devised with the long-term objective of offering two brands of condoms priced and promoted to reach separate target audiences: (a) the existing middle-class market for PRUDENCE; and (b) poorer, less well-educated potential customers. A two-tiered price structure could also enhance cost recovery in that the brand being marketed to middle-class consumers could be sold at a higher price.

2. **PSI should continue to investigate the feasibility of creating a local legal entity with which USAID could contract for CSM.**
3. **Constructive dialogue between all entities involved in family planning should be encouraged while maintaining PSI's semi-autonomous status with respect to other health providers.**
4. **PSI should continue to explore the possibilities for introducing oral contraceptives, oral rehydration salts, and other medications to its product line. However, given the uncertainties of the marketplace and USAID funding, the emphasis during 1991 should be on team building, market research, and recruitment and training of top level local talent, with only modest growth in sales projections and geographic coverage.**

3.4 The Population Council

Through a USAID "buy-in" to its "Strategies for Improving Service Delivery Project" contract, the Population Council is providing the services of two long-term advisors, one a Management Technical Advisor and the other an Operations Research/Family Planning Advisor, who comprise the Management Support Unit (MSU) for FPSP. The MSU works with various divisions of PSND to strengthen the agency's internal management capabilities as well as its external role and responsibilities for delivery of family planning services.

The two long-term advisors were fielded in late 1989. Recruitment of support staff was completed in July 1990.

The Management Technical Advisor is responsible for assisting PSND with the management and delivery of family planning services and for working with PSND, CECAP, and other participating agencies in the coordination (including budgeting and programming of resources) of A.I.D.-financed technical assistance and projects in family planning. His accomplishments to date include the following:

- **Equipment:** Identified FPSP equipment needs and finalized Life-of-Project procurement plan.
- **Financial Management:** Produced Project Operations Manual and initiated financial management reforms allowing PSND to apply for USAID financial certification.
- **Supervision Systems:** Developed and tested with PSND's staff a new and more effective supervisory checklist.
- **Logistics Systems:** Coordinated assistance from CDC/Atlanta with the design and implementation of an automated contraceptive and commodity MIS. The system is currently being implemented by CDC personnel.

- **Decentralization of Services:** Designed the FP component of a training course developed for PSND regional officers. Visited five out of seven regional offices and provided assistance to regional officers in the areas of financial and administrative management.
- **Planning Assistance:** Assisted PSND to establish a methodology to take into account intermediate and long-term service delivery objectives while developing annual action plans. Also assisted CECAP to prepare an action plan.
- **Training:** Assisted USAID in planning a micro-computer and MIS training program organized with MSH/Boston.

The evaluation team concludes that the Population Council's Management Technical Advisor is performing well. The tasks carried out to date are largely consistent with the job description for the position. The advisor has strong academic qualifications, African experience, and linguistic abilities as well as excellent contacts in the professional community. While there is genuine ambiguity in the incumbent's role and reluctance on the part of PSND Director to accept his advice, this is to be expected in most advisory situations.

It should be noted that a key determinant of the effectiveness of the MSU is the way in which its personnel perceive and/or act out their roles. Job descriptions aside, the interaction of the advisors and the advisees may change the way in which the latter ultimately carry out their responsibilities. Since the Management Technical Advisor does not have a direct decision-making role (as did one of his expatriate predecessors), it is essential that he have a real local counterpart, which he does not. He is in effect an advisor to the Director, but an assistant and trainer to the Division Chiefs. His job combines advisory and advocacy functions in helping to strengthen the management and coordination of family planning services.

The Operations Research/Family Planning Advisor is charged with helping to develop PSND's technical capabilities in areas including CBD program development and expansion; AIDS education and prevention; systems analysis and operations research to improve the quality of clinical services delivery; cost-effectiveness studies; and monitoring and evaluation of FP services and IEC.

Over the past five years, PSND's Operations Research unit has received assistance from Tulane University in carrying out some ten operations research projects, the majority of which were related to the CBD process. In addition, the unit has recently completed a 24-month Sentinel Site Survey which recorded data from 68 outlets in urban areas to compare service delivery among commercial pharmacies, clinics, and community-based distributors. The unit appears to have competent staff but does not seem to have been successful in demonstrating the value of operations research to the GOZ. However, the team expects that the GOZ may be willing to take on a greater share of the funding responsibility for research which is directly linked to programmatic problem solving, of the type now being undertaken by the Population Council.

The Council has already completed and/or planned a number of such studies, including:

- **A study to explore reasons why clients continue or discontinue using oral contraceptives, depo-provera, and IUDs in Zaire;**
- **A comparative study of the effectiveness of traditional birth attendants and "Mama Bongisa" as family planning educators in rural Zaire, in collaboration with SANRU;**
- **A impact study of integrating family planning services with an existing program for growth monitoring;**
- **A situational analysis of the family planning program in Zaire.**

The situational analysis involves an inventory and assessment of PSND assets -- what works, what does not work, and why. This type of study does not fit easily into the Population Council's typology of exploratory diagnostic, intervention, and evaluative studies and could have been performed by PSND staff as a part of their normal operations.

The evaluation team also noted that the review, approval, and funding process for operations research activities seems unduly cumbersome and lengthy.

Recommendations:

- 1. The Management Technical Advisor should remain in place for the term of the Population Council project. The incumbent should become increasingly involved in activities associated with the design of future USAID assistance to the population sector and with tasks for family planning groups that appreciate his skills and utilize his advice. He should give somewhat lower priority to working with CECAP than was envisioned in this job description so as to devote more time to family planning management issues.**
- 2. Full advantage should be taken of the Operations Research/Family Planning Advisor's expertise in the medical/clinical aspects of family planning, since PSND has no physician on staff with this type of expertise.**
- 3. The Population Council should consider developing stronger links with other indigenous groups and organizations (SANRU, AZBEF) which may wish to institute operations research.**
- 4. PSND's Operations Research unit should be integrated into a new "Research and Evaluation" unit. Consideration should be given to having operations research unit funded entirely by PSND by 1992.**
- 5. The Population Council and USAID should consider funding an operations research project on the promotion of family planning, breastfeeding, and child nutrition with low parity women. This project, which has been suggested by the OR/FP Advisor,**

would examine the impact of an early post-partum intervention on birth spacing, child survival, and experience with contraceptives.

Section 4

FUTURE DIRECTIONS

4.1 Potential Role of the Private Sector

Findings, conclusions, and recommendations with regard to the main actors in the Family Planning Services Project have been noted in Section 3. While it is recommended that USAID continue providing support to public sector activities, the Mission should consider allocating a greater percentage of its FP resources to the private non-profit and for-profit sectors that has been the case in the past. The advantages of working with non-profit private sector agencies like SANRU and AZBEF include:

- Their salary and overhead costs generally are lower than in government programs;
- Their internal administrative procedures usually are free of cumbersome bureaucratic inefficiencies;
- They often are able to develop technical expertise in a single specialty: witness AZBEF in family planning, and SANRU in rural primary health care;
- They can work in controversial areas such as family planning with less risk than can government agencies as they are represent only their constituents and not "the State";
- Their experience working at the grass roots level enables them to appreciate the needs and wants of their clients.

For the above reasons, the team suggests that USAID provide significant support to SANRU and AZBEF in the years ahead.

4.1.1 SANRU

Although SANRU's activities were not covered by this evaluation, the team gained a favorable impression of SANRU's capabilities from visits to a number of SANRU institutions in Sona-Bata and the Regional Hospital at Kimpese. The team concluded that SANRU has the infrastructure, dedicated staff, and interest to expand its activities in family planning and may represent the best way to create demand for contraceptives and provide contraceptive supplies in rural areas. However, continuing dialogue will be required to resolve the following issues that were raised by senior SANRU staff:

- Finding the appropriate emphasis to give to birth spacing in the truly integrated primary health care approach which is characteristic of SANRU zones;

- **Resolving misunderstandings related to the authority and responsibility of the MOH in health zones where the major burden of work falls on church-associated institutions;**
- **Correcting the erroneous notion that the SANRU program is entirely rural. Some zones where SANRU works are partly or largely urban or peri-urban. In addition, a number of rural regional hospitals in the SANRU system have undertaken excellent work with neighboring urban areas.**

The team supports the following suggestions made by SANRU for new activities in family planning:

- **Regional training of health center nurses in family planning. In the past this training was left to the health zone, but SANRU could accelerate it by organizing regional training courses serving several SANRU and non-SANRU zones.**
- **Village level development committee seminars. These seminars would take the form of day-long retreats for discussions and education about health problems, including family planning. Few health zones have been able to organize such seminars due to transportation costs.**
- **A family planning supervision subsidy. This subsidy would provide additional money to health zones with family planning programs to encourage them to carry out regular supervision.**
- **A study of decentralized depots for distribution of contraceptives. This suggested collaborative effort with PSND and AZBEF would test the feasibility of distributing contraceptives through seven priority depots.**
- **Printing and distribution of a family planning flipchart. This flipchart would be designed to teach health center nurses how to effectively use family planning materials.**

4.1.2 AZBEF

The team concluded that, with USAID assistance, AZBEF can once again become a major player in the family planning arena in Zaire. In its 1990 Work Plan and Budget, AZBEF set forth some ambitious plans to:

- **Reinforce their basic structure and management through training of volunteers and staff, initiating dialogue with national and international family planning agencies, and equipping their new regional offices;**
- **Publish a monthly liaison bulletin;**
- **Carry out an IEC program;**

- **Create an Information Center covering health and adolescent population issues;**
- **Initiate family planning programs in "Enterprises";**
- **Start a community based distribution program;**
- **Establish a family planning clinic in Kinshasa.**

The above suggests that AZBEF and its Board are once again prepared to take on the responsibilities of being the major private sector agency for family planning. The team believes that the potential is there provided the following problems can be overcome:

- **Chronic lack of funding;**
- **Probable over-centralization when fully staffed;**
- **Insufficient emphasis on IEC, which in the past was an area where AZBEF had great strength; and**
- **Management and administration that probably needs strengthening.**

The team envisages a phased program of activities in collaboration with IPPF. Phase I would involve recruitment, institutional development, staff training, and the placement of an expatriate advisor at the Deputy Director level. During Phase II, a major IEC activity would be initiated. During Phase III, a program to assist the government in establishing "centers of excellence" in each of the 11 regions would be instituted.

4.1.3 The For-Profit Sector

Employers, (and to a lesser extent, labor unions) are important financiers and providers of health care in much of the world and especially in Latin America, industrialized countries of Asia, and now Africa. In Zaire, all large employers in the "organized sector" provide primary health care at the worksite, and a few provide secondary and tertiary care as well. These facilities represent important health care resources in cities like Kinshasa and in some remote rural areas near large mines or plantations.

Given the economic importance of Zaire's "organized" sector, which accounts for 17 percent of the total workforce, it is unfortunate that a major effort has not been made to involve employers in this sector in the delivery of family planning services. PSND and AZBEF are, however, supporting some FP units in the organized sector and, in the past, FPIA made an effort which reportedly reached some 5,400 new clients through labor unions.

In recent years, the Technical Information on Population for the Private Sector (TIPPS) Project, a centrally-funded A.I.D. activity implemented through JS and A, has attempted to mobilize support for family planning within the private sector. The TIPPS approach is based on the concept that companies, once convinced of the potential financial impact

of family planning on their operations, will support family planning service delivery activities with their own resources. TIPPS provides a scientific methodology and funds for studies and dissemination of study results. It can also take on a brokering role between profit-making groups and local family planning service providers.

In Zaire, the TIPPS Project completed financial feasibility studies of adding family planning programs at UTEXAFRICA, the country's largest textile company, and at the Banque Commerciale Zairoise (BCZ), the country's largest commercial bank. In the team's judgment, these companies were ideal candidates for the TIPPS approach because of their location, size of workforce, influence, and management dynamism. While TIPPS' expenditures for the two studies were substantial, both companies also made modest contributions to the study costs. The team's very preliminary assessment of TIPPS activities in Zaire is that the work with UTEXAFRICA was not very successful but that TIPPS-initiated IEC work with BCZ had some modest success in generating some 85 new family planning acceptors.

A third project being undertaken in Zaire through TIPPS is a study of the cost-effectiveness of PHC interventions in Compagnie Sucriere, which has 8,000 employees. While this study perhaps falls outside the scope of "normal" TIPPS activities, it nevertheless should be of interest to organizations concerned with child survival and primary health care in that it may demonstrate that appropriate curative interventions for diarrhea and respiratory ailments as well as preventive interventions such as FP can reduce health care expenditures for private companies.

In addition to the above-mentioned studies, TIPPS also conducted a seminar attended by 16 companies. Follow-up activities with company representatives who attended the seminar would be of interest to the forthcoming TIPPS project evaluation.

The team believes that the TIPPS experience in Zaire has produced some useful lessons for future work with the private sector. First and foremost, using a "cost-benefit" model to show the cost savings which may accrue from family planning in the African context is only one of many approaches which donors or top management can use to argue for family planning in private sector entities. Most company directors in Africa are not accustomed to long-term planning. Other factors, such as worker morale, company image, and the health of mothers and children may carry greater weight in their decisions to initiate family planning than American-style "bottom line" considerations. Thus, excessive emphasis on cost benefit models may divert attention away from other more important incentives for program initiation.

Second, initiation and follow through of family planning project activities in Zaire requires continuous presence and pressure, and technical and commodity assistance of many sorts - particularly in the sensitive medical and family planning area. These ingredients were not part of TIPPS package which was limited primarily to analytical and brokering assistance.

Third, in countries such as Zaire where the local (private) family planning agency is weak and the government family planning organization is struggling to service existing non-

profit and governmental institutions, it is difficult to carry out the "brokering" process between companies interested in family planning and private sector agency sources of technical skills and commodities unless the private sector agency has financial or other incentives to expand their workloads. Also most businesses are reluctant to accept government involvement of any sort in their internal affairs, particularly in so sensitive an area as family planning.

Fourth, in most African countries the development and implementation of an "employee-based" family planning program requires far more support from top-level company management than do most commercial projects of comparable funding levels. In addition to supervision, the development of facilities and programs, and the hiring or training of special staff, consideration must be given to the flexibility of employee schedules to promote participation in the program. Management must be seen as committed to the program, and not just because it may save the organization money in the long term.

Fifth, private companies might have been more interested in initiating family planning activities under TIPPS had small amounts of "seed money" been available. The team interviewed top management in four major industrial conglomerates and one plantation owner in Equateur who indicated that they would, under certain circumstances, be willing to initiate or expand child spacing activities provided that they received quality technical assistance and financial start-up support from some competent outside agency. In short, they wanted some other group to "share the risk" in this sensitive area during the start-up or experimental phase, although they indicated their willingness to support the activity with their own resources if it proved successful.

4.2 New Departures

The evaluation team has suggested that both AZBEF and SANRU may play pivotal roles in USAID's long term family planning strategy. Both organizations are well known to the donors and the population community. The core of the new USAID program might be as follows:

<u>Sector</u>	<u>Organization</u>	<u>Approach</u>
Public	PSND	Family planning services through no more than 145 urban institutions
Public/Private	SANRU	Family planning integrated with primary health care programs in SANRU zones
Private	AZBEF	Institution building, IEC, and collaboration with PSND in one center of excellence per region
Public/Private	GOZ	Contraceptive prevalence survey

The team feels strongly that a contraceptive prevalence survey should be undertaken prior to the initiation of new long-term activities in the area of family planning. Ideally, a (third round) survey could be performed at the end of the current ten year USAID program. A concept paper for the survey is provided in Annex J.

In addition to these suggested approaches involving well known institutions, there is considerable potential for entirely new activities with organizations which are perhaps less prominent. The team suggests that USAID consider the following new departures with institutions with which it has had limited or no contact in the past:

<u>Sector</u>	<u>Objective</u>	<u>Approach</u>
Private	Provide birth spacing services to the urban public	Church of Christ parish-centered CBD program
Private	Provide birth spacing services to employees of plantations and mines in rural areas	Add-on to Medecins sans Frontieres rural primary care
Private	Provide birth spacing services to factories in urban areas	Program with Kinshasa Medical Center
Private	Carry out family planning, IEC, and contraceptive distribution programs with women's groups	Project with Working Women's Association of Zaire's Labor Union
Private	Encourage nurses to carry out adolescent pregnancy counseling and post-partum family planning	Project with Zaire Nurses Association
Private/Donors	Establish linkages with other population programs	Various groups

Concept papers for these suggested approaches are annexed to this report.

4.3 Natural Family Planning

When one method of contraception fails, there are three reactions possible on the part of the pregnant woman/couple: accept the failure and return to the same method after delivery; change to another method; or become discouraged with contraception altogether. Since, except in rare cases where couples are highly educated and motivated, natural methods have far higher failure rates than modern methods, it is important to know whether starting a client out with a natural method will result in a "lost" contraceptive should this method fail. While the team was in no position to conduct research on this important issue, informal inquiries among clinic personnel produced assurances that in such cases the client nearly always switches to a more effective method. Nevertheless, the team believes that this issue should be more vigorously studied. If the impressions of clinic personnel are correct, then NFP may be a useful "introductory" method, albeit one that can exact an "entry fee" in the form of an unplanned and presumably unwelcome pregnancy.

In keeping with Congressional mandates that there be no USG support provided to single-method family planning activities (whether NFP or sterilization) without concomitant referrals for other methods, the team feels that USAID support to NFP in Zaire should be contingent on formal agreements to cross-refer and, further, that NFP agencies should be encouraged to work with church authorities on promoting NFP while refraining from actively discouraging the use of modern methods by non-adherents to a particular faith. The example of the bishops public statement in Burundi in 1986 to that effect could be used as a precedent. As future plans for NFP are drawn up, contact with the Conduite de la Fecondite (Mme Kana Kundinda, Director) should be explored.

4.4 Linkages

The evaluation team recognizes that USAID's family planning program is at a crossroads, and that new directions, new alliances, and new avenues for collaboration lie ahead. It is suggested that the following potential linkages be explored in this regard.

UNICEF. Until recently, UNICEF in Zaire has focused exclusively on the health sector, and more specifically on immunizations and oral rehydration therapy (ORT). However, as UNICEF/Zaire is now reassessing its role and charting new directions, it may represent a future avenue of collaboration with FP activities, particularly in UNICEF-supported health zones. UNICEF's activities in sub-Saharan Africa typically include water projects and support to women's organizations through agricultural, forestry, and income-generating projects. UNICEF is particularly strong in matters of social motivation.

FAO. Although FAO's Population Unit does not appear to have any projects in Zaire, there are a variety of educational materials available from FAO headquarters in Rome (e.g., sowing seeds too close together results in overcrowding of crops and lower yields) that can be used as an entree for education in child spacing.

USAID's Agricultural Extension Program. The near exclusive emphasis in Zaire on the health sector as the context for family planning reflects an outmoded approach to service delivery which misses out on numerous opportunities for collaborative efforts and synergistic effects. Family planning education and referrals should be incorporated into agricultural extension activities, in light of the logical and potentially powerful linkages among family planning, nutrition, and agriculture. Other modes of collaboration (such as taking advantage of extension transport to distribute contraceptives to remote areas and providing extension agents with free samples of contraceptives to pass out along with input packages) should also be explored during the redesign and elaboration of USAID's HPN and agriculture programs.

Women's Organizations. The past neglect of women's organizations as channels for communication and recruitment may stem in part from the 1987 IEC strategy workshop which identified men as the first priority target group for IEC. While the reasons for this selection in the Zairian context are understandable, this does not preclude working with organized groups of women more vigorously in future.

There are several points of contact which offer opportunities for developing useful contacts with women leaders and women's organizations, such as the Working Women's Association (Departement des Femmes Travailleuses) of Zaire's only labor union and the African American Labor Center. The support of BUPROF (Bureau pour les Problemes Feminins), representing the interests of some 280,000 women union members, could be enlisted for family planning motivational and educational activities. Some of the "special projects" overseen by PSND might also be utilized more fully as communication and recruitment channels, including the Zaire Nurses Association (AIZA), Foyer Nouveau pour le Developpement Familial (FONDEF), and Centre d'Encadrement des Femmes (CEFD) in Affaires Sociales. PSND has already provided training in family planning to some members of these groups.

In both regions visited by the evaluation team, AZBEF's community outreach programs include church-based women's groups. AZBEF should be encouraged to collaborate with other women's groups as well, such as the Association des Femmes Commerçantes au Zaire (AFECOZA). Family planning information and motivation can be communicated through the newsletters, annual meetings, and conferences of these groups, and influential members can be given public relations duties in their communities.

Literacy Programs. Literacy courses for women and girls are provided outside the formal education system and offer a possible venue for family planning outreach. The subject matter covered in literacy courses includes agriculture, health, and nutrition -- and could incorporate family planning.

Traditional Healers. While the involvement of traditional birth attendants in a family planning program is commonplace, traditional healers are less frequently involved. Nevertheless, these traditional healers represent potential fruitful communication channels in that they are in a position to counsel mothers with malnourished, closely spaced children on the health benefits of child spacing.

There is a research institute for traditional healers in Kinshasa. Discussions with the researchers about the role of traditional healers in urban and rural settings, might produce ideas for useful alliances.

4.5 Assumptions about the Future

The team's recommendations are predicated on several short-term and long-term assumptions about the future. Over the short-term (1991-93), it has been assumed that:

- There will be no counterpart funds (CPF) available after September of 1992;
- USG funding for Zaire will be subject to the Brooke Amendment starting around June 1991;
- There will be a gradual reduction in new project starts, in risky or innovative activities, and even in technical assistance;
- Commodities, technical assistance, and perhaps training activities will continue to be provided consistent with the language of the Congressional resolution which reads in part: "none of the funds appropriated....shall be transferred to the Government of Zaire: provided that this provision shall not be constructed to prohibit non-governmental organizations from working with appropriate ministries or departments of the Government of Zaire."
- There will be deteriorating economic conditions, instability, and continual inflation, with concomitant problems for USAID project implementation.

For the long-term (1993-2003), two scenarios are possible:

Scenario A: Restricted Programming

- The Brooke Amendment will remain in force and counterpart funds will not be available;
- Project assistance will focus almost entirely on developing "private sector" activities;
- USAID assistance in the area of health and population will be substantially less than in the past;
- USAID assistance to the PSND will be phased out and replaced by assistance from UNFPA and other donors;
- Political and economic insecurity will continue.

Scenario B: Unrestricted Programming

- The World Bank and IMF structural adjustment program will be in place and Zaire's debt will be rescheduled by the Paris Club;
- The Brooke Amendment will be lifted allowing A.I.D./W to obligate new project funds;
- USAID will start a new PL 480 Title I program to generate counterpart funds. The funds will not be used to supplement local salaries or to support administrative and routine operating costs;
- An HPN project will be authorized for an eight year period (1993 -2001);
- Many organizations which had received support from USAID in the past will have difficulty re-establishing their family planning activity.

4.6 Proposed Organizational Structure and Responsibilities

The team's vision of the future of family planning activities in Zaire is best expressed by the matrix on the following page, which indicates major activities or focus areas, by responsible entity.

As the matrix suggests, USAID assistance to CONAPO would be phased out and responsibility for population policy would rest with the Ministry of Plan. It is possible that UNFPA may continue to provide support with policy analysis.

The MOH would eventually take over the supervisory functions of PSND's regional coordinators. In the interim, the role of these regional coordinators would be expanded and strengthened.

PSND would be responsible for establishing and maintaining a nationwide data bank, and for analyzing and disseminating the data to interested parties including service providers and policymakers. It would continue to supply contraceptive commodities to some health units and would be the lead agency for training of family planning personnel.

PSI would handle contraceptive social marketing and any related CBD activities, including provision of supervision and supplies.

AZBEF would play a central role in private sector family planning activities, first taking on the responsibility of lead agency for IEC, then revitalizing CBD in urban and periurban areas. AZBEF would collaborate with PSND in establishing one "center of excellence" in each region and producing a video on the essential elements of IEC and FP service delivery for training and public relations purposes.

SANRU would provide support and advice to AZBEF on IEC in rural areas and would incorporate CBD into its rural programs. SANRU would also take the lead in any decentralized depot system that may be adopted, working with AZBEF and PSND.

The for-profit sector (parastatals and private practitioners and clinics) would be encouraged to provide family planning along with other health services in hospital and clinic settings.

Linkages with women's organizations, professional nursing associations, UNFPA, UNICEF, other GOZ ministries (i.e. Agriculture and Education), and other USAID programs (i.e. agricultural extension) would be explored and developed as conditions warrant.

The School of Public Health would house the Operations Research unit which would provide services to all entities involved in family planning. The School would also collaborate with PSND on training activities.

All service entities (PSND, PSI, AZBEF, SANRU, for-profit hospitals and clinics) would be responsible for their own supervision, supplies, and internal monitoring.

Periodic external monitoring and contraceptive prevalence surveys would be carried out by USAID.

Function	Ministry of Plan	Ministry of Health	PSND	PSI	AZBEF	SANRU	For Profit Sector	School of Public Health	Donors
Policy	X								
Service Delivery (clinics,hospitals)		X					X		
CBD				X	X	X			
CSM				X					
Support					X	X			
Supervision		X		X	X	X	X		
Supplies			X	X	X	X	X		
IEC/Outreach					X	X			
Data Collection								X	
Analysis, Dissemination			X						
Training			X					X	
Operations Research								X	
Internal Review		X	X	X	X	X	X		
External Evaluation								X	X

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ANNEXES

ANNEX A

CONTACT LIST

KINSHASA

PSND

- Chirwisa Chirhamolekwa, Director
- Ngoie Mbuya, Chief of Training
- Buhendwa Rutemba, Chief of Administration and IEC Division
- Kadima Mbala, Warehouse Manager
- Bakadipanga Tuakule, Statistician
- Mbadu Muanda, Operation Research Chief
- Kidiadi Mavuela, Bureau Chief of Finance
- Mukengeshayi, Supervision Division Chief

Other

- Dr. Frank Baer, Project Manager, SANRU
- John Bierke, Director, Program Division, USAID
- R. Blattner, Director, Group Agro-Pastoral Management Advisor, Population Council
- Hervé Ludovic de Lys, Operations Research Advisor, Population Council
- Dr. Mamadou Diallo, Director, PSI
- Jay Drosin, Director, Hasson Frères
- Jacky Hasson, Director UNIDO
- J.A. Hebga, Chief Of Mission, Médecins Sans Frontières
- Bernard Hody, Director Developpement Minoterie de Matadi
- Larry B. Holmes, Director, National Association of Nurses
- Mr. Ilyelakongo, USAID Director
- Charles W. Johnson, Advisor, Private Sector, AID
- Arnold Lessard, Director, Adjustment of Social Sector Project, Min. of Plan
- Prof. Kabuya Lumuna, Health and Population Development Officer, USAID
- Bill Martin, Division Chief HPN, USAID
- Ray Martin, UNFPA
- Mpoi Mankindo, Coordinator, CECAP MOP
- Mme Insilo Nkoy, Medical Director, Church of Christ
- Dr. Nkumi, Director AZBEF
- Kazadi Polondo, Deputy Director, PSI
- Jessica Price, Director, Société de Cultures au Zaire
- Jean-Paul Rousseau, Director, Société de Cultures au Zaire

- Dr. Duale Sambe, Director, SANRU
- Sharon Shapiro, Evaluation Officer, Program Office, USAID
- Beth Stanford Assistant Project Officer, FP, USAID
- Et. Verpoorten, Director General, Kinshasa Medical Center

Shaba

- Dr. Mungul Médecin Inspecteur Regional (Shaba)
- Mr. Bukasa PSND Regional Coordinator
- Dr. Tshula Head, Rwanshi Training Center
- Dr. Nkakit Head, CCV Unit, University of Lubumbashi
- Dr. Mukendi Director, General Reference Hospital
- Mrs. Ilunga M. Nurse, Heald of FP Unit, General Reference Hospital
- Dr. Mutangala Head, Preventive Medicine, Gecamine Hospital (Likasi)
- Dr. Paluku Temporary Head, OB-GYN, Gecamines Hospital (Likasi)
- Mr. Tshibangu Administrator, Gecamines Hospital (Kipushi)
- Mrs. Hawamutake Nurse, Head of FP Unit, Gecamines Hospital (Kipushi)

Bas-Zaire

- Mr. Masunda Head Nurse, Muvulu Health Center
- Bimbibu Kuwuna PSND Coordinator, Matadi
- Dr. Munumu Médecin Chef de Zone, Kisantu
- Mutuba Nuyololo PRODEF

ANNEX B.

Other Evaluations, Audits, Research

The evaluation team took note of the fact that other "evaluative" activities were ongoing, recently completed, or imminent.

1. Tulane:
 - a. cost analysis
 - b. final report
2. Inspector General's program audit, to begin December 1990
3. Population Council:
 - a. Situation analysis (evaluating the quality of a nearly-representative sample of PSND-supported services)
 - b. Comparison of Mama Bongisas and TBAs as rural family planning educators
 - c. Discontinuation, reasons for
4. Association for Voluntary Surgical Contraception, evaluation to begin in early 1991?
5. Evaluation of IEC (a draft is available?)
6. Evaluation of INTRAH
7. Kinshasa-only Contraceptive Prevalence Survey, data collected, analysis completed, publication awaited

**BEYOND PROBLEM IDENTIFICATION AND LAMENTATION :
A SEARCH FOR SOLUTIONS :
A TWO-STEP PROCESS**

WHAT : A process which will stimulate all participants to try - and to document, then share - new approaches and creative solutions to difficult (and in many cases, common) problems.

1. a year-long informal "survey" asking providers to include a note on new approaches taken, if any, whether or not successful, and solutions they have found to persistent - or occasional - problems.
2. a workshop at which the findings (lessons learned) can be shared, and small-group, topic-specific discussions build upon these lessons.

WHO : All the "actors" - PSND/HQ (5 persons); AZBEF/HQ (2 persons); SANRU/HQ (2); PSI/HQ (2); field personnel from GECAMINES, SNCZ, SANRU, AZBEF, PSI, PRODEF etc. In short, a field-dominated workshop (not a political in gathering). A group of persons chosen for their creativity and dedication in the field. Few donors prowling the halls looking for "good" people/agencies to support - to prevent strutting and promote honest discussion of problems and solutions.

WHY : Lack of communication within and among agencies. Creativity not rewarded, or even stifled. Successes - and failures - not shared with others.

WHEN : At the end of a year of informal surveying and preparation.

WHERE : Probably not in Kinshasa - to ensure that HQ personnel do not feel "at home" and thus dominate.

ORGANIZED BY :

NOT by any of the participating agencies. Perhaps by a little known outside consultant, or a Zairian conference-organizing firm, or USAID. The small groups, addressing specific issues, can/should select a different facilitator each of 3-5 days.

I.E.C.
Training
Outreach sensibilisation
Supervision
Planning
Monitoring and Evaluation
Collaboration, cooperation
Linkages

OUTCOME : Intangible - linkages, friendships, understanding, channels for communication

Tangible - An idea bank - the more you put in, the more there is to take out, and all withdrawals are free!

GOAL

(general)

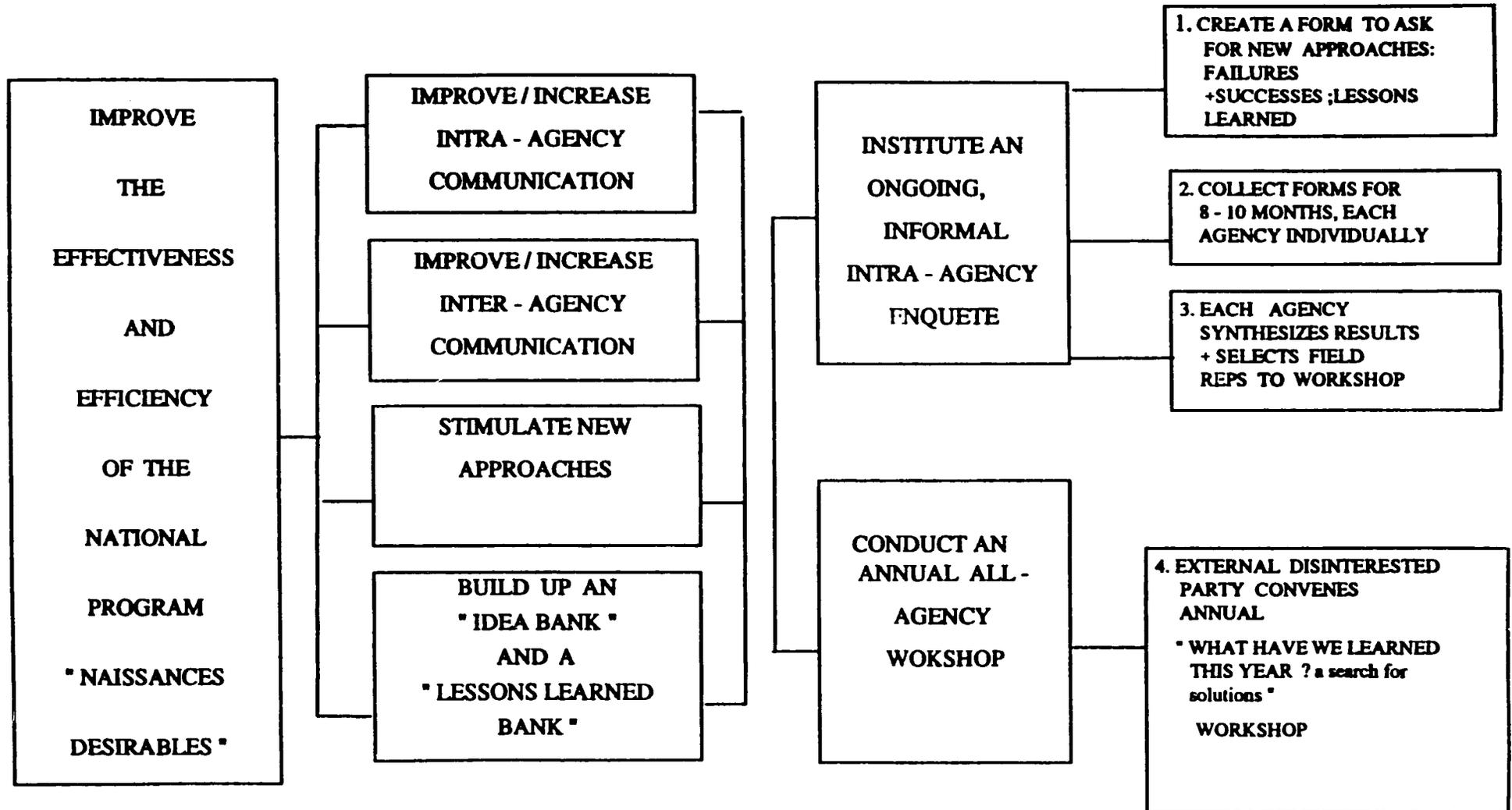
OBJECTIVES

(specific)

STRATEGIES

(les " chemins ")

ACTIVITIES



Annex D

CENTERS OF EXCELLENCE

FAMILY PLANNING "CLINIC"

FAMILY PLANNING "SERVICE"

It has been suggested that AZBEF, together with PSND, select one site in each region, focus on improving its family planning activities, and consider it a "center of excellence." Some have suggested there be a model family planning "clinic" in each region.

Presumably the purpose of such a site, or a collection of activities, is primarily for training purposes, as well as public relations -- a place to show off.

The purpose of such a concentrated effort needs to be more carefully considered before moving forward with the idea. First, one needs to clarify whether it is a place, a time, a collection of activities, or a total concept that is to be made "excellent," and if it is the latter, the question of "showing it off" to visitors or making it into a place for trainees to go to see how family planning is done well presents some problems -- unless the visitor/trainee is prepared to spend a week observing all clinic activities into which family planning may in fact be integrated.

In English, a "clinic" is either a place or a time.

"You can go to the family planning clinic on the corner of so and so." (A free-standing, family planning-only building or rooms.)

"You can go to family planning clinic at the health center; it's held on Wednesday mornings." (A family planning only block of time, held in a building where other services are also provided.)

The first refers to a truly "vertical" program. The second may refer to either a vertical or integrated program.

But a fully integrated service, such as we found in Zaire, makes it difficult to refer to "family planning clinic" in either sense. Family planning referrals can be made by clinic staff in the course of educating clients in a variety of topics - - if they are discussing nutrition, and the issue of the close spacing of births comes up, the educator may (should) note that it

is possible to obtain contraception in that same facility (or another) at such and such a time, or at any time if such walk-in services are indeed available.

Sometimes there are education sessions set aside for family planning education alone, and groups of women can be said to be attending family planning education, but this is not the same as having group education followed immediately by provision of contraceptive methods to those who want them, this combination of education-and-method-acquisition being called a "family planning clinic."

What, then, does it mean to say that AZBEF should set up model family planning clinics in each of the regions? A model is usually intended to be a showplace where others can come and see how to run a family planning service. But in a fully integrated "service," the visitor would have to remain a week or more, observing all education sessions (since family planning could come up in almost any of them), and watching for a family planning acceptor to come back and obtain a method at any one of many hours of clinic operation.

We suggest that instead of (or perhaps in addition to) the creation of a family planning clinic in the traditional sense (single service time and place, where people can visit and see all the elements at one time), that AZBEF be charged with describing - and capturing on an educational/promotional video -- the many elements that go to make up a proper family planning "service."

We would enumerate the general elements as follows:

1. Potential clients need to know that family planning methods do exist, and when and where they can obtain them (information/education outreach).
2. They also need, in some cases, to be motivated to accept these methods (motivational outreach).
3. There needs to be a place, premises, where services are delivered -- a CBD worker's home, under the baobab tree, in a pharmacy, clinic, hospital, etc. It need not necessarily be a medical setting for some methods. It need not be exclusively dedicated to the provision of family planning services.
4. There needs to be a staff, a provider, fully or partially dedicated to the provision of family planning services.
5. There need to be supplies: the contraceptives themselves, plus educational materials, forms for keeping track and reporting.
6. There needs to be certain equipment -- a chair for the CBD client to sit in during the education (so that she is not just being sold a method "over the home counter", for example), an exam table, an autoclave, etc.

7. There must be training for those who provide service.
8. There must be continuing supervision for those who provide service.
9. There must be management systems in place -- a process for planning, for monitoring, for evaluating, and for basing future planning on the results of monitoring and evaluating. There must be systems for ensuring method continuation, including client follow-up.
10. Finally, there must be appropriate "attitudes" on the part of service providers, and these either "come with the territory" or are acquired as a result of training, supervision, and retraining.

Annex E

Concept Paper - Professional Organization

Subject

Post-Partum Family Planning and adolescent sexual counseling with the Nurses Association of Zaire.

Background

The Nurses Association of Zaire is a powerful professional association created in 1977. It has approximately 27,416 members with chapters in virtually every medical institution in the country. The organization has undertaken and carried through on a variety of useful projects with international donor groups notably:

<u>Donor</u>	<u>Sum</u>	<u>Title</u>
CIDA	\$136,113	Improvement of the nursing image in Zaire.
UNICEF	\$300,000	Project to reduce infant and maternal mortality.
School of Public Health and AIZA	1,000,000 Zaires	General recap of nursing personnel.
WHO	-----	AIDS prevention project.
Cenc ic Public Health Association	\$127,000	Special immunization program.

The organization has taken little or no direct action in the area of family planning. However, they are interested in doing so with two approaches:

A. Post-Partum Family Planning

The AIZA has suggested a post-partum family program in Kinshasa, Bandundu, and Matadi. It would involve the special training of mid-wives, agreement of health educators, and home visiting by AIZA staff.

B. Education for Responsible Sexual Behavior

This project involves research into the sexual knowledge, attitudes, and practices of teenage Zairians. It involves sex-education of teachers in the school system.

Annex F

Concept Paper - Private "for profit" Sector

Subject

Initiation of (urban) family planning activities with the private "for profit" industrial and commercial sector in Kinshasa.

Background

About 17 % of Zaire's total workforce is in the organized sector. Being the nation's capital, Kinshasa has a large number of trading, textile, manufacturing and other companies. The large (trading) companies typically have their own small clinics and/or referral arrangements with local medical institutions. Their accounts are well kept, financial management good, and as a rule they have well defined organization charts with clear description of responsibilities. Besides these large private concerns - often with over 5,000 workers - there are numerous small enterprises employing less than 100 permanent employees. Visits to four major enterprises by the team seems to show that many of these firms are doing very little in the area of family planning and, might do more, if appropriate incentives existed.

Ostensibly large companies would be interested in developing family planning centers if their own facilities could be refurbished, equipment supplied, and staff trained. Contraceptives can come from PSND, but, the other support necessary might best be supplied by an efficient private sector health organization. Under normal circumstances a local family planning PVO could develop a contractual or other relationship with such companies. In Zaire AZBEF - for the time being - will be unable to initiate or follow through on such a program as it lacks the training capacity and other skills. It thus seems likely that a local (private sector) medical establishment of repute would be the most likely candidate to provide assistance to companies. The team has visited a number of such establishments in Kinshasa and has selected one - the Kinshasa Medical Centre - as a likely candidate to carry out "outreach" activities.

The Kinshasa Medical Centre was founded in 1970 by a large number of commercial and industrial firms in Kinshasa. It is legally constituted as a cooperative - its members being BATA, Zaire FINA, A.T.C., B.C.Z., etc. Salaried staff consist of 126 employees of which 9 are expatriates and 117 Zairians. The expatriate staff consists of 7 physicians, medical secretary and a Director. There are 19 local nurses. The center operates as a full service polyclinic with the whole range of diagnostic and treatment services as well as minor surgical interventions. Dr. Malderez (Belgian) is the Medical Director and Dr. Luccioni, a female gynecologist with extensive family planning experience, is head of gynecology. Dr. Bavi, Dr. Longo and Dr. Rudasewa are talented

local gynecological medical consultants. In addition two full time (expatriate) general medical practitioners and a number of consultants are already involved in family planning.

The polyclinic is prepared to undertake a contract with USAID (cost plus fee) to provide training, medical direction, outreach, and referral to the larger private companies in the Kinshasa area which are or would like to initiate or improve their family planning activities. For the smaller enterprises without health facilities they would be prepared to open a clinic in the industrial area to which referrals could be made. They are enthusiastic about this opportunity and their already existing contracts and contacts with their owners (cooperative members) who are 15 of the largest companies in Kinshasa should facilitate matters.

The Program with the Kinshasa Medical Center would consist of two parts:

- A. Information Gathering and Proposal Preparation Stage (1 year)
- B. Program Implementation (5 years)

At the end of five years it is assumed that the program will be entirely self-sufficient and no A.I.D. support would be needed. In the third year of the program investigations would be undertaken to see if the (no doubt successful) model could be replicated in other cities in Zaire. Companies in Zaire are primarily located in Kinshasa and Lubumbashi but the government has been trying to establish a third industrial center at Kisangani.

The Information Gathering Agency (see "A" above) could be carried out by the School of Public Health, the Zaire employers Association, or other qualified groups.

Annex G

Concept Paper - Private "for profit" Sector

Subject

MSF/Family Planning for Plantation and Mineworkers and their families.

Background

Medecins Sans Frontieres (Belgium) is an independent, private voluntary Agency loosely associated with Medecins Sans Frontieres (MSF) Europe. MSF is being registered in the United States as an American PVO in 1990. MSF has an excellent international reputation for emergency, medical and public health work. It has access to the largest reservoir of French speaking public health and medical talent in the world, and operates at far lower costs than most American PVOs.

MSF has taken on the responsibility of four rural health zones in Zaire - two in Shaba and two in Equateur. Both activities started in 1985 and are now well established. In each zone MSF provides two physicians and an engineer-builder working with two (Zairian) physicians and a public health educator - all paid for by MSF. In Kinshasa, the headquarters staff consists of a Medical Coordinator, Logistician, and a Director-Administrator.

MSF would be willing to add some additional (family planning) personnel to their teams on the ground in the zones where they now work to undertake a special program targetting the numerous plantations (and mines) in either or both of the regions. The Evaluation Team had lunch with one plantation owner from Equateur (one of the MSF regions) and he would welcome technical assistance, commodities, and other outside involvement by an outside professional agency (such as MSF) to help improve his plantation's nascent family planning program. The interest on the part of top management in family planning help is typical - for plantations (and mines) in Zaire often provide health, education, and housing facilities for all employees. This is a major and very expensive responsibility and most plantation Owners, Managers and Medical Directors recognise the need for effective family planning services appropriately integrated into their normal health care efforts. Naturally should a succesful program model be initiated (with outside help) the prospects of a plantation (or mine) continuing the family planning program after the departure of MSF in-puts are excellent. Some of the best employee based family planning programs are now run on plantations (India, Sri Lanka, Kenya) and mines (Zimbabwe, Phillipines, Zambia). There is every reason to believe that if a successful approach to the low cost introduction of family planning service into agro-business and mining can be developed in a few difficult zones in Zaire it would be replicable elsewhere in the country, providing adequate effort was made by the

business community (there are professional confederations of employers, agriculturalists, etc.) and MSF to disseminate the results of their joint efforts.

Implementation

In this program we envisage two stages:

A. A major survey of each zone where MSF works to determine the types of mines and plantations now out there, number of workers, family size, medical facilities, interest by management in family planning etc. Development submission and approval of project (9 months).

B. Project implementation (4 years). Until the survey is completed it is unknown what the exact composition of the MSF program and terms would be. It seems likely that for two zones there would be a physician (Belgian), nurse-midwife (Zairian), and (public) health educator (Zairian) skilled in family planning, I.E.C.

At the end of three years of (presumably) successful activities major efforts would be made to convince other technical groups (AZBEF for example) to work with other plantations and mines in other zones.

Given the enormous numbers of plantations (and mines) in Zaire - many of which are foreign owned - it seems likely that a pilot program could be replicable. It would be essential however to include a major research element in the project so as to measure change by the plantations and mines in terms of the knowledge, attitudes and practices in family planning as well as the benefits to the companies themselves.

Annex H

Concept Paper - Private Non-Profit Sector

Subject

To initiate family planning outreach activities in urban areas through the Medical Department of the Eglise du Christ au Zaire (E.C.Z.) and the parishes of local churches.

Background

The E.C.Z. represents sixty-two church denominations and communities. The Medical Department is the coordinator and promotor of health activities for these denominations. This includes the overseeing of eighty-six hospitals and 600 health centers. The SANRU project is part of ECZ jurisdiction. However the SANRU project is now, and will be in the future, focused on primary care activities only in rural areas.

There are two major elements to the urban parish based family planning program foreseen by the ECZ medical department. One is the evaluation of the present family planning activities and capabilities of church health facilities in major cities of Zaire. The other is the creation of "les aire d'appui" (areas of support) for the promotion and distribution of contraceptives through churches and church related health centers. This approach has been implemented in Kinshasa by the Presbyterian church with some degree of success. Churches were found to be good centers for family planning promotion because they reach whole family units. In this culture the mothers of couples often have as much say over the size of families as the couples themselves. As a center for actual contraceptive distribution churches were found to be weak. For this reason, the program will use local community health centers for physical exams and contraceptive distribution. Selected health centers in each city will be equipped and stocked, and the personnel trained to handle the demands.

Implementation

Two possibilities for implementing this program are:

- 1) That the evaluation or inventory of existing facilities and implementation of the program be done sequentially throughout all selected cities in Zaire.
- 2) That the two activities be done almost simultaneously, but only concentrating on a small group of cities at a time.

In either case the evaluation or inventory of existing church community and health center polyclinic structures will be carried out by the Church of Christ medical department personnel. Organization at a community level will be carried out by the

churches regional medical coordinator or a dynamic representative from the community. Their responsibility will be to identify and train several women volunteers (or CBD workers) from each congregation to do promotion and follow up on contraceptive-use among couples attending the church and within the community. The regional coordinator will also be in close contact with the health centers to facilitate the supply of contraceptives and maintain enthusiasm for the program. Training and equipping of the health centers will be the responsibility of the ECZ health department. Particular attention will be given to facilities (as appropriate) of the Salvation Army. This group has an excellent track record with USAID Zaire and has a significant interest in this area in the U.S.

It should be noted that the use of CBD workers in the urban setting is particularly cost effective. A thorough and technically correct cost effectiveness analysis has been conducted in Zaire comparing two delivery modes in a rural and an urban area (Bertrand and Mangani, 1985). Analysis suggests that urban outreach such as is proposed here is probably worthwhile but outreach cannot be justified in rural areas unless home visits achieve additional objectives (e.g., a rise in continuation rates).

All the activities of this project will be managed by a committee consisting of:

- The medical director of ECZ
- A Presbyterian missionary
- A pastor
- A SANRU administrator
- The medical coordinator for Kinshasa
- A member of AID (Ex-Officio).

The proposed cities for this program are: Kinshasa, Mbandaka, Kisangani, Goma, Mbuji-Mayi, Matadi, Boma, Kikwit and Lubumbashi.

If sequential implementation is used the timetable of activities is as follows:

- Completion of evaluation phase by the end of 1991.
- Full budget for equipment and training needs by end of 1991.
- Active program in all cities by January 1992.

If a simultaneous implementation is used, on the average, an active program will be established in a new city every two months. Budget needs will be presented incrementally on a city by city basis.

Annex I

Concept Paper - Private Non-Profit Sector

Subject

Initiation of Family Planning I.E.C. Activities with female labour union members of UNTZA.

Background

The Union National des Travailleurs du Zaire (UNTZA) is the sole labour union in Zaire. It is now completely independent of government control. It has 1300 employees, one central office in Kinshasa, 9 regional offices, and 66 local offices.

The African-American Labour Center has had a long history of work with UNTZA. Cooperation has focused its work on initiating a series of key activities enabling the Zaire labour movement to strengthen its organizational role under difficult political conditions and to make a solid contribution to improving the living standards of several hundred thousand workers. Democracy is not common in Zaire, but UNTZA holds open, contested, elections at all levels - from Secretary General to shop stewards.

The Women Workers Department (Departement Des Femmes Travailleuse, DFT) of the UNTZA is a powerful and influential force. Their structure consists of: National Committee - 26 members; National Secretariat - 6 members; and Regional Committees - 11 members, plus numerous committees at the enterprise level. The women members of the union total 279,445.

The DFT undertakes a large variety of activities some political and some social. For example, they run training programs, handicraft centers, restaurants, farms, large maternal and child health centers, day care programs etc.

Under a project with the DFT a major program could be undertaken with women leaders. Family planning motivators could be trained to carry out tasks in the workplace in conjunction with a variety of outside agencies. I.E.C. materials appropriate for union members and their families could also be produced. FPIA attempted to carry out a similar program seven years ago. FPIA was not able to continue its assistance because USAID saw no need for FPIA's assistance with the development of a bilateral project which would incorporate FPIA assisted projects. Project design issues were also a problem.

As it turned out PSND has not undertaken any significant work with the DFT and is unlikely to do so in the future given financial and other constraints.

Implementation

We envisage a two phased project:

One Year Phase I - A. Survey, examination and analysis of the project proposal received by the Team. B. Preparation of proposal.

Five Years Phase 2 - Implementation of project.

Annex J

Concept Paper

Subject

Zaire Contraceptive Prevalence and Health Survey.

Background

A Zaire Demographic and Health survey is proposed for the period 1991 to 1993. The primary purpose of the survey will be to provide data to the Ministry of Health, CONOPO and AID for the design and evaluation of population policies and programmes. The contractor for the survey will be selected as the result of the standard AID procurement process - through bidding.

The survey will be national in scope and will cover subjects in the interrelated areas of fertility, family planning and health. The last survey which collected detailed fertility and family planning information at the national level was the 1981/82 Fertility Survey carried out by Westinghouse. Since then there have been a number of zone specific surveys in family planning primarily associated with CBD programs which have provided useful information at individual sites.

The national survey will collect data from women of reproductive age on their socio-economic characteristics, marriage patterns, history of childbearing, breastfeeding, use of contraception, immunization of children, accessibility to health and family planning services, treatment of children during illness episodes, and the nutritional status of children. These data could also provide a national profile of the nine primary health indicators.

To the maximum extent possible, the family planning questions on this survey the second of three will be the same as those on the first Westinghouse Survey.

The survey will provide statistics pertaining to the above indicators at the national level, for urban/rural strata, and for health zones of particular interest to USAID should this be useful.

It is of particular importance that the survey be completed - on the ground - prior to the initiation of AID's next (umbrella) project in Health and Family Planning.

The Department of Statistics will have overall authority and responsibility for the coordination and execution of the survey. This will include establishing and convening the Survey Advisory Committee, coordinating meetings of pertinent agencies concerning questionnaire design, preparing the sample design, sample frame and sample selection, conducting a pretest, recruiting and training

male and female field editors and interviewers, data processing, analysis and report writing. AID will be represented on the Survey Advisory Committee and participate in questionnaire design, analysis, report writing and the presentation of results at the National Seminar.

Funding and provision of resources for the survey will be provided by USAID Kinshasa and the GOZ.

Sample Design and Implementation

Survey Design	1991 May - August
Sampling	
Sample Design	May - August
Preparation of sampling frame	June- August
Selection of PSUS (EAS)	August
EA Updating and Household Listing	Sept. - Nov.
Selection of Sample Households	Dec. - Jan.
Questionnaire Design	August
Questionnaire Translation	September
Pretest	October
Questionnaire Finalization	November
Finalization of Manuals	November
Questionnaire Printing	December
Main Survey Training	1992 Jan. - Feb.
Main Survey Fieldwork	Feb. - July
Data Processing	Feb. - Aug.
Reinterview Subsample	May - August
Preliminary Report	August
Final Edit	Aug. - Sept.
Tabulations for Survey Report	October
Analysis and preparation for Survey Report	Oct. - Dec.
Report Review	1993 Jan. - March
Publication of Survey Report	April - May
Publication of Summary Report	June
Publication of Summary Report	July
National Seminar	August
Audit	

Approximate Costs: \$700,000