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**MIDTERM EVALUATION OF THE
BOTSWANA POPULATION SECTOR
ASSISTANCE PROGRAM
(BOTSPA)**

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Glossary

A.I.D.	U.S. Agency for International Development
AIDS	acquired immune deficiency syndrome
BDF	Botswana Defence Force
BOFWA	Botswana Family Welfare Association
BOTSPA	Botswana Population Sector Assistance Program
CAFS	Centre for African Family Studies
CBD	community-based distribution
CES	Continuing Education Section
CMS	Central Medical Stores, MOH
CP	conditions precedent
CSM	contraceptive social marketing
CSO	Central Statistics Office
CYP	couple year of protection
EPI	Expanded Program on Immunization
FHD	Family Health Division
FIFO	first in, first out
FP	family planning
FY	Fiscal year
GOB	Government of Botswana
HEU	Health Education Unit
HPN	health, population, and nutrition
IEC	information, education, and communication
INTRAH	International Training for Health
IPPF	International Planned Parenthood Federation
IPSCPD	Interministerial Programme Steering Committee for Population and Development
IUD	intrauterine device
KAP	knowledge, attitudes, and practices
MCH/FP	maternal child health/family planning
MFDP	Ministry of Finance and Development Planning
MIS	management information systems
MLGLH	Ministry of Local Government, Lands, and Housing
MOE	Ministry of Education
MOH	Ministry of Health
NHI	National Health Institute
NDP-7	National Development Plan-7
NGO	non-governmental organization
NPA	non-project assistance
OPTIONS	Options for Population Policy (project)
ORS	oral rehydration salts
PAAD	project assistance approval document
PATH	Program for Appropriate Technology in Health
PHC	primary health care
PID	project identification document
PTA	Parent-Teachers Association
pula	Botswana unit of currency
S&T/POP	Bureau for Science and Technology/Office of Population, A.I.D./Washington

STD	sexually transmitted disease
SWEDIS	Inventory Monitoring Software used by CMS
TOT	training of trainers
ULGS	Unified Local Government Services
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development (mission)
WRA	women of reproductive age
YWCA	Young Women's Christian Association

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Executive Summary

Background and Objectives

The goal of the Botswana Population Sector Assistance Program (BOTSPA) is to assist the Government of Botswana (GOB) to strengthen the effectiveness and efficiency of its population and family planning programs and services through a process of policy formulation and implementation. Of the five million dollars earmarked for this project, \$3,000,000 are in the form of non-project assistance (NPA) funds, and \$2,000,000 are projectized funds. The project agreement, signed in July 1988, covers a five-year period.

BOTSPA's objectives in seven programmatic areas are to

- Support GOB efforts to develop a national population policy,
- Improve coordination among GOB institutions dealing with population programs,
- Improve the contraceptive logistics system,
- Expand IEC services,
- Improve the delivery and management of MCH/FP services,
- Increase the number of trained staff for population programs and increase the GOB financing in the population sector, and
- Expand participation of non-governmental organizations (NGO) and the private sector in population programs.

The specific objectives of this evaluation are

- To evaluate progress toward established objectives in seven programmatic areas,
- To assess the effectiveness of NPA in this project,
- To assess project management by GOB and USAID, and
- To re-examine the validity of the assumptions underlying the design of BOTSPA.

Findings

The main findings regarding the seven programmatic areas can be summarized as follows:

- **Policy.** There has been little progress toward developing a population policy, although National Development Plan-7 (NDP-7) paves the way for its development in the future.
- **Coordination.** The Interministerial Programme Steering Committee for Population and Development (IPSCPD) exists, but has neither an official authority nor a support staff to implement recommendations. The anticipated Population and Development Unit within the Ministry of Finance and Development Planning (MFDP) has yet to be formed.
- **Expansion of Maternal and Child Health/Family Planning Services.** Access to services is excellent by developing country standards; facilities are well equipped and clean. Integration of MCH/FP services has been successfully achieved, and authority has been decentralized from the central level to the districts.

- **Information, Education, and Communication (IEC) Activities.** Most work to date has focused on interpersonal communication and family life education. There is a need for greater use of mass media, as well as targeting of key populations (men, adolescents, policy makers), a recommendation also made by two conferences on population and development attended by high-level officials..
- **Contraceptive Logistics.** Impressive progress has been made by GOB in procuring its own contraceptives with non-donor funds, and systems exist to assure a timely flow of contraceptives to the field. Greater effort needs to be focused on improving the field management information system (MIS) and training staff in its use.
- **Number of Trained Staff and GOB Support of Family Planning.** Targets for short-term training were met, but there is a great need for a more systematic training strategy and greater in-service training. Available data do not allow for an assessment of overall GOB funding for family planning, although GOB has made excellent progress in contraceptive procurement.
- **Participation of NGOs.** This activity is still in the inception stage.

Other key findings regarding the funding mechanisms and management include the following:

- NPA as a funding mechanism has not been effective in overcoming two major GOB constraints: lack of action in areas critical to the development of a population policy (i.e., sensitization and consensus-building at the grassroots level) and lack of manpower to implement project activities in all seven programmatic areas.
- The perceived benefits of NPA (transferring the full responsibility of project implementation to the GOB, lightening the management load on USAID) have not been realized in practice.
- Although the GOB may have the absorptive capacity for this type of project, it did not succeed in fully harnessing its human and material resources in implementing and monitoring this project.
- USAID/Botswana also experienced difficulties in providing adequate managerial support to this project, although this problem appears to have been largely resolved by the hiring of a project manager as of December 1990.
- Correct assumptions underlying the project design are that BOTSPA is in line with GOB and USAID strategies, and that institutional/structural constraints exist which impede the expansion of family planning services.
- There are several assumptions which have not proven true: the lack of a population policy has not impeded expansion of family planning services, the GOB has not had the manpower needed to fully implement BOTSPA, and NPA has not proven an effective funding mechanism in this situation.

Recommendations¹

1. USAID should give BOTSPA a no-cost extension to allow additional time to work toward project objectives.
2. USAID should redesign the BOTSPA project, eliminating the NPA approach which has not proven effective in this specific project. All funds should be reprogrammed as project funds.
3. Under the reformulation of the project, the principal goal and main priority should be improved/expanded family planning service delivery. Policy formulation should receive support, but take second priority to service delivery.
4. MFDP should continue to play a central role in setting policy which will affect the population/family planning activities of individual ministries, in anticipation of the formulation of a population policy and the establishment of a permanent Population Unit.
5. In line with the GOB policy on decentralization, BOTSPA in its next phase should concentrate its efforts on the district (e.g., district teams and personnel).
6. Recommended areas of focus over the remaining life of BOTSPA should include upgrading the family planning skills of service providers, expanding the method mix available at the health post level by training all enrolled nurses in IUD insertion, adding implants to the method mix and expanding the family planning base further into the community through community-based distribution channels.
7. The MOH should finalize, approve, and implement use of the health systems' manuals on supervision, communication, referral, and health information systems.
8. The MOH and the Ministry of Local Government, Lands, and Housing (MLGLH) should conduct an updated needs assessment to ascertain equipment/logistics needs of isolated district health facilities and action should be initiated to meet priority, essential requirements.
9. The Family Health Division (FHD) should plan family planning promotion activities to include targeted campaigns to motivate clients to seek services. Audience segmentation, analysis of available research, and new research to determine why services are currently underutilized will increase the potential effectiveness of these campaigns.
10. FHD should conduct additional training in contraceptive logistics. This training should be expanded to include carefully considered interventions in the reporting system that include stock level reporting.
11. In the shorter term, FHD should request district health team assistance in the immediate distribution of those contraceptives, particularly Ovrette, which are nearing expiration.
12. FHD should implement the processes suggested in Appendix C to calculate continuation rates, method mix, and age and parity distribution.

¹Of the total list of recommendations, the most important are summarized here.

13. The MOH should design supervisory systems that promote the local use of family planning data and implement these procedures at facilities and districts through an MIS training process.
14. Short-term regional training should be emphasized and long-term undergraduate training de-emphasized in the next BOTSPA phase.
15. USAID support for NGOs should be continued and increased; GOB should be kept apprised of their efforts, but future grants should be monitored by USAID (or its contractor). USAID should understand that NGO support will require infrastructure development and training.
16. GOB should designate a project coordinator who can devote full time to coordinating and monitoring the activities of different divisions and units toward the achievement of project objectives.
17. Performance indicators should be established in family planning service delivery, in-service training, IEC, and MIS.
18. The USAID project manager should maintain frequent and open communication with the GOB project coordinator and other GOB officials involved in implementing population activities, in an effort to strengthen the partnership between GOB and USAID.

1. Introduction

1.1 Background on the Botswana Population Sector Assistance Program (BOTSPA)

1.1.1 Goals and Objectives of BOTSPA

Botswana was one of the first African countries to recognize the implications of rapid population growth for socio-economic development. In its recently approved National Development Plan-7, the Government of Botswana (GOB) has reiterated its commitment to reducing the high rate of population growth (currently 3.4 percent per annum). The GOB seeks to achieve a balance between population growth and the country's resources in an effort to improve the health status and quality of life of its population.

The goal of the BOTSPA project is to assist the GOB to strengthen the effectiveness and efficiency of its population and family planning programs and services through a process of policy formulation and implementation. The BOTSPA agreement, signed in July 1988, covers a five-year period. The seven objectives of the program are to

- Support GOB efforts to develop a national population policy;
- Improve coordination between GOB institutions dealing with population programs;
- Improve the delivery and management of maternal and child health/family planning (MCH/FP) services;
- Expand information, education, communication (IEC) services;
- Improve the contraceptive logistics system;
- Increase the number of trained staff for population programs and increase GOB financing in the population sector, particularly for contraceptive procurement; and
- Expand participation of non-governmental organizations (NGO) and the private sector in population programs.

1.1.2 The Dual Funding Mechanism

Bilateral population assistance is conventionally given in the form of project support for specific activities mutually agreed upon by the host country government and USAID, in which USAID plays a significant role in project management. The BOTSPA project differs in that it has a dual funding mechanism: a "non-project assistance" (NPA) component of \$3,000,000 and a "projectized component" of \$2,000,000 to cover technical assistance, training, and related support costs. BOTSPA represents one of the first times the NPA approach has been used to fund activities in the population sector, and thus the evaluation of this mechanism is especially pertinent.

The NPA component, also known as "sector assistance," is designed to encourage the GOB to maintain momentum in improving its population policies and programs. Under this mechanism, described in greater detail in Chapter 3, the GOB and USAID agree upon a certain number of policy and institutional reforms to be carried out over the life of the project. As each set of reforms or actions (known as "conditions precedent") is fulfilled, USAID disburses a "tranche" of funds to the GOB. In the BOTSPA project, the total of \$3,000,000 in NPA assistance is to be disbursed in five tranches over the five-year life of the project. To date, only one of the five tranches has been released (\$900,000 in NPA), while \$1,600,000 has been made available in project funds.

For each disbursement of NPA funds (in dollars), the GOB agrees to deposit an equivalent amount in local currency (*pula*) into a special account, to be used to support activities in the population sector. Although the use of these funds must be programmed jointly by GOB and USAID through an annual workplan, this mechanism is intended to give the GOB a stronger role in determining funding priorities and greater flexibility in accessing these funds.

The second vehicle for funding BOTSPA is the projectized component. This involves the conventional mechanism whereby the government and USAID agree to a set of activities to be carried out toward the achievement of project objectives; USAID then manages the funds used to cover these activities. In the BOTSPA agreement, these are intended primarily to cover technical assistance, training, and other costs in support of the seven project objectives outlined above. These funds are also jointly programmed by GOB and USAID through an annual workplan. Throughout this report, the phrase "project funds" refers to this type of dollar account managed directly by USAID.

1.1.3 Responsibilities for Project Implementation

The responsibility for implementing BOTSPA lies with three ministries of the GOB. The Ministry of Finance and Development Planning (MFDP) is responsible for coordinating programs and activities financed by the NPA component and for managing population analysis activities through its Central Statistics Office. The Ministry of Health (MOH) and the Ministry of Local Government, Lands, and Housing (MLGLH)¹ are responsible for executing specific programs and activities (financed by either of the two mechanisms).

USAID is responsible for monitoring and evaluating GOB progress in meeting the mutually agreed upon performance targets under the NPA component and for jointly managing the projectized component through annual workplans submitted by the GOB.

1.2 Purpose and Objectives of the BOTSPA Evaluation

The project agreement for BOTSPA did not call for a midterm evaluation; rather, progress was to be charted through program review meetings and annual population-based sentinel surveys.²

¹At the time the project agreement was signed, the name was Ministry of Local Government and Lands. It has since been modified.

²These surveys are conducted in a few areas rather than nationwide and are repeated periodically.

However, a joint USAID-GOB review of the program held in April 1991 identified significant problems in program implementation and signaled the need for a midterm evaluation.

USAID/Botswana and GOB intend to use the findings and recommendations of this evaluation to re-examine the role of the BOTSPA project within the GOB's population/development activities. The evaluation will also provide a basis for USAID/Botswana to address the following management issues:

- Is BOTSPA an appropriate mechanism for eliminating constraints to more effective family planning programs in Botswana?
- Have USAID and GOB had adequate managerial capability to implement a program of the scope and nature of BOTSPA?
- Should USAID consider modifying or redesigning its population strategy and/or the BOTSPA project?

The specific objectives of this evaluation are

- to assess progress toward established objectives in seven programmatic areas;
- to assess the efficiency and effectiveness of the funding mechanisms (both the NPA and projectized components), as well as their impact and sustainability;
- to identify factors (both positive and negative) which have influenced the implementation of BOTSPA; and
- to re-examine the validity of the assumptions underlying the design of BOTSPA, as described in the project assistance approval document (PAAD).

1.3 Evaluation Methods and Procedures

1.3.1 Composition of the Evaluation Team

This evaluation was conducted by a four-member team who spent approximately four weeks in Botswana (September 3-30, 1991). Team members were selected for their expertise in specific areas: family planning program design and evaluation, MCH/FP service delivery, IEC, and contraceptive logistics. Although only one team member had previously worked in Botswana, the other three have had extensive experience in other developing countries in Africa and other regions. Moreover, all had participated on previous evaluations of USAID-funded projects. A brief description of the qualifications of each team member is included in Appendix A.

1.3.2 Data Collection Methods

The findings and conclusions of this evaluation are based on three main sources: a review of documents, interviews with key informants, and site visits.

Review of Documents

Prior to arrival in Botswana, team members received a packet containing basic documents pertaining to BOTSPA, e.g., the project identification document (PID), PAAD, the project agreement, selected reports, and research findings. Once in Gaborone, the team had access to a voluminous collection of materials found in the USAID library and files. Additional documents were also provided by key contacts in the MOH. A list of the main documents reviewed in connection with this evaluation is provided in Appendix A.

Key Informant Interviews

Team members collectively and individually interviewed numerous officials from the three key ministries (MFDP, MOH, and MLGLH), staff from USAID/Botswana, representatives from other donor agencies (UNFPA, World Bank, UNICEF, etc.), and staff of NGOs in population (the Botswana Family Welfare Association [BOFWA] and the Young Women's Christian Association [YWCA]), among others. The USAID project manager provided an initial list of persons to interview, which was reviewed and updated by the Evaluation Reference Group (described below). Team members identified additional names in the course of interviewing. A complete list of the persons contacted appears in Appendix A.

Site Visits

During the four weeks in-country, team members (individually or in groups of two) visited a number of sites where project-funded activities were in progress. The team also contacted certain district-level personnel responsible for population policy issues. The site visits were made to the following locations in three of Botswana's 10 districts:

- 2 district commissioners (in Southern and Kweneng districts),
- 2 council deputy secretaries (Southern and Kweneng),
- 1 district hospital (Scottish Livingston),
- 2 primary hospitals (Good Hope, Thamaga),
- 4 clinics (Ntlhantle, Pitsani, Mmanthethe, Lentsweletau),
- 4 health posts (Magori Patsao, Kumakwane, Kasane, Lesoma), and
- 1 secondary school (Lobatse).

These site visits proved valuable in observing the extent to which activities and procedures described in documents and explained during interviews were actually being implemented in the field.

1.3.3 Evaluation Reference Group

For the purposes of this evaluation, USAID formed an Evaluation Reference Group consisting of three GOB officials from the ministries involved. The group was to guide the evaluation and facilitate information-gathering. Specifically, the Evaluation Reference Group

- reviewed the evaluation workplan that the team prepared during the first week of the evaluation;
- made suggestions of additional documents to review and persons to contact;

- recommended sites to visit (based on a list drawn up by the team of the number and types of facilities to be visited);
- contacted the personnel at these sites prior to the team's arrival and arranged for an escort from the MOH to accompany team members;
- reviewed sections of a draft of this report written in the third and fourth weeks of the evaluation and provided feedback regarding inaccurate facts, possible misinterpretations of events, etc.; and
- coordinated the review of the final draft of this report (after the team had departed) and provided feedback to USAID.

**2. Progress toward Established Objectives
in Seven Programmatic Areas**

2. Progress toward Established Objectives in Seven Programmatic Areas

2.1 Support for Policy Development

2.1.1 Background

The BOTSPA project was designed to support the efforts of the GOB in the development, formulation, and eventual implementation of an official population policy. The use of the non-project assistance mechanism — intended to encourage policy reform — reflects the importance given to policy. Moreover, the illustrative conditions precedent for four of the five tranches are markers toward this goal.

The climate for the development of a population policy is highly favorable. Botswana was one of the first African nations to recognize the detrimental effects of rapid population growth on socio-economic development. The first government family planning services were established in 1973, making this one of the few "mature" family planning programs in Africa. The GOB is particularly concerned with the current population growth rate of 3.4 percent which would result in a doubling of the population in 21 years.

The issue of rapid population growth has been put into public focus in recent years through two high-level conferences. In 1986, the Conference on Population and Development for Members of Parliament and House of Chiefs was held in Gaborone. This was followed in 1987 by a second conference on this topic for high-level policy makers. In line with this, government officials at the central and district levels are sensitized to population issues and stress the need for addressing the problem of rapid population growth. The National Development Plan-7 (NDP-7) provides further evidence of the strong commitment on the part of the GOB to reducing population growth.

It is interesting to note that the correspondence of the BOTSPA design team dating back to 1988 reflects an optimistic view for policy formation. Given the apparent widespread consensus on population issues at the highest levels, the team believed the GOB would fulfill the illustrative conditions precedent at dates earlier than stipulated in the PAAD.

2.1.2 Conditions Precedent under BOTSPA regarding Policy

The design of the BOTSPA project called for formulating and initiating the implementation of a national population policy by the end of the five-year project. Specific steps in this process, agreed upon mutually by the GOB and USAID as conditions precedent (CP) included the following:

- A written plan which sets forth the actions, including technical inputs and public consultations, required to develop a national population policy (CP for tranche 1, listed in the project agreement).
- Evidence that the GOB is preparing and consolidating draft National Population Program Guidelines, including the holding of consultations and discussions within the government and with the public (CP for tranche 2, listed in amendment no. 1).

- Evidence that the GOB has held consultations with the public and within the government on the formulation of a national policy on population and development in accordance with the policy statement on population contained in NDP-7 (CP for tranche 3, listed in amendment no. 2).
- (Note: Although "initiating implementation of the policy" was an illustrative CP for tranche 4 in the PAAD, the amendments to date indicating the concurrence of the GOB to specific conditions have yet to reach that stage in the process).

To date, only the first of these three CPs has been fulfilled. Despite the seemingly strong support of the concept of a national family planning policy, there has been little progress in drafting the above-mentioned guidelines or in initiating the consultative process. Although some might construe the four pages of NDP-7 on "Population and Human Resources" as containing elements of a policy, these concepts have not been formalized into a "white paper" that would explicitly detail targets, implementing agencies, timetables, etc.

2.1.3 Explanation of the Lack of Progress on Policy

The major constraints to the formulation of a population policy can be summarized as follows:

Insufficient Political Commitment to Making Population a Priority Issue

NDP-7 is unequivocal in stating the GOB's intent to formulate a population policy. However, several GOB officials close to the process explain that this commitment is in fact rather recent. As one official stated, "When BOTSPA began, we were in the Stone Age (with regard to a population policy), USAID was in the Space Age." Although the GOB has implicitly supported population issues, including the delivery of family planning services, for a number of years, there was still hesitancy in the earlier years of BOTSPA to move too quickly on an issue that was viewed as potentially sensitive.

Lack of Manpower

In all programmatic areas (not just policy), the lack of manpower was cited as the major constraint to project implementation. Personnel in the MFDP are the best placed to take the lead role in policy development. Over the past two years, however, they have focused on the preparation of the NDP-7 which prevented them from beginning work on policy development. Hiring of additional personnel within the MFDP for this task was not a viable option in that (a) qualified persons for this task would have been limited in number, and (b) the government is reluctant to add new, permanent positions to the public service work force. In short, the work of the MFDP has to be done with available personnel, according to priorities established by the top ministry personnel. In competition with the national development plan, the work on population policy was postponed.

Anticipating the limited manpower available for this work, USAID contracted with the Options for Population Policy (OPTIONS) project (through a buy-in) to provide technical assistance in the development of a population policy. An OPTIONS consultant made several visits to Botswana from 1988 to 1990. Although personnel from the MFDP and MOH seemingly appreciated the inputs, this assistance did not result in significantly advancing the process of policy development (in part because ministry personnel were drawn by other work between the consultant's visits and thus were not able to progress on tasks related to population policy development). The OPTIONS consultant expressed

her availability on several occasions in 1990, but USAID/Botswana postponed her travel until more progress could be made locally, thereby maximizing the benefit of her consultancy. By April 1991, USAID and GOB recognized that BOTSPA was not progressing satisfactorily and they jointly agreed to a midterm evaluation of the project, which resulted in a "freeze" on a number of activities and further postponed the OPTIONS consultancy. The freeze aside, this experience suggests that short-term technical assistance by itself cannot make up for the lack of a political mandate, local manpower, and the support facilities needed to get the job done.

Absence of Support Facilities

In addition to competent personnel who can concentrate fully on the task, the development of population policy requires secretarial assistance, office space, office equipment, and other types of support. The Central Statistics Office has served as an ad hoc secretariat for interministerial population work; however, this is no substitute for an officially designated office with permanent staff who can spend full-time on population issues, such as is envisioned with a Population Unit (as called for in NDP-7).

Need for the Consultative Process

Botswana place a tremendous importance on governing through consensus. Several ministry officials explained that it would be pointless to prepare a draft policy at the central level and send it down the line for endorsement; this would rob those at the lower levels of a sense of participation in the process and identification with the final product. Rather, the advised system is to introduce the issues relating to population growth, family size, development, etc., at the lowest level (the community) and let the ideas flow upward. The *kgotla* (a community meeting used to discuss specific issues with the aim of determining the majority opinion) is a traditional part of Botswana society and is viewed as an essential step in the development of a national population policy. District-level personnel would participate in this process, and the consensus from these meetings would in turn be communicated to the central level. Several government officials indicated one needed to go through the motions of the consultative process, even if one does not achieve full consensus on the issue.

Recommendation³

1. Future BOTSPA support for population policy should be modest and directed to activities identified by the GOB as most likely to result in the formulation of a policy (e.g., support for the anticipated Population Unit).

2.2 Coordination of Population Programs

Under the BOTSPA project, coordination of population programs was to be achieved by two main actions:

- Establishing an interministerial program steering committee for the implementation of this program (CP for tranche 1, listed in the project agreement); and

³Recommendations are numbered consecutively throughout the report.

- Assuring that the GOB's designated office responsible for the coordination of population activities and programs has adequate staff and facilities to function appropriately (referred to throughout this report as the Population Unit).

2.2.1 Interministerial Steering Committee

In January 1989, the Interministerial Program Steering Committee for Population and Development (IPSCPD) was officially formed. In fact, this committee had been established earlier to provide technical and logistical assistance to the two population conferences cited above. Its members included representatives from the MFDP, MOH, MLGLH, Agriculture, Office of the President, Ministry of Education, and Labour and Home Affairs. The principal statistician of the Central Statistics Office (CSO) was named committee chairman. In 1989 he was transferred to another post; the deputy secretary of economic affairs assumed the role but has never been officially appointed to this position.

The IPSCPD has not proven to be an effective mechanism for implementing BOTSPA. First, although IPSCPD was established by the permanent secretary for MFDP, it is an ad hoc committee with no legal standing and no clear terms of reference. It is unclear to whom the committee should report and who should act on any recommendations the committee makes. Second, the members selected when the committee had a different purpose are not necessarily those most suited to implementing BOTSPA. Third, the membership is by no means homogeneous in terms of level of authority of its members within their respective ministries and organizations. Although some members do interact with policymakers, others function at more operational levels. Fourth, there are some 20 committee members, making it difficult to convene the meetings, achieve consensus, and solicit the full participation of all members.

Finally, committee members have full-time positions in their respective ministries or organizations. Although they can make time for an occasional committee meeting, they are less able to block out periods of time to work on BOTSPA-related activities. For example, the current chairman indicated that the committee members were indeed aware that they were responsible for combining the workplans of individual ministries into a comprehensive interministerial plan for submission to USAID, as specified in the project agreement. However, members had difficulty making the time to take on such a task, especially in the absence of support staff dedicated uniquely to the job.

2.2.2 Population Unit

Currently, the CSO serves as an ad hoc secretariat for the IPSCPD. The staff of this unit are fully engaged in other activities, however, such that this arrangement does not fulfill the CP as stated above. Moreover, the CSO staff are trained to process and analyze data, not to formulate policy and oversee programs.

Failure to establish a permanent Population Unit relates in part to the lack of a population policy. Such a unit could theoretically facilitate both the development and implementation of population activities. The conventional practice in the GOB, however, is to establish such an office **only after a particular policy is approved**, at which point it becomes the job of the newly established office to implement the policy. Thus, given the lack of a population policy under BOTSPA, there has been little impetus for establishing the Population Unit.

2.2.3 Plans for a Population Policy and Unit

According to NDP-7, the GOB intends to transform the IPSCPD into a Standing Committee on Population and Development, to be chaired by the deputy secretary for economic affairs in MFDP. The secretariat to the Standing Committee will be located in MFDP. The Standing Committee will include representatives from all relevant ministries, selected trade/industrial federations, and NGOs.

Although this is a positive move toward establishing a base of operations for future population work in Botswana, it has been slow in coming. As early as October 1988, the issue of establishing a Population Unit and formalizing the technical steering committee was stressed by the OPTIONS consultant to the permanent secretary of MFDP (letter in file, 10/21/88). Since then, it has been the subject of correspondence between GOB and USAID. Yet for the reasons outlined above, this has not happened, nor has the NPA mechanism seemed to accelerate progress toward the objective. Indeed, the CPs have been modified to accommodate the constraints experienced in this area (explained in more detail in Section 3).

An effective Standing Committee and an official, permanent Population Unit are important to population activities in the long-term, even if their effects may not be felt during the lifetime of BOTSPA. Since the political will is obviously present, what is needed is an operational plan that would pave the way for implementation.

Recommendations

2. The Division of Economic Affairs should draft for the consideration of the minister and permanent secretary of MFDP a detailed proposal describing the purpose and composition of the Standing Committee mentioned in NDP-7. This draft should cover the mandate of the committee, the number of members, the criteria for their selection, the schedule for meetings, and other pertinent terms of reference.
3. The Division of Economic Affairs should draft for the consideration of the minister and permanent secretary of MFDP a proposal for the establishment of the Population Unit cited in NDP-7, describing the functions of this unit, requirements for staff, office space, equipment, and other pertinent resources, complete with budget.
4. USAID should agree to provide technical assistance on these two tasks, if requested, and should offer to support some of the costs related to the Standing Committee and/or Population Unit (on a limited scale).

2.3 Improvement of Delivery and Management of MCH/FP Services

2.3.1 Background

The PAAD identifies the limited availability of MCH/FP clinical services as a major institutional constraint to achieving the GOB goal of reducing Botswana's high population growth rate. Specific constraints include lack of integration of MCH/FP services in 40 percent of facilities, non-availability

of specific methods desired by clients, insufficient number of trained GOB staff at both the central planning level and at service delivery points, insufficient overall financing for population programs, and the limited participation of NGOs and the private sector in population programs.

The BOTSPA program was designed to address these and other constraints, drawing on both NPA and project funds. Progress toward improved and expanded MCH/FP service delivery can be evaluated (1) by successful fulfillment of the CPs in the case of the NPA funds, and (2) by progress on performance indicators in the case of the project funds.

The relevant CPs include the following:

- A written plan for improving the quality and effectiveness of existing MCH/FP clinical services and expanding the number of service delivery points (from the project agreement, for tranche 1);
- Evidence of the initiation of the 1989 plan to improve the quality and effectiveness of existing MCH/FP clinical services and to increase significantly the number of service delivery points (from amendment no. 1, for tranche 2); and
- Evidence of a significant increase in the provision of MCH/FP services through existing and additional service delivery points (from amendment no. 2, for tranche 3).

The program objective to improve the delivery and management of MCH/FP services is aimed at ensuring a full range of quality family planning services in all MCH/FP facilities by all family planning service providers (appropriate to the number and type of staff at each service delivery point). The expected impact would be seen in expanded MCH/FP services. Means to accomplish this include improving clinical skills of service providers, strengthening management and supervision systems, and supporting district MCH/FP services.

End-of-project success is to be measured by the following performance indicators:

- Integrated MCH/FP services in all health facilities in an effort to expand services;
- Strengthened operational policies for staff training, deployment, and supervision;
- GOB decentralization of health services, with a smooth transfer of responsibility from MOH to MLGLH;
- Expanded use of NGOs and the private sector in activities planning and implementation; and
- Increased couple years of protection (CYP).

2.3.2 Conditions Precedent

Under BOTSPA, one of the CPs for the disbursement of the first tranche is for the GOB to prepare and submit a comprehensive workplan to indicate its overall approach and activities for meeting BOTSPA's seven objectives. Each of the three implementing ministries (MFDP, MOH, MLGLH) were to prepare a workplan which would be submitted to the IPSCPD for review, coordination, and

approval. The IPSCPD was responsible for consolidating these into one comprehensive BOTSPA workplan for submission to USAID to facilitate coordination and joint management and monitoring of NPA funds.

Additionally, the project agreement calls for annual workplans from the same implementing ministries indicating the level, type, timing, and cost of technical assistance and training resources required over the following year, to be submitted to USAID and used in programming the project funds. These were to follow the same review process described above.

On February 20, 1989, a five-year (1988-1993) draft "BOTSPA Implementation Workplan for MCH/FP Activities Including IEC" was prepared by a USAID consultant and submitted to USAID through the MFDP⁴. This workplan incorporated activities to be implemented primarily by the Family Health Division (FHD) of MOH, but also by the MLGLH, Ministry of Education (MOE), the University of Botswana, NGOs, and IPSCPD. Implementation plans and estimated costs for fiscal year (FY) 1989/90 were listed in detail, and broad operational objectives for subsequent project years were described. Mechanisms to be set up for monitoring and reporting BOTSPA activities were described and the text stated that a BOTSPA coordinator for MOH would be named. Based on this and other required CPs, the first NPA tranche of \$900,000 was released to the GOB in March 1989. It is unclear whether this workplan was actually reviewed and approved by IPSCPD, and there is no evidence to show it was formally accepted by USAID.

The FHD followed up with an updated annual workplan (1990/92) for BOTSPA activities. In essence, this workplan represents a modified and updated version of the original 1988-1993 workplan and includes activities not completed in 1989/90 and brought forward for implementation during 1990/92. It also contains a status report on the progress of BOTSPA activities for the period 1989-1990, and a summary of 1990-1991 MCH/FP activities and expenditures (the latter are presumably projected expenditures). The principal family health officer reported that this plan was submitted to IPSCPD for review and approval; a copy was also submitted directly to USAID on August 20, 1990. There is no evidence that IPSCPD acted on this plan or that USAID formally accepted this document or provided any feedback to the FHD regarding its appropriateness or acceptability.

The MFDP through the CSO utilized BOTSPA NPA and project funds for long-term training, research studies, and purchase of equipment. Mostly funded through NPA, these activities were reportedly discussed and approved in IPSCPD meetings.

A workplan for IPSCPD was prepared in May 1991 by the Secretariat member of CSO for 1991 activities. This was processed through IPSCPD and approved. Subsequently, it was submitted to the MFDP permanent secretary for final approval in June 1991 but no response has been received to date. It has not been officially submitted to USAID.

There is no evidence to indicate that the MLGLH prepared a workplan or accessed BOTSPA resources directly (although a few of the district personnel under its jurisdiction have received BOTSPA-funded training).

⁴Letter signed by the chairman of the IPSCPD, to the director, USAID, dated March 20, 1989, concerning *First Annual Progress Report of the Botswana Population Assistance Program (BOTSPA)*.

Reasons why the workplan mechanism did not serve to facilitate joint coordination and management were discussed in Section 2.2.1.

The FHD MCH/FP Unit has assumed the lead for both the utilization of BOTSPA funds and implementation of MCH/FP activities. On the whole, the operational objectives stated in the FHD workplans are appropriate to the goal and objectives of BOTSPA. There does not appear to be a division-wide program strategy, however, whereby objectives and components of BOTSPA and other units are incorporated into a mutually supportive, coordinated whole. Greater emphasis needs to be placed on objectives that link the central office to and provide support for the district health teams and district activities, especially in the areas of in-service training and supervision. New approaches and operational objectives are needed to further expand family planning service delivery, especially in view of the limited success of the condom vending machines and the non-start of the pilot community-based distribution (CBD) project (see Section 2.3.7).

2.3.3 Effect of Integration of MCH/FP Services

Progress toward Integration

Integration has been defined as ". . . a service delivery approach whereby all MCH/FP services are provided on a daily basis to a family at a single visit." MOH policy states that MCH/FP services shall mainly be provided using this approach, and that all health facilities — from mobile stops to hospitals — shall provide family planning services.⁵

When the PAAD was written in mid-1988, 60 percent of the health facilities in Botswana were providing integrated services. By mid-1990, the Larson report on integration⁶ shows that 85 percent of primary health care (PHC) facilities and 64 percent of hospitals had been integrated.

Initiated in 1984 to increase access and utilization, integration of MCH/FP services has, for all practical purposes, been realized and represents a considerable achievement on the part of the MOH and MLGLH. One hundred percent of the districts offer family planning services. Access to family planning is excellent with services available at over 500 hospitals, clinics, and health posts, and at some 800 mobile stops which serve remote areas. Approximately 85 percent of the population live within 15 kilometers of a health facility; 76 percent live within 8 kilometers.

Family planning service providers are clearly committed to this approach, and the service statistics reflect a steady flow of clients. According to the Botswana 1988 Demographic and Health Survey, infant and child mortality have steadily declined to 37 per 1,000 and 16 per 1,000 respectively; vaccination coverage approaches 90 percent; 71 percent of children with diarrheal disease are appropriately treated with oral rehydration therapy; contraceptive prevalence has increased to 30 percent; and antenatal, delivery, and postnatal women are attended by a professional health care worker more frequently than at any time in the past.

⁵Ministry of Health, Department of Primary Health Care: *Botswana Family Planning General Policy Guidelines and Service Standards*. October 1987.

⁶Larson, Mary Kay. *A Follow-up Report on Integration of MCH/FP Services in Botswana*. August 1990.

BOTSPA made several important and direct contributions to the integration of MCH/FP services. These include

- short-term regional training in the areas of clinical family planning, family planning program management, family life education, adolescent fertility, and safe motherhood initiatives;
- provision of two consultants to (a) evaluate the MCH/FP program (1989) and (b) to evaluate the integration of MCH/FP services in Botswana;
- funding for printing of the family planning procedures manual;
- funding of district family planning logistics workshops;
- supervision by central level FHD staff of the process of integration at district level;
- funding of workshops in family life education for NGOs, educators, community leaders, and family welfare educators.

Integration was intended to lead to an expansion in the number of facilities providing MCH/FP. Over the past six years (1985-91), there has been a significant increase in MOH and MLGLH/ULGS⁷ clinics and health posts, as shown in Table 1.

Table 1
Operational Health Facilities
1985 -1991

Type of Facility	(1)	(2)			
	1985	1986/87	1989	1990	1991
District hospitals	NA	15	15	15	15
Health center (later renamed primary hospital)	NA	13	14	14	14
Clinics (with maternity)	142	53	63	63	68
Clinics (without maternity)	NA	89	102	107	114
Health posts (with enrolled nurse)	270	105*	161	168	207
Health posts (without enrolled nurse)	NA	165*	132	140	102
TOTAL	412	440	487	507	520

Source: (1) Ministry of Finance and Development Planning NDP-7

(2) Ministry of Health, MCH/FP Unit

- Estimated

⁷Unified Local Government Services

The number of clinics and health posts — the most peripheral fixed service points to serve rural or isolated populations — increased by about 16 percent from 1985 to 1991. Moreover, the number of enrolled nurses deployed to health posts over the period 1989-1991 increased by 22 percent, contributing to the further extension of MCH/FP services. Nonetheless, nursing and staff shortages at all facility levels remain a serious problem and barrier to expanded MCH/FP services.

Observation of Integrated Facilities

The evaluation team observed 16 integrated MOH and MLGLH/ULGS service facilities ranging from health posts to district hospitals (see list of locations in Section 1.3.2). All provided family planning services within the context of MCH and all (except the health posts) offered four family planning methods: oral contraceptives, injectable (Depo-Provera), intrauterine devices (IUD), and condoms. None of the clinics observed maintained a stock of creams/foams/jellies or diaphragms; nursing staff universally agreed that the pill, injectable, and condoms were by far the most popular methods, with little demand for the IUD and no demand for creams/foams/jellies or diaphragms. With regard to IUD insertion skills, only the staff nurse and enrolled nurse midwives have been trained in the IUD insertion technique (during pre-service training). It is difficult to gauge the extent to which provider-bias enters into the low numbers of IUD acceptors, but lack of competency in IUD insertion procedure certainly contributes to it. The nursing staff interviewed consistently reported that family planning services except the IUD were routinely provided at mobile stops. An enrolled nurse (without midwifery) or a family welfare educator manning a health post are permitted to initiate a new acceptor on one cycle of pills. The client is then referred to a health center (or waits for the monthly visit to the health post of a nurse or medical officer) for further assessment before being issued another cycle. Normally, clients are issued two to four cycles at a time.

A full range of PHC MCH services are being provided in all the centers observed; those with maternity beds averaged 5-11 deliveries per month. A cursory review of MCH registers indicated that there were roughly twice as many new antenatal cases as postnatal visits, but the numbers of postnatal cases also showed a slow upward trend. Clinics were not overly crowded and clients seemed to arrive in a steady flow; clients were observed coming in until 2:00 pm. Clinics generally maintain weekend hours, usually three to four hours in the morning; at least one member of the nursing staff remains on call. The quality of the physical structures observed, including the maternity wards attached to three of the health centers, was impressive. All facilities were clean, in good repair, and relatively well equipped.

Details regarding contraceptive logistics and the management information system are presented in Section 2.5.

With regard to supervision, most of the service providers visited in Southern District reported having received a visit from a district health team member within the past week. The district medical officer generally visits each clinic once a month to provide curative services. The tuberculosis coordinator, health education officer, EPI,⁸ and community health nurse/senior nursing sister visit at least quarterly. The supervisory visits are reported to consist of the district medical officer's giving curative services or other supervisory personnel checking on administrative details (e.g., records, cold chains). On-the-job training is not common although district health teams reported holding short topic-specific seminars. Some MOH district staff reported that supervision from the central level was less frequent

⁸Expanded Program on Immunization

than they would like. All reported they were short of staff of one cadre or another, particularly midwives. A major concern for nurses-in-charge was the frequent turnover in staff due to transfers. At one primary hospital, the only family planning-trained and experienced nurse midwife was being transferred to Gaborone, and the matron thought she might also lose three other experienced staff nurses and enrolled nurses. This was viewed as very disruptive to quality service delivery, as replacements would be inexperienced nurses.

A surprising number of reference manuals were observed in most of the clinics visited in Southern District, albeit some were stacked in the back of the drug storage shelves. These included *Family Planning Guidelines*, *Family Planning Methods and Practices/Africa*, *Malaria Manual*, *Drugs Manual*, and the *World Health Organization Poster Guides on the Management of Acute Respiratory Infections*, *Combating Diarrheal Disease*, and *High-Risk Pregnancy & Neonate Management*. One clinic had a small library containing copies of *Where There is No Doctor, On Being in Charge*, and books on communicable diseases, midwifery, and a few other basic texts. The *Botswana Family Planning General Policy Guidelines and Service Standards* was reported to be used occasionally and without exception was produced immediately from a desk when requested. As a limited amount of training has been conducted on the guidelines, this may have been so readily available because of a visit by a member of the Continuing Education Unit who had discussed this document in some of these clinics the week before.

Training Needs

The 1989 report on the evaluation of the MCH/FP program⁹ indicated gaps in the knowledge and skills of some nursing staff in the management of MCH/FP clients, especially IUD insertion skills, high risk pregnancies, and perinatal health. These training needs were identified again during the evaluation team's visits to the districts. Additionally, it was observed that refresher training is needed in data collection and recording skills, as well as in family planning counseling skills. The use of management information system (MIS) data by senior nurses and district health teams for program planning, management, and supervision appears to need reinforcement, as does the need to strengthen the supervisory process itself. It is clear that more and improved in-service training is required if progress achieved to date is to be maintained and family planning services are to be improved.

Four of the approximately 20 nurses interviewed had received recent in-service training (i.e., within the past year) in one of the following: three-day acute respiratory infections update, contraceptives, logistics, physical assessment skills, or supervision of family welfare educators. Only one of the 20 nurses interviewed had received family planning training outside of the pre-service training; this nurse had attended a six-week training of trainers (TOT) family planning clinical skills course in Zimbabwe in 1990 (funded by UNFPA). She had not trained anyone else since her return. No nurse reported having been trained in the *Botswana Family Planning General Policy Guidelines and Service Standards*.

The nurses identified three areas in which refresher in-service training is most needed: family planning clinical skills (including IUD insertion), family planning counseling skills, and a midwifery update.

⁹Ministry of Health/World Health Organization. *Report on the Evaluation of the Botswana Maternal and Child Health Family Planning Programme*. Gaborone, June-July 1989.

The consistency with which nursing staff identified family planning clinical and counseling training as a priority signals a strong message that they are not comfortable with their level of competency. Given that MOH/MLGLH MCH/FP facilities are the major source for family planning services (Botswana Health and Demographic Survey) and that quality of services is a major factor in utilization, meeting service providers' expressed training needs need to be viewed as a priority.

With the process of integration initiated in all districts and functioning in the majority of facilities, and with infrastructure in place, MOH efforts need to be directed at strengthening the quality of MCH/FP services.

Recommendations

BOTSPA re-design should continue to support the MOH in the following:

5. In-service training should focus on district-level staff, with priority given to MCH/FP service provider nursing staff for family planning skills training including IUD insertion, family planning counseling and communication skills, and improved MCH/FP data collection and recording.
6. Refresher training should be provided for district health teams, district supervisors, and nurses-in-charge in the use of service statistics for improved program planning and supervision, staff performance appraisal methods, and interactive, supportive supervision methods. The medical officer and nurse members of the district health team should also be trained in family planning clinical skills (including IUD insertion), and participatory on-the-job training methodologies.
7. To further expand family planning services, the MOH should
 - (a) explore the feasibility of adding implants to the method mix at the appropriate service facility level (e.g., hospitals);
 - (b) initiate pilot studies to determine if community-based distribution would be cost effective, and to identify the most culturally acceptable channels or approach to be used in its introduction; and
 - (c) in collaboration with the National Health Institute, examine the feasibility, certification, and training implications of training the non-midwife nurse and enrolled nurse in IUD insertion technique.

2.3.4 Strengthened Operational Policies for Staff Training, Deployment, and Supervision

The most important document on operational policies which has been approved and is in use is the *Botswana Family Planning General Policy Guidelines and Service Standards*. Although, as stated above, this document was known to service personnel in some of the facilities visited and some staff said they referred to it occasionally, none of the nurses interviewed had received training on the document. The guidelines were approved in late 1987 and a national workshop was convened in 1988/1989 to disseminate and discuss the document with supervisors and nurses. The guidelines were also included as an agenda item in a few training workshops. The FHD recognizes that service staff

and district health teams are not sufficiently knowledgeable about the guidelines, and training in the content and use of this document has recently begun through an MCH/FP Unit workshop.

Additionally, a *Family Planning Procedures Manual* to supplement the guidelines has been developed by the MCH/FP Unit and approved by the PHC Technical Advisory Committee. The MCH/FP Unit in collaboration with the Continuing Education Unit plans to introduce the manual (and the guidelines) through a series of workshops to be implemented at district level through a core training team. The team will consist of senior, experienced nurses from different districts, who will develop and implement in-service training based on the manual (see Section 2.6).

Four new health systems manuals have been drafted by the MOH Primary Health Care Department in collaboration with the District Management Improvement Project. These are currently under review, but none has been approved or adopted as policy to date. If and when approved, and assuming service personnel are effectively trained in their use, these manuals should make a significant contribution to improving and standardizing the referral, supervision, health information, and administrative communication systems at the district level.

The MOH Department Health Manpower Development Unit plans to develop service performance standards. This task requires a process of consultation and is expected to take some time. When completed, however, it will assist in improving professional staff efficiency, evaluation, and management practices.

The deployment of nursing staff to MOH or MLGLH is defined by an established ratio. Approximately 46 percent of the National Health Institute registered nurse/enrolled nurse graduates are deployed to ULGS, 54 percent to hospital services and PHC. (Similar figures were given by the MLGLH: 42 percent of enrolled nurses deployed to MLGLH and 48 percent to the MOH). These percentages are reversed each year.

The development of the *Botswana Family Planning General Policy Guidelines and Service Standards* and the *Family Planning Procedures Manual* represents an important and impressive accomplishment on the part of the MCH/FP and Continuing Education Units. Both are comprehensive in scope and content. The guidelines provide a framework for family planning program planning, development, and implementation; staff training; and to some extent, staff deployment. The manual will serve to provide an excellent base for training. These now need to be widely disseminated and service providers trained in their content and implications for program implementation.

Manpower shortages continue to be the major constraint to expanded and quality service delivery. So serious is this issue, the GOB has identified manpower development as its first priority during NDP-7. It is doubtful that health manpower numbers will keep pace with service needs within the near future. The National Health Institute Requirements Study¹⁰ calculates that the number of training places will need to double if the supply of health manpower is to match the effective demand by the year 2002. A training policy change that would contribute to expanding the range of family planning services and reducing the amount of family planning clinical skills training currently required would be to train all non-midwife nurses and enrolled nurses in IUD insertion.

¹⁰MOH. *National Health Institute Requirements Study*. Final report. 1989.

The manpower constraint issue needs to be kept in mind when BOTSPA undergoes re-design. The counterpart mechanism will need to be clearly identified and agreed upon to ensure achievement of institutionalization goals.

BOTSPA inputs to strengthen operational policies for staff training, deployment, and supervision were limited to funding the printing, binding, and shipping costs of the *Family Planning Procedures Manual*.

Recommendation

8. The MOH should finalize, approve and implement use of the health systems manuals on supervision, communication, referral, and health information systems.

2.3.5 GOB Decentralization of Health Services

The main purpose of decentralization is to gradually transfer responsibility for primary health care from MOH to MLGLH. Responsibility has been successfully transferred from MOH Central to 20 district health teams for overseeing PHC services in some 182 clinics, 309 health posts, and 834 mobile stops. This gives much greater autonomy and flexibility to the districts to resolve problems at the local level. District health teams have responsibility for local service delivery, planning, implementation, supervision, and monitoring. They report directly to the Local Council. The MOH retains the permanent functions and responsibility for policy, overall technical supervision, and support of PHC services. PHC services that permanently remain under the MOH are district hospitals (formerly called health centers) and the schistosomiasis and malaria programs.

Coordination between MOH and MLGLH is facilitated by the PHC Coordinating Committee. Communication between MOH and the MLGLH Training Section in regard to training activities has proven problematic on occasion, for example, when MLGLH is informed at the last minute of upcoming training activities. This has resulted in selecting district participants on the basis of availability and favoring those who can be contacted by telephone. Cooperation and collaboration at the district level between MOH and ULGS staff are reported to be good. MOH staff are often invited to participate in district training activities. Some friction over areas of responsibility and interpersonal conflicts still exist. It was reported that the district health team medical officer will soon be transferred to the ULGS during an upcoming MLGLH re-organization.

Interviews with a district commissioner and a deputy council secretary revealed that they view the district health team as the authority in areas related to health — especially the medical officer — and rely on the district health team to provide guidance and direction to the Local Council. Review of selected district health team annual reports for 1990 revealed that nursing staff shortages and logistics problems (transport, equipment, communication facilities, lack of a reliable power supply) were daily constraints impeding effective implementation, monitoring, and supervision of PHC services. These reports confirm the findings of a District Management Improvement Project needs assessment conducted in the districts in 1988. Transport, supervision, personnel, and communication were issues identified by district health team members at that time, and apparently remain the same in 1991.

The PAAD envisaged that BOTSPA would support expanded MCH/FP services through decentralization by addressing priority constraints associated with better staff training, supervision, and support equipment.

The FHD MCH/FP Unit workplan lists two actions to support the GOB decentralization process and MCH/FP service delivery in remote areas: (a) the purchase of solar power equipment, radios, and vehicles for district mobile and outreach staff, and (b) the purchase of two vehicles to strengthen implementation and supervision of MCH/FP and health education activities. The MLGLH did not respond to the MCH/FP notification (November 28, 1990) concerning the availability of BOTSPA funds for these purchases, and only the one vehicle for the MCH/FP Unit was purchased. Although every district was visited in 1990, fewer than usual supervisory visits were reported to have been made by the FHD to the districts to date in 1991, primarily because of staff constraints due to staff turnover and study leave, with subsequent work loads at the central level. Different members of FHD staff conduct supervisory visits, a checklist is used, and reports of findings are prepared and distributed. Review of MCH/FP Unit 1990 and 1991 supervisory reports suggests that staff shortages (especially midwives), statistics not up to date, insufficient or broken equipment, inadequate/lack of transport and communications were frequently reported.

Staff in the MOH PHC Support Unit, whose functions are PHC liaison and coordination with the MLGLH, were only vaguely aware of BOTSPA and had no knowledge of its potential for supporting district level activities. Similarly, few of the technical personnel at the district level knew of BOTSPA. The MLGLH, a prime ministry in decentralization, did not access BOTSPA funds which could have addressed some of these problems.

Given the minimal district supervision conducted to date in 1991 and the non-utilization of funds by the MLGLH, it can be concluded that BOTSPA's contribution to the decentralization process has been minimal.

Recommendations

9. The GOB and USAID/Botswana should assign priorities to support district-level activities in any BOTSPA re-design.
10. The MOH and MLGLH should conduct an updated needs assessment to ascertain equipment/logistics needs of isolated district health facilities, and action should be initiated to meet priority, essential requirements.

2.3.6 Increased Couple Years of Protection

The PAAD cited CYP as an appropriate indicator of the utilization of family planning services and assumed that these statistics would be collected at service delivery points starting in 1988. The calculation of CYP requires data on the quantities of contraceptives dispensed to clients. Contrary to expectation, the data collection for the quantity of each contraceptive sold at each service delivery point only began as of 1991. Moreover, the data are reported to be incomplete and unreliable, due to insufficient training. Thus, it is not possible to measure CYP in the BOTSPA program at this time. This issue is further discussed in Section 2.5.

2.3.7 Current Status of MOH/FHD BOTSPA Activities

Analysis of the selected sections of FHD BOTSPA workplans (1988-1993 and 1990-1991) indicates that 47 percent (30/64) of the planned activities described in workplan sections I, II, III, VI, and VIII,

for the period January 1989-August 1991 have been implemented by the FHD. These accomplishments are summarized in Table 2.

Table 2

Status of Planned MOH/BOTSPA Activities

<u>Training and Manpower</u>	
Long-term training:	<p>10 overseas fellowships planned:</p> <ul style="list-style-type: none"> • 5-currently enrolled in programs • 2-delayed by evaluation "freeze" • 2-postponed until Jan 1992, pending counterparts to replace them • 1-scheduled to begin in Sept 1992
Short-term external training:	<p>22 candidates attended short-term MCH/FP training courses or study tours in Zimbabwe, Kenya, USA, Indonesia.</p> <p>The breakdown by ministry or organization was</p> <ul style="list-style-type: none"> • 9 MOH • 5 ULGS • 2 NGOs • 4 MOE • 2 National Health Institute <p>Only one of the planned training opportunities has not yet occurred.</p>
Staff recruitment:	<p>3 MCH/FP officers and 1 graphics person were recruited; 1 counterpart was assigned to BOTSPA IEC advisor. Community health nurses were assigned to 4 district health teams.</p>
In-country/in-service training:	<p>The following workshops were planned but did not occur:</p> <ul style="list-style-type: none"> • Contraceptive technology and STDs • Minilap training for physicians • TOT for district level nurses • FP Clinical Procedures and Counseling skills (inter-district) • Creation of a Core Training Team
Contraceptive Logistics Workshops:	<p>18 were planned and conducted by the MCH/FP Unit primarily for district level nurses in 1990/91</p>
IEC workshops:	<p>9 were conducted in 1989/90</p>

Table 2 (Cont'd)

<u>Support for District MCH/FP Services</u>	
Purchase of two vehicles:	Only one procured
Purchase of solar power equipment and radios for isolated areas:	Not achieved
<u>Equipment and Supplies</u>	
Procurement orders for FP equipment and training aids:	2 of 5 were processed
Procurement of 250 IUD kits and 200 blood pressure machines:	Procured and distributed to government, mission and industrial health facilities
Procurement and distribution of mini-lap kits for hospitals and primary hospitals:	Not pursued, on the advice of a physician that the funds could be used better elsewhere

Reasons why the in-country/in-service workshops were not implemented were reported to include the following: delay in printing the *Family Planning Clinical Procedure Manual* (delivered in April 1991), shortage of available and appropriate core training team members who could add substantial training functions to their workloads, and difficulties in identifying technical assistance to facilitate the training of the core training team.

To expand the accessibility and acceptability of family planning through increased service delivery points, three major activities were identified:

- a pilot test of condom vending machines in selected public locations in Gaborone;
- a pilot test of community-based distribution of pills and oral rehydration salts (ORS) through community health workers supervised by health workers; and
- expansion of service hours for family planning at health facilities through integration, especially at hospitals and health centers (see Section 2.3.3).

Regarding the pilot test for condoms, 30 condom vending machines were purchased and 14 placed in two hotels, one large business place, two government buildings, a technical school, and a prison officers' mess. A follow-up evaluation by the FHD five months post-installation indicated that the

vending machines were popular with users: 92 percent of 50 respondents reported liking this system of obtaining condoms from machines and 98 percent cited AIDS and sexually transmitted disease (STD) protection as the major benefit of condom use. Maintenance of the machines was a major problem, however. Anecdotal information suggests that the machines are frequently out of order or empty. The MOH apparently has decided it does not have the human resources to maintain these machines and is currently looking for a private firm to take over this activity.

A pilot project to test the community-based distribution of oral contraceptives and ORS by community health workers was not implemented reportedly because of different opinions among health professionals regarding the appropriateness of non-professionals dispensing oral contraceptives.

2.4 IEC Support to MCH/FP Services

2.4.1 Objectives

The IEC component of the BOTSPA project as envisioned in the project agreement was to provide support for MCH/FP services. Overall program objectives listed in the project agreement for the IEC component include the following:

- Increase awareness of family planning to enable people to make informed choices;
- Motivate greater numbers of Batswana to use family planning methods appropriate to their circumstances;
- Increase overall demand for family planning services;
- Improve continuation rates; and
- Improve the method mix.

Specific IEC objectives are

- Strengthen overall IEC support systems for MCH/FP within public and private sectors;
- Improve IEC services from an expanded Health Education Unit (HEU);
- Strengthen IEC in district health education programs; and
- Support NGOs to develop and disseminate IEC materials.

In support of these objectives a number of activities have been and are being implemented by the FHD.

2.4.2 Activities Planned and Implementation Status

Workplans prepared by the FHD in support of MCH/FP programs detail IEC activities that are intended to take place during the life of the BOTSPA project. Plans for IEC were adopted from recommendations made by a World Bank IEC team in-country in 1987-88. These recommendations were further refined by the FHD in its August 1990 workplan. Other plans were compiled by the IEC consultant. In 1991, a progress report of BOTSPA-funded IEC activities was prepared by the consultant to document achievements.

The process for accessing BOTSPA funds, whereby ministries wishing to use funds submit workplans to the IPSCPD, is described in Section 3.1. The only workplans containing IEC activities were

drafted by the MCH/FP Unit of the MOH and were never officially approved by the IPSCPD. For practical purposes, however, the FHD considers them official working documents. Refinements of the workplans have not been forwarded to the IPSCPD but have instead been negotiated in-house.

The activities described in the workplans are followed by a description of their implementation status. A number of these activities have been carried out with funding from other donors.

1. Recruit a long-term IEC advisor.

This activity was completed. The IEC advisor worked with the project from May 1989 to May 1991.

2. Recruit and place a counterpart for the IEC advisor.

This activity was completed; however, the original counterpart left after some months for long-term training. A second counterpart was named a few months later. This second counterpart resigned and no other counterpart was nominated.

3. Identify an area for a pilot adolescent family life education project and implement it for three years.

See Section 2.7 for details on this project.

4. Strengthen family life education resources by training four youth trainees (one from MOH, one from BDF, two from MOE).

Botswana Family Welfare Association director attended a family planning communication course in Zimbabwe.

YWCA project director took an Adolescent Program study tour in the United States.

Two MOE and two BDF staff members received training in family life education at the Centre for African Family Studies (CAFS).

Two HEU staff received CAFS training in IEC.

5. Conduct intensive training in a selected region in family life education, concentrating on health workers, teachers, and principals.

Five family life education workshops were held in Serowe for teachers, headmasters, health personnel and community leaders.

6. Purchase production supplies, materials, and equipment to strengthen capacity of FHD to produce IEC materials.

Under BOTSPA, the FHD Health Education Unit received state-of-the-art desktop publishing equipment (an Apple computer, software, and a scanner).

Other equipment purchased for the radio or graphics studio included public address systems, duplicators, and slide projectors.¹¹

7. Recruit, train, and place two additional personnel in the graphics studio.

This has been successfully completed. Two persons have been recruited; one has been sent on long-term training.

8. Conduct continuing HEU staff training in IEC.

Two staff from the FHD have been sent for long-term training: one graphics officer to receive a 24-month diploma course in graphic art in Zimbabwe, and one health education officer to receive a bachelor's degree in health education in the United States.

Plans for other staff to attend bachelor's level courses in health education were delayed due to the project freeze pending the results of this evaluation.

Delays in training (pending since 1989) were due to the lack of a suitably qualified replacement. The FHD has since recruited a Zambian health educator and will shortly receive an additional health educator as interim contract staff.

A five-day in-service workshop for the HEU was held in June 1989.

9. Plan with University of Botswana officials a diploma course in health education at the National Health Institute.

No progress to date.

10. Conduct intensive training in IEC for community health nurses with the Continuing Education Unit.

No progress to date.

11. Integrate IEC for non-health extension workers.

No progress to date.

12. Implement a research study on a profile of male targets.

Study completed.

13. Develop materials for family life education in-school use in collaboration with the Curriculum Development Unit.

No progress to date.

¹¹In the opinion of the IEC expert on the evaluation team, little additional equipment needs to be purchased.

14. **Implement a male campaign using the Botswana Christian Churches (an umbrella organization of the church-related groups working in social welfare programs) and other organizations.**

No progress to date.

15. **Continue and sustain the participatory development approach undertaken in the village of Mochudi.**

Project activity has been supported under BOTSPA.

16. **Initiate a similar approach to Mochudi in another area.**

Not completed to date.

17. **Promote mass media use for family planning promotion through media dialogue and campaigns.**

One condom poster targeted at youth was produced. Otherwise, there has been little use of the mass media.

18. **Promote use of folk media.**

With funds from BOTSPA, 40 family welfare educators were trained by the Reetsanang Community Drama group. This group also produced a video entitled "Another Teenage Problem."

19. **Assess needs and procure audiovisual equipment for districts.**

Although not necessarily in response to a needs assessment, 23 copies of the video "Consequences" were purchased and distributed to district teams.

20. **Pilot test two audiovisual mobile vans at the district level.**

No progress to date.

21. **Pilot test display boards.**

No progress to date.

2.4.3 Additional Activities Developed in Connection with BOTSPA

The following activities, although not listed in the workplan, were also carried out:

Workshops for NGOs and Others

- A three-day workshop in IEC for family planning for NGOs and multisectoral participants was held at the Gaborone Sun Hotel in June 1990.

- A one-day orientation for NGOs on adolescent health and family life education was held.

Additional Materials Produced and Purchased

- Materials were purchased from the United States on family life education, counseling, focus group discussions, folk media use in family planning, print materials for illiterates and others. These were distributed to district teams, MOE, and others.
- Booklets No. 3 and No. 4 of a photonovella series entitled "I Need to Know" were produced, although booklet No. 4 has not yet been distributed. BOTSPA partially funded booklet No. 2.
- A condom leaflet to accompany condoms sold in the vending machines was produced and packaged with the condoms.
- A video entitled "People, Today, and Tomorrow" was produced featuring a prominent member of Parliament.

Other Indirect Outputs

The FHD, either in the person of the IEC consultant or through other staff, has been heavily involved in representational activities, serving on subcommittees of the IPSCPD, and supporting and providing technical assistance to other donor workshops and conferences related to the BOTSPA mandate. Although many of these activities do not have a specific output, they serve to assist in the mobilization of total available manpower for family planning IEC.

2.4.4 Assessment of the Impact of IEC Activities, Based on Performance Indicators

The following performance indicators specified in the project agreement are to be used in monitoring and evaluating BOTSPA activities:

- Increased number of first visits for family planning acceptors,
- Establishment of family life education in the schools,
- Improved continuation rates through improved counseling, and
- Expanded use of NGOs and the private sector in planning and implementing family planning activities (discussed in Section 2.7).

By way of preface, it should be mentioned that IEC is one of the most difficult areas of family planning to evaluate because of the difficulty in determining cause and effect. That is, a country may have a strong IEC program and contraceptive prevalence may increase, but based on this, one cannot conclude that the IEC program caused this increase in prevalence. In addition to this general limitation in assessing the impact of IEC activities, the current evaluation is further restricted by the lack of reliable data with which to calculate couple years of protection, continuation rates, and other indicators.

The project agreement includes increased awareness of and demand for family planning as overall program objectives, but does not call for evaluating these outcomes based on performance indicators.¹²

To assess the appropriate role of IEC, it is important to take into account the status of family planning in Botswana. The levels of family planning awareness and use in Botswana are high by African standards. By 1984, 75 percent of women of reproductive age knew at least one contraceptive method, and this had increased to 95 percent by 1988, before BOTSPA even began. As for contraceptive use, almost one-third of women in union were using contraceptives as of 1988, giving Botswana the second highest prevalence level in sub-Saharan Africa. Given the long history of family planning service provision (since 1973) and the current prevalence rates, Botswana has one of the more advanced family planning programs in the region.

In view of this level of awareness and use of contraceptives, IEC efforts (using a mix of motivational techniques) should have been directed toward creation of greater demand for family planning among specific segments of the population that were not using family planning services. No motivational campaigns were carried out under BOTSPA, however. In addition, research efforts should have been looking at constraints to use, to understand why increases were not taking place as expected.

New Acceptors as an Indicator of Demand

In the project agreement, it was anticipated that the IEC activities would result in a 15 percent increase in new acceptors in each of the first two years and 10 percent in each year thereafter. This project objective was met for only one of the three years under study. The project agreement was signed in July 1988. In 1988, there were 40,269 new acceptors; there was no increase between 1988 and 1989; a 17 percent increase between 1989 and 1990; and a 6 percent increase from 1990 to 1991.¹³

Can BOTSPA take credit for this change? Increased numbers of new acceptors and increased awareness are generally the result of community-based IEC efforts, whether directed at the larger national community through mass media efforts, or at targeted groups through a mix of media, or at local communities through efforts of family welfare educators and village health committees. FHD/BOTSPA implementors did not work directly with the family welfare educators on a large scale, nor was mass media used to any great extent. Consequently, it is doubtful whether the increased number of new acceptors can be attributed to BOTSPA. A more probable explanation is that this increase resulted from greater access to these services.

Although some respondents in a survey on male attitudes commissioned by FHD stated that they had heard about family planning from the radio, the main source of family planning information seems to be the clinics.

There is reason to question the use of new acceptors as the main indicator either for IEC or for the program as a whole. This issue is discussed in more detail in Section 2.5.

¹²Possibly because of the cause-and-effect problem described above.

¹³These data are presented in Table 4 in Section 2.5.5. Note that the percentage reported in the last column of the table is not the percent increase each year but rather the number of new users as a percentage of all women of reproductive age.

Recommendation

11. The FHD should plan family planning promotional activities to include targeted campaigns to motivate clients to seek services. Audience segmentation, analysis of available research, and new research to determine why services are currently underutilized will increase the potential effectiveness of these campaigns.

Establishment of Family Life Education

Formal Systems. Family life education is an area in which the IEC consultant and the MCH/FP Unit expended considerable energy. Although the family life education strategy has been completed with the participation of various ministries, and family life education has been introduced in some schools, one cannot conclude that this is a result of BOTSPA activities. Rather, to the extent family life education is in the schools, it seems to be the result of increasing awareness among MOE staff (possibly driven by the sub-committee on family life education) and among teachers. In the past, the MOH has collaborated with MOE to provide family life education training. As frontline workers, teachers and headmasters perceive daily the need for teenage counseling and services. The evaluation team observed the dedicated effort on the part of individual teachers in Lobatse, as well as individual efforts to integrate family life education into the school's formal and extracurricular activities.

There have been recent changes in the externally fixed O-level curriculum to include population matters as well as family planning, including contraception, in the secondary curriculum. It is dealt with in the biology unit and covers social issues and problems. Similarly, STDs and drugs are treated in this module. Increasingly, however, science teachers are being encouraged by the MOE to move away from social subjects to teach pure biology.

In Southern District, it was learned that most of the senior secondary schools are teaching a pure biology curriculum. In spite of this, teachers stated that they themselves insist on speaking of the matter to their pupils, recognizing a social emergency within the teen populations they serve.

Guidance counselors also provide family life education to the students and, at the junior secondary and primary levels, school health clubs supported by inputs from family welfare educators further strengthen family life education. This relationship between the schools and the family welfare educators who act as a resource for courses in human sexuality and for the health clubs is not formalized and is driven by the goodwill of the concerned family welfare educators and the individual teachers. Field observation indicated that the family welfare educators considered this one of their serious obligations.

BOTSPA has provided external short-term training to two MOE staff members in family life education, as well as to two BDF personnel. In 1989, Serowe was selected as a pilot site to test intensive family life education activities through training of the district health team, and awareness-raising workshops for headteachers, teachers, principals, and community leaders. Five workshops were held in the district but because formal mechanisms had not been implemented at the outset to measure success, evaluation has been problematic. Tentative evaluations suggest that teachers may have good results in passing on their knowledge but other participants may not, lacking the structure to provide family life education services. The summary report on this activity suggests that the effort is not replicable as is and will require significant methodology changes to be feasible.

Recommendation

12. FHD should continue its efforts to reach in-school youth through a variety of methods including coordination with the Curriculum Development Division of the MOE at the central level, and soliciting the cooperation of school health clubs, parent-teachers associations (PTA), etc., at the district level.

Informal Systems. Little work has been done to extend family planning information through informal systems. A grant to the Botswana Family Welfare Association was intended to reach out-of-school youth. Although the program is still in its infancy, the present population being served is in-school youth who come to the center at the end of the school day.

Unemployed youth in rural or urban settings have not been reached by a planned campaign. With awareness levels as high as they are, IEC programs to motivate youth to change their behavior is indicated. Some organizations, such as the military and police, have participated in training activities. The training was not followed up with campaigns and materials development, however. Efforts to reach this target group are insufficient and greater creativity needs to be used to reach young people who are not a part of organized groups.

Tirelo Setshaba (the Office of the President) is responsible for placing the country's high school graduates (Form 5) in a one-year program of national service, primarily in rural areas. One potentially effective activity would be to enlist these students to play a role in family life education, given that they are relatively well educated and young. Although the Tirelo Setshaba is represented on the IPSCPD, this institution has yet to be tapped as a resource for family life education activities under BOTSPA. The national service program would be a very effective means of reaching students if they were paired with family welfare educators or cooperated with field Peace Corps volunteers. They would, however, need orientation to their tasks and training in outreach. Currently, MOH only provides family life education orientation to these young people as part of a general orientation program at the start of their service year.

The use of Peace Corps volunteers to extend the field capacity of the BOTSPA project has been encouraged by other consultants working with the project. Peace Corps volunteers are particularly well suited to such field activities as social mobilization in support of population policy and reaching youth, and their support in family planning IEC programs has been successfully implemented in several countries. The volunteers can assist district training teams with family welfare educator training in family planning IEC. They can assist in the making of videos by grassroots organizations, in encouraging the formation of local drama groups promoting family planning, and in assisting the district health enrolled nurse monitor and in supervising family planning/health education activities.

Recommendation

13. The FHD should substantially increase its efforts to reach youth as a specific target group and to further segment this group, taking into account regional and cultural differences. Their attitudes towards family planning should be precisely determined so that message development can be precise. More than any other group, their communication patterns should be explored through a combination of anthropological, psychological, and communication approaches.

Improved Continuation Rates and Method Mix

Improved continuation rates and a better method mix are the result of higher-quality services and better interpersonal communication at clinic sites. Improved counseling and better follow-up of dropouts would have a positive effect on these indicators.

Two documents, both produced prior to BOTSPA, have formed the backbone of the counseling program. These are a document produced with technical assistance from the Program for Appropriate Technology in Health (PATH) entitled *Family Planning Counseling*, and the *Policy Guidelines for Family Planning Workers*. Both are comprehensive, the former providing case studies and the latter delineating the circumstances under which family planning is delivered (clinical and social).

These documents can be found in clinics; however, they have not yet been used as a basis for training of personnel. Other than pre-service training in counseling, few family planning service providers have received training in counseling. In the case of the family welfare educators who also provide limited family planning services in some regions, their knowledge of both family planning and counseling comes ad hoc and on the job. Discussions with these frontline workers suggest that they are eager for further training and wish to enhance their counseling skills. One workshop focusing on policy guidelines was held in September 1991 and others are planned for later in the year, using UNFPA assistance.

As stated in Section 2.3.3, pills, injectables, and condoms are the most frequently prescribed family planning methods. Service providers need to be able to counsel clients about alternative methods to the pill and condoms that are less prone to human error, such as the IUD and Norplant implants. Since in-service clinical training in IUD insertion has not taken place, however, service providers are unable to do this at present. Similarly, they have little preparation in counseling on permanent methods, in part because these methods are not readily available in the current system.

Currently, almost all family planning IEC activities are taking place at the clinic level in the form of counseling. Integration has had the unexpected effect of limiting access to groups for group lectures although they are still given at the mobile stops. Lack of counseling training for all cadres, especially the family welfare educators, further inhibits the quality of family planning education. At present, the family welfare educator has been subsumed as a regular clinical worker and her home visit time is substantially restricted as a consequence. Family welfare educators observed in the field would like more training, more guidance from their superiors, more educational materials to use (such as a motivation kit for family planning), and more time to make their field visits.

In the clinics and posts observed, there were few posters on family planning or useful handouts for clients. Some family planning client materials do exist and more should be available. No wall charts on contraceptive methods were observed (except a few a clinic nurse had drawn by hand) that would help the family welfare educator or nurse explain the different methods, and the family welfare educator had no flip charts to motivate or inform. Print materials in the clinics are quite limited. There are no method-specific pamphlets that can be distributed to clients to remind them how to use their chosen method. If the family welfare educator were freed of some of her clinic responsibilities and trained to do follow-up, continuation rates should increase.

At the present time, it is impossible to assess whether continuation rates have improved under BOTSPA. The registers at service delivery points provided are set-up to allow for calculation of

continuation rates. The visit the evaluation team made to the field suggests, however, that the needed information is not routinely entered into the registers.

The registers also provide information that could be used to calculate method mix for new users and to estimate method mix among continuing users. However, these data are not tabulated or analyzed, such that it is virtually impossible to gauge the progress of BOTSPA based on either continuation rates or method mix.

Recommendations

14. Three pamphlets, one each on the pill, the IUD, and the condom, should be developed and made available at clinics. A method pamphlet addressing young people should be prepared for distribution to schools and clinics. The pamphlet should stress abstinence as the preferred choice for young people.
15. Informational materials for the family welfare educators' home visits should be prepared. These may include flip charts, felt boards, or other materials that are highly portable. Content covered should include different methods of contraception, as well as other MCH topics.

2.4.5 Infrastructure Development

Problems with institutionalization of IEC can be traced to two main sources. First, there is some evidence to indicate that both GOB and USAID misunderstand how family planning IEC should function in support of family planning programs.

IEC is a horizontal activity that is intimately tied to policy and program, and it supports both. IEC is the process by which information and knowledge are passed to communities and groups such that it is understood and accepted, and motivates people towards behavior change. This transfer of knowledge can be indirect or direct, mediated, or interpersonal. It relies heavily on accurate and detailed knowledge of the program, the audience to be reached, the setting and the manpower resources available, and the available channels of communication. IEC is not "health education" although health education skills are subsets of IEC skills. Decisions made regarding BOTSPA project management, utilization and placement of technical assistance, selection of candidates for training, and purchases of equipment reflect a misunderstanding of this process and will be discussed in the section below.

Second, family planning struggles along with all other priority areas (EPI, water and sanitation, acute respiratory infections, safe motherhood, among others) for attention from an overworked staff.

Within the GOB itself there does not seem to be a sense of urgency to promote population policy. In the area of IEC this can best be seen by the lack of IEC in support of population policy. Two workshops have been held, one for parliamentarians and chiefs and another for senior government staff, both predating BOTSPA. Condom advertisements by BOTSPA in local newspapers and participation in one-day promotional activities such as World Population Day seem to be the extent of policy promotion. At the district level, no dialogue is taking place, although there seems to be

interest on the part of district-level administrators, to create awareness of the practical implications of unchecked population growth across sectors.

NDP-7 stresses the development of a national population policy, making conditions optimal for initiating awareness activities directed at leaders and policy makers on cross-cutting population issues.

Development of the Health Education Unit

One of the indicators suggested in the project agreement to evaluate the success of IEC programs is the extent to which the Health Education Unit has been expanded and reinforced to support the expected increase in family planning services. Early on in the project, the IEC consultant intended for that unit was removed to the MCH/FP Unit. As a result, her ability to interface with the Health Education Unit was compromised, and despite the best efforts of the MOH, the Unit remains weak in terms of qualified personnel.

Since project inception, two additional graphic designer positions have been added to the Health Education Unit, as well as one health education officer. One of the graphic designers is presently on long-term training, as is a health education officer. The other graphics post remains to be filled. In all, the unit has expanded from 16 persons in 1988 to 20 persons in 1990, showing commitment on the part of FHD to improving health education services.

Training obligations have left four out of 20 posts vacant. Two people (an assistant MCH officer and an information officer) have received CAFS training in health education. Few of the health education staff have received in-service IEC training. Most have a clinical background as nurses or enrolled nurses or health inspectors.

As indicated earlier, several staff in the Health Education Unit were scheduled for training in 1989. The training was delayed for two years until replacement staff could be identified, however, and the proposed trainees were caught in the project freeze in 1991. Short-term in-country technical assistance could have been contracted to provide in-country workshops for Health Education Unit staff, and the IEC adviser could have made a larger impact in this area.

The combined staff of the MCH/FP Unit and the Health Education Unit consists of 29 people. Theoretically, this is a large number of people and there should not be a manpower shortage. Trained professional staff are few, however. Given this constraint, FHD needs to consider alternative informal structures to get the work accomplished.

One possible alternative is the "team approach." Without adjusting the present structure of the ministry, specialists could be drawn from each of the units (i.e., the team would comprise specialists in family planning service provision, family planning/IEC, and family planning/training, with the FHD Division head to serve as its leader) to develop family planning strategies and concentrate on their implementation. The team would work together in the planning stages, meeting as often as necessary to ensure that the sequence of activities was being maintained and implementation was proceeding as planned. This would still leave staff for the continuing activities of the division and permit on-the-job training for those involved with teams.

Other institutionalization difficulties are posed by the lack of both pre-service and in-service training of family welfare educators. The training of family welfare educators was suspended as part of a World Health Organization project to train community health workers. This does not seem to have

been successful and at present neither family welfare educators nor community health workers are being trained. Since these are the grassroots mobilization workers, expansion of a grassroots program is seriously hampered.

Recommendations

16. To improve IEC implementation, there needs to be closer coordination between different units of the MOH so that those responsible for selection and training of personnel know the IEC needs of the Family Planning Unit. The Health Education Unit and the Family Planning Unit need to work more closely in the design of materials. The materials need to be prepared based on the research results coming from the appropriate unit responsible for research.
17. The GOB should continue to provide short-term training for staff, particularly those at the field level, at international and regional agencies providing IEC training. Particular attention should be given to courses specializing in counseling and to courses providing specialized training in IEC aimed toward adolescents. The GOB should also consider hosting in-country training programs at which a larger number of people can be trained under realistic conditions, again giving preference to those based at the periphery.
18. In the absence of an IEC adviser, USAID and GOB should give serious consideration to contracting for intensive, short-term IEC support in training, research, and campaign design in family planning and related subject areas. This assistance should focus on building capacity at the regional level to design and manage decentralized programs. Appropriate counterpart agencies should be established regionally to support these activities, and provided with an IEC budget and minimal equipment. Field-level agencies would liaise with the Health Education Unit at the MOH.

Management of IEC Technical Assistance

As stated above, placement of the adviser was key to coordination of family planning IEC activities and may have had a bearing on the effectiveness of her services. For example, the adviser should have been involved when IEC training decisions were made, but this was done without her participation. Ideally, she should have taken an inventory of IEC skills, matched the skills against IEC needs in the division, prioritized them, and assisted in the appropriate selection of candidates and the kind of training they would receive. All those decisions were made without the assistance of the IEC specialist.

Similarly, the IEC adviser was not involved in the purchase of equipment to support the Graphics Section. Ordinarily, purchases of this kind of equipment should be based on family planning program needs tied to strategies and workplans.

One final example that illustrates the need for cross-unit coordination involves the workplan objective to reach males. A study was commissioned to determine knowledge, attitudes, and practices (KAP)

in this population. The study cannot be completed, however, because of a lack of trained men to lead the focus group discussions. The IEC adviser should have assisted in the planning exercise for this activity.

For its part, USAID was inconsistent in its own contractual relationship with the IEC adviser, twice changing her scope of work without sufficiently briefing the GOB. This is discussed further in Section 4.

Some of the frustrations experienced by the GOB with regard to the technical assistance provided by USAID may have been due to unfamiliarity with the objectives of having a USAID adviser, as opposed to technical assistance provided by other donors. In the USAID system, an adviser is placed to facilitate transfer of knowledge and skills and to catalyze local counterparts. An adviser is not expected to replace a local worker or function in a line capacity. GOB experience with long-term advisers placed by other donors suggests that they are accustomed to consultants filling vacant positions and functioning as departmental staff. Lack of communication about this fundamental orientation to the function of an adviser has caused unnecessary frustration both to GOB and to the adviser.

2.5 Contraceptive Logistics System

2.5.1 Background

The PID, which first outlined the need for BOTSPA-type USAID assistance to the GOB, pointed out the 1987 expiration of USAID's contractual commitment to provide contraceptives to the GOB. It also stated that 40 percent of the women reporting problems with family planning listed lack of contraceptive availability as a source of their problem. The PID recommended a long-term advisor for monitoring and evaluation, but this recommendation was not finally included in the project.

The PAAD listed two objectives for the contraceptive logistics component of BOTSPA:

- GOB assumption of a major, long-term financing role in contraceptive procurement; and
- availability of a full range of contraceptives at all health facilities.

The PAAD, the project agreement, and subsequent amendments further emphasized the long-term financing role of the GOB in contraceptive procurement by introducing specific illustrative targets for accomplishing this goal.

Major issues related to contraceptive logistics include GOB contraceptive procurement; reliability of contraceptive supplies; and management information systems.

Additional technical issues worthy of review and comment include forecasting of contraceptive requirements; Central Medical Stores' (CMS) ordering procedures; brand selection and anticipated changes; warehousing; facility stock level monitoring; and logistics and MIS training.

2.5.2 GOB Contraceptive Procurement

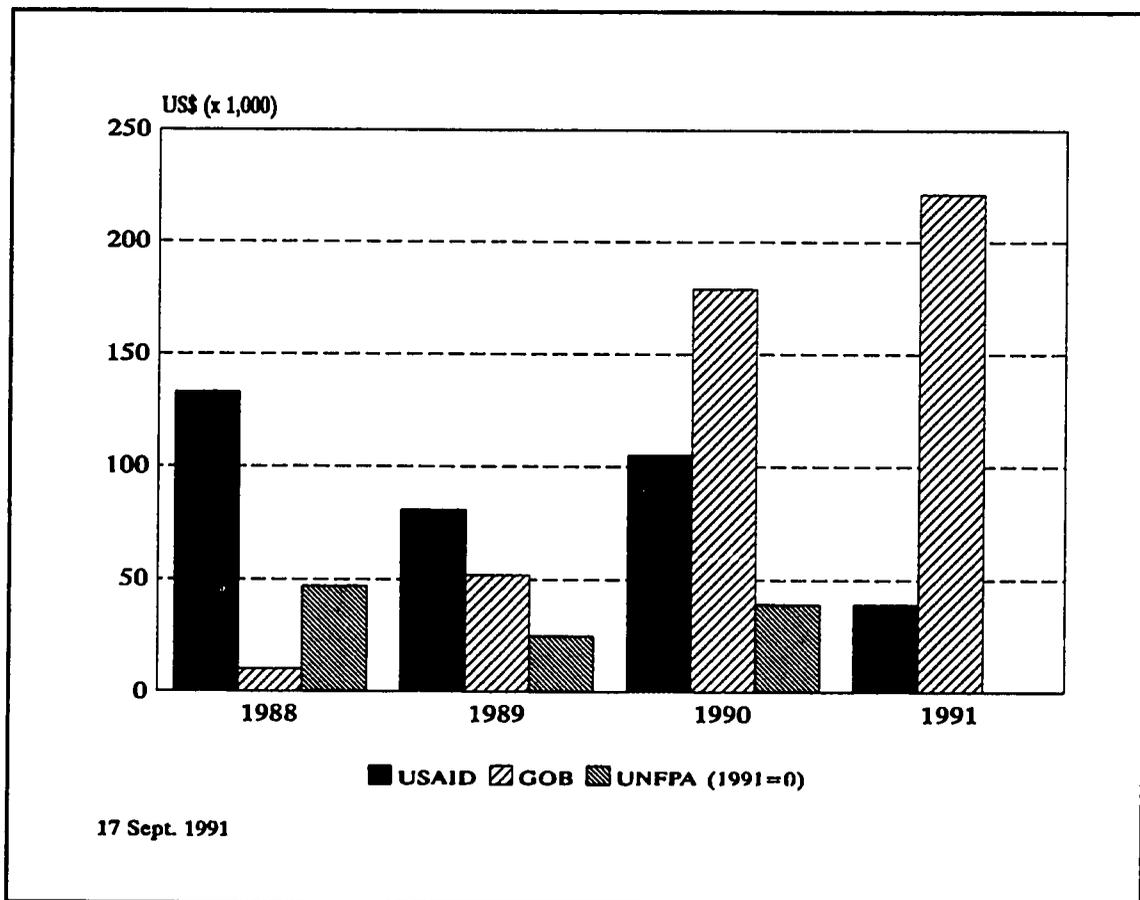
The BOTSPA PAAD emphasizes the importance of diminishing the reliance of the Botswana family planning program on donated contraceptives; these sources, particularly at the time of project conception, were unreliable.

Since then, A.I.D./Washington has emphasized the importance of "graduating" national family planning programs from a reliance on donated contraceptives in countries with the financial and technical resources to procure their own contraceptives.

The following graph illustrates Botswana's success at assuming full responsibility for the procurement of contraceptives.

Figure 1

Contraceptive Procurements by Donor



GOB procurement since the commencement of the BOTSPA project has increased dramatically, well in advance of the schedule specified in the PAAD and project agreement. It is clear that, with the exception of the constant UNFPA purchase of Depo-provera, GOB now purchases all contraceptives.

The UNFPA Depo-provera purchase typically occurs in October. The 1991 purchase is not included in the graph. The 1990 and 1991 USAID expenditure corresponds to special request purchases, which were necessary when GOB was unsuccessful in its negotiations with Wyeth for oral pill purchases. The problem was further aggravated when a manufacturer with a substitute pill supplied the wrong pill.

This problem has been temporarily resolved through the use of an intermediary (using GOB funds) and will be permanently resolved when CMS tenders the purchase of oral pills in a process that starts in November 1991 and will be completed with the issuance of procurement awards in May 1992.

GOB performance compared to the original BOTSPA targets (illustrative CPs) included in the PAAD are listed in the following table.

Table 3

**GOB Contraceptive Procurement vs.
BOTSPA PAAD Illustrative Conditions Precedent**

Tranche No.	Tranche Date	Cumulative Expenditure Proposed	Actual GOB Expenditure
1	Sept. 1988	0	0
2	Jan. 1990	<i>pula</i> 50,000	<i>pula</i> 114,431
3	Dec. 1990	110,000	354,667
4	Dec. 1991	380,000	762,211
5	Dec. 1992	930,000	NA

The actual GOB expenditure for 1991 (*pula* 762,211) corresponds to the first three quarters of 1991 only; nevertheless, it represents 82 percent of the end-of-project illustrative target.

CMS now handles contraceptives as it would any other pharmaceutical, using the same forecasting, tendering, and ordering procedures (described below) as for other pharmaceuticals procured overseas.

2.5.3 Financing Contraceptive Procurement

Currently, all costs for contraceptive procurement are attributed to the MOH budgetary vote (line item) for pharmaceuticals and drugs. For many non-contraceptive pharmaceutical items, the MOH is reimbursed through the use of transfer vouchers issued by the district councils from MLGLH budgets or checks written by town councils and private organizations receiving GOB pharmaceuticals. At present, town and district councils do not use their MLGLH budgets to reimburse the MOH for contraceptives.

Recommendation

19. The MOH should request from the MFDP that district councils, town councils, and private organizations reimburse the MOH for contraceptives purchased by the GOB.

2.5.4 Reliability of Contraceptive Supplies

The design of BOTSPA suggests that its authors considered distribution of contraceptives to family planning service delivery points to be a substantial problem. For the purposes of this evaluation, there is no contraceptive logistics reporting system that would yield a quantitative assessment of the percentage of facilities reliably supplied. Site visits, interviews, and anecdotal information, however, suggest that reliable and adequate supplies to family planning service delivery points are now the norm.

The problem of reliability of supplies may have been largely resolved as a result of the following:

- GOB procurement has assured more consistent supplies at CMS than was probably the case prior to BOTSPA. This has resulted from the inclusion of contraceptives in the well-established system used to forecast, order, inventory, and monitor GOB-procured pharmaceuticals.
- The manual *Managing Family Planning Commodities and Drugs in Botswana* was produced by the MOH in June 1989.
- Logistics training for senior field personnel began as early as July 1988. Logistics training for other field personnel began in May 1990.

Centrally funded A.I.D. technical assistance from the Division of Reproductive Health at the Centers for Disease Control (CDC) supported the production of the logistics manual, plus logistics training for both senior and other field personnel. The training team included the MCH/FP officer from FHD, the pharmacist from CMS with responsibilities for quality assurance, the United Nations volunteer evaluation officer, and selected district pharmacists.

At the time of this midterm evaluation, nurses from each of 18 districts had received a week-long TOT course in contraceptive logistics (funded in part by UNFPA). Many districts have replicated this training for providers.

Notable exceptions to success in assuring reliable supplies include the following:

1. A brief interruption of supplies at both CMS and service delivery points when CMS experienced difficulties in its negotiations with Wyeth for the purchase of oral pills.
2. Evidence of expired stock still in use. This may result from (a) habitual hoarding dating back to times when stock-outs were more common and revived by the recent and brief oral pill stock-out, or (b) documented problems with maintaining a FIFO (first in, first out) system.

3. **Lack of skills to monitor stock levels at health posts. Although referral hospitals and primary hospitals are staffed with trained pharmacists and pharmacy technicians capable of monitoring stock levels for pharmaceuticals, including contraceptives, these skills are less prevalent among enrolled nurses and family welfare educators at health posts.**
4. **Need for first-level TOT contraceptive logistics training in two remaining districts, and replication of this training for service providers which remains incomplete in other districts.**
5. **Need for a training manual on contraceptive logistics (which was planned but not completed).**

The most important omission is the lack of systematic assessment of stock levels at service delivery points. The FHD recognizes this shortcoming and has begun discussions to resolve this issue.

Recommendations

20. **FHD should conduct training in contraceptive logistics. This training should be expanded to include carefully considered interventions in the reporting system, including stock level reporting. The training should be preceded by the preparation of a training manual. (This recommendation is discussed further in Appendix C).**
21. **In the shorter term, FHD should request district health team assistance in the immediate distribution of contraceptives, particularly Ovette, to replace those which are nearing expiration.**

2.5.5 Current Family Planning Reporting Systems

The BOTSPA PAAD does not include activities in support of family planning reporting systems, much less an MIS. Instead, the authors refer to reporting systems anticipated to be in place upon commencement of BOTSPA activities.

These family planning reporting systems have yet to be initiated. Informants suggest the anticipated changes may have been based on planned World Bank health information system activities. These activities are listed by the World Bank Aide-Memoire, however, as not gaining the approval of the MOH.

As a result, many of the monitoring activities envisaged by the BOTSPA project have not proved feasible. For example:

- **There is no system to indicate stock-outages or adequacy of stock levels at service delivery points.**
- **Information on the volume of contraceptives issued has been recently added to the monthly reporting form and thus is theoretically available; in practice, it is incomplete and unreliable.**

- Reporting of the distribution of contraceptives by district has been attempted in the past, but CMS says such analysis is not possible, and it certainly is not being done on a regular basis.
- Continuation rates could be calculated from information in the current register, but record keeping on this aspect is not rigorous; in general, continuation rates have not been calculated or reported.

New Acceptors

The one indicator that is collected in a seemingly reliable fashion is number of new acceptors. Nurses interviewed consistently defined new acceptors as clients with no previous use of modern methods of family planning. This indicator, though, is rarely used, and in any case, fails to provide the most important management information for a mature family planning program.

Table 4

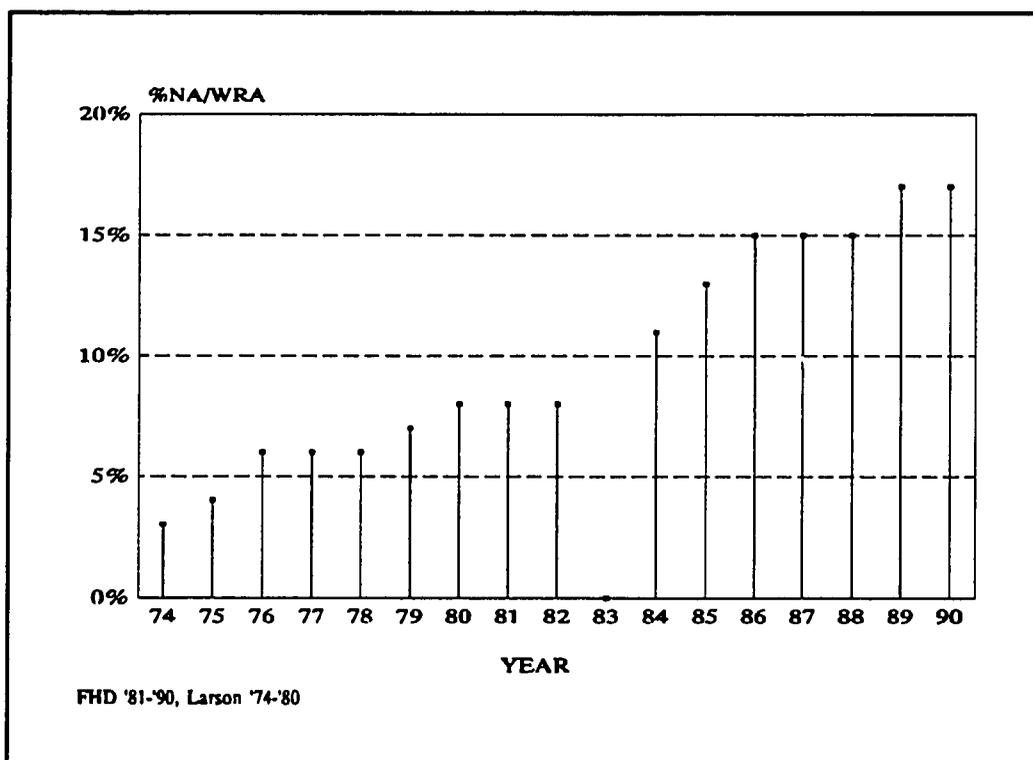
**New Acceptors per
Women in Reproductive Age (WRA)**

Year	New Acceptors	WRA (15-49 yrs)	Percent
1974	5,214	155,000	3%
1975	6,112	159,000	4%
1976	9,214	163,000	6%
1977	9,320	168,000	6%
1978	10,600	175,000	6%
1979	11,885	179,000	7%
1980	14,574	184,000	8%
1981	17,689	211,000	8%
1982	17,898	221,790	8%
1983	brand change		
1984	26,032	238,960	11%
1985	33,446	248,860	13%
1986	38,037	257,649	15%
1987	40,280	266,438	15%
1988	40,269	275,227	15%
1989	47,304	284,016	17%
1990	50,334	292,805	17%

The number of new acceptors is most often used as an indicator of programmatic growth and, more specifically, as a measure of IEC activities. It is, however, a decreasingly appropriate indicator for the family planning program in Botswana. Almost a third of the women in reproductive age (WRA) already use modern methods of family planning. Assuming a significant number of defaulters over the 16-year life of the program, the potential number of women who have never used a modern method of family planning is constantly shrinking. As the potential target group diminishes, new acceptors becomes a less salient indicator, while continuation rates and the prevalence rate become more important.

Figure 2

New Acceptors/WRA
1974-1990



CYP-Based Prevalence

Currently, demographic surveys provide the best measure of prevalence. These surveys are of limited use in the management of services, however, since they are carried out infrequently (once every three to five years) and are relatively expensive. Similarly, the sample size required for estimating frequency at district or facility levels is prohibitive.

Many family planning programs estimate prevalence from the quantities of contraceptives issued or distributed. This can be done with greater frequency than surveys, and estimates can be made for specific districts and facilities.

The SWEDIS inventory control computer software at CMS records and reports the distribution of pharmaceuticals, including contraceptives. Currently, SWEDIS reports contraceptive distributions by facility, but does not aggregate by district. Achieving district aggregates is likely to require only a very small modification. CMS has requested support from the software supplier in producing these reports. Such reports could be available within days.

FHD could, on a regular basis, use the process described in Appendix C to calculate CYP-based prevalence for districts. Such calculations would indicate relative performance among districts and progress over time.

Recommendation

22. FHD should request periodic reports from the SWEDIS software at CMS on district aggregate distribution of contraceptives, by product; FHD should use this information to produce CYP-based prevalence estimates.

Other Measures

Continuation rates, method mix, age distribution, and parity distribution of family planning clients are not currently calculated by FHD. The information needed for these calculations is routinely recorded at the service delivery points, but it is neither reported nor used.

Recommendation

23. FHD should implement the processes suggested in Appendix C to calculate continuation rates, method mix, and age and parity distribution.

2.5.6 Recommended Management Information System

Arguably, the most important use of family planning statistics is at the service delivery point. Providers should be able to estimate prevalence rates, programmatic growth, continuation rates, method mix, and age and parity distribution of family planning clients for their catchment area. They should be able to use these indicators to assess

- improvement in their own performance over time,
- their performance relative to neighboring facilities, and
- their performance compared to any existing national targets.

At the very least, using data at the point it is collected is probably the best means of improving the reliability of submitted reports.

Anecdotal evidence indicates district health teams have occasionally attempted to put existing data to constructive use. At least one district report includes graphic use of data. Another district has used a rather convoluted, though respectable, equation for converting revisits to prevalence. These attempts, though, are ad hoc and irregular. There is no evidence of district health teams using

statistics to justify increased priority and resource allocation for population activities. Of course, without feedback from the MOH, such promotional activities would be difficult.

At the central MOH level, there is evidence that in the past staff have attempted analysis of method mix and new acceptors as a percentage of women of reproductive age. Current practice, though, has deteriorated to reporting new acceptors as an absolute number. This does little to guide supervision and managerial decisions. Although there is intention to provide feedback to the districts eventually, data entry is behind and feedback has yet to occur.

The educational level and competence of family planning providers in Botswana, plus the maturity of the family planning program qualifies Botswana to become a family planning MIS model for other family planning programs in the region. Much of this could be accomplished in the near future through MIS in-service training at all levels.

Recommendation

24. The MOH should design supervisory systems that promote the local use of family planning data and should implement these procedures at facilities and districts through an MIS training process.

2.5.7 Technical Issues

The following describes important elements of contraceptive logistics as implemented in Botswana. This section documents the adequacy of systems already in place and, when appropriate, identifies anticipated problems and potential solutions.

Forecasting Contraceptive Requirements

CMS uses a seven-month reorder level for commodities on tender and a five-month reorder level for those commodities not on tender. Commodities procured overseas are topped up, or brought up, to a 13-month level for items ordered twice yearly and to a 19-month level for items ordered annually. Non-tendered items are topped up to a nine-month stock level. Average monthly consumption is calculated on historical distribution data.

CMS Ordering Procedures

CMS tenders any item with projected annual procurements in excess of US\$ 10,000. This process has already been applied to normal-dose oral pills. The same process will be applied to other contraceptives beginning in November 1991 with purchasing contracts awarded in May 1992.

Brand Selection and Anticipated Changes

The tendering process is likely to result in a change of contraceptive brands. As contraceptives are re-tendered in the future, these brand changes could conceivably reoccur. Brand changes increase the risk of discontinuation as acceptors are forced to abandon familiar brands.

The MOH assistant director of health services (PHC), when reviewing the new acceptor data included in Table 4, identified 1983, the one year for which there is no new acceptor data, as the year when oral pill brands were changed. According to her description, the difficulties resulting from this brand

switch were impressive. FHD will need to begin planning now for potential problems that may arise as early as June 1992 due to brand changes resulting from the tendering process.

Repackaging

One possible solution might be to repackage contraceptives under brand names appropriate for family planning clients in Botswana. This would assure continuation of a single acceptable brand regardless of any future changes in manufacturer. Given the disparity between the unit cost of the current US-manufactured contraceptives and the lowest-cost equivalents that should arise during the tendering process, the repackaging process might be implemented with little or no additional cost.

The MOH assistant director of health services (PHC) suggests repackaging could be accomplished either through expanded staffing at CMS or through contracting repackaging services from a private firm.

Alternatively, negotiations with contraceptive manufacturers might include requirements regarding packaging. The quantities of contraceptives ordered from Botswana, though, may not provide the GOB with sufficient leverage on this issue.

Promotional Activities

Repackaging would assure predictable brand names in the future. This would facilitate brand-specific multimedia IEC activities.

Repackaging and the possibility of promotional activities raise many issues beyond the scope of this evaluation. These issues need to be addressed in an organized format. USAID funds both repackaging and promotional activities in support of a number of family planning programs in Africa.

Recommendation

25. The MOH should request USAID technical assistance in identifying options for the repackaging and promotion of contraceptives. This request should occur now in anticipation of brand changes in mid-1992.

Warehousing

Comments during the BOTSPA design process suggested plans to construct a new building for CMS. This has yet to occur, but is currently planned for 1993. In the meantime, CMS has rented additional space. Site visits to both warehouses indicate adequate space and appropriate storage conditions.

Facility Stock Level Monitoring

Contraceptives have been added to the same stock monitoring format used for other CMS-supplied pharmaceuticals at health facilities. This format records, for each month, the quantity on hand, ordered, and received. The minimum stock and order quantity is listed for each commodity. The average monthly consumption is calculated using six months of historical data.

So long as contraceptives were a donated item, they were not formally included on this form. Some pharmacists and pharmacy technicians have still not added contraceptives to the existing process, and some nurses at health posts have not been adequately trained in the process. Resolution of this issue should occur through the in-service training recommended above (Recommendation 24).

Logistics and MIS Training

The logistics training conducted to date has reportedly been some of the most effective in-service training to occur during BOTSPA. The recent training has also incorporated MIS instruction in the use of the new family planning manuals.

Nevertheless, the inconsistent replication of the TOT logistics training, continued incomplete reporting, and the notable absence of any managerial or supervisory use of family planning data indicate that extensive additional training is required. This training should be accompanied by the production of a training manual for family planning MIS and contraceptive logistics, and it should include revisions suggested in Appendix C.

2.6 Trained Staff for GOB Population Programs and GOB Financing of Population Activities, Including Procurement

2.6.1 Number of Trained Staff

Background

The PAAD describes staff shortages of nurses, nurse-tutors, and family welfare educators as major family planning program constraints in 1988. It suggests in-service training, better supervision, increased effectiveness of family welfare educators to provide family planning information in the community, and shifting some of the responsibility for family planning IEC to NGOs and the private sector as ways to reduce these constraints. The importance of the Central Statistics Office in population program analysis and planning and the shortage of demographic staff at CSO is noted. Although the PAAD end-of-project success indicator is not specific for training outputs, it links the numbers of trained staff assigned to the management and implementation of population sector activities with the institutional objective of improving the MCH/FP service delivery system.

Current GOB Manpower Situation and NDP-7

Manpower shortages currently remain a major constraint in all sectors of the GOB. Significant health manpower production was achieved for many cadres during NDP-6, including the meeting of targets for enrolled nurse midwives, enrolled nurses, and family nurse practitioners. According to NDP-7, however, targets for registered nurse midwives and family welfare educators were about 50 percent less than anticipated in NDP-6. NDP-7 continues to address this constraint with a strategy to improve and expand health manpower training in order to adequately staff health facilities by 1997 and improve the quality of services. Priorities defined for health are manpower development, development of an improved health information system, and better organization and management at all levels. A major training objective is to improve health service delivery by strengthening management skills of supervisors and administrators through in-service and on-the-job training.

Pre-Service Training

Pre-service training is the domain of the National Health Institute and the University of Botswana.

The National Health Institute carries out the pre-service and post-basic training of some 600 students enrolled in nine programs. In addition to its Gaborone campus, it has branches in Francistown, Molepolole, Serowe, and Lobatse. Its programs include the pre-service training of registered nurses, enrolled nurses, laboratory technicians, pharmacy technicians, and dental therapists. Post-basic programs include those for nurse practitioners, nurse/enrolled nurse midwifery, community health nursing, and community mental health nursing. Additionally, the Seventh Day Adventist Hospital in Kanye trains nurses, and the Deborah Retief Memorial Hospital in Mochudi trains enrolled nurses. The University of Botswana has 45 baccalaureate students in its program. Discussions with the National Health Institute's Gaborone deputy principal and head of midwifery indicated that current space and tutor shortages (two full-time faculty for 18 community health nurse students; six faculty for 60 midwifery students) pose constraints. There is a lack of preceptors in the hospital clinical areas making it necessary for National Health Institute faculty to accompany the students. All established positions are filled but enrollment keeps increasing.

In addition to a family planning course, family planning skills training is integrated into the curriculum of the midwifery program (nurses and enrolled nurses). A review of the family planning course unit outline suggests that insufficient time is placed on counseling skills (two hours). Family planning skills training is part of the six-week MCH clinical practicum (three weeks at Princess Marina and three weeks in an integrated MCH/FP clinic). The course requirement is for a minimum of five IUD insertions but this target is not always met due to the low numbers of IUD clients (a situation which will affect any IUD training program in Botswana). It was stated that there is an insufficient number of faculty trained in family planning, especially family planning clinical skills, although there are trained preceptors to supervise nursing/midwifery students in the family planning clinical areas at Princess Marina and MCH/FP clinic. In the basic nursing program, family planning theory is taught but not IUD insertion skills, and it was reported that there are uneven opportunities for clinical skills practice.

In-Service Training

In-service training is a major task shared between the MOH Family Health Division (primarily through its MCH/FP Unit), the National Health Institute Continuing Education Section, and the district health teams.

- The major functions of the MCH/FP Unit include MCH/FP policy development, coordination, program planning, integration, monitoring, and evaluation of the MCH/FP program. The unit conducts MCH/FP and IEC workshops for district- and central-level PHC personnel, and also serves as a resource for the district health teams, other divisions, the private sector, and NGOs on request. Workshops conducted during the past year or so include TOT for MCH/FP staff, update for private practitioners, family planning logistics training, IEC workshops, and more recently (September 1991), training for nurses and supervisors on *Family Planning Policy General Guidelines and Service Standards*. The unit's workplan activities during 1990-1991 encompassed supervision and on-site training for integration of MCH/FP at the various service delivery levels, strengthening the MCH program components through supervision and inputs into the traditional birth attendants, acute respiratory infections, and child diarrheal disease programs, school health, family planning logistics training, health education, CBD pilot studies and other surveys, and processing of short- and long-

term participants for external training. Activities planned for 1991/92 include many of those described above but will place more emphasis on family planning workshops designed to prepare a core training team.

The MCH/FP Unit has been the major implementor of the activities carried out under BOTSPA which are discussed below. Currently, staff on study leave and staff turnover have left the MCH/FP Unit temporarily without several experienced officers.

- The Continuing Education Section (CES) operates under the National Health Institute and primarily at the central level. It lists among its primary functions the provision of continuing in-service training opportunities to central and district staff to enable them to maintain competencies. The CES reports that it coordinates all training through preparation of a master training plan derived from district and MOH plans.

Activities conducted during 1990/1991 included three workshops related to administrative/management techniques for senior hospital-based matrons, supervisors, and nurses, and one workshop to revise and finalize the family planning integration guide (to integrate family planning into the curricula of the National Health Institute's pre-service programs). CES cooperates closely with the MCH/FP Unit training section and provides clinical family planning and training assistance when requested.

CES staff took part in the development of the *Family Planning Clinical Policy Guidelines and Standards* and in development of the *Family Planning Procedures Manual*. CES has been operating under some rather severe staff constraints. During 1990/1991, out of a staff of five, three were on study leave. At present, there is only one full-time staff member left in the section, as two have been recently transferred to the Gaborone National Health Institute and Lobatse National Health Institute programs. The implications of this diminished number of staff are discussed below.

- District health teams are reported to conduct training for clinic and health post staff and to include those activities in their annual workplans. Discussions with two district health teams and review of four district annual reports (1989/90) and two district team training plans suggest that while training is occurring, it is not a systematic, integral part of district priorities and very little of it relates to family planning. For planning, coordination, and early identification of funding sources, it would be useful if MOH central-level staff were able to work with the district health teams during preparation of the district health teams' annual workplans to ensure that MCH/FP training activities are stressed.

It is clear that an insufficient number of clinically trained family planning staff at central and district levels is seriously affecting the amount of family planning in-service training being designed and implemented, particularly in the past year or so. Currently, the institutional capability at the MCH/FP Unit and at the CES to conduct in-depth, clinical family planning skills training is limited. The MCH/FP Unit relies on the UNFPA family planning training consultant to design and conduct non-clinical family planning training. Although there are three nurses in the MCH/FP Unit, they are reported to possess limited family planning clinical and trainer skills. The one person remaining at the CES is reported to be a skilled family planning trainer, but it is unlikely she will be able to commit much of her time to outside activities.

This situation has serious implications for the MCH/FP Unit. CES plans to launch, jointly with the MCH/FP Unit, a decentralized model for MCH/FP in-service training. Originally proposed to take place in 1990, possibly using Program for International Training for Health (INTRAH) technical

assistance, it was replanned for early 1991 using in-country resources, but postponed because of illness of one of the key personnel. A scope of work has been developed and senior nurses with family planning skills have been identified as the core team members (some of whom are BOTSPA/UNFPA-funded family planning clinical skills short-term training participants). The core training team will be trained in the use and application of the *Family Planning Policy Guidelines and Family Planning Procedures Manual*, and in turn will provide family planning skills training (including IUD insertion) to other service providers in the districts, using the manual as the base for training. This activity has a significant potential impact for improving family planning services in that it addresses the identified training needs of nursing service staff, addresses the issue of the low IUD acceptor rate, will serve to get the family planning manual (which cannot be distributed until training has occurred) into the hands of service providers, and decentralizes training. This activity is one of the more innovative activities developed under BOTSPA and deserves priority attention in the BOTSPA redesign.

BOTSPA Training Outputs

Under BOTSPA, the following training outputs have been realized, to date:

Long-term training:

1 MPH in Population Studies/FP - USA	MCH/FP Unit
1 M.Sc. in Statistics - USA	CSO
1 B.Sc. in Health Education - USA	Health Education Unit
1 Diploma in Graphic Design - Zimbabwe	Health Education Unit
1 Diploma Data Processing (ISPC) - USA	CSO

Short-term regional training:

9 FP Clinical Skills	4 ULGS; 2 NHI; 3 Health Services
2 CBD Study Tour	1 FHD; 1 PHC
1 Safe Motherhood	1 MOH Health Center
2 FP Management	2 ULGS
1 FP study tour	1 FHD
4 Family Life Education	2 MOE; 2 BDF
1 Adolescent Fertility	1 NGO/YWCA
1 FP Communication	1 NGO/BOFWA

In-country training:

- 1 computer training at the MCH/FP Unit
- Contraceptives logistics workshops for MOH/ULGS staff
- IEC family life education workshops (see Section 2.4 for description)

Other BOTSPA Long-Term and Short-Term Training Candidates

Five more long-term candidates have been identified for study in the United States under BOTSPA. Two FHD candidates were slated to leave for U.S. study in September 1991, but because of the BOTSPA current evaluation their departure dates have been postponed. Two other candidates had departure dates planned for January 1992 (until appropriately qualified individuals can be found to replace them). The fifth candidate has a September 1992 departure date. Four of these five candidates are to be enrolled in undergraduate programs. Assuming that each can complete a baccalaureate degree in three years and that all are accepted into a January 1992 program, the

earliest these candidates are likely to complete a course of study is December 1995. This would probably run about 16 months beyond the BOTSPA completion date, even with a no-cost time extension.

Given the cost and time frame required, the emphasis on long-term baccalaureate degree fellowships is not appropriate. The emphasis would be better placed on short-term regional training in the areas of family planning program planning and management, family planning clinical skills training, MCH courses that focus on high-risk case management approaches, etc. Central-level participants (FHD and National Health Institute), members of the district health teams, and PHC MCH/FP nursing supervisors are the best candidates for these courses, with some priority given to the selection of district health team members and supervisors (especially from the more isolated areas of the country).

The evaluation team met with two of the short-term third-country trained participants — one, sponsored by BOTSPA, took the CAFS family planning management course in 1990, and one, sponsored by UNFPA, took the Zimbabwe National Family Planning Council family planning update in clinical skills course in 1990. Both found that the courses attended were useful and had improved their skills. Each recommended that others be placed for similar training. The BOTSPA-sponsored participant had prepared a comprehensive CBD proposal which has been submitted to the FHD for funding consideration. She also works with the district health team in her area and arranges seminars for traditional healers, traditional birth attendants, and community leaders on MCH IEC topics. The UNFPA-funded participant reported she had not trained anyone formally since her return, but was confident she could if given the opportunity. It was reported that another two participants had been active since their return from the short-term training and had conducted MCH and family planning courses in their respective districts for other nurses and family welfare educators. It is unclear if the remaining BOTSPA-sponsored participants are utilizing new skills acquired, or if each has been deployed for maximum utilization.

Given the current lack of a qualified family planning clinical trainer in the training section of the MCH/FP unit, it would make sense for at least two of the MCH participants to be transferred there. Alternatively, at least two of the current MCH/FP unit nurses could be sent for the Zimbabwe family planning clinical skills course and posted to the training section. Reports prepared by UNFPA-funded participants were on file at the MCH/FP Unit; only one such report was there for BOTSPA-funded participants. These reports should be a USAID requirement.

A review of the list of short-term training participants indicates that each was well selected in terms of district/department representation and qualifications for the courses attended.

Increased Trained Staff Assigned to Population Sector

The number of trained nursing staff assigned to the health sector is slowly and steadily increasing as shown in the following tables.

Table 5
Nurses Employed in the Health Sector
by December 1987

Category	Employer				Totals
	Ministry of Health	Town & District Councils	Missions and Mines	Private and Other	
Registered Nurse	602	312	123	17	1,054
Enrolled Nurse	613	495	148	22	1,278
Total	1,215	807	271	39	2,332

Source: MOH Health Manpower Development Unit

Table 6
Nurses Employed in the Health Sector
by December 1990

Category	Employer				Totals
	Ministry of Health	Town & District Councils	Missions and Mines	Private and Other	
Registered nurse	653	357	139	25	1,174
Enrolled nurse	656	578	159	31	1,424
Total	1,309	935	298	56	2,598

Source: MOH Health Manpower Development Unit

Table 7
Nurses Employed in the Health Sector Variation from
December 1987 to December 1990 Numbers and Percentages

Category	Ministry of Health		Town & District Councils		Missions and Mines		Private and Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Registered nurse	+51	8	+45	14	+16	13	+8	47	+120	11
Enrolled nurse	+43	7	+83	17	+11	7	+9	41	+146	11
Total	+94	8	+128	16	+27	10	+17	44	+266	11

Source: MOH Health Manpower Development Unit.

Table 7 shows that the number of registered nurses/enrolled nurses posted to ULGS health center and health post facilities increased by an average of 16 percent over the three-year period 1987-1990. Although it is not possible to state how many of these are actually engaged in the "population sector," it can be assumed that a majority of the registered nurses/enrolled nurses employed by the ULGS work in integrated MCH/FP facilities, and thus, would be providing family planning services. The numbers trained to provide a full range of quality clinical family planning services, however, is probably much lower (for reasons discussed above), and these numbers must be balanced against the increase in new clinic and health post facilities opened in recent years (see Table 1, Section 2.3.3).

Conclusions Regarding Numbers of Trained Staff

The institutional capacity of the two major family planning in-service training units within the MOH to conduct clinical family planning training is currently very limited because of a shortage of staff trained in the clinical aspects of family planning. This has resulted in a limited amount of family planning training (both clinical and non-clinical) having been conducted for service providers over the past year. Little family planning training is being conducted by the district health teams, and pre-service family planning training is hampered by insufficient numbers of faculty trained in family planning. The MCH/FP and CES Units that are to develop a core training team to design, conduct, and oversee decentralized family planning training in the districts are being affected by the staff shortages.

Given the limited time and funds available under BOTSPA, it is important that undergraduate long-term training be de-emphasized in favor of short-term regional training. This will be in keeping with the MOH Departmental Training Plan.¹⁴

BOTSPA training outputs are significant in terms of long- and short-term trainee outputs. Its contribution to in-service, in-country family planning training has been modest and apparently confined to family planning logistics training and IEC/family life education training.

Recommendations

26. During the redesign of BOTSPA, emphasis should be placed on the following:
 - strengthening the MOH institutional capacity to design, conduct, and evaluate clinical family planning in-service and pre-service training, specifically the MCH/FP Unit, CES, and the National Health Institute's pre-service nursing programs;
 - providing full support for the MCH/FP Unit and CES to develop a core training team and to decentralize family planning training; and
 - emphasizing the family planning training of the district health teams, operations research, and other areas identified by a needs assessment.

¹⁴MOH Health Manpower Training Department - Departmental Training Plan, 1991-1992.

27. Short-term regional training should be emphasized and long-term undergraduate training de-emphasized in the next BOTSPA phase.

2.6.2 GOB Financing of Population Activities, Including Procurement

In addition to an increased number of trained personnel, the sixth objective of the BOTSPA project called for an increase in GOB funding for family planning, especially contraceptive procurement.

As shown in Section 2.5.2, contraceptive procurement is one of the most successful aspects of the project, with the GOB almost fully self-reliant in this area at present.

The overall levels of funding of family planning activities are much more difficult to evaluate. First, the GOB General Revenue Budget is composed of the recurrent and development budgets. The recurrent budget covers fixed expenses which are incurred continuously (e.g., salaries, fuel, maintenance, etc.). The development budget is based largely on donor contributions and covers expenses incurred during the life of specific projects.

Within the recurrent budget, it is virtually impossible to identify the absolute amount or the percentage of total MOH expenses corresponding to family planning. The development budget is reported by the categories shown in Table 8. Although some of the development budget consists of GOB funds ("domestic development funds"), the majority represents donor contributions.

The broad categories — family health project, health education program, district health teams — allow one to analyze the general trends over time; for example, the level of spending for the district health teams has increased steadily from 1985-1990. The available financial data, however, do not allow one to determine whether government spending on family planning has increased under BOTSPA, for the following reasons:

- these statistics do not differentiate between family planning and other health areas; and
- data are only available for one year of the BOTSPA project (1989-90), thus making any analysis of "trends over the life of the project" impossible.

In sum, the GOB has made impressive progress with regard to contraceptive procurement. The published financial data, however, do not allow for a determination of the GOB level of funding for family planning and how this may have changed over the lifetime of BOTSPA.

Table 8

GOB Expenditures on Health/Family Planning, 1985-90

		1985/86	1986/87	1987/88	1988/89	1989/90
MOH						
MCH/FP Project	DDF ¹	0	0	0	39,079	67,150
	Act. Exp. ²	89,830	286,298	59,189	57,112	544,141
	DDF % ³	0%	0%	0%	68%	12%
Family Health Project	DDF	82,247	107,104	2,071,630	146,999	0
	Act. Exp.	304,441	812,119	2,670,065	2,638,108	1,225,146
	DDF %	27%	13%	78%	6%	0%
Health Education Program	DDF	0	0	0	0	0
	Act. Exp.	34,726	56,649	51,314	90,958	129,689
	DDF %	0%	0%	0%	0%	0%
Nutrition Program	DDF	0	0	0	0	0
	Act. Exp.	16,829	355	0	2,342	0
	DDF %	0%	0%	N/A	0%	N/A
Total MOH	DDF	82,247	107,104	2,071,630	186,078	67,150
	Act. Exp.	445,826	1,155,421	2,780,568	2,788,520	1,898,976
	DDF %	18%	9%	75%	7%	4%
MLGL						
Basic Health Facilities	DDF	292,685	0	66,200	145,000	282,615
	Act. Exp.	1,770,395	2,093,267	2,908,818	2,686,913	651,090
	DDF %	17%	0%	2%	5%	43%
District Health Teams	DDF	2,167	0	0	620,765	1,466,253
	Act. Exp.	116,487	327,620	786,045	1,666,828	1,567,695
	DDF %	2%	0%	0%	37%	94%
Total MLGL	DDF	294,852	0	66,200	765,765	1,748,868
	Act. Exp.	1,886,882	2,420,887	3,694,863	4,353,741	2,218,785
	DDF %	16%	0%	2%	18%	79%

¹DDF = Domestic Development Fund²Act. Exp. = Actual expenditures in Pula³DDF% = DDF as a percentage of actual expenditures

Table 8 (Cont'd)

CSO						
Household Survey	DDF ¹	114,550	157,792	165,816	33,173	368,878
	Act. Exp. ²	194,118	157,793	165,817	199,623	500,343
	DDF % ³	59%	100%	100%	17%	74%
Population Census	DDF	0	0	0	0	0
	Act. Exp.	0	0	0	0	0
	DDF %	N/A	N/A	N/A	N/A	N/A
Total CSO	DDF	114,550	157,792	165,816	33,173	368,878
	Act. Exp.	194,118	157,793	165,817	199,623	500,343
	DDF %	59%	100%	100%	17%	74%
Grand Total	DDF	491,649	264,896	2,303,646	985,016	2,184,896
	Act. Exp.	2,526,826	3,734,101	6,641,248	7,341,884	4,618,104
	DDF %	19%	7%	35%	13%	47%
	Dev Exp	247,518,709	405,215,251	558,146,735	797,339,056	827,647,413
	FP Pct	1%	1%	1%	1%	1%
	Tot DDF	138,307,936	206,396,999	300,000,000	565,100,148	632,194,045
	FP Pct	0%	0%	1%	0%	0%

¹DDF = Domestic Development Fund

²Act. Exp. = Actual expenditures in Pula

³DDF% = DDF as a percentage of actual expenditures

2.7 NGO and Private Sector Participation

2.7.1 Background

To date, NGOs and the private sector have had relatively little participation in expanding services or promoting awareness. Until recently, NGOs did not have membership on the Interministerial Programme Steering Committee for Population and Development (IPSCPD), and today they have observer status only. Since this is the mechanism through which funding is granted and policy is promoted, NGO input into such processes is negligible. (It should be noted that NGOs have chosen to remain a certain distance from government in order to maintain their autonomy.) NGOs, however, participate fully on subcommittees created for subject-specific activities. For example, NGOs sit on a subcommittee for family life education and the Kalahari Conservation Society is represented on the subcommittee for population and environment. The University of Botswana, as a parastatal, is not considered private sector and is thus directly represented on the IPSCPD. No employers or private businesses are represented on any committee.

The FHD and USAID have an ongoing AIDS project with the organized sector through the Occupational Health Unit. In addition, BOTSPA funds supported the pilot project for condom vending machines (see Section 2.3.7). GOB purchased the machines and BOTSPA funds have covered condom repackaging and supplies, maintenance, and repairs. As stated earlier, FHD is currently looking for private sector businesses to take over responsibility for these machines.

A one-day orientation was held for NGOs to solicit their assistance for family life education. Four proposals were subsequently submitted to the IPSCPD, of which two were funded and two are in the review process.

2.7.2 NGO Participation in Family Life Education

YWCA

Family life education is being implemented by the YWCA and the Botswana Family Welfare Association (BOFWA) under grants from BOTSPA. Neither of these projects was submitted to the IPSCPD for review, but rather they were directly subcontracted by FHD.

The family life education program being implemented by the YWCA has been in operation for a year. It is carried out by two counselors, both female, neither of whom has family planning-specific training, although one is a professional social worker. Efforts to recruit a male counselor were frustrated by a lack of funds. Partially because it is church-based and partially because the counselors themselves are not well informed on the subject of family planning and contraception, the peer counseling aspect of the program does not include contraception and family planning except in a very general way in the training module on human sexuality. In the proposal submitted by the YWCA, peer counseling was listed as one of the primary subject areas. The peer counselors themselves are selected by school administrators, and one of the criteria for their selection is church participation. Thus, the YWCA serves as an example of a values-based program, whose principal message is delayed sexual gratification.

The YWCA program functions in 11 schools in Gaborone and seems to be popular with students, parents, and administrators. With the addition of summer courses in family life education (minus family planning), the program's administrators found the demand among teens to participate exceeded available space. Lack of alternative summer activities and employment opportunities for these youth no doubt contribute to the program's popularity, but there is obviously potential for more in-school activities. The director of the YWCA project went on a BOTSPA study tour in the United States, but has little day-to-day contact with the project.

BOFWA

The BOFWA-supported program includes a teen center which, though small, is immensely popular as a social center, according to program counselors. Use of this center is expected to further increase once recreational activities are instituted. The BOFWA staff are not shy about discussing family planning directly. The BOFWA mandate, however, is to reach out-of-school youth, and to date BOFWA serves primarily in-school youth from nearby schools. BOFWA has access to the services of an International Planned Parenthood Federation (IPPF) IEC adviser, but is currently going through difficulties because the BOFWA director has resigned. Since she was the BOFWA agent trained in family life education under BOTSPA, her training is lost to the project.

2.7.3 Other NGO Activities

Another NGO activity is the Machudi project, which was initiated by the World Bank and subsumed under BOTSPA. Conceived as an experiment in participatory development, the project started with 10 households that selected their development targets (initially sanitation and household hygiene), and then expanded to include other households and, now, nearby villages. Although the women in this project are organized and come together for lectures and discussions, family planning is rarely one of the topics. Project workplans called for replication of this model in another district. This should be encouraged, assuming that the FHD will begin family planning promotion through alternate sources (i.e., the family welfare educator, schools, PTAs) in the same location.

Another locality that has been identified for intensified family life education training is Serowe. Although the Serowe activity was initially conceived to include district-level NGOs such as the Girl Guides, these groups have yet to participate. This may be due in large part to the lack of groundwork when the family life education program was initially implemented in that area.

The Environmental Subcommittee of the IPSCPD also submitted a project which was to be subcontracted to the Kalahari Conservation Society. The proposal called for the preparation of a comprehensive population and environment awareness campaign, including preparation of materials for various levels of participants (parliamentarians and chiefs, teachers, village development councils, etc.) and conferences at both central and district levels; in short, a complete program to develop a national dialogue linking population and the environment. The IPSCPD approved the project and assigned an initial budget of 10,000 pula. When activities commenced, however, difficulties in reimbursement through the Ministry of Finance and Development Planning emerged, and in the general freeze that USAID imposed earlier this year the project was not pursued.

2.7.4 Discussion Regarding NGO Level of Activity

The limited NGO participation can be attributed to several factors. The absorptive capacity of most of the NGOs is highly limited, as is their reach. Because of their reduced capacity for fund-raising, almost the entire cost of activities and infrastructure is placed on the donor. Sustainability under these conditions is doubtful. Most of the NGOs rely heavily on the goodwill of their volunteers or on low-salaried staff, a practice which results in high turnover.

The centrally based NGOs have little reach outside the capital, although the Girl Guides and the Botswana Women's Association do have chapters in the larger towns and villages. This makes support of district-level activities difficult though not impossible.

A number of large industries (mining, meat packing) already provide family planning services, and some of the intermediate ones (e.g., the brewery) can be encouraged to provide family planning for their employees. Many are already cooperating with the AIDS Prevention Program and would not be averse to including family planning. Discussion with the general manager of one of these industries indicated that he was already aware of the problem in his own workplace, had made some effort to counsel his employees, and would welcome additional assistance.

At the district level, PTAs, school health clubs, and other groups can be enlisted and encouraged by the family welfare educator to assist with district-level education. A small budget, planned and managed by the district medical officer, could be made available for such activities.

In short, the opportunities for NGO and private sector participation exist and assumptions about their potential contribution made in the PAAD are still valid. The mechanism by which grants are awarded needs revision, however. One of the advantages of NGOs is that they can undertake innovative though potentially sensitive activities without pressure from the government. Under the revised BOTSPA, it would be advisable for USAID or its contractor to award and monitor NGO grants directly. The district health teams and Peace Corps volunteers can assist in identifying and monitoring potential candidates at the district level. The award process needs to be accelerated, and USAID will need to provide infrastructure support for NGOs, which may include salaried personnel, equipment, and some transportation.

Recommendation

28. USAID support for NGOs should be continued and increased; GOB should be kept apprised of their efforts, but future grants should be monitored by USAID (or its contractor). USAID should understand that NGO support will require infrastructure development and training.

3. Assessment of Funding Mechanisms

3. Assessment of Funding Mechanisms

3.1 Description of the Mechanisms

3.1.1 Non-Project Assistance

Under NPA, the host government and USAID jointly agree to a set (or sets) of conditions precedent (CP) and to the dollar amounts to be disbursed to the government for the successful fulfillment of the CPs. The BOTSPA project agreement includes actual CPs corresponding to the first tranche (or disbursement of funds), and illustrative CPS for the remaining tranches, the specific details of which are to be negotiated as the project evolves. A list of the illustrative CPs from the PAAD and subsequent amendments are given in Table 9.

Once the agreement is signed, the government works to satisfy these conditions. Upon fulfillment of a set of CPs, the government presents evidence to this effect to USAID, demonstrates need for local currency to fund project-related activities, and requests payment of the pre-established amount. Provided that USAID concurs that the CPs have been successfully met, it arranges for disbursement of the funds in U.S. dollars.

Under BOTSPA the first set of CPs was met in March 1989. At that time, USAID arranged for disbursement of a check for \$900,000 to the GOB.

3.1.2 Local Currency Account

The project agreement for BOTSPA stipulates that upon receipt of the dollar disbursement, the GOB will deposit an equivalent amount of local currency into an account designated uniquely for this purpose. The GOB has instead deposited the funds into the General Revenue Account, but has assigned them to a unique "ledger account" that differentiates BOTSPA funds from other GOB revenues.

As discussed in Section 2.6.2, within the government system, there are two types of budgets: recurrent and development. The recurrent budget covers fixed expenses that are incurred continuously (e.g., salaries, fuel, maintenance, etc.); the development budget is based largely on donor contributions and covers expenses incurred during the life of specific projects. The BOTSPA funds go toward the development budget.

The purpose of the local currency account is to support GOB programs and activities which contribute to attaining project objectives. Because the GOB is responsible for programming these funds (albeit in consultation with USAID), the mechanism is designed to strengthen GOB's capacity in managing funds for population activities. The advantage to the GOB is that it has greater flexibility in accessing these funds than is the case with USAID project funds. In essence, the government controls these funds.

Table 9

Conditions Precedent for the BOTSPA Project

First Tranche		Second Tranche	
Illustrative Conditions Precedent ¹	Amendments to CPS ²	Illustrative Conditions Precedent	Amendments to CPS
Establishment of an inter-ministerial program steering committee responsible for the implementation of this project.	Not Applicable	Draft of National Pop. Policy and consultations with public and within government	Evidence that the GOB is preparing and consolidating draft Nat'l Pop. Programs Guidelines, including the holding of consultations and discussions with GOB and with the public
A written plan which sets forth actions required to develop a Nat'l Pop. Policy	Not Applicable	Establishment or designation of a govt. office responsible for coordination of pop. policies and programs	Evidence that GOB's designated office responsible for coordination of pop. activities and programs has adequate staff and facilities to function appropriately.
Assignment of an official IEC counterpart	Not Applicable	Initiation of plan by CSM for procurement and distribution of contraceptives	(highly similar)
A written plan and procedures for the procurement and distribution of contraceptives by the CMS	Not Applicable	Written plan for expansion of IEC services provided by H.E. Unit and district H.E. teams	(highly similar)
A written plan for improving the quality MCH/FP clinical services; and expanding the number of service delivery points	Not Applicable	Initiation of plan to improve MCH/FP services and increase service delivery points	(highly similar)
A written plan which describes how GOB will increase the participation of NGOs, including private sector in pop. programs	Not Applicable	Initiation of plan to increase participation of NGOs, incl. private sector in pop. programs	(highly similar)
Establishment of a special local currency account in the Central Bank of Botswana for deposit of local currency	Not Applicable		

¹For the first tranche, these were actual, not illustrative CPs.

²The CPs for tranche 2 are established in amendment 1, thus replacing the illustrative CPs. The CPs for tranche 3 are established in amendment 2.

Table 9 (Cont'd)

Third Tranche		Fourth Tranche	
Illustrative Conditions Precedent	Amendments to CPS	Illustrative Conditions Precedent	Amendments to CPS
Adoption, public description, and endorsement of Nat'l Pop. Policy	Evidence that the GOB has held consultations with the public and within government on the formulation of national policy on pop. and development in accordance with NDP-7	Initiation of implementation of Nat'l Pop. Policy	Not Applicable
Initiation of plan for IEC expansion by HEU and district HE teams	(highly similar)	Substantial expansion of IEC services by HEU and district HE teams	Not Applicable
Improvement in quality and effectiveness of existing MCH/FP services; substantial increase in service points	Evidence of a significant increase in the provision of MCH/FP services, through existing and additional service delivery points	Procurement of non-donor funded contraceptives (Pula 110,000 or more)	Not Applicable
Procurement of contraceptives with non-donor funds (Pula 50,000 or more)	Evidence that by 1991/92 GOB fiscal year, GOB is financing the procurement of at least 60% of its contraceptives with other than donor-provided funding	Substantial increase in participation of NGOs, including private sector	Not Applicable
Successful implementation of plan to increase NGO participation	(highly similar)	Fifth Tranche	
	Evidence that the IPSCPD has been replaced by a Permanent Standing Committee on Population and Development with adequate support to monitor and oversee implementation of a nat'l pop. program	Plan to procure with non-donor funds at least (Pula 930,000) of contraceptives within five years	Not Applicable
	Evidence that a planning officer in the MOH's planning unit has been designated with responsibilities for pop. program coordination	Plan to procure with non-donor funds at least (Pula 930,000) of contraceptives within five years	Not Applicable
	Evidence that the comprehensive pop. program workplan and budget developed by the IPSCPD has been approved and is being implemented.		

The local currency funds are to be programmed according to a workplan. In the GOB system, the ministry in question prepares and submits a workplan to the Ministry of Finance and Development Planning; the plan is reviewed at MFDP's annual project review meeting in March of each year, and if approved, MFDP determines a certain funding level for the account. (The amount can be increased at a later date if there is need and funds are available.) In the case of BOTSPA, the MOH has submitted its annual workplan to the MFDP and received a finance warrant to cover its projected activities.

This is in line with the project agreement, except that the agreement stipulates a workplan to be mutually agreed upon by GOB and USAID. This "approved" workplan was not in place when the first tranche of BOTSPA funds was released. Nonetheless, funds were disbursed from the local currency account, based on compliance with general GOB procedures. The lack of an official interministerial workplan may account in part for the confusion expressed by several GOB officials over the types of expenses authorized under this account.

Although NPA is considered "new" within USAID, the deposit of funds into the local currency account, to be spent as needed for project-related purposes, is similar to the mechanisms of other donors in which the funds are "advanced" to government (as opposed to cost-reimbursement). Thus, for the financial officers of the MFDP, there was nothing unusual or difficult about this mechanism.

3.1.3 Accessing Funds

The mechanics of accessing these funds are also well known to MOH and MFDP officials, the only two ministries to access funds to date. Specifically, once the funds are made available, the MFDP issues a **finance warrant** authorizing a specific division of a ministry (e.g., the FHD or CSO) to spend up to a specified amount. A code or codes are assigned for the activities to be conducted. The official in charge of the division then can access those funds using a **request for payment**. This request is processed through the finance officer assigned to that ministry, who ensures that funds are available under the code assigned and that the type of expense falls within the project workplan. If this is the case, the finance officer processes the payment through the system and the funds become available.

Although this system generally works well, it has several limitations. First, all of the payments made by GOB are processed through the Government Computer Bureau, which then is able to produce expenditures by line item for specific projects such as BOTSPA. The categories are fairly general (e.g., salaries, transport, equipment, etc.), however, and do not allow one to identify specific activities paid for with project funds. The project agreement specifically states that the GOB is required to track expenses only to these line items, not to specific activities. The system has proven unsatisfactory, however, for USAID's need to monitor what has been paid under BOTSPA.¹⁵

A second problem is that because the computerized system tends to run five months behind the actual date, it is never possible to establish the current balance of an account based on the information in the system. This problem is similar for all GOB accounts, not just BOTSPA's. In response

¹⁵Originally, USAID did not anticipate this would be a problem, since USAID expected detailed workplans that would describe the nature of the expenditures. When workplans duly approved by the IPSCPD were not forthcoming, however, USAID became more interested in knowing what had been purchased with project funds. Also, it appears that USAID currently demands more rigor in accounting for local currency generated under NPA than it did at the time BOTSPA was signed.

to this problem, the GOB has established a manual system throughout the government, whereby the financial officer of each ministry maintains a written log of expenditures as they are incurred. (Moreover, four officers within the FHD have been given manual registers to record their own requests for payment; this constitutes an informal system to further document project expenses.) The manual system allows the financial officer to give the level of expenditure of project funds at any point and to identify the exact nature of the expenditures. This has enabled the GOB to provide USAID with lists of project expenditures to date.

The manual system, however, allows for omissions in the event that the finance officer fails to record a given expense. According to the chief finance officer at the MFDP, it is often the case that it is not possible to reconcile the balance from the manual system with that of the computerized system (when the data become available five months later). It does not appear that these discrepancies are rigorously pursued. (See comments below in Section 3.2 on the integrity of the GOB financial system.) In the BOTSPA report for the first year of project funding, this discrepancy came to 12,900 *pula* (approximately US \$6,450).

A third problem with regard to accessing funds involves the requirement of a workplan agreed upon by GOB and USAID for the disbursement of funds. As stipulated in the project agreement, such a workplan is necessary before funds are to be spent either from the local currency account or from the project funds administered by USAID. These workplans are to be a compilation of individual workplans drawn up by the ministries and organizations involved, and are in turn to be integrated into a comprehensive workplan by the IPSCPD. Once approved by the IPSCPD, the comprehensive workplan is forwarded to USAID for discussion and approval. According to USAID, it has yet to receive a comprehensive workplan duly approved by the IPSCPD and satisfactory to USAID. (In theory, this should have prevented the disbursement of funds from either the local currency account or the USAID project fund account, but this has not been the case.) In short, this is not a problem of the financial accounting system of the GOB, but rather it is a situation internal to BOTSPA.

3.1.4 Project Assistance

To date, \$1,600,000 has been made available under project funds for expenditures on training, technical assistance, and other activities intended to assist the project in reaching its objectives. It was unclear to at least one official involved in the project as to what types of expenditures should be made from the local currency accounts versus the USAID dollar account. MOH officials recognize, however, that they have greater and more flexible access to the local currency funds than USAID-managed project funds.

Of the \$1,600,000 obligated, \$899,833 has been earmarked to date. The project funds are disbursed through USAID direct contracts. The major line items include the long-term IEC advisor, the program manager, the buy-in to the OPTIONS project, and long-term training of GOB personnel overseas.

3.2 Integrity of the GOB Financial System

The PAAD indicates that the GOB has a strong record of managing assistance projects and that financial accounting systems are in place to ensure sound fiscal control of projects.

This is also basically the conclusion of a recently completed report by Deloitte Pim Goldby, which was commissioned largely to respond to USAID's concerns that the GOB is not able to track BOTSPA project costs to specific activities in its computerized system (as described above). The report refers to the manual system of tracking expenses, used to supplement the computerized system, concluding that

. . . Based on our limited research undertaken during the course of this assignment, we consider the prescribed system **will** adequately control project expenditures provided the system is strictly adhered to. We are, however, unable to comment on the extent to which the prescribed system is currently adhered to or deviated from.

Furthermore, they conclude

. . . We consider the prescribed system for use by the line ministries and the MFDP to report on donor funds to be the most practical in view of the reporting constraints described (elsewhere). Minor changes could be made to streamline the reporting but, in our opinion, the benefit of these changes, without a more complete evaluation, is marginal."

Finally,

. . . We are of the opinion that the area that requires urgent attention is the **control** of project expenditures. We consider this will require the improvement of the prescribed manual system of recording expenditures for use by financial officers. Although in principle the methodology is simple, there is a requirement to conduct research in all ministries to ensure all project and donor requirements are met. In addition, there is a substantial training component associated with ensuring all finance and planning officers are adequately trained, fully understand the system and adhere to the improved prescribed system.

The current evaluation is not intended as a financial audit. The scope of work, however, does require addressing the issue of the integrity of the GOB management information system, including the financial data. Based on the report by Deloitte Pim Goldby, the current system is adequate, but control should be improved by requiring stricter adherence to the **prescribed** manual system. Further recommendations on this point are beyond the scope of the current evaluation.

3.3 The Effectiveness of NPA under BOTSPA

In the context of BOTSPA, the NPA mechanism was intended to

- provide GOB with the opportunity to "take control" of its activities in the population sector, in terms of both technical direction and financial management;
- accelerate/encourage formulation of a population policy and the establishment of a Population Unit;

- achieve "results" (the conditions precedent), not just finance a string of activities; and
- lighten the managerial burden of the project on USAID.

Strengthening GOB Management Capability for Population Activities

The persons involved with BOTSPA have had considerable experience in managing activities and budgets, given the 18-year history of family planning in Botswana. It is unclear whether the NPA mechanism has strengthened their management skills. One very positive aspect of the NPA mechanism from the perspective of GOB officials, however, is the opportunity it allows them to determine their own allocation of resources.

Accelerating Formulation of a Population Policy

The formulation of population policy and the establishment of a Population Unit require action from the top policy levels of government. The officials who signed the project agreement on behalf of the GOB must have believed that it was realistic to fulfill these conditions over the life of the project, but in fact neither activity has been realized to date. GOB has publicly endorsed both these actions in NDP-7, but has not proceeded according to the time frame of BOTSPA. In short, GOB appears to have been favorably disposed toward formulating a population policy and establishing a Population Unit, even before BOTSPA, and the NPA mechanism has not served to accelerate this process. Rather, these are actions which will be taken according to the GOB's own timetable.

Producing Results

The NPA mechanism vested the GOB with the responsibility for producing results, not just implementing activities. As described in more detail in Section 4, however, the project was not structured to maintain a focus on the attainment of objectives. For example, BOTSPA did not have a GOB project coordinator whose sole job was to assure the implementation of activities that would contribute directly to project objectives (i.e., management by objectives). Quantifiable indicators of project performance have not been adequately established, and personnel at the district levels have not been trained to use the data they collect to measure their own performance. The idea behind NPA is to encourage government to produce results and to acknowledge progress through disbursement of funds, which go back into the system for further work in the sector. In this case, however, the GOB did not have the absorptive capacity to implement the full array of activities needed to reach specific objectives, and even the incentive aspect of complying with the CPs was insufficient to overcome the major constraint, the shortage of trained manpower.

Reducing USAID's Administrative Burden

BOTSPA was designed at a time when NPA was seen as a means of reducing the administrative burden on USAID. Over the past three years, there has been a growing awareness that (a) NPA requires policy dialogue and that A.I.D. must assume its role in the process, and (b) input from USAID must often come from a higher level than usual, i.e., mission management may find itself more involved than in the past. Mission management at the time of BOTSPA, however, did not have the benefit of this new awareness and seemingly underestimated the management needs of the project (this is discussed in more detail in Section 4).

3.4 The Impact of Renegotiating the CPs

The NPA mechanism is designed to provide leverage for policy and institutional change. The CPs are agreed upon mutually by GOB and USAID. The GOB then works to fulfill them, and when it does, USAID releases the predetermined dollar disbursement.

The initial set of CPs form part of the project agreement, whereas the CPs for remaining tranches are illustrative. As the project evolves, the actual CPs for the second, third, fourth, and fifth tranches are to be negotiated between GOB and USAID. This is to allow some flexibility to deal with the unforeseen and to modify the illustrative CPs before they become binding requirements.

The possibility of modifying the CPs can serve to increase the potential effectiveness of the project in some instances. For example, amendment 2 includes a CP that calls for the designation of a project coordinator within MOH, which was not required in earlier documents. Although this CP has not yet been fulfilled, it is potentially useful for strengthening project management.

By contrast, the process of modifying CPs can also serve to diminish the project's effectiveness, as seen in the case of policy formulation. According to the illustrative CPs, by tranche 3 a population policy should be adopted, publicly described and endorsed. When progress in this area proved much slower than anticipated, the CP was modified accordingly. Although this could serve to allow activities in other areas to move ahead, it removes some of the incentive for the GOB to strive to comply and thus reduces the probability of achieving the objective of formulating a policy (at least within the lifetime of BOTSPA).

3.5 Appropriateness of NPA for Botswana

The NPA mechanism has not yielded the desired results in the case of BOTSPA. In part, there have been deficiencies in implementation that are specific to BOTSPA and could be addressed in future NPA efforts in other countries; these include

- the need for a project coordinator from the host country government whose full-time job is to keep the program on track toward specific objectives;
- the need for a project manager or coordinator at USAID; and
- the need for increased levels of involvement of mission management in the process of policy dialogue.

There is, however, a lesson to be learned from BOTSPA which may be useful in assessing the appropriateness of this mechanism elsewhere:

Where the government is not in great need of foreign currency, the incentive value of NPA may be insufficient to overcome other obstacles such as the political sensitivity of population as an issue, lack of absorptive capacity, manpower shortages, and so forth.

4. Management of BOTSPA by GOB and USAID

4. Management of BOTSPA by GOB and USAID

The BOTSPA project is a collaborative effort between the Government of Botswana and USAID/Botswana. Both parties are committed to its underlying goals, yet the project is substantially behind schedule in fulfilling the CPs and in achieving the objectives as measured by the performance indicators.

Under the project agreement, the GOB is responsible for implementing the project, USAID for monitoring progress toward its objectives.

4.1 Implementation of BOTSPA by GOB

As stated above, GOB is responsible for implementation of the project. The MFDP is charged with coordinating programs financed by NPA funds and managing the population analysis programs through its CSO. The MOH and the MLGLH are the executing agents for the MCH/FP programs. The following summarizes implementation tasks that were completed satisfactorily and those that were not.

4.1.1 Ministry of Finance and Development Planning

The MFDP has accomplished a number of the implementation tasks, including the successful negotiation and signing of the agreement; negotiating with USAID for modifications in the CPs; authorizing the implementing agencies to commence incurring expenditures; and overseeing the financial accounting procedures used for all government projects, including BOTSPA. Areas in which problems were identified include the following:

Advising Implementing Ministries of the Terms and Conditions of the Grant Agreement

The project design calls for an interministerial steering committee to be chaired by an MFDP official. Apparently, it was assumed that staff from other ministries would attend these meetings and in this way become informed of the terms and conditions of the grant agreement. Although not specified as such in the project agreement, this is apparently the sense in which the MFDP is "responsible" for this task.

There are several indications that information about BOTSPA could have been disseminated more effectively than it was. First, it appears that one of the implementing ministries (MLGLH) is not fully cognizant of its role in the project. Until this evaluation, the permanent secretary was unaware that BOTSPA funds were under-utilized; to date, the MLGLH has never used BOTSPA funds. Second, MOH personnel experienced considerable confusion over the types of expenses that could be covered using BOTSPA funds, suggesting that this was not adequately communicated in the early days of the project. Third, many persons interviewed from institutions that could well have collaborated in the BOTSPA effort (e.g., PHC Support Division, National Health Institute, the Personnel Officer [Training] at MLGLH, district commissioners and district-level personnel, etc.) have never heard of BOTSPA or are only vaguely aware of its existence. It is evident that little attempt has been made to communicate the terms and conditions of this agreement down through the system to implementing levels that could benefit from the funds.

Determining Priority Activities to Be Financed Using Resources Provided through the Grant

The Interministerial Programme Steering Committee on Population and Development is responsible for this task. Specifically, workplans for the three ministries implementing the project are to be submitted to the IPSCPD; the IPSCPD is to review and compile them into a single comprehensive workplan for submission to USAID. Assuming approval by USAID, the funds can then be disbursed in support of the activities outlined in the workplan.

As noted above, this process has not occurred in a way which is satisfactory to either GOB or USAID. The MOH, the ministry most directly involved in implementation, has prepared a master workplan (under the Larson consultancy) and subsequent workplans. These have been submitted to the IPSCPD, but they have yet to be incorporated into a larger, comprehensive workplan for GOB population activities because of the limitations in the capacity of that committee to handle time-consuming technical tasks. Although the MOH has sent copies directly to USAID, these have not been formally accepted, since they were not part of a larger plan that had IPSCPD approval. In sum, the MOH has experienced frustration that the plans it submitted to the IPSCPD have never been acted upon and forwarded to USAID. USAID is concerned that since the onset of the project, it has never received a comprehensive workplan duly approved by the IPSCPD.

Monitoring and Reporting to USAID on the Progress toward Attainment of the Grant's Objectives

(See Section 4.2 below.)

Scheduling the Quarterly Review Meetings and ensuring that the recommendations of those meetings are implemented.

(See Section 4.2 below.)

Responsibility for Financial Accountability to the GOB and USAID for Expenditures and Disbursements

As explained in Section 3, the GOB is not required by the project agreement to keep records of individual expenses in the local currency account; rather, it is to use the computer-generated reports to indicate the major line item expenditures. This presupposes a workplan, however, which would allow USAID to identify the major activities for which expenses are incurred. Because the GOB computerized system does not allow for identification of specific activities, an alternative means of obtaining this information is through the manual system used by the GOB which allows tracking of specific expenses on a more timely basis. This system is less than optimal but, if adhered to strictly, should at least serve the purpose of providing itemized expenses incurred under BOTSPA. In short, this process has been problematic, though it is hoped that a solution is now at hand.

4.1.2 Ministry of Health

It is important to distinguish between the performance of the MOH in the provision of family planning services in general and its performance related to BOTSPA. Given Botswana's high rate of contraceptive prevalence for modern methods (by African standards) of 30 percent, it is clear that

the MOH has made tremendous strides in providing family planning services to its population. One should not lose sight of these impressive accomplishments in assessing specific tasks under BOTSPA.

The areas in which the MOH has performed well on implementation include the preparation of a master workplan for its activities under BOTSPA; integration of MCH/FP services; responsibility for the procurement of contraceptives; financing of contraceptives from GOB funds; and certain categories of training (specifically long-term overseas training, regional short-term training, and training of personnel in contraceptive logistics).

Implementation tasks outlined in the BOTSPA project agreement which have proven more problematic include the following:

Establishing and Monitoring Targets for Performance Indicators in Conjunction with the MLGLH

To do this task well, one first needs to identify the type of data needed to measure the performance indicators and then assure that the system is set up to collect such information. It should be noted that at the time BOTSPA was designed, the World Bank had plans to assist the GOB in improving its MIS. Thus, the project agreement anticipated much of this groundwork would have taken place by the time BOTSPA began, an assumption which proved to be unwarranted, since this consultancy was not successfully completed. Consequently, it is not surprising that the two ministries have not collaborated on establishing and monitoring targets for performance, given that this task requires a considerable investment of time and a special type of expertise. In fact, there has been little monitoring of performance indicators at the central level, in the districts, or at individual health facilities.

An example of this problem involves CYP, a widely used indicator to measure family planning program performance, which the project designers included in the project agreement to measure expansion of MCH/FP services. Although CYP is relatively easy to calculate, it is necessary to have data on the quantities of each type of contraceptive issued to clients at each of the service delivery points during the reporting period. In the case of Botswana, however, the forms were not even set up until 1991 to obtain information on the quantities of contraceptives issued to clients. Even though a space for reporting this information is now on the monthly summary form, it is frequently left blank or filled in incorrectly.

It should be noted that the MCH evaluation officer only began his service in late 1990. He has worked diligently in bringing the available information up to date and in making data collection more systematic. Thus, although this is an area in which improvements can be expected, the findings reported reflect the problems experienced before his contribution was felt.

It should also be mentioned that there was a lack of continuity in the leadership of FHD's MCH Unit during the BOTSPA project, with a change in the head of the unit. This, too, appears to have adversely affected continuity within the program.

In sum, the problem in the case of CYP (and quite possibly with other indicators) was not necessarily failure to compile and report available data, but in part the lack of clearly defined indicators which would be useful to monitor progress and for which the information would be available.

Preparing Quarterly and Annual Progress Reports for Submission to MFD

(See Section 4.2 below.)

4.1.3 Ministry of Local Government, Lands and Housing

As part of the decentralization process, the MLGLH has been responsible for recruiting and (through the district councils) employing the personnel at the district level responsible for providing primary health care, including family planning services. Although not specific to BOTSPA, these personnel appear to be handling this function adequately. In addition, they have participated in the IPSCPD meetings which have come to replace the quarterly review meetings (although their representative was not necessarily from the most appropriate division within MLGLH; it would have been more useful to have had a representative from ULGS and/or the Planning Unit.)

Apart from these functions, the MLGLH appears to have had little direct involvement with BOTSPA, as indicated by the fact that it has not accessed any BOTSPA funds to date. In November 1990, the principal family health officer sent a memorandum with a copy to MLGLH, announcing the availability of funds, but the MLGLH has not availed itself of this opportunity.

In relation to the MLGLH implementation tasks in the project agreement, the main shortcomings are as follows:

Preparing Justification and Supporting Documentation for Activities to Be Financed under the Grant, in Conjunction with the District and Town Councils

The districts are responsible for establishing their own priorities, which they communicate to the MLGLH through an annual workplan for the purposes of funding. For the districts to access BOTSPA funds, it would be necessary for the MLGLH to inform the districts of the objectives of BOTSPA and the availability of funds for specific activities, which the districts could then program into their workplans. There is no evidence that this process has taken place.

The MLGLH also can access project funds administered by USAID by requesting program financing through its annual workplan (which would be incorporated into the comprehensive workplan to be compiled by the IPSCPD). There is no evidence that the MLGLH has attempted to access funds through this mechanism.

Establishing and Monitoring the Targets Performance Indicators in Conjunction with the MOH

Although the MOH has the technical expertise for establishing performance indicators, the data to be fed into this system must come in large part from personnel at the district level who come under the administrative responsibility of the MLGLH. As discussed above, this information is not being routinely collected and reported. In fairness to the MLGLH and its personnel, however, the responsibility for making this system work falls more directly on the MOH.

4.1.4 Conclusions Regarding GOB Implementation of BOTSPA

Despite the dedication and hard work of a number of individuals, the GOB has experienced difficulties in implementing the project. Key factors responsible for this include

- the lack of an official Population and Development Office with permanent staff able to provide full-time support to population activities;
- the lack of an interministerial committee (a) that has a clear mandate, (b) that is permanent and official, and (c) whose members who are high level decision makers within their own ministries or organizations;
- the absence of an MOH project coordinator to coordinate and monitor the activities of different divisions and units toward the achievement of project objectives;
- the shortage of manpower within the participating ministries, a problem which is pervasive throughout the GOB; and
- a lack of feedback from USAID regarding project performance (discussed in Section 4.3 below).

Recommendation

29. The GOB should designate a project coordinator who could devote his/her full time to coordinating and monitoring the activities of different divisions and units toward the achievement of project objectives.

(Recommendations regarding the proposed Population Unit and Standing Committee appear in Section 2.2; recommendations regarding training appear in Section 2.3.)

4.2 Monitoring and Evaluation of the Project

The project agreement indicates three "complementary mechanisms" are to be used in evaluating BOTSPA: program review meetings, sentinel surveys, and a final evaluation.

4.2.1 Project Review Meetings

These meetings are to be convened quarterly during the first year and twice a year thereafter, and are to be chaired by the permanent secretary of the MOH and attended by representatives of relevant ministries. Agenda items are to include written updates on activities, a review of progress toward meeting the performance indicators, and any proposed modifications in BOTSPA activities. A report is to be prepared by the MOH following each meeting giving the status of progress under the grant and noting any necessary corrective action for the following quarter.

One meeting each year is to be used by GOB and USAID to (1) review evidence that the GOB has achieved the agreed upon performance indicators, (2) make necessary revisions in the performance indicators for the subsequent tranches, (3) review the financial position of activities financed through project funds, (4) review the workplan for the coming year to be financed by the project funds.

In the early stages of the project, these meetings were held as scheduled, although they were not chaired by the permanent secretary of MOH. More recently, the quarterly review meetings have been combined with the meetings of the IPSCPD, since many of the same individuals are involved.

A review of the minutes of these meetings suggests that "progress" has not been evaluated according to the quantifiable performance indicated in the project agreement. Moreover, there has been little follow-up on the recommendations made during meetings, in part because of the ad hoc nature of this committee and the competing obligations of its members.

The MOH is responsible for preparing a summary of each project review meeting, but there is no evidence of such reports in the files at USAID or at the MOH.

USAID also conducted a review of BOTSPA at the end of the first project year. This document contains a list of specific recommendations, but there is no evidence that these were used in redirecting the project.

4.2.2 Sentinel Surveys

These are envisioned as short surveys to be conducted annually in a period of two to three weeks to obtain immediate feedback on performance in the population sector. The questionnaire is to contain 10-15 questions; the sample of 2,000 men and women is to be drawn from four to six representative locations in the country. The variables to be included (i.e., the content of the survey) are not specified in the project agreement.

To date, none of the sentinel surveys has been conducted. The GOB is responsible for their implementation, but has not done so for at least two reasons:

- the Central Statistics Office that would normally have participated in this activity was involved in preparing for and conducting the 1991 census; and
- there has been a lack of consensus as to the objective of the sentinel surveys, especially in a country with a number of recent demographic/family planning surveys.

4.2.3 Final Evaluation

This evaluation is planned for mid-1993 and is to measure a number of central components of the GOB population program through a follow-up sample survey of the population. The evaluation will also look at program management issues related to the design and implementation of the sector grant approach.

4.2.4 Conclusion Regarding Monitoring and Evaluation of BOTSPA

Based on correspondence in USAID files and interviews with GOB and USAID officials, it appears that there was considerable discussion of progress toward meeting the conditions precedent. In fact, these discussions resulted in redefining the CPs on two occasions. The attention of both the GOB and USAID tended to focus on this aspect, since the disbursement of NPA funds revolved around the CPs.

There is little evidence, however, to suggest systematic monitoring of performance indicators related to family planning service delivery. (As explained above, this was not just a failure to compile existing information in a timely fashion, but in some cases a lack of clear definition and understanding of the data needed to measure the indicator.) Apart from the first annual progress report, submitted in March 1989, there are no quarterly reports describing the number of training courses completed,

CYPs provided, IEC materials produced, etc. The MOH has produced periodic financial reports in response to requests from USAID, but these have not had narrative descriptions on progress. In short, the indicators that best reflect progress in service delivery in the short-term have not been systemically monitored by GOB, nor has USAID been sufficiently vigilant in requiring these reports.

Recommendations

30. The project review meetings should be reinstated on a bi-annual basis. These should serve to review quantitative indicators of performance as well as to discuss problems related to project implementation.
31. Performance indicators should be established in family planning service delivery, in-service training, IEC, and MIS. These should be monitored at a central level and reviewed twice a year at the program review meeting. Moreover, service providers should be trained to use the data they collect at the service delivery point for ongoing evaluation of their own performance.
32. The sentinel survey idea should be abandoned. Rather, the MIS system should be improved to the point that it can provide ongoing feedback on program performance. This will be supplemented by data from the DHS every few years.

4.3 Management of the Project by USAID

According to the project agreement, the primary role of USAID/Botswana is to monitor and evaluate progress of the GOB in achieving program objectives in the population sector and, in particular, the progress of the GOB in meeting the mutually agreed upon performance targets. In addition to the quarterly review meetings cited above, USAID staff are to make periodic site visits and hold discussions with individuals directly responsible for the activities supported under BOTSPA.

With regard to financial management, USAID and GOB are to jointly program the use of funds in the local currency account. With respect to dollars spent under the projectized component, USAID is responsible for all aspects of disbursement and accounting, although the project agreement calls for jointly implementing with the GOB activities which support achievement of the overall objectives of the grant.

It is important to keep in mind that USAID's management of BOTSPA has probably been influenced by the prevailing belief within USAID at the time the project was designed that the use of the NPA mechanism would lighten the management burden for USAID. Although USAID now has the benefit of hindsight, the previous mission management appears to have operated on the principle of vesting all responsibility for the project in the hands of the GOB. Given the difficulties that the project is now experiencing, the present mission management is highly aware that NPA requires strong management input and from a higher level of personnel than the conventional project approach to assistance. Nonetheless, over the life of the project, there have been deficiencies in USAID's management of BOTSPA, and it is important to take these into account in assessing the overall project.

4.3.1 Personnel

BOTSPA needs two types of managerial inputs from USAID: (1) occasional assistance from mission management in the form of dialogue on policy issues with GOB decision makers, negotiations over modifications in the CPs, and related high-level contacts, and (2) ongoing monitoring of project activities and accomplishments by a project coordinator/manager.

For the reasons cited above, it is probable that the previous mission management did not appreciate the need for its intervention in this type of project. For example, according to the IEC advisor (who occasionally served as an ad hoc project manager), she was asked by mission management to discuss changes in the CPs with ministry officials on its behalf. This individual was not an official representative of USAID, nor was she considered "high level" within ministry circles. Mission management would have been far more effective in handling these negotiations, but did not perceive the need for doing so.

A second problem which was cited by at least two GOB officials involves turnover in mission management. During the life of BOTSPA, the mission has experienced a highly unusual situation in which there have been three mission directors or acting directors in less than three years. These particular GOB officials perceived that each of these individuals had a different idea of what BOTSPA was intended to accomplish. The turnover in mission personnel, especially in the absence of a project manager to provide continuity, may have contributed to the lack of close management of BOTSPA.

With respect to a project manager, the PAAD specified that a local hire should be employed to coordinate USAID's participation in BOTSPA; this message was reiterated by an A.I.D. Bureau of Science and Technology/Office of Population (S&T/POP) staff member who visited Botswana to assess the new project in its early stages and again in the first annual review of BOTSPA. No attempt was made, however, to recruit a coordinator during the first 23 months of the project.

The BOTSPA-funded IEC advisor arrived in July 1989. As stated above, USAID periodically used her in the role of ad hoc manager of BOTSPA. Not only was this an inadequate means of supervising activities under the BOTSPA project, but also it may have diminished her effectiveness as an IEC advisor.

Over time, the mission became increasingly aware of the need for ongoing management of BOTSPA, and in June 1990 (23 months after the signing of the project) it advertised for the position of project coordinator. The individual who accepted the position later declined it three days prior to beginning the job in September. The search was reopened, this time to non-Botswana as well, with the result that the current project manager was hired in December 1990. His main task to date has been to assist in assessing the current status of the project and progress in implementation. Since April 1991 there has been a substantial freeze on activities in anticipation of this evaluation, thus temporarily limiting the involvement of this individual in project management.

4.3.2 Monitoring Progress toward Achievement of Project Objectives

The responsibility for monitoring the progress of BOTSPA toward the achievement of project objectives rests with the GOB. It is the responsibility of USAID, however, to ensure that reports and other information are submitted in a timely fashion to provide USAID with evidence of progress toward project objectives.

As specified in the project agreement, USAID did establish an internal program committee to manage and monitor USAID inputs for the program. This committee is chaired by the deputy mission director; other members include the controller, regional population officer, and project manager. This committee, however, has not met on a regular basis over the life of the project, and it does not by itself serve to fill the management needs of the project.

Because USAID/Botswana does not have a health, population, and nutrition officer (especially in the absence of a project manager prior to December 1990), the regional HPN officer based in Swaziland has assisted in overseeing BOTSPA activities on his periodic visits to Botswana. As a mechanism for monitoring ongoing progress, this was less than ideal. (With a project manager now on board, however, such visits should prove useful for discussing implementation or management issues.)

In sum, one suspects that if USAID had given more attention to monitoring the project — especially to quantifiable indicators of progress in the seven programmatic areas — this might have communicated USAID's strong interest in the effort to GOB officials and created a greater sense of urgency in achieving project objectives.

With the arrival of the project manager in December 1990, efforts were made to establish the status of BOTSPA in terms of CPs and performance indicators. There is every reason to believe that in the future, USAID's monitoring of progress under BOTSPA will be vastly improved. Yet an evaluation of this type cannot overlook USAID's past performance in monitoring BOTSPA and its effect on project outcome.

4.3.3 Communication between USAID and GOB

Most collaborative efforts are greatly aided by a sense of partnership between the parties involved. This is formed through continuous dialogue between the partners and a shared commitment to reaching the objective.

It is difficult to assess the nature and frequency of communication between the GOB and USAID, since this evaluation took place at a point when BOTSPA activities had been temporarily halted (pending the outcome of the evaluation). Nonetheless, interviews with selected individuals as well as project documentation suggests some deficiencies in this area. Specific examples include the following:

Explaining BOTSPA to Ministry Personnel

According to the project agreement, it is the responsibility of the MFDP, not USAID, to "advise implementing ministries of the terms and conditions of the grant agreement." This was the first bilateral agreement between the GOB and USAID for population assistance, however, and the project was using a funding mechanism which was unfamiliar even to USAID. Based on documents in the files and interviews with GOB personnel, there was never any attempt to convene the persons most directly responsible for implementing BOTSPA activities to give a thorough briefing on the objectives of the project, the types of activities envisioned, the types of expenses which could be authorized, etc. In fact, documentation from June 1989 shows that the head of the FHD requested such a meeting, but it was not held.

One apparent result of this situation is that many persons interviewed during this evaluation, both at the central level and in the districts, either had not heard of BOTSPA or were only vaguely aware

of its existence. GOB officials who have had primary roles in implementing BOTSPA still report being confused over the types of activities which the project can and cannot fund.

Although USAID was not formally responsible for publicizing BOTSPA, the mission should have responded to the GOB request for a general briefing and/or worked to create greater interest in the project through continuous informal communication with counterparts.

Providing Feedback on Workplans

Under BOTSPA, the relevant ministries are to develop individual workplans, pass them to the IPSCPD who is in turn supposed to compile a comprehensive workplan for submission to USAID. This process has not worked smoothly, in large part because the IPSCPD has not had the manpower to assemble these comprehensive workplans. The result of this process has been a proliferation of different workplans, none of which to date have satisfied USAID.

Out of frustration over the process, the head of FHD has taken to sending an information copy of his part of the workplan directly to USAID, on which he reports never to have received any feedback. USAID's response is that the report did not come through the proper channels (IPSCPD) and thus was not acceptable. Whether acceptable or not, communication between USAID and GOB would have been improved by acknowledgement of the effort on the part of the FHD to produce the workplan.

Clarifying the Role of the IEC Advisor

During the two-year contract of the BOTSPA-funded IEC advisor, there was considerable confusion over her role vis-a-vis both the MOH and USAID. Although she was posted in the MOH, USAID regularly asked her to assist with tasks that would have fallen to the project coordinator or manager, had there been one. This exacerbated other problems which she was experiencing at the MOH. There were several instances when USAID could have alleviated misunderstandings through written communication with the MOH, but did not do so.

Communicating with Ministry Officials over the Freeze of Funds

USAID and the GOB mutually agreed in April 1991 that the project was not progressing as anticipated and that a midterm evaluation would be in order. At that point, USAID requested the curtailment of expenditures past September 1991, when the results of the evaluation would become available. This resulted in the cancellation of long-term training for five persons (see Section 2.6.1). MOH officials lost face with those whose travel plans were cancelled at the last minute. Moreover, the cancellation of training had staffing implications for the GOB in that expatriates had been recruited and hired to fill these positions which would have been left vacant by those on study leave, as well as to strengthen the unit.

USAID's response to the GOB consternation over this situation was (1) a suitable verbal apology over the inconvenience the decision had caused, and (2) an explanation that had the mission realized the training in question was to extend over the closing date of the project, these persons would not

have been able to go on the training in any case.¹⁶ This incident, although minor, could have been handled more appropriately, had USAID officials communicated more effectively with the GOB — first, in alerting them in a timely fashion to the deadlines for use of funds, and second, in reviewing with them the implications of the freeze on funds before announcing it.

USAID was required by the project agreement only to "hold discussions with individuals directly responsible for the activities supported under the grant," not to take an active role in its ongoing management. USAID has made a substantial investment in BOTSPA, however, and this investment needs to be protected by frequent, open communication between USAID and the GOB counterparts.

4.4 Conclusion regarding the Management of BOTSPA

The GOB experienced difficulties in implementing BOTSPA in a number of areas outlined above. The main constraints to implementation were lack of a permanent office in support of population activities, lack of an official interministerial committee with a clear mandate and appropriate membership, lack of a program coordinator for BOTSPA within the GOB, widespread manpower shortages, and lack of feedback from USAID on project performance.

The problems that the GOB experienced were further aggravated by certain deficiencies in USAID's management of the project. These included lack of regular input from mission management in the policy dialogue, (unusually) high turnover in mission directors over a short period, lack of a project coordinator/manager until late in the project, insufficient attention to monitoring quantifiable performance indicators, and occasional problems of communication between USAID and GOB.

Much of the material in this chapter is past history. NDP-7 calls for a formal population policy, a standing committee to coordinate interministerial activities, and a permanent office with staff to support population programs. The proposed chairman for the standing committee promises to be an effective leader of such a group, who with staff support could begin to make the progress which eluded BOTSPA in its first three years. On the USAID side, mission management is committed to getting BOTSPA "back on track" and appears willing to devote time and effort as needed. The new project manager brings a strong understanding of the country and culture to the job; he is clearly committed to the objectives of the project and is aware of the need for closer monitoring of this project than in the past.

In sum, BOTSPA has had serious management problems in the past. A number of the constraints have been overcome, however, such that BOTSPA has the potential to become more effective in the future.

Recommendations

33. The USAID project manager should (a) assist in identifying technical assistance for improving the MIS system, (b) once improvements are made, learn the data requirements of the system and interpretation of

¹⁶The project agreement is very clear as to the end date of BOTSPA. Certain other donors, however, apparently allow persons to begin training, even if it will not be completed within the dates of the project agreement. This may be the cause of the misunderstanding over this point.

the indicators, and (c) use this knowledge to monitor the project in terms of quantifiable gains toward project objectives.

34. **The USAID project manager should maintain frequent and open communication with the GOB project coordinator, in an effort to strengthen the partnership between GOB and USAID.**

5. Validity of Assumptions underlying the Project Design

5. Validity of Assumptions underlying the Project Design

5.1 Assumption No. 1: BOTSPA is relevant to GOB and USAID development strategies.

This project is highly consistent with the goals of the GOB and USAID in that (a) it takes a multisectoral approach to population issues, encompassing development, environment, agriculture, education, employment, and other sectors, in addition to fertility and family planning; and (b) it attempts to build on the demonstrated strength of the GOB in the area of family planning service provision. The project is also consistent with A.I.D. policy in encouraging the participation of the private sector in population programs.

5.2 Assumption No. 2: The lack of a population policy impedes the expansion of family planning services in Botswana.

This assumption does not hold true. Botswana has the second highest prevalence rate for modern contraceptives in sub-Saharan Africa without having an official policy. The remaining obstacles to service delivery can be found at an operational level, not at a policy level. Rather, an official population policy will serve to reinforce the urgency of population issues on the national agenda and will encourage actions in all sectors to achieve a balance between population growth and the country's resources.

5.3 Assumption No. 3: Institutional and structural constraints (involving service delivery, training, IEC, and contraceptive logistics) impede the expansion of family planning services.

The PAAD correctly identifies a number of constraints in these areas, including some which have already been successfully addressed (e.g., contraceptive logistics, integration of MCH and family planning) and others which need further attention in the final years of BOTSPA (e.g., in-service training, IEC targeted at specific segments of the population).

5.4 Assumption No. 4: The GOB has the absorptive capacity to implement BOTSPA.

The GOB has a number of well-educated, highly articulate, strongly committed individuals who contribute to the impression that the GOB has a strong implementation capacity. Moreover, it is generally considered that the GOB has sound administrative structures for managing the financial aspects of projects. Because the GOB is intent on training additional personnel, however, a considerable number of staff are away from their posts at any given time. Moreover, there are positions which remain vacant for lack of a qualified applicant. This manpower shortage affects virtually every branch of government.

Lack of manpower is not synonymous with a lack of absorptive capacity, though the two are closely related. In retrospect, it appears that this problem did not receive sufficient consideration when BOTSPA was designed.

5.5 Assumption No. 5: NPA is an appropriate funding mechanism for population activities in Botswana.

The NPA mechanism is most effective when (a) the local government is strongly committed to the goals of the project, (b) has the institutional capability to implement it, and (c) is counting heavily on the funds available through NPA to realize its programs.

In the case of BOTSPA, the GOB is strongly committed to reducing population growth and expanding family planning services (though not necessarily to formulating a population policy within the time frame of BOTSPA). The institutional capability of the GOB to implement this project was overstated in the PAAD, which focused on GOB's "good record" for implementing development activities without taking into account the current shortages in manpower throughout the ministries. Moreover, if a country has alternative means of funding its programs (including its own financial resources), the incentive aspect of NPA may not be sufficient to overcome other constraints, such as political sensitivity of population as an issue, lack of absorptive capacity, shortages of manpower, and so forth.

6. Conclusions

6. Conclusions

6.1 Policy Development

Population policy is important to the long-term development objectives of the GOB, but lack of a policy does not impede expansion of family planning services. Under BOTSPA the formulation of a population policy has not evolved at the rate anticipated in the project agreement.

6.2 Coordination of Population Programs

An effective Standing Committee and an official, permanent Population Unit are important to population activities in the long-term, even if their effect may not be felt during the lifetime of BOTSPA. Since the political will appears to be present, what is needed is an operational plan which would pave the way for implementation.

6.3 Improvement in MCH/FP Services

Integration of MCH/FP services is being successfully implemented in all 20 districts. As a result, MCH/FP services have been expanded both in terms of service delivery points and increased numbers of service providers. BOTSPA inputs contributed directly to this process through support of program areas in short-term training, contraceptive logistics, MCH/FP evaluation, and implementation of integration.

Decentralization of health services has taken place. BOTSPA's potential to assist in this process through support of district-level logistics and supervision was not realized and its contribution has been minimal.

Short-term external training of MOH, ULGS, and other participants from NGOs, the National Health Institute, and the Ministry of Education was well executed by the FHD and appropriate to MCH/FP program needs and BOTSPA program objectives. There is still a marked need for clinical family planning in-service training and other training at the district level.

Family planning supervision and management systems have not been substantially improved under BOTSPA.

6.4 IEC Support to MCH/FP Services

There is some evidence to indicate that GOB and USAID misunderstood how family planning IEC functions as a support to family planning programs. This resulted in inefficient utilization of technical assistance and inefficient management of the IEC program.

Institutionalization of family planning IEC was not achieved. IEC remains operationally a weak support service in the FHD, despite technical assistance provided by a long-term technical adviser.

IEC expertise is still not available to the MCH/FP Unit and the need for long-term technical assistance in family planning IEC remains.

The coordination mechanism of the project as a whole is not conducive to efficient implementation of a family planning IEC program. The interministerial steering committee, as constituted, is unable, for a variety of reasons, to adequately oversee the project.

Targets selected in the project agreement are still valid. Some research in support of audience segmentation and message development has been conducted, but not exploited.

Method mix has not improved as a result of BOTSPA counseling activities. This is primarily due to the lack of trained clinic staff in IUD insertion and in counseling.

IEC objectives outlined in the PAAD/project agreement are still relevant although indicators for achievement of objectives need review. First acceptors as an indicator, may not be the most sensitive measure of IEC progress.

6.5 Contraceptive Logistics/Management Information Systems

The GOB has successfully assumed responsibility for the procurement of contraceptives at a rate well in advance of schedules included in the project agreement. Contraceptives are now well integrated into the same systems used to forecast, tender, warehouse, and distribute pharmaceuticals.

Because of the tendering system, there are likely to be contraceptive brand changes by mid-1992. A partial solution may be repackaging, which FHD may investigate.

Reliable delivery of adequate supplies of contraceptives to facilities providing family planning services is now the norm, except in health posts where enrolled nurses still lack training in contraceptive logistics. A more immediate problem is evidence of expired stock, resulting from the lack of reporting on contraceptive stock levels.

The current family planning reporting system is inadequate for a program with the maturity and prevalence rate of the family planning program in Botswana. This program needs to be looking at method mix, client age distribution, continuation rates, and prevalence, yet there is no management information to support these discussions.

The only reliable information arising from the current family planning reporting system is new acceptors, but new acceptors is not the best indicator for a program with high prevalence and a long history. There is little evidence of family planning staff using the collected family planning data to assess their own progress or compare performance. Without considerable intervention, the family planning program will not achieve an MIS appropriate for such a mature program. Neither will it support assessment of impact of future BOTSPA activities.

6.6 Trained Staff and GOB Financing for Population Programs

The current institutional capacity of the MCH/FP Unit and the Continuing Education Unit to design, develop, and implement family planning clinical training is very limited because of a shortage of staff.

BOTSPA training outputs are significant in terms of long-term and short-term trainee outputs. Its contribution to in-service in-country family planning training has been modest and apparently confined to family planning logistics training and IEC/family life education training.

Given the limited time and funds available under BOTSPA, it is important that undergraduate long-term training be de-emphasized in favor of short-term regional training.

Data are not available to determine whether GOB financing for family planning in general has increased over the lifetime of BOTSPA. GOB financing of contraceptive procurement has exceeded expectations, however.

6.7 NGO and Private Sector Participation

NGOs and the private sector are only peripherally involved in family planning. Because of their limited capital base, NGOs have little reach beyond major urban areas. Small NGOs at the district level (PTAs, youth clubs, etc.) have not been adequately tapped.

6.8 Assessment of NPA Funding Mechanism

Although it is necessary to maintain flexibility regarding the implementation of the project agreement, the re-negotiation of conditions precedent tends to detract from the fundamental purpose of NPA.

The NPA mechanism has not been effective in the context of Botswana in bringing about policy change and interministerial coordination. It has resulted in certain notable improvements in family planning service delivery (e.g., contraceptive logistics); however, in other areas (in-service training for clinical skills, IEC) its impact has been more limited.

6.9 Management of BOTSPA by GOB and USAID

The GOB experienced difficulties in implementing BOTSPA in a number of areas. The main constraints to implementation were lack of a permanent office in support of population activities, lack of an official interministerial committee with a clear mandate and appropriate membership, lack of a program coordinator for BOTSPA within the GOB, widespread manpower shortages, and lack of feedback from USAID on project performance.

The problems which the GOB experienced were further aggravated by certain deficiencies in USAID's management of the project. These included lack of regular input from senior mission managers in the policy dialogue, (unusually) high turnover in mission directors over a short period, lack of a project coordinator/manager until late in the project, insufficient attention to monitoring quantifiable performance indicators, and occasional problems of communication between USAID and GOB.

A number of these constraints have been overcome, paving the way for a more effective project in the next phase.

6.10 Validity of Assumptions Underlying the Project Design

Assumptions which have proven valid: (1) the project is highly consistent with the development strategies of GOB and USAID, and (2) structural and institutional constraints exist which have impeded the expansion/improvement of family planning services.

The experience to date tends to contradict several earlier assumptions, specifically: (1) the lack of a population policy impedes the expansion of family planning services in Botswana, (2) GOB has the absorptive capacity to fully implement a project the size of BOTSPA,¹⁷ and (3) NPA is an appropriate funding mechanism in this particular situation.

¹⁷GOB may well have had the absorptive capacity to implement this project; however, the resources and institutional infrastructure were not harnessed in a systematic way to assure the success of BOTSPA. The constraints to implementing BOTSPA are discussed in detail in Section 4.

7. Recommendations

7. Recommendations

7.1 General Recommendations

1. USAID should give BOTSPA a no-cost extension to allow additional time to work toward project objectives.
2. USAID should redesign the BCTSPA project, eliminating the NPA approach which has not proven effective in this specific project. All funds should be reprogrammed as project funds.
3. Under the reformulation of the project, the principal goal and main priority should be improved/expanded family planning service delivery. Policy formulation should receive support, but take second priority to service delivery.
4. The Ministry of Finance and Development Planning (MFDP) should continue to play a central role in setting policy which will affect the population/family planning activities of individual ministries, in anticipation of the formulation of a population policy and the establishment of a permanent Population Unit.
5. In line with the GOB policy on decentralization, BOTSPA in its next phase should concentrate its efforts on the district (e.g., district teams and personnel).

7.2 Specific Recommendations

Policy

1. Future BOTSPA support for population policy should be modest and directed to activities identified by the GOB as most likely to result in the formulation of a policy (e.g., support for the anticipated Population Unit).

Program Coordination

2. The Division of Economic Affairs should draft for the consideration of the minister and permanent secretary of MFDP a detailed proposal describing the purpose and composition of the Standing Committee mentioned in NDP-7. This draft should cover the mandate of the committee, the number of members, the criteria for their selection, the schedule for meetings, and other pertinent terms of reference.
3. The Division of Economic Affairs should draft for the consideration of the minister and permanent secretary of MFDP a proposal for the establishment of the Population Unit cited in NDP-7, describing the functions of this unit, requirements for staff, office space, equipment, and other pertinent resources, complete with budget.
4. USAID should agree to provide technical assistance on these two tasks, if requested, and should offer to support some of the costs related to the Standing Committee and/or Population Unit (on a limited scale).

Improvement of MCH/FP Services

5. In-service training should focus on district-level staff, with priority given to MCH/FP service provider nursing staff for family planning skills training including IUD insertion, family planning counseling and communication skills, and improved MCH/FP data collection and recording.

6. Refresher training should be provided for district health teams, district supervisors, and nurses-in-charge in the use of service statistics for improved program planning and supervision, staff performance appraisal methods, and interactive, supportive supervision methods. The medical officer and nurse members of the district health team should also be trained in family planning clinical skills (including IUD insertion), and participatory on-the-job training methodologies.

7. To further expand family planning services, the MOH should

- (a) explore the feasibility of adding implants to the method mix at the appropriate service facility level (e.g., hospitals);
- (b) initiate pilot studies to determine if community-based distribution would be cost effective, and to identify the most culturally acceptable channels or approach to be used in its introduction; and
- (c) in collaboration with the National Health Institute, examine the feasibility, certification, and training implications of training the non-midwife nurse and enrolled nurse in IUD insertion technique.

8. The MOH should finalize, approve and implement use of the health systems manuals on supervision, communication, referral, and health information systems.

9. The GOB and USAID/Botswana should assign priorities to support district-level activities in any BOTSPA re-design.

10. The MOH and MLGLH should conduct an updated needs assessment to ascertain equipment/ logistics needs of isolated district health facilities, and action should be initiated to meet priority, essential requirements.

IEC Support to MCH/FP Services

11. The FHD should plan family planning promotional activities to include targeted campaigns to motivate clients to seek services. Audience segmentation, analysis of available research, and new research to determine why services are currently underutilized will increase the potential effectiveness of these campaigns.

12. FHD should continue its efforts to reach in-school youth through a variety of methods including coordination with the Curriculum Development Division of the MOE at the central level, and soliciting the cooperation of school health clubs, parent-teachers associations (PTA), etc., at the district level.

13. The FHD should substantially increase its efforts to reach youth as a specific target group and to further segment this group, taking into account regional and cultural differences. Their attitudes towards family planning should be precisely determined so that message development can be precise. More than any other group, their communication patterns should be explored through a combination of anthropological, psychological, and communication approaches.

14. Three pamphlets, one each on the pill, the IUD, and the condom, should be developed and made available at clinics. A pamphlet addressing young people should be prepared for distribution to schools and clinics. The pamphlet should stress abstinence as the preferred choice for young people.

15. Informational materials for the family welfare educators' home visits should be prepared. These may include flip charts, felt boards, or other materials that are highly portable. Content covered should include different methods of contraception, as well as other MCH topics.

16. To improve IEC implementation, there needs to be closer coordination between different units of the MOH so that those responsible for selection and training of personnel know the IEC needs of the Family Planning Unit. The Health Education Unit and the Family Planning Unit need to work more closely in the design of materials. The materials need to be prepared based on the research results coming from the appropriate unit responsible for research.

17. The GOB should continue to provide short-term training for staff, particularly those at the field level, at international and regional agencies providing IEC training. Particular attention should be given to courses specializing in counseling and to courses providing specialized training in IEC aimed toward adolescents. The GOB should also consider hosting in-country training programs at which a larger number of people can be trained under realistic conditions, again giving preference to those based at the periphery.

18. In the absence of an IEC adviser, USAID and GOB should give serious consideration to contracting for intensive, short-term IEC support in training, research, and campaign design in family planning and related subject areas. This assistance should focus on building capacity at the regional level to design and manage decentralized programs. Appropriate counterpart agencies should be established regionally to support these activities, and provided with an IEC budget and minimal equipment. Field-level agencies would liaise with the Health Education Unit at the MOH.

Management Information System/Contraceptive Logistics

19. The MOH should request from the MFDP that district councils, town councils, and private organizations reimburse the MOH for contraceptives purchased by the GOB.

20. FHD should conduct training in contraceptive logistics. This training should be expanded to include carefully considered interventions in the reporting system, including stock level reporting. The training should be preceded by the preparation of a training manual. (This recommendation is discussed further in Appendix C).

21. In the shorter term, FHD should request district health team assistance in the immediate distribution of contraceptives, particularly Ovrette, to replace those which are nearing expiration.

22. FHD should request periodic reports from the SWEDIS software at CMS on district aggregate distribution of contraceptives, by product; FHD should use this information to produce CYP-based prevalence estimates.

23. FHD should implement the processes suggested in Appendix C to calculate continuation rates, method mix, and age and parity distribution.

24. The MOH should design supervisory systems that promote the local use of family planning data and should implement these procedures at facilities and districts through an MIS training process.

25. The MOH should request USAID technical assistance in identifying options for the repackaging and promotion of contraceptives. This request should occur now in anticipation of brand changes in mid-1992.

Training of GOB Staff and GOB Financing of Activities

26. During the redesign of BOTSPA, emphasis should be placed on the following:

- strengthening the MOH institutional capacity to design, conduct, and evaluate clinical family planning in-service and pre-service training, specifically the MCH/FP Unit, CES, and the National Health Institute's pre-service nursing programs;
- providing full support for the MCH/FP Unit and CES to develop a core training team and to decentralize family planning training; and
- emphasizing the family planning training of the district health teams, operations research, and other areas identified by a needs assessment.

27. Short-term regional training should be emphasized and long-term undergraduate training de-emphasized in the next BOTSPA phase.

NGO and Private Sector Participation

28. USAID support for NGOs should be continued and increased; GOB should be kept apprised of their efforts, but future grants should be monitored by USAID (or its contractor). USAID should understand that NGO support will require infrastructure development and training.

Implementation of BOTSPA by GOB

29. The GOB should designate a project coordinator who could devote his/her full time to coordinating and monitoring the activities of different divisions and units toward the achievement of project objectives.

30. The project review meetings should be reinstated on a bi-annual basis. These should serve to review quantitative indicators of performance as well as to discuss problems related to project implementation.

31. Performance indicators should be established in family planning service delivery, in-service training, IEC, and MIS. These should be monitored at a central level and reviewed twice a year at the program review meeting. Moreover, service providers should be trained to use the data they collect at the service delivery point for ongoing evaluation of their own performance.

32. The sentinel survey idea should be abandoned. Rather, the MIS system should be improved to the point that it can provide ongoing feedback on program performance. This will be supplemented by data from the DHS every few years.

Management of BOTSPA by USAID

33. The USAID project manager should (a) assist in identifying technical assistance for improving the MIS system, (b) once improvements are made, learn the data requirements of the system and interpretation of the indicators, and (c) use this knowledge to monitor the project in terms of quantifiable gains toward project objectives.

34. The USAID project manager should maintain frequent and open communication with the GOB project coordinator, in an effort to strengthen the partnership between GOB and USAID.

Appendices

Appendix A

**Evaluation Scope of Work
Evaluation Team Members
Persons Contacted
Documents Reviewed**

Appendix A

Evaluation Scope of Work

SCOPE OF WORK: MID-TERM EVALUATION BOTSWANA POPULATION SECTOR ASSISTANCE PROJECT

1. PROJECT DESCRIPTION.

PROJECT NO. 633-T-601 & 633-0249

TITLE: BOTSWANA POPULATION SECTOR ASSISTANCE PROJECT (BOTSPA)

PURPOSE: To assist GOB to strengthen the effectiveness and efficiency of its population and family planning programs and services through a process of policy reform and implementation.

COST: USD 3,000,000 Non-Project (Sector) Assistance
USD 2,000,000 Project Assistance
USD 5,000,000 LOP Total

LOP: JULY 29, 1988 TO JULY 31, 1993 (Five Years)

PACD: JULY 31, 1993

2. PURPOSE OF EVALUATION.

A joint USAID/GOB review of BOTSPA has indicated significant problems in program implementation. The continued validity of existing program design is questioned. This evaluation will examine the continuing validity and relevance of design assumptions, review progress toward established objectives and assess the sustainability of impact at the purpose level.

The evaluation's findings and recommendations will assist program managers from USAID and GOB to re-examine the role of BOTSPA within GOB's approach to population and development. Specifically, the evaluation will provide an objective basis for assessment and resolution of the following set of management issues:

- o relevance of BOTSPA in addressing constraints to the effectiveness of population programs in Botswana;
- o capacities of USAID and GOB to implement a program of the scope and nature of BOTSPA;
- o need for modification or redesign of Mission population strategies and/or BOTSPA.

2. BACKGROUND.

BOTSPA is designed to assist the GOB to strengthen the effectiveness and efficiency of its population and family planning programs and services through a process of policy reform and institutional strengthening. BOTSPA is structured as a combination of project and non-project assistance (NPA). Planned NPA of \$3,000,000 is to be disbursed in five tranches over the LOP, contingent upon satisfaction of negotiated conditions precedent (CPs).

Conditions precedent to non-project assistance describe phased outputs of the program in three main areas: policy development, institutional development, and program implementation. Primary components of these areas include:

Policy development:

- o Development, promulgation and implementation of a national multi-sectoral population policy.

Institutional development:

- o Establishment of structures and mechanisms for coordination of population activities;
- o Strengthening of the contraceptive logistics system; and
- o Increased GOB staffing and financing for population activities.

Program implementation:

- o Maternal-child health and family planning (MCH/FP) service expansion;
- o Improved information, education, communication (IEC);
- o Expanded NGO/private sector participation in population and family planning activities.

Local currency generated by the tranching disbursement of NPA funds is jointly programmed by USAID and GOB. This is to involve development and approval of annual workplans which detail the nature and level of activities to be implemented in direct support of population programs. Expenditures are to be tracked to the GOB budget line-item level and reported to USAID on a quarterly basis. To date, only one of five planned annual tranches has been disbursed.

Project assistance is planned at \$2,000,000 to be disbursed through direct USAID contracting for technical assistance and training. Activities funded under project assistance are to be programmed through joint USAID/GOB workplans which are prepared annually.

USAID/GOB partner implementing agencies under BOTSPA include the following GOB institutions:

- o Ministry of Finance and Development Planning, including Central Statistics Office;
- o Ministry of Health;
- o Ministry of Local Government and Lands.

Implementation responsibilities of these entities are outlined in the PAAD (pp. 64-66).

A broad measure of progress toward BOTSPA objectives has emerged as a result of two exercises: (i) comparing CPs as amended in the Grant Agreement with illustrative CPs contained in the original project description; and (ii) a review of project implementation, inputs and outputs over the last six months. As BOTSPA nears the end of its third year, the likelihood that objectives will be achieved, with a resultant drop in total fertility and population growth rates and commensurate improvement in family welfare, is questionable.

Specific issues discussed in the April 1991 Project Implementation Review include:

- o rate of policy and institutional development;
- o programming of project assistance and use of local currency generated by NPA tranche disbursement;
- o expenditure reporting and other documentation; and
- o monitoring and evaluation.

Although this review has indicated significant problems of implementation in accordance with original design, the magnitude of these problems and their implications for future implementation are not clear. An independent, comprehensive evaluation is intended to provide clarity in these respects.

4. STATEMENT OF WORK.

The contractor will conduct the following tasks to provide empirical findings upon which conclusions and recommendations will be based. Attention should be given to both strengths and weaknesses of the project.

A. Evaluate progress toward provision of inputs, achievement of outputs and purpose in each of the seven priority program areas. Discuss the extent to which constraints in these areas have been reduced, including factors which may have affected progress:

- o Support for policy development;
- o Improved coordination of population programs;
- o Expansion of MCH/FP services;
- o Strengthening of IEC support to MCH/FP services;
- o Strengthening of the contraceptive logistics system;
- o Increase of trained staff and GOB financing for population programs;
- o Expansion of NGO and private sector participation.

B. Assess the specific roles of each of the mechanisms established for delivery of assistance in terms of effectiveness and efficiency of inputs provided, and impact on institutional development and sustainability of project achievements:

- o Non-project assistance;
- o Local currency generation;
- o Project assistance.

C. Identify factors influencing implementation and determine their effects; propose appropriate action and deal with the ramifications thereof. Include, but do not limit discussion to the following areas:

- o Policy and institutional development, including human resource allocation to population activities;
- o Capacity of USAID and GOB to execute implementation responsibilities and procedures as set forth in the Grant Agreement;
- o Integrity of GOB's management information systems, including health, demographics and finance;
- o Adequacy of the monitoring and evaluation system as designed to detect implementation problems and changes in status of program objectives.

D. Review assumptions made during project design and assess their continuing validity. Include consideration of the following:

- o Relevance of program objectives and strategies to GOB's long-term development objectives and USAID's country development strategy;
- o Effectiveness and efficiency of relevant organizations in planning, implementing and monitoring population programs and services;
- o Justification for program sector assistance as an effective mechanism of assistance delivery;
- o Need to address national policy requirements, relative to other sectoral needs, and USAID assistance in its development;
- o Definition of the population sector.

5. METHODS AND PROCEDURES.

A. Data Collection Methods.

An Evaluation Reference Group, comprising representatives of the partner implementing agencies and USAID, will guide the evaluation process. Secondary data collection will constitute the primary means of gathering empirical evidence to address the areas of concern detailed above. Methods will include document review, key informant interviews, systems review, and site visits, as well as other methods deemed appropriate by the contractors and Evaluation Reference Group (ref. 5.B. Review Procedures).

- 1) Document review. Illustrative documents to be reviewed by the Team include project documents (PID, PAAD, PROAG, PILs, PIRs), GOB-submitted status reports, technical assistance trip reports, and meeting minutes from key committees and other organizations. Essential documents will be sent to the contractor for preliminary review in the USA prior to travel to Botswana. Other useful documents have been compiled for the contractor's use at the Mission in care of the BOTSPA Project Assistant.
- 2) Key informant interviews. Illustrative informants might include representatives of the primary implementing agencies, relevant committees and sub-committees, NGO Grantees, USAID staff, and relevant contracting agencies.
- 3) Site Visits. With members of the Reference Group or designated others, the contractor will visit sites where project-funded activities are in progress. Information to be gathered will be discussed with the Reference Group, and guidelines developed before the visits to ensure optimal efficiency.

B. Evaluation Procedures.

This evaluation will be conducted in-country over a six-week period, in addition to four days in the U.S. for team preparation and report writing, commencing late July 1991. Up to four days are budgeted for the team leader to finalize the report upon return to the U.S. The following operational procedures will be in effect:

- 1) **Pre-Evaluation Activities.** USAID authorizes a two to three-day team-building exercise in a U.S. location. The team should review documents on or before that occasion, and conduct any interviews required prior to departing the USA for Botswana.
- 2) **Working Conditions and Support.** A six-day work week will be authorized, following regular USAID work hours. USAID will arrange in-country workspace and, insofar as possible, travel using Mission vehicles. GOB transport assistance will be solicited as appropriate. USAID will reserve accommodation to be paid by the contractor. However, to ensure efficient execution of the workscope, one rental car will also be authorized. Mission computers will be available for work at the Mission on an "as-available" basis. Consultants are encouraged to bring their own portable, WANG/IBM compatible PC. Production of the final report will be the full responsibility of the contractor.
- 3) **The Evaluation Process.** The process will be guided through close working relations and a series of regularly scheduled meetings of the contractors with the Evaluation Reference Group and USAID.
 - a) Courtesy calls will be paid to the appropriate officials of all implementing agencies on arrival in-country.
 - b) The contractor will meet with the Evaluation Reference Group constituted by GOB and USAID as follows:
 - o To present and obtain concurrence on the evaluation workplan by the end of Week 1.
 - o To present and review progress toward accomplishment of the evaluation workscope early in Week 4.
 - o To present and obtain input on the first draft of the evaluation report, including findings, conclusions and recommendations, early in Week 6.
 - c) The Mission will obtain concurrence from the Permanent Secretary/Finance and Development on the final evaluation report (bound), and take appropriate action.

6. TEAM COMPOSITION.

A. Qualifications.

A four-person team will be required to address the primary management and technical areas of the evaluation, i.e.: 1) Family planning program design and evaluation; 2) MCH/FP service delivery; 3) information, education and communication; and 4) contraceptive logistics. The effectiveness of BOTSPA design in supporting technical progress is an important consideration in each of these areas.

Each member will be expected to examine the local management information needs and system capabilities, in his/her area of responsibility. Prior work experience in Botswana is highly desirable. While each team member will remain primarily responsible for his/her area of expertise, the overall team composition should allow for input and cross-validation of findings and conclusions among team members. The following qualifications are required:

1) Family Planning Generalist/Team Leader:

- o Experience in AID project design and evaluation required, and experience with non-project assistance preferred;
- o Demonstrated oral and written communication skills;
- o Population or family planning program management experience;
- o Demonstrated ability to assess organizational assets and the interrelationships of organizational development and project implementation;

2) MCH/FP Service Delivery Specialist:

- o Nurse-midwife or nurse practitioner;
- o At least five years experience in needs assessment, evaluation and management of MCH/FP service delivery;

3) IEC Specialist:

- o At least five years experience in management and evaluation of IEC programs for family planning;
- o Experience in national-level public education, mobilization and advocacy efforts for policy change;

4) Contraceptive Logistics Specialist:

- o Field experience with contraceptive needs assessment, procurement procedures and logistics support;
- o Experience with design and implementation of training modules for contraceptive logistics preferred.

B. Relationships and Responsibilities.

To enable smooth and informed execution of the evaluation, the Contract Team will:

- 1) Work closely with the BOTSPA Project Officer and Project Assistant at USAID;
- 2) Keep the BOTSPA Evaluation Reference Group apprised of progress and constraints experienced in conducting the exercise;
- 3) Clear initial interviews and visits with the BOTSPA Evaluation Reference Group or the USAID Project Officer and Project Assistant, as appropriate.

The Team Leader will coordinate evaluation logistics and provide a focal point for the findings and conclusions of the evaluation, integrating team contributions into one comprehensive and stylistically consistent report. Except for the contraceptive logistics specialist, whose services are required for a period of three weeks, all team members are expected to remain in-country until the entire evaluation exercise is completed.

7. REPORTING REQUIREMENTS.

The output of this exercise will be a comprehensive Evaluation Report which includes the following sections:

- Executive Summary
- Table of Contents
- List of Acronyms
- Background
- Evaluation Purpose and Specific Objectives
- Methods and Procedures [including responsibility matrix]
- Presentation of Findings
- Conclusions
- Lessons Learned
- Recommendations in order of priority
- Appendices, as appropriate.

Although each team member will provide written sections in his/her area of responsibility, the team leader will have ultimate responsibility for the final product.

Appendix A

Evaluation Team Members

Jane T. Bertrand, Team Leader

Jane T. Bertrand, Ph.D. in sociology, is an Associate Professor at the Tulane University School of Public Health and Tropical Medicine. She has been project director of USAID-funded operation research projects in Zaire (1980-90) and the Caribbean (1982-86) and has directed a number of smaller research projects in Guatemala, El Salvador, and Kenya. Her professional interests include evaluation of family planning programs, information, education, and communication for family planning and health, and behavioral research on AIDS. Bertrand is currently directing a working group of the National Academy of Science on "Factors Affecting Contraceptive Use in Africa." In addition, she is on the Advisory Board for *Population Reports*, the Science Committee of the Association for Voluntary Surgical Contraception, and the Board of Governors of the National Council for International Health.

Maureen Brown

Maureen T. Brown, BScN, MPH, is a vice president at ISG, Inc., a Maryland-based international consulting and service firm. She has been involved in international development for 22 years, and has undertaken numerous short- and long-term health and population assignments in Asia, Africa, and the Middle East. Her professional interests include program development and management, health manpower development, project evaluation, and curriculum development.

Mona Grieser

Mona Grieser is the chief executive officer and owner of Global Vision, Inc., a firm specializing in communications and training. She has worked with development programs for the past 20 years, specializing in family planning/IEC and gender-related issues. Grieser has served as resident adviser for USAID in several countries and as director of the A.I.D.-funded Communication Services Project. She has also provided short-term assistance to over 40 countries in health, family planning, and gender-related topics for UNFPA, UNDP, ILO, the World Bank, and USAID in Africa and Asia. Grieser has degrees in communication and international health, and her doctoral work has been in the field of adult education.

Clifford Olson

Clifford Olson has provided technical services through A.I.D. contractors, UNFPA, WHO/GPA, IPPF/London, the Population Council, the Royal Tropical Institute, and the World Bank. Mr. Olson's areas of interest include family planning management information systems, contraceptive logistics, and PHC performance self-assessment tools. Mr. Olson has experience in 10 African countries, 5 Asian countries, and occasional experience in Central America. Previously, he taught in the Health Administration Department of the WHO graduate program in urban public health at Mahidol University in Bangkok and directed a federally funded domestic health planning agency in the United States.

Appendix A

Persons Contacted

Kgosi Seepapitso

Chairman, House of Chiefs

Ministry of Health

Dr. E. T. Maganu

Permanent Secretary

Mrs. W. G. Manyeneng

Assistant Director of Health Services/Primary Health Care

Dr. P. K. Mmatli

Principal Medical Officer, Head, PHC Support Division

Mr. L. T. Lesetedi

Principal Family Health Officer, FHD

Dr. Kerileng Moeti

Ag. Head, MCH/FP Unit

Ms. Lucy Maribe

Senior Nursing Sister - MCH/FP

Mr. T. Baakile

Ass. Research & Eval Officer, MCH/FP

Mr. Bholo

United Nations Volunteer MCH/FP Research and Evaluation Officer

Dr. M. R. Moeti

Principal Medical Officer/EPID, National AIDS Control Program

Ms. A. Majelantle

Medical Statistics Unit

Mrs. I. P. Mabona

Matron, PHC Support Division

Mr. N. Rambukwella

UNFPA Training Consultant

Mrs. T. S. Mphele

Ag. Chief, Health Education Officer

Ms. E. Segokotlo

Health Education Officer

Ms. M. Mobeza

Senior Health Education Officer (Radio Producer)

Mrs. R. B. Poonyane

Health Manpower Development and Utilization Officer

Mr. Harvold

Senior Health Manpower Development Planning Officer

Mr. Motladiile

Health Education Officer

Ministry of Local Government and Lands

Ms. P. Venson

Permanent Secretary

Mr. Peter Siele

Establishment Secretary

Mrs. S. Barau

SPO (Training)

Ms. V. Isaacs

PPO (Training)

Ministry of Finance and Development Planning

Mr. B. Gaolathe

Permanent Secretary

Mr. Nelson Mokgethi

Deputy Secretary for Economic Affairs

Mr. Jacobs

Mr. Edgar Edwards

Economic Consultant

Ministry of Education

Mr. Simon Coangae

Department of English

University of Botswana

Dr. D. Van Der Post

Lecturer, Dept. of Environmental Sciences

Dr. G. Ahmed

Head, Demography Department - U.B.

Central Statistics Office

Mr. Guest Charumbira
 Ms. Gwen Lesetedi

Government Statistician
 Demographer (IPSCPD Secretariat)

Central Medical Stores

Ms. B. Ottesen
 Mr. J. Botsang
 Mrs. Molefane

Principal Pharmacist
 Pharmacist
 Senior Pharmacist, CMS

Others

Mrs. Mogano
 Mrs. Manzana
 Mrs. P. Marole
 Mrs. G. Banda
 Mr. James Kuria
 Ms. Dorcas Mompoti
 Mr. Simeon Sertsu
 Mr. Greg Miles
 G. Moalosi
 Mr. David Mandel
 Ms. Barbara Belding
 Mr. Scott Stewart
 Mr. Jay Andersen
 Mrs. S. Barry-Tacon
 Dr. Ndombi
 Mr. Islay Rhind
 Ms. B. Mosiimang
 Mrs. K. Moeti
 Mr. R. Ngwenya
 Mr. W. Samson
 Ms. E. Patterson
 Dr. Linda Lacey

NHI, Dy Principal
 NHI, Head Midwifery Tutor
 NEI, Continuing Education
 Unified Local Government Services
 UNFPA, Country Director Botswana/Lesotho and Swaziland
 UNFPA, Program Officer
 USAID (formerly IPSCPD Secretariat)
 Senior MEDEX Project Advisor
 World Bank FH Prog. Coordinator
 Assistant Director, USAID
 Human Resource Development Officer, USAID
 BOTSPA Project Managr, USAID
 USAID Regional Adviser, Health/Population and Nutrition
 Resident Representative - UNICEF
 Programme Officer - UNICEF
 Managing Director, Botswana Breweries
 Counselor, Peer Approach Counseling Program, YWCA
 Counselor, Peer Approach Counseling Program, Botswana Family
 Welfare Association
 Finance & Admin. Officer (BOFWA)
 IEC Consultant, International Planning
 Kalahari Conservation Society
 OPTIONS Consultant

Ntlhantle Clinic, Southern District

Ms. K. Ramaja
 Ms. J. Fanilo
 Ms. Dikeledi
 Mrs. W. Mokotedi
 Ms. Dikeledi Ramaja
 Ms. Esther Moncho
 Ms. Dorcas Letlola
 Mr. Erasmuss Velema
 Ms. Emma Gower
 Mrs. Dineo Motlapeng
 Mogomitsi Mononi
 Mr. Legaenyana Matlhabaphiri

Family Welfare Educator (FWE)
 Enrolled Nurse
 Enrolled Nurse
 Senior Nursing Sister DHT Southern District
 Family Welfare Educator (FWE)
 Deputy District Secretary Southern
 Matron, District Health Team (DHT)
 Senior Health Inspector, DHT
 Community Health Nurse, DHT
 Health Ed. & Nutrition Officer
 Student, Pitsane Elementary School, FP Client
 District Commissioner, Southern District Council

Pitsane Clinic, Southern District

Mrs. A. P. Sebina	Matron/Staff Nurse
Ms. B. Monametsi	Family Welfare Educator

Mmanthethe Clinic, Southern District

Oakantse Lemmenyane	Enrolled Nurse/Midwife
Eva Molefe	Enrolled Nurse
Edna Kgosane	Staff Nurse
Dorcas Motswetta	Family Welfare Educator

Magori Patsao Health Post, Southern District

Grace Banda	Senior Nursing Sister
Keitumetse Nihutang	Staff Nurse
Gaolebale Phadima	Family Welfare Educator
Grace Banda	Senior Nursing Sister
Keitumetse Nihutang	Enrolled Nurse
Gaolebale Phadima	Family Welfare Educator
Ms. B. Munangetsi	Family Welfare Educator

Good Hope Hospital, Southern District

Ms. D. Wright	Matron/Senior Nursing Sister
Dr. D. Ekanew	Medical Officer
Ms. G. B. Dinake	Nursing Sister
Ms. H. O. Ngakantsai	Family Welfare Educator
Ms. M. Tumetsane	Family Welfare Educator

Kweneng District Offices

Mrs. Machacha	District Commissioner
Mr. P. Nkoni	Deputy Council Secretary
Mr. F. Clausen	District Medical Officer
Ms. N. Molekwa	Community Health Nurse
Ms. N. Mogomotsi	Clinics Matron

Thamaga Primary Hospital, Kweneng District

E. Chikuta	Staff Nurse/Midwife
B. Kenaape	Enrolled Nurse/Midwife
S. Martim	Staff Nurse/Midwife
R. C. Tshukudu	Pharmacy Technician

Kumakwane Health Post, Kweneng District

J. Mogutsi	Staff Nurse
E. Tsae	Enrolled Nurse/Midwife
M. Therego	Enrolled Nurse

Lentsweletau Health Post, Kweneng District

M.K. Mojalemotho	Family Nurse Practitioner
B. Methapele	FWE
R. N. Phurie	Enrolled Nurse
L. Isreal	Tirelo Setshaba participant
T. Thukwang	Tirelo Setshaba participant
T. Moepywa	General Duty Assistant
K. Ramokele	General Duty Assistant

Scottish Livingston Hospital, Kweneng District

K.T. Makhabenyane	Senior Nursing Sister
M. Mpatane	Supplies Officer
E.K. Ntwaagae	Senior Sister
B.G. Kgasa	Senior Admin Officer
Morea Sebel	In-Charge, MCH
B. A. Mogampane	Administrative Officer
Dr. Mowala	Medical Superintendent

Chobe District

T. Balapi	Health Inspector
Ms. L. Kgati	Nursing Sister, Kasane PH
Ms C. Petlo	Nursing Sister, Kasane PH
Grace Chika	Senior FWE, Kasane Health Post
Beauty Lenkwetse	Enrolled Nurse, Kasane Health Post
Gkofetamang Magapa	Enrolled Nurse, Lesoma Health Post

Good Hope Hospital

Doreen Wright	Senior Nursing Sister
Magdalene Tumetsane	Family Welfare Educator
Hilda Ope Ngakantsi	Family Welfare Educator

Appendix A

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Appendix B

**List of BOTSPA Workplans
Prepared by the Ministry of Health and
Ministry of Finance and Development Planning**

Appendix B

List of BOTSPA Workplans Prepared by the Ministry of Health and Ministry of Finance and Development Planning

<u>NAME</u>	<u>DATE</u>	<u>PREPARED BY/FOR</u>
1. BOTSPA Implementation Plan for MCH/FP Activities Including IEC 1989-1993	(Draft) January, 1989	Mary Kay Larson MOH Family Health Division
2. Five Year Implementation Plan for FP/Family Life Education/Maternal and Child Health (BOTSPA) August 1, 1990- March 31, 1994	(Draft) February 1, 1991	MOH Family Health Division
3. Implementation Plan for Family Planning/Maternal Child Health (BOTSPA) August 1, 1990 - March 31, 1994	(Draft) July 7, 1990	MOH Family Health Division
4. Short Term/Interim BOTSPA Plan, May, 1991 - March, 1992	Undated	MOH Family Health Division and Central Statistics Office
5. Family Health Division Annual Plan 1991 - 1992	Undated	Family Health Division: - EPI/CCD Unit - Food Nutrition Unit - Health Ed. Unit - MCH/FP Unit
6. (Untitled)	May 1991	ISCSCP/Central Statistics Unit

Appendix C
Impact Indicators for Family Planning

Appendix C
Impact Indicators for Family Planning

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INTRODUCTION. The following text describes a select set of standard FP impact indicators and suggests interventions required to convert the existing reporting system into one that provides these indicators.

The indicators are discussed in the context of improved management of the FP program. They are, first and foremost, intended to increase motivation and self-assessment at facilities and districts in a decentralized system. They enable comparisons:

- between like facilities, and between districts for the same time period, and
- of progress across time for the same facility or district.

In the future, a National Population Policy, or alternatively, a national FP Plan could provide targets for each indicator, against which each facility and district could compare its performance.

The described use of these indicators does not replace periodic demographic surveys; in fact, such surveys enable calibration of the management information system suggested by this text.

The following discussion is organized under the following headings:

<p>IMPACT:</p> <p>MEASURE:</p> <p>SOURCE OF DATA:</p> <p>REQUIRED ACTION:</p>

1.0 IMPACT: MONITORING CONTRACEPTIVE STOCK LEVELS

Currently (9/91) anecdotal information suggests there are large quantities of aging contraceptives hoarded at health centers with limited numbers of family planning acceptors. For example, one visited health post has a four year supply of expired Ovrette. Information is required to support periodic redistribution of contraceptives.

MEASURE: Stock Levels on Hand at facilities

SOURCE OF DATA: New Reporting Form. This data already exists on the CMS designed facility stock form but is not reported to CMS.

REQUIRED ACTION: A Botswana design group might produce a form that looks like the one below. It would be submitted quarterly to the district health team, which would be responsible for (1) redistributing contraceptives and (2) aggregating the data and submitting an aggregated form to FHD.

Maintaining responsibility at the DHT level is consistent with decentralization and enables scarce FHD processing and evaluation resources to be used for higher priority activities.

CONTRACEPTIVE STOCK LEVEL REPORT • facility • district date __/__/__			
BRAND	QUANTITY ON HAND	AVERAGE MONTHLY CONSUMPTION	NUMBER OF MONTHS ON HAND
Lo-Fem			
Noriday			
Ovrette			
Depo			
IUDs			
Condoms, plain			
Condoms, colored			
Other			
Other			

2.0 IMPACT: COVERAGE: Contraceptive Prevalence

This measures the percent of women of reproductive age (WRA) currently using modern methods of family planning.

MEASURE: Contraceptive Prevalence = $\frac{\text{women currently using modern methods of family planning}}{\text{WRA}}$

Contraceptive Prevalence can be measured by two means:

1. periodic demographic surveys
2. on a continuing basis, Contraceptive Prevalence can be estimated from (a) commodities issued to clients or (b) distributed to facilities. This calculation divides the number of a specific contraceptive commodity required to assure coverage to a couple for one year. The following CYP conversion factors are generally in use. The conversion factor for condoms is widely discussed.

CYP example table			
METHOD	QTY (for example)	CYP CONVERSION FACTOR (standard)	Couple Years of Protection (CYPs)
Oral Pills	1,300	13	100
Condoms	10,000	100	100
IUDs	40	.4	100
Depo-provera	400	4	100

SOURCE OF DATA: WRA is calculated by multiplying the population by the percent of women between the ages of 14 - 49. This is usually about 21 - 23 %.

Facility Level: Contraceptive Commodities issued to clients are reported by method on the "Monthly Summary Report. This commenced during 1990. There are no tally sheets to support the collection of this data. Reporting of contraceptives issued at the facilities remains incomplete and inaccurate.

District Level: In the future, when the accuracy and completeness of data submitted by facilities improves, contraceptive issuance data can be aggregated at the district as part of supervisory processes.

In the meantime, CMS is currently investigating modifications to the SWEDIS software which will enable the reporting of aggregate data on contraceptive distributions to each district.

National level: CMS SWEDIS currently has the capacity to report aggregate distributions by product for a specific time period.

REQUIRED ACTION:

Design: A contraceptive issuance tally sheet should be designed, tested, and introduced. It should be accompanied by extensive training. The Botswana design team might produce a tally sheet similar to this:

TALLY SHEET: CONTRACEPTIVES ISSUED			
BRAND			TOTAL
Lo-Fem	0000 0000 0000 0000 0000 0000 0000 0000		
Noriday	0000 0000 0000 0000 0000 0000 0000 0000		
Ovrette	0000 0000 0000 0000 0000 0000 0000 0000		
Other	0000 0000 0000 0000 0000 0000 0000 0000		
TOTAL ORAL PILL CYCLES ISSUED			
Depo	0000 0000 0000 0000 0000 0000 0000 0000		
TOTAL DEPO-PROVERA			
Condoms plain	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000		
Condoms colored	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000		
TOTAL CONDOMS ISSUED			
OTHER specify	0000 0000 0000 0000 0000 0000 0000 0000		

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3.0 IMPACT: PROGRAM EXPANSION: New Acceptors

Program expansion is often a measure of the success of IEC.

MEASURE: New Acceptors / WRA

In a FP program as mature as the one in Botswana, the ever-shrinking number of women who have never used a modern method of family planning makes New Acceptors a less viable measure.

SOURCE OF DATA: New Acceptors are listed by client in the register and checked off in the monthly tally book by method. The current monthly tally book does not have sufficient boxes for the number of new acceptors. All nurses interviewed correctly defined new acceptors as first time users of modern methods of family planning.

REQUIRED ACTION: Eventually the tally book needs to be changed to allow more boxes for new acceptors.

Site visits suggest the number of monthly new acceptors in (1) the register, (2) the tally sheet, and (3) the Monthly Summary Report, rarely agree. More training and supervision is required.

4.0 IMPACT: QUALITY OF CARE: Continuation Rates

From an MIS perspective, the best measure of quality of care is continuation rates. The assumption is that a significant portion of clients who don't return are displeased with the quality of service provided. In any case, and particularly in a mature FP program with a relatively high prevalence rate, continuation rates take on increased programmatic importance.

MEASURE: The number of clients not defaulting on their last appointment divided by the number of registered FP acceptors.

SOURCE OF DATA: The FP register currently in use, together with the practice of using Xs under the appointment month to indicate a fulfilled appointment, and a \ to indicate a scheduled appointment, enables calculation of continuation rates at each facility.

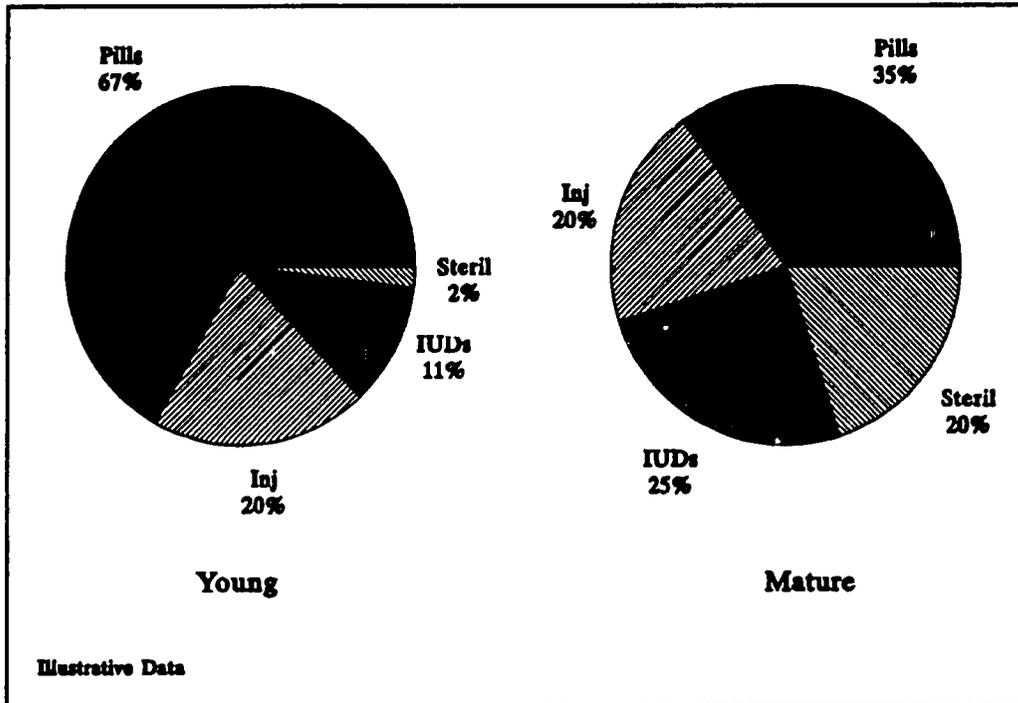
REQUIRED ACTION: Site visits suggest (1) nurses often enter revisits in the tally book, but not the register, and (2) almost no one uses the register for its intended purpose (i.e. identification of defaulters and calculation of continuation rates. More in-service training is required.

Since the geographical distribution of facilities and the relative training of posted staff determine expectations of continuation rates, district supervisors should assume primary responsibility for the use of this indicator during periodic supervisory visits and in-service training sessions.

5.0 IMPACT: METHOD MIX

Young FP programs typically rely on temporary methods of contraception (i.e. pills, injections, and condoms) while maturing FP programs attempt to shift their method mix emphasis to longer term forms of contraception (i.e., IUDs and sterilization).

**Relative Method Mix
Young and Mature FP Program**



MEASURE: CYP by method as a percentage of total CYP

SOURCE OF DATA:

Facility Level: Contraceptive Commodities issued to clients are reported on the monthly summary report by method. The supervisor can be trained to use this data to lead nurses through the calculation of facility-specific Method Mix at annual in-service training sessions.

District Level: District health teams can use aggregate data to do the same calculations. This can be done now using SWEDIS distribution data and, in the future, using aggregate issuance data submitted by facilities.

National level: FHD can use aggregate data to do the same calculations. This can be done now using SWEDIS distribution data and, in the future, using aggregate issuance data submitted by districts.

REQUIRED ACTION: Training in calculation of supervisory use of method mix.

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6.0 IMPACT: AGE OF CLIENTS

A 40-year-old FP acceptor represents far fewer averted births than does an 18-year-old acceptor of family planning. Informants in Botswana repeatedly refer to the growing problem of teen-age pregnancies. A number of programmatic interventions have been initiated to address the problem of teen-age pregnancy. This indicator will assess the impact of these programs.

Programmatic progress over time would be represented by a decreasing average age of FP clients.

MEASURE: FP clients by age groups divided by total FP clients

SOURCE OF DATA: The FP register records the age of clients.

REQUIRED ACTION: There is no evidence of anyone currently using the age data from registers to assess the age distribution of FP clients.

At each level, (i.e., facility, district, and FHD) training should be provided in the annual calculation of this indicator.

District health team supervisors should gather this information from facilities annually, either at in-service workshops or during site visits, aggregate the information and submit it to FHD.

7.0 IMPACT: PARITY

This indicator is similar to age in its justification and use. A FP Client who already has eight children represents fewer births averted than does a FP client with two children.

Programmatic progress over time would be represented by a decreasing average parity of FP clients.

MEASURE: FP clients by parity groups divided by total FP clients.

SOURCE OF DATA: The FP register records the parity of clients.

REQUIRED ACTION: There is no evidence of anyone currently using the parity data from registers to assess the parity distribution of FP clients.

At each level, (i.e., facility, district, and FHD) training should be provided in the annual calculation of this indicator.

District health team supervisors should gather this information from facilities annually, either at in-service workshops or during site visits, aggregate the information and submit it to FHD.

8.0 PROCESS: SUBMISSION FLOW and PERIODICITY

The aggregation envisaged in the above text would be flawed given current practices. Site visits suggested that some primary hospitals skipped the district health team and reported directly to the Medical Statistics Unit. Decentralized district analysis would require that all facility data be submitted to the district health team.

TABLE OF REPORTING PERIODICITY			
REPORT	FACILITY TO DISTRICT HT	FACILITY TO MOH	DHT TO MOH
Monthly Summary Rpt (incl New Accept & contraceptives issued)	monthly	monthly	
Stock level rpt	quarterly		quarterly
Contraceptive Prev	annual		annual
Method Mix	annual		annual
Age	annual		annual
Parity	annual		annual

9.0 PROCESS: SUBMISSION RATES

Current submission rates appear to be very high. Nevertheless, those reports aggregated at the district and submitted to the MOH must be accompanied by an indication of the number of reports included in the aggregation compared to the total number of facilities expected to report.

10.0 PROCESS: TRAINING MANUAL

An earlier attempt at producing a training manual for contraceptive logistics proved incomplete. The design and distribution of a training manual for FP MIS and logistics would document design and process decisions arising from a Botswana FP MIS design team.

11.0 PROCESS: TRAINING CURRICULUM

The same FP MIS design team should undertake the design of a curriculum used for nationwide training in the use of the resulting MIS. The curriculum should include pre-tested exercises with answer sheets for each learning objective.

12.0 PROCESS: CALCULATION OF WRA

Anecdotal information from site visits suggest many districts have calculated catchment populations for facilities while other districts have not. Support will have to be provided to those DHTs which have not yet assigned catchment populations.

The realities of constantly shifting populations and overlapping service areas means that the denominators determined from catchment populations will never be precise. This doesn't matter. Even imprecise measures can be used managerially to motivate and encourage self-assessment, particularly progress across time.

13.0 PROCESS: COMPUTERS

Many informants suggest more computers at more levels will resolve current problems. Computers are obviously useful tools; but alone, they resolve nothing. Worse yet, without extensive training, they set people up for failure.

On the other hand, the level of education and competence among FP staff at all levels in Botswana makes this FP program an attractive candidate to demonstrate the appropriate use of computers. Installation of computers should be accompanied by extensive training and an understanding of the tangential nature of such an intervention. But again, the installation of computers alone will not improve the reliability of data nor the managerial use of data.

14.0 PROCESS: FP MIS DEVELOPMENT TIMELINE

FP MIS DEVELOPMENT TIMELINE										
MONTH =	1	2	3	4	5	6	7	8	9	10
ACTIVITY										
Appt MIS design team	X									
Orientation of team		X								
Interview FP managers		X								
Fact Finding trips			X							
Study Tour				X						
Design workshop				X						
Field testing					X	X				
Redesign							X			
Material Production								X		
TOT									X	
Nurses training										X
Evaluation										->

Appendix D

**Contraceptive-Based Family Planning
Service Delivery Indicators — Botswana
September 1991**

Appendix D

Contraceptive-Based Family Planning Service Delivery Indicators — Botswana September 1991

by Clifford Olson

Sample Use of CMS Distribution Data

The following illustrates how contraceptive data can be used to estimate programmatic growth and method mix. The following example uses quantities of contraceptives distributed from CMS. Data on contraceptives issued to clients provides a more precise measure.

SOURCE DATA BY PRODUCT FROM CENTRAL MEDICAL STORES:

		1988	1989	1990
condoms, plain	x100	8,929	11,885	11,685
condoms, colored	x100	12,060	11,755	15,329
Lo-femenal	cycle	228,100	583,300	501,026
Noriday	cycle	108,725	109,300	158,400
Ovrette	cycle	110,500	146,307	461,640
Depo-provera	vial	37,767	49,408	54,463
Copper T	piece	5,607	12,878	5,088

SUMMARIZED BY METHOD:

		1988	1989	1990
Orals	pieces	447,325	838,907	1,121,066
Injectables	vials	37,767	49,408	54,463
Condoms	x100	20,989	23,640	27,014
IUDs	pieces	5,607	12,878	5,088

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CONVERTED INTO COUPLE YEARS OF PROTECTION (CYPs):

using the following CYP conversion factors:

CYP CONVERSION FACTORS	
ORAL PILLS	13
INJECTABLES	4
CONDOMS	200
IUDs	.4

PRODUCES THESE COUPLE YEARS OF PROTECTION (CYPs):

	1988	1989	1990
Orals	34,410	64,531	86,236
Injectables	9,442	12,352	13,616
Condoms	10,495	11,820	13,507
IUDs	14,018	32,195	12,720
TOTAL	68,363	120,898	126,079

THESE CYPs WOULD ACCOUNT FOR PREVALENCE RATES OF APPROXIMATELY:

CONTRACEPTIVE DISTRIBUTION BASED ESTIMATIONS OF PREVALENCE			
	1988	1989	1990
CYP	68,363	120,898	126,079
WRA	275,227	284,016	292,805
CYP est Prev	27%	42%	43%

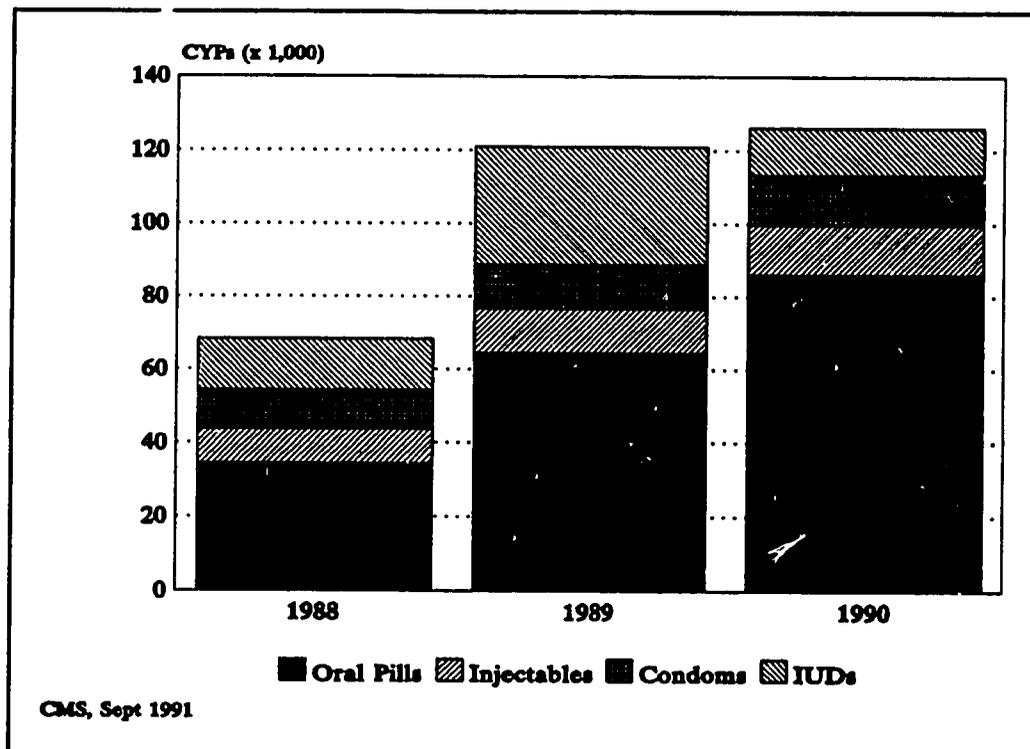
These numbers are credible given 1988 stockouts and the resulting tendency toward hoarding during the two years following stockouts.

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AND THIS DISTRIBUTION BASED METHOD MIX:

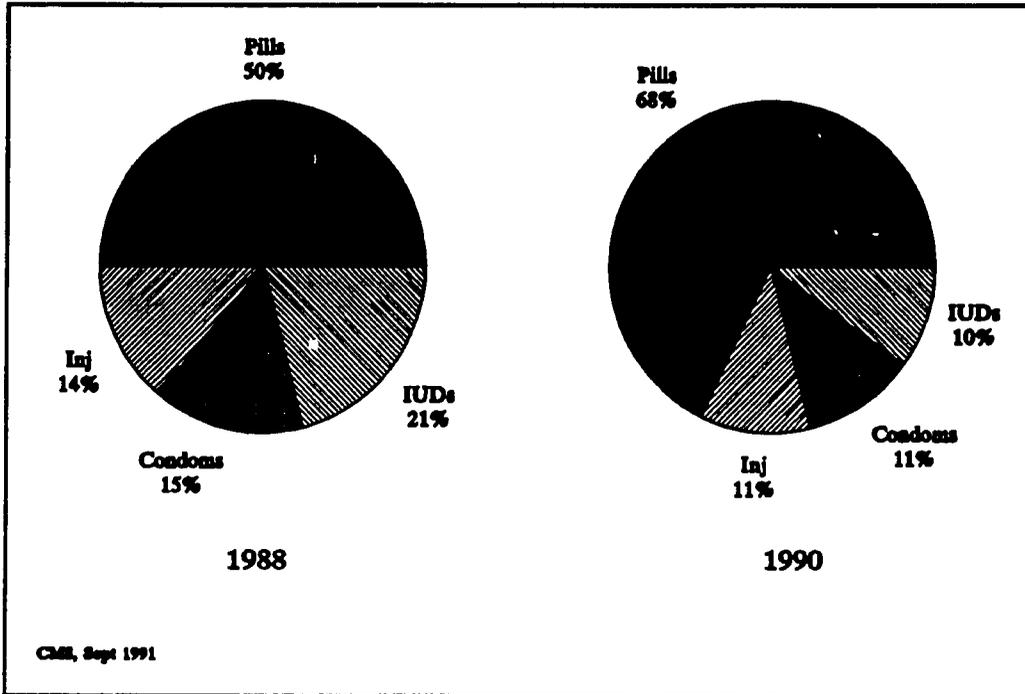
DISTRIBUTION BASED METHOD MIX			
	1988	1989	1990
Oral pills	50%	53%	68%
Injectables	14%	10%	11%
Condoms	15%	10%	11%
IUDs	21%	27%	10%

**Couple Years of Protection
Based on Contraceptive Distribution**



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**Method Mix
from Contraceptive Distribution**



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