ISA 91040 PPC/CDIE/DI

A.I.D. EVALUATION SUMMARY - PART I

PD-ABC-652

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE

IDENTIFICATION DATA

XD

A. Reporting A.I.D. Unit:

Mission or AID/W Office: USAID/Swaziland

(ES# _____)

B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan?

Yes [X] Slipped [ ] Ad Hoc [ ]

Evaluation Plan Submission Date: FY 90 Q ___

C. Evaluation Timing

Interim [X] Final [ ] Ex Post [ ] Other [ ]

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No	Project/Program Title	First PROAD or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
645-0228	Family Health Services Project	88	July 93	2,400,000	1,400,000

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
1. FLAS will recruit a chief for its Research and Evaluation Unit (REU) as soon as possible. In consultation with the long term advisor provided by Pathfinder, FLAS will expand the role of the REU to monitor the full range of FLAS activities. Increased emphasis will be placed on the routine use of data for program management. Priority will be given to the periodic estimation of continuing users and drop-outs by contraceptive method and clinic. Pathfinder will provide a full-time, resident Research and Evaluation officer until a Unit chief is assigned and sufficiently experienced. The REU will also conduct studies to document the reasons for an apparently high drop-out rate at FLAS clinics and the socioeconomic characteristics of FLAS clients and the reasons they prefer FLAS over the MOH. Pathfinder will send the Chief of the REU and his assistant to a course on the evaluation of family planning programs given by the Center for African Family studies in Tanzania.	FLAS	April 1991
2. FLAS will initiate a pilot industry-based family planning program (three industries) to begin to increase the utilization of family planning services among employees of large industries and their families. Pathfinder will provide a second long-term advisor for 12 to 24 months to assist FLAS to design a package of high quality services related to STD's and family planning tailored to the individual needs of three large agro-industrial estates. The package may include the supply of contraceptives, training in the management and delivery of clinical services, the initiation or improvement of community based distribution programs and IE&C activities. Program monitoring, supervision, evaluation and costing of services including the installation of management information systems will be basic, essential activities in all industries. FLAS will provide a full-time manager, preferably a nurse-practitioner, for the industrial program. The long-term advisor will work closely with the program manger to design, implement and evaluate the program to ensure that the program manger will be able to assume complete responsibility for it in two years.	FLAS/Pathfinder	March 1991

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) 09 (Day) 28 (Year) 1990

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or A.I.D/W Office Director
Name (Typed)	J. Anderson	N. Manzini	J. Bednar	R. Carlson
Signature	J. Anderson	N. Manzini	J. Bednar	Roger D. Carlson
Date	[illegible]	11/5/91	/	3-17-91

ATTACHMENT TO SECTION E. -
ACTIONS DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

2. Pathfinder will provide training for the industrial program manger in the form of study tours to countries with successful industrial programs.

3. Pathfinder will provide short-term technical assistance to assist FLAS to formulate communications objectives based on the results of broadly based, qualitative market research conducted in July/August 1990 and on FLAS's experience. These objectives will define the specific ideas and information which FLAS intends to communicate through its IE&C program and will determine the content of FLAS's Information Education & Communication (IE&C) activities. To monitor changes in knowledge and attitudes among the population in general, FLAS will, in 1992 and 1993, conduct focus group discussions to follow-up on the research done in 1991. To monitor changes among its own clients, FLAS will add to its management information system a clinic based IE&C monitoring system to assess client knowledge and attitudes. Establishing this system at a sample of MOH sites will enable FLAS to monitor FP client knowledge and attitudes among those not exposed to the IE&C activities conducted at FLAS clinics. Comparison between these two groups will facilitate judgments on the the efficacy of FLAS clinic based IE&C activities.

FLAS/Pathfinder March/April 1991

4. FLAS will consider expanding its clinic services to other areas of Swaziland. The quality of services at FLAS clinics will be optimized to insure that FLAS continues to set the standard for family-planning services in Swaziland. Pathfinder will provide a short-term consultant to review the clinical skills of FLAS's staff and design and implement an on-the-job training program in areas where improvement is indicated. In coordination with the REU, the consultant will also develop a clinic supervision and monitoring system based on specific performance indicators, including routine checks on client satisfaction. The REU and the Finance and Administration Division will assess the feasibility, cost and expected benefits of expanding FLAS's clinical services to Siteki and/or other areas. Improved management of FLAS's clinical services and IE&C activities will accrue through the work of short-term consultants provided by Pathfinder, who will assist FLAS staff at regular intervals. A program of medical backup, under which a physician will be available in each FLAS clinic for one half day per week to handle referrals and confer with nursing staff, will be instituted. FLAS will explore the possibility of raising revenue through the sale of contraceptives in conjunction with an AID-supported contraceptive social marketing program.

FLAS/Pathfinder February/March 1991

ABSTRACT

4. Evaluation Abstract (Do not exceed the space provided)

The Family Health Services (FHS) project was initiated on 27 July 1988 with the signing of two cooperative agreements; between USAID and the Family Life Association of Swaziland (FLAS) for $525,000 and USAID and the Pathfinder Fund for $875,000. FLAS is a local voluntary non-profit organization which was founded in December 1979. The effective start-up date for the FHS project was February 1989, when the Pathfinder resident advisor arrived in-country. The PACD is 31 July 1993. An additional $1,000,000 is expected to be provided after the mid-term evaluation, bringing the total to $2,400,000.

The goal of the project is to reduce high fertility rates and improve MCH in Swaziland. The purpose is to increase the prevalence of modern contraception and the practice of child spacing, with emphasis on expanding services into new areas and increasing accessibility of FP methods. Designed to be implemented in two phases over five years, the focus of Phase I was institutional development. Building on the accomplishments of Phase I, Phase II's priority focus was to expand FP services in the private sector (industry). Seven key areas were outlined in the project design: management and institutional development, service delivery expansion, IEC, program research and evaluation, leadership awareness, commodities and special activities.

The mid-term evaluation concluded that the project has made considerable progress towards achieving its objectives and should be continued, moving forward with a set of inter-related activities designed to continue the organizational strengthening started in Phase I, in addition to expanding programs. Priority areas of organizational strengthening include: staffing and staff development, priority setting, improved coordination and integration of the units in project development and management, more active networking in the family planning establishment and clarification of the role of external consultants. Priority areas of program development include: strengthening and possibly expanding clinic services, developing a major new industry-based program, expanding the IEC program to function in support of FLAS and national programs, continuing the leadership awareness program with particular attention to targeting areas of resistance, and research and evaluation activities in support of programs and overall program management.

COSTS

5. Evaluation Costs

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. $)	Source of Funds
Martin Gorosh	Colombia University	29	11,513	Project Funds
Lauri T. Lucinski	URC	22	6,226	
Pamela J. Putney	Consultant	23	7,636	
Lonna B. Shafritz	Consultant	20	4,909	

2. Mission/Office Professional Staff Person-Days (Estimate) 10 days

3. Borrower/Grantee Professional Staff Person-Days (Estimate) 10 days

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:
USAID/Swaziland	30 January 1991	Mid-Term Evaluation of USAID/Swaziland's Family Health Services Project, September, 19

The purpose of the FHS Project Evaluation was to: determine what has been accomplished under Phase I and what should be carried out during Phase II of the project; look at the FHS project's role in the context of USAID's evolving population portfolio; and make recommendations for appropriate changes in project design. The priority areas of interest delineated were: the feasibility and desirability of expanding programs in private industry; the advisability of FLAS clinics serving as models for family planning service delivery and nurses training; the desirability of attempting to make FLAS a major source of mass media education and promotion of family planning in Swaziland; the advisability of increased emphasis on leadership awareness activities; as well as support for FLAS's CBD program.

The core external evaluation team was comprised of four members, selected for expertise in program development, management and evaluation; workplace and industry-based program development; PHC, MCH and family planning service delivery; and IEC. A "participatory" methodology was used and FLAS and Pathfinder senior staff were invited to become involved in all aspects of the evaluation. FLAS and Pathfinder staff were also requested to conduct a self-evaluation using the SOW as a guide. Throughout the three-week visit: pertinent documents, IEC materials, and data bases and data processing systems used by the Research and Evaluation and Financial Units were collected and reviewed; observations at all three FLAS clinic sites and one CBD program site were carried out; and meetings were conducted with members of USAID, the MOH, representatives of Parliament, Government Agencies, private sector institutions and companies, USAID cooperating agencies (MSH and Project HOPE), FLAS's central office and clinic staff and recipients of FLAS's services.

The purpose of the FHS Project activities are to: increase access to family planning services and provide information on the health benefits of child spacing; improve knowledge of the availability, benefits and use of family planning and child spacing; improve capabilities for monitoring and evaluating program implementation; improve technical and management skills of FLAS staff; increase leadership awareness of the implications of rapid population growth; and assure a continued supply of contraceptives.

The key findings of the evaluation are:

FLAS is universally perceived as a pioneering organization doing important work in family planning and reproductive health in Swaziland.

Leadership awareness activities contributed to the formation of a Parliamentary sub-committee to study population and development issues and a recommendation calling for the establishment of a National Population Council to formulate a national population policy and coordinate population activities.

IEC and family life education programs in schools and radio broadcasts provide a consistent source of family planning information in Swaziland.

The three urban FLAS clinics provide twenty to thirty percent of all family planning services in Swaziland. These clinics also serve as sites for preservice nurses training in family planning service delivery.

The pilot CBD program stimulated the MOH to develop an operations research project to determine the effectiveness of RHMs in supplying condoms and foaming tablets and re-supplying oral contraceptives.

The creation of the Research and Evaluation Unit has contributed to an improved national contraceptive procurement system, improved information systems for national and FLAS programs and conduct of needed evaluation research studies.

In 1989, FLAS generated $33,500 from patient fees collected in its three clinics. FLAS was asked by the MOH to submit an application for a subvention, which if approved, will result in FLAS being a line-item in the MOH budget in 1991.

FLAS's Unit Heads require additional technical and managerial training and experience.

There is an overall lack of a 'systems approach" within FLAS in establishing priorities among activities and an absence of integration and coordination among units.

The organization's general policy which prohibits more than one long-term resident advisor at a time is a major contraint to the future development of important new initiatives and to FLAS as an organization.

The key recommendations of the evaluation are:

The FHS project should be continued and move forward in two interrelated sets of activities: those devoted to continuing the organizational strengthening started in Phase I and those devoted to strengthening and expanding programs.

The principal areas of organizational strengthening include staffing and staff development, priority setting, improved coordination and integration of units in project development and management, more active networking in the family planning establishment, and clarification of the role of external consultants.

Areas of program development include strengthening and possibly expanding clinic services, developing a major new industry-based program, handing the CBD program over to the MOH, expanding the IEC program to function in support of FLAS and national programs, continuing the leadership awareness program with particular attention to targeting areas of resistance, and research and evaluation activities in support of programs and overall program management.

FLAS should continue to search for a Head for the Research and Evaluation Unit. The REU should play an active role in all FLAS program activities. FLAS should also search for a qualified and experienced project manager to lead an expanded industry-based initiative.

The REU should carry out planned activities to examine utilization levels at Malkerns and client profiles and dropout rates at all clinics. FLAS as an organization needs to develop an more "market oriented" approach to all programs.

FLAS should develop a strategic approach to setting priorities among its various program components and develop a systematic approach to assure that all units are involved in the design, planning, implementation, monitoring and evaluation of each program component.

FLAS should reassess its position on the use of long-term resident advisors. Major new initiatives in IEC and an industry-based program, along with the upgrading and expanding of clinic services, indicate a need for an increased number of long-term advisors.

FLAS should develop and carry out programs that promote the clinic services to the community.

FLAS should provide a positive and systematic experience in family planning service delivery for ALL nursing students in clinic, industry and community settings.

FLAS should consider expanding its clinic services to other areas of Swaziland.

FLAS should initiate a pilot industry-based family planning program (two to three large companies operating in rural areas), combining elements of a traditional industry-based distribution program and a CBD program. During the pilot phase FLAS will be able to determine which services are most needed by companies, which are most marketable and which are within FLAS's capabilities to provide on a larger scale.

FLAS and the MOH should develop procedures which can accurately monitor the contraceptive procurement system already in place.

Mechanisms need to be developed to set, review and carry out IEC priorities. Significant additional TA (both short and long-term is needed to conduct an IEC program of the scope planned by FLAS.

More materials should be developed to support all FLAS programs (eg; Leadership Awareness, Industry), including method specific information sheets for use in the clinics. A system for quality control for all materials should be developed.

The major lessons learned are:

It is essential for timely project implementation to obtain the services of appropriate consultants within a schedule that meets the needs of the project, not the consultants. Significant delays in the development of the IEC program resulted from the reliance on one consultant, whose availability was limited and did not meet project requirements.

FLAS's inability to hire appropriate, essential and qualified staff resulted in a large unspent project balance by the mid-term evaluation.

The setting of priorities among program activities is critical to the effective implementation of the project. Trying to "do everything at once" leads to ineffective use of time and resources.

XD-ABC-652-A

MID-TERM EVALUATION OF USAID/SWAZILAND'S FAMILY HEALTH SERVICES PROJECT

645-0228

September 1990

XD-ABC-652-A
71041

MID-TERM EVALUATION

OF USAID/SWAZILAND'S

FAMILY HEALTH SERVICES PROJECT

645-0228

USAID COOPERATIVE AGREEMENT
645-0228-A-00-8021
THE FAMILY LIFE ASSOCIATION
OF SWAZILAND
MANZINI, SWAZILAND

USAID COOPERATIVE AGREEMENT
645-0228-A-00-8023
THE PATHFINDER FUND
BOSTON, MA., USA
NAIROBI, KENYA

Martin E. Gorosh
Laurie T. Lucinski
Pamela J. Putney
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Swaziland
September 10-29, 1990

University Research Corporation
Contract No. PDC-1406-I-00-7113-00

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The staff at FLAS, PathFinder, the USAID Mission, the MOH, the PHC Project Team, Project HOPE, and all the persons who generously gave us their time during the course of this evaluation.

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EXECUTIVE SUMMARY

Background

The FHS project was initiated on July 27, 1988 with the signing of two cooperative agreements; the first between USAID and FLAS ($525,000); and, the second between USAID and the Pathfinder Fund ($875,000). The effective start-up date was February 1989, when the Pathfinder resident advisor arrived in country. The PACD is July 31, 1993. Following the mid-term evaluation, USAID expects to provide an additional $1,000,000, bringing the total for both cooperative agreements to $2,400,000 ($800,000 for FLAS and $1,600,000 for Pathfinder).

The stated goal of the FHS project is to reduce high fertility rates and improve maternal/child health in Swaziland. The purpose of the project is to increase the prevalence of modern contraception and the practice of child spacing, with emphasis on expansion of services into new areas and increasing the accessibility of family planning methods to a wider number of Swazis.

The project was designed to be implemented in two phases, over five years. The focus of Phase I was institutional development with activities designed to strengthen the key areas of research, program monitoring, management and planning, IEC and service delivery. The plan for Phase II was to build on the accomplishments in Phase I, with the priority focus on the expansion of family planning services in the private sector (industry).

Seven key intervention areas were outlined in the project design:

1. Management and Institutional Development
2. Service Delivery Expansion
3. Information, Education and Communication (IEC)
4. Program Research and Evaluation
5. Leadership Awareness
6. Commodities
7. Mission Management and Special Activities

Scope of Work

The overall objective of the evaluation was to determine what has been accomplished under Phase I of the FHS project and what should be carried out during Phase II. The team was asked to evaluate the FHS project's role in the context of USAID's evolving population portfolio and make recommendations for appropriate changes in project design.

In addition to assessing progress in meeting specified project outputs, priority areas of interest delineated were: the feasibility and desirability of expanding programs in private industry; the advisability of FLAS clinics serving as models for family planning service delivery and nurse training; the desirability of attempting to make FLAS a major source of mass media education and promotion of family planning in Swaziland; the advisability of increased emphasis on leadership awareness activities, as well as support for FLAS's CBD program.

Methodology

The core external evaluation team was comprised of four members selected for expertise in program development, management and evaluation; workplace and industry-based program development; primary health care, MCH and family planning service delivery; and, primary health care and population communications The evaluators (each of whom had worked in Swaziland at least once during the two previous years) were joined at various times during the evaluation by key senior staff of both FLAS and PATHFINDER and representatives of USAID/Swaziland and the IPPF Regional Office for Africa.

FLAS and PATHFINDER were also requested to conduct a self-evaluation using the Scope of Work as a guide. This self-study was prepared and presented to the evaluation team during the first day of its work in Swaziland. Throughout the three-week visit, pertinent documents were collected and reviewed by team members. In addition to documents, the evaluation team reviewed IEC materials (including a visit to the FLAS booth at the Swaziland Trade Fair) and the databases and data processing systems used by the Research and Evaluation Unit and the Financial Department.

The team also carried out first hand observations at all three clinic sites operated by FLAS and traveled to one of the sites at which the FLAS CBD program is located. During the CBD visit, role-playing techniques were used to assess agent response to questions in a simulated agent-client interaction. The evaluation team also met with representatives of Parliament, Government Agencies, private sector institutions and companies, USAID cooperating agencies (MSH and Project HOPE), FLAS central office and clinic staff, and recipients of FLAS services. The evaluation team's first and last official visits in Swaziland were with the USAID mission for initial briefing and debriefing. The team also presented its findings and recommendations to the Ministry of Health. Regular meetings with the Health and Population Officer took place several times during the three-week period to share interim progress reports and to discuss preliminary findings.

Key Findings and Recommendations

FLAS' major strength is that it is perceived by Government, Parliament, NGO's, cooperating agencies, international organizations, industry and business, professional schools, A.I.D., members of the general public, and its own staff and Board of Directors as a pioneering organization doing important work in family planning and reproductive health in Swaziland. It is particularly noteworthy that Government explicitly expects FLAS to function in areas where Government itself is reluctant to venture. These areas include leadership awareness, IEC and service delivery targeting youth, clinic services, and developing alternative delivery systems such as CBD and industry-based approaches. Other areas of strength include research and evaluation, participation in the network of organizations involved in family planning activities in Swaziland, and successful cost recovery in clinic operations.

Some important accomplishments resulting from FLAS' strengths include:

- Leadership awareness activities contributed to the formation of a Parliamentary sub-committee to study population and development issues and a recommendation by that sub-committee to the Prime Minister's office calling for the establishment of a National Population Council to formulate a national population policy and coordinate population activities.

- IEC and family life education programs in schools, with youth groups, and through radio broadcasts provide a consistent source of family planning information and counseling to this segment of the population.

- The three urban clinics operated by FLAS provide twenty to thirty percent of all family planning services in Swaziland. The clinics are open to serve the public during lunch periods and Saturday mornings and provide particular access to youth seeking family planning services. The clinics have also served as training sites for Ministry of Health continuing education programs and for students enrolled in the nursing, midwifery, and community health educational programs at the Swaziland Institute of Health Sciences and the Nazarene College of Nursing.

- The pilot CBD program stimulated the MOH to develop an operations research project to determine the effectiveness of rural health motivators in supplying condoms and foam tablets and resupplying oral contraceptives.

- The preliminary work done in male motivation and condom distribution in industrial sites sets the stage for a major new industry-based program.

- The creation of the Research and Evaluation Unit has contributed to an improved national contraceptive procurement system, improved information systems for national and FLAS programs, and conduct of needed evaluation research studies. Perhaps the most important contribution of this new unit is the message it sends and its impact on the organization as a whole. The message conveyed is that of a serious organization concerned with improving its programs and their management through the use of monitoring, evaluation, and research findings based on sound and appropriate quantitative and qualitative methods. The impact of the unit on other organizational components has been to create awareness and to stimulate use of modern information management techniques.

- In 1989 FLAS generated $ 33,500 from the patient fees collected in its three clinics. During the period of the evaluation FLAS was asked to submit an application for a "subvention," i.e., a Ministry of Health budget allocation for services provided by FLAS. If approved, FLAS will become a line-item in the Ministry of Health budget in 1991.

- FLAS' programs are carried out by a dedicated, committed, enthusiastic, and highly motivated staff supported by an active and involved Board of Directors.

Areas Requiring Additional Development

As FLAS celebrates its tenth anniversary and approaches the mid-point of the FHS project, the evaluation team finds several aspects of its organization and programs that would benefit from additional development and strengthening. These are needed if FLAS is to continue its pioneering role through the remainder of the FHS project and into the future. These include:

- FLAS' Unit Heads require additional technical and managerial training and experience. In fact several of the individuals involved do not fully meet the qualifications and experience called for in their job descriptions. This finding has important implications for the overall improvement of FLAS' organizational capability and its capacity to improve existing programs and to undertake new directions.

- FLAS' overall program includes a full portfolio of activities: leadership awareness, IEC, family life education, youth programs, research and evaluation, clinic services, CBD, and industry-based programs. There is consensus among board members, senior staff, and unit heads that these areas constitute the FLAS program. However, while the individual activities are often carried out in a planned and systematic manner by the responsible unit, the evaluation team observed a lack of a systems approach to establishing priorities among the activities as well as an absence of integration and coordination the units. Through periodic meetings with unit heads, the Director of Programs does provide some of this integration and coordination, yet important gaps exist.

- The evaluation team had candid discussions with members of FLAS' board and FLAS senior staff concerning the role of advisors and consultants. FLAS' current position is clear. As a small organization, FLAS is concerned that the presence of long term advisors alters the character of the organization from one that is an independent and capable national organization to one that is dependent on outside expertise. Although unanimous in their praise for the work and demeanor of the current resident advisor, board and senior staff were explicit that upon completion of his assignment, FLAS would prefer to continue the FHS project without any long term resident advisors. Where technical assistance is required, FLAS is receptive to short term consultation. The evaluation team respects FLAS' position and at the same time is not able to support it. Given the current qualifications of key staff and the absence of a counterpart to the resident advisor, the team does not see how some of the new major initiatives called for under the FHS project can be effectively developed without some kind of long term advisory services.

The FHS project should be continued. It should move forward in two interrelated sets of activities: those devoted to continuing the organizational strengthening started in Phase I and those devoted to strengthening and expanding programs. The principal areas of organizational strengthening include staffing and staff development, priority setting, improved coordination and integration of units in project development and management, more active networking in the family planning establishment, and clarification of the role of external consultants. Areas of program development include strengthening and possibly expanding clinic services, developing a major new industry-based program, handing over the CBD program to the MOH, expanding the IEC program to function in support of FLAS and national

programs, continuing the leadership awareness program with particular attention to targeting areas of resistance, and research and evaluation activities in support of programs and overall program management.

Clearly, the implementation of all of the recommendations in this report would challenge the absorptive capacity of even the most highly developed organization. Priorities need to be established and plans for the phased introduction of new program components must be made. The priority-setting and planning should be carried out in collaboration and consultation among FLAS, Pathfinder, and USAID/Swaziland.

The evaluation team suggests the following package of programs as a possibility:

> **Continued strengthening of FLAS' organizational capability.** This is central to program development in all other areas and includes a strong Research and Evaluation Unit.
>
> **Developing the industry-based program** described in this report. In fact this is presented as a two-phased program including a pilot stage and a subsequent expansion phase.
>
> **Improvement and possible expansion of the existing FLAS clinic based service delivery program.** Given the existence and substantial accomplishments of FLAS' clinics, this may be viewed as a second phase of clinic service delivery improvement.
>
> **Strengthening the capability of the IEC unit** by focussing its programs and activities to support the existing clinic service delivery system and the pilot phase of the new industry-based initiative. Inevitably, some of the materials produced in support of these programs will have immediate use in the Government's national family planning service delivery system (e.g., revisions of existing print materials and development of new contraceptive method-specific informational materials). As the IEC unit becomes more accomplished and skilled, it will then be appropriate to consider a second phase in which it would become the major provider of family planning IEC materials for the nation.
>
> **Continuing the leadership awareness program** with an emphasis on targeting those groups in the official and traditional sectors (including the health sector) who have yet to develop an appreciation of the important relationship between population and development. This is an area with potentially high gain for generally low level investment of resources. It requires short and intensive inputs from FLAS senior staff and board members and is not likely to compete for resources or attention with the other elements included in this package of priorities.

Key Recommendations by Project Component

Organization and Management

FLAS should continue its efforts to improve the managerial and technical skills of the key group of unit heads to achieve an overall upgrading of performance in these key managerial positions and to increase the capacity of the organization to improve existing programs and to undertake new program initiatives.

FLAS should continue to search for a Head for the Research and Evaluation Unit. FLAS should also continue to search for a qualified and experienced project manager to lead any expanded industry-based initiative.

FLAS should develop a strategic approach to setting priorities among its various program components. As priorities are reviewed, FLAS should also reassess and clarify the place of the FHS project in relation to its overall program.

FLAS should develop a more systematic approach to assure that all units are more involved in the design, planning, implementation, monitoring, and evaluation of each program component.

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FLAS should reassess its position on the use of long term resident advisory services in the FHS project. Major new initiatives in IEC and an industry-based program combined with current staff capability indicate a continuing need for such services.

Pathfinder should attempt to provide short term consultants who will be available for repeated visits to follow up on their work and to develop FHS staff capabilities.

USAID/Swaziland should reassess its position regarding the use of consultants affiliated with centrally funded projects. The conflict to be resolved is the issue of "double overhead," versus obtaining qualified and institutionally-supported consultants.

Clinical Services

FLAS should continue to seek new approaches to recruit and retain nursing staff who are well-trained, highly motivated, and capable of innovative approaches to solving problems in family planning service delivery.

FLAS should develop and implement clinic protocols for all clinic services. FLAS should develop and carry out programs that promote the clinic services to the community.

The acceptance, expansion and sustainability of all family planning activities in Swaziland (in both the public and private sectors) depends to a large extent on adequate pre-service training in family planning and reproductive health for nurses. FLAS should expand its current nurse training program to provide a positive and systematic experience in family planning for ALL nursing students in clinic, industry and community settings.

FLAS should consider expanding its clinic services to other areas of Swaziland. Innovative ways of expanding services should be explored, such as: establishing mobile clinics and utilizing already existing facilities to provide family planning and reproductive health services on a part-time basis.

FLAS should undertake an analysis of the utilization rates and packages of services offered at each clinic to provide a firm basis for the development of new service delivery strategies.

Basic lab services for all the clinics should be set-up, including the capability to do microscopic "wet smears" for vaginal discharges, basic STD screening and hemoglobins.

FLAS should upgrade all three clinic facilities, including, equipment, physical appearance and removal of unsanitary carpeting.

FLAS should strengthen the links between the FLAS clinics and the central departments, primarily the IEC Unit and the REU.

CBD Demonstration Project

The success of the project has led to MOH recognition, replication and expansion of the program. Given the other major FLAS program priorities, all which are competing for FLAS resources, the team recommends that FLAS turn the rural CBD project over to the MOH at this time. Continued FLAS involvement in pioneering effective community based distribution should continue through its industry-based program and through exploring means of conducting greater outreach in urban and peri-urban areas using the urban clinics for supervision, supply and referrals.

Industry Based Family Planning

FLAS should initiate during Phase II of the FHS Project a pilot industry-based family planning program combining elements of a traditional industry-based distribution program and a CBD program.

A pilot project in two to three large companies operating in rural areas is suggested; during the pilot phase FLAS will be able to determine which services are most needed by companies, which are most marketable, and which are in FLAS' ability to provide on a larger scale.

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FLAS' services that would be provided to industry-based programs would include:

- Assessment of family planning services and identification of program strengths/weaknesses
- Overall program design
- Development and Supervision of Outreach Services:

  Recruitment, Selection, Training and Equipping CBD/IBD workers
  Assistance in Establishing Supervision System
  Training of nursing sisters in CBD supervision
- Supply of IEC materials
- Health Education Program Design and Implementation
- Contraceptive Supply System
- In-service Training for health providers
- Ongoing program management, monitoring and supervision
- Evaluation and Impact Assessments

Research and Evaluation

FLAS should continue to search for a head for the Research and Evaluation Unit. Recognizing the difficulties experienced in the past, FLAS should explore possibilities for filling this position through contracts with individual university faculty members.

Effective functioning of the REU is central to the continued strengthening of the FHS project and the development of its new and expanded activities. If the unit head position is not filled the project should seriously consider retaining the position of resident advisor. If the position is filled, there may still be a requirement for short term consultation to provide continuity and to offer assistance in specialized areas.

The REU must play an active role in all FLAS program activities. The expanded clinic programs, IEC efforts, and industry-based initiative will require a great deal of research and evaluation support, of both a qualitative and quantitative nature, to guide their efforts and to track their accomplishments.

The REU should carry out planned activities to examine utilization levels at the FLAS Malkerns clinic and client profiles and dropout rates at all FLAS clinics. The REU should also provide more interpretive commentary when providing data to top management and to program heads (e.g., program specific targets and indicators from service statistics).

The REU, in collaboration with the Finance and Administration Unit, should initiate studies of cost per unit of output and cost effectiveness of programs to guide management in priority setting and decision making.

FLAS and the MOH should develop procedures which can accurately monitor the contraceptive procurement system already in place, i.e. collect requisitions from clinics procuring supplies, and enable regional outlets to record supplies given to other clinics as something other than supplies distributed to clients. FLAS and the MOH should further discuss how best to unify the entire process: estimating demand, producing procurement tables, ordering supplies, clearing supplies through customs, maintaining the warehouse, honoring and monitoring requisitions, delivering supplies to outlets, establishing the information system needed to monitor supply levels centrally and regionally, collecting commodities data, and destroying expired commodities.

Information, Education, and Communication

Mechanisms need to be developed to set and review IEC priorities. The implementation of IEC programs and activities should be an integral part of an annual strategic planning process and reviewed on a regular basis during the year.

Based on the planning process recommended above, each staff member of the IEC unit should be given prime responsibility for specific projects or groups of activities.

The FHS project should continue its practice of using short-term consultants to provide on-the-job training in specific technical areas, in addition to carrying out the scope of work of the consultancy. In developing scopes of work for consultants, the FHS project should attempt to identify the consultant's related areas of expertise and include on-the-job training in these areas.

Given the numerous requests for the FLE component of the IEC unit's program, efforts should be continued to develop approaches to meeting the demand.

FLAS should continue to develop a plan for training a core group of school teachers to act as local family life educators.

Since local clinic or industry nurse participation in FLE community programs is uneven, efforts should be made to encourage their involvement. This would serve two important purposes: they would provide needed technical backup and they would be able to "promote" their clinics as sources of services.

More extensive exposure should be given to the topic of myths and misconceptions about family planning. Based on the findings of the focus group research, the topic should be revised and included in any presentations to service providers or educators who will be responsible for further education in the area of FP.

All print materials, starting with the condom brochure, should be in siSwati as well as English. The linguistics department of the University or Sebenta could assist with the difficult task of translating sensitive materials.

More materials are needed to support service delivery, particularly method-specific information sheets. More posters should be developed and distributed.

FLAS should employ marketing approaches to determine how the organization is perceived by its various targets and constituencies. This will facilitate the development of appropriate publicity activities and materials.

FLAS should make more effective u of the mass media for publicity by covering routine activities, preparing regular press releases, and creating news for the media to report.

FLAS should develop a system of quality control for all family life topic notes, media and print materials prior to production. Among the measures to consider are:

Rigorous technical review to insure accuracy;

Professional quality proofreading and literacy-level review;

Pre-testing with target audience for feedback on comprehensibility and appropriateness.

The IEC unit should work closely with the REU to develop systems to monitor and evaluate all IEC activities.

The IEC unit should consider developing an integrated male motivation program including a family life presentation, radio programs and other materials. Other underserved targets, such as refugee populations, should also be considered for special attention.

Significant additional TA will be needed to conduct an IEC program of the scope planned by FLAS. Key short-term needs are to determine and prioritize objectives, and to develop a program strategy.

The evaluation team recommends the appointment of an experienced IEC professional as a resident advisor in the IEC unit for a period of 12 to 24 months. The advisor would provide intensive on-the-job training in all phases of the program and would coordinate other specialized technical advisory services.

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The FHS project should seek immediate short-term technical assistance, as needed, to carry out activities that have already been delayed.

Should the scope and reach of the IEC activities be reduced as a result of changed priorities for the FHS project, it may be possible to consider frequent, consistent, and coordinated short-term technical assistance as an alternative to a long-term resident IEC advisor.

Leadership Awareness

Leadership awareness activities should continue to be a priority activity in the FHS project. These should include increased use of the mass media, continued workshops for leaders in both the formal and traditional sectors, and educational programs in collaboration with the Ministry of Education.

Concise, effective brochures and other educational materials, which contain brief high "impact" population messages, based on the Rapid Presentation model, should be developed and distributed by FLAS as soon as possible. This material should be targeted to key decision makers in all sectors.

The FHS project should target government and private health and medical officials for a scientific update of their knowledge of contraceptive methods, risks and benefits of contraception, contraception and maternal and child health, and the safety and effectiveness of community based programs. Prominent leaders who could alter the thinking of health professionals should be invited to make presentations and lead discussions.

Strategies to support the development and effective utilization of the Population Committee to promote family planning activities in Swaziland should be considered a priority for FLAS as an organization.

Finance and Administration

FLAS should develop a more systematic approach to assure that all units are more involved in the design, planning, implementation, monitoring, and evaluation of each program component.

FLAS should assure that its contraceptive distribution system will be able to meet the demands that will be placed on it by a proposed major industry-based initiative.

FLAS should continue its efforts to complete the transition from a manual to a computerized financial management system. Continued staff training and the recruitment of a junior accountant with computer skills should be considered.

The Finance Manager could benefit from greater interaction with the Pathfinder auditor and financial management staff. To date this contact has been limited.

FLAS should develop analyses of amounts budgeted vs. amounts spent to track expenditures in relation to progress of the FHS project. Studies should also be undertaken of cost per unit of output and cost effectiveness for use in program planning, decision-making, and evaluation.

FLAS should submit monthly invoices as requested by A.I.D. and FLAS and USAID should jointly develop and adhere to mutually acceptable billing and payment procedures. The evaluation team suggests consideration of a mechanism whereby a revolving fund is established. FLAS would submit invoices on a monthly basis and USAID would make payments to replenish the revolving fund.

FLAS and USAID should resume the schedule of regular monthly meetings to discuss progress and problems of the FHS project. Such regular meetings will foster communications in general and might serve to prevent some of the problems associated with billing and payment discussed above.

BACKGROUND

Scope of Work

The overall objective of the evaluation was to determine what has been accomplished under Phase I of the FHS project and what should be carried out during Phase II. The team was asked to evaluate the FHS project's role in the context of USAID's evolving population portfolio and make recommendations for appropriate changes in project design.

In addition to assessing progress in meeting specified project outputs, priority areas of interest delineated were: the feasibility and desirability of expanding programs in private industry; the advisability of FLAS clinics serving as models for family planning service delivery and nurses training; the desirability of attempting to make FLAS a major source of mass media education and promotion of family planning in Swaziland; the advisability of increased emphasis on leadership awareness activities, as well as support for FLAS's CBD program. (see Annex for complete Scope of Work)

Evaluation Team and Methodology

Evaluation Team

The core external evaluation team was comprised of four members:

> Martin Gorosh, Dr.P.H., Professor of Public Health and Director of International Training, Center for Population and Family Health, Columbia University School of Public Health, New York, N.Y. Team Leader and program development, management and evaluation specialist.
>
> Laurie T. Lucinski, Project Manager, University Research Corporation, Bethesda, Maryland. Workplace and industry-based program development and management specialist.
>
> Pamela J. Putney, C.N.M., Consultant, Cambridge, MA. Primary Health Care, MCH and Family Planning service delivery specialist.
>
> Lonna B. Shafritz, Consultant, Merion, PA. Primary Health Care and Population communication specialist.

The evaluators were joined on occasion during the evaluation by key senior staff of both FLAS and PATHFINDER and representatives of USAID/Swaziland and the IPPF Regional Office for Africa (please see comments on "participatory evaluation" in the section on Evaluation Methods, below).

These included:

FLAS

Mrs. K. Dlamini, Executive Director
Mrs. N. Manzini, Program Director
Mr. Jerome Shongwe, Head, IEC Unit
Ms. Frieda Maseko, CBD Program Supervisor
Ms. Martha Nkambule, Head, Clinical Services Unit
Mr. Khanya Mabuza, Industrial Nurse
Mr. Eric Maziya, Head, Finance and Administration Unit

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THE PATHFINDER FUND

Mr. Tom H. Fenn, Resident Advisor
Dr. Ayo Ajayi, Regional Director, Africa

USAID/SWAZILAND

Mr. Jay Anderson, Health, Population and Nutrition Officer

IPPF

Mr. Ben Pekeche, Program Officer

Evaluation Methods

The evaluation team pursued a "participatory" evaluation process. FLAS and PATHFINDER senior staff were invited to become involved in all aspects of the evaluation. The USAID/Swaziland Health, Population and Nutrition Officer and the IPPF Regional Program Officer were also invited to join in discussions and observations. The team was joined intermittently by these individuals, with the participation of FLAS senior management occurring less frequently. Appropriate staff from FLAS joined the team during site visits to the CBD area and industries. FLAS and PATHFINDER were also requested to conduct a self-evaluation using the Scope of Work as a guide. This self-study was prepared and presented to the evaluation team during the first day of its work in Swaziland. (The full Scope of Work and Self-Evaluation documents are reproduced as annexes to this report).

The evaluation team believes that the "participatory" approach offers several important benefits. The self-study component of evaluation promotes analysis of accomplishments, assessment of strengths and weaknesses, understanding of obstacles and opportunities in the environment, and delineation of alternative courses of action and their likely consequences. The contributions of the FLAS, PATHFINDER, USAID, and IPPF staff to describing and interpreting the context in which the Family Health Services Project operates provided a depth of understanding that otherwise would have been impossible for the evaluation team to achieve. This same appreciation of the context also facilitated the development of a set of recommendations that are feasible. Finally, the participation of the FLAS and PATHFINDER staff creates a sense of ownership of findings and recommendations and increases the likelihood that recommendations will be implemented.

All core team members had worked in Swaziland at least once during the two year period preceding the mid-term evaluation. Key documents pertaining to the Family Health Services Projects were obtained during Ms. Shafritz' July 1990 visit to Swaziland and were circulated to all team members prior to their arrival in Swaziland. Additional documents were compiled by the FHS project and were given to the team on arrival. Throughout the three-week visit, pertinent documents were collected and reviewed by team members. In addition to documents, the evaluation team reviewed IEC materials (including a visit to the FLAS booth at the Swaziland Trade Fair) and the data bases and data processing systems used by the Research and Evaluation Unit and the Financial Department. Team members also collaborated with the Pathfinder resident advisor in developing a series of estimates of contraceptive prevalence rates from the service statistics available from the MOH system. A complete list of documents and materials reviewed is included as an annex to this report.

The team also carried out first hand observations at all three clinic sites operated by FLAS and traveled to one of the sites at which the FLAS CBD program is located. During the CBD visit, role-playing techniques were used to assess agent response to questions in a simulated agent-client interaction. The evaluation team also met with representatives of Parliament, Government Agencies, private sector institutions and companies, USAID cooperating agencies (MSH and Project HOPE), FLAS central office and clinic staff, and recipients of FLAS services. The evaluation team's first and last official visits in Swaziland were with the USAID mission for initial briefing and debriefing. The team also presented its findings and recommendations to the Ministry of Health. Regular meetings with the Health, Population and Nutrition Officer took place several times during the three-week period to share interim progress reports and to discuss preliminary findings. A complete list of institutions visited and persons contacted is included as an annex to this report.

While the evaluation team was constituted to represent various specialties, the team attempted to make the most of its multi-disciplinary nature by working together throughout the three-week period. All team members reviewed all documents and attended all institutional visits, briefings, and debriefings. Follow-up visits and work sessions with particular individuals at specific institutions were carried out singly or in groups of two or three. All findings and recommendations were discussed during team meetings. Although discussions of recommendations often produced a range of solutions to problems and a range of strategies and activities to be considered, the findings and recommendations contained in this report represent a consensus of team members.

This report was prepared in draft and submitted for review to FLAS, PATHFINDER, and USAID/Swaziland. Comments from these organizations were incorporated into the report and a revised version was left in-country prior to the team's departure on September 29, 1990. Additional comments from USAID were incorporated into the final version prepared by the team at URC headquarters.

Swaziland: An Overview

The UN 1986 census estimated Swaziland's population to be 706,000, nearly half of which is under the age of 15 years. Approximately 75% of the population resides in rural areas. The country has one of the fastest growing populations in the world (3.4 percent per year according to some estimates), with the rate of growth expected to increase due to expected future reductions in mortality, and the low level of modern contraceptive practice, coupled with the continued decline in the use of traditional fertility limiting practices such as breastfeeding and postpartum abstinence. A discussion of some of the key demographic and family planning program indicators is included in annexes to this report.

There are approximately 1000 nurses and 40 physicians in Swaziland. Formal health services are primarily delivered through a network of MOH clinics (115) and hospitals (5), with Mission and industry-based clinics and small hospitals responsible for the remaining proportion. Traditional healers play a leading role in providing health care for the general population and estimates of currently practicing healers range from 8,000 to 10,000.

Despite the fact that the GOS lacks a formal population policy, it does support the provision of family planning services and the promotion of child spacing as part of its overall MCH strategy and limited family planning services have been offered in MOH clinics since 1973. Nurses and nursing assistants provide the majority of the care in the clinics, with little supervision or medical back-up. In a 1987 nationwide review of PHC service delivery, most clinics reported that they provided family planning. However, the general acceptance rate remains low, for a number of reasons including nurses' skill levels in family planning service delivery and lack of outreach and promotion activities. The most popular methods are oral contraceptives and injectables, although condom use appears to be increasing due primarily to HIV/AIDS prevention related promotional activities.

Population assistance has been provided to the GOS on a large scale by USAID, UNFPA and IPPF. UNFPA currently is implementing a three year project, with the main focus on nurses training in family planning service delivery (budget $980,000). IPPF support is through FLAS and at the present time is about $100,000 per year.

THE FAMILY LIFE ASSOCIATION OF SWAZILAND

Overview

FLAS is a voluntary non-profit organization, founded in December 1979. It is registered under the Protection of Badges and Names Act and the Ministry of the Interior. Initial support for the organization was provided by FPIA, the Unitarian Service Committee of Canada and USAID. Historically, it has maintained a close relationship with the MOH. In 1984, the MOH ceded its membership in IPPF to FLAS. The MOH has a representative who sits on FLAS's Executive Committee.

Currently the approximately 200 members of FLAS meet yearly to discuss the previous year's activities and future organizational directions. The affairs of the association are managed by the Executive Committee, which is elected biannually and meets at least once every three months. The Committee, whose duties are broad and far reaching, is composed of the association's officers, four volunteer members, a MOH representative and the Executive Director (who acts as the Secretary). The functions of the Board are implemented through three committees: Program, National and Finance/Administration. The committees are responsible for: the implementation of FLAS's policies; creating and abolishing posts within FLAS; employment, supervision and dismissal of staff; keeping records of financial transactions; drawing up by-laws and communicating with the organization's membership.

The principal philosophy of FLAS is "every individual has the right to choose when and whether to have children." The goals of the organization are:

1. To assist and supplement the activities of the MOH and other government agencies in the promotion of a healthy family life and the creation of a sense of awareness of the importance of family health in all respects so that it becomes a way of life.

2. To assist and supplement the activities of the MOH and other government agencies in the education and acceptance of child spacing as a basic human right available to all.

3. To work with other organizations and government agencies in the implementation of community schemes in family health so that the quality of life for the individual person, the family and the community may be improved.

4. To help and assist in the education for the understanding of the nature, cause and effects of rapid growth in population on people in their own communities, countries and in the world.

5. To assist in the distribution of information concerning all aspects of family health education and welfare.

FLAS promotes increased awareness on population related issues through a variety of educational activities and provides clinic, industry and community based reproductive health/family planning services through a network of three urban-based clinics, a condom distribution program in industry and a pilot CBD program in three rural areas of Swaziland.

The association's employees (over 30 full-time) all work for specialized program units. Under the Executive Director is the Deputy, who is also Director of Programs. Under her there are four department heads: the Senior Family Life Educator, the Senior Family Life Practitioner, the Training Officer and the Finance Officer.

Since 1980, the organization's projects have increased from six to 15, including the USAID funded, five-year FHS project.

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THE FAMILY HEALTH SERVICES PROJECT

Background

Rapid population growth has been identified by USAID's current CDSS as Swaziland's number one development problem. Although a number of family planning activities have been supported by USAID in recent years (including efforts within the PHC project), the FHS project is the Mission's initial major effort to reduce Swaziland's high fertility rate.

The FHS project was initiated on July 27, 1988 with the signing of two cooperative agreements; between USAID and FLAS ($525,000); and between USAID and the Pathfinder Fund ($875,000). The effective start-up date was February 1989, when the Pathfinder resident advisor arrived in country. The PACD is July 31, 1993. Following the mid-term evaluation, USAID expects to provide an additional $1,000,000, bringing the total for both cooperative agreements to $2,400,000 ($800,000 for FLAS and $1,600,000 for Pathfinder).

The stated goal of the FHS project is to reduce high fertility rates and improve maternal/child health in Swaziland. The purpose of the project is to increase the prevalence of modern contraception and the practice of child spacing, with emphasis on expansion of services into new areas and to increase the accessibility of family planning methods to a wider number of Swazis.

The project was designed to be implemented in two phases, over five years. The focus of Phase I was institutional development with activities designed to strengthen the key areas of research/program monitoring, management/planning, IEC and service delivery. The plan for Phase II was to build on the accomplishments in Phase I, with the priority focus on the expansion of family planning services in the private sector (industry).

Seven key intervention areas were outlined in the project design:

1. Management and Institutional Development:

   Short term TA and training was to be provided in program planning and management, clinical services, personnel development, financial accounting, commodity planning and logistics, fundraising and research and evaluation.

2. Service Delivery Expansion:

   Activities to strengthen the capacity of FLAS and private sector clinics (Phase II) in family planning service delivery, including cost recovery strategies, were the designated priorities in this area.

3. IEC:

   The continued development and expansion of the FLAS IEC unit was to be a major focus, in order to increase the unit's capability to produce and disseminate high quality IEC materials through mass media and other channels. The goal was for FLAS to become the principal supplier of IEC materials for Swaziland, including the MOH and the MOE.

4. Program Research and Evaluation:

   An REU was to be developed within FLAS in collaboration with a long term resident advisor. The unit was to develop the capacity to collect program statistics, monitor and evaluate program activities, test service delivery activities, conduct market studies, and project future program needs in program planning exercises.

5. Leadership Awareness:

   A primary focus of FHS activities were to be increased awareness among Swazi leaders, in both the formal and traditional sectors, regarding the negative implications of rapid population growth on health and development.

6. Commodities:

   FHS project funds were to be used for the procurement of necessary computers, software, IEC, clinical and office equipment, and vehicles. In addition, the A.I.D./Washington centrally funded Contraceptive Commodities Procurement Project was to supplement the FHS project with needed commodities.

7. Mission Management and Special Activities:

   Funds for evaluations and audits, as well as monies necessary to respond to special project related activities, were set aside by A.I.D. within the FHS project.

The above interventions were intended to: increase the availability of modern contraceptives; increase the demand for family planning services through IEC; initiate, improve and expand industry-based family planning programs (Phase II); and improve the MOH's family planning program.

PLANNED AND ACTUAL INPUTS AND OUTPUTS

Phase I of the FHS project focused on strengthening the organizational capability of FLAS. Accordingly, most of the inputs during Phase I were training and long-term and short-term technical assistance. These inputs were directed toward institution building to strengthen management and program operations to improve the quality of services in preparation for the expanded IEC, outreach and service delivery activities planned for Phase II.

Management and Institutional Development

Inputs

Pathfinder provided a long-term resident technical advisor to support the creation of a new Research and Evaluation Unit (REU) within FLAS and to provide technical assistance in program development and management. Pathfinder also provided some technical assistance through periodic project monitoring visits by its Nairobi-based Regional Director. The current head of the IEC Unit and the Head Nurse of the Manzini Clinic are presently participating in a six-week family planning management training program conducted by the Center for African Family Studies, Kenya. The FLAS Program Director attended a six-week course in program management at the University of Connecticut during April-May 1989. The industrial nurse attended the WHO course on fertility management in Mauritius during January-March 1989. Although not an FHS project input, the evaluation team notes and supports the FLAS Executive Director taking a one-year study leave to pursue a Masters Degree in Family Planning Program Management in the United Kingdom, sponsored by the U.K. Overseas Development Authority.

The work plan of the FHS project also included short-term training in the United States for the FLAS Executive Director in fund-raising techniques. This training has not taken place. FLAS recommends, and the team concurs, that U.S. training should not be pursued. In-country short-term technical assistance in fundraising for board members would be more appropriate. Staff computer training was provided through in-house workshops and tutorials run by the resident advisor and through enrolling selected program and secretarial staff in short courses offered by local computer service bureaus. Two FLAS staff members are currently enrolled in correspondence courses in business administration. Other FHS technical assistance to clinical services, IEC, finance and administration, and industry-based programs is discussed in the sections below.

The Pathfinder cooperative agreement has an approved budget of $875,000 for Phase I and the FLAS agreement has an approved budget of $525,000. The combined budget for Phase I is $1,400,000. Pathfinder projects expenditures of about $413,000 through January 31, 1991 leaving an available balance of $462,000. FLAS projects expenditures of about $140,000 through January 31, 1991 leaving an available balance of about $153,000. Based on average monthly rates of expenditures by the two organizations, the combined available balance of $615,000 would be sufficient for an additional thirty months.

Among the more important material inputs are four desk top computers and related peripheral hardware and software. The FHS project has purchased and installed 4 IBM PS/2's - one for the REU, one for the executive office, one for the financial office and one for the resident advisor's office. FLAS staff have been trained in WordPerfect, Lotus 1-2-3, dBASE IV, and DOS. The project has also purchased two vehicles, photocopying equipment, a facsimile machine, and a telephone system.

Outputs

In general, the outputs of these training and long-term and short-term consultant services have raised the qualifications of FLAS staff. This, combined with the efforts of the long-term resident advisor and the short-term IEC consultant who has made two visits to the project and who is scheduled to return shortly, has contributed to improved organizational capability in management techniques, research methods, developing certain IEC materials (e.g., the slide-tape presentation used at the recent Swaziland Trade Fair and the recently developed "How To Use a Condom" pamphlet). The acquisition of office equipment and computers has contributed to the modernization of FLAS systems and procedures.

Service Delivery Expansion

During Phase I, the work plan called for strengthening and streamlining FLAS' own clinical family planning services and initiating some activities in industry-based family planning.

Inputs

Short-term consultation was provided in September 1989 to conduct a clinical needs assessment and to make recommendations for improving clinic operations including the areas of clinical protocols, client load, re-aligning staff functions, staff training, and clinic facilities improvement. The contribution of the REU (through the resident advisor) to clinic services included improvements in record-keeping and clinic performance evaluation and feedback. As noted earlier, the Head Nurse of the Manzini Clinic is currently attending the Family Planning Management Workshop being offered by CAFS, Kenya. While this is a good general management course, it is not a course devoted specifically to clinic management.

During Phase I of the FHS project, a small FPIA-initiated industry-based program continued to work with mens' groups in industrial settings to inform and motivate group members to use the condoms that were available in this activity. Short term assistance through Pathfinder was used to conduct an assessment of the potential for expansion of the industry-based program. Also during Phase I, a pilot CBD Program (Community Based Distribution) was continued in three rural areas of Swaziland (including areas with refugee populations).

Technical assistance was to have been provided to improve the counseling skills and techniques of FLAS' clinic staff. This has not been provided. Technical assistance was delayed, in part, because a suitable "freelance" consultant could not be located and Pathfinder has not been permitted to subcontract with some outside institutions to obtain needed technical assistance. This issue is discussed in greater depth elsewhere in this report. The absence of key FLAS staff due to maternity leave and other factors also contributed to delays in this activity.

Material inputs include equipment ordered to improve the services offered at the three clinics operated by FLAS.

Outputs

In 1989 FLAS' three clinics averaged 67 new users, 376 revisits, and 116 CYP per month. Reporting MOH clinics averaged 15 new users, 55 revisits, and 30 CYP. Other private sector services averaged even less. FLAS' three clinics already serve a disproportionately large percentage (up to 30% depending on the indicator used) of the FP visits in the country. These clinics are all ranked among the top ten clinics in Swaziland (the clinics at Manzini and Mbabane are ranked first and second, nationally).

During Phase I FLAS has stepped up its efforts in the private sector (filling the position of industry nurse, providing him training, and expanding its own small private sector condom distribution program). This activity, originally initiated with FPIA support as a male motivation and work site condom distribution scheme, has now contacted some 80 industries and distributed 88,000 condoms during 1989. Assuming 20 condoms are roughly equivalent to one "visit" the cost per "visit" in this industry-based program is about US$1.00. This does not include the cost of contraceptives.

Also during Phase I, FLAS continued to operate its small pilot CBD activity (technically not and FHS activity) in three rural areas. In 1988-1989, twenty-eight community based distributors served 3107 new acceptors and 3344 revisit clients, dispensing 88,095 condoms and 21,952 foaming tablets. These distributors also made 1440 referrals to health centers for family planning and other health services. Preliminary estimates of the cost per unit of output for this program were made during the course of the evaluation. Not including the costs of IEC materials and contraceptive supplies, the cost per "visit" in the CBD program is about US$2.00.

Research and Evaluation

Inputs

Strengthening the REU has been the major emphasis of Phase I and the principal input has been the assignment of a resident technical advisor with highly developed research and evaluation skills. The advisor's arrival in Swaziland was delayed until the seventh month of the project. Other human resources related to the resident advisor position include an administrative assistant and a secretary, both of whom are in place. The FHS project implementation plan called for the recruitment and hiring of a counterpart to the resident advisor. Despite extended recruitment efforts, a suitable anc affordable person has not yet been appointed.

Material inputs related to the REU include the computers, peripherals, and software mentioned above.

Outputs

A Research and Evaluation Unit has been established at FLAS, currently under the supervision of the Resident Advisor. The unit is expected to have its own unit head and one research assistant, however at the present the unit is staffed by two research assistants. One began work in June 1989 and is seconded from the Lutheran World Federation for a period of 18 months ending December 1990. The other began work in late July 1990.

The work of the REU has focussed to date on revising and computerizing the collection, analysis and distribution of FP service statistics. The FP Management Information System (MIS) at FLAS is now fully computerized and compatible with the new system introduced by the Ministry of Health (MOH) as part of its Health Information System (HIS). During 1989 FLAS adapted its in-house MIS to analyze and produce Swaziland's 1989 summary FP reports for the MOH.

The REU also collaborated with the Primary Health Care Project (PHC), the MOH and UNFPA in designing and developing the FP component within the MOH's new HIS. The REU worked with UNFPA to design the new forms, and with the PHC project to produce instructions and training materials, and to provide training to users of the new HIS.

Primary research activities within the REU have suffered from a lack of staff. Although some research activities specified in the 1990 workplan have not yet been carried out, others not specified in the workplan have been conducted. The REU responded to rumors of condom breakage with a survey of condom users. The REU also keypunched and produced frequencies and tables from a teenage questionnaire administered as part of the IEC unit's market research activities. As part of the Private Sector FP Services Assessment the REU was involved in preparing a questionnaire that was distributed to the 380 members of the Federation of Swaziland Employers. Three studies that were planned but not yet carried out remain of interest: underutilization of the Malkerns Clinic, client dropout rates, and client profiles. Efforts to develop an appropriate sample for the second and third have begun.

The REU has also assisted with the baseline AIDS survey for FLAS' HAPA project, the Population Council's evaluation of FLAS' CBD project, and has met periodic requests for population related research and statistics from other organizations.

The REU has improved FLAS' monitoring and evaluation capacity for contraceptive forecasting and procurement of Swaziland's contraceptive supplies. FLAS conducts quarterly inventories at Central Stores and produces Contraceptive Procurement Tables for Swaziland which are used by both IPPF and USAID as support for orders placed by FLAS.

The REU also supports FLAS' forecasting and service statistics needs for IPPF work program budgets and three year plans.

Information, Education, and Communication

Inputs

The principal inputs to the IEC component of Phase I of the FHS project have been in the form of short-term consultations. One consultant conducted an IEC needs assessment early in the life of the project (May 1989). The second consultant has made two visits to date and advised the IEC unit on a third occasion when in Swaziland for other purposes. The focus of this second consultant's activities was on qualitative research to provide an informed basis for developing a FLAS IEC strategy. This consultant also provided assistance in pretesting print materials and radio programs and in developing slide-tape presentations. Project design also called for on-the-job training in video production, IEC program monitoring, and advanced script writing for radio and video. To date, such on-the-job training has not taken place. The IEC Unit Head is attending a six week management course at CAFS in Kenya. The course is designed to improve management capabilities in general and is not an IEC or IEC management course. Material inputs to the IEC component of the FHS project include several Caramates (slide-tape projection systems) and a 35 mm camera and related photographic equipment and supplies.

Outputs

Expectations regarding activities under this project output have been significantly revised since the inception of the project. The project paper and initial workplans called for recruiting a graphic artist, establishing an IEC materials production unit, producing new materials (which accounted for a large percentage of the FLAS project budget), and providing long-term overseas training for the IEC unit head. Following two weeks of technical assistance from the Johns Hopkins University Population Communication Services (PCS) project, and the arrival of a new population officer at USAID/Swaziland, FHS supported IEC activities were essentially put on hold pending the results of large scale qualitative market research. Actual materials production was postponed until development of a comprehensive IEC strategy, which itself was pending completion of the market research.

With these revisions, The FLAS IEC unit was to develop the capability to systematically assess public perceptions regarding family planning; set specific communications objectives to change those perceptions; design IEC messages in light of those objectives; implement production and distribution of these messages through appropriate media; test message impact and revise the messages based on subsequent assessment of attitudinal changes.

To that end the IEC unit, and others, received training in qualitative market research techniques and developed a research workplan in March 1990, then conducted six weeks of market research in July and August, at which time they also received some training in audio visual production techniques.

The Family Life Education Component of FLAS' IEC program (also a non-FHS activity) continued its work with Schools, Youth Groups, Community Groups, Business and Industry, Rural Health Motivators, Traditional Healers, and others. In 1989, there were 184 such events involving some 9000 participants. Through the first six months of 1990 there were 76 events involving more than 5500 participants.

Leadership Awareness

Inputs

Specific inputs to this important component of FHS project activities are not enumerated in the cooperative agreements.

Outputs

FLAS has held workshops for traditional healers, religious ministers, business leaders, top government officials and parliamentarians. A two-day conference for ministry and parliament leaders was recently conducted, during which family planning received numerous endorsements. The King himself has publicly-supported efforts to limit population growth. The press runs front page stories on how Swaziland's growth rate is among the highest in the world.

A group of parliamentarians and high ministry officials with whom FLAS has been working closely in recent years has put forth a proposal to the Prime Minister's Office calling for the creation of a National Population Council and the development of a population policy for Swaziland.

Finance and Administration

Inputs

A combination of visits by the Pathfinder Regional Director, Nairobi, and the Pathfinder Director of Internal Audit, Boston, have been provided to assist FLAS to upgrade its internal financial accounting and tracking system. These short term consultations have been augmented by Aiken and Peat, a local accounting firm contracted to provide continuing assistance. In October 1990, the Pathfinder Director of Internal Audit will return to Swaziland to assist FLAS in establishing an overhead rate and in restructuring its accounting procedures to accommodate the new system.

Material inputs include one of the four computers mentioned above and specialized accounting software required for the computerization of the accounting system.

Outputs

FLAS has improved its monitoring and evaluation capabilities in the area of financial management. The project contracted with a local accounting firm (Aiken and Peat) to revise and computerize FLAS' financial management system and to train FLAS staff in using the new system. This has been completed and staff are still making the transition from manual to automated financial management and accounting systems.

FINDINGS AND RECOMMENDATIONS

Cross-Cutting Themes and Recommendations

Phase I of the FHS project as carried out by FLAS and the Pathfinder Fund has made substantial progress in both the organizational strengthening domain (the principal focus of Phase I) and the areas of service delivery, IEC, leadership awareness, and research and evaluation. Much remains to be accomplished in both organizational and program development. The following themes and recommendations cut across projects and activities and are important for both organizational strengthening and program development. Specific findings and recommendations for program activities are contained in later sections of this report.

Human Resource Development and Policies

FLAS should continue its efforts to improve the managerial and technical skills of the key group of unit heads to achieve an overall upgrading of performance in these key managerial positions and to increase the capacity of the organization to improve existing programs and to undertake new program initiatives. These efforts should include short term training for unit heads, on-the job training by short-term and long-term consultants and advisors, and constant recruiting efforts to identify and employ appropriately qualified and experienced staff.

FLAS should continue to search for a Head for the Research and Evaluation Unit. Recognizing the difficulties experienced in the past, FLAS should explore possibilities for filling this position through contracts with UNISWA faculty members. FLAS should also search for a qualified and experienced project manager to lead any expanded industry-based initiative.

Since salary levels have been cited as an important reason for FLAS' not being able to attract the types of people needed, FLAS should press IPPF for prompt approval of the recently proposed salary increases.

Strategic Planning

FLAS should develop a strategic approach to setting priorities among its various program components. As priorities are reviewed, FLAS should also reassess and clarify the place of the FHS project in relation to its overall program. FLAS should also develop a more systematic approach to assure that all units are more involved in the design, planning, implementation, monitoring, and evaluation of each program component.

FLAS should continue to participate actively in the network of committees, councils, and advisory groups involved in family planning and related programs in Swaziland. FLAS should also selectively target organizations in this network to develop relationships that would support its ongoing and contemplated programs.

Technical Assistance

FLAS should reassess its position on the use of long term resident advisory services in the FHS project. Major new initiatives in IEC and an industry-based program combined with current staff capability indicate a continuing, even enlarged, need for such services.

Pathfinder should attempt to provide short term consultants who will be available for repeated visits to follow up on their work and to develop FHS staff capabilities. The most likely source of continuity is from Pathfinder's own field and central office staff. However, needed expertise may not always be available within Pathfinder's organization. In such cases the team suggests obtaining consultants from organizations with proven capabilities in the area of expertise required (including centrally funded A.I.D. contractors and cooperating agencies). This will provide institutional support for the consultant and a degree of continuity if consultants from the same organization are involved in FHS activities over time. The USAID/Swaziland Contracts Office has been reluctant to allow Pathfinder to subcontract to other organizations to obtain short-term technical assistance because such subcontracts involve "double overhead", i.e. the subcontractors overhead and Pathfinder's. Nonetheless, it is unrealistic to expect that the best consultants will always be available from Pathfinder's own staff or with no institutional commitments. As the quality and appropriateness of short-term technical assistance is an important variable contributing to the success of the FHS Project, it is suggested that this policy be reconsidered and that workable solutions to obtain the best possible technical assistance be developed.

FLAS should develop workplans that reflect the presence of short term consultants to ensure that program objectives and targets are not compromised by consultants' presence.

FLAS should consider establishing a mechanism for reviewing consultant reports that would promote both staff development and implementation of recommendations. Reports should be routed to appropriate staff for written comments. Staff should then meet to prepare an implementation plan with specific assignments of who is to do what and when.

Overall Recommendations and Priorities for the Future

The FHS project should be continued. It should move forward in two interrelated sets of activities: those devoted to continuing the organizational strengthening started in Phase I and those devoted to strengthening and expanding programs. The principal areas of organizational strengthening include staffing and staff development, priority setting, improved coordination and integration of units in project development and management, more active networking in the family planning establishment, and clarification of the role of external consultants. Areas of program development include strengthening and possibly expanding clinic services, developing a major new industry-based program, handing over the CBD program to the MOH, expanding the IEC program to function in support of FLAS and national programs, continuing the leadership awareness program with particular attention to targeting areas of resistance, and research and evaluation activities in support of programs and overall program management.

Clearly, the implementation of all of the recommendations in this report would challenge the absorptive capacity of even the most highly developed organization. Priorities need to be established and plans for the phased introduction of new program components must be made. The priority-setting and planning should be carried out in collaboration and consultation among FLAS, Pathfinder, and USAID/Swaziland.

The evaluation team suggests the following package of programs as a possibility:

Continued strengthening of FLAS' organizational capability. This is central to program development in all other areas and includes a strong Research and Evaluation Unit.

Developing the industry-based program described in this report. In fact this is presented as a two-phased program including a pilot stage and a subsequent expansion phase.

Improvement and possible expansion of the existing FLAS clinic based service delivery program. Given the existence and substantial accomplishments of FLAS' clinics, this may be viewed as a second phase of clinic service delivery improvement.

Strengthening the capability of the IEC unit by focussing its programs and activities to support the existing clinic service delivery system and the pilot phase of the new industry-based initiative. Inevitably, some of the materials produced in support of these programs will have immediate use in the Government's national family planning service delivery system (e.g., revisions of existing print materials and development of new contraceptive method-specific informational materials). As the IEC unit becomes more accomplished and skilled, it will then be appropriate to consider a second phase in which it would become the major provider of family planning IEC materials for the nation.

Continuing the leadership awareness program with an emphasis on targeting those groups in the official and traditional sectors who have yet to develop an appreciation of the important relationship between population and development. This is an area with potentially high gain for generally low level investment of resources. It requires short and intensive inputs from FLAS senior staff and board members and is not likely to compete for resources or attention with the other elements included in this package of priorities.

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Management and Institutional Development

Findings: Areas of Strength

FLAS' major strength is that it is perceived by Government, Parliament, NGO's, cooperating agencies, international organizations, industry and business, professional schools, A.I.D., members of the general public, and its own staff and Board of Directors as a pioneering organization doing important work in family planning and reproductive health in Swaziland. It is particularly noteworthy that Government explicitly expects FLAS to function in areas where Government itself is reluctant to venture. These areas include leadership awareness, IEC and service delivery targeting youth, clinic services, and developing alternative delivery systems such as CBD and industry-based approaches. Other areas of strength include research and evaluation, participation in the network of organizations involved in family planning activities in Swaziland, and successful cost recovery in clinic operations.

Some important accomplishments resulting from these strengths include:

- Leadership awareness activities contributed to the formation of a Parliamentary sub-committee to study population and development issues and a recommendation by that sub-committee to the Prime Minister's office calling for the establishment of a National Population Council to formulate a national population policy and coordinate population activities.

- IEC and family life education programs in schools, with youth groups, and through radio broadcasts provide a consistent source of family planning information and counseling to this segment of the population.

- The three urban clinics operated by FLAS provide twenty to thirty percent of all family planning services in Swaziland. The clinics are open to serve the public during lunch periods and Saturday mornings and provide particular access to youth seeking family planning services. The clinics have also served as training sites for Ministry of Health continuing education programs and for students enrolled in the nursing, midwifery, and community health educational programs at the Swaziland Institute of Health Sciences and the Nazarene College of Nursing.

- The pilot CBD program stimulated the MOH to develop an operations research project to determine the effectiveness of rural health motivators in supplying condoms and foam tablets and resupplying oral contraceptives.

- The preliminary work done in male motivation and condom distribution in industrial sites sets the stage for a major new industry-based program.

- The creation of the Research and Evaluation Unit has contributed to an improved national contraceptive procurement system, improved information systems for national and FLAS programs, and conduct of needed evaluation research studies. Perhaps the most important contribution of this new unit is the message it sends and its impact on the organization as a whole. The message conveyed is that of a serious organization concerned with improving its programs and their management through the use of monitoring, evaluation, and research findings based on sound and appropriate quantitative and qualitative methods. The impact of the unit on other organizational components has been to create awareness and to stimulate use of modern information management techniques.

- In 1989 FLAS generated $ 33,500 from the patient fees collected in its three clinics. During the period of the evaluation FLAS was asked to submit an application for a "subvention," i.e., a Ministry of Health budget allocation for services provided by FLAS. If approved, FLAS will become a line-item in the Ministry of Health budget in 1991.

- FLAS' programs are carried out by a dedicated, committed, enthusiastic, and highly motivated staff supported by an active and involved Board of Directors.

Findings: Areas Requiring Additional Development

As FLAS celebrates its tenth anniversary and approaches the mid-point of the FHS project, the evaluation team finds several aspects of its organization and programs that would benefit from additional development and strengthening. These are needed if FLAS is to continue its pioneering role through the remaindor of the FHS project and into the future. These include:

- FLAS' Unit Heads require additional technical and managerial training and experience. In fact several of the individuals involved do not fully meet the qualifications and experience called for in their job descriptions. This finding has important implications for the overall improvement of FLAS' organizational capability and its capacity to improve existing programs and to undertake new directions.

- To begin with the obvious, there is no Unit Head for the REU. This is an area of critical need if the momentum of this newly established unit is to be maintained upon completion of the current Resident Advisor's assignment.

- The IEC Unit Head is appropriately undergoing management training at CAFS and will certainly require additional preparation and experience in IEC program development and management as FLAS prepares to play a dominant role in family planning IEC in Swaziland.

- The newly appointed Head of the Service Delivery Unit is an experienced and qualified clinician. These credentials do not, however, begin to meet the managerial perspective required to carry out the improvements called for in existing clinics and to lead and direct the current and likely future initiatives in alternative delivery systems and to introduce quality assurance measures in all service delivery programs.

- The Finance and Administration Unit Head is currently dealing with the difficult transition from manual to computerized financial management systems and learning to carry out financial transactions with USAID.

- Both the CBD and industry-based programs have been carried out by relatively junior and inexperienced staff whose capabilities are appropriate for the activity levels of these programs but who do not have sufficiently developed program and management skills.

- FLAS' overall program includes a full portfolio of activities: leadership awareness, IEC, family life education, youth programs, research and evaluation, clinic services, CBD, and industry-based programs. There is consensus among board members, senior staff, and unit heads that these areas constitute the FLAS program. However, while the individual activities are often carried out in a planned and systematic manner by the responsible unit, the evaluation team observed a lack of a systems approach to establishing priorities among the activities as well as an absence of integration and coordination among the units. Through periodic meetings with unit heads, the Director of Programs does provide some of this integration and coordination, yet important gaps exist.

- The research and evaluation unit is not involved in the monitoring and evaluation of the CBD and industry-based programs. The unit is often requested to carry out data entry and analysis on topics where its expertise was not originally sought for advice in study design and methodology. The REU has done extensive analysis and reporting of FLAS and nationwide family planning service statistics, yet there is little evidence that these data are used in tracking programs and guiding management decisions.

- The IEC unit has not contributed to the design of new materials specifically geared to FLAS program initiatives. No new materials were developed in support of the CBD and industry-based activities. There also appears to be little contact between the IEC unit and the service delivery unit regarding the quality control of IEC materials, i.e., the accuracy of the information contained in pamphlets, radio scripts, and other presentations.

- FLAS' IEC and clinic programs have gradually become involved in numerous activities that go well beyond the basic mission of the organization. IEC community and youth programs get into areas of vocational counseling, mental health, and carrying the messages of other organizations with interests in reaching the target groups with whom FLAS works. The clinic program has introduced some curative services and child health services. This observation should not be interpreted as a negative finding; rather, it should stimulate the development of an ongoing process of reviewing priorities and assessing the extent to which new activities reinforce or dilute the basic mission of FLAS. It would also be appropriate to use this process to revise the basic mission, as this, too, is subject to change over time.

- The Finance and Administration Unit does not interact regularly with the REU and program units to develop measures of cost per unit of output and indicators of cost-effectiveness.

- FLAS is represented in all of the right committees, councils, and advisory and coordinating groups related to family planning and reproductive health in Swaziland. Such participation is important for information sharing and representation purposes, and may be extended to a more active and aggressive role in collaborative project development. The evaluation team did not observe FLAS participation in any of these groups, however, the team identified two areas where more active involvement might be indicated.

- As FLAS is already involved in a modest industry-based program and since FLAS wants to expand this program in the future, the evaluation team noted the lack of close involvement and coordination with the Swaziland Federation of Employers.

- The IPPF/UNFPA sponsored medical advisor in Swaziland is supposed to serve as medical advisor to FLAS. The evaluation team noted that this individual was not called upon by FLAS to advise and assist in program development.

- The evaluation team had candid discussions with members of FLAS' board and FLAS senior staff concerning the role of advisors and consultants. FLAS' current position is clear. As a small organization, FLAS is concerned that the presence of long term advisors alters the character of the organization from one that is an independent and capable national organization to one that is dependent on outside expertise. Although unanimous in their praise for the work and demeanor of the current resident advisor, board and senior staff were explicit that upon completion of his assignment, FLAS would prefer to continue the FHS project without any long term resident advisors. Where technical assistance is required, FLAS is receptive to short term consultation. The evaluation team respects FLAS' position and at the same time is not able to support it. Given the current qualifications of key staff and the absence of a counterpart to the resident advisor, the team does not see how the new major initiatives called for under the FHS project can be effectively developed without long term advisory services. These requirements are spelled out in detail in the sections that deal with specific program areas.

- The FHS experience with short term consultants has been mixed. Some have come and gone, left their reports behind, and have had little, if any, impact. Others have made positive contributions, especially through repeated consultations over time. The positive contribution of repeated consultations over time is somewhat offset by the long durations between visits required by the particular consultants schedule.

- The team noted that FLAS staff appear to view consultant visits as disruptions in their work rather then something that will assist them in doing their work better. All of the staff's "regular work" stops in order to concentrate on the consultant's scope of work. The evaluation team does not believe this has to be the case. In some instances, the scope of work may require work stoppage, but long term planning that includes the expected impact of consultant services should improve the ability of units to carry out their activities and meet their targets.

- The team noted that consultant reports may not have been reviewed by all staff affected by their recommendations and that action plans based on consultant reports were not prepared.

Service Delivery

The service delivery component of the FHS Project is carried out through the operation of three clinics, located in the populated "corridor" section of the country (Manzini, Mbabane and Malkerns). FLAS also has a pilot CBD program focused in three rural areas (Sipofaneni, Mafucula and Hhelehhele).

Clinical Services

Findings

In addition to family planning, FLAS clinics offer a range of reproductive health and MCH services, including treatment for STDs (for both men and women), antenatal and well-child care. FLAS clinics currently provide up to 30% of all family planning services in Swaziland (MOH statistics). In 1989, each FLAS clinics averaged a total of 67 new users, 376 re-visits and 116 CYP per month, compared to the MOH clinic average of 15 new users, 55 re-visits and 30 CYP. Although the majority of MOH clinics in both the rural and urban areas offer a full range of family planning services, (provided free of charge) they are under utilized for a variety of reasons, which probably include: privacy and confidentiality factors, problems with contraceptive supplies, ease of access to the clinics, and lack of knowledge and support for family planning services on the part of MOH nursing staff.

Unfortunately, no marketing surveys have been conducted to determine why clients use the FLAS services over those of the MOH. However, it appears that the FLAS clinics are generally perceived to offer superior services, for which clients are willing to pay the nominal fees charged by the organization. In addition to the perception that FLAS's services are of higher quality, factors such as: privacy, accessibility, convenient hours (FLAS clinics are open during lunch hours and Saturday mornings), the reliability of contraceptive supplies and staff treatment of and attitudes towards family planning clients, probably play an important role in clients' decision to use FLAS services.

Swaziland's two training institutions for nursing, Swaziland Institute for Health Sciences (SIHS) and the Nazarene College of Nursing, consider the FLAS clinics to be important sites for student clinical family planning training. However, the issue of responsibility for supervising nursing students has been an on-going problem between FLAS and these institutions. Due to staff shortages at FLAS, at the present time only the Manzini clinic is being utilized by students during their clinical rotation in family planning.

FLAS should be commended for providing low-cost, quality family planning/MCH services to a substantial proportion of the population of Swaziland. The overwhelming impression appears to be that the general public, MOH officials and industry leaders, among others, perceive that FLAS clinic services play a positive and significant role in promoting family planning in Swaziland.

Recommendations

In order to capitalize on the achievements that FLAS has made in family planning service delivery, the team recommends that significant increased attention and resources be given to the provision of services at the clinical level. Specific areas requiring additional resources, and in some instances, on-going technical assistance are presented below.

Clinic Staff

The recruitment and retention of qualified nursing staff appears to be a problem which is impacting negatively on the provision of clinic services and family planning training for nursing students. In order for FLAS to move into the next phase and to carry-out its goals to expand and improve family planning usage in Swaziland, it is critical for the organization to find ways to recruit and retain nursing staff who are well-trained, highly motivated, and capable of innovative approaches to solving problems in family planning service delivery. In addition to the obvious salary and benefit increases, creative approaches to staffing patterns such as hiring part-time nurses, expanded roles for nursing assistants and changing the hours of clinic operation should be explored.

Continuing Education/Staff Development

A plan for assessing and meeting the on-going continuing education and basic training needs of the clinic staff should be developed and implemented as soon as possible. This should include the provision of appropriate reference books and materials in all clinics for use by the staff when providing patient care on a day-to-day basis, as well as improved method specific IEC materials, and teaching and counseling aids. Priority in-service training areas include the development of improved counseling and community leadership/mobilization skills and techniques. Service providers need to enhance their skills in FP counseling in order to provide more effective counseling in the clinics; this should not be seen as replacing the work of the family life educators, nor the training they require.

The development and implementation of clinic protocols for all clinic services should be seen as an immediate priority.

Improved job descriptions for all clinic staff should be developed in collaboration with the clinic staff and the central office.

Strengthening Links Between the Clinics and Community

In order to significantly increase the number of family planning acceptors and decrease the number of discontinuers, a major priority for the organization should be the development and implementation of on-going programs that promote the clinic services to the community. For example, the Malkerns clinic, which is underutilized, is situated next to a slum where seasonal agricultural workers and others reside. Clinic staff should consider making visits into the slum housing and surrounding areas to promote the services available at FLAS and to provide health education and counseling. Other outreach activities include: using "FLAS" CBD agents operating from urban clinics into the surrounding communities; strengthening links with womens' groups and workshops; sponsoring regular community contests and neighborhood health fairs; selling and giving away "FLAS" T-shirts, bags and cards; developing innovative programs or special sessions for teenagers and men; and regular home visiting by clinic staff.

Pre-Service Family Planning Training for Nursing Students

The acceptance, expansion and sustainability of all family planning activities in Swaziland (in both the public and private sectors) depends to a large extent on adequate pre-service training in family planning and reproductive health for nurses.

It is essential for the appropriate pre-service training of nursing students in family planning to be seen both as a priority "service" and an "investment" in the future, on the part of FLAS and the MOH. Steps to provide a positive and systematic experience in family planning for all nursing students in clinic, industry and community settings should be implemented. For example, retired nursing tutors trained in family planning service delivery, or recent graduates of the UNFPA/MOH Family Planning Training Program could be hired on a part-time basis to supervise students. Ideally, the nursing training institutions should make contributions, however, nursing tutor shortages and other issues on the part of the nursing schools should not delay provision of adequate pre-service family planning training.

Expansion of Clinic Sites

Numerous officials stated a desire to see FLAS expand its clinic sites to other urban areas of Swaziland — particularly Siteki, Piggs Peak and Nhlangano. Prior to expanding, the evaluation team recommends that the FHS Project support an analysis of current FLAS clinic utilization, particularly in Malkerns, and the cost-effectiveness and feasibility of expanding FLAS clinic services to other areas. Analysis should explore the reproductive health services currently available in potential clinic sites to determine the extent of the underserved market. A financial analysis would estimate the costs of opening a new clinic and the potential funds to be generated from user fees.

More innovative ways of expanding services should also be explored, such as: establishing mobile clinics and utilizing already existing facilities to provide family planning and reproductive health services on a part-time basis (e.g., 1-2 times a week or month). If utilization rates at the Malkerns Clinic do not improve, consideration should be given to shifting those resources to a different site.

Medical Back-up and Package of Clinic Services

Without diminishing the clinical responsibilities of it's nursing staff, FLAS should strengthen the medical services and back-up provided to all the clinics by qualified MDs on a regular basis. This should include, among other things, regularly scheduled sessions for MDs at each clinic (e.g.; weekly or every other week) during which time the physician would see any complicated cases, such as persistent infections or difficult IUD removals, and perhaps conduct a case review with the nursing staff.

A careful and detailed analysis of the utilization rates and the package of services offered at each clinic should be carried out with technical assistance from experienced clinical and marketing experts and the appropriate changes made. The analysis should take into account priority health problems, client preferences and needs, other available health services in the area and strategies for increasing utilization rates at all clinic sites.

Basic lab services for all the clinics should be set-up, including the capability to do microscopic "wet smears" for vaginal discharges, basic STD screening and hemoglobins.

The ability to carry-out colposcopy examinations for abnormal Pap smears is an additional service which FLAS should consider adding to services already provided at the Manzini clinic. This is a service that is badly needed in Swaziland and which FLAS nurses could be trained to provide. There is ample space in the Manzini Clinic to accommodate the equipment and only routine medical backup would be necessary.

Clinic Facilities

All three clinic facilities need basic upgrading and equipment. The clinics lack the basic equipment necessary to safely and comfortably carry out even simple routine tasks such as speculum exams and IUCD insertions (e.g.; adequate exam tables and light sources for pelvic exams). The recommendations in Mary Ann Arnold-Mays consultancy report on clinic services conducted in November of 1989 should be implemented. In addition, given the fact that FLAS is considered a "model" for Swaziland, it is important for the clinics to be as attractive as possible. Clients and visitors entering any FLAS clinic should feel that the clinics are "special". The clinics all currently need re-painting and re-decorating, both of which could be done at a nominal cost. For example: curtains and exam room dividers could be made out of Swazi batiked material, new posters and IEC materials are needed in all the clinics, and Swazi art work (murals depicting Swazi life on exam walls, paintings and weavings by Swazi artists, local soap stone sculptures of families, women and children) should be prominently displayed. The wall-to-wall carpeting in the Manzini clinic is unsanitary and should be removed.

Clinic Links to FLAS Central Departments

Program links between the FLAS clinics and the central departments, primarily the IEC Unit and REU, need to be strengthened. Clinic data should be used for program planning and evaluation in collaboration with the REU. Clinic staff should actively and regularly collaborate with the IEC unit to develop appropriate and effective IEC materials for use by the clinic staff in the clinics and communities they are serving.

Individual clinic program targets should be developed and prominently displayed in each clinic on large, colorful graphs which are updated on a monthly basis by the clinic staff in collaboration with the central office.

Clinic Record Keeping System

The current clinic chart system, which files charts according to return visits, should be replaced by a system which allows for easy identification of clients by name, number and method of contraception. For example, patient cards should could be filed in one location by client number. A tickler file, holding index cards with each patient's name and number, could be arranged by appointment date. Color coded dots on each patient card could indicate current method used. The current system does not allow for easy access to and identification of patient charts, nor does is facilitate retrieval of information to calculate the number of continuing users and dropouts.

The CBD Program

The FLAS CBD program was initiated in 1986. The goals of the program were: to increase contraceptive availability and accessibility in the rural areas, and to develop and test a new model for delivering family planning services which could be replicated in other areas of Swaziland. Distribution of contraceptives was limited to condoms and foaming tablets. The program was implemented in three rural areas (Sipofaneni, Mafucula and Hhelehhele) and in two refugee camps, with a total of 31 CBD workers trained since the program's inception. Targets of 3000 new family planning users, with a 70% continuation rate by the year 1990 were set.

Findings

Until April of 1990, the Senior Family Life Educator in the FLAS IEC unit was responsible for overall coordination of the project. Currently, the overall responsibility has shifted to the FLAS Service Delivery Unit, however the FLE continues to coordinate the project's activities. The coordinator spends approximately 25% of her time on CBD related activities, including monthly visits to the sites for supervisory purposes, which includes paying the workers their monthly stipend of E20, collecting service statistics and resupplying contraceptives.

FLAS conducted an internal evaluation of the project in 1987. The evaluation concluded that the project's objectives were being met. As a part of its scope of work for the FHS project evaluation, the evaluation team made a site visit to Hhelehhele, accompanied by the FLE/CBD coordinator. The team met with seven, out of nine, local CBD workers, one of whom was the designated local coordinator. In addition, the brother of the area Chief and the nurse from the local MOH clinic were interviewed.

The FLAS CBD Project has helped to convince the MOH of the feasibility and acceptability of using CBD workers to increase contraceptive availability in the rural areas of Swaziland. As a result of the FLAS program, the MOH plans a pilot project that will allow RHMs in certain areas to distribute condoms and foaming tablets and resupply oral contraceptives. This is a significant example of the innovative leadership FLAS has provided in promoting new ways to deliver family planning services in Swaziland.

Some observations made by the team during the site visit were:

> The nurse at the local MOH clinic had never met any of the CBD workers, although she expressed positive opinions about their work.
>
> The CBD workers stated they preferred condoms to the foaming tablets because "the tablets don't dissolve fast enough", although a comment was made by one person about the condom that "who would eat a sweet wrapped in plastic?".
>
> None of the CBD workers were carrying condoms or foaming tablets with them at the time of the site visit.

The workers stated a preference for OCs, over injectables and IUCDs, because if "you have trouble you can easily switch to another method".

There is a widespread belief that OCs (and family planning methods in general) cause impotence in men. Men often complain that the condom makes them take longer to reach orgasm and that contraception "makes women wet" (they prefer women to be "dry" vaginally). Men in general object strongly to their wives using contraceptives.

A significant increase in teenage pregnancy has been observed by the workers. The local RHMs have accused the CBD workers of "working for the devil" because they promote family planning.

The workers cover between 15 to 40 homesteads each (total of 149 in Hhelehele).

Reasons given for working as a CBD were:

> "It helps the country. Women with fewer children are able to work at small businesses and earn money."
>
> "Its hard for women to talk about sex to their children, but as a worker I am able to."
>
> "I have a lot of children and it is too much money to pay for school."
>
> "Help young people from getting pregnant before marriage."

The Chief's brother stated that he supported the program because it was healthier for the community if children weren't spaced too closely. He stated that since the CBD program he has noticed that "you can tell that the children in a family are different ages now. Before they all looked the same age".

Recommendations

The success of the project has led to MOH recognition, replication and expansion of the program. Given the other major FLAS program priorities, all which are competing for FLAS resources, the team recommends that FLAS turn the rural CBD project over to the MOH at this time. Continued FLAS involvement in pioneering effective community based distribution should continue through its industry-based program and through exploring means of conducting greater outreach in urban and peri-urban areas using the urban clinics for supervision, supply and referrals.

INDUSTRY BASED FAMILY PLANNING PROGRAM

Industry-based Family Planning Activities Undertaken to Date by FLAS

FLAS has been implementing industry-based family planning activities since 1987. While FLAS efforts have initiated the provision of services to a large and currently underserved population, the impact of such efforts is limited, and acceptance and utilization of services could be greatly enhanced through employing a more systematic and comprehensive approach to the provision of services in industrial settings. Furthermore, a greater commitment of resources to this activity could increase contraceptive utilization, industry and leadership awareness and support for family planning and the sustainability of FLAS.

The FLAS "Demonstration Private Sector Distribution Program", initially funded by FPIA, is providing a supply of free condoms at selected workplaces, sometimes accompanied by motivational talks. To date, FLAS has provided these services in approximately 80 companies; their statistics indicate that they have distributed about 88,000 condoms. Each company is visited once every two to three months at which time they are resupplied with condoms. Commodities are usually not distributed directly to the potential users, but instead are left in places accessible to all workers such as the toilets and by the time clock. No evaluation studies have been conducted and no information is available concerning the actual utilization of the condoms. However, because of the distribution system, the program appears to be reaching primarily the workers, usually men, and not their spouses.

FLAS has attempted to recruit Industry Based Distributors but has met with limited success. No compensation or honoraria is offered to prospective IBDs, nor, according to the Industry Nurse, is it generally perceived as an activity that carries status. It should be noted that Mantalks' success in recruiting distributors has also met with little success, although, in the case of the Mantalk, distributors have an added economic incentive.

Currently, all industry-based family planning activities are carried out by the FLAS Industry Nurse, with limited support from the IEC Unit, the Research and Evaluation Unit and senior management. The Industry Nurse calls upon Family Life Educators to give talks to groups of workers when their schedules and workload permits. No written materials, such as a brochure or prospectus, are available to the Industry Nurse to facilitate understanding and acceptance of the program by company management.

FLAS has not attempted to involve the Federation of Swaziland Employers (FSE) in recruiting companies and the President and Executive Director of the Federation, while aware that FLAS was "doing something in industry-based family planning", did not know of the specific nature of their activities; nor did they know that FLAS had an industry nurse. The Executive Director of the FSE is an experienced family planning program manager who felt that the combined resources of the FSE and FLAS could produce important new programs. Of the four companies visited by the team, two indicated they had been contacted by the FLAS Industry Nurse.

Proposed Activities in Industry-based Family Planning for the Continuation of the FHS Project

Findings

It appears that there is considerable opportunity to increase the level of family planning services being provided in industrial settings. Furthermore, because it is perceived as the most knowledgeable, experienced organization in the field and because some links with industry have already been established, FLAS is in an excellent position to expand its efforts in this area.

Swaziland's industrial sector varies from large companies employing 3,000+ workers to small operations employing no more than 10 people. Thus it is important, in developing a strategy for service delivery in the industrial sector, to differentiate between the various types of companies. The Federation of Swaziland Employers (FSE) characterizes its 370 member companies as belonging to one of three groups:

1) Large Industrial Concerns: approximately 10 companies with workforces at or above 2,000; benefits are provided through a complete infrastructure including medical facilities, housing, schools, etc.

2) Matsapha Industrial Area Companies: medium to small companies, including textile companies employing mostly women, offering little or no health benefits. Employees commute to work from the Manzini-Matsapha area and thus have access to public and private health facilities.

3) Small Companies: geographically dispersed, typically offering no health benefits.

According to the FSE, approximately 10 large companies employ the majority of the workforce. The team visited four of these companies, Usutu Pulp, Swazican, Mhlume Sugar and Ubombo Ranches to assess: the level of health and family planning services currently offered; the size and composition of population served; knowledge and opinions about FLAS services and potential services; interest in and commitment to an expanded, intensified family planning program; and willingness to commit company resources to such a program. To supplement visits to individual companies, the team also met with the President and Executive Director of the Federation of Swaziland Employers.

Large companies are providing extensive health care services to employees, their dependents and the surrounding communities. Costly infrastructures have already been established; health facilities are well-equipped and staffed by trained, competent medical personnel.

Swazican employs a workforce of 1,000 - 3,000 depending upon the season, 85% of whom are women. Health services are available to employees and nonemployees alike and the company contracts with OHS to provide the services of a physician and some supervision of the clinic.

Usutu Pulp operates four clinics to serve a population of approximately 3100 employees (2800 male), their dependents and members of the community. Assuming that each employee has five dependents, this results in a service population of 15,000; not counting the community at large. Approximately 4,500 attendances are made each month to the Usutu health facilities. Health education is promoted during clinic visits and during small group talks arranged during working hours.

Ubombo Ranches employs a full-time medical staff of 35; services are provided to approximately 4,500 employees and their dependents including employees of several other private sugar estates in the area. Ubombo is active in recruiting, paying and supervising village health workers in 19 company villages. These health workers are visited one time per week by a nursing sister. They are trained to dispense over-the-counter drugs such as painkillers, and to assess the seriousness of a complaint and refer for appropriate medical treatment when needed. Although these village health workers are in fact MOH rural health motivators, they are considered salaried staff and are paid between E300 and E400 per month.

Mhlume Sugar Estate provides comprehensive health services for about 2,000 permanent employees of four local companies managed by the Commonwealth Development Corporation (CDC). They estimate that they serve a total population of about 10,000-15,000, and have about 5,473 patient visits per month. The cost of such services is approximately E60 per month per employee.

As can be seen by the figures provided above, a family planning program servicing these four industries alone would reach over 10,000 employees and their spouses; plus, potentially, an equally large number of community members not employed by these companies.

Large companies are already providing family planning services to their workers and community, but utilization is low. While services are made available, outreach, education and motivation activities are limited. All of the companies the team visited are providing family planning services, however utilization appears to be fairly low. While the level of services provided varies from company to company all are providing basic family planning services and all had sent at least one nursing sister to the eight week family

planning course offered by the Ministry of Health and UNFPA. However none of the companies we contacted believed that they had adequate resources and information to conduct the kind of health education necessary to significantly increase the utilization of the FP services.

Contrary to the findings of the industry assessment conducted by the Pathfinder consultant team in July 1990, we found that those industries we contacted were aware of how many family planning clients they were seeing and most were filling out the HIS reporting forms. For example, Swazican estimates that they are seeing approximately 20 FP clients per week and last year Mhlume clinics served 300 new users and 1350 revisits (from a total population served of approximately 15,000). Medical staff were concerned that these numbers were low, given the quality of care offered through company facilities, the high overall number of patient visits, and the large populations served.

Medical staff were also concerned about irregular supply of contraceptives and would like assistance in this area. Industry based clinics are not receiving a regular supply of contraceptives and are having to purchase certain commodities from South Africa in order to supply their clients. The shortage of Noristerat was most often mentioned as a problem. To cope with the shortages companies are buying Depo Provera and certain brands of oral contraceptives, and in some cases, passing the cost along to the user.

All the companies perceived STDs and AIDS to be significant health problems affecting their workforces. They attribute a higher demand for condoms to the growing consciousness of AIDS. Treatment of STDs consumes a large amount of the health resources. Usutu Pulp estimated that 25% of clients seen have a STD (although they may be seeking treatment for another illness or injury). The amount of money being spent on drugs to treat STDs is high, and an educational campaign which resulted in a reduction in cases could potentially be cost effective for the company.

The Federation of Swaziland Employers is very supportive of family planning activities and is prepared to play an increased role in promoting the provision of such services by industry. The Federation's support of family planning and its influential coordinating role with industry has not been exploited thus far. The FSE is knowledgeable about the effects of rapid population growth and particularly the effects on the growth of the economy and the viability of Swaziland's industries. The Federation's President produced figures which demonstrated this effect during his meeting with the team. In many countries, the need still exists to demonstrate to industry the importance of family planning — this is clearly not the case in Swaziland. Industry is convinced of the problem and interested in seeking workable solutions.

The FSE has regular access to the top management of its 370 member companies who can be particularly important in determining the level of financial support the company offers to family planning and in establishing within the company that the program is important and deserving of commitment. Although the support of top management is important to cultivate, a successful industry-based program will depend on the active support from all levels of the company including the top management, personnel officer, medical staff, and labor representatives. As such, it is important that FLAS establish a working relationship with the Federation. Specific opportunities were suggested by the Federation. For example, FLAS would be welcome to give a presentation to the bi-annual general meeting or monthly meetings of the Board of Directors. This would be most appropriate after FLAS had developed a strategy for providing services to industry. The Federation also suggested setting up a sub-committee for population within the Board of Directors.

Large companies are already spending a considerable amount on health services; their willingness to pay for family planning services and commodities and the level of cost they are willing to absorb has not been adequately demonstrated. All of the companies visited by the team were making a considerable investment in health services. Mhlume Sugar estimated that it was spending approximately E60 per month per employee. While all the companies were receiving commodities free of charge from the MOH, adequate and regular supply was highlighted as a problem. This was most notable for injectables;

three out of the four companies said they were purchasing Depo Provera because they had run out of MOH-supplied Noristerat. Two of the three companies indicated that they would have to charge the users for the commodities if they were forced to continue buying it. In contrast, Swazican is currently purchasing an upscale brand of condoms from OHS because they are preferred. the cost is not passed onto the user. Those companies who do charge for contraceptives use the medical tariffs established by the South African Medical Aid Society; for example an injection of Depo Provera currently costs E6.

Willingness to pay for contraceptives varies by company, and should the GOS and USAID discontinue the supply of free commodities, it is not safe to assume that industry would be willing to pay for them and also, whether they would then charge the user. In the interest of promoting increased acceptance of family planning and expanded industry-based programs, the team recommends that a decision on charging industry for contraceptives be deferred. A more prudent approach to cost recovery would address the problems in service delivery in industry by offering them carefully costed alternative packages of services which are currently not available to them and which address their most serious concerns: STDs, AIDS and family planning.

Willingness to pay for a comprehensive, high quality package of services would be greater, and this strategy would also contribute to the sustainability of organizations such as FLAS. Companies are aware of the cost of the extensive social services they are providing and several stressed that they believe they are already providing some services which were more appropriately the responsibility of the Government. For this reason, the team believes that companies would be more receptive to marketing approaches which stress the importance of family planning in improving the overall health of the workers and their dependents and, ultimately, cost containment. Given this, should the supply of free contraceptives be discontinued, support for family planning programs may not continue to grow.

Recommended Strategy for Pilot Industry-Based Family Planning Program

Based on the findings presented above, the team recommends that FLAS initiate during Phase II of the FHS Project a pilot industry-based family planning program combining elements of a traditional industry-based distribution program and a CBD program. After assessing the various strengths and weaknesses of existing family planning programs in large companies, it is apparent that there is a strong need for technical assistance to these programs to increase their effectiveness. FLAS has the potential capability to develop and market a package of services and products which will help industry-based family planning programs attract more users and provide a greater share of Swaziland's family planning services. Furthermore, it is the team's belief that industry would be willing to pay for such services if they directly address problems facing the industry health services, are of high quality and are affordable.

The services described below are comprehensive; given this, it is not likely that FLAS will be able to service all large companies. A pilot project in two to three large companies operating in rural areas is suggested; during the pilot phase FLAS will be able to determine which services are most needed by companies, which are most marketable, and which are in FLAS' ability to provide on a larger scale. The pilot will have other important advantages: pilot companies can be used to elicit support from other companies when expanding the program and a cost-benefit analysis could also be undertaken to determine the benefits accruing to individuals and the company as a result of an intensified family planning program. Such a cost-benefit analysis can then be used as a tool to enlist other companies to join the program, and perhaps more importantly, to finance the cost of the services.

Suggested FLAS Services for Industry-Based Family Health Programs

Identified weaknesses in existing Swazi company-based programs include: outreach, health education, including small group talks; IEC materials, including print materials and audio visual materials; a regular, consistent supply of contraceptives; in-service training for providers, and evaluation. On the basis of this assessment, a FLAS industry-based program could market all or some of the following services to selected companies. Marketing materials should stress that FLAS is able to develop and cost a tailor-made

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package of services geared to the needs of the individual company, incorporating as many or as few of the services as are required.

FLAS SERVICES FOR INDUSTRY-BASED FAMILY HEALTH PROGRAMS
▪ Assessment of family planning services and identification of program strengths/weaknesses
▪ Overall program design
▪ Development and Supervision of Outreach Services:
Recruitment, Selection, Training and Equipping CBD/IBD workers
Assistance in Establishing Supervision System
Training of nursing sisters in CBD supervision
▪ Supply of IEC materials
▪ Health Education Program Design and Implementation
▪ Contraceptive Supply System
▪ In-service Training for health providers
▪ Ongoing program management, monitoring and supervision
▪ Evaluation and Impact Assessments

Lack of outreach was identified by companies as a primary obstacle to greater utilization of family planning services. The workforces are predominantly male and often live in concentrated settlements that are disbursed around central health facilities. When their wives utilize clinic facilities, they often have to travel large distances to do so. One company visited by the evaluation team, Ubumbo Ranches, had already initiated an outreach system utilizing paid village health workers; although the primary goal of that system was to conduct "triage"; that is to prevent people from travelling into the clinic if their complaint was minor and could be treated by a visiting nurse or to refer clients to the clinic if further treatment was necessary. Another industry had initiated a village health worker system, but found that the workers were not motivated and eventually stopped coming to meetings. A third company expressed the desire to initiate a contraceptive distribution program utilizing the network of foresters who supervise groups of workers operating in remote locations.

The FLAS program could address this area by assisting industries to establish community based distribution programs within their service areas. FLAS would offer assistance in recruiting, selecting, and equipping CBD agents; establishing supervisory systems; and providing ongoing support to resolve problems or modify the program as needed. Since oral contraceptives were the most popular method in all the companies we visited, the ability of CBD agents to resupply orals, and hopefully in the future to provide initial supplies, will be key to their effectiveness.

Adequate training and supervision will go a long way in motivating CBD workers; however, if compensation is to remain minimal, creative ways of eliciting participation should be explored. For example, FLAS could

equip CBD agents with special bags, umbrellas, badges and record books. Companies might also consider supplementing the minimal MOH honorarium.

While industry is conducting some health education, their services admittedly have a curative focus, and personnel constraints are consistently cited as a barrier to more intensive health education in the workplace. Health Education is a FLAS service which is perceived to be of high quality, is in high demand and has already been provided to industry on a limited basis. Part of the process of initiating a service agreement with a given company could be an assessment of the health education capabilities of the company personnel as well as the needs for health education within the company. As part of the service agreement, FLAS would agree to provide a specified number of health talks to various group of workers.

Company health facilities are severely lacking in appropriate IEC materials, and they recognized that IEC materials are needed to adequately promote acceptance and utilization of contraceptives for family planning and prevention of STDs and AIDS. One company who has experienced several AIDS deaths attempted to procure AIDS IEC materials from FLAS and was unsuccessful, but was later able to procure them from South Africa. If FLAS is to develop credible services and be able to market them to industry, it must have high quality, relevant IEC materials. FLAS could act as the procurement agent and keep industry health facilities and CBD workers equipped with a regular supply of up-to-date IEC materials. For example, on monthly visits, the FLAS representative could supply new posters for the waiting rooms. Although materials developed and produced in Swaziland will be limited, FLAS could use its ties to IPPF, Pathfinder, PCS and the family planning community in general to procure appropriate outside materials to supplement the materials produced in Swaziland.

As mentioned above, lack of adequate contraceptive supplies was cited by nearly all the companies as a problem. Although this problem may be resolved in the future through improving the MOH distribution system, FLAS could supply contraceptives to the industry clinics and CBD agents. FLAS would develop and distribute a requisition form to be filled out by the participating industries on a monthly basis. The form would be collected during the regular visit by the FLAS industry nurse and submitted to the FLAS supplies officer as is currently the procedure for requisitioning supplies for the three FLAS clinics. The order would then be filled and delivered to the industry site during the next visit. Care would have to be taken to assure that the commodities distributed were not double counted in the MOH health information system.

Although this system would help alleviate the problems in requisitioning contraceptives, it would not address the more serious problems of the MOH running out of certain contraceptives altogether. The feasibility of FLAS purchasing contraceptives for industry when MOH supplies are not available should be explored. Alternatively, should a social marketing program be developed in Swaziland, these commodities could be marketed to the industry health services and CBD agents. Regardless of the sources, the key to FLAS' service would be to assure a regular supply of all needed contraceptive methods.

Company providers need a regular support system and infusion of new information and skills. All of the companies the team visited had sent one or more nurses to the eight week MOH/UNFPA family planning course. However, several indicated that sending nurses to long courses such as this one was disruptive to their service delivery efforts. While FLAS should not attempt to replace the MOH/UNFPA course, they could provide ongoing in-service training in family planning to medical personnel. One company suggested that FLAS give a presentation at their regular biweekly meeting of medical staff. Such a forum could be used to discuss such topics as new advances in contraceptive technology; rumors and misconceptions and how to deal with them; or how to counsel particular groups of users. In addition, FLAS could conduct limited, periodic training to upgrade the skills of various medical personnel, such as training nursing assistants in FP counseling or training nursing sisters in IUD insertion.

In order to continue serving the needs of the companies and their service populations, ongoing monitoring and evaluation and modification of the program could be incorporated into FLAS' services. FLAS could routinely provide program performance indicators to management such as number of new acceptors, number of continuing users, etc. Performance over time can be compared with pre-program figures to

simply assess the impact of the program. More sophisticated measures of impact can be considered, in particular the use of the cost-benefit analysis since this would also serve as a useful marketing tool to generate the participation of new companies.

Components in the Development and Implementation of an Industry-based FP Program

Given FLAS' limited resources, it is not reasonable to expect that a comprehensive program covering all large industries will be within its scope. During the start-up phase companies will require more intensive technical assistance; however, once a program has been successfully established the ongoing support needed from FLAS will decrease. The support could be limited to resupply of materials, periodic refresher training for CBD workers and other areas as identified by company management and medical personnel. Thus, should the pilot program be successful in two to three companies, plans to expand the program could be made. As FLAS phases out it's support to a company, new companies can be recruited to the program. A technical advisory group composed of representatives from industry, FLAS, FSE, and the MOH would be instrumental in guiding the expansion of the program, including recruiting new companies; helping to resolve implementation problems, and maintaining quality assurance.

The following steps should be considered in developing and implementing an industry-based family planning program:

1. Design of implementation plan; specification of required inputs, including technical assistance. This should take place in consultation with members of the FSE, including company representatives, to ensure that the program meets the needs of industry and will be marketable.

2. Costing of services

3. Development of simple marketing materials, possibly a one page program description/brochure

4. Introduction of the program to selected industries in collaboration with FSE; solicitation of support from top management, medical personnel and labor

5. Selection of industries

6. Establishment of a Technical Advisory Group

7. Program implementation

8. Cost-benefit analysis

9. Program evaluation and possible expansion

Program Inputs

The program outlined above will require a significant commitment of resources from the FHS Project and FLAS as an organization; it is a program that will require the close collaboration of all the units: IEC, Service Delivery, Finance & Administration and Research & Evaluation. Since most companies are already providing family planning services and would like to be assisted in their efforts, marketing FLAS' services to companies will be less important than ensuring that high quality services are consistently provided. The following inputs would be required:

Personnel and Materials:

Project Manager: A project manager with strong service delivery management skills and experience in CBD programs will be required to manage the industry-based program. Clinical skills would be a plus. While in the pilot phase, operating in two to three companies, a one-half to three-quarters level of effort might be sufficient. The responsibilities of the project manager would include: establishing good working

relationships with medical staff, top management and personnel officers; assessing company needs and assisting in establishing the package of services most appropriate to meet those needs; developing an implementation schedule; coordinating the necessary resources of the various FLAS units such as IEC; and monitoring program implementation and solving problems as they arise. These activities will take place during biweekly visits to each company with additional visits as needed (especially during program implementation). The Project Manager would be assisted in carrying out the program by a family life educator and an industry nurse. The team believes that a staffperson possessing the appropriate skills and ability does not now exist on the FLAS staff.

Family Life Educators: A family life educator will be required. The FLE would make one to two visits initially to assess company needs. The level of effort would be variable after that according to the company program, but it could be intensive if an ambitious health education campaign reaching most employees and their spouses is desired. The FHS project should contemplate hiring a new family life educator for the industry program as the present staff is occupied full-time with its current responsibilities. While experience in industry-based health education would be desirable, specialized training will probably be necessary. In order to find the most appropriate training opportunities and resources, links to the industry-based family planning programs already established in Africa through the Enterprise Program and other programs should be made. The FLE should also be able to provide in-service training in health education to company medical personnel.

Industry Nurse: An industry nurse, such as the nurse presently employed by FLAS, would make regular company visits for in-service training, resupply of contraceptives, health education activities, supervision of CBD workers and other assistance as needed. A part-time level of effort, approximately 50% would be probably be sufficient to cover two to three companies.

IEC materials: materials from within Swaziland and relevant materials from other countries. The FHS Project should consider developing IEC materials specially targeted to industry populations if such a need exists.

CBD workers kit: carrying bag, umbrella, badge, record book (approximately 20 per company)

Training:

Training needs will vary depending upon the qualifications of the program manager, family life educator and industry nurse. Special care needs to be taken to choose the most appropriate, useful training experiences in support of the industry-based program. Many prearranged courses will not be appropriate and will not allow the program staff to gain the skills and experience to operate the program effectively. Nonetheless, there are many existing resources in industry-based family planning which should be fully explored and tapped into for training, materials development, marketing, etc.

A study tour to one or more successful industry-based family planning programs would be appropriate, especially where a CBD component is included. Zimbabwe would be a good site as would Indonesia. For example, the Matron at Ubombo Ranches recently attended a workshop on industry-based family planning at Lonhro Mines in Zimbabwe and was highly enthusiastic about the experience. She commented that the most important thing was that she got to see a company with similar facilities at Ubombo implementing a family planning program and it made her realize that they could do the same at her company. On the basis of the workshop, she developed an action plan for expanding family planning services and submitted it to the Chief Medical Officer for consideration.

International Health Programs/Western Consortium for Public Health (IHP) also offers a number of courses which are relevant to the needs of FLAS staff and the industry-based program in particular. These include IEC Programs for AIDS Prevention, IEC Program Management, and Training for Family Life Education Trainers. IHP also designs individualized training programs and has experience in designing such programs for industry-based programs under the TIPPS Project.

The project manager may need more structured training in program management skills — covering supervision, cost containment and costing of services, implementing successful CBD programs, marketing, etc. Much of this training could be provided through on-the-job-training by the resident advisor.

Technical Assistance:

The industry-based program is characterized by comprehensive services where quality, supervision and responsiveness to company needs will be crucial to its success. While FLAS already provides all the basic elements of the package, technical assistance will be required to develop a package of services; develop marketing materials; improve some inputs, such as IEC materials; and conduct a cost-benefit analysis. Technical assistance in the following areas will be required:

- Development of industry-based program implementation plan
- Design of marketing plan and appropriate marketing materials
- Costing of services and products
- Provision of technical assistance to industry in establishing CBD programs
- Cost-benefit analysis: design of methodology, conduct of study

The difficulties in establishing and operating a program that industry will buy should not be underestimated. Extensive and ongoing technical assistance by a consultant(s) with demonstrated capacity in designing and managing industry-based family planning programs will be required. If consistent, high quality short-term technical assistance cannot be obtained, the assignment of a LT resident advisor (18 months) will be essential. Given FLAS' concern about the presence of resident advisors, perhaps the industry-based advisor could be physically located in the offices of the Federation of Swaziland Employers.

This is particularly important as both of A.I.D.'s centrally-funded private sector family planning projects are ending within several months (TIPPS and Enterprise); thus there will not be a central repository of experience in industry-based programs which the FHS Project can call on. However, part of the OPTIONS II mandate will be to carry out work with the private sector, in particular conducting cost-benefit analyses. As a number of OPTIONS staff were previously involved with the TIPPS Project, this would be a possible source of TA in conducting cost-benefit analyses and developing marketing strategies and materials. These will be needed in the second, or expansion, phase of the industry-based program. The REU could be called upon to assist in conducting the cost benefit analysis.

Mounting a major new industry-based program will be consistent with FLAS' pioneering reputation and role in family planning in Swaziland. The initiative is also consistent with MOH policy as industry is an area in which the Ministry wants FLAS to work. The project has great potential to increase contraceptive use in rural areas of the country; and industry is highly receptive to working with FLAS to achieve this goal. Finally, the project also has strong potential for cost-recovery and sustainability. Industry is aware of the assistance they need and should a high quality affordable service be presented to them, there is every indication that they would be willing to pay for it.

RESEARCH AND EVALUATION UNIT

The creation of the Research and Evaluation Unit has contributed to an improved national contraceptive procurement system, improved information systems for national and FLAS programs, and conduct of needed evaluation research studies. Perhaps the most important contribution of this new unit is the message it sends and its impact on the organization as a whole. The message conveyed is that of a serious organization concerned with improving its programs and their management through the use of monitoring, evaluation, and research findings based on sound and appropriate quantitative and qualitative methods. The impact of the unit on other organizational components has been to create awareness and to stimulate use of modern information management techniques.

Findings

Primary research activities within the REU have suffered principally from a lack of staff. As a result a number of specific research activities specified in the 1990 workplan have not yet been carried out. However, some research activities not specified in the workplan have been carried out. The REU responded to rumors of condom breakage with a survey of condom users, the results of which are being analyzed. The team reviewed the work to date on this survey and noted that the sampling plan did not produce a large enough sample size to permit the analysis of groups by age, level of education, etc. There also appears to be some confusion concerning the analysis of responses as the survey included both users and non users. The objective of the survey was to examine use; the inclusion of non users in the sample produces a reduced number of users and complicates the analysis of responses.

The REU also keypunched and produced frequencies and tables from a teenage questionnaire administered as part of the IEC unit's market research activities. The REU should be more involved in surveys initiated in other FHS units. Consultation on design and methodology is essential to assure quality control and ease of analysis.

As part of the Private Sector FP Services Assessment the REU also prepared and distributed a questionnaire to the 380 members of the Federation of Swaziland Employers. The questionnaire appears to be reasonable, however, it was not pretested and one of the industrial sites visited by the evaluation team reported difficulty in responding to the question on population served.

Three studies that were planned for have not been carried out but remain of interest: 1) under utilization of the Malkerns Clinic 2) client dropout rates 3) client profiles. Efforts to develop an appropriate sample for the second and third have begun. The evaluation team concurs with the importance of these studies and the potential utility of their results for program improvement.

In addition to its work on the FP MIS and FLAS service statistics, the REU has also assisted with the conduct of a baseline AIDS survey for FLAS' HAPA project (this survey also raised methodological issues such as sample size, length of questionnaire, and data analysis), assisted the Population Council with the evaluation of FLAS' CBD project, and has met periodic requests for population related research and statistics from other organizations.

The REU has also significantly improved FLAS' monitoring and evaluation skills in the area of contraceptive forecasting and procurement. FLAS is responsible for the procurement of Swaziland's contraceptive supplies, and the REU has helped improve the system through which this is accomplished. FLAS conducts quarterly inventories at Central Stores and produces Contraceptive Procurement Tables for Swaziland which are used by both IPPF and USAID as support for orders placed by FLAS. The REU also supports FLAS' forecasting and service statistics needs for IPPF work program budgets and three year plans.

The REU has not been the only unit to computerize its operations. The project has purchased and installed 4 IBM PS/2's - one for the REU, one for the Executive office, one for the financial office and one for the resident advisor's office. FLAS staff have been trained in WordPerfect, Lotus 1-2-3, dBASE IV, and DOS.

Recommendations

FLAS should continue to search for a Head for the Research and Evaluation Unit. Recognizing the difficulties experienced in the past, FLAS should explore possibilities for filling this position through

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contracts with individual university faculty members. It is expected that once the unit has a trained and established unit head, the REU can expand its activities beyond service statistics collection and reporting.

Effective functioning of the REU is central to the continued strengthening of the FHS project and the development of its new and expanded activities. If the unit head position is not filled the project should retain the position of resident advisor. If the position is filled, there may still be a requirement for short term consultation to provide continuity and to offer assistance in specialized areas.

The REU must play an active role in all FLAS program activities. The expanded clinic programs, IEC efforts, and industry-based initiative will require a great deal of research and evaluation support, of both a qualitative and quantitative nature, to guide their efforts and to track their accomplishments.

The REU should carry out planned activities to examine utilization levels at Malkerns and client profiles and dropout rates at all clinics.

The REU should provide more interpretive commentary when providing data to top management and to program heads.

Clinic-specific targets should be developed and periodic reports of progress (in text, tabular, and graphic formats) should be provided. Indicators from service statistics should be developed as part of the routine progress reporting system (e.g. percent of target accomplishment, method mix, comparisons among clinics, comparisons with past performance and ratios of new clients to revisits). Similar approaches are needed as new IEC and industry-based programs are developed.

The REU, in collaboration with the Finance and Administration Unit, should initiate studies of cost per unit of output and cost effectiveness of programs to guide management in priority setting and decision making.

FLAS and the MOH should continue to refine procedures which can accurately monitor the contraceptive procurement system already in place, i.e. collect requisitions from clinics and enable regional outlets to record supplies given to other clinics as something other than supplies distributed to clients. FLAS and the MOH should further discuss how best to unify the entire process: estimating demand, producing procurement tables, ordering supplies, clearing supplies through customs, maintaining the warehouse, honoring and monitoring requisitions, delivering supplies to outlets, establishing the information system needed to monitor supply levels centrally and regionally, collecting commodities data, and destroying expired commodities.

Ultimately, with an adequate staff in the REU, FLAS should explore approaches to income generation by marketing the unit's computer services and research skills.

INFORMATION, EDUCATION AND COMMUNICATION

FLAS' IEC unit has played an active role in family planning promotion, education, and motivation in Swaziland. Through the years it has built up a particularly strong capability and reputation in working with schools and community and youth groups. The staff of the unit, under the newly appointed unit head, is dedicated, energetic, and hard working. As the unit moves into the next phase of the FHS project, it wishes to add to its well-developed family life education program and build new capabilities in IEC strategy and program design and in developing and producing high quality IEC materials.

Organization and Management of the IEC Unit

Findings

The IEC department is involved in most, if not all, of FLAS's programs. In addition to its directly-managed family life education activities and radio programs, it provides limited IEC support to CBD, industry, clinic-based services, and leadership awareness activities. The IEC department is also involved in programs with other NGOs, such as Project HOPE's AIDS HAPA project. As part of its continuing liaison with other organizations involved in health related activities, the unit often communicates messages and distributes materials related to vocational counseling, mental health, and substance abuse.

The demands placed upon the IEC staff are often excessive and often go beyond the current technical capacity of the unit, e.g. production of quality print materials, evaluation of IEC materials, etc. Moreover, there appears to be little interdepartmental interaction among the FLAS program units to facilitate the kind of planning and coordination essential for the effective utilization of IEC services.

The current status of documentation in the IEC unit is incomplete. Transcripts of recent focus group discussions and up-to-date inventories of IEC materials were not available. This was due in part to the lack of clerical support in the unit; professional staff often have to do their own clerical work.

Recommendations

Mechanisms need to be developed to set and review IEC priorities. The implementation of IEC programs and activities should be an integral part of an annual strategic planning process and reviewed on a regular basis during the year. As new projects and activities are added, their placement within this framework and their inclusion in a revised workplan would contribute to the unit's effectiveness in carrying out programs.

Based on the planning process recommended above, each staff member of the IEC unit should be given prime responsibility for specific projects or groups of activities. The responsible staff member would monitor progress in the assigned area and would coordinate activities with other IEC staff members as well as the staff of other FLAS units. The responsible staff member would also keep records and other documentation up-to-date for all assigned activities.

The IEC department should have its own secretary with word-processing ability. This would facilitate revisions in scripts and print materials and serve as a computerized documentation center. A priority task for this person would be to organize a usable hard copy filing system. The secretary should also be given responsibility for maintaining an inventory of all print and audio visual materials and equipment used by the IEC unit.

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Staff Qualifications

Findings

Staff capabilities have been upgraded in several areas during Phase I of the FHS project:

- A short-term consultant provided training in using qualitative research methods, pretesting print materials, and producing slide-tape presentations.
- The head of the IEC unit is currently enrolled in a six-week management training workshop, offered by CAFS, Kenya.

IEC Staff have requested additional on-the-job training in data analysis, media and materials production, IEC strategy development, advanced interpersonal communications skills, and management information systems.

Recommendations

Additional training and technical assistance will be needed to continue to build the IEC capability of the FHS project. The CAFS management course is a general family planning management course, and additional short-term training for the unit head in IEC program design, management, and evaluation should be arranged. International Health Programs/Western Consortium has several excellent courses which would be relevant to the needs of the IEC unit as would the offerings of Cornell University Department of Communication.

The FHS project should continue its practice of using short-term consultants to provide on-the-job training in specific technical areas, in addition to carrying out the scope of work of the consultancy. In fact, in developing scopes of work for consultants, the FHS project should attempt to identify the consultant's related areas of expertise and include on-the-job training in these areas in the formal scope of work.

Media, Materials, & Interpersonal Communication

The IEC unit has been involved over the years in a full range of interpersonal and media education. In recent years, however, there has been little in the way of production of print materials. Moreover, no new materials were developed that were specifically designed for use in the CBD or industry-based activities.

Family Life Interpersonal Education

Findings

The major strength of the IEC unit is its long-established interpersonal communication activities. Key beneficiaries are youth (through high schools, colleges, UNISWA, and youth groups) and communities. Other groups receiving family life presentations include businesses and industries, traditional healers, police, chiefs and local officials, farmers, educators from teachers colleges and literacy training programs, and service providers such as Red Cross and RHMs.

Teacher and community support is strong as evidenced by the continued and increasing requests for family life programs. The IEC unit head expressed interest in finding ways to meet the demand more efficiently and thought had already been given to training a core group of teachers to act as local FLEs.

As stated in the outputs section above, in 1989, 184 field activities reached about 9000 people, or just over one percent of the population. These activities are by their nature labor-intensive; often three of the five person staff will go to the same school to present multiple programs. Another reason more than one person often goes is that two of the five staff do not have drivers licenses, despite this being in their job description.

The evaluation team and the unit staff reviewed the programs delivered between January 1989 and June 1990. More than 30 different topics, with two or three often presented at the same time, were presented.

There are certain sets of topics used for different school classes, and these topics account for most of the more frequently presented topics.

The family life education "Top Eleven" for January, 1989 through June, 1990 includes (theme and number of presentations):

STDs (60)
Family Planning Methods (55)
Benefits of Family Planning (50)
Human Reproduction (35)
AIDS (30)
Decision Making on Becoming a Parent (25)
Risks of Teenage Pregnancy (25)
Maturation (often with Personal Hygiene and Nutrition) (20)
Youth Problems (15)
Planned Parenthood (10)
Myths and Misconceptions about FP (usually presented at RHM training sessions) (10)

Recommendations

Given the numerous requests for the FLE component of the IEC unit's program, efforts should be continued to develop approaches to meeting this demand efficiently. For example, FLAS should continue to develop a plan for training a core group of school teachers to act as local family life educators. The plan might include the preparation of teaching materials, based on the more popular topics, for use by teachers in science and social science curricula. Teachers would be trained in the use of these materials and FLAS could provide other appropriate supporting educational aids (films, videos, slide-tape presentations, posters, and pamphlets).

Additional approaches to meeting demand include reducing the number of educators involved in any one presentation and assisting those who do not have driving licenses to obtain them.

Since local clinic or industry nurse participation in FLE community programs is uneven, efforts should be made to encourage their involvement. This would serve several important purposes: local nurses would provide needed technical backup, they would be exposed to the value of community outreach activities, and they would be able to "promote" their clinics as sources of services.

More intensive exposure should be given to the topic of myths and misconceptions about family planning. Based on the findings of the focus group research, the topic should be revised and included in any presentations to service providers or educators who will be responsible for further education in the area of FP.

Radio

Findings

FLAS has been active for some time in radio broadcasting in the country. Currently there are three weekly programs, "Temindeni", "These Family Affairs" (in its English version), and "The Swazi Teenager", each managed by a Family Life Educator with radio training and experience. Air time is donated by SBS radio.

While the team heard some positive comments on these programs, there has been no recent evaluation of them. A 1987 national listenership survey including about 2500 radio listeners produced contradictory findings: Temindeni was one of the least liked radio programs yet 74% of respondents also said they were interested in it.

The evaluation team's review of several available radio scripts revealed important inaccuracies. For example, one of the 1987 programs, "Risks of Teenage Sex", contained the following: "Those who started (having sex) before they were 16 years of age are likely to develop a disease known as cervical cancer..." "Teenagers who have cervical cancer have their future destroyed..." "If boys start having sex too soon they are likely to have a disease known as pre-ejaculation. This disease is so destructive same as cervical cancer".

The scripts reviewed tended to use mostly lecture and interview formats and often cut away to music without any introduction to the music or indication that more information would be coming up afterwards. Recommendations from Dr. Polly McLean's 1989 consultancy to assist FLAS in designing more creative and appropriate radio programming included increasing use of dramas and placing more spot messages during top programs and prime time. The team was informed that these recommendations had been implemented, however we were unable to assess progress since scripts and tapes of programs or spots after 1988 were not available at the FLAS office.

Recommendations

The IEC unit should continue to produce a variety of program formats and develop succinct spots to be aired during other programs.

The IEC unit should attempt to systematically obtain current feedback on its radio programs through qualitative and quantitative listenership studies.

Audio-visual

Findings

Television is appropriately perceived by the IEC unit as an important channel to reach youth, men and influentials. However, in Swaziland television reaches primarily urban audiences, and air time is expensive. Moreover, the capability to produce high-quality TV material does not currently exist within the unit.

The unit is also concerned that there are no locally produced films or other audio/visual material for their school and community activities. There are, however, some materials in the Zulu language which is understood by many Swazis. IEC unit staff suggested that such films are well received by Swazi audiences. They also indicated that many of the films they have are worn-out from overuse.

The staff of the IEC unit received seven days of training in August in developing slide-tape presentations. At the completion of this training, staff members were able to prepare a slide-tape on FLAS activities and programs. This presentation was shown on a Caramate at the FLAS booth at the Swaziland Trade Fair. Visually, it appeared to be a good first execution with this medium. The accompanying tape was not available for the team to review as it was being reproduced outside of FLAS' offices.

The Senior Family Life Educator prepared a list of desired equipment including: new films and replacements for well-used ones; room darkeners to cover windows at schools for better viewing; additional tape recorders and tapes; a luggage trolley to transport projectors and generators to the field; still and video cameras, and additional slide and film projectors.

Recommendations

Given the limited reach of television in Swaziland and the extensive training required to produce broadcast quality materials, FLAS should not consider television as a high priority for its IEC activities. However, use of "low-tech" home video by the IEC Unit for in-house training, clinic use and for use with community groups should be considered.

The IEC unit should obtain fresh copies of the most popular and relevant films to replace the worn versions. The unit should acquire new films on subjects not covered in its present collection, e.g. STDs, AIDS, population issues, maturation. Translations of some of the better films could be taped and played instead of the current audio portion. A recent compilation of films available from Johns Hopkins Population Communication Services is attached as an annex. FLAS should also get on appropriate mailing lists such as LINK Line (PPFA) that review new IEC resources.

The unit should produce additional slide tapes for use in clinics, FLE talks, and leadership awareness seminars.

The evaluation team supports the purchase of additional Caramates, cassette recorders, and a still camera. On a practical note, luggage trolleys are essential for moving heavy equipment and locally made room darkeners should be purchased.

Print Materials

Findings

The few posters used by FLAS and the MOH for family planning date from 1985 and 1986 and are out of print. Family Planning posters were seen in some, but not all the clinics the team visited. One of the posters was well designed and targeted to rural men; the other was not memorable.

FLAS currently has two pamphlets, "Family Planning Explained", from 1986 and "Teen-Talk" from 1987. There are also brochures originally produced in 1983 entitled, "Girls Growing Up" and "Boys Growing Up". These are generally of low quality and overly technical. In 1989, a brochure entitled "How to Use a Condom" was produced in English. This represents a significant improvement over the earlier materials. Highly graphic, with realistic drawings in two colors and few words, it deals with a practical problem and also tells clearly where to go for condoms. According to the IEC staff, this brochure was pretested several times prior to printing. As was the case with posters, pamphlets and brochures were not available in all clinics.

During its review of the older materials, the team noted inaccurate information, and is concerned about the effect this might have on the readers. Examples of inaccurate information in these materials are: sexual intercourse will always result in pregnancy, women can only become pregnant on one day during a menstrual cycle, wet dreams occur because "stored sperm have to be pushed out of the body naturally, to make way for new sperm," and Noristerat is only available from private doctors.

These materials also contain too much text and medical terminology, few illustrations, poor grammatical usage, and typographical errors. To date they have been available only in English.

Recommendations

FLAS should withdraw from circulation those pamphlets and brochures with erroneous information including: . "Family Planning Explained", "Teen-Talk", "Girls Growing Up" and "Boys Growing Up".

All print materials, starting with the condom brochure, should be in siSwati as well as English. The linguistics department of the University of Sabenta could assist with the difficult task of translating sensitive materials.

More materials are needed to support service delivery, particularly method-specific information sheets.

More posters should be developed and distributed. The targets and themes of the posters should be determined by the new IEC strategy.

If FLAS' new IEC strategy calls for major print materials production, consideration should be given to purchasing appropriate computer graphics capability and to related staff recruitment and/or training.

Promotion and Publicity

Findings

FLAS appears to have been effective in collaboration with Project HOPE in promoting special events, such as their booth at the Swaziland trade fair and the AIDS telephone hot-line set up in connection with trade fair activities. The evaluation team was able to visit this booth on the Sunday of the team's arrival in Swaziland (the closing day of the fair). The activities observed by the team at the trade fair were impressive. The FLAS/Project HOPE corner was well-attended and the audience was quite involved in discussion. Multi-media materials (films, slides and tapes) were also used. A unique feature was an AIDS hotline number that was advertised on the radio and generated a significant number of calls.

There are also a series of activities planned for the 10th anniversary of FLAS, including a public competition for a radio drama to be aired during prime time.

Efforts to promote FLAS as an organization appear to be minimal, particularly in use of media for publicity about its ongoing activities.

Recommendations

FLAS should conduct research to determine how the organization is perceived by its various targets and constituencies. This will facilitate the development of appropriate publicity activities and materials.

FLAS should make more effective use of the mass media for publicity by encouraging media coverage of routine activities, preparing regular press releases, and creating news for the media to report.

All FLAS personnel should be clearly identified with the FLAS logo by means of badges, pins, etc. This will serve to promote the image of a group of professionals and create a stronger presence of FLAS as an organization.

Based on the response to the AIDS hotline at the Trade Fair, FLAS should investigate the potential of instituting a family planning hotline.

Integration of Media and Materials Activities

Findings

Media and materials development appear to be undertaken on an ad hoc basis. A pamphlet is developed, a radio program is broadcast, a family life presentation is given, and all are treated as discrete activities.

Material production ability, particularly print and audio-visual, within the department is limited.

Recommendations

The IEC unit should reorient its approach and view the management of IEC activities as an integrated program. For example, a new Family Life Education curriculum topic would be developed with a matching brochure which summarizes the curriculum. The brochure would be distributed each time the topic was presented. The curriculum and the accompanying brochure could be produced on the same color paper to facilitate recognition.

For further integration and reinforcement, radio programs could be developed based on elements of each curriculum unit. The radio programs could specifically advise listeners, "for further information on this topic, look for the (red, yellow) brochure at (specify locations). The overall program could be seen as "The Rainbow of Information."

The actual mix of materials and media should be specified in the IEC strategy. The strategy should be used to determine what type of additional staff, training and technical assistance is needed.

FLAS should develop a system of quality control for all Family Life topic notes, media and print materials prior to production. Among the measures to consider are:

Rigorous technical review to insure accuracy;

Professional quality proofreading and literacy-level review;

Pre-testing with target audience for feedback on comprehensibility and appropriateness.

The IEC unit should work closely with the REU to develop systems to monitor and evaluate all IEC activities.

The IEC unit should develop an integrated male motivation program including a family life presentation, radio programs and other materials. Other underserved targets, such as refugee populations, should also be considered for special attention.

The IEC unit should continuously monitor public and private media and materials production capabilities to ensure that it does not duplicate existing resources.

Research and Strategy Development

In 1989, all materials production was put on hold pending development of an overall IEC strategy. Since then, technical assistance has focussed on providing skills to collect the information necessary as input to strategic planning.

In order to provide that information, an extensive qualitative study (78 focus groups among seven types of users) was conducted from July 10 through August 9, 1990. At the same time, individual in-depth interviews were conducted with 40 service providers, and 202 teenagers responded to a questionnaire.

Findings

The research was multi-faceted and appears to have been well-executed. An expected result from this research will be the identification of major attitudinal barriers and practice gaps, as well as providing the basis upon which appropriate messages can be developed to address them. Most of this research was carried out in close collaboration with IEC unit staff who were trained in qualitative research. It is unfortunate the final stages of data analysis had to be conducted outside of Swaziland, thus depriving IEC unit staff of a good opportunity to learn about this important part of the research process.

The evaluation team observed that FLAS staff, MOH officials, and others involved in family planning in Swaziland refer to this research effort as one that will provide all of the answers to the many questions being asked about family planning knowledge, attitudes, and practices in Swaziland. These expectations may be inflated.

Recommendations

All future research analysis should be done in-country in collaboration with the IEC staff.

Some material development could be started before the final qualitative research report is available. For example, the condom pamphlet can be translated into siSwati. Also, some format design could be developed for other materials including contraceptive method specific pamphlets and revised materials for male and female teenagers. This will result in having prototypes available to pretest shortly after the official research findings have been reported.

The evaluation team reaffirms its support of the use of qualitative research methods. At the same time, the team observes that often studies involving many groups are no more valid than studies with fewer groups, i.e., in the future, useful findings may be obtained more quickly and with a much reduced level of effort and expense. Further, the team cautions that the results be viewed in proper perspective. Despite the large number of groups, they were not statistically sampled and thus, they are not representative of any larger populations.

Technical Assistance and Training

IEC technical assistance since 1989 consists of a needs assessment visit, two training sessions in focus groups (one for pre-testing in July 89 and one as preparation for formative research in March 90), supervision for the large-scale research study in July - August 1990, and training on production of slide-tape programs.

Findings

There have been long delays between TA visits, due mainly to the consultant's schedule. This has substantially delayed the progress of the IEC component, since all materials production was put on hold pending final report of the research.

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The research skills this TA has provided the IEC staff are impressive. The ability to execute the recent effort is commendable. Also, the successful development of the condom pamphlet mentioned earlier resulted from repeated pre-testing. The IEC unit head is currently undergoing management training at CAFS and will certainly require additional preparation and experience in IEC program development and management in the future.

Recommendations

Significant additional TA will be needed to conduct an IEC program of the scope planned by FLAS. Key short-term needs are to determine and prioritize objectives and to develop a program strategy. Once the program strategy is established, the focus shifts to program implementation and management of research and production activities.

The evaluation team recommends the appointment of an experienced IEC professional as a resident advisor in the IEC unit for a period of 12 to 24 months. The advisor would provide intensive on-the-job training in all phases of the program and would coordinate other specialized technical advisory services.

The FHS project should seek immediate short-term technical assistance, as needed, to carry out activities that have already been delayed excessively. Until the resident advisor actually arrives (or if none will be coming), the team recommends that short-term technical assistance visits be stepped-up, so as not to cause further delay.

LEADERSHIP AWARENESS ACTIVITIES

Increasing leadership awareness regarding the serious implications of rapid population growth on national health and development has been considered a priority goal in the FHS project by both FLAS and USAID. The team met with three members of parliament, as well as key MOH staff and leaders in the business community to discuss FLAS's contribution in this area.

Findings

The FHS project has used the media, workshops, and formal and informal educational talks to inform leaders in both the formal and traditional sectors of Swaziland to build support for child spacing and family planning activities.

In 1988, two workshops on "Population and Development" were organized and conducted by FLAS, one for Parliamentarians (June 1988) and the other for Principal Secretaries and Senior Government Officials (November 1988). The workshops resulted in the unanimous recommendation that steps be taken by the GOS to formulate a population policy, along with strategies to implement population policy goals.

In 1989, FLAS conducted a week long workshop (June 1989) for traditional healers to introduce them to modern contraceptive methods and increase their acceptance and awareness regarding the benefits of family planning. A two day seminar for religious leaders was held in November 1989 to increase their knowledge regarding the relationship between population growth and development and to build support within the religious community for population related activities in Swaziland.

The GOS is in the process of forming a Population Council to coordinate and mobilize population activities within Swaziland. According to a member of Parliament who is actively concerned about population issues, the establishment and development of a Population Council is a major priority. The Council's role will be to: formulate a population policy; act as a population information gathering and dissemination body; and promote population activities. He stated that "FLAS should actively "push" both the Ministries and Parliament to implement population programs."

It was the general opinion of all those interviewed that during the past two years there has been a noticeable increase in the level of awareness and concern among leaders in Swaziland regarding the negative effects of rapid population growth. This was largely attributed to the efforts of FLAS. The Prime Minister stated recently in a speech to literacy graduates that the illiteracy rate was linked to problems with over population and he called for families in Swaziland to produce fewer children.

There is strong support for and consensus on the need for increased population awareness and educational activities targeted to reach key persons in government, the Ministries, education (at all levels), and the traditional leadership sector (Chiefs), in addition to the general public.

The Permanent Secretary for Education stated that some money may be available for printing educational materials for use in school programs.

Recommendations

Leadership awareness activities should continue to be a priority activity in the FHS project. These should include increased use of the mass media, continued workshops for leaders in both the formal and traditional sectors, and educational programs in collaboration with the Ministry of Education.

Concise, effective brochures and other educational materials, which contain brief high "impact" population messages, based on the Rapid Presentation model, should be developed and distributed by FLAS as soon as possible. This material should be targeted to key decision makers in all sectors.

The FHS project should target government and private health and medical officials for a scientific update of their knowledge of contraceptive methods, risks and benefits of contraception, contraception and maternal and child health, and the safety and effectiveness of community based programs. Prominent leaders who

could alter the thinking of health professionals should be invited to make presentations and lead discussions. Suggestions include: Dr. Allan Rosenfield, Dean of Columbia University's School of Public Health and Professor of Obstetrics and Gynecology and Dr. O.A. Ladipo, Professor of Obstetrics and Gynecology, University College Hospital, Ibadan, Nigeria.

Strategies to support the development and effective utilization of the Population Committee to promote family planning activities in Swaziland should be considered a priority for FLAS as an organization.

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FINANCE AND ADMINISTRATION

The strategic and organizational dimensions of FHS project management have been dealt with in earlier sections of this report. This section is concerned with findings and recommendations related to the financial and administrative management support activities of the FHS project.

Findings

The FHS project is integrated into the overall organization of FLAS and FHS activities are carried out by the IEC and Service Delivery Units with the support of the Research and Evaluation Unit and the Finance and Administration Unit. In a recent reorganization, the Communications and Training Unit was abolished and incorporated into the IEC Unit, and the CBD program was transferred from the IEC Unit to the Service Delivery Unit. The Finance and Administration Unit reports directly to the Executive Director while the IEC, REU and Service Delivery Unit report to the Program Director. For the coming year, all units report to the Program Director who is Acting Executive Director while the Executive Director is on study leave in the U.K.

A Board of Directors oversees the operations of FLAS including hiring professional staff and setting salary schedules. The Board meets quarterly and most of its activities are carried out by committees, notably the program committee and the executive committee.

FLAS coordinates much of its work and communications through a series of regularly scheduled meetings including board and board committee meetings, a management committee meeting, and unit meetings. Meetings are regularly scheduled and minutes are recorded and filed. The evaluation team reviewed some of the minutes of the board program committee, board executive committee, the finance and administration committee, and the management team committee. The minutes appeared to be concise and in most cases included an action column indicating the nature of action required and the individual responsible.

The policies and procedures governing FLAS are set forth in a comprehensive policy manual with chapters on: constitution and by-laws, vehicle use, personnel, training and development, allowances, life assurance, and pension. Neither the manual as a whole nor the specific policies it contains are dated.

The evaluation team reviewed the file of job descriptions maintained in the executive offices of FLAS. The file was not well organized and several descriptions for the same position (some dated and some not) were included. The descriptions were uneven in that many did not include a qualifications and experience component. Where such a component was included, the incumbent of the position often did not meet the qualifications and experience for the position. There was no evidence in the file that employees had reviewed their own job descriptions, although some clinic personnel suggested that they felt their job descriptions were out of date and did not reflect their actual work. FLAS should also consider instituting a system of regular performance appraisal, tied to promotions and salary increases.

Top management and unit heads maintain schedules of activities and major reporting dates and other important events on calendar schedules usually displayed in offices. These are up to date and useful. Units prepare weekly schedules of activities and these are communicated to top management.

In January, 1989 FLAS moved to new facilities in a modern office building in Manzini. The offices are spacious and well appointed. Personnel of all units are easily accessible for consultation. Project HOPE recently moved into a suite of offices on the same floor of the building thus facilitating contact between the staff of FLAS and the HAPA project.

The storage facility for contraceptive supplies is secure and well organized. Since FLAS' clinics are nearby and since the CBD and industry-based programs are supplied during supervisory visits, distribution of supplies is not a problem.

During the evaluation team's visit, office services appeared to be effective including transportation, telephone services, photocopying, and facsimile transmission.

During Phase I a major effort was made to upgrade the financial management systems of FLAS. This entailed conversion from a manual system to a computerized system. The installation of the computer system is now complete and staff have been trained in its use. A continuing service contract is being negotiated with a local accounting firm to provide additional consultation and assistance in the use of the new system. At present aspects of the old manual system are still being used to carry out financial management functions.

The computerized accounting system installed in January by Aiken and Peat consultants is not being utilized to its full capabilities. For example, preparation of the monthly A.I.D. vouchers is being done manually, instead of generating a report from the Profitwise system. It does not appear the Finance Manager is sufficiently comfortable with the system to have it integrated into his daily job responsibilities and have it make his job easier instead of more difficult. The Finance Manager is not adequately trained in the computerized accounting system to allow him to make program changes and to carry out marginally complicated functions. Aiken and Peat consultants continue to provide assistance both via the phone and in person, although no service agreement is currently in place.

The evaluation team participated in discussions with FLAS and USAID concerning the procedures to be followed in submitting invoices to USAID and making payments to FLAS under the cooperative agreement. Questions arose about submitting charges before the completion of an activity and about whether reimbursement was to take the form of a direct payment or a charge against a previous advance of funds.

The evaluation team requested the Head of the Finance and Accounting Unit and the Pathfinder resident advisor to prepare an analysis of expenditures to date, and anticipated expenditures and available balances through the end of Phase I (January 31, 1991). These analyses (included as an annex to this report) indicate substantial balances available at the end of PHASE I.

The Pathfinder cooperative agreement has an approved budget of $875,000 for Phase I and the FLAS agreement has an approved budget of $525,000. The combined budget for Phase I is $1,400,000. Pathfinder projects expenditures of about $413,000 through January 31, 1991 leaving an available balance of $461,000. FLAS projects expenditures of about $140,000 through January 31, 1991 leaving an available balance of about $153,000. Based on average monthly rates of expenditures in the two organizations' budgets, the combined available balance of $615,000 would be sufficient for an additional thirty months.

Pathfinder explains the underspending as follows: the resident advisor was not appointed until seven months of the project had passed and has since cost less in overall support, professional time from Boston based staff was not used as planned, savings in travel as only partial air fare is charged when travel to and from Swaziland is combined with travel for other purposes, and savings in overhead attributable to savings in other categories. FLAS' explanation includes: savings in personnel due to delays in recruiting research officers, research assistant, and a graphic artist; and savings in supplies, training, and materials production due to the decision to defer these items pending the formulation of an overall IEC strategy.

At this point in its development the financial management component of the FHS is not carrying out analyses of cost per unit of output and cost-effectiveness studies. Such analyses, in collaboration with the REU are needed to document the cost of FLAS programs and to relate these costs to program accomplishments to guide management in priority setting and resource allocation. These analyses are especially important if the proposed industry-based program is to develop alternative packages of services at different cost levels for presentation to industries and businesses in Swaziland.

Recommendations

As stated earlier, FLAS should develop a more systematic approach to assure that all units are more involved in the design, planning, implementation, monitoring, and evaluation of each program component.

FLAS should revise, update, and date its policy manual and the job descriptions of all staff. Staff should be invited to read and comment on the policy manual and to review their job descriptions for accuracy.

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FLAS should assure that its contraceptive distribution system will be able to meet the demands that will be placed on it by a proposed major industry-based initiative.

FLAS should continue its efforts to complete the transition from a manual to a computerized financial management system. Continued staff training and the recruitment of a junior accountant with computer skills should be considered.

The Finance Manager could benefit from greater interaction with the Pathfinder auditor and financial management staff. To date this contact has been very limited. Some mechanism should be developed to allow the Finance Manager to develop his financial management skills — those skills which are necessary to successfully manage donor funds including liaison with the contracting officer, preparing vouchers, allowable and unallowable costs, cash flow, tracking vouchers and reimbursements, etc.

FLAS should fully exploit the capabilities of computerized accounting to develop analyses of amounts budgeted vs. amounts spent to track expenditures in relation to progress of the FHS project. Studies should also be undertaken of cost per unit of output and cost effectiveness for use in program planning, decision-making, and evaluation.

FLAS should submit monthly invoices as requested by A.I.D. and FLAS and USAID should jointly develop and adhere to mutually acceptable billing and payment procedures. The evaluation team suggests consideration of a mechanism whereby a revolving fund is established at a level representing FLAS' estimated monthly expenses over a period corresponding to the processing time for submission of invoices and their payment plus an allowance for delays (say three months). FLAS would submit invoices on a monthly basis and USAID would make payments to replenish the revolving fund.

FLAS and USAID should resume the schedule of regular monthly meetings to discuss progress and problems of the FHS project. Such regular meetings will foster communications in general and might serve to prevent some of the problems associated with billing and payment discussed above.

LIST OF ANNEXES

LIST OF ACRONYMS

LIST OF INDIVIDUALS AND INSTITUTIONS CONTACTED

LIST OF DOCUMENTS REVIEWED

SCOPE OF WORK

FHS SELF EVALUATION

FHS FINANCIAL ANALYSES: EXPENDITURES TO DATE, ESTIMATES THROUGH JANUARY 1991, UNSPENT BALANCES

ESTIMATES OF CONTRACEPTIVE PREVALENCE RATES FROM SERVICE STATISTICS

ESTIMATING CURRENT USERS FROM SUPPLY AND NEW USER DATA

JOHNS HOPKINS UNIVERSITY/POPULATION COMMUNICATION SERVICES LIST OF FILMS

TABLE OF ACRONYMS

A.I.D.	-	Agency for International Development
CAFS	-	Centre for African Family Studies
CBD	-	Community Based Distribution
CDC	-	Commonwealth Development Corporation
CDSS	-	Country Development Strategy Statement
CYP	-	Couple Years of Protection
FHS	-	Family Health Services
FLAS	-	The Family Life Association of Swaziland
FLE	-	Family Life Education
FP	-	Family Planning
FPIA	-	Family Planing International Assistance
FSE	-	Federation of Swaziland Employers
GOS	-	Government of Swaziland
IBD	-	Industry Based Distributor
IEC	-	Information, Education and Communication
IHP	-	International Health Programs
IPPF	-	International Planned Parenthood Federation
IUCD	-	Inter-Uterine Contraceptive Device
MCH	-	Maternal Child Health
MOE	-	Ministry of Education
MOH	-	Ministry of Health
MSH	-	Management Sciences for Health
NGO	-	Non-Government Organization
OC	-	Oral Contraceptive
PACD	-	Project Anticipated Completion Date
PCS	-	Population Communication Services
PHC	-	Primary Health Care
PPFA	-	Planned Parenthood Federation of America
REU	-	Research and Evaluation Unit
RHM	-	Rural Health Motivato
SBS	-	Swaziland Broadcasting Service
SIHS	-	Swaziland Institute of Health Sciences
STD	-	Sexually Transmitted Disease
TIPPS	-	Technical Information on Population for the Private Sector
UN	-	United Nations
UNFPA	-	United Nations Fund for Population Activities
URC	-	University Research Corporation

LIST OF CONTACTS

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DOCUMENTS REVIEWED

1. FHS Project Paper
2. Cooperative Agreement 8023 Attachment 1 and 2
3. Pathfinder/FLAS Memorandum of Understanding
4. Current 8023 Contract
5. Current 8021 Contract
6. Current 8023 Expense Report
7. Current 8021 Expense Report
8. 1989 FHS Workplan
9. 1989 FHS Chronogram as of 12 December 1989
10. USAID PIR April 1989 - September 1989
11. 1989 FHS Project Annual Report
12. 1989 Swaziland FP Service Statistics
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15. USAID PIR October 1989 - March 1990
16. Current Contraceptive Procurement Tables and 12 April 1990 Procurement memo
17. Current Quarterly Report (April 1990 - June 1990)
18. 1990 FLAS Service Statistics (current)
19. USAID FHS Evaluation Scope of work and FHS Response
20. FHS Activities List
21. FLAS Self Evaluation of FHS Project
22. FLAS Ninth Annual Report, January - December 1989
23. IEC Needs Assessment, Wilma Lynn, May 1989
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31. Swaziland 1987 Statistical Bulletin, 1988
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33. USAID Population Priorities, March 1990
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56. Material from focus group taining seminar, March, 1990
57. Material from focus group research, July 1990
58. Minutes of FLAS Finance and Administration Meeting (undated)
59. Minutes of FLAS Executive Committee Meeting, September 4, 1990
60. Minutes of FLAS Management Team Meeting Aug 17 1990
61. Minutes of FLAS Program Committee Meeting Nov 24, 1989
62. CBD Statistics, 1988 and 1989
63. CBD Evaluation Report, The Population Council, May 1990
64. CBD Operations Research Proposal, The Population Council, Summer 1990
65. CBD Evaluation Report, FLAS, March 1986
66. CBD KAP Questionnaire, FLAS (undated)
67. CBD EValuation Report, FLAS October 1987
68. Family Planning Coordination Meeting Aug 23 1990
69. FLAS Policy and Procedures Manual
70. Ministry of Health Primary Health Care Project Service Statistics through August 1990, dated September 14, 1990
71. Swaziland 1988 Family Health Survey Final Report, Ministry of Health, March 1990
72. Analysis of expenditures to date, estimates through Jan 1991, and balances available for both FHS cooperative agreements, FLAS and Pathfinder, September 1990.
73. Family Health Services Project Paper, USAID Swaziland, July 1988
74. Objective Tree of USAID Swaziland, July 1990
75. Concept Paper, Family Planning and Child Survival, USAID, Swaziland (undated).

ARTICLE III - STATEMENT OF WORK

Scope of Work. The evaluation will look at FHS in the context of USAID's evolving population portfolio and FHS's appropriate place therein, taking into account FLAS's own views of its current and future role in Swaziland. It should answer two basic questions:

What has been accomplished under Phase I of FHS and what should we do in Phase II?

Specifically, the evaluation will:

A) Assess progress in the production of project outputs over 19 months of implementation; recommend specific areas where, due to satisfactory progress or other reasons, emphasis should be lessoned in Phase II; and recommend where and how emphasis should be increased during Phase II. The project's original outputs are as follows:

i) Increased access to family planning services and provision of information on the health benefits of child spacing;

ii) Improved knowledge of the availability, benefits and use of family planning and child spacing;

iii) Improved capabilities for monitoring and evaluating program implementation;

iv) Improved technical and management skills of FLAS staff;

v) Increased leadership awareness of the implications of rapid population growth; and

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vi) An assured continued supply of contraceptives . (Problems with contraceptive procurement will be reviewed in a separate consultancy and need not be addressed in the evaluation.)

B) Recommend any revisions in project outputs to increase their specificity and measurability and to clearly differentiate them from the project's EOPS, which are described in similar fashion.

C) Recommend additions to or deletions from the project's outputs in light of their probable success and potential impact in achieving the project purpose.

D) Recommend appropriate changes in the project design in light of progress to data, FLAS's capabilities and interests, USAID's evolving population portfolio and the current status of family-planning in Swaziland.

E) Review FLAS's financial, managerial and personnel resources and the likelihood of completing and sustaining project activities in light of those resources. A shortage of personnel in FLAS's Research and Evaluation Unit and IE&C Unit are of special concern.

F) Recommend the optimal mix of technical assistance, either long or short-term, required during Phase II to attain the project's (possibly revised) objectives in a sustainable fashion The advisability of full-time TA in IE&C and industry based family-planning are of special interest.

G) Review the project budget and expenditures and recommend whether all or part of the planned addition of $1 million is required for Phase II.

As indicated above, USAID desires not only an assessment of progress to date, but a complete re-appraisal of the project and its objectives prior to initiating Phase II. We want to know whether we are headed in the right direction with FLAS and what changes in the project, if any, are advisable for Phase II. Of primary interest in this regard are the feasibility and modality of FLAS working with private industry on a significant scale; the advisability of making FLAS clinics models of professional excellence and innovation for possible use in training nursing students; the desirability of making FLAS a major source of mass-media education and promotion of family planning in Swaziland; the advisability of increased emphasis on leadership-awareness activities; and the advisability of support for FLAS's CBD program.

PHASE I SELF-EVALUATION
FAMILY LIFE ASSOCIATION OF SWAZILAND

USAID COOPERATIVE AGREEMENT 645-0228-A-00-8021/3

THE PATHFINDER FUND

SEPTEMBER 1990

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V. CONCLUSIONS

I. INTRODUCTION

The Family Health Services (FHS) Project is a five year project that began in July 1988. The first two and a half years (Phase I) have been funded through two cooperative agreements: one between USAID/Swaziland and the Family Life Association of Swaziland (FLAS), the other between USAID/Swaziland and The Pathfinder Fund (PF). As the scope of work for the mid-term evaluation indicates, while Phase I began in July 1988, the project did not field its Resident Advisor until February 1989, the effective starting point for most project activities. As a result, while Phase I was to cover a period of two and a half years, its evaluation has only nineteen months of project experience to review.

The specific goal of the FHS Project is to raise contraceptive prevalence to "at least 25%" by the end of the project, in July 1993. The Family Health Survey, conducted in October 1988 shortly after the start of the FHS project, estimated contraceptive prevalence to be 17 percent.

To achieve this goal the project expects six outputs at the end of the five years. These outputs are:

Increased access to family planning services

Improved knowledge about the availability, benefits and use of FP

Improved capabilities for research, monitoring and evaluating program implementation

Improved technical and management skills of program staff

An assured continual supply of contraceptives

Increased leadership awareness

In effect, the project outputs focus on three areas: Institutional Development (by improving monitoring and evaluation capabilities and management and technical skills); Increasing Demand (by increasing knowledge and leadership awareness); and Increasing Supply (by increasing access and assuring adequate contraceptive supplies)

The emphasis during Phase I was primarily on institutional development. This development was to enhance FLAS' ability to increase demand for FP services and to meet that demand by increasing access to FP services. The purpose is to strengthen FLAS such that FLAS can capably increase demand and supply for FP services in the private sector.

Within this framework we will assess the progress FLAS has made in each of the six outputs, and make preliminary recommendations regarding the emphasis placed on each.

II. INSTITUTIONAL DEVELOPMENT

Phase I has been viewed principally in terms of strengthening FLAS' capabilities to increase and meet demand for family planning services in the private sector. Overall, the project has improved FLAS capabilities in the areas of research, monitoring and

evaluation; IEC programs; clinical services; clinic management; and financial management. Two project outputs focus on institutional development: Improved monitoring and evaluation capabilities and improved management and technical skills.

A) IMPROVED MONITORING AND EVALUATION CAPABILITIES

Progress:

Many of the FHS project activities have focussed on this particular output, most of which focus on establishing the Research and Evaluation Unit (REU). The production of the REU is under the supervision of the Resident Advisor. The unit is expected to have its own unit head and one research assistant, however at the present the unit is staffed by 2 research assistants. One began work in June 1989 and is seconded from the Lutheran World Federation for a period of 18 months ending December 1990. The other began work in late July 1990.

The work of the REU has focussed to date principally on revising and computerizing the collection, analysis and distribution of FP service statistics, although recently it has undertaken more primary research activities.

The FP Management Information System (MIS) at FLAS is now fully computerized. Revisions made earlier this year have also ensured that the system is entirely compatible with the new system introduced by the Ministry of Health (MOH) as part of its Health Information System (HIS).

The FLAS system works as follows: FLAS nurses complete a daily visit register and the register's page totals. The REU gathers the page totals at the end of each month and produces monthly totals for FLAS, MOH and IPPF. Several summary reports on new users, revisits and supplies distributed are available, as are reports highlighting user/supply discrepancies, and graphs.

During 1989 FLAS also adapted its in-house MIS to produce and analyze Swaziland's 1989 summary FP reports for the MOH, although these are now integrated into the MOH's new system and for 1990 FLAS is responsible solely for its own service statistics. Details regarding its efforts in this area can be found in other annual and summary reports.

The REU also collaborated with the Primary Health Care Project (PHC), the MOH and UNFPA in the design and development of the FP component within the MOH's new HIS. The REU worked with UNFPA to design the new forms, and with PHC to produce instructions and training materials, and to provide training to users of the new HIS. Primary research activities within the REU have suffered principally from a lack of staff. As a result a number of specific research activities specified in the 1990 workplan have not yet been carried out. However, some research activities not specified in the workplan have been carried out. The REU responded to rumors of condom breakage with a survey of condom users, the results of which are being analyzed. The REU also keypunched and produced frequencies and tables from a teenage questionnaire administered as part of the IEC unit's market research activities. As part of the Private Sector FP Services Assessment the REU also prepared and distributed a questionnaire to the 380 members of the Federation of Swaziland Employers. Three studies that were planned for have not been carried out but remain of interest: 1) under utilization of the Malkerns Clinic 2) client dropout rates 3) client profiles. Efforts to develop an appropriate sample for the second and third have begun.

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In addition to its work on the FP MIS and FLAS service statistics, the REU has also assisted with the conduct of a baseline AIDS survey for FLAS' HAPA project, assisted Population Council with the evaluation of FLAS' CBD project, and has met periodic requests for population related research and statistics from other organizations.

The REU has also significantly improved FLAS' monitoring and evaluation skills in the area of contraceptive forecasting and procurement. FLAS is responsible for the procurement of Swaziland's contraceptive supplies, and the REU has helped improve the system through which this is accomplished. FLAS conducts quarterly inventories at Central Stores and produces Contraceptive Procurement Tables for Swaziland which are used by both IPPF and USAID as support for orders placed by FLAS. The REU also supports FLAS' forecasting and service statistics needs for IPPF work program budgets and three year plans. Additional detail regarding FLAS' efforts in this area are included under the output regarding contraceptive supplies.

The REU has not been the only unit to computerize its operations. The project has purchased and installed 4 IBM PS/2's - one for the REU, one for the Executive office, one for the financial office and one for the resident advisor's office. FLAS staff have been trained in WordPerfect, Lotus 1-2- 3, dBASE IV, and DOS.

FLAS has also improved its monitoring and evaluation capabilities in the area of financial management. The project contracted with a local accounting firm (Aiken and Peat) to revise and computerize FLAS' financial management system and to train FLAS staff in using the new system. This has been completed. Several reports and memos describe the assistance provided.

Recommendations:

While FLAS has improved its abilities to monitor and evaluate program implementation it must now find a way to sustain the activities of the REU, and that may be difficult. Staffing the REU has been the most persistent problem encountered under this output, both because of the limited number of qualified candidates and also because FLAS has been unable to attract the few qualified candidates to the positions available. The position of Unit Director will be filled by training the research assistant remaining beyond December. Another research assistant will need to be hired to replace the assistant departing in December. It is expected that once the unit has a trained and established unit head, the REU can expand its activities beyond service statistics collection and reporting.

Once the staffing issue is resolved, the unit should continue to play an active role in FLAS program activities. Notably, the IEC unit will require a great deal of research support, of both a qualitative and quantitative nature. In addition, FLAS management has some research needs that have not been adequately addressed, specifically utilization levels at Malkerns and client dropout rates. The REU should also be involved more directly in evaluating and expanding FLAS' CBD program. Finally, the REU will need to provide continuing support to FLAS in its role as the national contraceptive procurement agency.

Ultimately, with an adequate staff it should be possible for FLAS to generate some income with its REU, through both its computer services and research skills.

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B) IMPROVED TECHNICAL AND MANAGEMENT SKILLS

Progress:

In addition to the activities above which impact on this output, the project sent the FLAS Deputy Director to the Project Management Program at UCONN's Center for International Community Health Studies, sent its Industry Nurse to the Fertility Management Course at the Mauritius Institute of Health, and plans to send the Manzini clinic supervisor and the IEC unit head to courses at CAFS. As previously mentioned, Aiken and Peat's financial management training and the IEC unit's training in qualitative research methods have also improved FLAS technical and management skills. Finally, the project has enrolled FLAS staff in secretarial and correspondence courses.

The project anticipated providing technical assistance (TA) to further develop FLAS clinic protocols and to train nursing assistants in IUD insertion and FP counselling. Through a series of setbacks including FLAS staff shortages, incompatible schedules, and consultant availability little headway has been made on this activity, despite a great deal of planning.

Recommendations:

With the increased role played within FLAS by the IEC unit, the unit head needs some management training and perhaps additional IEC skills. The Executive Director is, during the course of this evaluation, embarking on a 12 month training course in Population Studies at Exeter. FLAS should proceed with its plans to obtain additional training in fund raising, and to identify and hire a marketing officer to assist with its expanded role in the private sector.

In general, this output could receive less emphasis in Phase II, and where needed, could be better addressed by bringing technical assistance to Swaziland for on the job training, rather than continuing to send FLAS staff out of Swaziland.

III. INCREASING DEMAND

Two project outputs focus on increasing demand for FP services: Improving knowledge about the availability, benefits and use of FP, and increasing leadership awareness of population problems and FP services.

A) IMPROVED KNOWLEDGE OF FP

Progress:

Expectations regarding activities under this project output have been significantly revised since the inception of the project. The project paper and initial workplans called for recruitment of a graphic artist, establishing an IEC materials production unit, producing new materials (which accounted for a large percentage of the FLAS project budget), and overseas training for the IEC unit head. Following two weeks of technical assistance from the Johns Hopkins University Population Communication Services (PCS) project, and the arrival of a new population officer at USAID/Swaziland, FHS supported IEC activities were essentially put on hold pending the results of large scale qualitative market research. Actual materials production was postponed until development of a comprehensive IEC strategy, which itself was pending completion of the market research.

With these revisions, The FLAS IEC unit was to develop the capability to systematically assess public perceptions regarding family planning; set specific communications objectives to change those perceptions; design IEC messages in light of those objectives; implement production and distribution of these messages through appropriate media; test message impact and revise the messages based on subsequent assessment of attitudinal changes.

To that end the IEC unit, and others, received training in qualitative market research techniques and developed a research workplan in March 1990, then conducted 6 weeks of market research in July and August, and received some training in audio visual production techniques. A final trip report on this research and training activity is expected within 2 weeks. A final presentation of findings from the research is expected in January 1991.

Recommendations:

Different consultants and teams have at various times over the past two years reviewed FP IEC activities in Swaziland. There have been claims that knowledge is high and claims that knowledge is low. One could be true or both could be true, the latter given different definitions of knowledge. There have been recommendations for a high tech materials production unit and recommendations for a unit limited to cassette and slide show materials. There have been recommendations to contract for outside production services, and to set up an in-house capability.

FLAS needs to develop an overall strategy, based on the newly completed market research, and obtain support for in house materials production, perhaps including a desktop publishing capacity. In addition, as mentioned elsewhere, the new IEC unit head needs some additional training in IEC program management.

B) IMPROVED LEADERSHIP AWARENESS

Progress:

FLAS has held workshops for traditional healers, religious ministers, business leaders and parliamentarians. A two day conference for ministry and parliament leaders was just completed, during which family planning received numerous endorsements. The king himself has at least publicly supported efforts to limit population growth. The press runs front page stories on how Swaziland's growth rate is among the highest in the world. FLAS still intends to hold workshops for village chiefs.

Recommendations:

FLAS would like to continue leadership awareness workshops, but with less emphasis on increasing the awareness family planning benefits and more emphasis on producing active leadership participation in FP program development. FLAS also believes continued leadership awareness efforts are needed as part of its efforts to promote adoption of a national population policy.

IV. INCREASING SUPPLY

Two project outputs focus on increasing supply: Increased access to FP services and; Assuring a continual supply of contraceptives.

A) IMPROVED ACCESS TO FP

Progress:

As has been stated repeatedly, improved access has principally been expected as an output of Phase II. During Phase I FLAS has stepped up its efforts in the private sector (filling the position of industry nurse, providing him training, and expanding its own private sector condom distribution program) and enhanced its own clinical services (as a result of a clinical needs assessment). As a result of the MOH/Population Council evaluation of its Community Based Distribution (CBD) project, FLAS also plans to expand its CBD pilot project activities, both by increasing the geographic area covered and also by expanding the services available through CBD agents.

As part of the anticipated expansion of project activities into the private industry clinics, FLAS and Pathfinder recently completed an assessment of private sector FP services available to employees and their families through the industries. The final report included a number of specific recommendations for Phase II activities.

Recommendations:

The extent to which FLAS should play an active role in improving access is determined by the question of whether contraceptive prevalence is suppressed by a lack of demand or a lack of supply. Westoff has recently made the case, as have others, that while the "KAP GAP" is traditionally used as an argument for increasing service availability, low usage levels accurately reflect demand and do not indicate high levels of unmet need. Preliminary findings from the Family Health Survey support this notion, at least among women who do not want any more children. Among that group, less than 3% were in need of FP services. However this is not a static group. Breastfeeders and ammenhoreic women are among those not in need, and the study excludes birth spacers.

It seems clear that in Swaziland, regardless of demand levels, access to FP services is indeed limited. Swaziland's numerous MOH clinics are underutilized at least in part because access to the facilities and staff is sometimes difficult to obtain. There is no alternative source of supply, such as a CBD program or an extensive employee based program, to meet the needs of those whose access to MOH and other clinics is limited. There is limited support for a social marketing program. And to date only condoms and foaming tablets have been available outside a clinic or hospital setting, and even these are not always available on a regular basis.

If in fact there is a clear need to increase access, there is still the question of whether or not FLAS has the resources to significantly enhance access. In 1989 FLAS' three clinics averaged 67 new users, 376 revisits, and 116 CYP per month. MOH clinics averaged 15 new users, 55 revisits, and 30 CYP. Other private sector services averaged even less. FLAS' three clinics already serve a disproportionately large percentage of the FP visits in the country. Its clinic in Malkerns, which FLAS considers underutilized, is among the busier clinics in the country. Access to its existing services is already quite high. As a result, FLAS' alternatives for increasing access include expanding the number of clinics it runs, expanding its CBD project, starting a marketing program, or playing a larger role in trying to increase access to FP services in the industrial sector.

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B) ASSURED SUPPLY OF CONTRACEPTIVES

Progress:

Despite ongoing difficulties assuring an adequate supply of contraceptives, a great deal of progress has been made in this area. Contraceptive Procurement Tables were first produced in June 1989, revised in September 1989 and revised again in March 1990. Revised demand estimates were recently reviewed and approved by an independent assessment team from IPPF. Inventories and stock card reviews are completed at least quarterly at central stores and recorded on standardized forms capturing balances, receipts, issues and expected balances. The destination and amount of all large issues for each brand are also recorded to monitor transaction patterns and the still informal use of regional supply depots. In general, all supplies are now procured either through Pathfinder (USAID supplied condoms, Lo-Feminal and IUD Cu-T 380A's) or IPPF (Noristerat, other orals, NeoSampoon).

Coordinating procurement has at times been difficult. USAID/Pathfinder, IPPF, and UNFPA are all involved to some extent in contraceptive supply. Recent changes in USAID commodity procurement regulations have also raised new questions about how USAID supplied commodities reach Swaziland. In addition there is no formal system in place for clinics to procure contraceptives from central stores. When a clinic detects the need for contraceptive supplies, it goes to central stores and picks some up. Or it goes to one of the larger clinics in the region to replenish its stores.

There is no order form completed, although the need for one has recently been discussed, and no way for the larger clinics to record the supplies given to the smaller clinics. FLAS is responsible for the estimation of demand and the procurement of supplies, but is not responsible for the warehouse, for distribution, for monitoring, nor for gathering the data it needs to accomplish its task. The MOH continues to have administrative problems such as adequately staffing the warehouse, accurately maintaining supply records, keeping the warehouse clean, disposing of expired contraceptives, clearing contraceptives through customs, and storing contraceptives anywhere other than central stores.

Recommendations:

Develop procedures which can accurately monitor the system already in place, i.e. collect requisitions from clinics procuring supplies, and enable regional outlets to record supplies given to other clinics as something other than supplies distributed to clients. FLAS and the MOH should further discuss how best to unify the entire process: estimating demand, producing procurement tables, ordering supplies, clearing supplies through customs, maintaining the warehouse, honoring and monitoring requisitions, delivering supplies to outlets, establishing the information system needed to monitor supply levels centrally and regionally, collecting commodities data, destroying expired commodities etc.

V. CONCLUSIONS

As expected, in the 19 months since FHS Project activities began in earnest, the project has focussed primarily on strengthening FLAS' institutional capabilities in the areas of monitoring and evaluation, IEC programs, clinical services, and management. While much progress has been made in this area, remaining institutional development needs include sustaining the research and evaluation unit, developing marketing and fund raising skills, developing material production capabilities and perhaps some additional management training.

Project support for efforts to increase the demand for FP services have focussed primarily on strengthening the IEC unit, conducting large scale qualitative market research, and promoting leadership awareness. For Phase II to actually generate significant increases in demand for FP services the FHS project must enable FLAS to develop an overall IEC strategy and to develop, distribute and test effective IEC messages capable of promoting FP acceptance and reducing barriers to contraceptive use.

Project support for efforts to increase the availability of FP services have focussed primarily on enhancing FLAS' own clinical services, on developing the capability to provide services to industry clinics (including the private sector assessment) and on assuring an adequate supply of contraceptives for Swaziland. Improving access to FP services in the country as a whole is beyond the scope of this project alone. Actually improving access will require, among other things:

1) enhancing the availability and quality of MOH clinical services,

2) establishing a large scale community based distribution program that in addition to supplying condoms and tablets can also resupply oral contraceptive users and recruit new oral users (with a clinic referral for follow-up);

3) improving the access employees and their families have to FP services through the workplace and/or company villages

4) liberalizing the marketing of contraceptives, either through a social marketing program or as part of the CBD and/or private sector projects.

5) continuing to assure an adequate supply of contraceptives

While FLAS cannot independently impact all of the above, during Phase II FLAS could contribute to these five potential improvements in FP availability as follows:

By enhancing its collaboration with FP training institutions and by portraying itself as a model clinic program FLAS can have some impact on the first. By expanding the services provided through its own CBD project FLAS can also have an impact on the second, although a large scale program will probably require mobilizing the MOH's rural health motivators. The private sector assessment concluded that with the support of the MOH and some additional marketing experience FLAS could play a significant role in the third, workplace family planning. By starting its own marketing program FLAS could contribute as a model program to the fourth, although this will require an expansion in the commodities procured with USAID funding. And finally, with the modified contraceptive logistics and management procedures discussed above, FLAS could have more impact on the fifth.

FHS PROJECT FINANCIAL ANALYSES

PROJECT START DATE:	JULY 1988
END OF PROJECT DATE:	JAN. 1991
FINANCIAL REPORTS TO:	JUNE 1990
MONTHS OF EXPENDITURES:	19
MONTHS REMAINING TO EOP:	7

I. PATHFINDER COOPERATIVE AGREEMENT (8023)

LINE ITEM	BUDGET AMOUNT	EXPEND TO DATE	AVERAGE MONTHLY	ESTIMATE TO EOP	BALANCE AVAILABLE
Personnel Compensation	251,290	80,896	4,258	30,987	139,407
Fringe Benefits	62,823	30,679	1,615	7,747	24,397
Allowances	44,597	19,397	1,021	14,722	10,478
Travel & Transportation	153,161	17,569	925	5,690	129,902
Consultants	40,804	17,550	924	21,809	1,445
Other Direct Costs	36,062	34,208	1,800	12,856	(11,002)
Indirect Costs	189,263	58,682	3,089	27,686	102,895
Participant Training	82,000	11,659	614	6,500	63,841
Equipment & Supplies	15,000	23,135	1,218	(8,388)	253
Total	875,000	293,775	15,462	119,608	461,617

II. FLAS COOPERATIVE AGREEMENT (8021)

LINE ITEM	BUDGET AMOUNT	EXPEND TO DATE	AVERAGE MONTHLY	ESTIMATE TO EOP	BALANCE AVAILABLE
A. EMALANGENI					
Personnel Compensation	79,105	15,296	805	5,635	58,174
Commodities	142,205	125,037	6,581	46,066	(28,898)
Supplies	49,900	6,367	335	2,346	41,187
Training	81,785	21,146	1,113	7,791	52,848
Lump Sum	40,500	39,525	2,080	14,562	(13,587)
Research	28,825	0	0	0	28,825
Materials Production	223,450	7,985	420	2,942	212,523
Emalangeni Subtotal	645,770	215,356	11,335	79,342	351,072
Dollar Equivalent	256,506	85,541	4,502	31,515	139,449
B. DOLLARS					
Commodities	20,560	11,655	613	0	8,905
USAID Activities	247,934	5,929	312	240,000	2,005
Dollar Subtotal	268,494	17,584	925	240,000	10,910
Total	525,000	103,125	5,428	271,515	150,359

III. FHS PROJECT TOTALS

LINE ITEM	BUDGET AMOUNT	EXPEND TO DATE	AVERAGE MONTHLY	ESTIMATE TO EOP	BALANCE AVAILABLE
PATHFINDER (8023)	875,000	293,775	15,462	119,608	461,617
FLAS (8021)	525,000	103,125	5,428	271,515	150,359
Total	1,400,000	396,900	20,889	391,123	611,976

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ESTIMATES OF CONTRACEPTIVE PREVALENCE FROM SERVICE STATISTICS

Swaziland's demographic indicators include a TFR (estimated at 5.1 by the 1988 Family Health Survey and 6.87 by the 1987 Statistical Bulletin) and a contraceptive prevalence rate of 16.9%, estimated by the 1988 Family Health Survey.

While the Family Health Survey was carried out in the tradition of WFS and DHS FP/KAP surveys, with the assistance of the CDC's Reproductive Health Division, the CPR estimate has often been questioned. During this evaluation the team and the Pathfinder resident advisor investigated the extent to which the contraceptive prevalence estimate of 16.9% could be supported by existing service statistics.

Swaziland's new (March 1990) Health Information System includes a family planning component with data on new users, revisits and supplies distributed, by method. Through the Primary Health Care project the team obtained data on each of these indicators through July 1990. Attached are two spreadsheets which estimate prevalence, one using visit counts and the other using supplies distributed, as presented in the HIS reports.

Using visit counts to estimate prevalence requires knowing the policies (or better yet, averages) regarding supplies given at each visit for each method. The following "rules" are presently used and incorporated into the model.

1. Pills: Three cycles to new users, 3 cycles at each revisit.

2. IUDs: The second visit is 6 weeks after the first, the third 3 months after the second, the fourth six months after the third and all subsequent visits at 9 or 12 months.

3. Injectables: the first, second, third and fourth visits are two months apart, the fifth is three months after the fourth, and all subsequent visits are three months apart.

4. Condoms: Clients receive 25 at each visit, which at 100/year last for 3 months

5. Tablets: Clients receive 20, which at 100/year are good for 2.4 months.

The following assumptions are also made in this model.

1. All revisits are for resupply

2. All visits are by women

The first model estimates prevalence as of July 31, 1990 as follows:

> All new users of orals in May, June and July are current users on July 31, as are all oral revisits from May, June and July because they all received 3 cycles. No visits prior to May are counted since all would have had to visit again before the end of July to continue use, under the above assumptions. No adjustment is made for wasted or unused cycles.
>
> All new IUD users in July are counted, as are half the new users in June, since new users must return in six weeks. All revisits are included for May June and July, because none have to return in less than three months. 66% of revisits from February, March and April are counted as current users, as we assume that 2/3 of those visits are due in 6 or more months. 33% of January visits are taken as we assume 33% of January visits are due in 9 or more months.
>
> All new injectable visits from June and July are counted, as are all revisits from June and July. Half the revisits from May are also current, since some (50%) of May's revisits do not need to return for three months.
>
> All condom new users and revisits are counted for the previous three months.
>
> All tablet new users and revisits for June and July, plus 40% of those from May are counted.
>
> Users of diaphragms, spermicides and other methods are excluded.

Under the above stated assumptions we estimate that on July 31, 1990 21,896 women were using contraception. While some of the above assumptions might lead to an overestimate, it would seem that any overestimation inherent in the model is offset and probably exceeded by the underestimate produced by incomplete reporting.

The 1986 census placed Swaziland's population at 681,059. Using a 3.2% growth rate over the past three years produces a 1990 population estimate of 748,555. We estimate from this figure that there are 157,197 women of reproductive age (21% of the total population). If 21,896 women are contracepting, this produces a contraceptive prevalence estimate of 13.9%.

The CPR can also be estimated from supplies distributed, under a similar set of assumptions, as evidenced by the second spreadsheet. In this model the inputs include the amount of supplies distributed for each method, the number of months over which these amounts were distributed, the number of new users served over the same time span, and estimates of continuation rates.

This model produces three estimates: The most generous assumes that all active users and all new users are "current". Under this assumption the prevalence rate is 15.09%. The least generous applies a 60% yearly continuation rate to all new users and active users served over the previous seven months. This assumption produces a CPR of 11.45%. An intermediate estimate applies the continuation rate only to the new users, since the active user estimate is based on the supply consumption rates over the entire period. This assumption produces contraceptive prevalence rate of 13.21%. (Note that these estimates are not to be confused with CYP, which have been included on the first spreadsheet. The supplies distributed over the first seven months of 1990 produce 12,453 CYP).

The service statistics not only offer a remarkable degree of internal consistency (as both the visit and supply models produce a contraceptive prevalence rate of approximately 14%), but also support the Family Health Survey's contraceptive prevalence rate of 16.9%. It could in fact be argued that, if the underreporting encountered within the service statistics system was eliminated, the prevalence estimates from service statistics would be comparable to (or possibly higher than) those derived from the family health survey.

ESTIMATING CURRENT USERS FROM FAMILY PLANNING VISIT COUNTS

	1990 FP VISITS								CURRENT USERS
	JAN	FEB	MAR	APR	MAY	JUN	JUL	TOTAL	31JUL90
NEW VISITS									
Orals	381	292	586	508	421	433	759	3380	1613
IUDs	155	40	122	65	50	42	80	554	101
Inject	465	477	664	473	604	430	369	3482	799
Condoms	343	607	591	403	455	550	835	3784	1840
Tablets	146	51	92	81	161	116	231	878	411
Dia	71	0	5	4	5	0	0	85	0
Spermicide	59	18	16	13	11	2	1	120	0
Other	80	23	101	3	1	0	3	211	0
									4764
REVISITS									
Orals	1205	941	1906	2076	1806	1772	1751	11457	5329
IUDs	184	133	249	244	245	173	207	1435	1105
Inject	1844	1460	2546	1771	2614	2237	2571	15043	6115
Condoms	445	398	1170	580	984	810	1456	5843	3250
Tablets	157	146	267	345	276	698	524	2413	1332
Dia	51	1	2	7	9	23	0	93	0
Spermicide	81	12	11	3	13	6	1	127	0
Other	101	11	15	7	1	3	2	140	0
									17132

USERS	21895.94
POP	748555.2
WRA	157196.6
CPR	13.93

ESTIMATING CURRENT USERS FROM SUPPLY AND NEW USER DATA

	Supplies Dist'd	Number Months	New Users	Yearly Factor	Contin Rate/YR
Pill	42667	7	3380	13	.6
IUD	1362	7	554	.4	.6
IUD (1989)	1089	12	366	.4	.6
Noris	22355	7	3482	6	.6
Depo	0	7	0	4	.6
Condom	176465	7	3784	100	.6
Tablet	27519	7	878	100	.6

				CURRENT USERS		
	New User Supplies	Supply Balance	Active Users	All New All Act	Adj New All Act	Adj New Adj Act
Pill	12816	29851	3936	7316	6528	5609
IUD	554	808	808	1362	1233	1044
IUD (1989)	366	723	723	1089	943	653
Noris	6094	16262	4646	8128	7316	6232
Depo	0	0	0	0	0	0
Condom	110367	66098	1133	4917	4034	3770
Tablet	25608	1911	33	911	706	698

USERS	23723	20759	18006
CPR	15.09	13.21	11.45
POP	748555		
WRA	157197		

CONTRACEPTIVE PREVALENCE AND GOS TARGETS

Through 1989, reports on Swaziland cited the following demographic indicators and family planning statistics:

Population Size (1986 Census)	681,059
Population Size (1990 Projection at 3.2% per year)	748,555
Women of Reproductive Age (21% 1990)	157,197
Rate of Natural Increase	3.20
Total Fertility Rate (1987 Stat Bull.)	6.87
Total Fertility Rate (1988 FH Survey)	5.10
Contraceptive Prevalence Rate (WB)	4.00%
Contraceptive Prevalence Rate (FHSurv)	16.90
Previous Target CPR	15.00%
Current Target CPR	30.00%

The evaluation team noted considerable discussion concerning the results of the Family Health Survey and the extent to which the new target CPR was a realistic target. Discussions with representatives of the Primary Health Care Project, the Pathfinder Resident Advisor, and a UNISWA demographer produced the following observations. The CDC is a respected survey research organization with considerable experience in conducting surveys of the type carried out in Swaziland. Their methods are proven and tested and have been reviewed extensively by peers in the field. Their instruments have been repeatedly validated and successfully adapted to a variety of national settings. There is little reason to suspect the Swaziland survey results.

The evaluation team met with a representative of the Department of Demography and Statistics of UNISWA to discuss the discrepancies between the TFR's calculated from Census Data and the Family Health Survey. It was noted that the Age-Specific Fertility Rates from both sources were virtually identical and that the differences were due to upward adjustments in the census data to reflect underreporting of children born in the past year when collected during census enumeration. The ASFR's obtained from the survey were not adjusted. This may be justified by more in-depth interviewing and probing by better trained interviewers in a survey context. Further demographic analysis of this discrepancy should be undertaken as well as study of the relationship between a TFR of 5.1 and a CPR of 16.9. The Bongaarts Target model is a useful tool for such analysis as well as for determining whether the 30% CPR targeted for the end of 1991 is a realistic target. (Review of family planning program accomplishments to date, discussions

with various family planning managers and advisors, and observations of selected health service delivery systems at industrial estates suggest that the 30% CPR target may be achievable in urbanized areas and on industrial estates pursuing aggressive family planning programs. The 30% target appears to be optimistic for rural zones).

The evaluation team, in collaboration with the Pathfinder advisor and based on data from the Health Information System established by the Primary Health Care Project, attempted to estimate contraceptive prevalence from current family planning program service statistics. Using the 1990 data collected through August for all reporting units, the estimate made assumptions about supplies given to new clients and revisiting users in May, June, and July, in order to generate a numerator for the calculation. This numerator was not adjusted to reflect non reporting service units (estimated at 20%) and the result was applied to the denominator of women of reproductive age producing an estimated CPR of 13.93%. A similar estimate was made using data on contraceptive supplies distributed in the same period. Admittedly these are rough estimates, nevertheless the results produced CPR's ranging from 11.45% to 15.09% as of July 31, 1990.

The estimates from service statistics offer a remarkable degree of internal consistency and support the Family Health Survey's contraceptive prevalence rate of 16.9%. It could in fact be argued that, if the estimated 20% underreporting encountered within the service statistics system was eliminated, the prevalence estimates from service statistics would be comparable to (or possibly higher than) those derived from the family health survey. The estimation methods used and the results obtained are included in an annex to this report.

Repeated exercises of this kind (with refinements) may be used to track the progress of the CPR until mid-1992 which is the earliest date for new data to be available from the planned baseline study of the anticipated new Child Survival Project.

THE JOHNS HOPKINS UNIVERSITY
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CENTER FOR COMMUNICATION PROGRAMS

FILM LIST

All 16-mm films in this listing were produced by The George Washington University Airlie Center with funding from the U.S. Agency for International Development. They are now distributed by Population Communication Services from the Center for Communication Programs at The Johns Hopkins University.

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The films are also available on a rental basis, U.S. only.

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Ms. Ann Simmons
Population Information Program
The Johns Hopkins University
527 St. Paul Place
Baltimore, MD 21202
USA
Telephone: (301) 659-6300

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Contact:
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Population Communication Services
The Johns Hopkins University
527 St. Paul Place
Baltimore, MD 21202
USA
Telephone: (301) 659-6300

October 1988

Population Communication Services
The Johns Hopkins University
16-mm Films

Title: The Cheerful Revolution

Language: Arabic, Chinese, English, French Portuguese, Spanish

Audience: Policy makers, family planning promoters

Setting: Thailand Date: 1979

Length: 25 minutes Price: $160.00

Commentary: This entertaining and fast-paced film describes how community development has been integrated into Thai Coummunity Based Family Planning Services, under the guidance of Mechai cooperation to achieve a climate for social change and depicts the unique, playful approaches used by Mechai to make family planning and contraceptive methods familiar and acceptable--condom inflating contests, T-shirts bearing family planning slogans, and more, Shows rural and urban approaches to family planning and discusses how new ideas are creatively integrated with old valus and customs.

Title: Choice Not Chance

Language: English

Audience: General public, family planning acceptors

Setting: Jamaica Date: 1973

Length: 10 minutes Price: $80.00

Commentary: A film about men's attitudes toward family planning using narration, discussion and testimony of urban Jamaican men. "Family planning is not just for your woman," summarizes the narrator. "It's my future and I'm not leaving it up to chance." The basic ideas of family size and economic hardship are discussed with emphasis on the loss of individual opportunity for a man with many children.

Title: The City: Implication for the Future

Language: English, French, Portuguese, Spanish

Audience: Policy makers

Setting: Colombia Date: 1977

Length: 19 minutes Price: $130.00

Commentary: The reasons for rural to urban migration and its consequences are discussed using the example of Bogota, Columbia. A successful community based distribution (CBD) program of PROFAMILIA serving these new urban residents offers one positive step in assuring them easy access to contraceptives and an alternative to the large family. It concludes by contending that urbanization is irreversible and that more services as well as expansion of the present family planning program are needed.

Title: Communicationg Family Planning: Speak--They are Listening

Language: English

Audience: Policy makers, family planning promoters

Setting: Costa Rica, El Salvador, Hawaii, Indonesia, Kenya, Korea, Pakistan, Philippines, Tunisia, Vietnam Date: 1974

Length: 28 minutes Price: $190.00

Commentary: Case studies from many countries explore family planning communication. The film describes a variety of messages and channel for their delivery, including the use of field workers to inform and educate th public. Discussed are various information, education, and communication (IE&C) media, including flipcharts, radio television, films and traditional music and drama incorporating family planning messages. Emphasizes the need to pretest and evaluate IE&C materials and messages. The necessary components for successful communication programs are described.

Title: Indonesia: Family Planning First

Language: English

Audience: Policy makers, family planning promoters

Setting: Indonesia | Date: 1978

Length: 23 minutes | Price: $140.00

Commentary: The village family planning program in Java and Bali has contibuted to a remarkable decline in fertility. The film explains how--in a rural, traditional and relatively poor society-family planning has become an integral part of village life. Reasons fc success include: strong government support, a visible and well-known education and information program, strong assistance from donor countries, utilization of the existing political and community structure and acceptor's clubs.

Title: Laparoscopic Equipment Care

Language: Chinese, English, French, Portuguese, Spanish

Audience: Medical personnel

Setting: General | Date: 1979

Length: 25 minutes | Price: $160.00

Commentary: This film is divided into two sections, "Care of the Laprocator" and "Care of the Dual Purpose Laparoscope." The former device : a laparoscope used for tubal sterilization by electrosurgery, tr latter is a dual-purpose laparoscope for Falope-ring applicatic and electrosurgery. The film demonstrates step-by-step assembl preparation for cleaning, and care of these instruments. It ca be used to teach proper maintenance practices, which are essent for the continued functioning and effective use of laparoscopic equipment. Used by The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). (See also Technique of Laparoscopy.)

Title: Lessons for the Future

Language: English, French, Portuguese, Spanish

Audience: Teachers

Setting: Mexico

Date: 1980

Length: 17 minutes (in English, French and Portuguese)

Price: $120.00 (in English, French and Portuguese)

19 minutes (in Spanish)

$135.00 (in Spanish)

Commentary: This film focuses on the teacher's influence on social change as it was discussed in a planning conference on the teacher's role in the Mexican population program. The three stages of this program -delaying reproduction until the age of 23-25, spacing one's children, and early termination of one's reproductive capacity--are illustrated by the examples of three teachers shown in and out of the classroom. These teachers demonstrate their concern for their students by becoming agents of change.

Title: Mexico in the Year 2000

Language: English, Spanish

Audience: Opinion leaders (local), policy makers

Setting: Mexico

Date: 1979

Length: 12 minutes (in English)

Price: $85.00 (in English)

17 minutes (in Spanish)

$120.00 (in Spanish)

Commentary: The film describes Mexico's rapid development growth since the year 1900, and projects increasing problems in labor, housing, food production and education for a population likely to double in the year 2000. The film proposes family planning as one of the solution to the problem. Most scenes focus on heavy industry and crowded cities. Produced in cooperation with the Mexican government.

Title:	The Moment of Truth		
Language:	English		
Audience:	Family planning promoters, medical personnel		
Setting:	Jamaica	Date:	1973
Length:	10 minutes	Price:	$80.00

Commentary: This film shows an effective family planning/contraceptive choic group which is part of Jamaica's post-partum program. A nurse demonstrates teaching techniques as the narrator points out impo tant training techniqus: "use charts and visual aids," anticip questions un-asked due to shyness," "be candid about side effec "be positive." Narrator states that these couseling sessions w mothers, before they go home, are a successful part of Jamaica's national plan to slow rapid population growth because they educ and motivate mothers when they are available and receptive. Fi begins showing birth of a child.

Title:	A Question of Choice		
Language:	English, French, Spanish		
Audience:	Policy makers, medical personnel		
Setting:	Bangladesh, El Salvador, Philippines, Thailand, USA	Date:	1978
Length:	23 minutes	Price:	$150.00

Commentary: The film presents examples of voluntary sterilization programs i Bangladesh, El Salvador, the Philippines, Thailand, and the US. Services include clinic- and hospital-based programs and outreac mobile surgical teams. "Full and candid counseling is the keystone" to the voluntary sterilization programs. The film emphasizes the worldwide acceptance of sterilization as a method of permanent contraception.

Title: Social Marketing

Language: English, French, Portuguese, Spanis

Audience: Family planning promoters, policy makers

Setting: Bangladesh, El Salvador, Jamaica

Date: 1978

Length:

Price: $145.00

Commentary: The delivery of condoms and oral contraceptives through a social marketing or commercial retail sales program is demonstrated usin projects in Jamaica, El Salvador, and Bangladesh as examples. In all three of these countries, product marketing campaigns have made use of indigenous research, product symbols and slogans, advertising, education, and the selection and development of new and traditional outlets to increase contraceptive availability an use.

Title: Sowing the Seeds of Health [Sembrando salud]

Language: English, Spanish

Audience: Family planning promoters, general public

Setting: Mexico

Date: 1979

Length: 22 minutes

Price: $145.00

Commentary: Using three short dramatized stories, the film shows how trained village women in Mexico help to change attitudes about health ca practices--primarily maternal, childcare, and family planning guidance.

Title: To the People

Language: English

Audience: Policy makers

Setting: Bangladesh, Egypt, Tunisis Date: 1977

Length: 23 minutes Price: $150.00

Commentary: Case studies in Bangladesh, Egypt, and Tunisia demonstrate successful household delivery of oral contraceptives. Leaders in these two countries explain how direct household distribution programs have been put into operation. From these case studies other pilot projects in household distribution some "fundamental truths" are derived: oral contraceptives can be distributed through home visits without major problems; oral contraceptives one's hand" are most persuasive; oral contraceptives are perceiv as valuable; and household delivery has resulted in a leap of acceptance among rural women.

Title: Two Roads [Dos caminos]

Language: Enlish, Portuguese, Spanish

Audience: Adolescents

Setting: El Salvador Date: 1979

Length: 21 minutes Price: $140.00

Commentary: This short dramatic film, made in El Salvador, addresses the problems caused by ignorance about human sexuality and by myths about how a girl can become pregnant. It depicts two village girls who go to the capital for schooling. One is studious and returns to her village to work in the health clinic. The other becomes enchanted with the city's social life, becomes pregnant and dies following an illegal abortion. The film is narrated b the surviving girl. Discussion guide included.

Title: Technique of Laparoscopy

Language: Chinese, English, French, Portuguese, Spanish

Audience: Medical personnel

Setting: Thailand Date: 1979

Length: 16 minutes Price: $115.00

Commentary: This introductory medical training film shows female sterilizatic by laparoscopy under local anesthesia in an outpatient clinic. Preoperative evaluation, including history-taking, contraindications, counseling, and informed consent; operative technique and instrumentation; and postoperative procedures are demonstrated. In addition, several diagnostic uses of laparoscopic equipment are described. (See also Laparoscopic Equipment Car

Title: The Time of Your Life

Language: English

Audience: Adolescent girls

Setting: Jamaica Date: 1973

Length: 11 minutes Price: $85.00

Commentary: This film carries the message of responsible parenthood through a of young women choosing to plan thir futures for further education, training or career. It includes the opinions of many young women and is accompanied by youthful music.

Title: We Go Where They Are

Language: English, Spanish

Audience: Policy makers, family planning promoters

Setting: Colombia | Date: 1977

Length: 12 minutes | Price: $85.00

Commentary: The successful community based distribution (CBD) program of rura Colombia is portrayed by following the work of a family planning promoter and one of her contraceptive distributors. The film stresses the importance of recruiting highly-respected women as distributors and attributes program success to these rural women.

Title: You [Tu]

Language: English, Portuguese, Spanish

Audience: Adolescents

Setting: Mexico | Date: 1976

Length: 15 minutes | Price: $100.00

Commentary: The film depicts a young man in his last year of medical school a his fiance as they plan for their future. The narrator describes the differences between this young couple's hopes for the future those of their parents at a similar age, and the changes in the world in which they live. The couple decides to have two childr after waiting a few years so they can enjoy life without a great financial burden. Main message is to plan ahead for the number children wanted.