PD-AB6-972
84742

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: — DOCUMENT CODE: 3

COUNTRY/ENTITY: ZAMBIA

3. PROJECT NUMBER:

4. BUREAU/OFFICE: AFR — 6

5. PROJECT TITLE (maximum 40 characters): FAMILY PLANNING SERVICES

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 98

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 93 B. Quarter 4 C. Final FY 97

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 93 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	3,070	1,430	4,500	13,630	6,370	20,000
(Grant)	(3,070)	(1,430)	(4,500)	(13,630)	(6,370)	(20,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS	3,070	1,430	4,500	13,630	6,370	20,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DFA	440					4,500		20,000	
(2)									
(3)									
(4)									
TOTALS						4,500		20,000	

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

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To increase the use of modern contraceptives

14. SCHEDULED EVALUATIONS
Interim MM 01 YY 96 | | | Final MM 01 YY 98

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [X] Local [ ] Other (Specify): 935

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

USAID/Zambia Controller concurs with the proposed methods of implementation and financing.

CLEARANCE: CONTROLLER, USAID/ZAMBIA:MGweshe MGweshe 9/29/93

17. APPROVED BY
Signature: Fred E. Winch
Title: FRED E. WINCH, DIRECTOR, USAID/ZAMBIA
Date Signed: MM 09 DD 29 YY 93

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/ZAMBIA

FROM: Dave Straley, PDO Dave

SUBJECT: Family Planning Services Project (611-0235); Request for Approval of the Family Planning Services Project Description and the Project Authorization

DATE: September 30, 1993

Action:

Pursuant to Sections 104 and 496 of the Foreign Assistance Act of 1961, as amended, your approval is requested for a grant in the amount of $20,000,000 to the government of Zambia for the Family Planning Services Project. It is planned that $4,500,000 will be obligated in FY93. You are also requested to approve i) the subject Project Paper, ii) the Project Authorization and iii) the Project Grant Agreement. The Project will have a Project Assistance Completion Date of September 30, 1998.

Background and Description:

The total population of Zambia has been increasing rapidly over time, rising from 4.1 million in 1969, to 5.7 million in 1980, to 7.8 million in 1990 (National Census Reports). The growth rates were 3.1 and 3.2 percent per annum between 1969-80 and 1980-90, respectively. The population of Zambia will continue to increase for many decades due to the youthfulness of the population structure (almost 50 percent under age 15). If the current population growth rate continues, the population is expected to double in just 22 years.

Information from the 1992 Demographic and Health Survey indicates that knowledge of contraception is high (over 90 percent of married women reported knowing about at least one modern contraceptive method), but only 15 percent of married women are using a method, and only 9 percent are using a modern one. If Zambia is to address the high population growth rate, it will have to increase the use of modern contraceptives.

The delivery of quality family planning services in Zambia is limited by the lack of trained health personnel, the theoretical and actual limits of the method mix, the paucity of hours each week when family planning services are scheduled, and the operational problems of the contraceptive logistical management information system which are recognized but not fully resolved.

The Project will address the constraints to increased use of modern contraceptives. The Project will achieve the Project Purpose (to increase the use and diversity of modern contraceptives) with activities in five components: Contraceptive Social Marketing; Information, Education, and Counseling; Service Delivery; Policy;

and Project Management and Administration.

Contraceptive Social Marketing will promote the sale of oral contraceptives through retail outlets capable of adhering to proper screening and counseling standards. The NGO responsible for marketing and distribution under Social Marketing will also supply clinics with commodities not provided by other donors and provide the public sector with a back-up logistic system to ameliorate occasional shortages and stock-outs. IEC will fund a nation-wide mass media campaign to properly inform the populace on the benefits of smaller families, the physiological affects of modern contraceptives, and gender responsibilities for reproductive behavior.

Service Delivery will increase the demand, increase the accessibility, and improve the quality of family planning services at strategic sites throughout the country. By focusing on strategic sites, Project-supported providers will be able to offer quality services to approximately 65 percent of the nation. Service Delivery will support district level integrated clinics, currently being placed under the authority of District Health Boards, NGO managed community based distribution programs, private sector employer based programs, and privately run clinics. Under the Service Delivery component, the Project will also fund operation research into cost effective delivery methods.

Policy will provide short- and long-term technical advisors to the GRZ to assist with legislation that ensures that the current favorable environment for family planning continues beyond the PACD. Project management will provide for evaluations, audits, and a personal service project manager.

Analyses and other requirements:

A Project Paper was reviewed and approved by AID/Washington. The analyses in the Project Paper demonstrate that:

the project is technically, economically and socially sound, and administratively feasible;

the technical design and cost estimates are reasonable and adequately planned, thereby satisfying the requirements of Section 611(a) of the Foreign Assistance Act of 1961, as amended;

the timing and funding of project activities are appropriately scheduled and the implementation plan is realistic and establishes a reasonable time frame for carrying out the project;

adequate provision has been made for evaluation and audit; and

the project is environmentally sound (the Bureau Environmental

Officer approved a Categorical Exclusion for the Project on March 3, 1993).

Conditions and Covenants:

The Project contains a series of conditions precedent to disbursement. Prior to first disbursement the GRZ will provide the standard opinion of legal counsel and name authorized representatives. Prior to disbursement for Contraceptive Social Marketing, the GRZ will allow for the advertising of contraceptives and the dispensing of oral contraceptives by appropriately trained individuals without the need for a physician's prescription. Prior to disbursement for Service Delivery, the MOH will have issued Family Planning Policy Guidelines and Standards.

Waivers:

On September 27, 1993, the Acting Assistant Administrator for Africa waived the requirement under Section 110 of the Foreign Assistance Act of 1961, as amended, calling for a host country contribution of at least 25 percent of Project costs.

Responsible AID Officer:

The Health, Population and Nutrition Officer will be responsible for the project as soon as the position is filled. Until that time, the Program Officer with periodic assistance from REDSO/ESA/HPN will be responsible for implementation.

Project Review Action:

AID/Washington reviewed the Project Paper on September 20, 1993. The Executive Committee for Project Review (ECPR) approved the Project subject to modifications which have now been added to the Project Paper. The cable reporting on the ECPR is included as a part of this authorization package.

Notification to Congress:

A Congressional Notification (CN) and Technical Notification (TN) expired without Congressional Objection on September 23, 1993.

Authority:

Delegation of Authority 551 dated December 23, 1986, provides you the authority to authorize a project if the project: does not exceed $20 million in life of project funding; does not present significant policy issues; does not require waivers which can only be granted by the Assistant Administrator for Africa or the Administrator; and does not have a project life in excess of 10 years. Authorization of this project is within your delegated authority.

Recommendation:

That you approve the Family Planning Services Project by approving this Action Memorandum and signing the Project Paper Data Sheet, and that you authorize the Grant by signing the attached Project Authorization.

Approved: JEW

Disapproved: _____

Date: 9/29/93

Attachments:

Project Paper
Project Authorization
STATE 295735

Drafted:PDO:DStraley

Clearance:PRM:JWiebler JW 9/29/93
CONT:MGweshe 9/29/93
RLA:RSarkar draft

PROJECT AUTHORIZATION

Country: Zambia

Project Title: Family Planning Services

Project Number: 611-0235

1. Pursuant to Delegation of Authority 551, I hereby authorize the Family Planning Services Project involving planned obligations of not to exceed Twenty Million United States Dollars ($20,000,000) in grant funds ("Grant") over a five year period from the date of authorization subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is five years from the date of initial obligation.

2. The Project will assist the Government of the Republic of Zambia (the "GRZ") to increase the use of modern contraceptives. It will do so by providing technical assistance, training, commodities, and/or grants to the Ministry of Health, autonomous District Health Boards, selected non-governmental organizations (NGO), and private sector organizations.

3. The Project Agreement shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities, Nationality of Suppliers of Services

Except as A.I.D. may otherwise agree in writing:

Commodities financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Georgraphic Code 935. Except for ocean shipping, the suppliers of commodities or services shall have countries included in A.I.D. Geographic Code 935 as their place of nationality. Ocean shipping financed by A.I.D. under the Project shall be financed only on flag vessels of countries included in A.I.D. Geographic Code 935, subject to the requirements of Section C.6(c) of the Project Grant Standard Provisions Annex of the Project Agreement with respect to cargo preference. Air travel and transport to and from the U.S. shall be upon certified U.S. flag carriers to the extent possible.

b. Condition Precedent

Prior to first disbursement under the Project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., (a) a written opinion of legal counsel acceptable to A.I.D. that the Agreement has been duly authorized and/or ratified by, and executed on behalf of the Grantee, and that it constitutes a valid and binding obligation of the Grantee in accordance with all of its terms; and (b) a written statement setting forth the name of the person holding or acting in the office of the Grantee specified in the Project Agreement and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the Grantee, together with a specimen signature of each such person.

c. Conditions Precedent for Contraceptive Social Marketing

Prior to disbursement of funds under the component for Social Marketing, the MOH will authorize advertising of socially marketed oral contraceptive(s). The GRZ/MOH will provide written evidence in form and substance satisfactory to A.I.D., except as A.I.D. may otherwise agree in writing, which allows advertising of contraceptives and the dispensing of oral contraceptives by appropriately trained individuals without the need for a physician's prescription. The MOH is expected to authorize this within the first six months of the Project.

d. Conditiions Precedent for Service Delivery

Prior to disbursement in excess of $3 million the MOH will provide written evidence in form and substance satisfactory to A.I.D., except as A.I.D. may otherwise agree in writing, that Family Planning Policy Guidelines and Standards have been issued and include:

1. The providers who can dispense oral contraceptives include doctors, clinical officers, midwives, nurses, pharmacists, community-based distribution agents and TBAs who have been trained to screen clients for contraindications.

2. Service delivery sites for oral contraceptives include hospitals, health centers, pharmacies, shops and CBD agent outlets, where screening of clients for contraindications will take place before the first cycle of orals is dispensed.

3. The providers who can dispense injectibles include doctors, clinical officers, midwives and nurses. Services delivery sites for injectibles include hospitals, health centers and private clinics.

4. The providers who can insert IUCDs and implants include doctors, clinical officers, midwives and nurses who have been specifically trained and certified to perform these procedures. Service delivery sites for insertion of IUCDs and implants include hospitals, health centers and private clinics that have been authorized to provide these services.

Prior to disbursement in excess of $3 million the MOH will also provide written evidence in form and substance satisfactory to A.I.D. that: the position of MCH/FP Specialist, or its equivalent, has been filled.

e. Covenants

The Grantee covenants that none of the funds available to the Grantee under the Grant shall be used to pay for the performance of abortion as a method of family planning, including without limitation: financing or supporting (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to women to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communications programs that seek to promote abortion as a method of family planning; or (v) lobbying for abortion.

The Grantee further covenants that none of the funds available to the Grantee under the Grant will be used to pay for: (i) the performance of involuntary sterilizations as a method of family planning, or to coerce or provide any incentive for any individual to undergo sterilization; or (ii) any biomedical research which relates to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. Finally, the Grantee covenants that all necessary steps will be taken to ensure that funds made available to the Grantee under the Grant will not be used to coerce any individual to practice methods of family planning inconsistent with such individual's moral, philosophical, or religious beliefs.

f) Waivers

The Assistant Administrator for Africa waived on September 27, 1993, the requirement under Section 110 of the Foreign Assistance Act of 1961, as amended, pertaining to a host country contribution of at least twenty-five percent of project costs.

Fred E. Winch, Director

Date: 29 September '93

Drafted:PDO:DStraley

Clearance:CONT:MGweshe draft 9/13/93
R&D/POP:SLutjens draft 9/2/93
REDSO/ESA/RLA:RSarkar fax 9/9/93
PRO:JWiebler draft

FAMILY PLANNING SERVICES PROJECT

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I. SUMMARY & RECOMMENDATIONS

A. Project Summary

USAID/Zambia proposes to grant $20,000,000 in project assistance to the Government of the Republic of Zambia (GRZ) for the Family Planning Services Project (FPS). FPS will be a five year project. Even though the GRZ will contribute personnel and office space to the Project, the Mission and the GRZ will not be required to account for this contribution. The GRZ has received a Section 110 waiver of a mandatory 25 percent of total Project cost counterpart contribution. A.I.D. will obligate $4,500,000 in Fiscal Year 1993.

The purpose of FPS Project is to increase the use of modern contraceptives. It will do so by providing technical assistance, training, commodities, and/or grants to the Ministry of Health, autonomous District Health Boards, selected non-governmental organizations (NGO), and private sector organizations. The Project will achieve the Project Purpose with activities in five components: Contraceptive Social Marketing; Information, Education, and Communication (IEC); Service Delivery; Policy; and Project Management and Administration.

Contraceptive Social Marketing will promote the sale of oral contraceptives through retail outlets capable of adhering to proper screening and counseling standards. The marketing entity for contraceptive marketing will also supply clinics with commodities not provided by other donors and provide the public sector with a back-up logistic system to prevent shortages and stock-outs.

Service Delivery, through an integrated family planning/maternal and child health (IFP/MCH) approach, will increase the availability and accessibility of quality family planning services at strategic sites throughout the country. By focusing on strategic sites, Project-supported providers will be able to offer a wide range of quality services to approximately 65 percent of the nation. Service Delivery will support district level integrated clinics, currently being placed under the authority of District Health Boards, NGO managed community based distribution programs, private sector employer based programs, and privately run clinics. Under this component, the Project will also fund operation research in areas such as financing of and reimbursement for family planning services, cost recovery, and alternative methods of service delivery.

The IEC component will provide for a nation-wide mass media campaign to properly inform the populace on the benefits of smaller families, the physiological affects of modern contraceptives, and gender responsibilities for reproductive behavior. It will also support an IEC effort at the provider level

in selected districts.

Policy will provide short- and long-term technical advisors to the GRZ to assist with legislation that ensures that the current favorable environment for family planning continues. Project management will provide for evaluations, audits, and a personal service project manager.

The Project will include several Conditions Precedent (CPs) designed to facilitate achievement of the Project Purpose. The CPs include: authorizatiion for advertising of socially marketed oral contraceptives; permitting a broader range of specifically trained health workers to dispense oral contraceptives and increase the types of service delivery sites where oral contraceptives are available and; increasing the number and type of service providers who can dispense injectables and insert IUCDs after being trained and certified to perform these procedures.

It is expected that by the End of the Project: the contraceptive prevalence rate will have increased from 9 percent to 20 percent among married women, and from seven percent to 18 percent among all women; service delivery at strategic sites will have increased by 75 percent; and couple years protection (CYP) will have reached 380,000.

B. Project Issues

AID/Washington reviewed and recommended revision of the Mission's Project Identification Document (PID) for FPS. The PID proposed almost complete reliance on the private sector for delivery of publicly-funded family planning services. A subsequent cable (LUSAKA 02750) was sent to AID/Washington which proposed support for a broader approach involving social marketing, clinic provided services through public and private clinics, and policy changes. AID/Washington agreed to the concept of a broader approach and concurred with the development of a Project Paper (PP) to be approved in Washington.

Guidance for the preparation of the PP, a summary of the issues raised by AID/Washington concerning this Project, and the Mission's responses to the issues appears in Annex E.

AID/Washington reviewed the Project Paper on September 20, 1993, and made a series of recommendations for modifications of the Project Paper (see Annex R). The recommendations have been incorporated into this Project Paper.

C. Recommendations

The proposed Project fully supports the Mission's goal of a socially stable, politically active, economically productive population. Increased use of modern contraceptives will lead to

healthier and more productive families by reducing the high dependency ratio in Zambia.

The Project has been designed to be technically, financially, socially, and economically sound. Therefore, it is recommended that the Mission Director approve the Project Paper and authorize negotiation of a grant agreement with the Government of the Republic of Zambia for the Family Planning Services Project.

II. PROJECT BACKGROUND AND RATIONALE

A. Economic Performance and Problems

The Zambian economy has essentially been in a downward spiral since the mid 1970's. The economy's fundamental problem is rooted in its heavy dependence on a single commodity (copper) and the statist economic policies it followed in the past. The prior government under United National Independence Party (UNIP) implemented import substitution policies, maintained an overvalued exchange rate, kept interest rates artificially low, and embarked on a program of nationalization of firms to the point that the GRZ controlled almost all sectors and no less than 80 percent of the economy.

Rising copper prices at first concealed the distortions and allowed the economy to grow at an annual rate of four percent per annum during the first decade after independence. When copper prices began to fall, however, Zambia experienced a general deterioration in terms of trade, coupled with a failure to develop a dynamic, diversified economy. Attempts to support continued consumption through foreign and domestic borrowing failed and created an exceptionally severe debt problem. In the last years of the 1980s, the Government's response to a failing economy was to increase expenditures and borrow from the domestic banking system. This led, in turn, to monetary expansion and heavy inflationary pressures.

The macroeconomic consequences of the past policies has been a per capita GDP which is now one-third of what it was in 1978, an inflation rate which peaked in 1993 at 207 percent, and a foreign debt level of about $600 per capita ($5 billion) in 1993 which is among the highest in the world. Zambia's social and health sectors have suffered from the failed economic policies of the past. Real expenditures on health have declined steadily for the last several years, and the outlook for an early improvement in GRZ health care expenditures is dim given the tightly controlled monetary and fiscal policies the GRZ must adhere to as it attempts to restructure its economy.

B. Sector Background and Constraints

1. Sector Background

Zambia is a landlocked country in Southern Africa covering a total of 752,614 square kilometers. The total population has been increasing rapidly over time, rising from 4.1 million in 1969, to 5.7 million in 1980, to 7.8 million in 1990 (National Census Reports). The growth rates were 3.1 and 3.2 percent per annum between 1969-80 and 1980-90, respectively. Contributing to the significant increase in the size of the population and the high growth rates were high fertility rates coupled with declining under five mortality rates. Recent data, however, indicate an apparent reversal in both of these trends. While the total fertility rate (TFR) remained persistently high for several decades (7.2 estimated from the 1980 census), the 1992 Zambia Demographic and Health Survey (ZDHS) shows a decline to 6.5. Urbanization and the difficult economic conditions may be factors contributing the decline in TFR. The infant mortality rate, on the other hand, had steadily declined to 97/1000 (estimated from the 1980 census), and was expected to decline to 90 by 1990, but has instead risen to 107 (calculated from the ZDHS data). The deterioration of health services, the spread of HIV/AIDS, and a poorer general health and nutritional status, have probably all contributed to the increase in the infant mortality rate.

With a population density that increased from four persons per square kilometer in 1969, to 10 in 1990, Zambia is a vast and sparsely settled country. The population, however, is very unevenly distributed: Copperbelt and Lusaka Provinces, covering only seven percent of the national land area, accommodate 35.7 percent of the population. Due to migration of people to the Copperbelt mining towns and the urban centers, the proportion of the population living in urban areas has increased steadily from 29 percent in 1969 to 42 percent in 1990. This makes Zambia the most urbanized country in Sub-Saharan Africa. Furthermore, more than 60 percent of Zambians live along the line of rail which connects Livingstone in the South, with Ndola in the Copperbelt. These factors strongly influenced the project strategy to increase client coverage for family planning services through development of strategic service delivery sites.

Information from the 1992 ZDHS indicates that knowledge of contraception is high (over 90 percent of married women reported knowing about at least one modern contraceptive method), but only 15 percent of married women are using a method, and only 9 percent are using a modern one. The most popular methods are the pill (4 percent), withdrawal (3 percent), female sterilization (2 percent) and condoms (2 percent). Women most likely to be using contraceptives are those resident in urban areas, those with higher education and those with four or more children. Urban women, who have better access to health facilities are more likely to be using a modern contraceptive method (pill, female sterilization and condoms), than their rural counterparts, who rely primarily on traditional methods (withdrawal, post-partum abstinence, beads and herbs).

The majority of contraceptive users (56 percent) obtain their methods from government sources: MOH health centers supply 50 percent of all oral contraceptives (OC); MOH hospitals supply 45 percent of all female sterilizations. Private and Mission hospitals and clinics provide 54 percent of female sterilizations and 20 percent of OCs. While 41 percent of all condoms are supplied by MOH hospitals and centers, an equal amount (41 percent) are purchased from pharmacies and shops, indicating significant coverage of USAID supported social marketing interventions (PSZ with FPIA and Pathfinder).

Based on the data that indicate 33 percent of married women have an unmet need for spacing (21 percent) and limiting (12 percent) births (1992; ZDHS), the ZDHS estimates that 350,000 married women in Zambia are in need of family planning services.

Of the women interviewed by the ZDHS who were not using a method of contraception at the time of the survey, but indicated that they intended to use a method in the next 12 months, 59 percent said they preferred to use the pill and 8 percent preferred female sterilization. Five percent indicated they would like to use an injectable, which is a method not readily available at present. This shows a high level of interest and potential acceptance of Depo Provera and Noristerat when they are included in the contraceptive method mix later this year.

Even with a considerable decline in the levels of fertility, the population of Zambia will continue to increase for many decades due to the youthfulness of the population structure (almost 50 percent under age 15). The GRZ developed the National Population Policy in 1989 recognizing that rapid population growth will undermine the achievement of the country's development objectives. The GRZ's National Family Planning Program for 1992-2000 sets ambitious objectives and targets for the revitalization of family planning service delivery. Significant constraints will have to be overcome if the program's targets are to be achieved.

2. Constraints to Reduced Population Growth

a. Technical Constraints

The delivery of quality family planning services in Zambia is limited by the lack of trained health personnel, the theoretical and actual limits of the method mix, the paucity of hours each week when family planning services are scheduled, and the operational problems of the contraceptive logistical management information system which are recognized but not fully resolved.

Lack of Trained Personnel

The integration of family planning (FP) with maternal and child health (MCH) program interventions began in earnest in 1986, when the MOH introduced a new in-service family planning training of health providers. This MCH/FP course was designed to provide theoretical (seven weeks) and practical (seven weeks) training in MCH/FP service delivery, but only two weeks of classroom work are devoted to FP. Offered one to four times per year (depending on availability of financial resources and qualified trainers), to a class of 35 students, more than 200 graduates have earned the title "Family Health Nurse" upon successful completion of the course (see Annex P). Besides nurses who work with MCH/FP activities at MOH district offices, hospitals or health centers, other course participants have included MOH clinical officers, and clinical officers and nurses from NGOs and from industries that provide health and FP services to their employees.

The lack of qualified staff, adequate FP curricula, training manuals and materials and financial support are factors which limit the amount and quality of FP training being provided by the MOH MCH/FP Unit. Family Health Nurses were on duty in the hospitals and health centers visited by project paper development team members, but their knowledge and skill level related to FP methods and services were limited. They did not recruit clients but rather waited for people to come to the health center for services. IEC materials to promote FP were either limited or not available to these service providers. PP team members also observed that several of the course graduates had been reassigned to positions where their FP skills could not be utilized.

In July 1992, a FP component was incorporated and/or strengthened in the curricula of the Zambian Nursing and Midwifery Schools (for both registered and enrolled nurses and midwives). The first midwives trained under this program will graduate this year, while enrolled nurses will not graduate until 1994. The clinical officers trained at the Chainama Environmental and Health Sciences Institute also receive limited training in FP during their rotation in obstetrics and gynecology. Although they have been strengthened, pre-service curricula for the clinical officers and the nurses should be revised to include teaching of new contraceptive methods and more practical work related to management of complications and counseling.

While lack of adequately trained nurses and clinical officers has constrained FP service delivery at health centers, the lack of hospital based physicians, who are trained to provide FP services and offer backup support to lower level workers for patient referral, is an equally serious human resource constraint. There are few physicians available to meet the demand for permanent surgical contraception to limit births. In a like manner, since few physicians have been trained to insert IUCDs,

this method is virtually unavailable to FP clients.

Limited Method Mix

There is one modern contraceptive method offered to Zambian FP clients--the pill. Several types of pills and a variety of brands with identical formula are available. differing only in brand names and not formula content. Less popular brands sit on the shelf until they expire, while the more popular brands stock out. Condoms are widely available and appear to be a popular contraceptive as well as a contrainfective. The only other modern FP method available to women at health centers was a spermicide (vaginal foaming tablet or can of foam). Even these were popular alternatives that were stocked out at several sites. The MOH is planning to introduce an injectable hormonal method when the product arrives. This would significantly enhance the method mix at health centers. Providing adequate training and guidelines for clinical officers and nurses to insert IUCDs, would go even further to remove this constraint to adoption of a modern FP method. At the present time, a client must go to a hospital and seek the services of a physician for an IUCD insertion, with limited chances of success.

Health center providers are interested in referring clients for long-term permanent FP methods, but very few hospitals offer sterilization on a regular basis. Doctors are not equipped or trained to perform minilaparotomy under local anesthetic, so the unmet demand for this method only continues to increase. If surgical methods could be offered on a regular basis by hospital based physicians, another contraceptive method--the implant--could easily be added to the choice of surgical methods. NORPLANT trials were successfully conducted in Lusaka beginning in 1988, but the implant has not yet been registered and is not being offered. The Population Council is developing a proposal to make this method more widely available. Since the implant is long-term but reversible, it could become very popular and would significantly increase the total couple years of protection.

Limited Hours for FP Services

With the exception of the six pilot health centers and a few hospitals that offer FP services at all hours everyday, it is very difficult to get access to services. Health facilities that provide MCH/FP services on a schedule will provide FP only one or two days per week for approximately two hours. At a popular clinic a client has to wait in a long queue for services. The introduction of integrated FP services at six pilot sites was evaluated and found to be successful because client waiting time was reduced and satisfaction was increased, and providers had more time to counsel patients. The nationwide introduction of the new integrated system will significantly increase the accessibility and availability of FP services for clients. All FPS project strategic

sites will offer FP services integrated with MCH service on a daily basis.

Logistics Management Information System

Stock-outs of contraceptives, plus distribution problems at the district level and below have plagued the MOH FP program over the years. The high demand for condoms to prevent the spread of HIV has further increased the need to strengthen the logistics management information system (LMIS). Over the past six years, several donor agencies have provided contraceptives as well as logistical management support to the FP program. A Management Information System Working Group (MISWG) was established and has been responsible for the design of the improved systems for collection of statistics related to FP and HIV prevention service delivery and commodity distribution. The following forms were designed, tested and introduced and were observed in the field: monthly stock report form, the FP clinic card, the daily register. The Medical Stores Limited (MSL) has become the distributor of MOH contraceptives which it ships to districts on a regular schedule with essential drugs kits.

The PP team noted that upon arrival in the district, contraceptives are separated from essential drugs which are administered by the pharmacist. Contraceptives go to the MCH/FP Coordinator who is not trained in logistics management. While a new stock report form was being used by the health centers and the districts, more training is needed to assure the health workers fill it out correctly and actually order more stock based on their usage rates. Contraceptive products were not stored in an organized fashion. Health workers had no idea of how many contraceptives they actually had, and could not locate products which they thought were available. While none of the product expiration dates had passed, there were pills that had no date on the packaging or any indication of when they had been manufactured.

The correct completion of the monthly stock reports and the forwarding of the information to MSL, will improve the overall operation as long as MSL has contraceptives to meet the district requests. At the present time there appears to be a stockout of vaginal foaming tablets (VFTs) and a limited supply of condoms. Ample supplies of three to six brands of pills were seen at every service delivery site. IUCDs were available at a hospital that was visited, but there was a problem finding a physician to do insertions.

Realizing that contraceptive stocks were down, the MOH requested an emergency order through ODA which has already been processed. ODA has also developed a five year project to begin in 1994, which will provide technical assistance in logistics management to the MSL as well as providing the contraceptive supplies requested by the MOH for the next five years. The

commodity list for the FPS project includes supplementary supplies of orals and injectables and increased quantities of IUCDs and implants which the MOH request has underestimated. The FPS project will also provide management assistance to the MOH MCH/FP unit to improve collection and analysis of LMIS data.

b. Health Care Financing and Reimbursement

The foremost constraint to sustainable improvements in health care delivery and family planning in Zambia is funding. Zambia has allocated insufficient public and private sector resources to health care (including family planning), and the amount it has allocated has been spent inefficiently. While greater funding is desirable, the first priority is to utilize available resources more efficiently.

The GRZ has funded health care from a centralized approach. This has distorted the incentives to provide adequate health care at the beneficiary level. Everything from staffing patterns to procurement of equipment and supplies have been determined at the central level and delivered on a central government schedule. The allocation and delivery of resources has been divorced from the needs of patients and beneficiaries. The GRZ recognizes the need to reform the health care delivery system. It plans on having a decentralized delivery system in place by January 1, 1995. While decentralization is expected to improve the delivery of public health and family planning services, the extent of the greater efficiencies remains to be determined.

The options for increasing the funding available for health care are limited. The GRZ is unable, at the present time, to raise additional funding through supplementary national taxes. The national economic base is not strong enough to support additional taxation for health care. If the GRZ is to provide a basic level of care for all, in addition to improving the economy, the GRZ will have to introduce, utilize and/or improve compulsory/private insurance, user charges (co-payments), and community-based financing (tax) programs.

In terms of family planning, the financing constraint is formidable. If Zambia is to attain a contraceptive prevalence rate of 18 percent women of reproductive age using modern methods, it will require commodities and services for approximately 380,000 individuals. At $20 per CYP,[1] the total cost will come to about $7.6 million, or approximately $.79 per capita for the population as a whole. If the current public per capita

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[1] Duff Gillespie, et al., "Financing the Delivery of Contraceptives: The Challenge of the Next Twenty Years," USAID, Oct. 7, 1988 (Committee on Population, National Academy of Sciences, Washington, D.C.).

expenditure for health care remains at approximately $5, a successful publicly-funded family planning program would need over 16 percent of the health care budget. Since family planning is funded out of the budget for primary health care, publicly supported family planning would claim three quarters of all spending for primary health care.

The high subsidy for curative care in three urban areas with higher per capita incomes complicates the financing constraint for preventative health care needs such as family planning. While cost recovery will occur throughout the country, it is doubtful, given the poverty levels in Zambia, that the collections at the health centers will approach anything close to sustainability. Cost recovery at the major hospitals in the urban areas holds the greatest potential for freeing up more of the health care budget for preventative care and family planning at the local level. But, until the quality of the three urban hospitals is improved and a reasonable cost of care is determined, it will be financially difficult to set appropriate fees for those with the ability to pay and politically difficult to reduce the heavy subsidies.

Without greater reliance on the private sector, more efficient allocation of the existing budget, and improved financing arrangements, increasing the use of modern contraceptives will continue to be difficult and come at the expense of donors or other health care needs.

c. Institutional Constraints

The traditional service provider, the Ministry of Health (MOH), has been unable to maintain health care standards given the financial constraint and the centralized system that was in place. The centralized system is about to change to an organizational structure that will require District Health Boards to provide services and the central government to establish policy and provider oversight. The institutional structure for policy and oversight which is evolving under the decentralization of health care may not be in concert with the needs and national strategy for population. For instance, what role will the National Family Planning Program play if the decentralized districts were to choose alternate strategies for service delivery, or no delivery at all? How will the proposed National Population Council relate to the District Health Boards and the National Health Reform Implementation Team? These institutional questions of how population planning will be incorporated into development planning and policy implementation have yet to be answered.

In addition, the decentralization of publicly provided health care to the district level is expected to improve the delivery of health and family planning services. While details for the implementation are still being developed, the MOH

anticipates making block grants to the districts for the delivery of preventative and curative health services. District Health Boards will be required to submit budgets and health plans that specially identify the health needs of their communities. The MOH will then provide districts with block grants and the District Health Boards will then be responsible for the implementation of the plans.

Even though the GRZ concern for moving health care planning to the provider level closest to the family is appropriate and laudable, the proposed decentralized approach still bases allocation of funding on the input needs of institutions and not necessarily the demand needs as determined by epidemiological methods. For example, the MOH originally intended to have all health plans and budgets prepared at the district level. The MOH found the first district health plans to be heavily biased toward providing the majority of resources in the areas where the members of the District Health Boards lived. Based on the first set of plans (June-December 1993), the MOH reformulated the process for decentralized planning and organized district level planning workshops for representatives from all health centers to secure their participation in the development of the 1994 District Action Plans.

Even if the decentralized approach is more favorable to the beneficiaries, the incentive system that seems to be unfolding is still not dependent on meeting beneficiary needs. The introduction of user fees is expected to improve the focus onto the demand for family planning and health care, but until the user fees become substantial, the bias is expected to be weighted towards the institutional needs, albeit closer to the family, than it has been.

It is also uncertain to what extent the decentralized approach will improve the health and family planning institutional capability to motivate and retain qualified staff. National figures for the number of health workers in Zambia are incomplete. The lack of relevant data makes it extremely difficult to analyze the adequacy, effectiveness of use, productivity and quality of the country's health workers in general. For family planning, however, the human resource skill base is known to be thin. (See technical constraints above for training weakness.)

Complicating the inadequate training is the poor distribution and retention of professionals capable of providing family planning services. The career and material incentives are so inadequate for health workers that the retention rate for health care professionals is extremely low. The institutional structure to address human resource incentive problems, currently tied to the civil service system, needs to be reformed. ODA is providing technical assistance to the MOH to examine human resource development issues and provide guidance for

new personnel policies under the health reform program.

Finally, the physical infrastructure has deteriorated so badly over the last two decades that it now seriously affects the functioning of health and family planning services. The complex facilities built in the sixties and seventies were unsustainable. The centrally planned approach adopted by the prior administration, ended with health facilities constructed, often for political reasons, in locations where they were underutilized. The emphasis was on numbers of facilities which tended to outpace the availability of health care personnel to staff them. During the 1980s when funding for social programs tightened, funding to maintain and rehabilitate the aging stock of health care infrastructure was dropped, or diverted, to salaries and operating costs. Health staff and local authorities have resorted to sub-standard, ad-hoc solutions to keep the public services going.

With decentralization, it is not certain as to who will be responsible for capital costs and replacement. The Public Investment Program will fund infrastructure projects to include rehabilitation of rural health centers by the Ministry of Works and Supply. At the central level, the Ministry of Works and Supply has very few qualified staff and hardly any operational budget. It has no capacity to undertake urgently needed projects.

d. Policy and Legal Constraints

Numerous assessments have reported that according to law, condoms can be sold in non-pharmaceutical outlets (supermarkets, drugstores, shops and kiosks) but that oral contraceptives are to be distributed only in pharmacies. In theory oral contraceptives are sold upon presentation of a prescription; in practice, it is known that Ocs are sold, more often than not, without the required prescription.

The law states that IUCD insertion is a procedure which physicians can perform. Regulations regarding the insertion of IUCDs by nurses are ambiguous because, while it is not strictly prohibited, it is also not explicitly permitted. While several nurses, who attended FP courses in Zimbabwe, have been trained to insert IUCDs, few of them perform this practice due to lack of specific MOH and General Nursing Council guidelines.

The lack of official MOH Policy Guidelines and Standards for Family Planning Services is a major constraint to the provision of family planning options in Zambia. Such Policy Guidelines are needed to spell out which service providers are authorized to deliver each method and specify the approved service delivery points. By issuing official family planning guidelines and standards, the MOH will be able to design training courses and implementation schedules that not only allow nurses to insert IUCDs

and implant but also clarify the services that can be performed by clinical officers, health assistants, TBAs and CBD agents who have been trained to provide family planning information and services. It is crucial to have these guidelines and standards written and officially sanctioned in order to implement the FPS Project activities.

Until recently, it was believed that injectables were banned for use as a contraceptive method. PPAZ has been providing the injectable Noristerat to its clients for several years. The MOH has also requested supplies of Noristerat from ODA under both the emergency and the five-year contraceptive procurement projects. According to the Minister of Health, registering Noristerat and Depo Provera with the GRZ will not be a problem if the medication is also registered in the country of origin. There remains, however, a reluctance on the part of providers and clients to use injectibles because they have been associated in the past with harmful side effects (see Annex H).

Finally, although there are no restrictions on the advertising of non-prescription products such as condoms, mass media advertising of pharmaceutical products, which include oral contraceptives, is not permitted. The Minister of Health is prepared to grant an exception to this rule for a socially marketed OC.

MOH officials have assured USAID/Zambia that they have all the administrative powers necessary to ensure that: para-medical personnel appropriately trained, will be authorized to provide the longer-term methods of contraception; retail outlets with trained staff will be authorized to sell Ocs; and, advertizing of socially marketed oral contraceptives will be permitted.

The legal constraints to increased use of modern contraceptives are not caused by restrictive policies; the current government is supportive of family planning. As a democratic country, however, a new administration might not support the present family planning policies and programs. The FPS project, therefore, will provide technical assistance to help establish the basis for supportive family planning legislation, based on open debate and a democratic consensus.

e. Social Constraints

Woman's fertility and child bearing practices are highly correlated with the level of education. Although it is improving, the education level of women in Zambia is low. Only 20 percent of Zambian women have attained an education beyond primary school level. As of 1992, about 60 percent of both males and females had attained primary level of education; 22 percent of males and 13 percent of females attained a secondary level; and only one percent of females had reached a higher level of

education.

Social pressures also limit the control women have in determining their family sizes. Decisions on the number of children a woman should have and when she should start using a family planning method are very much affected by the advice (or pressure) of kin group and in-laws. Moreover, the husband generally has the final say, regardless of whether the couple discusses these issues or not. Even when women know about family planning methods or wish to space their children, a reported barrier to using a method, whether it be natural or modern, is their husbands' refusal. While not MOH policy, many clinics are still requiring spousal consent for FP, and/or women assume consent is mandatory. Nurses who have had experience with women whose husbands would come to the clinic in a fury upon discovering the women were using contraceptives expressed preference for obtaining the consent of both spouses in advance. A man will suspect his wife of being promiscuous if he learns that she is using a method without his permission.

FP services and educational messages have not been adequately targeted towards men. These have been predominantly oriented to female clientele. However, because men are the major decision makers, their knowledge about fertility and family planning is as critical as women's knowledge. Since many misconceptions exist about the physiological effects of modern contraceptives, this is another area that will be addressed under the IEC component.

Focus group discussions and interviews with men as well as other secondary sources of information strongly indicate that family planning for the purpose of limiting family size is not consistent with cultural views; child spacing, however, is an integral part of tradition and a more acceptable argument for family planning practice.

The traditional values regarding children favor the woman having as many children as possible. Children are considered a source of prestige, labor, and support in their parents' old age. Unmarried women will sometimes bear children to prove their fertility and to consolidate their relationships with men, in anticipation of marriage, even when fathers are married to other women. This seems to be true even among married women; in the male focus group discussions (male study), some men admitted it was their wives who wanted more children because the woman feared the man would divorce her once she stopped having children. The female study showed that the most common reason for women wanting more children was to ensure economic support in their old age.

Fertility among adolescents also needs to be addressed. In the 16-18 age group for girls, all were sexually active but less than half were using family planning. Abortion is

regarded as the easiest form of family planning but most abortions carried out are unsafe, illicit abortions, using herbs or other methods secretly administered. A 1992 study on teenage pregnancy cited in Likwa (1993:9) showed that 93.5 percent of pregnant adolescents never used modern family planning methods. Most of the young women studied, nonetheless, had some knowledge about family planning services available at service delivery points. At the time of the DHS, more than one quarter of teenage women had already had a child and another seven percent were pregnant with their first child (Likwa, 1993:11f). Early childbearing is more predominant among rural women and those who have not attended school.

Finally, interviews with traditional healers and male focus groups indicate that reliance on traditional methods for family planning is quite common. Traditional beads and withdrawal are considered to be effective methods and in some provinces, the use of traditional methods is higher than for other methods, according to the DHS.

3. Host Country Strategy

The GRZ recognizes the negative impact of rapid population growth on socio-economic development and the consequent need to systematically integrate population issues into the nation's development planning and implementation process. The GRZ's National Family Planning Program: 1992-2000 describes the activities the GRZ endorses which will achieve national family planning goals, objectives, and targets. Its well defined strategy covers: service delivery; information, education, and communication (IEC); commodity and equipment logistics; and training.

To improve access and availability of family planning services, the National Program has deliberately chosen to promote family planning services via a variety of service providers: Community Based Services (CBS), Employer Based Services (EBS), Contraceptive Social Marketing (CSM), and Integrated Family Planning clinic-based services (MCH/FP).

The GRZ considers information as well as access to family planning services a fundamental human right. Mass media IEC concerning family planning encompasses the entire population. While family planning services are able to offer specific IEC information and counselling to men and women in order to meet their needs. The National Commission of Development Planning has recently completed the design of a National Population Information, Education, and Communication Program to promote the most appropriate use of all available IEC channels.

The Ministry of Health (MOH) and non-governmental organizations (NGO) have been primarily responsible for procuring and distributing commodities, equipment, and supplies. The

national strategy suggests that all donor-funded family planning commodities be delivered to the MOH-owned parastatal (The Medical Stores Limited) with descending delivery to provisional level pharmacies, then to the districts, and finally to the clinics and family planning outlets. The national strategy calls for monitoring and evaluation of the public sector logistics system in six selected districts over a two year period. With decentralization, the strategy for commodities is in a state of flux.

Finally, the GRZ strategy recommends a standard training curriculum for all health workers. As the coordinator for family planning services, the Ministry of Health expects to develop integrated basic and in-service training curricula for all health workers and conduct such training where necessary. The GRZ has set some ambitious family planning targets for itself. By the year 2000 it expects to increase the family planning prevalence rate[2] from 8.9 percent to 25 percent; to reduce the total fertility rate to 6 from 7.2[3] in 1980; and to reduce the infant mortality rate from 112 per 1000 in 1991 to 65 per 1000.

The GRZ recognizes the need for improved family planning and health care delivery to be coupled with financing reform. The GRZ is anxious to test and implement alternative financing strategies. The GRZ is proceeding to test a rural financing scheme that allows beneficiaries to pay for health care with contributions of crops. UNICEF has provided some technical assistance in health care financing as it relates to the decentralization program. To date, no donor has committed itself to providing long-term support for health care financing.

C. USAID Strategy

1. Program Strategy

The last two years have been a period of accelerating change in Zambia. In October 1991, Zambia became the second English-speaking country in post-colonial Africa to undergo a democratic transition. Since taking power, the new government has aggressively pursued an economic and political restructuring program designed to dismantle the state economy and promote democracy. Visible improvements in the quality of life are critical during the period of economic restructuring to reinforce public confidence and attitudes for a continuation of the new

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[2] Percent of women of reproductive age or their partners practicing family planning.

[3] More recent statistics indicate that some of the GRZ targets need to be revised. UNICEF, for example, has reported the fertility rate at 6.5 in its The State of the World's Children 1993.

economic and political agenda.

The GRZ selected health and education as the two social sectors where demonstrable improvements in the access to and quality of service would strengthen the mandate for change. Better child spacing and lower fertility will improve the standard of living at the household level, and a reduced population growth rate will allow the GRZ to use its scarce fiscal capacity to improve the quality of social services on a per capita basis. Therefore, USAID/Zambia selected reduced population growth as its highest social priority and made it the Mission's Second Strategic Objective. Reducing the population growth rate is consistent with the GRZ strategy and USAID/Zambia's Program Goal.

2. Project Strategy

To assist the GRZ in resolving the constraints to increased use of modern contraceptives, the USAID strategy focusses on the immediate technical problems of service delivery: improving the method mix, enhancing access to services, upgrading the quality of services offered, increasing general awareness about the need for family planning services, and providing a social marketing commodity supply system which will fill gaps and prevent shortages. By addressing technical constraints first, USAID/Zambia expects to bring about the greatest immediate increase in use of modern contraceptives at the least cost.

The Project strategy will address the immediate technical constraints upon clinic services in strategic sites. The Project will concentrate clinic delivery of services in strategic sites to achieve a straight-forward Project Purpose at the least cost and reduce the Mission's management burden.

The Project strategy will also address the longer-term legal, social, and financing constraints with operations research and technical assistance. While the eventual resolution of these constraints will address sustainability and continuity concerns, the first priority is to ensure that the unmet demand (1992; ZDHS) for modern contraceptives is overcome.

The institutional constraint to efficient delivery of family planning services is also a longer-term constraint that the GRZ is currently addressing with other donor support. In the next two to three years, the institutional issues related to family planning will either have been worked out with the unfolding of decentralization, or surface as identifiable constraints to be resolved. The current status, or ambiguity, of institutional roles and responsibilities will not preclude the Project from promoting the use of modern contraceptives.

D. Other Donors

USAID/Zambia maintains a close working relationship with the resident donors involved in health and nutrition. USAID/Zambia, the British Overseas Development Agency (ODA), and the United Nations Fund for Population Activities (UNFPA) have met regularly on population matters since late January when USAID/Zambia selected family planning as a strategic objective. The World Bank has also been instrumental in ensuring that donor governments and agencies in Zambia coordinate efforts in the health and population sector. Through the GRZ, the visiting Bank missions schedule donor coordination meetings and exit conferences which have occurred more or less on a quarterly basis. The following summarizes the on-going and planned donor programs in population and family planning.

United Nations Fund for Population Activities (UNFPA): UNFPA has been a lead population donor in Zambia providing $2.8 million between 1984-87; and $10 million ($4 million which was supplied by other donors) between 1988-92. UNFPA has provided 30 percent of the contraceptives during the last five years as well as funding for maternal and child health and family planning; population information, education, and communication; training of labor leaders in family welfare and health; basic data collection and analysis; population policy formulation; population dynamics; and women, population, and development.

UNFPA's Program Review and Strategy Development (PRSD/1993) has considered the following areas as priorities for UNFPA's third program, expected to start in 1994: integration of population into development policy and planning; basic data collection and analysis, demographic training and research; maternal and child health and family planning; women, population and development; youth, focus on adolescent fertility and teenage pregnancies; population information, education and communication; and migration, urbanization, population and environment.

What UNFPA will fund during its third program will be finalized in September 1993 taking into account activities programmed in the new USAID/Zambia and the British Overseas Development Agency population and family planning projects.

British Overseas Development Agency (ODA): ODA has funded and provided technical assistance to the Planned Parenthood Association of Zambia (PPAZ) to develop its four year (extended to six years) strategic plan. ODA plans to provide $800,000 to $1.2 million to PPAZ over the next five years to strengthen its management capability and to develop and implement community-based distribution projects in specific geographic regions where PPAZ has resident staff. In addition, ODA plans to provide approximately $1 million for contraceptive procurement (through UNFPA) to address the present shortfall of contraceptive supplies. The October 1993, emergency procurement will be followed by a long-term procurement effort scheduled to begin in 1995. ODA will provide approximately

$6 million over the next five years to purchase contraceptives and to strengthen the management and logistical operations of Medical Stores Ltd. for contraceptive procurement and distribution.

ODA's support to the health sector includes working with the MOH in the development of human resources in order to introduce and operationalize the personnel practices and policies that will be followed under the health reform program.

World Bank: The Bank may fund a major population program with first funds available in FY94 if the GRZ concurs that additional support is needed. The areas of focus for the World Bank would be in institutional development and capacity building, policy planning and development, service delivery, and IEC. IDA has planned to finance additional preparatory activities such as studies on the provider training needs and knowledge, attitudes and practices (KAP) surveys. With the development of a family planning project by USAID, the need for a World Bank project is being reconsidered by the GRZ and the Bank.

Other health sector donors with peripheral involvement in population include Norway, the Netherlands, Sweden, and Denmark.

Norway (NORAD): NORAD funds bicycles for district PPAZ offices and training for women in income-generating activities.

Netherlands: The Dutch support primary health care (PHC) activities primarily in Western and Northern Provinces.

Sweden (SIDA): As a major donor in health (1993 budget of approximately $5 million), SIDA supports projects in health planning and management development, health information systems, training of district teams in financial management, operations and supply of the essential drug program, and maintenance of the MOH transportation system. HIV/AIDS and support to external procurement of goods and services are also components of SIDA's program in 1993/94. SIDA will also develop a project on reproductive health services and sexual education. The purpose of the project is to improve sex education in the schools. A team will arrive in late 1993 to begin project development.

Denmark (DANIDA): DANIDA supports the MOH process of decentralization with capacity building and institutional development at the district level as well as development of a system for assuring managerial and clinical quality of care and service. DANIDA plans to provide financial and material resources for recurrent expenditures in all districts including salaries, drug kits, office equipment, and vehicles, will also train district managers.

III. PROJECT DESCRIPTION

A. Project Goal and Subgoal

The Goal of the Project is a socially stable, politically active, economically productive population. This is the Mission's Program Goal which was approved in the Mission's Country Program Strategic Plan in July 1993. The Goal recognizes the importance in raising the standard of living, especially during the period of economic restructuring.

The Project's Subgoal, sustainable improvements in general health status, recognizes the priority of health conditions in raising living standards and improving the quality of life. FPS is the second of three projects included in the USAID health population portfolio (HIV/AIDS Prevention and Selected Child Survival Activities) to address the most pressing health and population problems in Zambia. A reduction in the total fertility rate will improve life at the household level as large family size exacerbates the problem of low income by reducing the resources available for each member of the family.

B. Project Purpose

The Purpose of the Project is to increase the use of modern contraceptives (Ocs, IUCDs, Implants, VSC). It is expected that by the End of the Project: couples year protection in Zambia will reach 380,000; the modern contraceptive prevalence rate will increase from 9 percent to 20 percent among married women, and from 7 percent to 18 percent among all women; and family planning services delivered at strategic sites throughout the country will increase by 75 percent from the baseline period.

The Project will achieve the Purpose by providing technical assistance, training, commodities, and/or grants to the Ministry of Health, autonomous District Health Boards, various non-governmental organizations (NGO), and the private sector. The Project will increase the demand for modern contraceptives, increase access to modern contraceptives, and improve family planning service delivery with activities in five components: Contraceptive Social Marketing; Information, Education, and Communication; Service Delivery; Policy and Operations Research; and Project Management and Administration.

C. Project Components

USAID/Zambia has chosen the components based on GRZ preferences, guidance from AID/Washington and recommendations of the design team.

1. Contraceptive Social Marketing (CSM)

To increase access to contraceptives, the Project will utilize a contraceptive social marketing program to expand the

number of private sector outlets supplying contraceptives and broaden the method mix. The Project will build on the Mission's condom social marketing infrastructure.

In October of 1992, USAID/Lusaka signed a cooperative agreement under the bilateral HIV/AIDS Prevention Project with Population Services International (PSI) for a five year condom social marketing program. PSI chose the Pharmaceutical Society of Zambia (PSZ), a trade association for public and private sector pharmacists, as its in-country collaborating partner. PSZ had experience supplying contraceptives to 106 retail outlets since 1985, with assistance originally from Family Planning International Assistance (FPIA). When FPIA support terminated, due to the loss of an AID grant, PSZ continued the program with a commodity grant from Pathfinder.

The rationale for supporting a CSM component is three-fold. First, it will increase access to modern contraceptives and broaden the method mix. The existing condom social marketing structure lends itself well to a series of product add-ons at minimal cost. Most CSM programs initiate business by launching condoms, then move to sales of oral contraceptives. This sequencing is appropriate for Zambia. By using private sector marketing channels and sales methods, the Project can guarantee a steady supply of commodities and funding needed for advertising, training and storage/delivery facilities.

The expected increase in the sales of socially marketed oral contraceptives (Ocs) is especially promising under the Project. Under administrative authorities granted as a result of this Project, the marketing of Ocs will be permitted through non-traditional outlets. Based on the recommendation of the MOH, PSI/PSZ will be permitted to market Ocs to non-traditional outlets (other than pharmacies) provided the outlets adhere to MOH guidelines in selling. PSI/PSZ will be responsible for adherence to the MOH guidelines. While PSI/PSZ will work out the details with the MOH, the guidelines may require PSI/PSZ to supply non-traditional outlets with sphygmomanometers and stethoscopes, training in taking blood pressures, and screening forms that would be completed and collected prior to filling additional OC orders. Recognizing the necessity for advertising, the MOH has indicated that it will authorize advertizing of contraceptives. PSI/PSZ will supply approximately 250 non-traditional outlets with Ocs.

Second, CSM adds a back-up logistics system for both the public and private sector. The GRZ established a parastatal, the Medical Stores Limited (MSL), to serve as a central procurement center for generic drugs and other pharmaceuticals, medical supplies and equipment, and family planning commodities for public sector health care providers. It is clear that MSL has the mandate, facilities and staff to continue to be the main agency for procuring, storing and delivering medical supplies, including

contraceptives, for public sector health service points. The commodities to be procured with ODA funding will be distributed through the MSL. The Districts will only be required to pay the MSL the costs of in-country transport. Yet, if past is prologue, there will continue to be supply/resupply problems with sole reliance on the MSL.

The CSM component will resolve any sole-reliance supply problems. Even though the MSL will be the dominant supplier, the Cooperative Agreement for the CSM component will require PSI/PSZ to have sufficient contraceptive supplies on hand to fill occassional public sector supply gaps. Under decentralization, the districts will be free to purchase their own pharmaceuticals and contraceptives, so payment by the public sector for CSM commodities will not be a problem. If the ODA assistance to the MSL does not improve the reliability of the supply chain, this Project will be prepared to fund technical assistance out of the budget for contingencies to analyze the problems and assist the GRZ in resolving them.

Finally, the contraceptive social marketing program will provide commodities to public sector providers in strategic sites that are not available from the MSL. The ODA grant to the MOH for contraceptive supplies does not include implants (NORPLANT), and is not expected to provide sufficient quantities of IUCDs or injectibles. The Project will also fund additional local hire staff for PSI/PSZ and local cost operating expenses of the social marketing campaign.

2. Service Delivery

In addition to contraceptive social marketing, the FPS Project will support the main strategies of the GRZ National Family Planning Program (NFPP) to increase the use of modern contraceptive methods through: (1) clinic-based integrated family planning (IFP); (2) community-based services (CBS); (3) employer-based services (EBS); and (4) long-term FP methods (IUCD, implants, ML/LA, NSV). All of these service delivery programs will require provider training and technical support from a substantially strengthened Maternal and Child Health/Family Planning Unit (MCH/FP Unit) and the General Nursing Council. The service delivery initiatives will be implemented through both the government and private sector and will be integrated through activities at the community, clinic and hospital levels.

A Family Planning Services Project Management Team (FPSPMT) will be responsible for providing technical assistance in training, service delivery, management and institutional development as well as management of the overall project. USAID/Zambia and the MOH will award a contract to an institutional contractor to act as the FPSPMT. The identified FPSPMT will support a U.S. staff including one Project Director (25%) and one

secretary (100%); and a long term field staff for four years to include a Chief of Party (management/logistics specialist) and one Training Advisor. In-country staff will include the following four Zambian or third-country national professionals: Training Consultant (1), CBD/EBS Advisor (1), Management Advisor (1), and Assistant Financial Officer (1). Two local secretaries and six drivers will also be funded by the Project. Since the institutional contractor awarded the contract as the FPSPMT will be making sub-grants, the Mission Director will provide the FPSPMT with specific approval to make sub-grants as required by Contract Information Bulletin 92-7, dated March 8, 1992. AID/Washington FA/PPE will provide comments on the proposed use of an institutional contractor to make sub-grants prior to the Directors specific approval.

a. Integrated Family Planning Clinics

A major constraint to increased use of family planning is accessibility to services. Most health care facilities offer services only a few days a week for several hours. A pilot project which offered family planning services with other MCH activities everyday demonstrated that beneficiaries were more satisfied with the services provided. This integrated approach which is one of the four main strategies of the GRZ will be supported through the FPS Project.

USAID/Zambia and the MOH have identified an illustrative list of priority districts which will be the strategic sites where the IFP strategy will be implemented. The list was developed based upon the following criteria: (a) high population distribution and density; (b) high unmet demand for family planning services; (c) level of commitment and priority given to family planning by the District Health Management Team (DHMT) in the district action plan; (d) adequate service delivery infrastructure; (e) accessibility of population; and (f) potential for strong program linkages among the community, clinic and district hospital (see Annex F).

The FPSPMT, in coordination with the individual District Health Boards (DHB), DHMTs and USAID will select two to three health centers in each district to participate in the program. These sites will be strengthened to integrate high quality family planning services into their ongoing MCH programs. The centers will also serve as model clinics or centers of excellence that will be used as practicum sites for health care provider training in family planning. It is anticipated that the percentage of clients being seen for family planning services will increase by 75 percent. Continuing users will be tracked as an indicator of the quality of services provided.

Based upon site visits and interviews during the preparation of the Project Paper, health centers in strategic

sites will require varying degrees of renovation to ensure privacy for counseling, examination and IUD insertion as well as general upgrading to alleviate deteriorating conditions. Health centers will also require essential family planning equipment and supplies, method-specific IEC materials for service providers and clients, a consistent and adequate supply of contraceptive commodities and a complement of service providers trained in family planning motivation, counselling and clinical skills.

The FPSPMT will assist the DHMT to conduct a specific inventory of strategic sites with regard to: facility organization and physical condition; number, qualifications and current skill levels of staff with respect to family planning; basic equipment and supplies; levels of activity of MCH/FP program; supervision, reporting and logistic support systems; counselling activities; and IEC materials.

The FPSPMT will provide a small grant for each strategic site to support renovation and refurbishing. The grants will be limited to $5,000 per health center for materials. The health centers will furnish labor, most likely from community volunteers. FP equipment required for the clinical sites will be provided under the project through the DHMT based on a standardized list of equipment (see Annex K Note 2).

The FPS Project will also provide resources for family planning clinical skills training and contraceptive technology updates for clinical officers, registered nurse-midwives, and enrolled nurses and midwives associated with each clinical site. All health center workers at strategic sites will be trained in family planning motivation and provided with IEC materials. Technical assistance from the FPSPMT will assist the DHMT members to strengthen program management in information systems, and logistics and supervisory systems for improving program quality and cost-effectiveness.

The FPS Project will take a proactive role in addressing the particular needs of adolescents by providing quality services to this vulnerable group. As described in the Social and IEC analysis (Annex H and Q) the problems faced by adolescents in obtaining FP services are, to some extent, unique and will require specific attention by the FPS Project. A clinic-based study conducted in 1986 indicated that the majority (75%) of women who resorted to induced abortion were between the ages of 14 and 19 (Likwa, 1993:15). The adolescents also expressed reluctance to use family planning services because of fears they might be treated badly by service providers or parents might find out. Therefore, the PP Design Team identified adolescents as a target group to focus particular attention.

The Project will address the particular needs of adolescents through promoting an atmosphere, in the IFP clinics

in strategic sites, which allows for privacy and provision of services in a non-threatening or judgmental manner (see Training and IEC sections for details). The FPSMT will design culturally appropriate programs to deliver services which target adolescents and might include setting aside specific times for services and/or FP education programs for this group. The FPSPMT will also collaborate with other donor agencies to support development of family planning education programs in secondary schools to include abstinence/waiting as a viable option.

b. Community Based Distribution

In Zambia with its combination of densely populated urban and peri-urban areas and widely dispersed rural communities, community based distribution (CBD) is an effective way of expanding the delivery of family planning services and providing an entry point for women to use modern contraceptives. CBD programs utilize men or women who are selected by members in their communities to motivate eligible women/men/couples and to provide information and a selected range of contraceptives to potential clients in an assigned area. CBDs also serve as referral agents for long-term and permanent methods that are provided at the health centers and hospitals.

At present in the NGO sector, Planned Parenthood Association of Zambia (PPAZ), Makeni Ecumenical Center and the Seventh Day Adventist Church (at Kabwe Dorcas and Chipata) are implementing CBD projects. The Social Mobilization Program of the MCH/FP Unit in the MOH planned to develop a CBD program using Community Health Workers as CBD agents, however, funding was unavailable. Lusaka Urban District was also exploring the possibility of incorporating CBD into its primary health care (PHC) program through the NGOs operating in the district. PPAZ has identified CBD as a major element of its new program strategy. With the growing interest in CBD on the part of NGOs and government entities along with the decentralization of health services and the focus on community participation and involvement, CBD has the potential of becoming a significant service delivery approach in Zambia.

The FPS Project will expand availability and accessibility to family planning services by continuing USAID support to the ongoing community based-distribution (CBD) projects with local and international NGOs and fund up to eight additional CBD projects over the life of the project. The FPS Project will provide grants to NGOs to finance development and implementation of these CBD projects. Based upon experience in on-going Zambian CBD projects, other CBD programs in the region and an increasing body of literature on CBD, the NGOs will be free to propose creative incentive plans for CBD workers. The Project will also fund costs related to staffing, training, equipment and supply procurement, transportation, baseline surveys and project management and

evaluation activities.

The FPSPMT will provide assistance to the MOH MCH/FP Unit to establish national guidelines, standards and procedures for CBD programs including: selection criteria for CBD agents; checklists for distribution of Ocs by CBD agents; standardized reporting formats; and CBD supervision guidelines. PPAZ staff members, as well as technical managers of the Seventh Day Adventist and Makeni CBD projects will be invited by the FPSPMT to form a CBD Consortium and to assist the MOH in developing CBD guidelines. The FPSPMT will work with the MOH and the CBD Consortium, to test and implement the new CBD curriculum which is presently under review at the MCH/FP Unit, and assist with development of a trainer's guide and associated teaching materials.

The FPSPMT and the CBD Consortium will organize an orientation and training workshop to introduce the concept of CBD to a broad group of NGOs who are implementing programs in PHC and related fields and therefore potential candidates to develop CBD Projects. The CBD Consortium members and the FPSPMT will provide technical assistance with proposal writing to identified NGOs that are interested in developing CBD projects.

The FPSPMT will meet with the NGOs executing CBD projects on a quarterly basis to review project implementation progress and to exchange information and identify issues and topics that must be addressed to improve delivery of services through this mechanism. The CBD Consortium will report to USAID and the MOH on project implementation using reporting formats designed for CBD programs.

Staff from the most successful projects will be nominated to attend international conferences, workshops or courses related to family planning CBD programs. The Project will fund training to managers, supervisors, and/or program officers identified by the CBD Consortium, in a Management of Community Based Family Planning course offered by the Centre for African Studies (CAFS). This participant training intervention will provide family planning professionals with motivation, enhance their professional development and strengthen their organization's capacity to implement CBD project.

c. Employer Based Services

According to the Quarterly Employment and Earning Statistics 1992 of the Central Statistics Office, approximately 483,000 workers are employed by the organized sector with well over 80 percent being males. Focus group discussions carried out during the project design confirmed that males are the primary decision makers with regard to use of family planning. Since 1976, UNFPA and ILO, through the Family Welfare Project, have

supported family planning IEC, and more recently, service delivery. In Phase III of the program (1990-1992) 105 industries were surveyed and 43 out of a group of the 65 meeting basic criteria were selected to participate in the program. Based upon a 1992 program evaluation and discussions with key project personnel, the following program constraints with respect to EBS were identified: service providers and program workers were only able to work with half of the couple, mainly males; inadequate family planning equipment was available; managerial support, clinical support and training in family planning clinical skills and IEC were weak and required greater attention; supply of contraceptives was inconsistent; there were inadequate IEC materials in local languages; IEC materials were needed to address rumors and widespread misconceptions about family planning in general and the pill in particular; and lack of adequate transport prohibited effective monitoring of the project.

The FPS Project will build upon previous programs and address above constraints by providing IEC and family planning services in the workplace. The Project will reinforce and expand efforts to have private employers add family planning to the health services provided by company clinics.

The FPSPMT will review and update the 1990 Pathfinder/Ministry of Labor survey of public, parastatal and private enterprises that were participating in the Family Welfare Project. Forty to 50 enterprises will be selected to participate in this initiative based on the following criteria: (1) previous orientation and participation in above-mentioned efforts and present commitment of employers to offering family planning services to their employees and families; (2) location in the FPS strategic district sites; (3) total number of employees served; and (4) type of health benefit package and social services offered to employees and their dependents. The FPS Project will schedule five sites for development during the first year with 10 to 12 sites added each succeeding year. In addition to providing IEC and services to their employees, these five initial companies will serve as demonstration sites to show employers and employees at other firms the advantages of company-based family planning services. The FPS Project will: include EBS staff in family planning skills and counselling training courses offered through the IFP initiative; introduce the standard protocols and guidelines developed for the national family planning program; and introduce innovative strategies to expand and improve quality services and increase program cost recovery.

Clinic equipment and supplies for the first project year will be provided to the participating enterprises by the FPS Project. Contraceptive commodities will be purchased by the companies through the CSM component. Under the CSM intervention, forms and reporting systems will be developed for the EBS initiative. CSM will report acceptor information to USAID and

the MOH.

d. Long Term Methods (ML/LA, NSV, IUCD, Implants)

According to the ZDHS, 1.5 percent of all women currently using contraception have received tubal ligations. Eighty-nine percent of these women are over the age of 35 and 63 percent are over the age of 40. Voluntary Surgical Contraception (VSC) services are needed for both this high age, high parity at-risk group of women as well as for the younger, medium parity women who have completed their families.

Yet, there are no organized government or NGO programs to promote and provide VSC services. Tubal ligations have generally been carried out in government, private and mission hospitals usually under general anesthesia by specialists or interested doctors. The FPS Project will support the development of a VSC program that expands the availability and accessibility of these methods and establishes and provides quality VSC services through minilap procedures under local anesthesia (ML/LA) and no-scalpel vasectomies (NSV). The surgical family planning method of NORPLANT implants will be introduced in year 3 or 4 of the FPS Project.

In coordination with the decentralization of health services, 10 - 15 district, provincial, mission, NGO and company hospitals/clinics will be selected to develop and implement VSC programs. These hospitals will serve as referral sites for IFP project clinics, EBS and CBD programs. Projects will be developed in a phased manner, beginning in the Copperbelt where it is anticipated that high demand and population density will provide significant client population interested in accepting VSC. Two sites will be initiated during Year 1 of the Project and approximately two to three additional sites will be added during each of the following years.

The FPSPMT will develop, in coordination with the MOH MCH/FP Unit, selected hospital personnel and the Zambian Medical Council, protocols, standards and guidelines for the Zambia VSC Program. Key personnel in MCH/FP and from the district, provincial and mission hospitals will participate in a study tour to neighboring countries that have mature and newly developed VSC programs (Kenya, Zimbabwe and Uganda). Initial training and certification of three to four teams consisting of a doctor, nurse or clinical officer will be provided in Zimbabwe or Kenya where VSC training capability exists and the caseload is sufficient to develop the skills of the VSC team. These teams will serve as the nucleus for establishing Zambia's VSC program.

IUCD insertion and removal will be included in this training program with the teams acting as core trainers for IUCD insertion and removal to physician/nurse/clinical officer

teams in strategic sites. Training in implant insertion and removal will also be provided when the method is introduced into Zambia's family planning program. Sustainability of the program is anticipated as the in-country capacity of trained personnel increases and cost recovery principles are applied to this function.

To ensure quality of VSC programs, service standards and protocols will be developed and will include screening to select appropriate recipients for each method. Clinical screening for STD's will also be performed at the time of IUCD insertion in order to decrease the potential for complications. Guidelines will be developed for the following cadres of family planning providers:

(1) Doctor, nurse, clinical officer teams
- mini-lap training
- operation theater management and asepsis
- IUCD insertion/removal
- implant insertion and removal (years 3 & 4)
- Counselling

(2) Nurse/midwives
- counselling
- IUCD insertion/removal
- Post-surgical care and monitoring of new IUCD and VCS cases

(3) Health Assistants
- motivation
- monitoring new IUCD and VCS cases

Specialized in-country training workshops will be conducted annually to strengthen counselling skills for providers at facilities that offer long-term FP methods.

The FPSPMT will procure the necessary equipment to establish long-term methods in the identified hospitals and health centers over the life of the project. Through the FPSPMT, the Project will establish the VSC programs at the hospital sites. Six person-months of short-term technical assistance from a medical advisor will be required during the first Project year to assist with developing protocols and standards for Zambia's VSC program, provide inputs to the training program and develop and implement quality assurance interventions. In subsequent years, four person-months of technical assistance from a medical advisor will be required to ensure continuing quality of services, review training capabilities and assist in adding implants to the program. Additional technical assistance requirements will be identified during the mid-term evaluation of the FPS Project.

e. Training of Service Providers

FP training in the past has been relatively minimal, un-coordinated and sporadic. Historically, the GRZ has provided education and training for the health services, both for pre- and in-service training. With the deteriorating economic situation and the move towards decentralization, the GRZ is transferring the responsibility for providing training and associated costs to pre- and in-service training institutions and the District Health Boards. At one pre-service institution, some of these costs are already being passed on to students in the form of higher fees for which they are responsible.

The FPS Project will play a major role in providing technical and financial resources for the training of FP service providers. Support for training from other donors include projects in health planning and management development, training of district teams in financial management, and future plans for a project in reproductive health services and sexual education. ODA will support a CBD effort in a specific geographic region not included as a FPS Project strategic site (see Section II, e).

The USAID/Zambia PP design team, through discussions with staff from the MOH/FP Unit, General Nursing Council, Chainama College of Health Sciences and Post-Basic School of Nursing, identified areas where pre- and in-service programs required development and/or strengthening. These include: curricula development, human resource development, practical training, follow-up and refresher courses. There is also a lack of comprehensive planning and coordination of FP training efforts.

Pre- and in-service programs will also provide interpersonal communication and counselling (IPC/C) skills in order for service providers to adequately address the needs of women and specific target groups such as adolescents and men. In the past, some service providers attitudes, lack of technical knowledge and/or poor communication skills in counselling were identified as barriers to women who come for family planing and will be addressed in training provided by the FPS Project (see Annex Q).

The training component of the FPS Project will address the specific needs of adolescents through development of pre- and in-service curricula to include a module which addresses the problems and barriers faced by adolescents in obtaining family planning services and information. Training will include strategies in counselling adolescents, methods of contraception most appropriate for this age group, as well as HIV/AIDs education and prevention messages. During practical training adolescents will be identified as a client population either through schools or IFP clinics. Abstinence and/or waiting will also be promoted as an option. This will provide those practitioners who for cultural, religious or personal reasons are uncomfortable with promoting family planning for adolescents, an

alternative where they have the opportunity to provide educational messages in FP/HIV/AIDs.

To strengthen the institutional capacity to plan, implement and manage a comprehensive FP training program, the FPS Project will provide a long-term technical advisor for Training. During the first year, the Training Advisor will assist a core group of representatives from the MOH MCH/FP Unit, General Nursing Council (GNC), and the Zambian Medical Council to develop a comprehensive training plan to strengthen and coordinate both pre- and in-service training for health service providers, supervisors and managers in IFP. The training plan will clearly define service provider and trainer preparation, standards and protocols for service delivery, geographic phasing of training, and training follow-up.

There is a shortage of trained, practicing, MCH/FP service providers at all levels. During the life of the project, training activities will be designed for each cadre of health worker through the development of strong in-service training programs implemented at strategic sites. FP training will also be strengthened in the pre-service institutions where nurses, midwives and clinical officers are trained. The FPS project will support family planning training for the following cadres of health service providers:

(1) Community-Based Distributors (CBDs)

The FPS Project will provide assistance to the MOH MCH/FP Unit to develop national guidelines, standards and procedures for CBD programs. Through CBD sub-projects CBD agents will receive training. Advanced training in the management of community-based family planning programs presented by the Centre for African Studies (CAFS) will also be offered to outstanding CBD managers identified through the CBD Consortium.

(2) Nurses/midwives/clinical officers/health assistants

The Project will address both pre-service and in-service training needs of these cadres of health workers by providing short-term technical assistance to review and strengthen the FP curriculum in all pre-service institutions; assisting the MCH/FP Unit and GNC to finalize FP standards and protocols; and by providing resources for instructional and IEC materials. Both in-country and participant training will be provided and will include courses in training of trainers (TOT), contraceptive technology updates, as well as workshops in IPC/C and motivation.

(3) Physicians

The project will provide participant training to physician, nurse, and clinical officer teams in long-term contraceptive methods and counselling; IUCD, implants, mini-laparotomy under local anesthesia (ML/LA), and non-surgical vasectomy (NSV). (See Section III.C, 2.d. for a complete description)

Pre-Service Training

In 1992, technical assistance was provided by the GNC, to incorporate/strengthen the FP component in the curricula of all schools of nursing and training the tutors in the revised program (see detailed description in Annex P). To date, there has been no formal evaluation of the revised curricula or the teaching by tutors presenting the new material. Clinical supervision during the practicum is minimal.

Chainama College of Health Sciences, the pre-service institution for clinical officers and health assistants, and the University Teaching Hospital for medical students, also have FP components incorporated into their curricula. The number of hours allocated for both practical and didactic components, is dependent on time constraints related to the entire training program. Supervision during clinical rotations is also weak due to a lack of qualified trainers.

The FPS Project will provide short-term technical assistance to develop/strengthen the pre-service FP component in all curricula including practical training and supervision. The improved pre-service training will serve as a framework and provide a strong knowledge base for the more specialized in-service courses.

In-Service Training

The Project will support the development of training capacities of both public and private organizations at the central level during the first year. Capacity building at the provincial and district levels will be determined by the role each eventually plays in the decentralization process. Participants for a Training of Trainers course, will be identified from staff at the MOH/MCH/FP Unit, General Council of Nurses, pre-service training institutions and NGOs involved in FP. This core group of trainers will form a Master Training Team and will serve as the initial trainers and technical resource persons for FP service providers at strategic sites. In addition, the Master Training Team will provide the over-all training coordination, continue to develop up-to-date protocols and standards, and organize national conferences and workshops.

Provincial/district staff will be trained by the Master Training Team and participant training courses in contraceptive technology skills, motivation techniques, and

interpersonal communication skills (IP/C). These provincial/district trainers will then assess training needs and conduct in-services and follow-up for the FP services providers in their catchment areas.

The GNC will coordinate in-service training and will collaborate with the MCH/FP Unit and Medical Council to develop an overall in-service training plan. The GNC is responsible for the qualifications of all cadres of nurses through examinations and licensing regulation as well as monitoring for disciplinary matters concerning nurses. The FPSPMT Training Advisor will assist the GNC to develop an incentive structure for continuing education credits (C.E.s) and certification. It is anticipated that incentives such as attending a professional workshop or conference will be given to nurses who receive a certificate after attending a specified number of in-services and an identified competence performance level. This structure may also provide the basis for development of a career ladder in the future, another form of incentive.

The FPS Project will support pre-service and in-service training by providing nursing, medical, clinical officer and health assistant training institutions with audio-visual equipment, reproductive models, flip charts, up-to-date textbooks and other pertinent publications. The Project will finance salaries of a training coordinator, two additional training staff, an accountant, and an administrative assistant to supplement the staff at GNC.

f. Support to the MCH/FP Unit

The MCH/FP Unit coordinates the provision of family planning services within the primary health care program (PHC) of the MOH. Its present responsibilities include: (1) developing standards, guidelines and protocols; (2) training and supervising service providers and supervisors; (3) collecting family planning data and monitoring program performance; and (4) coordinating with MSL on the logistic system for procurement and distribution of commodities and equipment for the family planning program.

Assessments by several donor agencies, identified areas of weakness in the MCH/FP Unit's efforts in family planning. They include weak management, limited resources and lack of technical staff as major constraints to achieving its objectives. The training section of the MCH/FP Unit is presently stretched beyond its capacity to adequately provide all in-service training resources required for the implementation of the National Family Planning Program.

The FPS Project will provide short-term technical assistance to strengthen the capacities of the MCH/FP Unit to develop and manage a logistics management information

system (LMIS). The FPSPMT Training Advisor will assist the MCH/FP Unit to implement the strategies of NFPP including finalizing the national standards and guidelines, collecting and disseminating service delivery statistics, and conducting research and evaluation studies. The MCH/FP Unit will also be provided with office equipment, supplies, and training materials.

g. Operations Research

The primary thrust of the Operations Research will be to test the premise that the current general incentive structure for the delivery and use of quality family planning and health services in Zambia can be improved. The current structure, even under a decentralized system is not sufficiently demand oriented; that is it pays salaries and supplies inputs irrespective of the outputs. As such, the existing and decentralized delivery system is expected to be less efficient and more costly than a system where rewards are based on output.

For the most part, the implementation of the pilot activities being researched will be undertaken by locally based NGOs and contractors. However, oversight and review of the pilot activities is critical to ensuring that the activities provide quality research results. USAID/Zambia will arrange for a consulting firm to conduct operations research that tests the impact of modified incentive systems on the delivery of services. The firm will most likely be contracted through a "buy-in" to a centrally-funded Project. The OR contractor will work with USAID/Zambia to develop the research agenda and topics. The consulting firm conducting the research will be managed by the FPSMT.

While illustrative of the types of research eligible under the Project, the following examples are indicative of how the research will focus on the incentive structure for the delivery of health care. The research is expected to analyze cost effectiveness and productivity by examining areas such as reimbursement, cost recovery, and alternative approaches to service delivery. Three illustrative examples of potential research topics are fee-for-service reimbursement, KAP incentive payments, and venture capital financing.

(1) Fee-for-Service Reimbursement

Several sites will be chosen for research into direct reimbursement to providers for clinical family planning services rendered. The premise of the research is that given the right incentive structure, providers are best capable of pulling the factors of production together to deliver family planning services. The providers, rather than a national or district organization, will be responsible for obtaining their own training and technical knowledge, procuring their own supplies, designing

and implementing their own information, education and counselling programs, and managing their own administration. The proper function of the GRZ or a district entity is to establish and publicize standards, monitor quality control, and collect and analyze data, not be a provider or planning entity for providers.

It is important to note that this OR is research into alternative reimbursement methods, not cost recovery. It will provide information on how to improve the allocation of limited funding available for family planning. It will not test or uncover ways to raise additional funding for health and family planning through cost recovery, insurance schemes, or health maintenance organizations. It is research into reimbursement that will compare cost and productive output of clinics providing family planning services under a central budget authority against independent clinics providing family planning services on a fee-for-service basis.

The objective of the research is to prove that GRZ and A.I.D. can purchase family planning services at a lower cost and more efficiently by direct reimbursement to providers on the basis of a productive unit, rather than by mounting large projects which are dependent on high-overhead, centrally-managed technical assistance contracts that provide training, commodities, and IEC support to publicly funded clinics, or through block grants to district health boards for service delivery through a local, bureaucratic structure.

Direct reimbursement to providers for services rendered is theoretically sound. Market economic theory supports the contention that care, even in developing countries, can be more efficiently delivered on a fee-for-service basis by qualified providers than it can by public clinics managed by a central or district-level authority. If the price signals are right, providers will meet required quality standards, expand, relocate, and outperform the public sector in supplying the demand in even the hardest to reach areas and among the hardest to reach target populations. The research is expected to prove that fee-for-service providers will have the services the public wants on a more reliable basis than their publicly-run counterparts because if they do not, unlike their counterparts, they do not get paid. It is also expected to prove that hard to reach beneficiaries can have access to a steady supply of services without the need for a parastatal supply chain, annual donor-funded studies into logistics constraints, and donor-funded advisors for logistic management.

An OR contractor will identify 5 health centers where fee-for-service will be tested. With an average population of 10,000 per health center, the number of eligible couples at all four sites will be 10,000. If the providers raise the CPR to 20 percent, the providers can be expected to submit claims for approximately 2000 CYP, depending on the mix of family

planning methods provided.

Although A.I.D. Policy Determination 3 (September 1982) allows for cost reimbursement for voluntary surgical contraception (VSC), this OR project will not include VSC for direct reimbursement. Since VSC is a sensitive legal, political, and social topic, it carries too great a potential to compromise research into the expected benefits of an alternative to traditional family planning delivery programs.

(2) Provider Incentive: Communication

The best communication about family planning takes place between the provider and beneficiary. This OR will measure the impact of incentives on the quality and quantity of provider provided communication services. After Project-funded training is completed, a test group will be selected and offered cash incentives tied to their performance. Providers in the test and control groups will be required to keep day sheets indicating the beneficiaries they have counselled in family planning. Periodic independent surveys of randomly selected beneficiaries will determine whether or not the counselling has resulted in informed beneficiaries.

Local researchers will question the randomly selected beneficiaries about their knowledge of modern contraceptives beyond the superficial questions asked in the ZDHS. If the randomly selected beneficiaries from the test group demonstrate a firm grasp of technical and social knowledge (i.e. enough of the sample answer enough questions correctly) about family planning, the provider who rendered the counselling will receive a bonus payment. The Clinical Officer at the test site will also qualify for a bonus based on a given performance level at his/her clinic. The research will distinguish KAP levels of beneficiaries serviced by providers eligible to receive incentives as opposed to those providing services under the traditional program. This OR will test whether performance based communication reaches more beneficiaries with a higher degree of accuracy than family planning communication delivered through traditional methods.

(3) Venture Capital

To reduce the emigration of health care professionals and increase the number of private sector providers, the GRZ has allowed public sector doctors to maintain private practices on the side. Given the socialist background of Zambia, the number of private sector facilities is limited and attends generally to the upper and middle classes. In concert with the GRZ to encourage private sector health care, the Project will fund pilot research which will make equity funding available through an NGO (i.e. ownership in private practices) to doctors and/or other

health professionals capable of providing private sector family planning and health services in poor urban areas. Registered Nurse Midwives, trained registered nurses, and Clinical Officers will be eligible to participate in this OR program if the MOH authorizes them to privately own and operate federally qualified urban health centers. The equity financing offered by the OR will be limited to $5,000 per recipient and only be available to those willing to open and operate a private clinic in an urban or peri-urban compound.

Compounds are generally large peri-urban areas that have the largest segment of urban high risk births and deplorable sanitation problems. They are also in the monied economy, albeit poor, which can support private sector services. The public clinics which serve the compounds tend to be overwhelmed. The OR will test whether the incentive program to introduce private sector clinics offering quality family planning services in compounds can sustain services to a segment of the population willing to pay for a private sector level of care.

The $5,000 limit is based on pro-forma start-up needs of a clinic. The NGO making the equity investments will advertise and compete the equity investments to the professional with the best proposal. Based on discussions with the MOH, USAID/Zambia expects the NGO to make 10 of these grants. The operations of these clinics will be monitored over a three year period for sustainability and cost-effectiveness. If successful, the GRZ and USAID/Zambia will consider expanding the program.

3. Information, Education, and Counseling

The main focus of the IEC component will be to link the 350,000 married women in Zambia who want to practice family planning to quality services (i.e., clinic-based, community-based, employer-based, or the contraceptive social marketing program) with appropriate information. The secondary focus is on linking youth aged 15-25 (both male and female) to reproductive health information and services. To achieve this the IEC component will:

1) Obtain men's commitment to family planning so that they support their wives in obtaining family planning services or are motivated to use a method themselves;

2) Enlist the support of community elders who are influential in women's reproductive decision-making to family planning;

3) Enhance service providers' attitudes toward family planning and provision of family planning services;

4) Enlist support of community influentials' (including traditional, political, and religious leadership); and,

5) Seek District Health Management Team members' commitments to

family planning.

The IEC component will be implemented with assistance from Johns Hopkins University/Population Communications Project working with the Zambian Information Services (ZIS) and District Health Management Teams. The component will include a mass media and research activity and district mobilization activities carried out at the strategic sites.

Since mass media reaches a predominantly urban audience, it will be an important channel of communication in the dissemination of family planning information and the marketing of family planning services. The campaigns to be conducted will target: (1) men; (2) youth; and (3) women by promoting family planning services, including the positive portrayal of the service provider; and allay fears of FP methods.

Prior to designing these mass media campaigns, researchers will be contracted to conduct a baseline survey, focus group discussions and in-depth interviews to obtain qualitative information on family planning KAP of urban and rural men and women. The specific groups to be studied will be: urban and rural women of reproductive age (15-49); urban and rural men aged 15-49; urban and rural youth; community leaders in reproductive decision making; service providers; and, District Health Management Team members.

A three-month campaign targeting men and another for youth will be designed and implemented. Sexually active girls in the 16-18 age group, identified abortion as the easiest form of family planning and were less knowledgeable than the boys about protection against AIDS. A 1992 study on teenage pregnancy cited in Likwa (1993) showed that 93.5 percent of pregnant adolescents never used modern family planning methods. Most of the young women had some knowledge about family planning services available at service delivery points but were reluctant to use them due to fears they would be badly treated and that their parents would find out. Clearly, this target group, both boys and girls, requires specific attention during the IEC campaigns and the development of specific educational materials.

Campaigns targeting men and youth will have five main messages which will be disseminated in radio spots, TV spots, newspaper inserts, billboards, bus advertisements, and posters. A radio social drama in Bemba that deals with such issues as family planning, STDs including HIV/AIDS, gender issues and concerns, youth's concerns, will be launched at the beginning of the campaign for men. In order to maximize resources, this drama will be produced in collaboration with the AIDS Project. Promotional materials such as T-shirts, key chains, stickers, and activities, such as competitions, to support the radio social drama and both campaigns' messages will also be developed and distributed. Also

in order to engage both men and youth in a national discussion of sexual responsibility, debates with two teams taking opposite stands on topics such as "are Zambian men (substituted with teenagers) are sexually irresponsible?" will be conducted on radio.

The campaign targeting women will be three-pronged and therefore considerably different from the campaigns for men and youth. A family planning logo will be designed and promoted and the service provider will be portrayed in a positive light, i.e., someone who cares and treats you with kindness, understanding, and respect. To support this, radio and TV spots, newspaper inserts, billboards, handbills (single sheet flyers), and bus signs will be used. Radio spots that advertise quality family planning services will be developed and aired for a year. TV spots will be produced and aired twice a night during the same months that the radio spots are on. Billboards, bus signs, and newspaper inserts promoting the family planning logo and positive image of the service provider will also be used.

During the second and third phases of the campaigns other activities have been programmed including 15-minute radio features which will have a nurse or doctor being interviewed about the safety and effectiveness of a specific method, the various side-effects, and the rumors and misinformation associated with that particular method. Each program will also feature short inserts from satisfied users of the particular method being discussed. In addition to promoting family planning services, women in districts without family planning services will be encouraged to approach their DHMTs and advocate for such. More detailed information on the mass media campaigns is contained in the Detailed IEC Plan in Annex Q.

To promote IEC at the district level in concert with the MOH decentralization effort, the Project will make small grants to the DHMTs in the FPS Project strategic sites districts. Depending on the size of the district, the District Health Education Unit will be responsible for organizing meetings and group talks with community leaders, and social influentials. Powerful social networks and groups like women's groups, church groups, clubs, political organizations, and development committees will be identified and mobilized to promote family planning. Community theater, which is a popular traditional medium, will be used for promoting family planning and as it is now used to promote HIV/AIDs prevention.

In addition to developing a national family planning logo to be used for the identification of family planning service outlets, IEC materials such as pamphlets on each method and one on all methods, posters, flip charts, calendars, and other IEC materials that will be used in clinic and outreach activities will be developed involving the target audience in all stages of the

materials development process. A low-literate (this depends on selection criteria of CBD) manual for community-based distributors and other identified family planning promoters will also be developed. All FP/IEC outreach activities will be closely coordinated with the AIDS program to ensure the promotion of reproductive health.

4. Policy

The lack of official MOH Policy Guidelines and Standards for Family Planning Services is a major constraint to the provision of family planning options in Zambia. Such Policy Guidelines are needed to spell out which service providers are authorized to deliver each method and specify the approved service delivery points. By issuing official family planning guidelines and standards, the MOH will be able to design training courses and implementation schedules that not only allow nurses to insert IUCDs and implant but also clarify the services that can be performed by clinical officers, health assistants, TBAs and CBD agents who have been trained to provide family planning information and services. It is crucial to have these guidelines and standards written and officially sanctioned to implement the FPS Project activities.

The USAID Mission has begun a policy dialogue on family planning issues with the Ministry of Health. The MOH is committed to reforming and liberalizing regulations that at the moment stand in the way of effective contraceptive social marketing and an improved performance of the national family planning program. At the moment, the most troubling areas are restrictions on the type of provider who can insert IUCDs and prescribe oral contraceptives, prohibition against advertising of the social marketing program oral contraceptive(s), and the registration of injectibles and implants.

Specifically, the MOH plans to facilitate the passage of the revised Nurse-Midwife Act, now being reviewed by a Task Force, which will officially broaden the scope of functions performed by nurses and midwives, including insertion of IUCDs, keyed to a requisite of training. Legislation will be proposed in 1994 with an expectation that the Act will become law by January 1995, when the Ministry-wide decentralization plan is to take full effect. In the meantime, the MOH will issue detailed policy guidelines which will allow appropriately trained nurses, midwives and clinical officers to insert IUCDs.

The MOH also recognizes that the requirement that one obtain a prescription to receive oral contraceptives is a severe legal limitation to broadening OC use in Zambia, a country with a 1/13,000 doctor to population ratio. Consequently, the MOH leadership is willing to establish guidelines and standards, such as contra-indication checklists for use by non-medical personnel, which will allow appropriately trained individuals to sell and

dispense oral contraceptives.

The MOH will address the prohibition on advertising of oral contraceptives by using its administrative authorities to permit advertising of the social marketing program oral contraceptive(s) since it has a social welfare purpose. The MOH Family Planning Policy Guidelines that are being drafted at this time should specify the following:

1. The providers who can dispense oral contraceptives include doctors, clinical officers, midwives, nurses, pharmacists, community-based distribution agents and TBAs who have been trained to screen clients for contraindications.

2. Service delivery sites for oral contraceptives include hospitals, health centers, pharmacies, shops and CBD agent outlets, where screening of clients for contraindications will take place before the first cycle of orals is dispensed.

3. The providers who can dispense injectibles include doctors, clinical officers, midwives and nurses. Services delivery sites for injectibles include hospitals, health centers and private clinics.

4. The providers who can insert IUCDs and implants include doctors, clinical officers, midwives and nurses who have been specifically trained and certified to perform these procedures. Service delivery sites for insertion of IUCDs and implants include hospitals, health centers and private clinics that have been authorized to provide these services.

In the case of injectables and implants, the MOH adheres to the principle of international recognition of the safety and efficacy of drugs, following the guidance of WHO and the U.S.FDA. As long as the drug is registered and used in the country of origin, it is eligible for registration in Zambia. As part of the Project, the Pharmaceutical Division of the MOH will submit a request for registering Depo Provera and NORPLANT to the Pharmacy Board. Because of prior problems with Depo Provera in Zambia, USAID/Zambia will meet with the GRZ and ODA to work out a plan and strategy for the promotion and standardization of Depo Provera. The Project expects to only fund Depo Provera as the injectible as it has proven to be effective for longer periods and has fewer side-effects. While the Project expects to introduce NORPLANT, the AID/W Office of Population will be reviewing its overall policy on this contraceptive after 1993. AID/W guidance and issues concerning NORPLANT will be factored into the Project's funding for NORPLANT.

As mentioned in the constraints analysis, the general policy constraints relates to the need for continuity between administrations (See IIB2d). Administrative directives, which will be sufficient and in effect throughout the life of the

Project, can be reversed with the same ease with which they were authorized after the PACD. To ensure the long-term continuity of family planning policies, the Project will support the MOH with three person months of short-term technical assistance and funding for Zambian (non-governmental) counterparts to analyze, draft, and promote family planning legislation that will be submitted to Parliament for consideration and approval. This legislation will simply act as a safeguard for the long-term, family planning environment. Legislative approval of the yet to be analyzed and drafted legislation is not necessary or required for the implementation of this Project.

5. Project Management and Administration

The Project will fund a long-term PSC Project Manager and Administrative Assistant/Secretary. The A.I.D. Project Manager will be based in the A.I.D. Mission and will work collaboratively with the MOH and the technical advisors. The estimated cost of the Project Manager with assistant for two years is approximately $515,000.

The Project will also provide for two evaluations and up to two audits. The evaluations will concentrate on output and purpose level indicators, contractor performance, MOH collaboration, and USAID project management. In addition, the evaluators will examine the results from the operations research to determine if output and purpose-level achievement is being reached in the most efficient and cost-effective manner. The expected cost of evaluations and audits is $300,000.

IV. PROJECT MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

A. Project Financial Plan

The Project will have a total budget of $20.0 million. A.I.D. will contribute the entire amount, subject to availability of funds and progress in achieving Project Purpose and Conditions Precedent. The Mission has requested and received a Section 110 waiver of the host country counterpart. Zambia qualified for a waiver as it is a "relatively least developed country" on the U.N. General Assembly list and a low-income country on the Development Assistance Committee (DAC) list of the OECD.

The standard tables to the financial plan indicate the overall allocation of financial responsibilities and the sources from which each individual project element will be financed. Annex F provides sufficient detail to demonstrate reasonable cost estimates for the Project. An inflation and contingency factor of approximately 15 percent was applied to the total Project cost.

The FPS Project addresses sustainability with its design. Under the decentralization program, the districts will be free to

set their own priorities and allocate funding accordingly. This Project will only work with those districts which have recognized family planning as a priority. Consequently, there is a built-in bias for Project activities to be funded by the districts after the PACD.

The Project also addresses the issue of sustainability in the overall health and population sector. Since there is not enough money to cover Zambia's health care needs, the allocation of appropriate levels of district funding to family planning merely come at the expense of another priority. As such, family planning will be sustainable, but the delivery of other health care services will not be. To ameliorate the displacement effect increased commitments to family planning will have on the Zambia health sector, the Project will seek ways to deliver family planning as cost effectively as possible and thereby stretch the health and family planning budgets as far as possible.

The Project's research emphasis will not be on cost recovery, but rather reducing the cost of delivery. The GRZ decentalization program will allow the districts to experiment and seek the appropriate cost recovery levels. Consequently, the Project strategy to promote the sustainability is to explore ways of reducing the cost of service delivery.

This strategy will also apply to the CSM component and private sector support from employers. Under social marketing, there is an estimated gap of $1,000,000 between the sale and cost of each 225,000 cycles of Ocs sold. Clearly, sustainability after the Project can be achieved by raising the prices to cover the gap. However, this works against the purpose of the Project as it will discourage those who are unable to pay the higher prices.

The best approach for the sustainability of social marketing in Zambia that maintains high sales of modern contraceptives is to reduce the cost of operations by building up the local capacity to market and distribute as cost-effectively as possible. In this manner, if subsequent donor funding is not available to subsidize the cost of the commodities and the marketing, PSI/PSZ will have at least kept the required price increases to the minimum level necessary. Employer based services will be sustainable as long as employers are cognizant of the benefits of family planning and profitable enough to support it.

SUMMARY COST ESTIMATE (US$ 000)

Type of Expenditure	A.I.D. FX	A.I.D. LC	GRZ	TOTAL
Technical Assistance	8,192	4,337		12,529
Training	393	42		435
Commodities	2,752	959		3,711
Audit & Evaluation	178	47		225
Inflation/Contingency	2,115	985		3,100
Total	13,630	6,370	0	20,000

PROJECTIONS OF EXPENDITURES BY FISCAL YEAR (US$ 000)

Fiscal Year	A.I.D.	GRZ	TOTAL
FY 1994	1,943		1,943
FY 1995	6,534		6,534
FY 1996	4,959		4,959
FY 1997	2,886		2,886
FY 1998	3,678		3,678
Total	20,000		20,000

COSTING OF PROJECT BY INPUTS AND OUTPURS

Project Inputs	Contraceptive Social Mktg	Service Delivery	IEC	Policy & OR	Project Mgmnt	TOTAL
AID Appropriated						
Technical Assistance	1,269,000	6,879,000	3,080,000	786,000	515,000	12,529,000
Training		435,000	0	0	0	435,000
Commodities	1,815,000	1,695,000	0	126,000	75,000	3,711,000
Audit/Evaluation				0	225,000	225,000
Inflation/Contingency					3,100,000	3,100,000
Total	3,084,000	9,009,000	3,080,000	912,000	3,915,000 0	20,000,000

Project Inputs	Service Delivery IFP	Service Delivery CBD	Service Delivery EBD	Service Delivery VSC	Service Delivery MCH/FP	Service Delivery Inst Contractor	TOTAL
AID Appropriated							
Technical Assistance	301,200	2,734,000			154,000	3,690,000	6,879,200
Training	216,000	111,375		108,000	0		435,375
Commodities	1,376,050	0	165,000		154,000		1,695,050
Audit/Evaluation							0
Inflation/Contingency							
Total	1,893,250	2,845,375	165,000	108,000	308,000	3,690,000	9 009,625

FPS2 WK1

B. Implementation Plan

1. Implementation Plan

An implementation schedule of major events appears below. Based on past experience, the GRZ will rapidly comply with the standard Conditions Precedent to this Project. The most critical events in the implementation of this Project are the hiring of a Personal Services Project Advisor and the assignment by AID/Washington of an HPN and Population Officer to USAID/Zambia. USAID/Zambia has been actively recruiting an HPN Officer since January 1993. USAID/Zambia will rely on REDSO/ESA/HPN assistance until the position is filled. The recruitment for a Personal Service Contract Project Advisor will begin after obligation of the Project. Since the organizations are in place for the CSM component, CSM will begin immediately.

2. Implementation Schedule

ACTIVITY	ACTION	DATE
Project negotiated with GRZ	PDO	9/93
Pro Ag drafted	PDO	9/93
Pro Ag signed	GRZ/DIR	9/93
PIO/T RFP	REDSO/ESA/HPN	12/93
PIO/T PSC completed	REDSO/ESA/HPN	12/93
RFP issued	REDSO/ESA/RCO	1/94
1. CONTRACEPTIVE SOCIAL MARKETING		
PIO/T Admend. CoAg/PSI/PSZ	PDO	10/93
U.S. Support Staff		
STTA	1/94, 1/95, 1/96, 1/97,	1/98
Hire field staff		12/93
2. IFP SERVICE DELIVERY		
Commodity Procurement		
Complete CPTs	FPLM	10/93
Contraceptive Pro.Schd.CPSD	REDSO/ESA/HPN	10/93
CPSD OYB transfer	PRM	10/93
Training		
Estab. Central Tr. Unit/GNC		3/94
PIO/T ST TA-guidelines dev.	PDO	10/93
PIO/T TA-curri. dev.	PDO	10/93
PIO/P (CAFS) TOT	PSC	4/94
PIO/T (CAFS) Contracep/Tech	PSC	12/95

PIO/P	(CAFS) CBD Mang.Tr	PSC	1/96
PIO/P	(CAFS) CBD Mang.Tr	PSC	1/97
PIO/P	(AVSC)	PSC	3/94
"		"	2/95
"		"	2/96
"		"	2/97
"		"	2/98

FPSPMT

Institutional Contractor:

LT Chief of Party hired and in country	9/94
LT Training Advisor hired and in country	9/94
local staff hired	9/94
ST TA-commu. mobil.	1/96
ST TA-TOT eval.	1/96
ST TA-eval.FP trng.prog.	1/98
NGO sub-grants/CBD Trng.	10/94
Workshop for CBD consortium	9/94
DMT sub-grants/re.	7/94
Health center improv/equip. (1/95, 1/96)	

3. IEC

Buy-in RD/POP-JHU/PCS	PDO	10/93
Senior expat. TA hired and in country		1/94
Senior local TA hired		1/94
Local research group contracted		2/94

4. OPERATIONS RESEARCH

Buy-in RD/POP/Research	PDO	11/93
ST TA legislation		1/94
Local TA hired		1/95
Local TA hired- research coord.		2/95
Local staff hired; admin. & research		1/95
ST TA eval.		1/95, 1/97, 1/98

5. PROCUREMENT

PIO/C USAID Proj.pro.	PSC	1/94

6. PROJECT AUDIT/EVALUATIONS

PIO/T 1st eval	PSC	1/96
PIO/T audit	PSC/Cont	1/97
PIO/T final eval.	PSC	1/98

3. Mission Management Plan

This Project requires four major organizations to provide implementation support and technical assistance. Each of the four organizations will have sub-activities which USAID/Zambia will need to monitor and coordinate. To reduce the management burden, USAID/Zambia will rely on two buy-ins to centrally approved Projects and amend the existing cooperative agreement with PSI to include CSM. This will leave the Mission with one major contracting assignment for the Service Delivery Component.

Type of Assistance	Method of Implementation	Method of Financing
1. Contraceptive Social Marketing	Amendment to existing Cooperative Agreement under HIV/AIDS Prevention	Advance Payment
2. Service Delivery - Overall Management	Institutional contr.	Cost Reimburse.
3. IEC	Buy in: Centrl Prj	LCOM
4. Policy and Operations Research	Buy-in: Centrl Prj	LCOM
5. Project Management	PSC	Cost Reimburse.

C. Monitoring and Evaluation Plan

As discussed in Annex M, the monitoring and evaluation of FPS will be related to the impact indicators for the Mission's CPSP.

1. Monitoring

Day-to-day project monitoring will be the responsibility of the PSC Population Advisor under the direction of the USAID HPN Officer. Specific monitoring support assistance will also be provided by the Program Officer and Controller. For monitoring the Project in achieving the outputs and impact USAID/Zambia will rely on Implementing Organizations; Quarterly reports for the Service Delivery and IEC components; MOH and PSZ logistics management reports, baseline and follow-up surveys at strategic sites, periodic inventories; reports from operations research; and internal Project Implementation Reports (PIRS).

AID will also utilize site visits, by the HPN and other staff as well as short-term consultants to assess progress in meeting project objectives. After field trips, de-briefings will be held with all relevant parties to discuss progress and problems identified.

Baseline information on rates of use of modern contraceptives, access and other key variables are available from the 1992 Zambia Demographic and Health Survey (ZDHS). This data, in addition to baseline surveys and periodic surveys at the district level, will serve as the benchmarks to gauge the impact and outputs of the FPS Project and each Project component.

a. Contraceptive Social Marketing

Outputs for the CSM component include the expansion of distribution points and the increase of the private sector share of FP financing. Monitoring of this component will include monthly marketing sales and distribution reports from PSI/PSZ, quarterly reports, stock control and acceptor reports of EBS and CBD implementing agencies, and the 1996/97 ZDHS.

b. Service Delivery--Strategic Sites

The two outputs of the service delivery--strategic sites component are; improved access to FP services and improved quality of FP services. Monitoring will include Quarterly Reports from the implementing organization, periodic inventories, survey data collected by District Management Teams, patient flow analyses, and reports from MOH District Health Boards, NGOs implementing CBD activities, and the 1996/97 ZDHS.

The outputs of the operations research activity are improved availability of services and establishment of appropriate incentive-based systems. The implementing organization will provide quarterly reports as to the progress of the operations research activities.

c. Information, Education and Communication (IEC)

The outputs of the IEC component include increased demand for FP services, increased knowledge of FP and increased motivation to use FP. Monitoring of the IEC component will include Quarterly reports by the IEC implementing organization, including baseline surveys at district sites, data from the 1996/97 ZDHS, and periodic surveys of health center FP clients.

d. Policy

Short-term TA to support positive policy environment for FP, will provide written reports that identify change in legislation regarding advertisement for contraceptives and the revised Nurses and Midwives Act allowing insertion of IUCDs and expansion of the present mix of hormonal contraceptives.

2. Evaluation

Two major project evaluations will be conducted

during the life of the Project. An interim evaluation is scheduled for 1996 and a final evaluation for 1998. A Demographic and Health Survey, presently scheduled for 1996 (approximately 4 years after the previous ZDHS), will provide essential data for the final evaluation.

The purpose of the interim evaluation is to assess progress toward achievement of the major Project outputs and purpose, and recommend mid-course corrections in project strategy, componentry and/or project objectives.

The final evaluation will assess overall Project impact, progress towards achievement of project objectives, and sustainability of sub-projects. The team will make recommendations regarding a follow-on project and suggestions for its design. Planning for the final evaluation will start at least one year in advance of the PACD.

3. Audit

Given the number of grants under this Project, effective financial management, accountability and audit will be a primary concern. The implementing organizations which will manage the components of the Project will be required to have a well-established track record in the administration and management of AID-financed project monitoring. The implementing organizations will be expected to ensure that subgrantees possess adequate administration and financial control systems to meet USAID's accountability requirements. Audit firms will be engaged to conduct annual financial and compliance examination of subgrantees. The implementing organizations must comply with Standard Provisions for grants to NGOs which include requirements for submission of annual independent CPA-audited financial statements to USAID. In addition USAID/Zambia will arrange for a project audit to examine compliance to AID policy and regulations.

D. Procurement Plan

An itemized Procurement Plan appears as Annex L. As this is DFA financed, the authorized code is 935. The Mission will maximize procurement from U.S. sources in accordance with AID/W policy emphasis. PSI will carry out the Contraceptive Social Marketing component under an amended Cooperative Agreement awarded under the authority provided by HB13 2B2e. USAID/Zambia will request redelegation of authority from AA/FA to amend the Cooperative Agreement. The Mission estimates that almost $2 million of the $3 million expected for Contraceptive Social Marketing Component will be from A.I.D. Geographic Code 000.

USAID and the MOH will select one institutional contractor to provide long- and short-term technical assistance, arrange for training, and supply certain commodities for the

Service Delivery Component. The selected contractor will also be responsible for making sub-grants to local NGOs for community based distribution. The Mission will prepare a Project Implementation Order for Technical Services (PIO/T) to request the Regional Contracting Officer to issue a request for proposal and negotiate an institutional contract. The Mission expects the Service Delivery contract to be for $8.9 million and estimates that $1.8 million of it will be from A.I.D. Geographic Code 000. In accordance with AIDAR 726.301(B), the institutional contractor will subcontract with disadvantaged enterprises for at least 10 percent of the value of the contract.

USAID/Zambia will issue a PIO/T for AID/W to arrange for the implementation of the IEC Component under the AID/R&D/POP Population Communication Services Project. The Mission expects this "buy-in" to be for approximately $3 million and estimates that approximately $2.5 million of it will be from A.I.D. Geographic Code 000.

The Mission will also utilize the AID/R&D/POP Population Council Programmatic Grant for the Operations Research Component. This "buy-in" will be for approximately $912,000. The Mission estimates that $560,000 of it will be from A.I.D. Geographic Code 000.

Project Management will fund a PSC Project Advisor, one audit, and two evaluations. USAID/Zambia will utilize Gray Amendment firms for the Project audit and evaluations. Approximately $765,000 of Project Management will be procured from A.I.D. Geographic Code 000.

V. PROJECT ANALYSES

A. Economic Analysis

The World Bank's report for the 1993 Consultative Group meeting, noted that the rate of population growth is one of the most powerful elements affecting economic growth in Zambia. The current high 3.2 percent growth rate, together with the high dependency ratio of about 100 percent, makes positive per capita growth in Zambia very difficult.

The Bank presented two economic growth scenarios, one based on a standard fertility rate decline and the other on a rapid rate of decline (see Annex J). With the former, total population would double in 25 years; with a rapid decline in the fertility rate, it would take 45 years for population to double.

The impact on average living standards from a rapid decline in the fertility rate would be considerable. Under the rapid fertility decline scenario, total population would be 3 percent lower after 10 years. In terms of per capita income, this

is equivalent to having 3 percent more total output or approximately 0.3 percent per year higher growth rate. The Bank points out that this is the equivalent of having additional investment of 1.5 percent of GDP every year (which in 1992 prices would be nearly 10 billion Kwacha--$30 million at the end of October 1992 open market exchange rate).

The decline of three percent in total population would lower the dependency ratio by 6 percent in the same period. By 20 years, with the rapid rate of fertility reduction, the dependency ratio would have fallen 33 percent. Thus, not only would output per person be higher, but services for children and the aged could be enhanced because available resources would be spread over a smaller dependent population.

The number of children between the ages of five and 15 was 2.2 million in the 1990 census. The impact of the standard and rapid fertility declines on this age-group is presented in Annex J. With the rapid fertility decline scenario, the number of school-aged children will be 25 percent less in 20 years.

High fertility rates contribute significantly to the high rates of morbidity and mortality for both mothers and children. High fertility rates also determine the numbers of females in child bearing ages and the number of children under five, the two segments of the population which make the greatest demand on health services. Per the data in Annex J, the difference in mothers to be served does not become significant for 30 years, but the potential savings for services for the under-five group becomes significant within 10 years, the numbers being almost 40 percent less under the rapid decline scenario.

An accelerated reduction in fertility can also be expected to have a significant economic and social impact through the demand for urban services. Assuming a rural/urban migration trend of 0.9 percent (a 1985 GRZ estimate), one can extrapolate the demand for urban services using as a proxy the number of new dwellings that will be needed. Currently, about 620,000 dwellings are in place, and an additional 400,000 are expected to be needed under the standard scenario. The requirement under the rapid decline scenario would be somewhat less in 10 years, but about one-third less within 20 years.

Based on its analysis, the World Bank concluded that moving to something like the rapid fertility decline scenario would be the single most powerful step Zambia could take if they wish to make substantial progress in increasing the standard of living. Without such a change, progress will be frustratingly slow.

The analysis in Annex J also looks at the costs and benefits of various interventions at sustainability issues for each of the four types of activities included in the FP Services

project: the MOH integrated family planning program; the community-based services program; the employer-based services program; and the contraceptive social marketing program.

The focus is on building human resource capabilities so that follow-on programs could be implemented with minimal expatriate technical assistance. Financial sustainability will depend primarily on a revival of the economy and the success of the MOH's decentralization of the planning and management of health programs to districts. If substantial cost reduction and cost recovery occurs, the MOH should be able to reduce significantly its outlays for curative care and shift resources to preventive and promotive activities, including particularly family planning.

B. Institutional Analysis

The institutional analysis assesses the administrative capabilities of the several implementing agencies in areas relevant to execution of the project. (See Annex I.) The FPS Project design provides support and resources (technical, financial, material) to both public and private institutions for expansion of family planning services, while maintaining strict accountability for AID funds and material inputs and maximizing Zambian participation in the process. The technical assistance provided through the Project will support the institutions responsible for implementing and sustaining the Project.

The principle agencies expected to receive support under the FPS Project are: the Ministry of Health, MCH/FP Unit, General Nursing Council (GNC), the Ministry of Labor, Social Development and Culture; the Pharmaceutical Society of Zambia (PSZ); Zambia Information Service (ZIS); autonomous District Health Boards, and targeted non-governmental organizations (NGO). With the Project support, the FPS Project activities will be institutionally feasible.

C. Social Analysis

An obvious gap between the demand for family planning and practice as well as between knowledge and practice best describes the "problem" with family planning in Zambia and is the central problem which the social soundness analysis seeks to explain (see Annex H).

Clearly, the quality, availability, and accessibility of family planning services in Zambia have constituted one roadblock to meeting the demand for family planning and are in need of improvement. However, the demand is not merely a function of service performance or availability; it is also influenced by attitudes and regulations of the service providers, the kind of knowledge women and men have about family planning methods and fertility, and intervening socio-cultural factors.

For example, some clinics insist on written permission from husbands for contraceptives, although spousal consent is only required for surgical contraception. In some cases, nurses invoke the spousal consent requirement to protect themselves from angry husbands who learn of their wives' unilateral decision to use modern contraceptives. Provision of family planning for unmarried people is a grey area and staff attitudes towards family planning are sometimes inappropriate, regardless of the client's age. Some health providers maintain divergent views on family planning service delivery that are inherent in their religious inclinations; or, some may have method biases. Whether the health provider is not adequately trained in family planning counseling or is not favorably disposed to the use of family planning methods, the result is discouraging the acceptance of family planning and building reluctance among potential users to seek family planning services.

A female acceptance survey, a male acceptance study, and interviews with various informants on family planning in Zambia have revealed poor or inadequate knowledge on the part of both men and women on the use and effects of modern contraceptives. The pill is sometimes thought to cause infertility or STDs. Myths about the IUCD exist, such as the notion that it will travel up through the circulatory system to the heart. The condom is associated with promiscuity and extra-marital relations. Non-users often express the fear that using modern contraceptives will make them unable to conceive later. Injectables, such as Depo Provera, are not widely available and suffer from a history of bad press.

Knowledge, attitudes, and decisions relating to fertility, marriage, child spacing, and family planning continue to be influenced by traditional views, customs, and laws. According to traditional law, women marry as soon as they reach menarche, which could be as young as 12 years old. Initiation ceremonies prepare young girls for marriage. It is expected that the marriage will be consummated and under customary law, a husband who turns out to be impotent on the wedding night is sent home the next day and the marriage is regarded as dissolved. The male study revealed that the urgency for a couple to prove immediately after marriage that they are fertile persists. This was the most common reason given by the male focus groups for waiting until after the first child is born to begin using family planning methods, if at all. Infertility is one of the primary ailments in both men and women treated by traditional healers.

Children are highly valued as a source of prestige, labor, and support in their parents' old age. The fertility rate for Zambia stands at 6.5. While the ideal family size in the male acceptance study ranged from 3 to 10, child spacing is more readily accepted than child limiting. Traditional precedents exist for child spacing. There was usually a three-year interval in between births during which the mother was sent to her parents' home until

the baby was weaned and was old enough to "fetch water for his father." Breastfeeding continues to be very common in Zambia, although exclusive breastfeeding is not. It is also evident in Zambia that fertility preferences are strongly affected by the parents' level of education.

Household decisions about child spacing, child limiting, family planning practice, and choice of contraceptive methods are never the right of one individual. Women especially are expected to consult a male (husband, uncle, or guardian) or member of her kin group for any important decisions affecting her life. Despite fertility preferences, women in the female acceptance survey felt that the decision on when a woman should start using a family planning method or service should be the man's and an almost equal number felt it was the woman's. A small percentage said it was both spouses' decision. It was clear in the male study that decisions about when to practice family planning and how many children to have can be discussed between husband and wife, but ultimately the decision is the man's decision. Nonetheless, most men, when asked about their needs for family planning, expressed the wish for counseling and services available to couples and not to the man or the woman separately.

The benefits of a family planning services project to meet the unmet demand for these services in Zambia are multiple, particularly in view of the reality that 48 percent of the total population is made up of people under 15 years of age. The population of women in their reproductive ages is expected to increase from 1.7 million in 1988 to 2.63 million by the year 2000 based on a constant population growth rate of 3.7 percent. The ZDHS revealed that more than one quarter of teenage women had already had a child and another 7 percent were pregnant with their first child. Moreover, 40 percent of the population in Zambia are living in urban areas. The proportion urban is highest for the Copperbelt province (91%) which, in addition to Lusaka province, is expected to benefit most immediately because the province ranks high in terms of all of the selection criteria for districts to be served by the project.

A lower fertility rate and higher contraceptive prevalence rate are two of the long-term objectives for the Project. Among the long-term benefits are the right of all couples and individuals to choose from a range of family planning methods and to decide freely and responsibly the number and spacing of their children; improved maternal health due to child spacing which in turn contributes to the welfare of families and economic productivity; a decrease in neonatal and perinatal mortality and morbidity resulting from the increased birth weight of spaced children and a decrease in high risk births; and the improved status of women (based on her access to educational and employment opportunities, improved decision-making power at all levels, increased self-esteem, and in possession of her rights as an

individual) which in turn contributes to national development.

The two main groups of direct beneficiaries are (1) health service providers and contraceptive supply outlets and (2) women and men of reproductive age in the strategic districts. Other direct beneficiaries are the MCH/FP unit of the MOH, the NGO(s) involved in CBD, the employer-based clinics, and the PSZ. The training and technical assistance given directly to these institutions and family planning providers will strengthen their capacity to meet the current need for their services. Children constitute a large group of indirect beneficiaries. The higher the level of a mother's education, the greater the probability of a child surviving from birth to any age up to 5 years and the better the child's nutritional status. Reducing fertility also enables families to provide better education for their children. Investing in girls' education is known to generate a cycle of benefits.

Information to show improvement in or alleviation of constraints to knowledge and acceptance for men, women, and youth should be based on records and analyses done by the health centers and CBDs aggregated at the district level. Periodic workshops should be held for this purpose and comparisons made with the performance of other participating districts. Additionally, the research and evaluation unit of the MCH/FP in the MOH should be solicited to repeat acceptance surveys for females and males to include districts covered by this project and other districts and provinces for a comparative assessment. The baseline for these surveys are the acceptance studies used for this project design.

D. Technical Analysis

The FPS Project aims to increase the use of modern contraceptives from 9 percent to 20 percent among married women and from 7 percent to 18 percent among all women within the 5-year time frame of the project. The GRZ's National Family Planning Program for 1992-2000 sets ambitious objectives and targets of increasing family planning prevalence rate from 8.9 percent to 25 percent and reduce total fertility rate to 6 from 7.2 in 1980. Constraints identified by the Project include; lack of trained health personnel, limitations of method mix, limited hours during the week when family planning is provided, and operational problems of contraceptive logistical management. To achieve these targets and decrease the negative influence of the identified constraints, FPS will expand the number of FP service delivery sites, develop in-country capacity for training, IEC, and logistics management.

The FPS Project design proposes to build upon and strengthen the existing infrastructure, both the public and private sector as well as supporting the present process of decentralization. In order to meet the sizable unmet need for family planning the Project will support the provision of a broader range of contraceptive methods and expansion of the number of

service delivery sites and hours per week when FP is offered. The technical analysis of the present situation as well as attention to the continued decentralization, indicate that these objectives are feasible. The service delivery components of the Project are sound and tested. They build on existing USAID activities and match the objectives of the National Population Policy of 1989 and the implementation guidelines of the National Family Planning Program for 1992-2000.

Contraceptive Social Marketing (CSM) of condoms is being successfully carried out by PSI/PSZ. Increasing the contraceptive products to include orals, IUCDs, injectibles, implants and spermicides will provide a private sector logistics system as well as a back-up system to the GRZ MSL. The CSM component will also provide product distribution and CYP data for the non-governmental sector that will be used to monitor the achievement of the Project objectives. CBD and EBS projects are already being implemented successfully and will be expanded and strengthened under the FPS Project. Successful implementation of MOH pilot IFP clinics, where FP services are offered on a daily basis, indicates the excellent potential to increase FP service accessibility through further expansion of IFP at all the FPS Project strategic sites.

Increasing the availability of long-term methods (ML/LA, NSV, IUCD, implant) needs to be initiated with physicians at hospitals. Once the doctors are trained to provide these methods, they can act as the supervisors/technical advisors for clinical officers, nurses and midwives who will be trained to insert IUCDs and implants. It is also feasible to train clinical officers to perform minilap surgery at hospitals. Once these services are established at the hospital level, selected health centers in strategic sites will be upgraded to provide IUCDs and implants.

The reintroduction of the injectable Depo Provera is technically feasible once the product is registered. Health workers will need to be trained to counsel and advise clients on its appropriateness as a method and potential side effects. IEC messages will also be specially developed to counteract the rumors and bad press that previously surrounded this method.

Training of staff has been sporadic. Standards and protocols will need to be developed to guide training activities and set standards for service delivery as well as developing an overall in-service training plan. The MCH/FP Unit and the General Nursing Council have both identified this as a significant weakness in the present institutions and have already attempted to address this issue. The Project will continue to support this endeavor.

The technical analysis identified key problems and constraints in family planning service provision and made

recommendations for overcoming these constraints that were addressed in the project design. (See Annex G for detailed Technical Analysis.)

VI. NEGOTIATING STATUS, CONDITIONS, AND COVENANTS

USAID/Zambia has developed this Project with technical advice and input from the MOH. The recommendations to resolve the policy constraints were made by the MOH. With this setting, USAID/Zambia expects no difficulties in negotiating a Grant agreement.

A. Conditions Precedent to First Disbursement

Binding Obligation. Prior to the first disbursement of funds under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, except as A.I.D. may otherwise agree in writing, the Grantee shall furnish or have furnished to A.I.D., in form and substance satisfactory to A.I.D.:

(a) a written opinion of legal counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of the Grantee, and that it constitutes a valid and binding obligation of the Grantee in accordance with all of its terms; and

(b) a written statement setting forth the name of the person holding or acting in the office of the Grantee specified in section 8.2. of the Project Agreement and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the Grantee, together with a specimen signature of each such person, certified as to its authenticity by the Minister of Justice or the person acting in their capacity.

B. Conditions Precedent for Contraceptive Social Marketing:

Prior to disbursement of funds under the component for Social Marketing, except as A.I.D. may otherwise agree in writing, the MOH will authorize advertising of socially marketed oral contraceptive(s). The GRZ/MOH will provide written evidence in form and substance satisfactory to A.I.D. which allows advertising of contraceptives and the dispensing of oral contraceptives by appropriately trained individuals without the need for a physician's prescription. The MOH is expected to authorize this within the first six months of the Project.

C. Conditions Precedent for Service Delivery

Prior to disbursement in excess of $3 million the MOH will provide written evidence in form and substance satisfactory to A.I.D., except as A.I.D. may otherwise agree in writing, that it

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has issued Family Planning Policy Guidelines and Standards which include:

1. The providers who can dispense oral contraceptives include doctors, clinical officers, midwives, nurses, pharmacists, community-based distribution agents and TBAs who have been trained to screen clients for contraindications.

2. Service delivery sites for oral contraceptives include hospitals, health centers, pharmacies, shops and CBD agent outlets, where screening of clients for contraindications will take place before the first cycle of orals is dispensed.

3. The providers who can dispense injectibles include doctors, clinical officers, midwives and nurses. Services delivery sites for injectibles include hospitals, health centers and private clinics.

4. The providers who can insert IUCDs and implants include doctors, clinical officers, midwives and nurses who have been specifically trained and certified to perform these procedures. Service delivery sites for insertion of IUCDs and implants include hospitals, health centers and private clinics that have been authorized to provide these services.

Prior to disbursement in excess of $3 million the MOH will also provide written evidence in form and substance satisfactory to A.I.D., except as A.I.D. may otherwise agree in writing, that: the position of MCH/FP Specialist, or its equivalent, has been filled.

D. Special Covenants

The Grantee covenants that none of the funds available to the Grantee under the Grant shall be used to pay for the performance of abortion as a method of family planning, including without limitation: financing or supporting (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to women to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communications programs that seek to promote abortion as a method of family planning; or (v) lobbying for abortion.

The Grantee further covenants that none of the funds available to the Grantee under the Grant will be used to pay for: (i) the performance of involuntary sterilizations as a method of family planning, or to coerce or provide any incentive for any individual to undergo sterilization; or (ii) any biomedical research which relates to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. Finally, the Grantee covenants that all necessary steps

will be taken to ensure that funds made available to the Grantee under the Grant will not be used to coerce any individual to practice methods of family planning inconsistent with such individual's moral, philosophical, or religious beliefs.

Family Planning Services
611-0235

Project Logical Framework

Narrative	Indicators	Means of Verification	Assumptions
Goal Socially stable, economically productive, politically active population	Increase in real GDP per capita Decrease in % of Zambian living below poverty datum line Increase in % of registered voters	CSO Selected Economic Indicators CSO Selected Economic Indicators Registrar	Political and social stability maintained GRZ implements full range of economic and political reforms
Subgoal: Sustainable improvements in general health status	Total fertility rate declines from 6.5 (92) to 6.0 Decrease in the prevalence of diarrheal diseases, ARI, and malaria HIV prevalence rate declines among women attending antenatal clinics HIV incidence rates decline among targeted populations: workplace, traditional healers, out-of-school youth, and counselling centers	Demographic Health Survey Demographic Health Survey WHO epidemiological records HIV/AIDS Prevention Project Monitoring	
Purpose: Increased use of modern contraceptives and improved child spacing	End of Project Status: Couple years protection reaches 380,000 Modern Contraceptive prevalence rate increases from: 9% to 20% among married women, and from 11% to 18% among all women Service delivery at strategic sites increases by 75% from base period	Supply statistics Demographic Health Survey Baseline survey/project evaluation	Per capita incomes increase and education levels improve

Family Planning Services Project
611-0235

Project Logical Framework

Narrative	Indicators	Means of Verification	Assumptions
Outputs	Magnitude of Outputs:		
1. Social Marketing			
Contraceptive social marketing program established	1	Social marketing records	
OCs marketed through social marketing	710,000 cycles	Social marketing records	
No. of distribution points: OCS	500		
No. of distribution points: injectables	250		
No. of distribution points: implants	40		
Commodities delivered			
Oral Contraceptives	160,000		
Implants	43,000	Social marketing records	
Injectibles	100,000	Social marketing records	
IUCDs	43,000		
2. IEC			
Audience Research	1 contract		
Mass media campaign initiated	1	Project evaluation	
Men	1		
Women	1		
Youth	1		
Localized geographic campaign initiated	20	Project evaluation	
3. Service Delivery – Strategic Sites			
Trained service deliverers at strategic sites	500	Project evaluation	
Facilities upgraded	60	Site visits/project audit	
Family planning protocols & standards developed	1 set	Project evaluation	
FP supervision and mgmnt systems developed	1 set	Project evaluation	
CBD programs initiated	11	Project evaluation	
Incentive program identified which increases and sustains high levels of provider productivity and improves staff retention rates	1 or more	Project evaluation	
4. Policy & Operations Research			
Increased availability	Trained nurses and midwives allowed to prescribe OCs and insert IUCDs	Government gazette	
	GRZ approved use of USFDA approved implants and injectibles	Government gazette	
Increased demand	Public advertizing of contraceptives made legal	Government gazette	
Pilot research projects that test alternative incentive efforts	3		
5. Project Management			
Project manager	1	Project records	
Interim evaluations	1	Project records	
Final evaluation	1	Project records	
Project audits	1	Project records	

Family Planning Services Project
611-0235

Project Logical Framework

Narrative	Indicators			Means of Verification	Assumptions
	AID	GRZ ($US000)	TOTAL		
Inputs:					Commodities and TA arrive in timely fashion.
1. Technical assistance	$12,529		$12,529	Contractor quarterly reports	
2. Training	435		435	A.I.D. Disbursement Records	
3. Commodities	3,711		3,711	A.I.D. Audit Reports	
4. Proj Mgmnt, Audit & Evaluation	225		225		
			0		
5. Inflation & contingency	3,100		3,100		
Total	$20,000	$0	$20,000		

INITIAL ENVIRONMENTAL EXAMINATION OF CATEGORICAL EXCLUSION

PROJECT COUNTRY: Zambia

PROJECT TITLE AND NO: Family Planning Services Project (611-0235)

FUNDING: FY(s) 93 98 US$20,000,000

IEE PREPARED BY: Richard Harber, AFR/SA

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination _____
Negative Determination _____
Categorical Exclusion X
Deferral _____

SUMMARY OF FINDINGS:

Summary of Findings:

The Family Planning Services Project will finance technical assistance, training, commodity procurement, and studies designed to increase the use of modern contraceptives and improve child spacing. The Project will not fund any activities that directly affect the environment such as construction, water supply systems, or waste water treatment. Because Family Planning Services will not directly affect the environment, it qualifies for a Categorical Exclusion under 22 CFR, Section 216, 2(c)(2)(viii).

CONCURRENCE:
Bureau Environmental Officer:
John J. Gaudet, AFR/ARTS/FARA:

Approved: [signature]
Disapproved: _____
Date: 3/3/93

CLEARANCE:
GC/AFR: [signature] Date: 3/5/93

Communications should be addressed
to the Permanent Secretary
Telephone 263349
Telegrams
Telex ZA 40140
Fax No 263353
LUSAKA
ZAMBIA

ANNEX C

In reply please quote
No NCDP/101/7/68

REPUBLIC OF ZAMBIA

OFFICE OF THE PRESIDENT

Development Co-operation Division
National/Mbala Road
P.O. Box 50268
LUSAKA
ZAMBIA

25th March, 1993

Dr. Fred Winch,
Director,
U.S.A.I.D,
LUSAKA

Dear Dr. Winch,

On behalf of the Government of the Republic of Zambia, I hereby request the Agency for International Development (AID) to provide a grant of US$ 20 million for a project in Family Planning Services. It is our understanding that this grant will be used over the next five years to increase the use of modern contraceptives, improve child spacing and women health in Zambia.

In line with the Government's plan for decentralisation of health care, we expect AID funded family planning activities to enable clinics, outlets and other service centres to operate as independently and as close to the family unit as possible. Initiation through AID grant of a reimbursement system that directly supports clinics, including those of the Ministry of Health, on a fee for service basis would be consistent with our decentralisation strategy.

Finally, we anticipate that the AID grant for family planning services will adhere to the Government's desire to uphold the principle that all people should make a contribution for good quality health care, including family planning services.

Yours sincerely,

M. M. LISWANISO
PERMANENT SECRETARY
DEVELOPMENT CO-OPERATION
OFFICE OF THE PRESIDENT

ANNEX C

Annex D

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH CHECKLIST UP TO DATE?

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage developments and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

(a) Yes, by increasing the demand for modern contraceptives manufactured outside Zambia. (b) Yes, by relying on the private sector to deliver family planning services. (c) N/A (d) N/A (e) Yes, the private sector approach to family planning will increase efficiency and cost effectiveness. (f) N/A

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. pharmaceutical companies will initially provide Project-funded contraceptives, and be able to compete to meet the increased demand after the start-up period of the Project.

3. **Congressional Notification**

a. **General requirement** (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

A Congressional Notification was sent to Congress as required. It expired without objection on

b. **Notice of new account obligation** (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided with a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance** (FY 1991 Appropriations Act Sec. 575 (b) (3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000 will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonable firm estimate of the cost to the U.S. of the assistance?

N/A

5. **Legislative Action** (FAA Sec. 611(a) (2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

The GRZ does not require legislative approval of the obligation.

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A
7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575 (b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?	N/A
8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	N/A
9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	(a) Yes, by increasing the demand for modern contraceptives manufactured outside Zambia. (b) Yes, by relying on the private sector to deliver family planning services. (c) N/A (d) N/A (e) Yes, the private sector approach to family planning will increase efficiency and cost effectiveness. (f) N/A
10. **U.S. Private Trade** (FAA Sec. 501(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	U.S. pharmaceutical companies will initially provide Project-funded contraceptives, and be able to compete to meet the increased demand after the start-up period of the Project.

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

N/A, Zambia has received a Section 110 waiver.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. **Separate Account** FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act. Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and in such assistance likely to cause substantial injury to U.S. procedures of the same, similar or competing commodity? N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? N/A

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? (a) No (b) No

14. **Sahel Accounting** (FAA Sec. 121(d)): If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?	N/A
15. **PVO Assistance**	
a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?	Yes
b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?	Yes
16. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	Mission will comply when date of signing is confirmed.
17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants and other business-related activities, except to the	Yes

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes, women are the primary Project beneficiaries.

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

No

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No

b. Will any funds be used to lobby for abortion?

N/A

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperative, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

22. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs.. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

U.S. does not have excess holdings of kwacha.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

The U.S. does not own excess Zambian currency.

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Small businesses are free to supply commodities and technical services on a competitive basis.

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

Yes.

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminated against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

N/A

d. Non-U.S. agricultural procurement (FAA Sec. 604 (e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those

N/A

countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. **Cargo preference shipping** (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? **No.**

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? **Yes.** Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? **Yes.**

h. **U.S. air carriers** (International Air Transportation Fair Competitive practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? **Yes.**

i. **Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? **Yes, standard clauses.**

j. Consulting services (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes.

k. Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? N/A

Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? N/A

l. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

24. Construction N/A

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional presentation), or does assistance have the express approval of Congress? N/A

25. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

26. **Communist Assistance** (FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

27. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops eradicated? Yes.

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entitles which we know or have reason to believe have Yes.

either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? **Yes.**

29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? **Yes.**

30. **CIA Activities** (FAA Sec.. 662): Will assistance preclude use of financing for CIA activities? **Yes.**

31. **Motor Vehicles** (FAA Sec... 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? **Yes. DFA procurement rules apply.**

32. **Military Personnel** (FY 1991 Appropriations Act. Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? **Yes.**

33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act. Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? **Yes.**

34. **Multilateral Organization Lending** (FY 19911 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) transfer of FAA funds to multilateral organizations for lending)? **Yes.**

35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? **Yes.**

36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human rights? **Yes.**

37. **Publicity or Propaganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? **No.**

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 5633): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? **Yes.**

39. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (included any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? **No.**

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? N/A

2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits? N/A

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government. The Project was designed in collaboration with the GRZ. The social analysis examined the particular needs, desires, and capacities of the people.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Yes.
6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	N/A
7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	No. This Project qualified for a 110 waiver.
8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Program includes an monitoring and evaluation activity to assure beneficiary impact.

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? N/A

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? N/A

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? N/A

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? The Project will not make grants for Natural Family Planning.

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	None. The Project will work throug two PVOs and UNFPA. Mission's Gray Amendment plan has been met through other Projects.
12. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?	N/A
13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):	Yes.
a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?	N/A.
b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent	

feasible: (1) stress the importance of conserving and sustainable managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watershed and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss or degradation; (9) conserve biological diversity in foresty areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. Government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

N/A

N/A

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

No EIA is necessary. The Project received a Categorical Exclusion.

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? **N/A**

15. **Sub-Saharan Africa Assistance** (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided inclose consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks,

a) Yes

b) Yes

c) Yes

d) Yes

e) Yes

f) N/A

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

N/A

16. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. **Deobligation/Reobligation** (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

18. **Loans**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	Yes.
c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	N/A.
d. **Exports to United States** (FAA Sec. 629(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?	Assistance is to GRZ to sell parastatals to the private sector. Assistance is not for any enterprise.
19. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?	1) N/A 2) N/A 3) N/A 4) Project will measure and monitor impact of Project activities on women. 5) N/A

20. **Agriculture, Rural Development and Nutrition, and Agricultural research** (FAA Secs. 103 and 103A):

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor, or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made. N/A

b. **Nutrition:** Describe extent which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people. N/A

c. **Food security:** Describe extent to which activity increases national security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution. N/A

21. **Population and Health** (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. **Education and Human Resources Development** (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities. N/A

23. **Energy, Private Voluntary Organizations, and Selected Development Activities** (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is: N/A

a. concerned with data collected and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources, energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment; N/A

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques; N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness: N/A

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; N/A

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. N/A

24. Sahel Development (FAA Secs. 120-21): If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A

AID/W GUIDANCE ISSUES

1. Policy Impediments

Issue: The policy constraints to improving family planning in Zambia are formidable. If NPA is proposed, a full constraints analysis is required.

Response: As explained in Section III.C.4, the policy constraints are not formidable. The current policy environment is excellent because of the progressive nature of the current GRZ and MOH leadership. Since the policy environment for the Project is based on ministerial authority, the GRZ needs a sounder legislative basis to ensure long-term continuity of appropriate, family planning policies. The Project addresses this need with technical assistance.

Even though the PP includes a contraints analysis based on numerous studies, USAID/Zambia is no longer proposing NPA.

2. Role of Public and Private Sectors

Issue: A thorough analysis/description should be provided of the logistical arrangements, mechanisms, and procedures required for the private sector to carryout an expanded supply role required by the Project.

Response: USAID/Zambia modified the original expanded role for private sector supply of contraceptives. Under the new design, PSI/PSZ will be responsible for CSM, EBS, and back-up supplies for the public sector. USAID/Zambia revised the role of the private sector to supply commodities because of large ODA grant of commodities to the public sector.

Issue: Given the strong private sector focus of the proposed project, the PP should provide a discussion of why the public sector will be largely bypassed.

Response: The revised Project works with the public sector to complement the large ODA grant of commodities and logistics management assistance to MSL. The Project will assist the MOH MCH/FP Unit with assistance in logistic management.

3. IEC

Issue: The PP should include a carefully drawn strategy and preliminary implementation plan for an IEC component.

Response: See Project Description (Section III.C.1. and 3.) and IEC Analysis (Annex Q).

4. Service Orientation and Quality of Care

Issue: The PP should indicate the strategy to increase access. The PP should differentiate between attempts to test various cost recovery schemes and increase access.

Response: The design of the Project is based on the constraints to increased access. Access is increased through a nation-wide social marketing effort; and increased number of delivery points, number of methods being offered and hours of service. See Technical Analyis (Annex G).

Issue: The revised PID limits operations research to the area of cost recovery. A larger operations research agenda needs to be considered.

Response: Operations research is a minor component under the Project. While a wider agenda was explored during Project design, it was determined that a focus on improved productivity and cost effectiveness was appropriate.

Issue: The PP should provide a comprehensive analysis/assessment of the current state of family planning in Zambia.

Response: See Social Analysis (Annex H), Technical Analyses (Annex G), and Monitoring and Evaluation Plan (Annex M). The PP design was also based on the 1992 ZDHS, World Bank Health Sector Study Review, the UNFPA PRSD 1993, the GRZ Population Policy 1989, and the National Family Planning Program 1992-2000.

Issue: The PP should describe with as much specificity as possible, the improvements in the quality of service expected as a result of FPS, GRZ activities, and other donor projects.

Response: See Technical Analysis (Annex G) and Project Description.

Issue: The PP should provide a careful description of the training to be provided. It should describe who will be trained, and for what purpose.

Response: See the Training Analysis (Annex P) and Project Description (Section III.C.2.e.).

5. Health Financing

Issue: The feasibility of a system to reimburse providers for services to the medically indigent needs to be

addressed. The Project Committee was troubled as to how reimbursement procedures would be implemented and what class of provider would qualify for reimbursement.

Response: This activity has been confined to a pilot effort under Operations Research. The feasibility of it will be tested.

6. Project Focus and Concentration

Issue: The rationale for a focus on clinic-based services in designated target areas needs to be described.

Response: The rationale for a focus on designated target areas is the same as the A.I.D. emphasis of population activities in five large, priority countries. USAID/Zambia wishes to focus on selected sites because of the higher population densities, the higher benefit cost ratios, and the more reasonable basis for management. See Service Delivery (Section III.C.2.).

Issue: Apart from geographic focus, subareas such as urban, periurban, males, and adolescents needs to be considered and justified.

Response: See the IEC Analysis (Annex Q) for targeting of subgroups. Service Delivery will also raise the awareness of providers to target subgroups.

Issue: The PP should set realistic implementation targets and goals.

Response: The implementation targets and goals reflects the Mission's analysis of family planning status in Zambia.

7. Policy and Project Management

Issue: If NPA is included in the PP/PAAD the Mission has to adhere to the Africa Bureau guidance for NPA. This requires a full sector analysis leading to alleviation of the policy reform constraints that will result in people level impact. Performance based disbursement is not acceptable under DFA NPA guidance.

Response: The World Bank, UNFPA, and the GRZ have produced numerous studies and analyses in the last six months on family planning constraints in Zambia. The Mission has ample sector analysis to meet the DFA requirements. NPA was dropped from consideration because the policy and institutional constraints are neither formidable nor priority. The priority constraints to

increased use of modern contraceptives are social and technical.

Issue: The PP design team will determine whether a sub-grant to a PVO or an openly competed contract is the most appropriate mechanism for implementing the Project. AID/W assumes USAID/Zambia is aware that grants may be competed as well as contracts.

Response: USAID/Zambia has conferred with REDSO/ESA/RLA concerning competition and the awarding of grants and contracts. Based on consultation with the RLA and PP design team members, the Project will award one grant, one competed grant/contract, and two buy-ins (see Procurement Plan: Section IV.D.).

Issue: The Mission should submit an IEE as soon as possible.

Response: An IEE was submitted with the PID. It appears again in the PP as Annex B.

ACT: AID-3 INFO: AMB DCM

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TO RUEHLS/AMEMBASSY LUSAKA PRIORITY 5357
INFO RUEHNR/AMEMBASSY NAIROBI 1662
BT
UNCLAS SECTION 01 OF 03 STATE 253063

LOG: 127/8 33
19 AUG 93 0600
CN: 44926
CHRG: AID
DISTI: AID

ACTION DS 08/23

AIDAC, FOR REDSO RLA

E.O. 12356: N/A
TAGS:
SUBJECT: ZAMBIA FAMILY PLANNING SERVICES (FSP) PID REVIEW

REF: LUSAKA 2750

1. SUMMARY: THE REVISED SUBJECT PID LIKE DOCUMENT WAS REVIEWED BY THE PROJECT COMMITTEE (PC) IN AID/W ON MONDAY, JUNE 14, 1993. THE REVISED PID INCLUDED THE ORIGINAL PID AUGMENTED BY THE MISSIONIS CABLE RESPONSE (REF CABLE - LUSAKA 2750) TO PC ISSUES AND CONCERNS RAISED DURING THE ORIGINAL PID REVIEW ON MAY 13, 1993 WHICH WERE FAXED TO THE MISSION ON MAY 25, 1993. THE DECISION OF THE PC AT THE JUNE 14 REVISED PID REVIEW WAS THAT THE REVISED PID APPEARED CONCEPTUALLY SOUND BUT STILL LACKED THE FULL INFORMATION NEEDED FOR THE COMMITTEE TO FEEL COMFORTABLE WITH PROVIDING UNCONDITIONAL PID APPROVAL FOR PROJECT PAPER (PP) AUTHORIZATION IN THE FIELD. HOWEVER, IN VIEW OF THE URGENT NEED FOR SUPPORT TO THE HEALTH/POPULATION SECTOR IN ZAMBIA AT THIS TIME, THE PC DECIDED TO APPROVE THE PID-LIKE DOCUMENT AND WAIVE THE REQUIREMENT FOR A PAID WITH THE STIPULATION THAT THE PP/PAAD BE REVIEWED IN AID/W AND THAT THE PC WOULD ASSIST THE MISSION WITH PP/PAAD DESIGN BY IDENTIFYING AND FIELDING THE PP/PAAD DESIGN TEAM.

2. THE PROJECT COMMITTEE IDENTIFIED MAJOR ISSUES AND CONCERNS TO BE ADDRESSED DURING PP DESIGN IN THE FOLLOWING AREAS:

POLICY IMPEDIMENTS
ROLE OF THE PUBLIC AND PRIVATE SECTORS
INFORMATION, EDUCATION AND COMMUNICATION (IEC)
SERVICE ORIENTATION AND QUALITY OF CARE
HEALTH FINANCING
PROJECT FOCUS AND CONCENTRATION
NGA
CONTRACTING MECHANISM

3. POLICY IMPEDIMENTS

AS INDICATED IN THE REVISED PID, THE POLICY CONSTRAINTS TO IMPROVING FAMILY PLANNING IN ZAMBIA ARE FORMIDABLE AND

ADDRESSING THEM IS CRITICAL TO PROJECT SUCCESS. THE PROPOSED NON-PROJECT ASSISTANCE (NPA) MAY BE AN APPROPRIATE MECHANISM TO HELP IMPROVE THIS POLICY ENVIRONMENT. HOWEVER, A FULL CONSTRAINTS ANALYSIS IS REQUIRED TO DETERMINE WHETHER THERE ARE POLICY REFORMS REQUIRED IN ADDITION TO THOSE IDENTIFIED IN REFTEL PARA 2C. AS WELL, THE PP/PAAD NEEDS TO EXAMINE HOW SUCH REFORMS CAN BEST BE ACCOMPLISHED AND SPECIFY STRATEGIES FOR THEIR EXPEDITIOUS IMPLEMENTATION. THE REQUIREMENTS FOR A POSSIBLE NPA COMPONENT ARE ADDRESSED IN PARAGRAPH BELOW.

4. ROLE OF THE PUBLIC AND PRIVATE SECTORS

A. GIVEN THE EXISTING PROBLEMS WITH PUBLIC SECTOR CONTRACEPTIVE PROCUREMENT AND DISTRIBUTION IDENTIFIED IN THE REVISED PID, AND THE PROPOSAL TO ADDRESS THIS DEFICIENCY THROUGH PRIVATE SECTOR CHANNELS, A THOROUGH ASSESSMENT OF THE ZAMBIAN PRIVATE SECTOR'S CURRENT AND PROJECTED CAPACITY IN THE AREAS OF CONTRACEPTIVE PROCUREMENT AND DISTRIBUTION IS CRITICAL FOR PROJECT SUCCESS. ALSO, A THOROUGH ANALYSIS/DESCRIPTION SHOULD BE PROVIDED OF THE LOGISTICAL ARRANGEMENTS, MECHANISMS AND PROCEDURES REQUIRED FOR THE PRIVATE SECTOR TO CARRY-OUT THE EXPANDED SUPPLY ROLE ENVISIONED FOR IT UNDER THE PROJECT.

B. GIVEN THE STRONG PRIVATE SECTOR FOCUS OF THE PROPOSED PROJECT (FOR BOTH SOCIAL MARKETING OF CONTRACEPTIVES AND ST OF THE CLINIC-BASED ACTIVITIES), THE PROJECT PAPER SHOULD PROVIDE A DISCUSSION OF WHY THE PUBLIC SECTOR WILL BE LARGELY BYPASSED. A DISCUSSION OF THE RELATIVE STRENGTHS AND WEAKNESSES OF THE TWO SECTORS WITH RESPECT TO PROVISION OF FAMILY PLANNING SERVICES DELIVERY WOULD BE USEFUL.

5. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

ONE OF THE THREE COMPONENTS OF THE PROPOSED FAMILY PLANNING SERVICES PROJECT IS INCREASED DEMAND FOR FAMILY PLANNING SERVICES. A WELL DESIGNED IEC STRATEGY IS ESSENTIAL TO INCREASING DEMAND FOR FAMILY PLANNING SERVICES. ALTHOUGH FULL SPECIFICATION OF THE IEC COMPONENT OF THE PROJECT WILL FALL TO AN INSTITUTIONAL CONTRACTOR OR OTHER IMPLEMENTING AGENCY, THE PP/PAAD

SHOULD INCLUDE A CAREFULLY DRAWN STATEGY AND PRELIMINARY IMPLEMENTATION PLAN FOR THE IEC COMPONENT. THE STRATEGY AND IMPLEMENTATION PLAN SHOULD IDENTIFY AND JUSTIFY ATTENTION TO SPECIFIC TARGET GROUPS, AND DISCUSS THE MOST APPROPRIATE APPROACHES IN THE ZAMBIAN CONTEXT, E.G., RADIO AND TELEVISION CAMPAIGNS TO REACH A LARGELY URBAN POPULATION. ALSO, THE PP/PAAD SHOULD SHOW HOW THE IEC THRUST WILL BE INTEGRATED WITH THE SOCIAL MARKETING AND CLINIC- BASED SERVICE DELIVERY ACTIVITIES.

6. SERVICE ORIENTATION AND QUALITY OF CARE

A. THE EFFORT TO IMPROVE ACCESS TO FAMILY PLANNING SERVICES UNDER THE PROPOSED PROJECT SHOULD BE FULLY ELABORATED IN THE PP/PAAD. THIS COMPONENT IS GIVEN INADEQUATE ATTENTION IN THE REVISED PID. IT IS DISCUSSED ONLY IN RELATION TO THE PILOT COST RECOVERY SCHEMES. THIS RAISES QUESTIONS AS TO WHETHER THE INTENT IS TO INCREASE ACCESS, TO TEST DIFFERENT COST RECOVERY INITIATIVES, OR SOME COMBINATION OF THE TWO. SUCH ISSUES SHOULD BE FULLY CLARIFIED DURING PROJECT DESIGN.

B. THE REVISED PID LEAVES THE IMPRESSION THAT PILOT ACTIVITIES WILL BE UNDERTAKEN ONLY IN RELATION TO COST RECOVERY RESEARCH. IS A LARGER OPERATIONS RESEARCH AGENDA PLANNED UNDER THE PROPOSED PROJECT? THE PP/PAAD SHOULD FULLY ADDRESS THE ISSUE OF OPERATIONS RESEARCH UNDER THE PROJECT.

C. THE PP/PAAD SHOULD PROVIDE A COMPREHENSIVE ANALYSIS/ASSESSMENT OF THE CURRENT STATE OF FAMILY PLANNING IN ZAMBIA. THIS ASSESSMENT CAN PROVIDE SUPPORT FOR THE INTERVENTIONS PROPOSED BY THE MISSION AS WELL AS ESTABLISH A BASIS FOR MEASURING PROJECT PROGRESS AND SUGGEST AREAS FOR POSSIBLE FUTURE INTERVENTION.

D. ONE OF THE THREE COMPONENTS OF THE PROPOSED PROJECT IS IMPROVED QUALITY OF FAMILY PLANNING SERVICES. AS INDICATED IN 6C ABOVE, SOME INDICATION OF THE CURRENT SITUATION IS REQUIRED TO DEVELOP A STRATEGY TO IMPROVE THE QUALITY OF SERVICES. THE PP SHOULD DESCRIBE WITH AS MUCH SPECIFICITY AS POSSIBLE THE IMPROVEMENTS EXPECTED AS A RESULT OF THE PROPOSED USAID INTERVENTIONS. THE PROJECTED IMPACT OF GRZ AND OTHER DONOR RESOURCES ON IMPROVING THE QUALITY OF SERVICES SHOULD ALSO BE DESCRIBED.

E. A CAREFUL DESCRIPTION OF THE TRAINING TO BE PROVIDED UNDER THE PROPOSED PROJECT SHOULD BE PRESENTED IN THE PP/PAAD. THE PP/PAAD SHOULD DESCRIBE WHO WILL BE TRAINED (E.G. PUBLIC OR PRIVATE SECTOR AND TYPES OF PERSONNEL), AND FOR WHAT PURPOSE. THIS SECTION SHOULD ALSO DESCRIBE WHO WILL DO THE TRAINING AND THE TYPE OF TRAINING TO BE PROVIDED (E.G. WHETHER THE TRAINING WILL PROVIDE BASIC INFORMATION ON PROVISION OF VARIOUS CONTRACEPTIVES OR WHETHER THE FOCUS WILL BE ON COUNSELLING AND OTHER INPUTS DESIGNED TO ENHANCE THE QUALITY OF SERVICES.)

7. HEALTH CARE FINANCING

THE FEASIBILITY OF THE PROPOSED INTRODUCTION OF A SYSTEM TO PROVIDE SERVICES TO THOSE CLASSIFIED AS MEDICALLY INDIGENT INCLUDING A COST RECOVERY MECHANISM SHOULD BE FULLY ELABORATED IN THE PP. THE PC WAS LEFT WITH SUCH TROUBLING QUESTIONS AS HOW REIMBURSEMENT PROCEDURES WOULD ACTUALLY BE IMPLEMENTED AND WHETHER PVO OPERATED CLINICS AS WELL AS PRIVATE COMPANY OPERATED CLINICS WOULD BE INCLUDED IN THE COST RECOVERY SCHEMES. SUCH QUESTIONS SHOULD BE FULLY ADDRESSED IN THE PP.

8. PROJECT FOCUS AND CONCENTRATION

A. THE REVISED PID INDICATES THAT ALTHOUGH THE SOCIAL MARKETING ACTIVITIES WILL BE UNDERTAKEN NATIONALLY, THE PROJECT WILL FOCUS ON CLINIC-BASED SERVICES IN DESIGNATED TARGET AREAS. THE RATIONALE FOR SELECTION OF THESE TARGET AREAS AND HOW THEY FIT WITHIN THE WIDER SERVICE DELIVERY SYSTEM SHOULD BE DEVELOPED DURING PROJECT DESIGN AND FULLY DESCRIBED IN THE PP.

B. APART FROM THE GEOGRAPHIC FOCUS INDICATED IN THE REVISED PID, THE SUBAREAS (E.G., URBAN, PERI-URBAN) AND SUBGROUPS (MALES, ADOLESCENTS) ON WHICH THE PROJECT WILL CONCENTRATE ATTENTION ALONG WITH THE JUSTIFICATION FOR THE CHOICES MADE SHOULD BE SPECIFICALLY DESCRIBED IN THE PP.

C. THE PP DESIGN TEAM SHOULD PAY CAREFUL ATTENTION TO THE SETTING OF REALISTIC IMPLEMENTATION TARGETS AND GOALS. THE SUGGESTION IN THE REVISED PID THAT THE PROJECT WOULD

AIM AT INCREASING CONTRACEPTIVE PREVALENCE FROM 10 TO 30 PERCENT IN FIVE YEARS AND REDUCING THE TOTAL FERTILITY RATE (TFR) FROM 6.5 TO 5.2 WITHIN THE SAME TIME PERIOD ARE UNREALISTIC GOALS AND SHOULD BE REVIEWED AND REVISED.

9. PROPOSED NPA COMPONENT

A. IF A NON-PROJECT ASSISTANCE (NPA) ELEMENT IS INCLUDED AS PART OF THE PROPOSED PROJECT, THE PP/PAAD MUST DEMONSTRATE THAT ALL THE REQUIREMENTS OF THE AFRICA BUREA NPA GUIDANCE ARE MET. THIS INCLUDES WITHOUT LIMITATION: EVIDENCE OF A FULL SECTOR ANALYSIS; IDENTIFICATION AND RANK-ORDERING OF SECTOR CONSTRAINTS; EVIDENCE THAT THE PROGRAM, THE HOST GOVERNMENT OR OTHER DONORS ARE ADDRESSING ALL THE CONSTRAINTS NECESSARY FOR PEOPLE-LEVEL IMPACT; AND AN EXPLANATION OF HOW ALLEVIATION OF THOSE CONSTRAINTS (THE POLICY REFORMS) WILL LEAD TO THE PREDICTED, QUANTIFIABLE PEOPLE LEVEL IMPACT AS WELL AS ALL OTHER ANALYSES REQUIRED UNDER THE CURRENT GUIDANCE. USE OF CASH TO FACILITATE ATTAINMENT OF PROJECT OBJECTIVES WITHOUT THIS FULL SECTOR ANALYSIS (SOMETIMES KNOWN AS PERFORMANCE-BASED DISBURSMENT) IS NOT ACCEPTABLE UNDER THE DFA/NPA GUIDANCE. DUE TO TIME CONSTRAINTS, THE MISSION MAY PROCEED WITHOUT AN AID/W PAIP-LEVEL REVIEW OF THIS COMPONENT, PROVIDED THAT THE PP/PAAD TO BE SUBMITTED TO AID/W DEMONSTRATES FULLY HOW THE NPA GUIDANCE IS FULFILLED.

B. IF THE PP/PAAD DESIGN TEAM CONCLUDES THAT THE ANALYSIS AND PLANNING FOR THE NPA PROGRAM CAN NOT BE INCLUDED IN THE INITIAL PP/PAAD DOCUMENT, THE MISSION MAY CHOOSE TO DELAY SUBMISSION OF THE NPA COMPONENT UNTIL FULL ANALYSIS AND PLANNING FOR IT CAN BE COMPLETED. ALTERNATIVELY, THE POLICY REFORMS MAY BE MADE CONDITIONS PRECEDENT TO PROJECT ASSISTANCE DISBURSEMENTS OR THE INITIATION OF APPROPRIATE PROJECT SUB-COMPONENTS.

10. CONTRACTING MECHANISM.

THE REVISED PID INDICATES THAT BECAUSE OF THE MODIFICATIONS TO THE PROPOSED SCOPE OF THE FAMILY PLANNING SERVICES PROJECT, THE MISSION WILL DESIGN A BILATERAL GRANT AND THE PP/PAAD DESIGN TEAM WILL THEN CONSIDER WHETHER A SUB-GRANT TO A PVO OR AN OPENLY COMPETED CONTRACT IS THE MOST APPROPRIATE MECHANISM FOR IMPLEMENTING THE PROPOSED PROJECT. WE ASSUME THE MISSION IS AWARE THAT GRANTS MAY BE COMPETED AS WELL AS CONTRACTS.

11. PER PARAGRAPH 1 ABOVE, THE PP DESIGN TEAM HAS BEEN IDENTIFIED AND ARE EXPECTED TO BEGIN WORK ON THE FAMILY PLANNING SERVICES PROJECT DESIGN BEGINNING [illegible] AND [illegible] OF [illegible] 10, 1983.

12. THE MISSION SHOULD SUBMIT AN IEE, A [illegible] REQUIREMENT, TO THE BUREAU ENVIRONMENTAL [illegible] AS POSSIBLE.

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SELECTION CRITERIA FOR STRATEGIC SITE SELECTION

USAID/Zambia and the MOH will identify a list of priority districts which will be the strategic sites where the Integrated Family Planning strategy will be implemented. The list will be based upon the following criteria: (a) high population distribution and density; (b) high unmet demand for family planning services; (c) level of commitment and priority given to family planning by the District Health Management Team (DHMT) in the district action plan; (d) adequate service delivery infrastructure; (e) accessibility of population; and (f) potential for strong program linkages among the community, clinic and district hospital.

The list in this Annex is illustrative, based only on population density, unmet demand (by province), and accessibility. The MOH and the Family Planning Services Project Management Team will compile the actual list and select enough clinics within each district to make quality access to the longer term methods of family planning available to almost everyone in the district. Level of commitment by a district to family planning will be heavily weighted in the final selection. Increasing the use of modern contraceptives depends upon the commitment of the family planning providers. The Project will not force funding into districts that have decided that family planning is a low priority. The weighting of the criteria and the final list will be approved by USAID/Zambia.

STRATEGIC SITES SELECTION DATA

PROVINCE/DISTRICT		TOTAL POPULATION	POPULATION DENSITY	FP UNMET NEED	HOURS BY CAR FROM LUSAKA	TOTAL POPULATN FACTOR	POPULATN DENSITY FACTOR	FP UNMET NEED FACTOR	ACCESS/ LUSAKA FACTOR	TOTAL FACTORS
1 LK	Lusaka–Urban	982,362	2728.0	30.5	0	5	5	2	5	17
2 CB	Ndola–Urban	376,311	341.2	39.3	2	5	3	3	5	16
3 CB	Kitwe	348,571	448.5	39.3	5	5	3	3	4	15
4 S	Monze	157,451	32.4	37.1	3	3	2	3	5	13
5 CB	Chingola	186,769	111.3	39.3	6	3	3	3	4	13
6 E	Chipata	294,204	24.5	35.1	3	4	1	3	5	13
7 CB	Luanshya	147,747	182.2	39.3	5	3	3	3	4	13
8 CB	Mufulira	175,025	106.9	39.3	5	3	3	3	4	13
9 E	Katete	139,679	35.0	35.1	6	3	2	3	4	12
10 E	Petauke	251,144	13.4	35.1	5	4	1	3	4	12
11 S	Mazabuka	157,724	23.1	37.1	2	3	1	3	5	12
12 CB	Kalulushi	90,630	125.0	39.3	6	2	3	3	4	12
13 S	Livingstone	84,116	28.9	37.1	3	2	2	3	5	12
14 LK	Lusaka–Rural	209,318	11.6	30.5	2	4	1	2	5	12
15 CN	Kabwe–Rural	219,865	8.5	26.6	3	4	1	2	5	12
16 CB	Ndola–Rural	167,852	7.1	39.3	3	3	1	3	5	12
17 CN	Kabwe–Urban	166,619	106.0	26.6	1	3	3	1	5	12
18 S	Kalomo	154,875	5.0	37.1	6	3	1	3	4	11
19 S	Choma	164,387	22.5	37.1	5	3	1	3	4	11
20 CB	Chililabombwe	86,637	84.4	39.3	6	2	2	3	4	11
21 CN	Mkushi	107,264	4.7	26.6	3	3	1	1	5	10
22 N	Kasama	192,046	9.3	35.1	11	3	1	3	3	10
23 E	Lundazi	173,018	12.3	35.1	9	3	1	3	3	10
24 CN	Mumbwa	127,821	6.1	26.6	3	3	1	1	5	10
25 S	Siavonga	45,874	17.5	37.1	3	1	1	3	5	10
26 N	Mpika	116,653	2.8	35.1	8	3	1	3	3	10
27 S	Sinazongwe	62,337	12.6	37.1	6	2	1	3	4	10
28 N	Chinsali	86,852	5.6	35.1	10	2	1	3	3	9
29 LK	Luangwa	16,300	4.7	30.5	2	1	1	2	5	9
30 N	Mbala	138,193	7.5	35.1	14	3	1	3	2	9
31 S	Namwala	83,416	3.8	37.1	9	2	1	3	3	9
32 N	Isoka	121,907	8.8	35.1	12	3	1	3	2	9
33 CN	Serenje	104,042	4.5	26.6	5	3	1	1	4	9
34 N	Mporokoso	53,911	4.5	35.1	14	2	1	3	2	8
35 E	Chama	52,234	3.0	35.1	12	2	1	3	2	8
36 S	Gwembe	36,173	2.9	37.1	8	1	1	3	3	8
37 N	Chilubi	39,956	8.6	35.1	9	1	1	3	3	8
38 NW	Solwezi	120,590	4.0	34.5	12	3	1	2	2	8
39 W	Kaoma	112,747	4.8	21.2	5	3	1	0	4	8
40 NW	Kabompo	51,587	3.5	34.5	11	2	1	2	3	8
41 E	Chadiza	63,539	24.7	35.1	12	2	1	3	2	8
42 NW	Zambezi	69,795	3.8	34.5	10	2	1	2	3	8
43 LP	Nchelenge	111,735	13.9	25.6	12	3	1	1	2	7
44 N	Luwingu	66,763	7.5	35.1	15	2	1	3	1	7
45 NW	Mwinilunga	81,899	3.9	34.5	12	2	1	2	2	7
46 W	Kalabo	101,410	5.8	21.2	11	3	1	0	3	7
47 LP	Mansa	142,613	8.8	25.6	12	3	1	1	2	7
48 N	Kaputa	51,514	4.0	35.1	21	2	1	3	1	7
49 W	Mongu	142,213	14.1	21.2	8	3	1	0	3	7
50 LP	Samfya	108,233	10.5	25.6	13	3	1	1	2	7
51 W	Senanga	135,210	4.5	21.2	9	3	1	0	3	7
52 NW	Mfumbwe	22,303	1.1	34.5	14	1	1	2	2	6
53 LP	Mwense	81,277	12.1	25.6	14	2	1	1	2	6
54 W	Lukulu	51,016	3.1	21.2	11	2	1	0	3	6
55 NW	Kasempa	36,971	1.8	34.5	14	1	1	2	2	6
56 LP	Kawambwa	82,846	4.3	25.6	15	2	1	1	1	5
57 W	Sesheke	64,901	2.2	21.2	13	2	1	0	2	5

NOTES 1) TOTAL POPULATION & POPULATION DENSITY data from 1990 Census report; UNMET NEED from DHS r 79
2) HOURS BY CAR FROM LUSAKA from USAID drivers, except figures for Ndola, Livingstone and Chipata modified to take account of access by air

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STRATEGIC SITES SELECTION DATA

PROVINCE/DISTRICT		TOTAL POPULATION	POTENTIAL CLIENTS	POPULATION DENSITY	FP UNMET NEED	HOURS BY CAR FROM LUSAKA	TOTAL POPULATN FACTOR	POPULATN DENSITY FACTOR	FP UNMET NEED FACTOR	ACCESS/ LUSAKA FACTOR	TOTAL FACTORS
1 LK	Lusaka – Urban	982,362	244373	2728.0	30.5	0	5	5	2	5	17
14 LK	Lusaka – Rural	209,318	51802	11.6	30.5	2	4	1	2	5	12
	TOTAL LUSAKA	1191680	296175								
2 CB	Ndola Urban	376,311	92,992	341	39.3	2	5	3	3	5	16
3 CB	Kitwe	348,571	86137	448.6	39.3	5	5	3	3	4	15
5 CB	Chingola	186,769	46127	111.3	39.3	6	3	3	3	4	13
7 CB	Luanshya	147,747	36059	182.2	39.3	5	3	3	3	4	13
8 CB	Mufulira	175,025	43437	106.9	39.3	5	3	3	3	4	13
12 CB	Kalulushi	90,630	22243	125.0	39.3	6	2	3	3	4	12
16 CB	Ndola – Rural	167,852	41680	7.1	39.3	3	3	1	3	5	12
20 CB	Chililabombwe	86,637	21261	84.4	39.3	6	2	2	3	4	11
	TOTAL COPPERBELT	1203231	296944								
6 E	Chipata	294204	75364	24.5	35.1	3	4	1	3	5	13
9 E	Katete	139679	36232	35	35.1	6	3	2	3	4	12
10 E	Petauke	251,144	65488	13.4	35.1	5	4	1	3	4	12
	TOTAL EASTERN	685027	177084								
4 C	Monze	157451	40241	32.4	37.1	3	3	2	3	5	13
11 C	Mazabuka	157,724	39007	23.1	37.1	2	3	1	3	5	12
13 S	Livingstone	84,116	20826	28.9	37.1	3	2	2	3	5	12
18 S	Kalomo	154,875	39634	5.0	37.1	6	3	1	3	4	11
19 S	Choma	164,387	42177	22.5	37.1	5	3	1	3	4	11
	TOTAL SOUTHERN	718553	181885								
15 CN	Kabwe – Rural	219865	55214	8.5	26.6	3	4	1	2	5	12
17 CN	Kabwe – Urban	166,619	41482	106.0	26.6	1	3	3	1	5	12
	TOTAL CENTRAL	386484	96696								
	ALL STRATEGIC SITES	4184975	1048784								

NOTES 1) TOTAL POPULATION & POPULATION DENSITY data from 1990 Census report; UNMET NEED from DHS report. m DHS report
2) HOURS BY CAR FROM LUSAKA from USAID drivers, except figures for Ndola, Livingstone and Chipata modified to take account of access by air
3) POTENTIAL CLIENTS is 50 percent of the total females of the district

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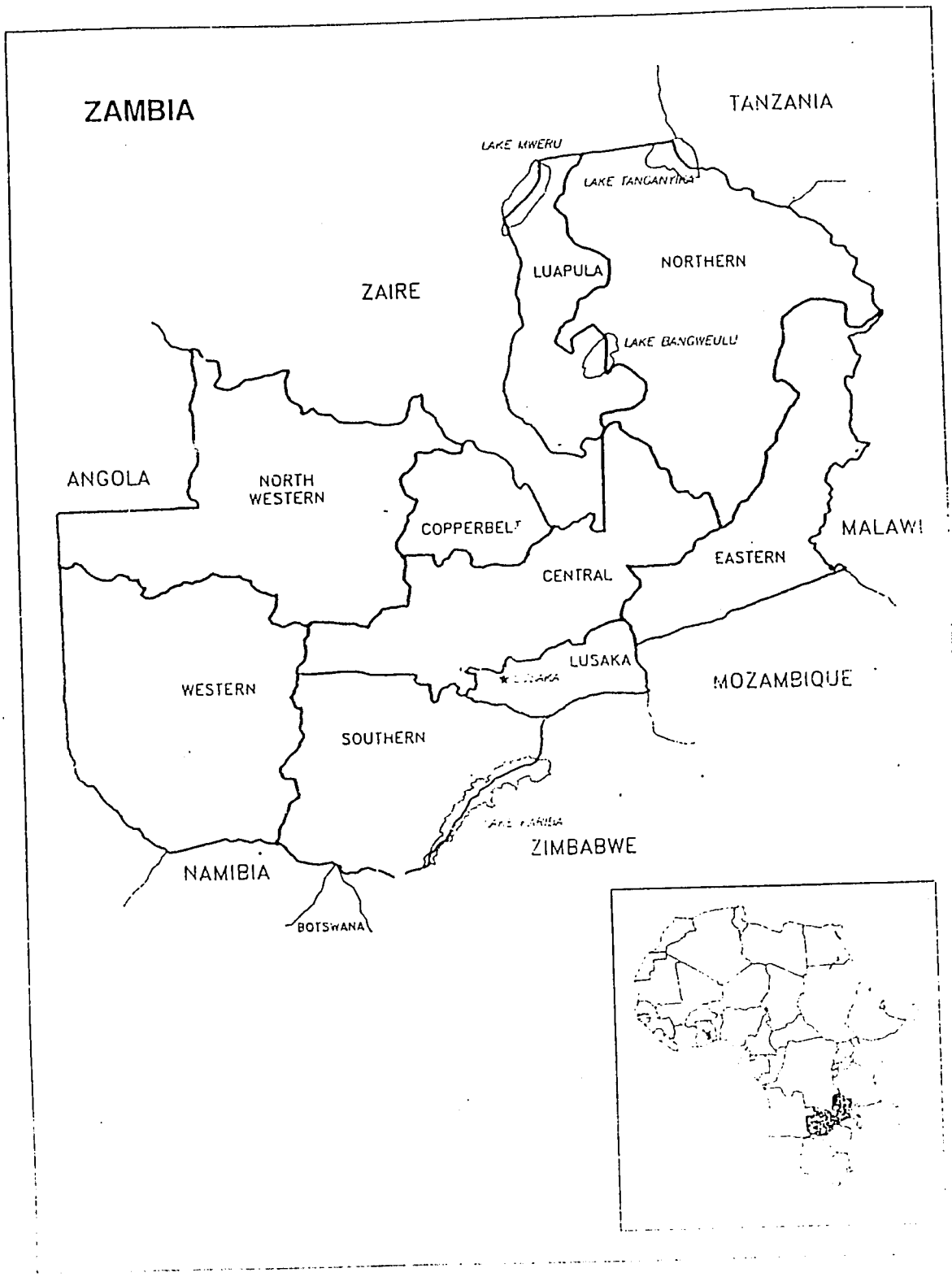
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COPPERBELT
CENTRAL
EASTERN
MALAWI
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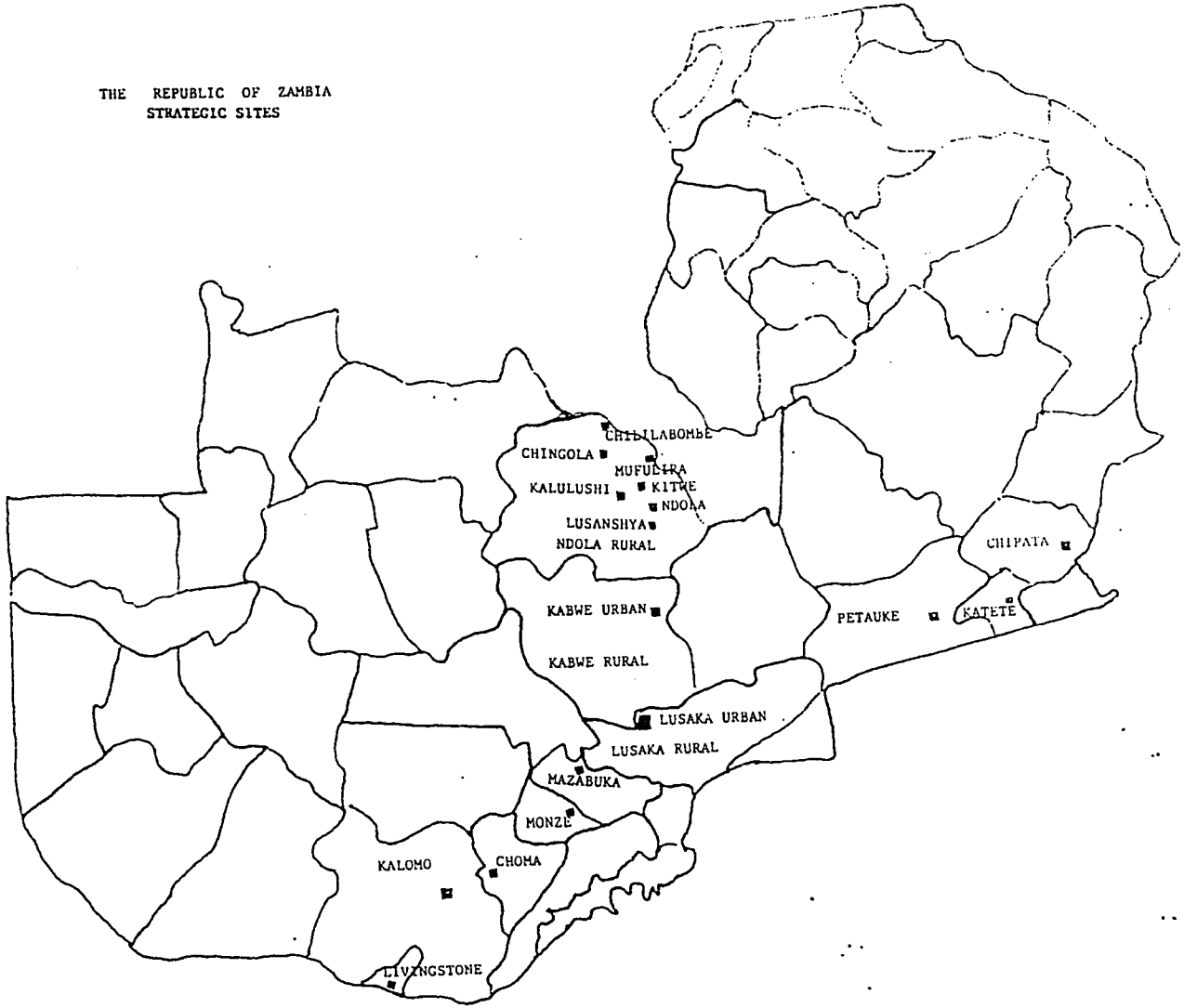
ZIMBABWE
NAMIBIA
BOTSWANA

THE REPUBLIC OF ZAMBIA
STRATEGIC SITES



TECHNICAL ANALYSIS FOR FAMILY PLANNING SERVICES

A. Summary of Proposed Family Planning Interventions

The Family Planning Services (FPS) project will provide support to the Government of the Republic of Zambia (GRZ), non-governmental (NGO) and private sector organizations to increase and improve the family planing (FP) services offered at strategic sites throughout the country. The five project components are: 1) social marketing; 2) information, education and communication (IEC); 3) FP service delivery through Ministry of Health (MOH) integrated family planning (IFP) clinics, NGO community-based distribution (CBD) and private sector employer-based projects; 4) policy strengthening and operations research (OR); and 5) project management and administration.

The on-going condom social marketing activities being carried out under a project with Population Services International and the Pharmaceutical Society of Zambia (PSI/PSZ) will be expanded under the FPS project social marketing component to include distribution and sale of all modern contraceptive methods that are included in the national FP program--orals, IUCDs, injectables and vaginal foaming tablets (VFT). These products will be marketed to FP clients, private practitioners, private sector and NGO agencies and to any GRZ entities that wish to utilize the PSZ distribution system. Under this component the marketing capacity and logistics management system of PSZ will be strengthened, and PSZ will provide information on product sales to the USAID FPS project manager to ensure adequate monitoring of FP program coverage nationwide. USAID will also share sales data with the Ministry of Health project counterparts, so that private sector FP coverage data can be incorporated into the MOH contraceptive prevalence estimates for the country.

The IEC component which will be implemented with assistance from Johns Hopkins University/Population Communications Project working with the Zambian Information Services (ZIS), will conduct research and develop national mass media campaigns that will promote a smaller family norm, refute rumors about contraceptive side effects and direct clients to public and private FP service providers. Another element of this component will support clinics and communities in strategic sites by developing provider and client materials, such as information on specific FP methods and financing social mobilization activities. Under the GRZ health reform decentralization initiative, District Health Boards will be assisted to tailor IEC materials to the cultural and language requirements of the area and to develop specific IEC interventions such as dramas and songs based on resources available within each district. Social mobilization activities include training of health assistants, community health workers

(CHW), traditional birth attendants (TBA) or other community leaders to promote a smaller family norm, direct messages at men, teenagers or other target groups and direct potential clients to FP services.

The service delivery component of the FPS project will support an increase in the number of modern FP methods available through public and private hospitals and clinics by supporting the provision of an injectable contraceptive (Depo Provera) and an implant (NORPLANT), and by supporting the training of service providers to expand the number of sites providing IUCDs and permanent surgical contraceptive methods (tubal ligation and vasectomy). The availability of FP services will also increase as MOH hospitals and health centers switch from a limited (one or two days per week) schedule for FP services, to a daily integrated (MCH) FP program. NGO community-based distribution (CBD) projects will be expanded and private employer-based FP services will also be supported under this service delivery component.

Expansion of FP services will also require support to the Ministry of Health (MOH) Maternal Child Health/Family Planning (MCH/FP) Unit to establish and implement FP guidelines and standards, to increase its in-service training capability, to monitor progress through the logistics management information system (LMIS) and to coordinate FP activities of GRZ, NGO and private sector agencies.

Institutionalization of FP services will be enhanced by improving the FP content of the curricula of the medical school and of the nursing, midwifery, clinical officer and health assistant schools. This will reduce the need for extensive in-service training after the completion of the FPS project. The project will support the development and redesign of curricula, training of trainers and providers, and will finance the needed equipment and supplies to expand FP services.

A FPS Project Management Team (FPSPMT) will provide long and short term technical assistance for the service delivery components of the project, and will set up a grants management unit to develop and support NGO CBD sub-projects and employer-based services sub-projects. A cooperative grant agreement will be competitively awarded to secure these services for the life of the project.

The policy and operations research component will provide technical assistance and local cost support to the MOH to refine specific aspects of the health reform process which began in 1993 and is scheduled for full implementation in January 1995. While the MOH establishes policy guidelines on implementation of the MCH/FP program, technical assistance provided under this

component will be used support the enactment of updated health legislation to ensure that the current favorable environment for FP continues. Operations research studies will evaluate pilot efforts in areas such as financing of and reimbursement for FP services, and service delivery in and among hard-to-reach populations. These studies will test the willingness of clients to pay for FP services. Under the FPS project, successful approaches will be expanded within districts through decentralized financing arrangements.

The project management and administration component will finance a personal services contractor (PSC) project manager within the USAID/Zambia office and annual financial audits of FPS project accounts.

B. National Setting

Knowledge Attitudes and Practices

According the Zambia Demographic and Health Survey (ZDHS) of 1992, 91% of married women reported knowing a modern method of family planning (FP)--pill, condom, sterilization, IUCD, injection--while 87% of married women reported knowing where to obtain a modern method. Over 81% of married women who know a contraceptive method approve of FP. Just over half of the women say that their husbands also approve of FP; 17% say that they approve of FP and their husbands do not. A sizeable proportion of married women living in rural areas do not know their husbands' attitudes towards FP (7.5%), an indication of the extent to which FP is discussed by rural couples. Fifteen percent of married women were currently using a method in 1992 at the time of the ZDHS, with the most popular methods being the pill (4%), withdrawal (3%), tubal ligation (2%) and condom (2%). Other traditional methods--mostly abstinence, strings and herbs--are used by 2% of married women.

While overall use of FP is quite low, the ZDHS data show that some married women are more likely to be using contraceptives than others. Women most likely to be using contraceptives are those resident in urban areas, those with higher education and those with four or more children. Not only are urban women twice as likely as rural women to be using a method (21% vs. 10%), but urban users are also more likely to be using a modern method. Urban women depend on methods such as the pill, female sterilization and condom, while rural women rely primarily on traditional methods such as withdrawal, wearing beads or herbs around the waist and drinking African medicine made with roots and leaves.

The majority of contraceptive users (56 percent) obtain their methods from government sources: MOH health centers supply 50

percent of all oral contraceptives (OC); MOH hospitals supply 45 percent of all female sterilizations. Private and Mission hospitals and clinics provide 54 percent of female sterilizations and 20 percent of OCs. While 41 percent of all condoms are supplied by MOH hospitals and centers, an equal amount (41 percent) are purchased from pharmacies and shops, indicating significant coverage of USAID supported social marketing interventions.

Based on the data that indicate 33 percent of married women have an unmet need for spacing (21 percent) and limiting (12 percent) births, the ZDHS estimates that 350,000 married women in Zambia are in need of family planning services. The strategic sites to be included under the FPS project should be concentrated in the Provinces of Copperbelt, Lusaka and Southern, which, according to ZDHS data, have the largest unmet need.

Of the women interviewed by the ZDHS who were not using a method of contraception at the time of the survey, but indicated that they intended to use a method in the next 12 months, 59 percent said they preferred to use the pill and 8 percent preferred female sterilization. Five percent indicated they would like to use an injectable, which is a method not readily available at present. This shows a high level of interest and potential acceptance of Depo Provera and Noristerat when they are included in the contraceptive method mix later this year. The FPS project should include IEC, training and supplies to support the re-introduction of injectable methods in the Zambia program.

Reasons for non-use among currently married women who did not intend to use a contraceptive method were explored in the ZDHS 1992: 37% wanted to have children; 31% cited infecundity (either "difficult to get pregnant" or "menopausal"); 11% lacked knowledge; 8.1% mentioned religion and opposition to FP by self, spouse or others; and 4.5% cited side effects.

ZDHS 1992 data indicate that the median age at first marriage has increased by one to one and a half years--from 17 years or less among women now in their 30s and 40s to 18 and over among women in their 20s. The same data, however, indicate that the median age at first sexual intercourse--16.3 years--has not changed significantly, and is about 1.4 years earlier than the median age at first marriage--17.7 years. Childbearing in Zambia begins early with 27% of 15-19 year olds having already borne a child. By age 19 two-thirds of Zambian women are either mothers or pregnant with their first child.

Exclusive breastfeeding is not common in Zambia: only 16 percent of children under 2 months of age are fed only breast milk. According to the ZDHS, most children are given water in addition to breast milk (68% of children < 2 months). Supplements other

than water are introduced mainly when the children are 2-3 months old; as many as 48% of children age 2-3 months are receiving supplements, as are 84% of children age 4-5 months. Zambian women recognize that breastfeeding is a method controlling fertility, but Lactation Amenorrhea Method (LAM) is not fully understood by health workers or mothers. The early introduction of water and other supplements can reduce the protective effects of breastfeeding in addition to introducing pathogens that can cause disease. Promotion of exclusive breastfeeding until is child is six months old should be promoted and included in the training of MCH/FP workers.

Service Delivery Points for Health Care

Zambia has approximately 1,036 health centers and 83 hospitals operated by the GRZ, missions, and industries. Of the total number of health centers, the GRZ operates 832 (80%), missions support 69 (7%) and industries run 135 (13%). Seventy-seven per cent of health centers are located in rural areas and 25% in urban settings. Exact figures are not available, but the majority of these service delivery points (SDP) provide FP services only once or twice a week at specified hours. Six health centers began providing them on a daily basis under a pilot project that began in 1991. The pilot study proved very successful and the government plans now call for all health facilities to drop the present MCH/FP schedule, where antenatal, immunization, growth monitoring and FP services are offered at separate times on one or two specified days a week at certain hours, and instead offer all services in an integrated fashion to all clients on a daily basis. UNFPA printed posters for the MOH that advise clients that all services are provided every day. The project paper development team observed these posters in sites where integrated services were being pilot tested and in health centers where the daily schedule was still in effect and health workers said they had no immediate plans to offer FP on a daily basis. Other facilities not included in the pilot, however, i.e., Kabwe General Hospital, had begun offering daily integrated FP as an innovation and a service to clients.

The GRZ has approximately 12,140 technical and administrative staff operating its hospitals and health centers, with the Lusaka based University Teaching Hospital (UTC) employing approximately 10% of the national total. Doctors are found only at the national, provincial and district hospitals. The majority of health centers are managed by clinical officers, while the more rural and distant one have nurses and even health assistants in charge.

National FP Program Policy and Strategy

The National Family Planning Program (NFPP), 1992-2000, which was drafted in July, 1992, describes four components which constitute the national family planning strategy and the MOH decentralization plan for health care delivery.

1. Service Delivery

The national program is promoting FP services through four types of services: 1) Community Based Services, 2) Employer Based Services (EBS), 3) Contraceptive Social Marketing (CSM), and 4) clinic-based Integrated FP services (MCH/FP).

2. Commodity and Equipment Logistics

Commodities under the FP program to date are received by the IPPF-affiliate, Planned Parenthood Association of Zambia (PPAZ) and the MOH with funding provided by UNFPA. Apparently, 52.3% of the service delivery points reported having run out of family planning commodities at the end of 1991 and 16.2% reported receiving supplies irregularly (NFPP, 1992:24). More than half of all service delivery points reported having had expired commodities in the past and the major reasons for this were: (a) low clientele, (b) over-supply, (c) available commodities or brands not popular with clients, and (d) commodities were supplied to them when about to expire.

A subcommittee (Management Information Team) was established by the MOH in November 1991 to move commodities from the MOH and the PPAZ to Medical Stores Limited (MSL), a MOH-owned parastatal. Both the MOH and NGOS have been responsible for procuring and distributing commodities, equipment and supplies. The national strategy is to deliver all FP commodities to MSL to send out to the provincial level pharmacies, then to districts, and finally to clinics and FP outlets. The rationale for this strategy is to enable procurement discounts by buying for the nation, establish an accurate information database on usage, and ensure continuity at all service delivery points (SDPs) in three of MOH's four proposed strategies: service-based FP, employer-based FP and community-based FP. Commodity flow monitoring system which includes orders, receipts, stock holdings and distribution has to date been unavailable in the MOH but under the new system these problems are being addressed.

Family Planning International Assistance (FPIA) was supporting population activities in Zambia, which included distribution of contraceptives, until mid-1990 when funding from USAID ended. This led to major stock-outs because the MOH did not find alternative sources in time nor was it able to indicate or project its contraceptive requirements.

The USAID HIV/AIDS project is supporting a social marketing

strategy for condoms through Population Services Inc. (PSI) in conjunction with the Pharmaceutical Society of Zambia (PSZ) which is a private organization founded as a trade association and lobby group for public and private sector pharmacists. Distribution of condoms to the private sector (retail outlets, company/institutional hospitals) and employer-based clinics is carried out through the PSZ responsible for the population policy's fourth strategy, social marketing. The PSZ has been active in contraceptive retail sales since 1985 with support from FPIA until the 1990 stock-out. It has since received a commodity grant from Pathfinder under which it is selling spermicides, IUCDs and oral contraceptives to the private sector outlets.

The contraceptive supply chain in Zambia has been extremely problematic. At the root of the problem is Zambia's family planning history which developed in an uncoordinated fashion out of separate interests of NGOs and donors. In the absence of a population policy (until 1989) the Government relied on donors, without insisting on guidelines. In June 1993, the GRZ requested assistance from ODA to cover (a) emergency supply needs for the period of November 1993 to December 1994 and (b) all MOH contraceptive supplies for the next five years.

3. Information, Education and Communication (IEC)

The GRZ has a National Population IEC Program to promote the most appropriate use of all available IEC channels. The UNFPA has been instrumental in the IEC activities carried out by government departments and in supporting a number of NGOs involved in the sector. Material production includes design and printing of posters, television and radio spots, etc. The responsibility for building public opinion lies with the Zambia Information Services which is part of the Ministry of Information and Broadcasting Services (MOIBS). There is an IEC subcommittee to the ITCP and is headed by the Director of the Population Communication Unit of MOIBS. It consists of representatives from various ministries (MOH, NCDP, Labor, General Education) as well as NGOs. The new plan for the IEC Program designed by the NCDP became available the end of May, 1993.

4. Training

The MOH MCH/FP Unit coordinates family planning services has been conducting an integrated MCH/FP in-service training course for health workers since 1986. Nurses who complete the 14 week course (seven weeks theory, seven weeks practical) are given the title "Family Health Nurse."

Under the PHC program (MOH/FP) 3,646 Community Health Workers (CHW) were trained and there has been a 30% dropout rate. A major problem has been the supply of drug kits which include

condoms. In urban areas, it was noted that some CHWs had no drug kits for community level use, but did have access to condoms for distribution.

About 2,154 Traditional Birth Attendants (TBAs) have been trained but the number who are active is unknown. Problems of supervision and remuneration by the community exist. Trained TBAs are not used as FP agents for modern methods but counsel on traditional methods.

5. Decentralization

The Ministry of Health has initiated a plan for decentralizing health care delivery which will give autonomy to the districts for planning their programs and obtaining resources and managers. The MOH itself is playing a prominent role in putting through the legislation for decentralization which will be fully in place by January 1995. The plan will allow for the provision of basic primary health care (PHC) packages directly to the district under the direction of district health boards. Hospitals will increase their autonomy by having their own budget or block grant and a health management board and will supplement MOH funds with user fees. The provincial level will provide storage, auditing, technical assistance and some training.

FP Guidelines and Service Standards

The MOH MCH/FP Unit is in the process of drafting policy guidelines and service standards for the provision of FP services. The FPS project should support the finalization, printing and dissemination of these documents as a first priority.

Current MOH Method Mix

The current FP commodity list includes: oral contraceptives (OC) combined (Microgynon, Eugynon, Neogynon, Nordette); OC progestin-only (Microval, Microlut); injectable methods (Noristerat); intrauterine contraceptive devices (IUCD) (CopperT 380A); barrier methods (condom, spermicides); permanent methods of voluntary surgical contraception (VSC) (tubal ligation, vasectomy); and, natural methods (scientific methods).

Method Preferences

Among consumers of FP services (56% GRZ, 36% Private (medical), 8% other), there is a preference for OCs, especially Microgynon. IUCDs have been reported to have low popularity due to rumors that they migrate within a woman's body and cause heavier and longer menses. They are only available in urban facilities which have water, electricity, proper sterilization equipment and

trained physicians. Use of condoms is spreading from the urban areas to the rural areas as a result of HIV prevention messages and the expansion of HIV interventions that include the distribution of condoms. The social marketing program for Maximum condoms has also increased public awareness of availability and total number of condom distribution points.

C. Field Observations and Recommendations

PP design team members visited MOH central, provincial (Lusaka, Central and Luapula) and district (Lusaka, Kabwe Urban, Mansa, Mwenze) level offices, hospitals (2), clinics (7), CBD projects (2) and EBS projects (1), as well as organizations involved in social marketing (PSZ, PSI, pharmacies).

Observations at FP Service Delivery Points

The commodities found at SDPs on field visits varied slightly from the MOH's list. Although not all SDPs had the four combined OCs listed above, many of them did. Microgynon was the most popular product. Lo-Femenal, a combined OC with the same formulation as Microgynon, was found at several SDPs and was also said to be very well accepted. This product had been supplied in 1990 or 1991 by USAID through the cooperating agency FPIA. Since USAID is able to secure this product through the contraceptive procurement project of RD/POP/CPSD, it is recommended that Lo-Femenal be marketed by PSI/PSZ under the social marketing component of the FPS project.

The wide array of OCs available at hospitals and health centers that were visited on field trips, had both advantages and disadvantages. While FP service providers had alternative OCs available to provide to clients who did not adjust well to the first contraceptive that was tried, it was unclear what criteria providers were using to determine the best choice of OC. Neogynon and Eugynon supplies were not being utilized very rapidly and expiration dates were fast approaching on many of the observed contraceptives. The formulation of Nordette is exactly the same at Microgynon. It was not available at all SDPs and was dispensed to few clients where it was available. Since it duplicates the more widely accepted Microgynon formula, it is recommended that it be dropped from the commodity list. To simplify the commodity list even further, it is recommended that Microlut be eliminated.

Microlut and Microval are the two progesterone only OCs on the list. These are to be provided to breastfeeding mothers who should not be given estrogen, which is contained in the combined OCs, as it adversely affects breastmilk production and is passed through breastmilk to the suckling child. Microlut was not seen

in any of the SPDs. While Microval was available at most health centers and hospitals, several FP service providers indicated that they did not dispense these orals to breastfeeding women, but gave them combined OCs instead.

It is recommended that all FP curricula that include training on OCs be strengthened to improve providers' understanding of the advantages and side effects of the different OC formulations that are included on the MOH and the PSZ commodity lists.

Besides OCs, condoms and spermicides were dispensed at all sites visited. MOH health centers had initiated a social marketing of condoms project under instruction from the National AIDS Control Program. Green Cross condoms in light blue packages, provided by WHO, were being sold for 5 Kwacha a piece. While some health workers reported success in marketing the condoms to shops and hotels, free condoms for distribution under the family planning program were no longer available in some places. The demand for condoms seems to be steadily increasing. The supply of condoms that will be brought in by ODA under the FP program should be revisited and revised each year, to avoid stockouts to the extent possible.

The varieties of spermicides seen at SDPs included Emko and Delfan foam and Neosampoon vaginal foaming tablets (VFT). The VFTs were out of stock at more than one SDP. Health workers said the stock out was due to the fact that they were well accepted and supplies were short. Since VFTs are the most easily secured contraceptive available to women (no need for an exam or prescription) and can be used alone or with a condom, or as a backup method to the pill (during the first days of the first OC cycle, and when one forgets to take the pill for two days in a row), it is recommended that the PSI/PSZ social marketing intervention include the sale of VFTs to complement the condom sales activities. USAID is able to procure Conceptrol VFTs, which could be marketed at the same locations as the Maximum condom.

Recommendations for Augmenting the FP Method Mix

While injectables were not available at any of the sites visited, some health workers knew of SDPs where the method was being offered, i.e., a German mission health center in Mwenze District and at PPAZ's Lusaka clinic. The Minister and Deputy Minister of Health indicated that there is no obstacle prohibiting this method from being added to the list. In fact, Noristerat, is on the MOH commodity list, but the most recent request for supplies that includes this product is still in the process of being approved and procured. Depo Provera is another injectable that could be provided by USAID under the PSI/PSZ social marketing

component. The product should be registered as soon as possible, and other sources of supply should be explored. Because Depo Provera has mixed reputation due to bad publicity it received several years ago, its advantages and side effects should be clearly spelled out in IEC messages and in provider training courses. The widespread introduction of injectables will increase choice of FP methods available to FP providers and acceptors. Adequate IEC and training will improve providers' ability to counsel clients and continuing FP acceptor rates. Injectables are often preferred by rural clients because they only require a visit to the health center every two or three months (no pills to remember each day), and the progesterone only formula is safe for breastfeeding women and their children.

In a like manner, the implant is also a long-acting progesterone only hormonal FP method. It requires minor surgery to insert and remove, so it should be provided only a health facilities where trained providers and aseptic conditions are present. NORPLANT field trials were conducted in Zambia from 1986 to 1990 with positive results. There was no follow-up, however, to introduce the method on a regular basis. It is recommended that during years 2 or 3 of the FPS project, NORPLANT be included at those sites that have successfully established surgical services for tubal ligation under local anesthetic and no-scalpel vasectomy during the first year(s) of the project.

While permanent methods are available at public, private and mission hospitals, the modern practice of providing tubal ligation by minilap under local anesthesia (ML/LA) is not widely available. Female sterilization is the next most preferred method of FP after the pill by nonusers who said that they did intend to use FP in the future (8%), but accessibility is a major obstacle for many urban and most rural clients because physicians are not trained or equipped to provide the service. The FPS project should address this need beginning with the hospitals located in the strategic site districts where the project will begin operations.

The lactational amenorrhea method (LAM) should be added to the training curricula of nurses, clinical officers and health assistants in order to correct the present practices of giving water and other supplements to newborns less than six months old. By promoting exclusive breastfeeding, the post-partem, amenorrhea period of protection will be extended and the health of the infants will be better guarded. USAID should work with UNICEF to promote the development of IEC client and provider training materials to promote exclusive breastfeeding to age six months.

Recommendations for Service Delivery Standards

The MOH Standard for FP services should delineate the range of

offerings per health facility. The following standard is recommended:

Community-based outlets (community based distribution (CBD) agents, mobile clinics) can provide barrier methods (condom, spermicides), OCs and LAM. Licensed private clinics without doctors/inpatient facilities can provide barrier methods (condom, spermicides), OCs, LAM and injectables. Health centers, PPAZ and private clinics with doctors/inpatients facilities, and hospitals can offer barrier methods (condoms, spermicides), OCs, LAM, injectables, IUCDs and VSC, provided the physician, clinical officer or nurse is trained and that the site meets the standards for performing the procedures. Implants will be available at this latter category of health facility when the method is officially introduced.

Pharmacies, drug stores, CBD agents, and private practitioners are permitted to sell socially marketed condoms, spermicides and pills. Other marketing sites include general goods stores/kiosks, gas stations and private clinics.

STD/HIV prevention should be included in the FP Policy Guidelines and Service Standards and district health boards should be assisted to improve the capacity to provide STD screening, treatment and prevention by supporting training of health workers, diagnostic equipment and supplies and appropriate medicines for treatment.

Due to lack of health professionals, especially physicians, trained to manage FP related complications, health workers at health centers are unable to make proper referrals for clients with FP related complications. The availability of physicians trained to manage FP complications is very low or even non-existent in some areas. The FPS project should provide participant and in-country training for physicians in FP service delivery and assist hospitals to improve backup and referral services for FP clients.

Health Personnel FP Skills and Recommendations

FP tasks for clinical officers should be delineated in the FP Policy Guidelines and Service Standards. The present curriculum for clinical officers includes a limited FP component and only a few have participated in the MCH/FP clinical skills in-service training courses. The in-service training, however, does not prepare them to handle FP complications beyond the level of the midwife.

The many health training institutions have a total output of approximately 1,000 graduates per year. While many of those graduates are now being trained in FP (ZEM/ZEN and ZRN/ZRM) FP

information and skills are not included in the pre-service curricula for health assistants. District MCH/FP Coordinators and health center family health nurses should organize courses for the health assistants in the field so that they can knowledgeably answer questions and motivate rural clients to seek FP services. In order to contribute to the sustainability of FP service delivery, FP components should be added to all pre-service training curricula as soon as possible. Another obstacle to adequate FP training of health personnel is the lack of clinical sites with well trained preceptors to carry out the practical training skills. The project should support the establishment of clinical training sites at the strategic site locations so that they can serve as centers of excellence for training other health workers in the district. In order to develop appropriate clinical skills the training should be offered in a clinical setting, rather than in a hospital, and should focus on skills development, be closely supervised, make use of detailed skills performance assessment tools and terminal skills performance requirements.

D. PROPOSED ACTIVITIES FOR FPS

Background

The componentry of the FPS program was based on GRZ priorities that flow from the National Population Policy of 1989 and the eight year National Family Planning Program 1992-2000 strategy document. USAID considered its experiences with past and on-going FP interventions for contraceptive social marketing (with the Pharmaceutical Society of Zambia, PSI, Pathfinder and FPIA), and the community based distribution projects (with Makeni Ecumenical Center, ADRA, Pathfinder and FPIA). These interventions had produced results and have been included in the project to enhance and expand on previous USAID investments.

The high unmet demand for surgical FP methods was weighed against the less than successful intervention that AVSC tried to implement with physicians at the University Teaching Hospital (UTH). Financial management vagaries and operational problems that still exist to some extent led the team to propose and alternative approach to the expansion of long-term FP methods. This approach is based on the careful selection and development of strategic sites that will be targeted for implementation of all the components of the project.

Strategic Sites Strategy

The idea of the strategic sites was proposed at the beginning of the project design, in order to develop a comprehensive yet cost-effective FP project that would achieve the greatest impact in providing FP services. Criteria were proposed based on

population density and site accessibility. The ZDHS provided data on unmet need for FP services. Although the criteria favored urbanized sites near to Lusaka, PP design team members visited more rural sites in Luapula district to assess the possibility of including more distant rural sites on the priority list. It is recommended that Mansa and Mwenze Districts in Luapula Province be considered for operations research projects, but not be named strategic sites because they are too distant and sparsely populated. (Based on USAID PP team visit results, ODA/UK is interested in following up on those sites and might include them in a CBD project under development with PPAZ.)

The following is a more detailed technical analysis of the components developed under the FPS project.

1. SOCIAL MARKETING

A condom social marketing program was launched in December 1992, under a Grant Agreement with Population Services International (PSI), a U.S. PVO. The Project is being implemented with the Pharmaceutical Society of Zambia (PSZ), a local non-governmental organization with several years of experience marketing contraceptive projects to private sector pharmacies, shops and FP employer based services of private companies and GRZ parastatals. Maximum condom distribution and sales have been well above projections since the project launch. The PSI/PSZ sales strategy focuses on urban areas but will expand to over 800 outlets by 1997. Condoms are to be sold at 4 pieces for 20 Zambian Kwacha (ZK). The first year target was 4 million and after 7 months (June 1993) 2.9 million had already been sold and 391 outlets established.

One of the major problems with the social marketing sales program is the variable price at which condoms are actually offered. Some packages are sold for two and three times the planned amount. The variation in price is associated with distance from the capital and the hour and day of purchase, with Saturday nights being more expensive than weekday daytime prices. The National AIDS Program has recently begun to social market its condoms for 5 ZK a piece. As condom sales become more competitive, pharmacies, drug stores and other vendors might start to reduce prices. If the sale price were to be advertised, vendors might also be encouraged by customers to sell at lower prices. managers.

Under the expansion of the project it is recommended that two pills be launched in early 1994--a low-dose combined oral contraceptive and a progesterone only (mini-pill) for women who are breastfeeding. IUCDs, injectibles, and vaginal foaming tablets (VFT) should also be included under the social marketing

scheme. NORPLANT implants should be supplied to hospitals and trained physicians when the method is introduced during year 3 of project implementation.

This component will also provide support to PSZ to improve logistics management of the contraceptive products so that stockout problems that were experienced under previous projects will be overcome. PSZ will needs to collaborate with the MOH MCH/FP Unit and the USAID FPS project manager on the development and implementation of a management information system that will quantify the number of couple years of protection (CYP) provided by sales of social marketing contraceptives. Information should be disaggregated by service delivery point (pharmacies, NGO CBD projects, etc.) and by geographic locations (districts). This information will supplement the data collected for public service delivery points under the MOH management information system.

2. FP SERVICE DELIVERY

The service delivery component will increase access to FP services and improve the quality of services. The delivery of quality FP services in Zambia is limited by the lack of trained health personnel, the theoretical and actual limits of the method mix, the paucity of hours each week when family planning services are scheduled, and the operational problems of the contraceptive logistical management information system which are recognized but not fully resolved. These constraints are described in detail below. The elements of the FP service delivery component have been specifically designed to address and resolve them.

Lack of Trained Personnel

The integration of family planning (FP) with maternal and child health (MCH) program interventions began in earnest in 1986, when the MOH began in-service family planning training of health providers. An MCH/FP course was designed to provide theoretical (seven weeks) and practical (seven weeks) training in MCH/FP service delivery, but only two weeks of classroom work are devoted to FP. Offered one to four times per year, to a class of 35 students, more than 200 graduates have earned the title "Family Health Nurse" upon successful completion of the course. Besides nurses who work with MCH/FP activities at MOH district offices, hospitals or health centers, other course participants have included MOH clinical officers, and clinical officers and nurses from NGOs and from industries that provide health and FP services to their employers. There has been no organized follow-up of course graduates. Family Health Nurses were on duty in the hospitals and health centers visited by project paper development team members, but their knowledge and skill level related to FP methods and services were limited. They did not recruit clients but rather waited for people to come to the health center for

services. IEC materials to promote FP were either limited or not available to these service providers. PP team members also observed that several of the course graduates had been reassigned to positions where their FP skills could not be utilized. Refresher training courses have not been organized nor planned.

In July 1992, and expanded and improved FP component was added to the curricula of the Zambian Nursing and Midwifery Schools (for both registered and enrolled nurses and midwives). The first nurses trained under this program will not graduate until 1994, however. Nurses trained previously received much more limited training in family planning, as have the clinical officers trained at the Chianama Health Training Institute. Although they have been strengthened, pre-service curricula for the clinical officers and the nurses should be revised to include teaching of new contraceptive methods and more practical work related to management of complications and counseling.

While lack of adequately trained nurses and clinical officers has constrained FP service delivery at health centers, the lack of hospital based physicians, who are trained to provide FP services and offer backup support to lower level workers for patient referral, is an even more serious human resource constraint. There are few physicians available to meet the demand for permanent surgical contraception to limit births. In a like manner, since few physicians have been trained to insert IUCDs, this method is virtually unavailable to FP clients.

Limited Method Mix

There is one modern contraceptive method offered to Zambian FP clients--the pill. Several types of pills are available, but the multitude of brands does not appear to be advantageous. Less popular brands sit on the shelf until they expire, while the more popular brands stock out. Condoms are widely available and appear to be a popular contraceptive as well as a contra-infective. The only other modern FP method available to women at health centers was a spermicide (vaginal foaming tablet or can of foam). Even these were popular alternatives that were stocked out at several sites. The MOH is planning to introduce an injectable hormonal method when the product arrives. This would significantly enhance the method mix at health centers. Allowing clinical officers and nurses to insert IUCDs would go even further to remove this constraint to adoption of a modern FP method. At the present time, a client must go to a hospital and seek the services of a physician for an IUCD insertion, with limited chances of success.

Health center providers are interested in referring clients for long-term permanent FP methods, but very few hospitals offer sterilization on a regular basis. Doctors are not equipped or

trained to perform minilaperotomy under local anesthetic, so the unmet demand for this method only continues to increase. If surgical methods could be offered on a regular basis by hospital based physicians, another contraceptive method--the implant--could easily be added to the choice of surgical methods. Since the implant is long-term but reversible, it could become very popular and would significantly increase the total couple years of protection.

Limited Hours for FP Services

With the exception of the six pilot health centers and few hospitals that offer FP services at all hours everyday, it is very difficult to get access to services. Health facilities that provide MCH/FP services on a schedule will provide FP only one or two days per week for approximately two hours. At a popular clinic a client will have to wait in a long queue for services. The introduction of integrated FP services has been very successful at the pilot study sites because client waiting time is reduced and satisfaction is significantly increased, and providers find they have more time to counsel patients. The nationwide introduction of the new integrated system will significantly increase the accessibility and availability of FP services for clients. All of the FPS project strategic sites will offer integrated FP services on a daily basis.

Logistics Management Information System

Stockouts of contraceptives and distribution problems to the district level and below have plagued the MOH FP program over the years. The high demand for condoms to prevent the spread of HIV has further increased the need to strengthen the logistics management information system (LMIS). Over the past six years, several donor agencies have provided contraceptives as well as logistical management support to the FP program. A Management Information System Working Group (MISWG) was established and has been responsible for the design of the improved systems for collection of statistics related to FP and HIV prevention service delivery and commodity distribution. The following forms were designed, tested and introduced were observed in the field: monthly stock report form, the FP clinic card, the daily register. The Medical Stores Limited (MSL) has become the distributor of MOH contraceptives which it ships to districts on a regular schedule with essential drugs kits.

The FP team noted that upon arrival in the district, contraceptives are separated from essential drugs which are administered by the pharmacist. Contraceptives go to the MCH/FP Coordinator who is not trained in logistics management. While a new stock report form was being used by the health centers and the districts, more training was needed to assure the health

workers fill is out correctly and actually ordered more stock based on their usage rates. Contraceptive products were not stored in an organized fashion. Health workers had no idea of how many contraceptives they actually had, and could not locate products which they thought were available. While none of the product expiration dates had passed, there were pills that had no date on the packaging or any indication of when they had been manufactured. .

The correct completion of the monthly stock reports and the forwarding of the information to MSL, will improve the overall operation as long as MSL has contraceptives to meet the district requests. At the present time there appears to be a stockout of VFTs and a limited supply of condoms. Ample supplies of three to six brands of pills were seen at every service delivery site. IUCDs were available at a hospital that was visited, but there was a problem finding a physician to do insertions. Realizing that contraceptive stocks were down, the MOH requested an immediate emergency order through ODA, and a follow-on five year project to provide technical assistance to MSL and additional contraceptive supplies. The FPS project should provide management assistance to the MOH MCH/FP unit to improve collection and analysis of data and the overall functioning of the LMIS.

A. MOH Integrated FP Services

By integrating FP services (IFP) with other MCH services and offering them on a daily basis, the accessibility of FP increases from 2 to 35 hours per week at each service delivery point. The change in schedule has been operational in six pilot clinics for over 18 months with no detrimental effects. Only limited project resources required to introduce this modification. MOH inputs that would facilitate the change would include an official policy guidelines that mandates the new daily IFP program. A training component to introduce new patient flow procedures and refresh clinical staff and non-clinical staff on FP motivation, counselling and method selection should be introduced with the scheduling change. The injectable FP method should also be introduced at this time. IEC activities should be carried out to inform the community of the new clinical hours for FP services, the increased range of methods that are available, and the new training that the health center staff have received to improve the quality of services.

Districts should inventory all of their corresponding health centers to find out before the project begins what are the hours of FP services, the training of the staff and the equipment and supplies available, and numbers of clients serviced. This baseline data should be used to select the health centers that will be the strategic sites, identify missing equipment and

supplies that must be provided and the appropriate staff member who should be trained. Follow-up inventories should be carried out each year to monitor and evaluation changes in FP services and clientele. This intervention should be easy to implement if staff receive adequate orientation regarding the purpose of the change, the advantages and disadvantages. Staff should be consulted and participate in introducing the new schedule.

B. NGO Community Based Distribution (CBD) Services

Three NGOs are implementing CBD projects with assistance from Pathfinder Fund. These activities have been successful. The problems have been related to the uncertainty of future funding. Under the FPS project, USAID will make a commitment to finance these three groups for 3-5 more years and will work toward developing mechanisms to increase their potential sustainability.

PPAZ is another local NGO (IPPF affiliate) that carries out CBD activities and is involved with the MOH in finalizing a CBD curriculum that will be official sanctioned for use across the country. ODA/UK has been working with PPAZ on a long-term strategic plan and intends to finance PPAZ CBD activities in several districts. It is recommended that the FPS project include PPAZ participation in a technical advisory role related to CBD activities, inviting PPAZ, the MOH and the three USAID financed CBD projects to come together to finalize the curriculum, develop training materials and master trainers, and share the CBD concept with other NGOs that might be interested in developing projects. The FPS project TAMT will administer a small grants program to up to 7 additional NGOs to carry out CBD activities in the strategic sites. While USAID does not plan to finance PPAZ CBD projects during the first years of the FPS project, PPAZ could request funds from USAID in future years if their ODA projects have been successful and ODA funds are not available for sites where USAID is working. Both donors (ODA and USAID) agreed to coordinate closely on CBD activities over the lives of their projects.

C. Employer Based Services (EBS)

ILO and UNFPA have worked with the Ministry of Labor to motivate and provide FP services in private companies, industries and parastatal organizations for the past 8 years. Motivational activities have been successful. Service delivery, however, needs to be strengthened. The EBS concept fits well under the strategic sites approach, because so many industries and factories are located in the strategic sites. Project inputs would include orientation for business and industrial managers regarding the advantages of having employees who use FP, training and equipping of service providers, developing linkages with other service deliverers for referral of clients interested in

long-term methods, and linking EBS projects with the PSI/PSZ contraceptive social marketing program to guarantee the supply of contraceptives. Although the Ministry of Labor introduces another management organization into the project, the MOL comes with substantial experience with FP projects and a unit that has a vehicle and audio visual equipment and materials that can support EBS interventions. Working with the MOL will also facilitate access to industry and business managers as MOL District Officers are responsible for industrial relations and are very influential with private sector managers.

D. Long Term Contraceptive Methods

The ZDHS pointed to a significant number of women who were interested in limiting births. Sterilization services are available in some hospitals but minilap under local anesthetic (ML/LA) is not widely available, and it is not easy to find a physician who will perform a tubal ligation. The project needs to develop capabilities at hospitals and then strategic health centers to offer long term methods including IUCD, implants, ML/LA and no-scalpel vasectomy (NSV).

It is proposed that in addition to training physicians to provide these services, clinical officers be trained in all four and nurses be trained to insert IUCDs and implants. This component will require training (out of country to begin with, where client loads are available to meet training requirements), equipment, some refurbishment of operating theaters, and good counselling and supervision. The program will begin with the district and mission hospitals in the strategic sites. It is important that this more sophisticated level of services be developed to expand the number of FP methods available and to provide backup and referral services for all FP providers at health centers. The program will not be complete until this element is fully developed.

E. Central Level Support

1. MCH/FP Unit--Policy Guidelines and Service Standards

The MOH must develop FP Policy Guidelines and Service Standards which set the minimum standard for service delivery and the parameters within which the districts can provide FP services.

2. MCH/FP Unit--Logistics Management Information System

Forms and training are needed to facilitate the gathering of management information on distribution and use of contraceptives and numbers of acceptors. The ODA will work with the Medical Stores Limited on the supply and logistics system, but the USAID project should provide technical assistance and local cost

support to link the MCH/FP unit with MSL and the districts. This will enhance the ability of the TAMT and the project manager to monitor project activities and measure impact. It is essential to the monitoring of the project and reporting in the Assessment of Program Impact (API). The TAMT should include short term logistics and management assistance.

F. FP Training

i. Pre-service Medical and Para-medical Curricula

In order to improve the sustainability of the delivery of reproductive health services when the DISH project is completed, the project will support the development of pre-service training curricula to incorporate the cadre-specific FP content and assist certifying bodies to include FP content in standard examinations of physicians, midwives, medical assistants and nurses. The project will also support training of pre-service tutors in FP service delivery skills so that they will be able to incorporate the FP content into pre-service training.

The introduction of the FP content into pre-service training curricula will reduce the need for in-service training to a growing pool of both established health personnel and new graduates. Instead, it will allow in-service training to concentrate on preparing established providers with the required skills for service delivery.

ii. MCH/FP Unit Training Division

The MOH MCH/FP Unit will establish a Master Training Team that will develop standardized in-service FP training curricula, provided training technical support to district and NGO trainers and assist with the development of district training sites.

To support the districts in their transition to district-level health services management, the MCH\FP Master Training Team will need to provide training and supervision technical support to the district trainers and supervisors of FP training and service delivery.

iii. District Level Training

The FP training program will include a comprehensive training and supervision package that will target the medical assistants, midwives and nurses at health centers. With technical assistance from the FPS project TA Team, the cadre-specific tasks for FP services including, STD screening, treatment and counselling for STD and HIV prevention will be identified, and the existing standardized in-service MCH/FP training curriculum will be modified to incorporate the cadre-specific content, including

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counselling skills for adolescents. Clinical training sites will then be identified and properly equipped before the first training activities begin.

With trainers from the MCH/FP Master Training Team the first training in FP services will be scheduled for selected clinical and community-based MOH and private sector practitioners. Trained personnel will be provided with the basic equipment needed to provide FP services at their clinical sites upon completion of training.

From this trained pool, individuals will be identified for further training skills development and will receive additional training to become in-service trainers for FP. Health practitioners from NGOs that provide FP training will be invited to actively participate in these training interventions.

In order to increase the capacity of medical workers to manage complications related to FP, a new module will be developed to train clinical officers and physicians in the management of FP complications. Training for VSC service delivery will be increased so that there are at least two sites per district.

These activities will contribute to the basic uniformity of FP service delivery according to the MOH standards and guidelines. Development of district-level training capacity will allow the districts to develop human resources according to their needs. The district trainers' primary, initial responsibility will be to develop clinical training sites to support district-level training. Training of community-based health personnel (community health workers, CBD agents and TBAs) will greatly increase accessibility to FP services, which in turn will increase the CPR. Increasing the capability of health providers to manage FP complications will contribute to the reduction of mismanagement which fuels the rumors related to FP methods and FP practice. It will also strengthen the credibility of providers by having in place a system to appropriately resolve FP related problems.

iv. District Supervision

Supervision activities have been neglected by district health officials due to lack of funds and personnel trained and motivated to carry out supervision visits. Using supervision forms, one of the first supervision interventions will be training of the key members of the District Health Management Team (DMO, DNO, DHE, DHI) in the utilization of health information for monitoring, evaluating and planning health services. A supervision tool will be developed and tested which incorporates the expanded features of FP service delivery standard. Training in supervision will emphasize the provision

of on-the-job training and problem-solving support to personnel at service sites.

In order to enhance the sustainability of district level supervision activities, the project will work toward the development of a mechanism to finance them. While the FPS project will initially support supervision activities the districts will progressively (each year) increase their financial contributions for supervision activities by setting aside a percentage of the user charges paid by health facility clients.

These activities will contribute to the project's aim of strengthening the districts' abilities to supervise health service delivery, utilize health data in planning for district health needs and establish an effective supervision system that improves the quality of reproductive health services.

G. Equipment and Supplies

For each FP service delivery point the project will provide basic equipment needed to deliver FP services, including blood pressure machines, stethoscopes, weighing scales, specimen collecting supplies, specula, IUCD kits/instruments, reusable gloves and visual aides. Delivery points that provide VSC will receive VSC kits and commodities and supplies required to upgrade operating theater facilities.

The project will supply contraceptives, purchased through the AID/W Contraceptive Procurement Project, including, OCs, IUCDs, vaginal foaming tablets, injectables, implants and condoms. Contraceptives will be provided to PSZ for social marketing program outlets, EBS and CBDS projects and to MOH facilities.

Although the project will not address the rehabilitation of health structures, coordination with other donors who would be willing to provide this support will be needed to upgrade the existing facilities to provide private and confidential expanded FP services.

3. IEC Activities

A. National Level Mass Media Activities

FP IEC activities have been underway for several years. The ZDHS indicated that urban women had seen television spots and heard FP information on the radio. Urban women also read newspapers and messages can be designed to reach them through this medium. Knowledge, attitude and practice (KAP) surveys have been conducted to identify which groups should be targeted and what information needs to be delivered. Focus groups discussions in preparation for this PP revealed that not much research has been

done on men's KAP and the findings revealed they were much more interested and supportive than was originally believed. In fact, men have felt left out of the MCH/FP interventions and expressed a desire to learn more about different methods and how they work.

Men have been specially targeted under this component as have teenagers, who begin sexual activity at a young age without good knowledge of the potential disease and pregnancy outcomes. The national campaign on television and radio will be broadcast to the majority of the FPS project strategic sites. Mass media campaigns are a good means to pass information, but should not be relied on to change behaviors. It is hoped that the result of the campaigns will be greater communication between husbands and wives about the need to plan the size of the family, and where to go to find the services.

Interpersonal communication and social mobilization will take place at the district levels where the project will support the training of FP motivators and the development of educational materials for clinic providers and for community clients.

Johns Hopkins University/Population Communication Services (JHU/PCS) project is proposed to be the implementor for this component. The Zambian Information Service (ZIS) was identified as the most appropriate counterpart agency because it is charged with implementing GRZ population education activities. It is the only agency with previous mass media experience. Working with ZIS, JHU/PCS will develop a research agenda and contract an individual or organization to carry out a baseline survey and FGDs to develop messages for target audiences (women, men and youth). A family planning logo will be developed to identify FP services delivery sites and distribution points. It is proposed that an advertizing agency be contracted to assist with the final production of spots and with media placement and monitoring. JHU/PCS and ZIS will work with the FPS project technical assistance management team (TAMT) that is charged with implementation of the FP services component to develop clinic and community based IEC interventions in the health districts that follow on the mass media messages and interventions.

B. District Level IEC Activities

Most district health facilities lack client materials, posters or any FP promotional materials. During field visits carried out in conjunction with FPS project development, consultants only found posters at some facilities. There were no simple printed materials for clients or health workers.

Under the FPS project IEC component, the MOH and all NGOs that provide FP services will combine efforts to develop an FP logo, client brochures, practitioner signboards, posters, stickers and

radio advertisements. IEC messages and materials will be designed for specific target groups that include men, adolescents, and high risk women. Materials will be prepared in non-literate designs and in several local languages. The FPS project will finance research and the results will be used for the development of IEC messages and materials. The FP logo, provider signboards and posters will be distributed at the FPS project strategic sites. Radio ads and radio dramas will be incorporated into the district IEC plans. In addition to providing information on the location of FP services and the FP methods that are available, IEC messages will counter the prevailing rumors about contraceptive methods and will also include messages on HIV/STD prevention and detection and treatment of STDs.

Client level materials on specific methods and responses to the most common questions and rumors about FP are priority topics. The JHU/ZIS team will assist districts to tailor materials to the local language and cultural environment by organizing workshops on materials development and facilitating materials production and distribution.

The development of a training curriculum for FP motivators will also be designed for the health assistant level. In districts named as strategic sites, health assistants will be trained to promote FP and train community health workers and TBA to promote child spacing and to refer clients to the health clinics for FP services.

4. POLICY AND OPERATIONS RESEARCH

A. Policy

Upon investigation of the policies that constrained the implementation of the family planning program, the PP team members determined that they were not as significant as they originally seemed. Efforts were already underway to legislate a new Nurses and Midwives Act. There were no restrictions to registration of injectibles or implants. The most pressing need was for the MOH to issued family planning program guidelines, standards and procedures that specified the methods included in the program and the appropriate care givers and sites of service delivery for each method. The GRZ fully supports the implementation of the 1989 Population Policy.

What became evident from the meeting with the Minister and Deputy Minister of Health was that they themselves were not clear about the legal constraints posed by the present laws and regulations and those newly proposed acts which are undergoing approval at this time. They requested short term technical assistance to review and make recommendations on further legal interventions needed to fully support the family planning program. It was

determined that this component would support that request for technical assistance at this time. With the health reform program being only in the initial implementation stage, it is not feasible to determine what future actions will be needed to support the policy reforms. When USAID develops its Child Survival intervention next fiscal year, these policy issues for the health reform should be revisited and any outstanding issues should be addressed in the next project.

B. Operations Research

The operations research projects that are described in the PP document have been included to provide information and test financing schemes that fit under the new health reform program. While this was originally envisioned to be a major component of the FPS project, it has been relegated to a smaller activity under the operations research component.

The team also considered other possible OR projects that might be carried out under the project. It was felt that in addition to the financing studies, there will be need to examine other aspects of family planning service delivery. The Population Counsel has carried out studies on the introduction of NORPLANT and on abortion practices. Any studies that are identified as a result of project implementation issues, should be financed under this component.

5. PROJECT MANAGEMENT AND ADMINISTRATION

The major issue for the USAID/Zambia mission is the need to fill the BS-50 position for a direct hire Health Population and Nutrition Officer. The health and population portfolio has grown to a significant size and the need for an experienced HPNO is acute. This mission has been recruiting for this position since January 1993. The position should be filled within the next six months. In the meantime, REDSO/ESA/HPN technical assistance should be regularly scheduled to assist with the launch of the FPS project.

SOCIAL SOUNDNESS ANALYSIS
OF THE FAMILY PLANNING SERVICES PROJECT
USAID/LUSAKA

ANNEX H

LIST OF ACRONYMS

CBS	Community Based Services
CHW	Community Health Worker
CMAZ	Churches Medical Association of Zambia
CSM	Contraceptive Social Marketing
DHS	Demographic Health Survey
EBS	Employer Based Services
FLMZ	Family Life Movement of Zambia
FP	Family Planning
FPIA	Family Planning International Assistance
GRZ	Government of the Republic of Zambia
IEC	Information, education, communication
IPPF	International Planned Parenthood Federation
ITCP	Inter-Agency Technical Committee on Population
KAP	Knowledge, Attitude and Practice
LAM	Lactational Amenorrhea Method
MCH/FP	Maternal and Child Health/Family Planning
MOH	Ministry of Health
MOIBS	Ministry of Information and Broadcasting Services
MSL	Medical Stores Limited
NCDP	National Commission for Development Planning
NFPP	National Family Planning Programme
ODA	Overseas Development Administration
PPAZ	Planned Parenthood Association of Zambia
PSI	Population Services International
PSZ	Pharmaceutical Society of Zambia
SDP	Service Delivery Point
SNFP	Scientific Natural Family Planning
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
WHO	World Health Organization

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I. OVERVIEW OF THE INSTITUTIONAL FRAMEWORK FOR IMPLEMENTING THE POPULATION POLICY

A. Role and Responsibilities of the GRZ

In 1984 the National Commission for Development Planning (NCDP) - now the Ministry of Planning and Development Cooperation - was given the mandate to initiate a draft population policy which would aim at achieving a population growth rate consistent with the growth rate of the economy. The National Population Policy was launched in May 1989. One of the objectives of this policy was to integrate population factors into the nation's development planning and the plan implementation processes.

The National Population Policy set some concrete goals to attain by the year 2000, namely, to reduce the rate of population growth from 3.7% a year in 1989 to 3.4% a year; to reduce the total fertility rate from 7.2 to 6; and to increase the family planning prevalence rate from 8.9% to 25%.

According to a needs assessment conducted by Pathfinder in January/February 1991, some of the overarching problems which the NCDP has had in implementing the policies are summarized below:

1. programming is uncoordinated and piecemeal, reflecting donor rather than national priorities;

2. an overstretched staff who lack familiarity with past and ongoing activities and the experience to be effective coordinators and catalyzers of population-related initiatives;

3. no system for collecting and disseminating information on programs, resources of manpower and equipment, training or research; and

4. no operational plan for strengthening coordination or for participatory agenda- and priority setting.

Since the National Population Policy was published in 1989 and since the Pathfinder assessment, two significant events have occurred:

(a) a new government has come into power (November, 1991). Although the new regime has put into question everything introduced by the outgoing government, support for implementing the National Population Policy has continued. The NCDP spearheaded the effort to engage the incoming political leaders, as is evident in the July 1992 seminar held on the national population policy specifically for the new political leadership.

(b) The NCDP has also issued a National Family Planning Programme (NFPP), 1992-2000 (July, 1992) which has four components: service delivery; commodity and equipment logistics; information, education and communication; and training. It just completed the design for the Population IEC (information, education, communication) programme the end of May 1993. The programme is intended to build on previous activities as well as to establish a framework for the activities of all relevant players - government, NGOs, donors, private sector.

To date, policy implementation has been carried out by the Inter-agency Technical Committee on Population (ITCP) whose function is to reinforce the institutional capacity for program design, development, coordination and evaluation. The ITCP is also the mechanism for bringing together government, NGOs, donors, and the private sector on the issue of population regarded as a cross-cutting theme. The ITCP has established subcommittees, such as health systems research, IEC, among others, to build better collaboration. Issues of collaboration are discussed in more detail below.

Below is a description of the four components which constitute the national family planning strategy and the MOH decentralization plan for health care delivery.

- **Service Delivery**

The national program is promoting FP services through four types of services: (a) Community Based Services, (b) Employer Based Services (EBS), (c) Contraceptive Social Marketing (CSM), and (d) the clinic-based Integrated FP services (MCH/FP). These components are discussed in detail in section II.

- **Commodity and Equipment Logistics**

Commodities under the Family Planning program to date are received by the IPPF-affiliate, Planned Parenthood Association of Zambia (PPAZ) and the MOH with funding provided by UNFPA. Apparently, 52.3% of the service delivery points reported having run out of family planning commodities at the end of 1991 and 16.2% reported receiving supplies irregularly (NFPP, 1992:24). More than half of all service delivery points reported having had expired commodities in the past and the major reasons for this were: (a) low clientele, (b) over-supply, (c) available commodities or brands not popular with clients, and (d) commodities were supplied to them when about to expire.

A subcommittee (Management Information Team) was established by the MOH in November 1991 to move commodities from the MOH and the PPAZ to Medical Stores Limited (MSL), a MOH-owned parastatal. Both the MOH and NGOS have been responsible for procuring and distributing commodities, equipment and supplies. The national strategy is to deliver all FP commodities to the **Medical Stores Limited**, to send out to the provisional level pharmacies, then to districts, and finally to clinics and FP outlets. The rationale for this strategy is to enable procurement discounts by buying for the nation, establish an accurate information database on

usage, and ensure continuity at all service delivery points (SDPs) in three of MOH's four proposed strategies: service-based FP, employer-based FP and community-based FP. Commodity flow monitoring system which includes orders, receipts, stock holdings and distribution has to date been unavailable in the MOH but under the new system these problems are being addressed.

Family Planning International Assistance (FPIA) was supporting population activities in Zambia, which included distribution of contraceptives, until mid-1990 when funding from USAID ended. This led to major stock-outs because the MOH did not find alternative sources in time nor was it able to indicate or project its contraceptive requirements.

The USAID HIV/AIDS project is supporting a social marketing strategy for condoms through Population Services Inc. (PSI) in conjunction with the Pharmaceutical Society of Zambia (PSZ) which is a private organization founded as a trade association and lobby group for public and private sector pharmacists. Distribution of condoms to the private sector (retail outlets, company/institutional hospitals) and employer-based clinics is carried out through the PSZ responsible for the population policy's fourth strategy, social marketing. The PSZ has been active in contraceptive retail sales since 1985 with support from FPIA until the 1990 stock-out. It has since received a commodity grant from Pathfinder under which it is selling spermicides, IUDs and oral contraceptives to the private sector outlets.

The contraceptive supply chain in Zambia has been extremely problematic. At the root of the problem is Zambia's family planning history which developed in an uncoordinated fashion out of separate interests of NGOs and donors. In the absence of a population policy (until 1989) the Government relied on donors, without insisting on guidelines. In June 1993 the GRZ requested assistance from ODA to cover (a) emergency supply needs for the period of November 1993 to December 1994 and (b) all MOH contraceptive supplies for the next five years (see section III.C.1 for more details).

- **Information, Education and Communication (IEC)**

The GRZ has a National Population IEC Program to promote the most appropriate use of all available IEC channels. The UNFPA has been instrumental in the IEC activities carried out by government departments and in supporting a number of NGOs involved in the sector. Material production includes design and printing of posters, television and radio spots, etc. The responsibility for building public opinion lies with the Zambia Information Services which is part of the Ministry of Information and Broadcasting Services (MOIBS). There is an IEC subcommittee to the ITCP and is headed by the Director of the Population Communication Unit of MOIBS. It consists of representatives from various ministries (MOH, NCDP, Labor, General Education) as well as NGOs. The new plan for the IEC Program designed by the NCDP became available the end of May, 1993.

- Training

Family Planning Training in the past has been minimal and un-coordinated. Historically, the GRZ has provided education and training for the health services, both for pre and in-service training. The MOH MCH/FP Unit coordinates family planning services has been conducting a revised integrated MCH/FP in-service training for health workers since 1986. Training is provided one to four times a year and is dependent on availability of financial and human resources. The General Nursing Council has been active in pre-service FP training by assisting with strengthening the FP curricula of all schools of nursing in 1992. The practical component still remains a weakness in the training programs.

There is a shortage of trained, practicing, MCH/FP service providers at all levels. Many of the service providers trained in previous programs, including out-of-country training, have either left the country to work elsewhere or are not actively practicing some of the techniques learned during training. The move towards decentralization will transfer much of the training responsibilities to the District Health Boards.

- **Decentralization**

The Ministry of Health has initiated a plan for decentralizing health care delivery which will give autonomy to the districts for planning their programs and obtaining resources and managers. The MOH itself is playing a prominent role in putting through the legislation for decentralization which will be fully in place by January 1995. The plan will allow for the provision of basic primary health care (PHC) packages directly to the district under the direction of district health boards. Hospitals will increase their autonomy by having their own budget or block grant and a health management board and will supplement MOH funds with user fees. The provincial level will provide storage, auditing, technical assistance and some training. (See Annex B for details.)

B. The Role of NGOS, Donors, and the Private Sector

- **NGOs**

UNFPA, PPAZ, and the Family Life Movement of Zambia (FLMZ)[1] provide material, financial and technical assistance and operate family planning clinics, supplementing the efforts of the Ministry of Health (MOH). Other major providers are the Pathfinder Fund working with Makeni Ecumenical Center and the Adventist Development and Relief Agency (ADRA) and some members of the Churches Medical Association of Zambia (CMAZ) also provide family planning services.

The Makeni Ecumenical Center provides family planning services at the Makeni clinic, mobile sites in peri-urban areas of Lusaka and Kabwe rural; distributes contraceptives in over ten CBD

[1]See also section IV.A, under subheading "religion" for more details on FLMZ.

areas; and training of CBD workers. ADRA provides family health/child spacing IEC and counseling in self-help clinics as well as contraceptive distribution through a CBD network of the all-women Dorcas Family Health Project in Kabwe District, among others and has another CBD project in Chipata. Pathfinder provides support for the Makeni and ADRA Projects through an A.I.D. Washington project.

CMAZ is responsible for 50% of the health care service delivery in rural Zambia and 30% of health services in whole country. CMAZ is made up of 86 member institutions, 32 of which are hospitals and 54 rural health centers. There is much variability in the type and amount of family planning services they provide.

Over the past 21 years, PPAZ has established family planning services through 34 branches in 34 districts spread out over all nine provinces. Margaret Mutambo, the Executive Director of PPAZ, feels that NGOs have been very effective in promoting population programs. They are nonetheless constrained by such factors as irregular and unreliable financing. They are also mostly urban-based and funded almost entirely from outside the country. But once identified and provided with the necessary support from the political leadership, their activities would be greatly expanded.

PPAZ also has a Model Clinic in Lusaka which opened in 1988 which was intended to allow integration of services as well as to serve as a training site for industrial and MOH nurses. Among its other objectives were: (a) to provide services at minimal cost, (b) offer a choice of methods and limit the number of brands, (c) enable nurses to take responsibility for counseling and inserting IUDs, i.e. that a physician was not necessary, (d) establish quality of care (fewer users who achieve continuity in use is preferred to a larger number of users who abandon family planning), (e) encourage client evaluation of the facilities, and (f) introduce management of family planning services. There is a considerable need to plan for supplies, maintain a sufficient stock, monitor quality of care, and ensure consistency in record-keeping and reporting. Medical staff cannot be assumed to have these skills when starting out.

- **Donors**[2]

The UNFPA is the largest single donor giving financial assistance to population and related activities. It is reported that disbursements to UNFPA-funded projects in the area of population and development amounted to US $ 9.2 million from 1988 to 1992 (Muchelemba, 1993:133). UNFPA is involved in virtually all sectors of the GRZ's population programme: population policy and development planning; population dynamics; population data collection and analysis; maternal and child health/family planning; IEC; and women, population and development. UNFPA's next three-year plan is supposed to be finalized in September of this year.

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[2]See Section II.E for a more detailed outline of donor activities.

Other donor agencies have contributed various degrees and types of assistance to population and family planning activities. UNICEF focuses on maternal and child health/universal child immunization, control of diarrhoeal diseases, and sexually transmitted diseases. NORAD had provided assistance to the MCH/FP project in strengthening its services and in data collection and analysis. It also contributed to the DHS and to the national HIV/AIDS prevention and control activities. For a five-year period, NORAD financed the costs of PPAZ in establishing its 10 branches, in addition to providing motorcycles for all the branches. NORAD is interested in an improved contraceptive distribution network. SIDA provided bilateral funds for the purchase of contraceptives for the MCH/FP programme and supported the MOH in its essential drug kit program as well as HIV/AIDS prevention and control. SIDA is also the lead donor in the management aspects of health care and will be developing a project to support sex education in the schools. ODA/UK is supporting PPAZ in the development of strategic planning and will be strengthening its management capacity. ODA financed an emergency supply of contraceptives through the MOH through December 1994 and will be the major supplier of contraceptives to the GRZ program over the next five years. In addition to contraceptives, the ODA project will also strengthen the contraceptive procurement and distribution capacity of Medical Stores Limited (MSL). FINNIDA is providing technical assistance to PPAZ in training and the development of community-based service programmes. GTZ is supporting an integrated rural nutrition programme in one district in Luapula Province and Ireland supports ante-natal and maternity services in urban maternity clinics (UNFPA, 1993). DANIDA is supporting the MOH to provide basic packages, salaries and vehicles at the district level and training of district managers under the health reforms' decentralization program. The EC has been rehabilitating infrastructure and providing medical equipment. The Dutch are supporting primary health care activities in the Western and North-Western provinces.

The World Bank has played the role of coordinating meetings with the GRZ and the donor agencies. It also carried out a review of the health sector in Zambia in 1992 which consisted of seven studies (A-G), one of which was focused specifically on population and family planning (E). Because of USAID's family planning intervention, the World Bank is reconsidering its plan to fund a population project in 1994.

- Private Sector

There is an unspecified number of private clinics mostly in the cities and towns. Most private family planning services go unreported, according to the World Bank Health Sector Review. There are also private medical practitioners, nurses and pharmacists who are not legally supposed to prescribe oral contraceptives, but sometimes do. In the big cities, specialist doctors offer an alternative service for VSCs, abortions and infertility treatment for those who can afford it. According to the DHS, 36% of current users of modern contraceptives are supplied by the private sector.

The Pharmaceutical Society of Zambia, as previously mentioned, offers contraceptive social marketing strictly to the private sector through 136 retail outlets composed of pharmacies, drug

stores, ZCCM Ltd., mine hospitals, and supermarkets in Lusaka, Central, Copperbelt, Southern, Northern, Luapula and Eastern provinces.

C. Areas of Collaboration Between the GRZ, NGOS, Private Sector, and Donors

With the GRZ's population policy in place and a national family planning programme developed, the country is in a better position than ever before to coordinate and phase-in family planning activities as well as provide a framework for coordinated donor support to these activities. As ambitious and comprehensive as its family planning programme is, the MOH will need a tremendous amount of resources to implement it, particularly in view of in the decentralization of functions to a more local level. Moreover, the decentralization plan under the MOH fits into the larger context of Zambia's transition to a more liberal economy which will require concomitant, across-the-board changes in behaviors away from public sector support.

The family planning programme, therefore, should serve as a "channel" to donors for planning their interventions. Most of the donor projects mentioned above are discrete and limited forms of assistance. If the MOH is to succeed in implementing its programme and decentralization plan, it needs consistent support and a large commitment from a lead donor. USAID's family planning project would assist the MOH in each of the four components and in the process retain and strengthen the implementing NGOs which have contributed to the government's family planning activities to date. Apart from public sector family planning activities, there is also a key role to be played by PSZ whose capabilities in contraceptive social marketing would be strengthened to expand availability of contraceptives through private sector channels.

II. EXISTING SERVICE AVAILABILITY AND ACCESSIBILITY

The following sections A through D describe the types of service mechanisms available and the GRZ's plans to improve and expand them.

A. Integrated Family Planning Services

One of the aims of the National Family Planning Programme is to deliver family planning services through Integrated Family Planning (IFP). This involves provision of family planning services, together with MCH, reproductive health and other curative services on a daily basis in all the health institutions in the country. It was estimated that, given the number and spread of health centers in Zambia, probably 75% of the population now live within 15 km of a health facility. Generally, though, rural areas are deprived of adequate staff.

Pilot studies in the integration of MCH/FP were carried out in selected health centers of four districts: (1) Kabwe Urban (Nakoli and Poleni clinics), (2) Kaoma (Mbanyutu clinic), (3) Lusaka Urban (Chelstone and Chilenje clinics), and (4) Mazabuka (Magoye clinic). The original design called for 15 pilot clinics but funds were available to cover only six. Positive evaluation results

support a rapid expansion of the program to MOH facilities with trained personnel (family health nurses). The target set in the NFPP is an increase from 5.8% (113,800) of family planning users in 1992 to 15.4% (402,100) by the year 2000 (p. 48).

The evaluation of the six trial health facilities, most of which had been involved in integrated MCH/FP for a year, conducted In September-October, 1992 revealed positive effects in reducing staff workload, the provider-client relationship, reducing client waiting time, the learning process of staff due to wide exposure, and the quality of care within the service delivery area of the clinic. In fact, the integrated clinics in Chilenje and Chelstone have increased client load because clients prefer them to other clinics.

B. Community-Based Services

Community-based services refers to the delivery of family planning services, supplies, and information within the community utilizing local resources through community agents. Apparently, this approach is being implemented on a small scale by some NGOs, notably the Makeni Ecumenical Center, the Adventist Development and Relief Agency at its Dorcas and Chipata clinics, PPAZ, and FLMZ. PPAZ's CBD programme is active in Lusaka and Ndola districts and Makeni provides CBD services in ten areas in Lusaka province. This approach is especially intended to cater to densely-populated areas and the underserved populations in rural, urban and peri-urban communities. The NFPP calls for pilot studies to be undertaken, as for the IFP option and sets a target of 59,500 women (or their parents) served by this strategy by the year 2000 (up from 6,000 in 1992). A CBD training curriculum has been designed and needs testing before it is finalized.

C. Employer-Based Services (EBS)

This option is aimed at providing family planning services as an integral component of the health services provided by employers to their employees. These are generally companies that employ a large enough staff to justify an investment in family planning as part of their overall health care package. These would include commercial firms, government departments, training institutions, agricultural farms, and so on, in rural and urban areas. All non-surgical family planning methods will be provided by this option. The provision of IUCDs and other surgical family planning methods will depend on the availability and competence of the health personnel and the adequacy of those facilities. The health personnel will be trained in all aspects of family planning service delivery. The target set by the NFPP for employer-based services is an increase from 0.3% (6,300) of family planning users in 1992 to 2.1% (54,600) in the year 2000 (p. 58).

Companies with clinics will be given incentives to include family planning services by being exempt from paying the annual registration fees to the Medical Council of Zambia, after payment of the initial registration fee (p. 60).

The degree to which the CBD and EBS approaches have been implemented systematically and effectively to date has not been ascertained. No inventory has yet been done of the number of employers that provide clinics for their staff.

D. Contraceptive/Commodity Social Marketing (CSM)

Contraceptive Social Marketing means making family planning commodities available to potential users and at affordable prices through commercial outlets. The pill, IUCD, fertility thermometers, charts and non-prescriptive family planning methods will be available for purchase through this option, but clinical procedures will not, according to the NFPP. The target of the NFPP is an increase to 2.3% (61,100) of family planning users by the year 2000, up from 0.5% (10,500) in 1992 (p. 62). Various agencies will be encouraged to establish outlets and/or expand CSM activities to meet the target. Operators under this option will also undergo training or retraining in social marketing of family planning commodities.

E. A Summary Analysis

The four components should serve to maximize delivery and availability of family planning services for the whole country, beginning with specific districts selected by the MOH and gradually expanding. While all four of the strategies are essential to improving the supply side of family planning, the availability and accessibility of these services need to be linked to a clear indication of the demand and where the demand is located.

The data from the DHS on demand from married women by age group, urban or rural residence, province and education, is the best available source of information. The unmet demand for family planning (for spacing and for limiting) increases progressively with age, from 15 to 39. Total demand for family planning is 55.2% for urban areas and 42.9% for rural areas. The total demand for currently married women by province in descending order is as follows:

Copperbelt	58.3
Lusaka	54.7
Northern	52.6
Southern	45.6
North-Western	44.9
Eastern	44.8
Western	39.0
Central	35.8
Luapula	35.1

One-third of married Zambian women have an unmet need for family planning services. Combined with the 15 percent of married women who are currently using a contraceptive method, the total demand for family planning comprises almost half of the married women in Zambia (DHS, 1993:73).

It is clear from both the NFPP information of service providers and the DHS that women of reproductive age (15-49) constitute the largest target group for family planning services. However, other family planning acceptance surveys indicate that men and adolescents also need to be targeted, particularly since clinics have not encouraged them to come for counseling in family planning. How those messages should be delivered is discussed in the IEC section of the project paper.

III. DE JURE AND DE FACTO REALITIES OF SERVICE PROVISION

A. Macro-Level Policy Guidelines[3]

The Nurses and Midwives Act of 1970 is the referral document which sets standards for, among other things, administering contraceptive methods. According to the Act, physicians are permitted to administer contraceptive methods, such as dispensing the pill or inserting IUDs. Although the language does not exclude trained or qualified nurses from this practice. the latter perceive it as risk without the backing of a physician. The Act is currently under review by the MOH and the Nurses' Council has recommended to government that appropriately trained nurses be able to act independently of physicians. The MOH responsible for proposing the legislation expects it will go into effect by January 1995. The MOH is now in the process of developing policy guidelines and standards to explicitly give nurses the authority to administer contraceptives.

The Drugs and Poisons Act is also germane to the marketing of contraceptives, as it does not permit advertisement and dispensation of contraceptives by pharmacies and stores. This legislation is also to be amended under the National Family Planning Programme. The MOH, nonetheless, has the authority to exclude oral contraceptives from the advertising prohibition, provided they are being promoted for social welfare purposes.

The MOH abandoned injectables in the early 1980s, even after Depo Provera had been successfully used, due to public opinion in Zambia and an international controversy over the safety of Depo. The World Health Organization's announcement at a meeting in Lusaka in June of this year that the contraceptive Depo Provera has been officially approved as safe for use by women (The Times of Zambia, June 3, 1993) is sufficient grounds for the Pharmaceutical Division of the MOH to request registration of Depo by the Pharmacy Board.

B. Micro-Level Rules/Regulations

Some clinics insist on written permission from husbands for contraceptives, while in the case of surgical contraception, spousal consent is required (tubal ligation for females and vasectomy

[3]See also section III C.1 for a discussion of policy and regulatory implications.

for males). Provision of family planning for unmarried people is a grey area and staff attitudes towards family planning are sometimes inappropriate, regardless of the client's age. Some health providers maintain divergent views on family planning service delivery that are inherent in their religious inclinations. Whether the health provider is not adequately trained in family planning counseling or is not favorably disposed to the use of family planning methods, the result is discouraging the acceptance of family planning and building reluctance among potential users to seek family planning services at all.

A Fact Finding Mission in 1991 reported that 24.3%, 28.4% and 10.3% of health providers interviewed acknowledged having refused services to adolescent pupils, wives without consent letters, and unmarried persons, respectively (NFPP, p.23). A 1989 Rapid Evaluation of MCH/FP services showed that health providers (73.2%) are more willing to provide family life education for adolescents and 62.9% support providing them with counseling, but only 36.1% favored actually providing them with methods.

Another deterrent which has been cited is that some clinics charge for family planning record cards which can be prohibitive for some clients.

[This section should benefit from questions on micro level regulations in the female acceptance survey.]

C. Structure and Availability of Services at Delivery Points, Including Information

The MOH June 1993 report on Health Facilities lists 1036 health centers for all of Zambia. Of the total, fifty to sixty percent offer family planning services. The World Bank Health Sector review reports that service delivery points are distributed unevenly and inequitably. The problem is worst in regions of low density and scattered population, away from Lusaka with its principal road network. Facilities in peri-urban areas are also lacking. Under the MOH decentralization plan control and resources will be shifted from the capital to the periphery and service delivery points will be expanded and improved under the direction of district health managers.

Until recently, family planning services were offered for a few hours/week, separately from other MCH activities. Now, mission and MOH clinics are moving towards integrating MCH/FP into everyday MCH activities, with six MOH pilot integrated clinics already in place: two in Lusaka, one in the Southern Province, one in the Western Province, and two in Kabwe.

Rural health centers (RHCS) vary in the range and quality of family planning services in terms of staff and equipment. Among the RHCs which have registered acceptors, they are getting between 5 and 10 new acceptors/month. Rural health clinics can offer condoms (in the drug kit), oral contraceptives, foam tablets, and basic advice on family planning and infertility. In urban areas, one clinic in Lusaka, for example, have had an increase in acceptors from under 100 in

1990 to 676 in 1991. Inadequate staffing, however, has been identified as a serious problem prevalent among health centers. These centers offer the same methods as the rural clinics.

Hospitals have doctors some of whom perform surgery - tubal ligations and terminations of pregnancies. They can also offer IUD insertion if a physician has been trained. There are 3 central referral hospitals, 9 general hospitals and 8 specialised and other government hospitals. There is also the University Teaching Hospital (UTH) which offers family planning services and abortion services. The UTH has a family planning clinic which is meant to be a referral facility but also handles patients who are self referred. It shares facilities with other clinics and has the same hours each weekday as the gynaecological out patient service. Some hospitals do not carry out abortions and others carry out up to 24 a year.

The range of methods is limited at almost all delivery points. The World Bank conducted a study which found that several women were only offered oral contraceptives. Oral brands were limited or different brands were given each month. Post-partum patients were often not seen until after their first post-partum period, by which time some had become pregnant. IUDs were rarely available, the supply of condoms varied, no injectables were available, and VSC was essentially unavailable. Method switching was frequent. Counsellors for natural family planning are not widely available, and legal abortion is only accessible in large centers in urban areas or in the private sector for a cost (Study E, p. 28). Information, education, and communication (IEC), an important accompaniment to family planning services, is available in the form of posters, leaflets and other materials developed by PPAZ, but are not very targeted. Districts will need to develop their own IEC programs under the decentralized system which will lend itself to translating the messages and targeting audiences more appropriately.

The MOH has a health information system. Routine information is kept at different service delivery points, but, according to the World Bank review, does not allow staff and visiting supervisors to see trends or problems. The hospital delivery book, for example, does not always show which patients are presenting as normal and which are high-risk. The information which goes from the district to the central level is collated but does not always return to the district. There are research institutions such as UTH and the University of Zambia which do operational research and in-depth anthropological studies but little collaboration exists between them and the MOH staff to date, in particular, the Family Health Unit responsible for research and surveys.

IV. SPECIFIC SOCIAL AND GENDER-BASED CONSTRAINING AND REINFORCING FACTORS

Section IV and subsequent sections of this report rely on empirical data from narrative secondary sources, interviews with health care professionals, and on two social acceptance studies. The two separate studies are (1) a survey carried out by the MOH MCH/FP Research and Evaluation Division on the low utilization of family planning among a sample of 400 women aged 15-49 in four provinces and eight districts: in Eastern province, Chipata (urban) and Petauke (rural); in Southern province, Livingstone (urban) and Gwembe (rural); in Lusaka province, Lusaka (urban) and Lwangwa (rural); and in Luapula province, Mansa (urban) and Chelenge (rural). The data collection and entry had just been completed and, since the analysis had not yet been started, the findings for this report are based on a random sampling of the 400 cases requiring further verification when the final analysis is made. Hence, findings incorporated here should be treated as tentative and are not for quotation. (2) The second study on male attitudes was commissioned for the purpose of this project paper and carried out by two nurse tutors at the University Teaching Hospital in Lusaka. The objective was to obtain some impressions of the role and attitudes of men in family planning through focus group discussions with men as well as interviews with traditional healers and community-based distributors for their role in communicating information and methods for family planning to both men and women. Because the appraisal study sought to capture a variety of characteristics in a short amount of time, it could best be called a pilot test case. Yet, the findings were revealing enough to suggest how little is known about men's knowledge, attitudes and practices and how neglected they have been in the design and orientation of family planning interventions.

The male study was carried out in seven sites in five provinces. Twelve focus group discussions were conducted with men, ages 18 to 99. The groups were comprised separately of marketeers; college students; workers in a health institution, Zambia Railways Work Plant, Bata Shoe Company; and elders in the villages. Eight interviews were conducted with traditional healers, half of whom were women, and two with community-based distributors. A separate, final report is available from USAID/Lusaka.

Throughout the remaining sections, the first study will be referred to as the "female study," and the second, as the "male study."

A. Social and Environmental Factors Influencing Family Planning Behavior

Structure of the Population

According to a 1991 study (Mukoboto, 1991) Zambia is characterized by a large proportion of young people. Forty-eight percent of the total population is made up of people under 15 years of age. The population of dependents (under 15 and over 64) is half of the total population. For each person in the working age group, there is one dependent. The percentage of females

in the reproductive age group (15-49) is 22% and expected to continue to increase, given the number of females under 15 years of age. Hence, mothers and children will constitute the largest proportion of the total population. The population of women in their reproductive ages is expected to increase from 1.7 million in 1988 to 2.63 million by the year 2000 based on a constant population growth rate of 3.7%. The increase in the dependency ratio upon the economically active population, coupled with the predicted impact of HIV death rates, will tend to affect women more profoundly because they bear the primary responsibility for caring for the sick and dying in addition to their contributions to their children's and families' welfare. Treatment of surviving widows under customary law is another reason discussed under the section on the laws governing marriage and fertility.

Cognizance of the demographic trends in gender terms would need to be taken by the policymakers, in addition to the other arguments being articulated for formulating a population policy for the nation.

Gender-Based and Rural/Urban Disparities

The status of women in Zambia is generally not very high. "The low socio-economic status of women puts them at a disadvantage, whether it be in gaining access to information, influencing the process of making decisions with their husbands, or being able to stand up for their right to protect themselves against unwanted pregnancies and infections." (World Bank, 1993:11).

Given the recent political changes in Zambia, this assessment was made by the Central Statistical Office: "It was assumed that both men and women would benefit equally from the development process. However, experience has shown that women have tended to lag behind their menfolks in all fields, and have tended to have a limited access to land, capital, gainful employment, and positions of decision-making" (ibid.).

Since the change in government in 1991, the situation for women in politics has actually worsened. There is now no female member of the Cabinet comprising 23 ministers. There are five women among the 36 deputy ministers (13.9%); and four women out of 38 executive committee members (10.5%). At the top of a number of important institutions, for example, the district governments, men occupy all or almost all the top positions. Women now form a higher proportion of the seconds-in-command (ibid., 10). It is reported that in the Ministry of Health, for instance, leadership roles are male-dominated. Also, most senior planners and managers are male physicians.

One of the strategies for achieving the goals of the National Population Policy is to "improve the status of women through the removal of various social, legal, administrative, and cultural barriers to their effective participation in national affairs in order to enhance their participation in national development efforts and as a way of ensuring demographic transition from high to low population growth rates" (NPPP, 1992).

Accentuated differences exist between the rural and urban economies and populations. This is largely as a result of the mining sector which employs a largely male workforce. Zambia has a mixed economy consisting of a modern and urban-oriented sector confined to the rail line running from the Copperbelt to Livingstone and a rural agricultural sector. Both Lusaka and the Copperbelt Province are heavily urbanized with average density in 1990 at around 50 people per square kilometre as compared to 3 people per square kilometre in the North-Western Province (DHS, 1993:3).

There has been almost continuous migration of people to mining towns and urban centers, resulting in 40% of the population living in urban areas. The proportion urban varies among the provinces from 91% in Copperbelt Province to 9% in Eastern Province. Regional disparities have contributed to a polarization of gender roles. For example, in Lusaka men outnumber women and in the more remote areas, women outnumber men. Women frequently become de facto household heads because of the death of the husband; because he has left to seek work; or because the union has ended. Lusaka has 21% female-headed households and Eastern Province has 38%, according to 1980 figures (World Bank, 1993:8).

Two issues emerge in relation to regional disparities: (1) like any other service or good, family planning is more concentrated in urban areas; and (2) Male migration and female headship constrain women's ability to profit from economic or educational opportunities and increase the women's burden to raise and educate her children. It also reported that the absence of men compels young women to enter into polygamous marriages and temporary unions. In places like Luapula, this has had a disruptive effect on child-spacing, resulting in high parities that endanger the health of both mother and child (GRZ and UNICEF, 1986:20).

Religion

Zambia is 60 percent Catholic. The Catholic Church, through the Family Life Movement of Zambia (FLMZ), has had significant influence nationwide on views about fertility and population issues. The philosophy of FLMZ, as it exists today, is that (1) every individual has a right to space their children, independently of the number of children desired, and (2) given the broader impacts of high fertility and rapid population growth rate on the economic development of the country, they advocate natural family planning but ensure, in their outreach education programs, that individuals are given an overview of all available contraceptives. As of June 1992 FLMZ had 217 active teachers in "scientific natural family planning" (SNFP) with supervisors at the local, district and provincial levels. The teaching system has administrative staff in Lusaka, Choma and Kitwe. Besides the Catholic Church, the other churches supporting SNFP are Seventh Day Adventist, Baptist, the Evangelical, and the Episcopal. FLMZ also provides family life education to schools around Lusaka which are intended to promote sexual abstinence among adolescents.

While FLMZ is not against contraception, many Mission clinics and hospitals are said, in practice, not to condone the use of contraceptives. However, condoms are considered acceptable

for use as protection against AIDS.

Although statistics were not available, the remaining 40 percent of the population includes a large percentage of Protestant denominations as well as Muslims.

A pilot survey done in 1988 on the sociocultural determinants of fertility in Zambia (Munachonga, 1989) examined the influence of religion, among other variables, on perceptions about fertility. Of a sample size of 143 residents in Lusaka, members of Watch Tower predominated among respondents who gave 10 children or more as the ideal family size. Members of the United Church of Zambia, followed by Catholics, responded positively to the question of children as important for status. The emphasis on children as a source of security cut across religious lines. Protestants were more disposed to the idea of modern contraceptives than Catholics.

Ethnicities and Their Institutions

There are 73 tribes in Zambia but basically five major tribal groupings: the Lozi in the Western Province, the Tonga in Southern Province and some parts of Central Province, the Ngoni and Cewa in the Eastern Province, and the Bemba and Lunda in the Northern and Luapula Provinces. The majority of ethnic groups are matrilineal, except for the Ngoni, Mambwe, and Ndebele who are patrilineal and the Lozi who are bilateral.

Among the Lozi and some Zambian Ngoni, descent is traced through either the father's or the mother's lineage. The bilateral descent system emphasizes sexual rights as opposed to parental lineage which ensures claims to children (Parpart, 1988:117).

In matrilineal societies inheritance passes through females, from mother's brother to mother's brother's sister's son to his sister's son, as opposed to patrilineal inheritance from father to his son to his son's son. Hence, the most important bond is said to be that between a brother and a sister. Children belong to their mother or rather to their mother's brother who has formal authority within the matriliny. Daughters tend to be preferred more than sons among matrilineal groups because they provide heirs to the group.

A study of the matrilineal Kunda in Eastern province (Drew, 1992) revealed that the matrilineal group does not pay a brideprice, 'lobola,' but the family of the husband might give a token marriage payment, the 'chimalo,' as payment for the husband's sexual, economic and personal rights over his wife (Drew, 1992:5). Drew (1992) explains that payment does not guarantee access, as both partners have sexual rights and obligations to one another in a marriage. Men's labor and capacity to impregnate are perceived as a critical factor in the reproduction of the group and male reproductive capacity receives greater ritual attention than female's. Women's responsibility is to "produce healthy off-spring" and failures are regarded as due to men's partial impotence, as the failure to impregnate a woman is mainly ascribed to the husband's impotence. Male impotence is also said to explain frequent abortions or neonatal deaths. For the Kunda

tribal group, 'chimalo' is no more than the right of the husband to consummate the marriage. In fact, under customary law, a husband who turns out to be impotent on the wedding night is sent home the next day and the marriage is regarded as dissolved. If the couple cannot have children and the husband wants to save his marriage and his honor, he can send his wife to another man for a limited period in order to enable the woman to have a child. Formerly, infertility in women could be easily "corrected" by polygamy.

The male study revealed that the urgency for a couple to prove immediately after marriage that they are fertile persists. This was the most common reason given by the male focus groups for waiting until after the first child is born to begin using family planning methods, if at all. Infertility is one of the primary ailments in both men and women treated by traditional healers.

Patrilineal societies, such as the Ngoni, the largest patrilineal group in Zambia, are different from matrilineal in a variety of ways. Power and property pass from father to son and are said to emphasize males.[4] If a wife did not produce a son, the husband had justification to take another wife. Contrary to matrilineal societies, patrilineal groups pay a large brideprice (lobola) in cattle, which in precolonial times, ensured the father's rights to his children. According to Parpart (1988), "the brideprice purchased exclusive sexual rights to the wife and rights to her children (genetrical rights)." Divorce was rare among the Ngoni and only men could ask for divorce. If the wife was at fault, her parents could be forced to return the brideprice (ibid., 117).

Later, colonial policies and laws pertaining to marriage, divorce and adultery, in combination with policies intended to manage or control the labor force in the Copperbelt mines, transformed the traditional system of rights and obligations. Women acquired rights to ask for a divorce, and by the early 1950s, 47% of Copperbelt first marriages survived twenty years; Patrilineal marriages seemed to survive better than matrilineal ones (ibid., 130).

Marriage in matrilineal societies is seen as a central institution in their society. This is apparent in girls' initiation rites. After her first menstruation, the girl is instructed on the teachings of her ancestors by her personal advisor, other elderly women and recently initiated girls. The girl's role as wife is dramatized and played out, with the girl participating so that she can experience the shame related to 'bad behavior.' She is also taught to "respect her husband, to serve him and to make him enjoy sex life" (Drew, p. 10). She equally learns that a wife's indifference towards her husband's bad behavior, e.g. going to visit a girlfriend, is punishable.

Later on in life, when the girl is preparing for her wedding, it is customary for the young

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[4]In Munachonga's pilot survey of ethnicities in Lusaka (1989:18), the respondents for the most part preferred a balance between sons and daughters. A plausible explanation she gives is the impact of the patriarchal system imposed on matrilineal groups through colonial rule.

woman to have what is called a "kitchen party." Again, this is an opportunity for her female relatives and friends to advise her on how to behave in marriage. The message conveyed is to "submit to your husband and satisfy his needs."

The traditional values regarding children favor the woman having as many children as possible. Children are considered a source of prestige, labor, and support in their parents' old age. "Societal pressure was (and still is) reflected in the fact that a woman acquired status after the birth of a child or a specified number; otherwise she was treated as a minor" (Munachonga, 1989:5). Unmarried women will sometimes bear children to prove their fertility and to consolidate their relationships with men, in anticipation of marriage, even when fathers are married to other women. This seems to be true even among married women; in the male focus group discussions (male study), some men admitted it was their wives who wanted more children because the woman feared the man would divorce her once she stopped having children. The female study showed that the most common reason for women wanting more children was to ensure economic support in their old age.

In traditional societies of Zambia motherhood and the desire of both men and women to have children were praised and accompanied by various forms of birth control, in particular avoiding closely spaced pregnancies. The survival of the infant was stressed and the expectant mother would be sent away to her parents until the child was able to walk. Abstinence while a mother was breastfeeding was emphasized, as it was thought to spoil the mother's milk and endanger the life of the baby (Munachonga, 1989:5). Focus group discussions with elderly men (male study) corroborated the importance attached to child spacing in former times and the practices in place to reinforce it. Women who did not space their children were punished by having to carry two babies on their back at one time. When a woman had her baby, they would remain with her parents. The father would test whether or not the period of spacing was long enough by asking that the child fetch him some water. If the child was able to do so, the father would actually be seeing his child for the first time and the mother and child would rejoin him. A measure for when the next child should be born was whether the first child was big enough to carry the infant on his/her back. The elderly group claimed that a three-year interval in between births was ideal, and that the final number of children a family had was not as important. This explains the fact that many of them had as many as 10 children.

Breastfeeding continues to be very common in Zambia, although exclusive breastfeeding is not. Almost all Zambian children (98%) are breastfed for some period of time (DHS, 1993:109). Women are now weaning their children earlier, partly because the need to engage in other productive and remunerative activities has increased. Generally, the baby is weaned in the eight month. Rural women still breastfeed longer than urban women. With the rise in formal education and to a lesser degree formal employment, fewer women should be expected to breastfeed intensively and over longer periods as was the case in the past.

The traditional use of abortion as a method of avoiding motherhood in Zambia has not been documented. It is not known what the historical and traditional roots are of the use of abortion,

especially among young teenage girls today. Many of these abortions are done in secret and have proven unsafe or incomplete (see section C. below).[5] Munachonga (1989:6f) attempts to advance some explanations for a woman's decision to abort, such as the expectant mother in a polygynous marriage jealous of her co-wives who does not want to be separated from her husband for the duration of her pregnancy and breastfeeding period; or an adulterous pregnancy which was strongly disapproved of in patrilineal societies where the amount of bridewealth paid out was higher for virgins than for women who had given birth before marriage. In the interviews with traditional healers (male study), they admitted women came to them for unwanted pregnancies but all of them "refused" to treat them.

The Laws Governing Marriage and Fertility

There are two forms of contracting marriage in Zambia, either by the Marriage Act or by the traditional or customary laws. Under the Marriage Act, marriage is permissible above the age of 16, which is very low. But it can also be contracted at ages below 16 provided written consent is furnished by the parent of the girl. By traditional law, women marry as soon as they reach menarche, which can be as early as 12 years old. A statistical survey has shown that 11% of married women were married between 12 and 14 years (CSO, 1991). According to a World Bank assessment of gender issues in Zambia's economic development, the Constitution in Zambia legalizes discrimination against women by providing this exception which permits customary law to prevail over matters of personal law. In fact, the Constitution is under review now to eliminate biases and guarantee a range of human rights to all citizens regardless of social status or sexual orientation.

Inheritance in Zambia is governed by the Intestate Succession Act no. 5 of 1989 and the Wills and Administration of Testate Estates Act No. 6 of 1989. The laws are intended to protect the rights of widows and children. At the death of the husband, the estate is distributed as follows: (a) 20% goes to the surviving spouse, except when there is more than one surviving widow. In the latter case, the 20% will be distributed in accordance with the duration of their marriages to the deceased. Other factors may also be considered, such as the widow's contribution to the deceased's property; (b) 50% goes to the children, the division of which takes into account the child's age, educational needs or both; (c) 20% of the estate goes to the parents of the deceased; and (d) 10% goes to the dependents in equal shares. However, the law makes an exception for, and does not apply to, land which has been acquired and was held under customary law. When the husband dies, the relatives of the deceased take property under the guise of customary law of inheritance, a practice called property grabbing. There have been a few cases where the widow manages to get the property back but it usually takes considerable time for processing in the courts. Even if the widow does go to the court, it is often said that the widow ends up

[5] According to a report by Likwa (1992), a study done in 1989 on maternal mortality at the University Teaching Hospital in Lusaka indicated one fourth of the women under 18 years of age died as a result of self-induced abortion.

preferring to let the relatives take the property away rather than continue to molest her.

Property inheritance is an important factor in assessing women's status, but more relatedly, it portends the consequences for women who survive their husbands, especially those with larger families.

It should also be noted that polygyny is still the customary form of marriage. The practice of polygyny, as indicated earlier, served to facilitate child spacing. Today, urbanization and western education have made polygyny unpopular among women. Moreover, polygyny was strongly discouraged during colonial times in order to increase fertility rates and the values of monogamous relationships were promoted (Munachonga, 1989:24).

One more piece of relevant legislation pertains to abortion. Zambia was one of the first African countries to make abortion legal in the early 1980s under very specific conditions: (a) if the woman's condition is life-threatening; (b) if the continuation of the pregnancy threatens the woman's mental or physical well-being; (c) if continuation threatens the mental or physical well-being of existing children, or (d) if the foetus is handicapped. Access to legal abortions is limited to urban areas, particularly Lusaka. The University Teaching Hospital claims the general public is not very aware of the legality and availability of abortion services, which explains the large number of illegal abortions. There may also be strong resistance on the part of health staff to these services.

Employment and Education

Only 20% of Zambian women have attained an education beyond primary school level. As of 1992, about 60% of both males and females had attained primary level of education; 22% of males and 13% of females attained a secondary level; and only 1% of females had reached a higher level of education. The gender imbalance at the primary school level begins between grades 4 and 5. The reasons for this are varied. Either sex roles at home take effect and affect girls more than boys, or, because this is the age at which most girls are approaching puberty, parents' attention for girls shifts to non-school activities or insufficient school places compel parents to favor boys' education (UNFPA, 1993:23).

As late as 1985, only 13% of females at grade 7 level the previous year managed to obtain places in secondary school. Another important factor is that when a girl is discovered to be pregnant, she is subject to expulsion immediately (most secondary schools examine girls by palpation of their abdomen once per term). In many schools, a boy who makes a girl pregnant is expelled if the charge can be proven (Mudenda, 1992:26). To wit, there are over 80% of girls at grade 7 level who cannot go to secondary schools. They enter the reproductive age group, armed with little skills for the labor market and less knowledge of their own fertility. In Zambia, statistics show that 28% of total households are headed by women (Siandwazi, 1992:12). Of the 28%, it is reported that 41% had no formal education.

In 1990 the literacy rate for women aged 15 and over was 60% and for men, 80%. Literacy rates differ between rural and urban areas and among provinces.

Studies have shown that when girls are better educated, more of them obtain employment in the formal economy, marriage tends to be delayed, and concomitant improvements are likely in child survival as well as fertility reduction. Indeed, the DHS reveals that the median age at first marriage for women 25-49 increases steadily with education, from 16.7 among women with no education to 19.9 for women with secondary or higher schooling (p. 61). More educated women also tend to delay their first birth later than less educated women (p. 34).

Munachonga's study (1989:21f) provides insight into how education and employment affect fertility patterns. Uneducated and nonearning wives value a larger number of children because (1) they provide insurance against divorce, (2) children are their only tangible contribution to marriage; (3) wives have difficulty justifying their usefulness to their husbands in the absence of many children; and (4) the more children, the more chances of being supported in old age when the children become employed. These reasonings also emerged in the male and female studies.

Women have more difficulty than men to find paid work in urban areas because of their educational handicap. Women's participation in the formal sector, in particular, is low. Historically, women were not allowed to migrate to urban areas until the ban was lifted in 1953. Also, women's multiple roles prevent them from career advancement and these forces actually discourage high fertility. As a result, women are either concentrated in service-oriented occupations or have entered the informal sector where they tend to be concentrated in low paying activities, mainly marketeering (UNFPA, 1993:30).

There is a high participation of women in the labor force in rural areas where females outnumber males. In addition to agricultural activity, the other important reason for this is more female-headed households in rural vs. urban areas. This puts pressure on women to be more economically active in order to support themselves and their families (UNFPA, 1993:32). A report on Women's Income, Fertility and Development Policy (Turchi et al., 1991) attempts to demonstrate that women's labor force opportunities can affect the short range and long range demand for children. It is argued that if attractive labor market opportunities exist that more or less conflict with child rearing, there is pressure for women to postpone child bearing.

The AIDS Epidemic

HIV/AIDS prevalence in the reproductive age group, especially among the young is likely to affect fertility rates and the socio-economic development of the communities. One of the problems associated with HIV/AIDS is the growing number of orphans and widows. By 1992 the projected number of orphans was estimated at 219,101 while the projected new orphaned children stood at 28,172 during 1992 (Women, Pop and Dev, UNFPA, 1993).

Among secondary school children, knowledge of AIDS is relatively high, according to a study entitled The Needs and Aspirations of Secondary School Pupils and Their Attitudes and Advisers on Selected Issues of Sexuality (Mudenda, 1992). Over 80% of the 123 students surveyed knew there was no cure for AIDS and over half have seen a person suffering from AIDS. The school children in the sample link AIDS with sexual intercourse, but very few, less than 5%, mentioned mother-to-child transmission. Contaminated blood transfusion or contaminated sharp instruments were each mentioned by about one third of the sample. About half felt that the most likely victims would be those who are promiscuous or are expected to be promiscuous (beer drinkers, travellers). One quarter mentioned that anyone can be infected. Generally, those students who had benefitted from the Anti-AIDS Clubs showed more awareness.

Knowledge of AIDS is almost universal among women in Zambia (DHS, 1993). The vast majority know it is transmitted through sexual intercourse, however, the proportion of women who are aware of mother to child transmission is small (1%). Knowledge of transmission of HIV/AIDS has contributed to improving the quality of safety of blood transfusion, clinical procedures especially during delivery, and screening for women, men and children. More significant is the gradual reduced practices of traditional cleansing following the death of a spouse (Women, Pop and Dev, UNFPA, 1993:17).

Condom social marketing to date in Zambia has been associated mainly with AIDS prevention and not family planning specifically. The view has been expressed that family planning initiatives should assume a more critical role in AIDS prevention. The reality is that anyone who gets pregnant risks getting AIDS. Emphasizing other methods, such as oral contraceptives, removes the fear of pregnancy but not the fear of AIDS. It was suggested by one source that targeting men for condom usage and women for long-term contraception simultaneously might be a good strategy, although additional strategies are needed to empower women to demand their partners use condoms as protection against AIDS.

B. Intra-Household Decision Making and Economic Issues

The tradition of 'lobola' has acquired different interpretations in a changing economy. Formerly, it meant the wife deferred to her husband in major family decisions, including those relating to the use of family economic resources. In urban conditions it has come to be interpreted in such a way that the husband "owns" his wife's earnings. The wife who earns money is expected to seek her husband's consent before disbursing some of her earnings to her extended family. The distortion of customs has been seen as a corrupting influence on the tradition of brideprice, making it something that it never was. With the paying of lobola, men claim to have the right to control where women work as well as a right to their earnings. The size of the lobola payment is also proportional to the woman's level of education and earning power.

The tradition of 'lobola' has even been invoked by husbands who do not agree with their wives using family planning methods. Family planning providers that promote the philosophy that

every individual has the right to space their children or the right to make decisions affecting her own body have had to contend with husbands who assume it is their sole right to "make decisions regarding something they paid for." However extreme this case may be, it was clear in the male study that decisions about when to practice family planning and how many children to have can be discussed between husband and wife, but ultimately the decision is the man's decision. Even when women know about family planning methods or wish to space their children, a reported barrier to using a method, whether it be natural or modern, is their husbands' refusal. While this is not always the case, it may be the reason some women choose a contraceptive that she can use without her husband's knowledge. Alternately, some women never make it to the clinic either because some clinics require spousal consent or the woman assumes consent is mandatory. Men tend to suspect their wives of promiscuity once they learn the woman is using a method without informing the husband (male study). Most of the respondents in the female study felt that the decision on when a woman should start using a family planning method or service should be the man's and an almost equal number felt it was the woman's. A small percentage said it was both spouses' decision.

Family Life Movement of Zambia (FLMZ) promotes the use of natural family planning (NFP) which necessitates the consent and practice of both partners. Encouraging couples to communicate about child spacing is part of the counseling offered. This approach is challenging because couples do not necessarily spend much time together and there are strong traditional taboos against discussion of sexual matters, even between husband and wife. At the PPAZ Model Clinic, some of their clients are men, but they rarely come at the same time as their spouses because couples are not able to talk comfortably about family planning. Or, typically, the man speaks freely and chooses the contraceptive, only to discover later that the wife would have preferred another method. Women are socially constructed to be reticent or not contradict their husbands in public.

A research project (Mtonga, 1991) on determining the effects of inter-spousal communication on the acceptability of contraceptive methods in the town of Maamba in the Southern Province produced some interesting findings. By age 30, most men were married and had children. They communicated more with their wives in this age group while women were more communicative after 25. Ten out of 25 couples communicated and used family planning. They knew what to communicate to each other except were not aware of the advantages and disadvantages of the family planning methods. Education also had an effect on inter-spousal communication. Finally, a negative relationship existed between communication and information about family planning provided by nurses who apparently were not adequately equipped with family planning knowledge.

Women are socialized to be subservient to and dependent on men. "Women are...seen by males and also by themselves, as persons to be taken care of and protected. Girls are not expected to leave home and live on their own before marriage. Even if a girl is employed, important decisions about her life are to be discussed with her father, uncle or other male guardian. On the other hand, even if a married woman is employed, she expects her husband to support her

completely" (Mudenda, 1992:14). Further, from the same study (Mudenda, 1992:49): "Girls take on a dependent and powerless aspect when talking about their problems. Although some are concerned about taking care of dependent relatives in future, many express themselves in terms of 'who will take care of me.' More than one girl in ten sees pregnancy, or the death of a supporter, as the prime worries of a girl who looks as if she has a problem."

The study on the matrilineal Kunda (Drew, 1992:12) sheds further light on the question of household decision making. Among the Kunda, no decision is ever made by an individual autonomously. It is common for members of the kingroup and in-laws to be involved. With respect to fertility, the husband and the wife's matriliny are the decision-makers. Although the children belong to the wife's family, traditionally it was incumbent upon the husband to look for medicine either to enhance, prevent or end a pregnancy. Abortion is an alternative for good reason, e.g. the last-born is still breast-fed, and requires the consent of all parties concerned. The same is true for sterilization. It was reconfirmed in the male study that even today, women who want to undergo tubal ligation would first consult her family and in-laws who have a say in her fertility.

Despite the fact that a young girl is taught in initiation to react against any "bad behavior" on the part of her spouse, her response is more often non-confrontational and suggestive of an instilled sense of subordination to her spouse. According to Mudenda (1992:14), "Males are expected to be promiscuous, by both males and females. Women's acceptance of this fact is so complete that when a man is discovered to be unfaithful, the injured girlfriend or wife goes to confront the 'other woman' instead of dealing with the unfaithful partner." It is said that while many women are in monogamous unions, fewer of their husbands follow the same behavioral codes.

In view of the present-day AIDS pandemic, it becomes even more difficult to reconcile the controlling force which the sociocultural context has on a woman's life. Traditionally, in a matrilineal society, the family of a female who marries always stands to gain, i.e. children, labor, financial support, but the parents of the boy lose. Hence, it is rational in this context for parents to bring more pressure to bear on their daughters concerning marriage than on their sons, and the young woman's dependency on the elder generation within her matrikin, who wish to retain the services of the male, influences her to accept her husband's oppression (Drew, 1992:17). While urbanization has had a loosening effect on some of these ties, there continue to be examples, most notably in the face of AIDS, of women's lack of control over her own life.[6]

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[6]A young Kunda woman who married a Tonga man from the South of Zambia explains her dilemma when she learned her youngest son was born with AIDS (Drew, p. 15):

> I knew that we had 'it'...I already knew when we were still living in the Copperbelt. My husband had plenty of girlfriends, some of them died a long time ago of aids. I was afraid but I couldn't talk When I discovered that my husband was sleeping with my little sister, I was broken. I was really up to a divorce. But my parents

C. Individual Knowledge, Attitudes and Practice (KAP)

Women of Reproductive Age

Precise reasons for non-use not related to logistical and institutional factors need to be ascertained. The World Bank Health Sector review calls it a "KAP gap." Women know about family planning methods but this does not necessarily translate into practice. Statistics show that family planning awareness among women of reproductive age stands at 90% but Zambia's current contraceptive prevalence rate is only 11.5%. The difference in family planning use is marked between urban areas (21%) and the rural areas (10%). However, the latter is in part explained by the concentration of services in urban areas.

According to the female study, women who were not using family planning at the time gave the following reasons in descending order of importance: (1) infertility, (2) health problems, (3) not regarded as necessary, (4) husband opposed, and (5) lack of knowledge. Other reasons offered did not figure as significantly. The same study showed that most women who were using family planning methods wished to practice child spacing and the second most important reason was child limiting. In a random sample of 199 cases (a subset of the survey), 69 were current users, 124 were non-users, and six cases could not be ascertained. The majority of the users were using the pill. Most of the users obtained information on contraceptives from clinical staff, and a significant but lower number from their husbands, and then friends. Pills and condoms were the most frequently available methods provided by the clinic in the area where the respondents lived. Reasons given in descending order for the respondents' preferred family planning method were: (1) more effective than the others, (2) easy to take, (3) accessible or available, (4) unknown, and (5) no side effects.

Men of Reproductive Age

Except for the elders, men interviewed for the male study obtained information on family planning from their wives, newspapers, books, and radio. The source for some traditional methods (e.g., medicated string around the woman's waist) was the elderly people, mostly grandparents. It was clear that men rarely go to clinics to obtain information or contraceptives and admitted they would be willing to go if they felt "invited." The clinic is generally regarded as for women, not for men. The majority of the men in the focus groups were practicing family planning (condoms, pill, withdrawal, spermicides, traditional beads, safe period), although they primarily used condoms in their sexual relations outside of marriage or if they were not married. Most of them felt it was their wife's responsibility to identify and seek a family planning method, but most also felt family planning should be discussed between the husband and wife.

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didn't agree. They said: 'Don't be silly. He is a man, you should respect him!' They even didn't agree on the divorce when my sister died three years later of aids, aged 18!! 'Such is life' they commented. They don't see any reason why I should divorce from my wealthy husband. Though there are many reasons, apart from his girl-friends.

When asked whether services should be offered to men and women separately, almost all expressed the need for a place where couples could go and discuss options together. One group commented that the information they access through their wives is not reliable.

Most of the men wished to know more about family planning methods, ranging from the advantages and disadvantages, information on ideal family size, scientific explanations of the method use, ideal number of years for method use, conception, and premarital counseling. When asked from whom they would prefer to obtain the information, almost all stated from trained health workers. Employer-based discussion groups wished to obtain educational materials and information on contraceptives from the clinic at the workplace. Some felt it was important to offer family planning services on a daily basis to be offered to couples who could be counseled privately by a trained health worker. Men interviewed in the market wished to obtain materials at the market, in part to avoid confronting relatives (in-laws) at the health facilities. Video, drama, pamphlets, and posters in public places were also regarded as essential to learning more about family planning. Some also recommended the information be brought to them through home visits, particularly the elders who also wished to include their wives on family planning sessions. Clubs mostly attended by a male clientele were also thought to be a site for family planning information dissemination.

Children and Teenagers

The problem starts with an understanding of sexuality and family planning among teenagers. Knowledge, attitudes and practice among teenagers is a persistent problem. In the 16-18 age group for girls, all were sexually active but less than half were using family planning. They saw abortion as the easiest form of family planning and were less knowledgeable than boys about protection against AIDS. (A clinic-based study conducted in 1986 indicated that the majority (75%) of women who resorted to induced abortion were between the ages of 14 and 19 [Likwa, 1993:15]). They also expressed reluctance to use family planning services because of fears they might be treated badly or parents might find out. Focus group discussions revealed that school is one source of information on the facts of life, AIDS, etc, but not as important as friends, films, and family elders.

Traditionally, children are taught the facts of life during initiation ceremonies or by older relatives. For girls, this would have happened at menarche, and marriage would have followed soon after. Menarche is happening at a steadily earlier age; girls are expected to stay on at school. The period between physical and social maturity becomes longer, and with migration to urban areas the extended family can be lost.

In the survey of secondary school pupils, girls and boys were asked about their knowledge of the uses of condoms (Mudenda, 1992:31). Girls mentioned prevention of pregnancy (73%) most frequently, followed by prevention of STDs (65%), and HIV/AIDS transmission (18%). Boys mentioned prevention of STD transmission (82%) most frequently, then prevention of pregnancy (67%), and HIV/AIDS transmission (29%). Girls and boys also were asked their opinions on

who should tell them about condoms (health workers, grandparents/elders, sibling/friend, Anti-AIDS members, teacher) (see pages 32f). While most children feel the need to know more about condoms, it also serves to provide females under pressure a means to protect themselves. Single-sex school girls seem to be most under pressure (p. 37).

A 1992 study on teenage pregnancy cited in Likwa (1993:9) showed that 93.5% of pregnant adolescents never used modern family planning methods. Most of the young women studied, nonetheless, had some knowledge about family planning services available at service delivery points. At the time of the DHS, more than one quarter of teenage women had already had a child and another 7% were pregnant with their first child (Likwa, 1993:11f). Early childbearing is more predominant among rural women as well as those in the Eastern province and those who have not attended school (ibid.).

The Curriculum Unit of the Ministry of Education has developed some teaching modules on population and family life education. They form part of two science subjects. Some schools, mainly Catholic, run anti-AIDS Clubs, encouraging abstinence. The IEC system, in schools, the health system, and other formal and informal channels, at present is not nearly sophisticated enough to deal with such complex issues of culture, gender, sexual behaviour, and family planning decision-making. Other constraints prevail: (1) contraceptive services are difficult for adolescents to access, (2) school policy does not allow pregnant adolescents to continue nor do they have nurseries, and (3) unmarried mothers are socially isolated.

Deterrents for Female Use of Family Planning Methods

The deterrents in this section have been cited by various individuals or reports relating specifically to Zambia but have not been ranked in order of importance or based on any large-scale study. .

1. One reason offered earlier on is that even when women know about modern methods and wish to prevent further births, their husbands refuse them permission. The DHS reports that of the 81% of married women who knew of a contraceptive method and approve, half said their husbands also approved (1993:54).

2. Educated women may refrain from using contraceptives either because they hope to develop a lasting relationship with the child's father or because they fear the possible side-effects of the methods available to them (ZARD, 1985:136).

3. Women are generally not well informed about their own fertility. Those women who go to family planning clinics are also educated about reproduction and their own bodies. They then become cognizant of changes in their body which they may not have been aware of before. The problem is that noticing changes, such as normal discharge, they then attribute to taking the pill.

4. Illustrative misconceptions about modern contraceptives:

a. The pill: (a) causes infertility, (b) causes a growth in the stomach, (c) causes STDs and AIDS.

b. The loop: (a) it will travel up through the circulatory system to the heart. One woman who had the loop removed without returning to the clinic, then became pregnant, and had an "illegal" abortion, died after the abortion. Women who knew about this case now think the loop is what killed her.

c. Condom: (a) associated with promiscuity, (b) subject to taboos about throwing away bodily products or excretions

d. Sterilization: causes abnormality

5. With specific reference to the intra-uterine contraceptive device or IUCD, a sample survey of 50 female users of family planning (Muyanza, 1991) revealed the following reasons for not choosing the IUCD:

a. inadequate knowledge about the IUCD

b. concerns about menstrual irregularities

c. negative attitudes of male partners to the method

d. service inaccessibility and procedural constraints.

6. Norplant was chosen as a method by 53 women who obtained it at UTH in 1986. Records show that only 10 out of the 53 returned for removal at the end of five years. A study conducted in 1991 to investigate the factors influencing 20 clients who did not return for the scheduled removal of norplant revealed the following reasons for this: 25% experienced no problems with the contraceptive, 25% claimed there was no doctor at the clinic to attend to them, 20% had social problems (had other concerns to attend to on the day of their appointment), 10% feared they would get pregnant once it was removed, 10% reported no specific instructions were given, 5% were "busy at work," and 5% were told by the doctor to leave it in until after sterilization (Maimbolwa, 1992).

7. Non-users, in particular, fear they will not be able to conceive after they have stopped using a contraceptive.

8. Health care providers can be misinformed about family planning methods or have method-specific biases.

9. How women access information on family planning and how accurate the information is constitute another consideration. In a study of 50 women of reproductive age in urban Lusaka and why women fail to utilize family planning services (Luhanga, 1990), the women reported receiving information according to the following breakdown:

40% from friends
38% from health workers
8% from "other"
4% from their families
10% no information.

The DHS reports that 8 in ten women said they had not heard of a family planning message on radio, while 7% saw a message on TV. One-third of women in urban areas and in Copperbelt and Lusaka Provinces had heard any messages, compared to only 7% of women living in rural areas or in Eastern and Western Provinces (1993:52).

10. Another study of 50 women of childbearing age in Chipata district, Eastern Province (Chilufya, 1991) documented the following reasons women were not practicing family planning:

38% - have not yet reached the desired number of children (reported that husbands decided on the number of children)
24% - using traditional methods
20% - did not know about family planning clinic
18% - misconceptions about family planning

Other characteristics of the 50 women are: (a) mostly Roman Catholics and (b) low educational level.

11. The DHS has data on why married women are not using contraception. Of all the reasons for not using contraception cited among the married nonusers, the top five are: (1) 36.7% want children, (2) 20.2% have difficulty getting pregnant, (3) 13.3% meet with opposition (self, spouse or other), (4) 10.7% are menopausal, and (5) 10.6% lack knowledge, however this was defined.

12. The amount of time it takes to travel to a source of contraceptive supply is 30 minutes for half of urban users and one hour for half of rural users (DHS, 1992:47). Certainly, there are limits on the amount of time a woman is willing to spend to travel to a clinic, especially if she must return on a regular basis, as for the pill.

Deterrents to Male Acceptance of Family Planning

1. The findings of a small-scale survey of 50 men in the Cabinet Office Personnel Division

(Mayondi, 1990) are indicative. Most men preferred at least four children. Men over 40 years of age preferred larger families. Fifty percent did not know about family planning. The majority preferred condoms over other methods.

2. The same study (Mayondi, 1990) documented reasons why men did not accompany their spouse to the clinic:

   a. against God's will
   b. wife's responsibility
   c. encourages promiscuity

3. The unspoken reason men do not accompany their spouses-- notwithstanding the fact that natural family planning services require initial attendance by both partners--is that men and women have difficulty talking about such matters as a couple publicly (with a counselor) or privately. The DHS reports that a sizeable proportion of married women living in rural areas do not know their husbands' attitudes towards family planning, an indication of the extent to which it is discussed (1993:55). The other reason pointed out earlier on is that men regard clinics as strictly for women.

4. That women use family planning services without their husbands' consent, this sort of unilateral decision breeds suspicion among men.

5. Traditionally, a large number of children is a sign of male prowess. "Child limiting" is much less acceptable an approach to introducing family planning than "child spacing," which was given considerable emphasis by elders.

6. The use of condoms to date, which can obtained at commercial outlets, is primarily associated with AIDS prevention and not family planning.

7. Mayondi's (1990) study revealed that men rely first on the media and secondly on friends for information on family planning. How they obtain information and what kind of information they get are a consideration, as for women. This is also discussed in more detail for men who participated in the male study under the section of "men of reproductive age."

It is clear that IEC strategies need to be improved and aimed at behavioral changed. Targeting has been very broad, basically addressing either men and women with little refinement of target or message. IEC has not addressed the different perceptions and needs of different age groups, of urban versus rural populations, or cultural attitudes to family planning in different provinces (World Bank, p. 52).

Besides the World Bank Health Sector Review and the Pathfinder Assessment of Family Planning Service Delivery, UNFPA recently completed a set of background papers, one of

which reviews its country programme (1992). The UNFPA review acknowledges that "Zambia has not yet developed systematic and extensive [IEC] programmes in the field. Existing programmes are largely in their infancy, on a very small scale (often covering only the more easily accessible and converted urban population), and characterised by a serious lack of co-ordinated and complementary effort" (p. 61f). Emphasis is placed on IEC as an important catalyst in narrowing the KAP GAP.

KAP by Province

Findings of the DHS report at the province level are worth noting for purposes of further investigation and formulating more specific strategies of intervention and assistance. Explanations for the phenomena may be supply- or demand-based. Some of the findings are:

1. Fertility rates by province are highest for Luapula, Northern, Southern and Eastern relative to the other provinces (over 6.5), and Luapula and Northern combined still desire 6.4 children.

2. Knowledge of any contraceptive method and a source is lowest in Central province and diverges from percentage rates for all other provinces by about 20%. The others range in knowledge of a source of a modern method from 97% to 78%. The percentage gap between knowledge of any method and knowledge of a source for a modern method is greatest for both the Northern and Western provinces compared to the gap for other provinces. In fact, the data of use of methods show that withdrawal obtains a notably high rate of use in the Northern province (12% as compared to 1.8% or less for each of the other methods, traditional and modern), and "other" under traditional methods for Western province is significantly higher than the others. Some informants have proposed "other" may pertain to the traditional beads worn around a woman's waist. It could be hypothesized that both the Western and Northern provinces rely mostly on traditional methods, and secondly, that this greater reliance is causally linked to the relatively low level of knowledge about a source of a modern method.

3. For the total of all age groups across provinces, the pill has the highest usage rate among all modern methods and "other" has the highest rate for traditional methods. Identifying the methods used in the "other" category would seem particularly pertinent.

4. Among the modern contraceptives used, the pill and condom have the highest usage rates for Copperbelt and Lusaka provinces. Female sterilization is also significant. These usage rates are almost double those in other provinces.

5. For all the provinces, 84.8% of all currently married women are not using a contraceptive. Of all currently married nonusers, 34.5% intend to use contraception in the next 12 months compared to 44.8% who do not intend to use in the future. The specific age groups for these percentages would be worth investigating.

6. Approval of family planning by either the respondents or their husbands was lowest for Eastern province. In Eastern and Western provinces, more than 25% of approving wives are unsure whether their husbands approve, indicative of limited interspousal communication on family planning. While Lusaka province would be expected to have the highest rate of both partners approving a method, it is curious that the Northern province surpasses Lusaka slightly. It would be more telling to know what the approval rate would be for modern versus traditional methods, given what other data show for the Northern province.

7. Monogamous relationships are highest for the Copperbelt and Lusaka provinces, and the Southern province has a high proportion of polygynous marriages relative to all the other provinces.

8. Grouping them into high, medium, and low, the provinces can be categorized, as follows, in relation to total demand for family planning (child spacing and limiting): (a) HIGH: Copperbelt (58.3%), Lusaka, Northern; (b) MEDIUM: Southern, North-Western, Eastern; and (c) LOW: Western, Central, and Luapula (35.1%).

VI. DIRECT AND INDIRECT BENEFICIARIES

A. Immediate and Long-Term Benefits of Family Planning Services Provision

Immediate benefits will go to the strategic districts which were selected for the following combined characteristics: (1) highest unmet demand for family planning, (2) highest population distribution and density, (3) good accessibility to services, (4) highest commitment of district leadership to family planning (health facilities which condone the use of contraceptives), (5) available service delivery infrastructure, (6) accessibility of populations, and (7) potential for strong program linkages among the community. These districts should anticipate an improvement in performance and capability of family planning services, more reliable supply of contraceptives, better method mix, and an increase in acceptors among men and women of reproductive age at all service delivery points.

Results should be most immediate in the districts in the Copperbelt and Lusaka provinces where activities begin first because they rank high in terms of all of the above-mentioned characteristics.

The long-term benefits of improving family planning services provision in Zambia are multiple:

1. improved sustainability of all service types resulting from local capacity to carry out the activities

2. increase in contraceptive prevalence rate (15% of all married women use a method)

3. the right of all couples and individuals to choose from a range of family planning methods and to decide freely and responsibly the number and spacing of their children

4. lower fertility rate (currently at 6.5 children/woman)

5. improved maternal health due to child spacing which in turn contributes to the welfare of families and economic productivity

6. a decrease in neonatal and perinatal mortality and morbidity resulting from the increased birth weight of spaced children and a decrease in high risk births (currently, 23% of children up to age 5 are underweight; percentage of neonatal deaths occurring at 0-6 days of age: 67.4%; percentage of infant deaths occurring under one month of age: 42.4%)

7. reduced infant and child mortality rates due to reduction in high risk births (currently, the infant mortality rate is 107 per 1000 live births; child mortality is 94 per 1000 live births)

8. improved status of women (based on her access to educational and employment opportunities, improved decision-making power at all levels, increased self-esteem, and in possession of her rights as an individual) which in turn contributes to national development

9. less stress on the environment and natural resources, resulting from a lower fertility rate and population growth rate (currently at 3.2 per annum)

10. improved food security

11. lesser burden on critical, basic services such as education and health.

B. Direct and Indirect Beneficiaries

The two main groups of direct beneficiaries are (1) health service providers and contraceptive supply outlets and (2) women and men of reproductive age in the strategic districts. Other direct beneficiaries are the MCH/FP unit of the MOH, the NGO(s) involved in CBD, the employer-based clinics, and the PSZ. The training and technical assistance given directly to these institutions and family planning providers will strengthen their capacity to meet the current need for their services. An approximate total of 500 staff will have undergone training by the end of the project

For current users of MOH clinics, the integrated approach to MCH and FP and expanded service hours will enable women to reduce the number of visits to the clinic for preventive care for their children and themselves. Making a wider range of contraceptives available at commercial outlets

with a reliable supply, besides the clinics and other health care facilities, will also help to ensure more sustained use. In those areas of the country where service delivery points are too widely dispersed, making contraceptives available through community-based distributors and shops will fulfill the demand of populations marginalized by the scarcity and remoteness of clinics. Options for men to seek family planning counseling and obtain contraceptives and information will be expanded. Husbands will be encouraged to accompany their wives to clinics for counseling or the man can obtain services at the workplace for employer-based clinics, or from community-based distributors or retailers.

Maternal mortality will be reduced by fewer pregnancies and a smaller proportion of pregnancies that are high-risk and result in obstetric complications. Fewer pregnancies will also reduce the incidence of illicit, induced abortions which are fairly common among teenagers in Zambia. Fewer pregnancies also positively affect a woman's health and nutrition which in turn diminishes the risk of unfavorable pregnancy outcomes. A fewer number of children or waiting longer to have a first child opens up more opportunities for women to develop their educational status.

Children constitute a large group of indirect beneficiaries. It is observed that the higher the level of a mother's education, the greater the probability of a child surviving from birth to any age up to 5 years and the better the child's nutritional status. Reducing fertility also enables families to provide better education for their children. Investing in girls' education is known to generate a cycle of benefits. "When girls are educated, they have economic opportunities. Their families have more a stake in their survival and their success. They marry later and are able to take part in household decisions. They choose to have fewer children and can invest more in the health and development of each child. Their daughters and sons have expanded horizons. And often they escape from poverty" (Summers, 1992).

C. Short-Term Disincentives to Family Planning Practice

The following disincentives do not apply universally but are occasional and some contingent on full implementation of the National Family Planning Programme.

1. Nurses and clinical officers are reluctant to practice insertion of IUDs or dispensation of contraceptives because the Nurses and Midwives Act does not explicitly permit them to do so, although physicians are permitted. Removing this constraint depends on how soon the MOH sets and implements interim guidelines until the legislation is passed and on the availability of trained nurses to do IUCD insertion. Even nurses who had been trained at one time report the lack of practice as a prohibitive factor.

2. Although clinics no longer require spousal consent for family planning methods, some are still not aware the requirement has been abandoned, or alternately, some clinics insist on the requirement to protect themselves against disapproving husbands. Male disapproval of female contraceptives will continue to be a constraint until IEC messages

start to have an impact.

3. The availability of multiple brands of oral contraceptives can cause confusion regarding the selection of the best brand. The less popular brands expire without being used while the more popular ones suffer from stock-outs. Having multiple brands available does not prevent stock-outs.

4. Injectables, such as Depo Provera, are not widely available and suffer from a history of bad press. The product should be registered and IEC and training interventions developed to promote it as an alternative hormonal method. Norplant implants are another hormonal contraceptive method that should be registered in Zambia and promoted as a method after a training program for physicians is carried out.

5. On the one hand, the increasing demand for condoms advertized for prevention against AIDS suggests they could equally be sold with a family planning message; on the other hand, the close association of condoms with AIDS is reported to raise suspicions when condoms are brought up in the context of a conjugal relationship for the alleged purpose of family planning.

6. There are currently not enough trained health professional, especially physicians, able to provide a range of contraceptive methods (IUCD, tubal ligation, implants, injectables) for family planning or deal with family planning complications. This in turn limits referral possibilities, especially for expanding the availability of "child limiting" methods. Health centers only offer spermicides and one hormonal method (pill). They need to offer other methods. including injectables and IUCDs.

7. Condoms are sold at higher prices than expected in many places. To increase accessibility, the price will have to be brought down. The AIDS control program is marketing a condom that seems to cost less than the brand name.

8. Although not a disincentive per se, the MOH decentralization of functions to the district level will undoubtedly be a long and involved process, and these adjustments at all levels, but especially the district level, are likely to create some delays or stumbling blocks not written in to the MOH family planning programme and timetable.

VII. PROBLEMS ASSOCIATED WITH HIGH RISK BIRTHS AND IMPLICATIONS FOR FAMILY PLANNING ACTIVITIES TO REDUCE MATERNAL AND INFANT/CHILD MORTALITY RATES

A. Beneficiaries by Age and Locality

The DHS has a section on high-risk fertility behavior (pp 86f). Single high-risk categories are

the following:

1. mothers under age 18
2. mothers over age 34
3. birth interval less than 24 months
4. birth order over 3

The multiple high-risk categories are the following:

1. age <18 and birth interval <24 mos.
2. age >34 and birth interval <24 mos.
3. age >34 and birth order >3
4. age >34, birth interval <24 mos., and birth order >3
5. birth interval <24 mos. and birth order >3

The highest mortality occurs for children of very young mothers (under 18) and mothers nearing the end of their reproductive lives (>34). Since birth order and maternal age are highly correlated, mortality risks are greater among first births (to young mothers) and births of order seven or higher (to older mothers). Shorter birth intervals are associated with higher mortality both during and after infancy.

Sixty-three percent of children in Zambia are at elevated risk of mortality due to their mother's fertility behavior. Births in the single high-risk categories (43%) are more than double those in the multiple high-risk categories (19%). Birth order higher than 3 is the major contributing factor to elevated mortality risks. Fifteen percent of babies born in Zambia are at elevated risk of mortality because they are born after an interval of less than 24 months. Three-quarters of currently married women are at risk of conceiving a child with an elevated risk of mortality.

The DHS (pp. 82f) shows that both infant and child mortality are higher in rural than in urban areas. Infant mortality has actually been on the rise in Zambia. Infant mortality and child mortality rates are provided by province below:

Province	IMR	CMR
Copperbelt	68.9	80.8
Eastern, Central	114.1	108.2
Lusaka	76.8	69.3
Luapula, Northern	148.5	112.6
Southern	70.5	68.5
North-Western, Western	132.0	90.2

It appears that the Copperbelt, Lusaka, and the Southern Provinces compare favorably to the other provinces in terms of infant and child mortality rates.

According to the UNFPA study on Women, Population and Development in Zambia (1993), maternal mortality is estimated at 200 per 100,000 delivers. It is difficult to provide adequate information on maternal mortality when 60% of deliveries take place outside health facilities (p. 13). The number of home deliveries in rural areas is 73% as compared to 30% in urban areas. The major causes of morbidity among women of childbearing age in 1988 were anemia, malaria, STDs, hypertension and malnutrition.

Certainly, the information on infant and child mortality offers up a message in promoting family planning policies that family planning is a means to improve both maternal and child health. This rationalization should be "sold" as part of the message being delivered in marketing family planning methods.

B. Proposed Family Planning Services Provision by Category of Provider

This section will be updated and be made more specific once the data comes in from the acceptance studies. It will help to identify specific needs in Kabwe, Kitwe, Monze, Lusaka, etc.

Family planning services should be proposed in line with the four strategies of the MOH Family Planning Programme adopted by the project. The following is an illustration of services to be offered at the district level.

- **Clinics**

Clinics would include the MOH clinics with an integrated MCH/FP approach and would not exclude Mission clinics, private clinics, and other health centers offering family planning services. These health centers should be equipped to offer counseling in and information on all methods (pills, condoms, foaming tablets, IUCDs, injectables, implants, sterilization for men or women, SNFP, LAM) administer spermicides, condoms, orals and injectables, and be able to make referrals to a nearby higher level facility for IUCDs, implants and permanent surgical contraceptive methods or pregnancy termination. The IEC component needs to be carefully tailored to the local population in the catchment area.

- **Employer-Based Clinics**

These clinics based in a range of companies and industries, especially in urban areas, have special potential to reach a target group of men and women who cannot spare the time to walk to a clinic or wait in line. Companies with hospitals should be able to offer the complete gamut of contraceptive methods. Clinic providers should be able to offer spermicides, pills, injectables, and IUCDs, if there are providers trained to do insertions. These clinics will be able to make referrals for clients who desire surgical methods. The employer-based clinic should be able to offer information and counseling on all methods. As many companies, such as the mining industry, have a preponderance of male employees, the clinic's services should be adequately tailored to this clientele group.

- **Community-Based Distribution Services**

Community-based distributors should be able to distribute educational materials on family planning methods, be linked to a health center, and trained in communicating information about all methods and know where to refer a client for a particular method. CBD agents should be qualified to administer barrier methods (condoms and spermicides) as well oral contraceptives, and give instructions for lactational amenorrhea method (LAM). Among potential CBD agents drawn from the community or district are traditional birth attendants (TBAs), community health workers (CHWs), or health assistants (HAs). This type of family planning service is appropriate for marginalized areas requiring outreach to the community.

- **Contraceptive Social Marketing**

The CSM component would include sales of condoms and spermicides through pharmacies, retail stores, gas stations, and any number of other private sector outlets. Pharmacies would be authorized to dispense oral contraceptives to clients and IUCDs and injectables to health care providers.

VIII. SUITABILITY OF THE PROJECT IN THE CONTEXT OF THE EXISTING SOCIAL AND ECONOMIC ENVIRONMENT

A. Social and Political Commitment to Project Methods and Objectives

There is clear support and commitment from the top levels of policy making and program planning in Zambia for the family planning project which has been conceptualized collaboratively and vetted with ministry officials. Key donors and NGOs have also been consulted throughout the development of the project. The most definitive evidence of all is that the project was construed to support the principal components of the MOH Family Planning Programme.

Where there is less certainty of a commitment is at the individual district level. The key players and intermediaries will be members of the District Health Management Teams who determine the district health program priority areas. Since family planning is one of ten programs included in the district plans, it is uncertain what level of priority it will be given. The annual plans for 1994 are being developed in August and September of 1993.

Assuming some "pre-screening" of health centers is done to not include those opposed to contraceptive methods or family planning in general, the social commitment to the family planning project on the whole exists on the basis of the large unmet demand for services among the strategic districts. Some qualifying factors, such as spousal approval, tribal beliefs about various methods, religious beliefs, the aggregate experience with modern contraceptives and preference over traditional methods by district, have not been assessed at the district level. IEC messages need also to be targeted at community influentials and local political leadership to

ensure their support. Every district have a long way to go to increase the method mix, availability/accessibility to services and significantly improve the quality of counseling and service delivery for family planning.

B. Potential for Sustainability

Improvements in service delivery will rely heavily on building the institutional capacity of the implementing NGOs and the MCH/FP unit of the MOH who will be responsible for offering training to clinical staff at the district level. Additionally, the curriculum in the nursing school will be strengthened to broaden its coverage of family planning.

In terms of the demand for services, it will be important for health centers and community-based distributors belonging to the same district to convene periodically to review their records on new acceptors and returnees in order to identify any constraining factors to acceptance or continued use. Community-based distributors, through their links with the community, could contribute information about non-users and their attitudes towards family planning.

The relative autonomy of the district health centers under the decentralized plan, on the one hand, introduces the variability potential in performance and commitment, and on the other, more manageable oversight and monitoring of activities. In Annex K-1 of the Project Paper this sort of issue and other sustainability and motivational issues are covered in greater depth for each component.

IX. STRATEGIES AND INDICATORS FOR MONITORING AND EVALUATING THE SOCIAL AND GENDER IMPLICATIONS OF PROJECT IMPLEMENTATION

Information to show improvement in or alleviation of constraints to knowledge and acceptance for men, women, and youth should be based on records and analyses done by the health centers and CBDs aggregated at the district level. Periodic workshops should be held for this purpose and comparisons made with the performance of other participating districts. Indicators to track the social and gender implications of the family planning project could include the following:

FOR KNOWLEDGE:

- Users who abandon a method because of myths or inaccurate information about the method

FOR ATTITUDES:

- Users who report spousal approval (either male or female)

- Clients at service delivery points who decline use of contraceptives because of provider attitudes

FOR PRACTICE:

- Adolescent pregnancies and adolescent abortions
- Age at which women are having their first child
- Women over 40 years of age who opt to limit either through surgical contraceptive methods or implants
- Male clients of counseling and/or contraceptive methods at service delivery points
- New female acceptors

The aforementioned should be obtained from the participating service delivery centers, but additionally, the research and evaluation unit of the MCH/FP in the MOH should be solicited to repeat acceptance surveys for females and males to include districts covered by this project and other districts and provinces for a comparative assessment. The baseline for these surveys are the acceptance studies used for this project design.

The more qualitative information that could be obtained from acceptance surveys would include the following:

- Relationship between educational background and method use (traditional, modern, natural; pill, IUCD, injectables, implants, tubal ligation, beads, etc.)
- Relationship between ethnicity and the same
- Relationship between religious background and the same
- Who makes decisions about method use and number of children - woman, husband, or both

ATTACHMENT A

Persons Contacted

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ATTACHMENT B

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INSTITUTIONAL ANALYSIS

I. BACKGROUND

The introduction of the primary health care (PHC) approach in August 1981 was the first organized effort by the Government of the Republic of Zambia (GRZ) to include family planning information and services into its health program. Prior to this some Zambian nurses received family planning training outside the country and Planned Parenthood Association of Zambia (PPAZ), the local affiliate of International Planned Parenthood Federation (IPPF) was the main organization involved in family planning. Population issues and programs began to receive greater emphasis and focus with the launching of the National Population Policy in 1989 and the inclusion, for the first time, of a chapter on population in the Fourth National Development Plan (1989-1993). At present a number of ministries, parastatals, private companies, mission facilities and non-governmental organizations (NGO) are active participants in Zambia's population program.

II. INSTITUTIONS INVOLVED IN THE NATIONAL FAMILY PLANNING PROGRAMME

The National Commission for Development Planning (NCDP), located within the President's Office, is tasked with integrating population into national development planning. It has also been proposed to act as the secretariat to the National Population Council (NPC) once it is formed. NCDP has issued a National Family Planning Programme (NFPP) 1992-2000 and is in the process of developing an IEC Strategy.

The Inter-agency Technical Committee for Population (ITCP) has been responsible for implementing population policy in the absence of the NPC. It serves as a coordinator for government, NGOs, donors and the private sector and has established information. education and communication (IEC), service delivery and research subcommittees which address technical issues and promote collaboration amongst member agencies.

The Ministry of Health (MOH) through the Family Health Unit (FHU) coordinates and provides MCH/FP services within the PHC program. Its responsibilities include: developing standards, guidelines and protocols; training service providers and their supervisors; monitoring program performance and supervising service providers; and coordinating inputs for family planning including commodities and equipment.

The Ministry of Labour and Social Security is involved in family planning training, motivation and service delivery in the organized

labor sector.

The Ministry of Information and Broadcasting and the Zambia Information Service (ZIS) are the major players in family planning IEC. The Zambia Information Service, the public relations branch of the Ministry with units and infrastructure throughout the country, has recently become the major institutional locus for IEC within the Ministry. The United Nations Fund for Population Activities (UNFPA) is providing technical support to strengthen this unit which will enable it, amongst other things, to carry out audience research, develop focused messages for target audiences and introduce evaluation into the IEC program.

The Ministry of Education has implemented a pilot project to introduce population concepts and family life education into both primary and secondary school curricula.

Medical Stores Limited (MSL) is responsible for procurement and distribution of most pharmaceuticals, medical supplies and equipment to government hospitals and clinics. This includes contraceptive commodities.

The University of Zambia is responsible for training demographers. To date there have been 64 graduates and 100 students are taking demography as a minor subject.

Research related to family planning and population is carried out by a number of institutions including the **MCH/FP Unit, University Teaching Hospital (UTH), Post-Basic School of Nursing and University of Zambia.** A major constraint to utilization of this research for program planning and implementation is the minimal communication between these institutions. On occasion, duplication of research by institutions has consumed scarce resources.

The roles and relationships of the organizations involved in population and family planning and the provision of services over the next two years will be influenced by increasing donor attention to this sector and the introduction of the Health Reforms.

III. DECENTRALIZATION AND THE INSTITUTIONAL INFRASTRUCTURE FOR FAMILY PLANNING PROGRAMS

Although Zambia was a country with a good health service infrastructure and a well-trained cadre of health personnel for a long period after independence, declines in the economy over the past 10 - 15 years and the impact of structural adjustment have negatively affected the health status of the population. In January 1991 a National Conference reviewed the National Health

Policies and Strategies with particular regard to current performance of the MOH and attempted to realign resources and commitments towards objectives which would improve the effectiveness and efficiency of the Health Care System. The resulting document, the National Health Policies and Strategies (Health Reforms) published in October 1992 established the basis for improved leadership, better management, accountability, partnership, and improvements in quality of service that is aimed at providing cost-effective quality health care as close to the family as possible.

Implementation of the Health Reforms is receiving attention from the GRZ at national, provincial and district levels as well as from the donor community. Activities are moving rapidly creating a dynamic situation that changes from month to month. It is anticipated that by January 1995, a fully functioning decentralized system will be in place. Since a major focus of the Reforms relates to PHC, present and future planning for population and family planning interventions and activities has to be carried out in the context of the Health Reforms and the decentralization of health services.

Organizational Structure of Health Reforms

The highly centralized institutional structure which up to now has been responsible for health policy, program and implementation will change to an organizational structure that focuses on provision of services which will be managed by autonomous District Health Boards (DHB) with the input from newly created Area Health Boards. Independent Hospital Management Boards are being created to oversee and manage the operations of individual hospitals. Organograms for the overall organization, MOH Headquarters organization, provincial and district organization are appended in Attachment 1.

Policy direction will come from the national level via a newly established, multi-sectoral National Health Council which is accountable to the President.

MOH Headquarters will be responsible for: (1) developing visions, operational policy and national guidelines and standards; (2) setting objectives and a financial framework for districts and other health care providers; (3) ensuring public accountability through auditing and evaluating performance by all health care providers; (4) ensuring implementation of effective health promotion programs; (5) coordinating biomedical and health systems research; (6) collecting health information; and (7) coordinating donor contributions within the health sector.

The Provincial level, substantially decreased in

size and function, will be headed by the Regional Health Advisor. He/she will provide technical and advisory support to the districts without having any command authority over the district. The Provincial level will also be tasked with training, audit and bulk storage functions.

The autonomous DHBs will be responsible for the provision of a basic health program in their district through the identification of health priorities and the management of resources to address these needs. The position of District Director of Health will be established as the Chief Executive of the DHB. The functions of the present District Health Management Team (DHMT) will be taken over by the DHB but the DHMT will still be one of the executive arms of the DHB.

Area Health Boards will be set up by the DHB to link the community with the institutions planning for and providing services at the next higher level. In this way inputs from beneficiaries will be integrated into the system.

Financing Health Reforms

A working group, initiated by the Minister of Health, has been established to restructure, review and explore financing mechanisms for the health sector within the context of the following guiding principles:

-Before charging consumers for health care, improvement of quality utilizing better management to reduce costs and enhance efficiency and effectiveness is essential;

-Epidemics, chronic infectious diseases and natural disasters will be exempt from charges;

-The principle of Essential Drugs should be maintained, strengthened and expanded;

-MCH and family planning are priority areas for Social Action Program Support. Free referrals for the needy should be reinforced to improve safe motherhood;

-Village level participation is part of the system for health care financing. Incentives for community health workers should be developed and supported; and

-Priority should be given to income generating activities for women.

A number of mechanisms have been proposed and are at various stages of formulation and introduction. Firstly, budget

reform decentralizes the budgeting process to the district level and is based on a program oriented format. Health insurance schemes to be introduced in urban and rural areas are being developed and various forms of user fees and drug charges are being introduced at service delivery points. Community financing schemes are being looked into and private practitioners are being encouraged to play a more active role in the provision of health services through easing of regulations and incentives through the revised Investment Act. The Danish International Development Agency (DANIDA) is providing financial resources in the form of block grants to the districts to implement the Health Reforms. The amount each district received is based on its population.

Current Status of Health Reform Process

Initially 22 districts in the nine provinces were identified to serve as pilot districts for Health Reform implementation. However once the process started, all districts were included in the training activities and each developed a district action plans, thus the pilot phase was subsumed by an unplanned nationwide implementation process.

The first training of the DHMTs took place in March and April 1993. The focus was on team building and introduction of the planning process which included problem identification, prioritization of needs and development of interventions to address these needs. Skills were developed to enable the DHMT to determine objectives, outputs and outcomes for their district plans and identify strategies and activities to achieve these objectives. During this period Financial Officers in the districts received three days of training from Price Waterhouse which enabled them to provide input to the budget and budgeting process for the district plans. The DHMTs were then given eight weeks to further develop and review their plans and submit them to Headquarters.

After Headquarters reviewed the plans a second workshop was held in which the Headquarters and Districts finalized a six month action plan which addressed four out of the 10 - 12 priority health areas. Specialists in the MOH were to have completed discussion papers on particular health areas e.g. MCH/FP, nutrition, environment, universal childhood immunization, acute respiratory infection, malaria etc. by the end of July, however, this activity is somewhat behind schedule. The discussion papers identify various interventions to address particular health areas along with the merits and demerits of those interventions, so that districts will have full and reliable information regarding alternative interventions on which to base their programs and budgets.

The third series of workshops is for district

personnel who have been doing the planning to date and Health Center Managers who are more knowledgeable about the health realities and problems of the beneficiary population. These were held during the period that the FPS Project was being designed. The workshops were being facilitated by teams consisting of selected participants from previous training sessions and staff from the MOH and UNICEF.

Funds from the Block Grant provided by DANIDA to the districts, are being released in stages. Upon receipt of the Action Plans by the MOH and certification by the Government Accounting Office, funds are handed over to the districts. UNICEF, ODA and the Sweedish International Development Agency (SIDA) provided resources for the first grants since DANIDA had not received its resource allocation in time.

Constraints to the Reform Process in Relation to Family Planning

Aside from the larger issues of institutionalization and sustainability of the Health Reform process which affects provision of health services on a countrywide basis, there are implications for the provision of family planning services within the new system. To date, family planning services have been marginalized and weak in many districts. This is in part due to constraints such as lack of a strong cadre of trained service providers, unavailability of a consistent commodity supply, inadequate information regarding family planning in general and lack of accessible specific family planning services. In addition many health leaders at headquarters, provincial and district levels do not have as strong a commitment to family planning as some of the other vertical health programs such as immunization.

Since districts will now identify program priority areas to concentrate their resources, there is the possibility that an intervention such as family planning which will not collect substantial user fees or show immediate visible benefits will remain marginalized. These constraints are being addressed within the context of the national PHC priorities. Districts, although theoretically autonomous, will have to show cause for deviating from these priorities. "Confirmation" of district health action plans, for at least the first year of the program, will be the responsibility of a team at MOH headquarters. Family Planning ranks high on the list of PHC priorities and although many districts may not identify this preventive, long-term health intervention as an immediate felt need, it is anticipated that it will be included as an activity in district action plans.

IV. FAMILY PLANNING SERVICES PROJECT (FPS) COUNTERPART INSTITUTIONS

The institutional analysis for the FPS Project focuses on the following major counterpart institutions: the MCH/FP Unit of the MOH; the Pharmaceutical Society of Zambia (PSZ); Zambia Information Service (ZIS); Chainama School for Environmental and Health Sciences and the Zambia Council of Nurses. In addition the Church Medical Association of Zambia (CMAZ) which has a coordinating role for 32 Mission hospitals and 54 Mission health clinics; and selected NGO sector institutions which are active in the area of PHC and family planning are reviewed.

MCH/FP Unit

The MCH/FP Unit was established with the assistance of UNFPA in 1983/84. As mentioned previously it is the main coordinating body for the national family planning program. The Unit is under the directorship of the MCH/FP Specialist who reports to the Deputy Director for Medical Services. Below the MCH/FP Specialist, the National Coordinator for Family Planning oversees the following functional sections: IEC, Training, Clinical Services, Research and Evaluation, and Administration. UNFPA still provides the major funding for the Unit's staff, including six nurses, the Family Planning Coordinator, the Administrative Officer and the statisticians. UNFPA previously provided funds through its Executing Agency, the World Health Organization (WHO), for a Technical Advisor but at present the position is vacant. Although funds remain available for this position, the Unit has not requested a new Advisor.

The MCH/FP Unit is troubled by human resource issues such as lack of career structure and internal inconsistencies in levels of remuneration. Although progress in the areas of training, research and systems development for family planning have been achieved by the Unit, weakness in terms of managerial skills and resources have served to limit integration of these achievements and other family planning efforts within the national health program. In addition, while MCH is seen as a priority in the PHC approach, family planning has often been viewed as an NGO initiative and not given the attention or high level focus and integration within the government program. Another constraint is the organizational and programmatic separation of the AIDS and family planning programs despite the related nature of interventions.

Recognition of the need to strengthen the capacity of the MCH/FP Unit in order to effectively carry out the NFPP has come from the World Bank, UNFPA and the NFPP itself. Specific recommendations include:

(1) The institutional position in the MOH of the MCH/FP Unit

should be clarified and its mandate, roles and tasks be strengthened and defined so that it is able to provide the management and technical oversight to assist in the implementation plan for the NFFP in the context of the Health Reforms.

(2) The structure and relevant expertise of the Unit needs to be adapted and rationalized to maximize integration with other programs in the MOH and minimize the isolation that has occurred in the past.

(3) Increased resources in terms of funding and competent staff should be made available to the MCH/FP Unit immediately. The vacant position of national MCH/FP Specialist should be filled with the identified nominee and she should be supported with resident technical assistance. Disincentives in the personnel process should be addressed.

It is acknowledged that the MCH/FP Unit will play a critical role in guiding and strengthening the family planning program in Zambia so that the country's population goals are achieved. It is strongly recommended that everything possible be done to strengthen the capacity of this Unit. USAID, with its comparative advantage and long years of experience in the field of population and as a major donor to the population program of Zambia, will be well suited to provide the support and resources to strengthen the capacity of the MCH/FP Unit.

The General Nursing Council

The GNC of Zambia is a Statutory organization established by an Act of Parliament known as the Nurses and Midwives Acti of 1970. The Act has recently been revised to strengthen and expand the role nurses play in all methods of family planning and is awaiting confirmation by Parliament.

The Council is comprised of a Board of seventeen members who are appointed by the Minister of Health for a period of three years. The full Council meets quarterly with standing committees meeting as necessary. The four standing committees are:

(1) Education Committee- which is responsible for all issues pertaining to nursing education, certification, monitors curriculum development, approves health institutions for nursing and midwifery training.

(2) Examination Committee- which approves examination questions and results.

(3) Disciplinary Committee- addresses the discipline of qualified nurses.

(4) Executive Committee- deals with financial and administrative matters of the Council. It also carries out investigations into cases of alleged professional misconduct.

The day to day operation of the GNC is supported by a professional staff of four including the Registrar, Deputy Registrar, Inspector and accountant as well as administrative support staff.

The GNC has been creative in fund raising schemes in order to purchase the lease on the land and build the structure in which they are presently working. In addition, funds for operating expenses are obtained through small government grants, capital grants, nursing registration fees, examination fees, seminar fees, and fines. GNC financial books are audited yearly by the Office of the Auditor General.

In 1991, the GNC assisted with the revision of all nursing curriculum either to strengthen or incorporate FP for all cadres of nurses. The GNC provided training for forty-one tutors from nursing schools throughout the country in the revised curriculum. There has been no evaluation or follow-up on these tutors and was identified, by the Registrar of GNC, as a major constraint to quality asssurance for training. The absence of transportation was sited as the reason for lack of follow through.

The required examinations for licensing serve to set standards for the necessary requisite knowledge for each cadre of nurses. Therefore, with financial and technical assistance from the FPS Project, the GNC is in an ideal position to coordinate in-service training, assist with development of standards and protocols, provide certificates for training, and initiating continuing education as an incentive approach.

Pharmaceutical Society of Zambia

PSZ is a private, non-governmental, professional organization for private and public sector pharmacists which was established in 1982 with the following five main organizational objectives:

-To facilitate communication and cooperation among pharmacists in the government and private sector in Zambia and abroad and with its worldwide organizational counterparts;

-To provide opportunities for exchange of information about

new techniques and developments in the pharmaceutical industry;

-To raise professional standards of pharmacists throughout the country by organizing programs, seminars and training courses to enhance skills and knowledge of its members;

-to reinforce GRZ guidelines governing pharmacists and introduction of drugs or other pharmaceutical into Zambia; and

-to increase public awareness about general health and family planning issues, and the role that proper use of medications and contraceptives can play in ensuring physical well-being of Zambians of all age levels.

The organization has approximately 100 dues-paying members and is managed by a six-person Executive Committee elected by the members. Past activities have included exhibitions, seminars, public information campaigns and selected activities with pharmaceutical societies in other countries. A major responsibility of PSZ is to work with the GRZ Poisons Board, government inspectors and Provincial Medical Officers in setting standards and providing technical inputs for drugs imported into Zambia.

PSZ has been the single largest distributor of condoms in Zambia. Under a five-year project with Family Planning International Assistance (FPIA) which ended in 1991, PSZ supported the distribution of pills and condoms to 126 outlets throughout Zambia. These outlets were primarily pharmacies of members. In October 1992 Population Services International (PSI), the contractor for the USAID HIV/AIDS Social Marketing Project selected PSZ as the implementing agency for this project. Since the collaboration with PSI commenced, PSZ has increased and diversified its outlets for condoms to 390 including pharmacies, grocery stores, private/parastatal medical clinics, wholesalers, bars and hotels. PSZ is also implementing a $26,000 commodities distribution project (condoms, pills and IUDs) with Pathfinder International.

In 1990, PSZ generated K443,500 in income which represented about 22 percent of its overall budget. Under the present social marketing project 15 percent of revenues generated are being returned to PSZ to support operational expenses and 85 percent are being placed in a special account to promote sustainability efforts. PSZ is committed to long-term growth and self-sustaining activities.

Assessments by PSI field personnel and Pathfinder International have identified PSZ weaknesses in the areas of

management, sales, marketing, media and IEC outreach capabilities. However with targeted technical assistance, supervision, training and continued implementation experience, PSZ organizational capabilities can be effectively strengthened.
PSI's Project Management Team has developed plans to work with PSZ management to: (1) improve skills in accounting, logistics and quality control, sales and financial data analysis and service delivery; (2) provide key PSZ members with training in market research, price determination, advertising and promotional strategies, sales management and reporting and product development; and (3) introduce training and supervision of sales techniques, presentation and motivation.

To date PSZ has sold 2.9 million condoms in the seven months of operations. Present social marketing staff includes: a Finance and Administration Manager; a Sales Director; a Warehouse Manager; 3 sales representatives; and 2 drivers. The Marketing Manager who will be the "understudy" to the PSI Resident Advisor has not yet been hired. The program has a fleet of four vehicles.

PSZ is well positioned to play an important role in social marketing for family planning. It is the only organization in Zambia that has experience in social marketing and its capabilities and infrastructure are continually being enhanced through its activities with the ongoing HIV/AIDS project; it has the logistic resources and can serve as a link between public and private sector family planning initiatives; it has the infrastructure in place to initiate immediate action with respect to social marketing for family planning; and it has the potential to make contraceptives more accessible through advertising and IEC campaigns.

Zambia Information Service

ZIS, a department of the Ministry of Information and Broadcasting Services (MOIBS), undertakes government publicity and development-oriented communication through its network of provincial and district offices, the (irregular) publication of six vernacular newpapers and magazines, and district-based public address systems. It has a staff of 4,400 employees and has its headquarters in Lusaka, and offices in each of the nine provinces, and 47 of the 64 districts. Eight more district offices are to be established shortly. The District Information Officer and the Campaign Van Operator are based at the district offices; the Provincial Information Officer, the Deputy Maintenance Officer for the public address system, and photographers are at the provincial office. The video crew is based at the headquarters in Lusaka.

ZIS managed and executed the UNFPA-funded Population Communication Project from 1986 until 1991 when it was moved to the office of the Assistant Secretary of Press aat the MOIBS headquarters. The Population Communication Project has recently been moved to ZIS once again. The World Bank and UNFPA (1993) assessments and the Director of ZIS have indicated the need for training and technical assistance in management, strategic planning, and audiovisual production.

Gorman Advertising

Gorman Advertising, which was established in April 1991, has a staff of 12 people, including the Managing Director, two account executives, four graphic artists, one accountant, two secretaries, and two messengers. The Managing Director was the Account Executive for the 1991 PPAZ family planning multi-media campaign when he was with Fleetfoot Advertising. The company's billing in April 1991 was Kwacha 95,000 and Kwacha 18 million in April 1993. Some clients include Premium Oil Industries, Ltd., Honda, Big Five Car Rental, ROP Ltd., and WHO (Anti-AIDS Campaigns).

Gorman Advertising has in-house capabilities in developing print advertisements from concepts to the finished product, including placing, monitoring, and feedback. However, Gorman contracts all research and some evaluation to local marketing research companies and hires Videocraft, a sister organization, for all audiovisual projects. Gorman and Videocraft will be merging shortly.

V. MISSION AND NGO SECTOR INSTITUTIONAL BASE

Churches Medical Association of Zambia

CMAZ, founded in 1970, coordinates the health programs being offered through 14 different Protestant and Catholic denominations in Zambia. There are 86 member institutions of which 32 are hospitals and 54 are rural health centers. CMAZ estimates that its memberS are responsible for 50 percent of health care service delivery in rural Zambia and 30 percent of health services in the entire country. It is generally agreed that services offered through this system are effective, well coordinated and of high quality.

CMAZ and its affiliated organizations receive funding from the MOH, WHO, Norwegian Agency for Development (NORAD), UNICEF, other donor agencies and church institutions from abroad. In 1989, funding constraints brought about by difficulties in

processing CMAZ's government grant led to the introduction of "contributions" for curative services.

CMAZ public health efforts focus on PHC, immunization and AIDS. Over the past six years the CMAZ AIDS program has stressed counselling and home based care in rural areas. Approximately 80 health personnel, including clinical officers, nurses, health assistants, doctors and social workers, from small hospitals and rural health centers have been trained as AIDS counsellors.

Family planning is offered by a number of Mission facilities, usually through an integrated MCH/FP approach. Although statistics on the methods and volume of services offered by these institutions are not regularly aggregated by the MOH, evidence exists that a variety of methods including injectables and VSC are offered. Catholic institutions support natural family planning methods. Expansion and strengthening of family planning services provided through the churches medical infrastructure and personnel deserves attention. Targeting individual institutions, as opposed to the coordinating organization of CMAZ will have a greater impact.

Planned Parenthood Association of Zambia (PPAZ)

PPAZ is a charitable, non-profit NGO involved in promoting information about and use of family planning services. It was registered in March 1972 under the Societies Act of Zambia and established its first branches in Kitwe and Ndola. Initially activities were organized by volunteers, but now in addition to a strong volunteer base, the organization employs approximately 70 paid staff. The approved staff establishment is 91. PPAZ has 34 branches located in five regions. Its Board of Directors has representatives from government, the private sector and health organizations. Attachment 2 provides details on its overall organization as well as its volunteer and staffing patterns.

Under its current program PPAZ is implementing seven projects based upon four main strategies.

(1) Family planning motivation for the general public and specific target groups encompasses:

- motivational campaigns for community leaders and industrial workers;
- production and distribution of family planning posters in local languages; and
- empowerment of young rural woman.

(2) Training and service delivery through:
- The PPAZ Family Planning Center in Lusaka

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- The Integrated Family Planning Nutrition and Parasite Control Project in Ndola and Samfya districts and through the Flying Doctor, Tropical Disease Research and National Food and Nutrition Commission.
- CBD services in Ndola and Lusaka

(3) Family Life Education and Youth Development in 12 branches, providing non-prescription family planning methods and skills training.

(4) Staff and Volunteer Development to improve program effectiveness and efficiency.

PPAZ also gathers information related to family planning through MIS and research studies and it has implemented a company based family planning project with the Enterprise Program. Until recently PPAZ supplied and distributed a large portion of the contraceptives for the government program. However, within the past three years MSL has been officially designated as the responsible organization for family planning logistics. Commodities provided by IPPF are currently routed through the MSL system.

With technical and financial assistance from the British Overseas Development Administration (ODA), PPAZ participated in a strategic planning exercise and developed a strategic plan for 1994-1998. Based upon an identified high knowledge and demand for family planning, PPAZ's major focus during this period will be on service delivery and intensified IEC motivation for use of family planning. ODA estimates that it will provide between a half and one million pounds to support this effort.

In addition to funding from IPPF, the Organization receives resources from UNFPA, Africa 2000 through the Canadian International Development Agency (CIDA), JOICFP, and ODA. PPAZ raised about K2.7 million through fund-raising activities at the national and branch level, membership subscriptions and donations. In 1992, PPAZ was one of the two NGOs that received a K500,000 grant from the GRZ. This was the first time that the GRZ has provided financial grants directly to NGOs for general program purposes.

In its strategic planning exercise, PPAZ identified the following organizational weaknesses: (1) financial dependency on donors; (2) lack of clarity in delegated roles and responsibilities leading to delayed decision-making; (3) lack of control measures in accounting and reporting procedures; (4) implementation of an organizational restructuring process without the concomitant strengthening of management capacity at all levels (5) lack of clear and rational guidelines and policies on staff

remuneration, benefits and responsibilities; (6) inadequate information exchange and information systems; and (7) inadequate resources.

PPAZ's management and structural weaknesses are being addressed in part by the organization in its strategic plan and through assistance given by ODA. It is clearly an organization that has a continuing role to play in family planning especially in the area of service delivery and IEC. Discrete PPAZ programmatic initiatives and/ or collaborative activities can be supported by the FPS Project, but should be analyzed in context of PPAZ's current level of programming and absorptive capacity. All FPS Project interventions with PPAZ should include a management support element.

The Family Life Movement of Zambia (FLMZ)

The FLMZ was established in 1981 as an affiliate of the International Federation for Family Life Promotion. It is registered under the Societies Act, incorporated under the Lands Ordinance and has no religious or political affiliations. The organization promotes natural family planning (NFP) methods e.g. cervical mucus, sympto/thermal and breastfeeding. Its headquarters are in Lusaka and it operates programs in all regions of the country. There are 22 employees and approximately 50 volunteer teachers. Although 300 teachers were trained, most dropped out of the program because of lack of remuneration. FLMZ collaborates with most church organizations and the ministries of Health, Education, Youth and Social Welfare. Both government and employer clinics provide space for FLMZ volunteers. FLMZ also received a GRZ grant of K500,000 in 1992.

Between October 1983 and March 1988 FLMZ enrolled 3701 learner-users of NFP. It took an average of 8.5 months to learn the method without assistance and during that time 75 percent dropped out of the program. Of the remaining 25 percent approximately 70 percent continued with the method. This calculates to approximately 647 continuing acceptors during this period. Unplanned pregnancies amounted to 8.9 per 100 years of woman-use. FLMZ has a crisis pregnancy counselling service and has assisted in introducing family life education into 10 schools in Lusaka. The organization has published and IEC pamphlet entitled "Fruitful Love" which has been translated into Bemba and is presently undergoing translation into Nyanja.

Makeni Ecumenical Centre

The Makeni Ecumenical Centre founded in 1971 implements programs in health including family planning, agriculture, adult education, pre and primary school education,

nutrition and homecraft. Family planning was originally incorporated into the organization's health services once a week for a few hours in 1975. In 1981 FPIA provided funding for Makeni's family planning program and this assistance was continued by Pathfinder International when FPIA terminated its assistance in 1989. The Center operates two static clinics and 15 outreach service delivery sites. There are ten CBD agents, four male and six female, who provide services in three peri-urban and seven rural areas including farms and industries. The CBD agents coordinate their activities with the mobile outreach program. CBD agents provide condoms and spermicides and resupply pills to clients. Their activities also include male motivation in nearby industries and farms.

Seventh Day Adventist Church - Dorcas Family Health Project

The Adventist Development and Relief Agency (ADRA) has two CBD Projects - Chipata Dorcas Community Family Health Project and the Kabwe Dorcas Family Health Projects which are implemented by its womens' associations and funded by Pathfinder International. Family planning activities are offered in clinics, through mobile outreach where it is integrated with other MCH services and through CBD programs. Both rural and urban areas are served and in addition to service delivery IEC and counselling are emphasized.

Young Womans Christian Association (YWCA)

The YWCA of Zambia was established in 1957 and is "dedicated to the empowerment of women in order to achieve a better community". Activities include: skills development and income generation projects; PHC including AIDS awareness and family planning; introduction of appropriate technology devices; nursery schools for children of working women; hostels for young women and female transients; and consciousness-raising and empowerment.

The YWCA is governed by a National Council served by a Board of Directors. Standing committees guide the work of the ten active branches. Five of these branches have full-time paid staff while the rest are operated by volunteers. The YWCA is financed by: member support; World YWCA; volunteer fund-raising activities and income generation schemes; and donors e.g. Protestant Association for Cooperation in Development of Germany, Interchurch Organization for Development Cooperation of Netherlands, CIDA, NORAD, the Catholic Agency for World Development and SIDA. Separate accounts are maintained for donor-funded projects and auditor's reports are available. The annual budget for 1992 was K 30 million of which about 50 percent is generated locally.

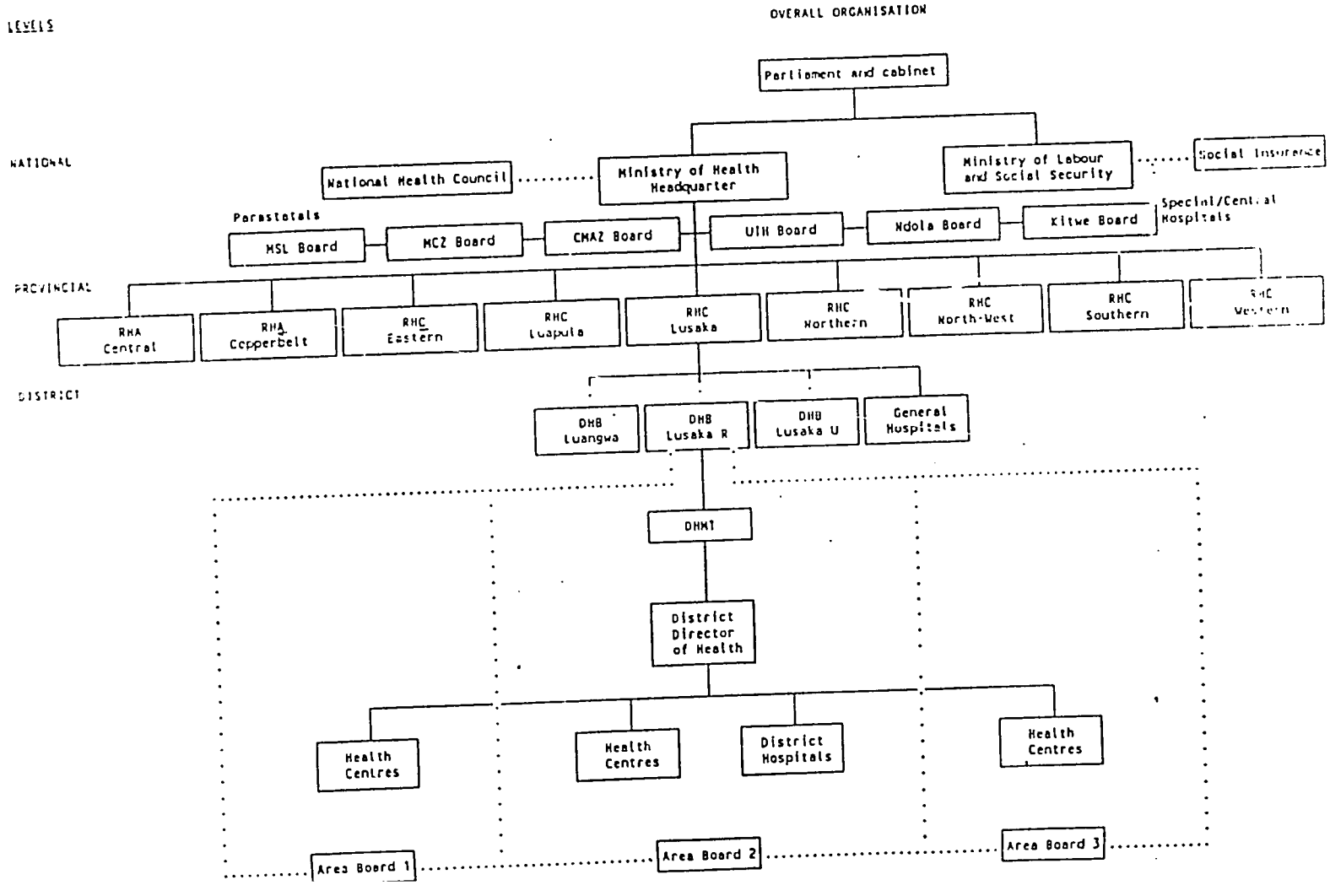
The YWCA has a substantial PHC program which draws on community resources and is geared to community participation. During 1992 its family planning program served 458 new acceptors and 1,175 continuing acceptors. The 1992 report prepared by the Family Health Nurse in the Office of the Provincial Medical Officer of Lusaka Province reported that family planning clients have substantially increased but contraceptive commodity supply has been a major constraint. The YWCA has the necessary infrastructure, staff and commitment to effectively expand family planning services once these constraints are addressed.

Environment and Population Centre (EPC)

The EPC, founded by a former President of the African Development Bank, was established in 1989 with the general objective of creating awareness of the inter-relationships between environment, population and development. EPC receives funds from the McArthur Foundation via the Population Resource Center in New York. The organization sponsors seminars, study tours and research with the purpose of fostering interest and participation in public-private dialogue and joint action to address relevant issues. Since 1989 the following topics have been covered in EPC's seminar series:

(1) Causes and effects of child morbidity and mortality in Zambia;
(2) Urbanization and environmental degradation;
(3) Population growth and socio-economic implications on education and employment;
(4) The relationship between family planning and health;
(5) Wildlife Management in Zambia;
(6) Population growth: its socio-economic implications on land and food;
(7) Population trends in sub-saharan Africa;
(8) Population, environment: Prevention and control of epidemics - Case of Cholera; and
(9) Population, environment and development: The missing links.

In addition to these, a number of other NGOs (Attachment 3) are implementing health and community development programs in Zambia. The major constraints associated with NGOs are lack of adequate funding, dependency on donor support and variable management capacity. However their major strengths of being able to implement innovative programs, having direct access to the beneficiaries and exhibiting strong commitment to their programming efforts, place them high on the list to implement family planning projects under the FPS Project.


LEVELS
OVERALL ORGANISATION
NATIONAL
Parliament and cabinet
National Health Council
Ministry of Health Headquarter
Ministry of Labour and Social Security
Social Insurance
Parastatals
MSL Board
MCZ Board
CMAZ Board
UTH Board
Ndola Board
Kitwe Board
Special/Central Hospitals
PROVINCIAL
RHA Central
RHA Copperbelt
RHC Eastern
RHC Luapula
RHC Lusaka
RHC Northern
RHC North-West
RHC Southern
RHC Western
DISTRICT
DHB Luangwa
DHB Lusaka R
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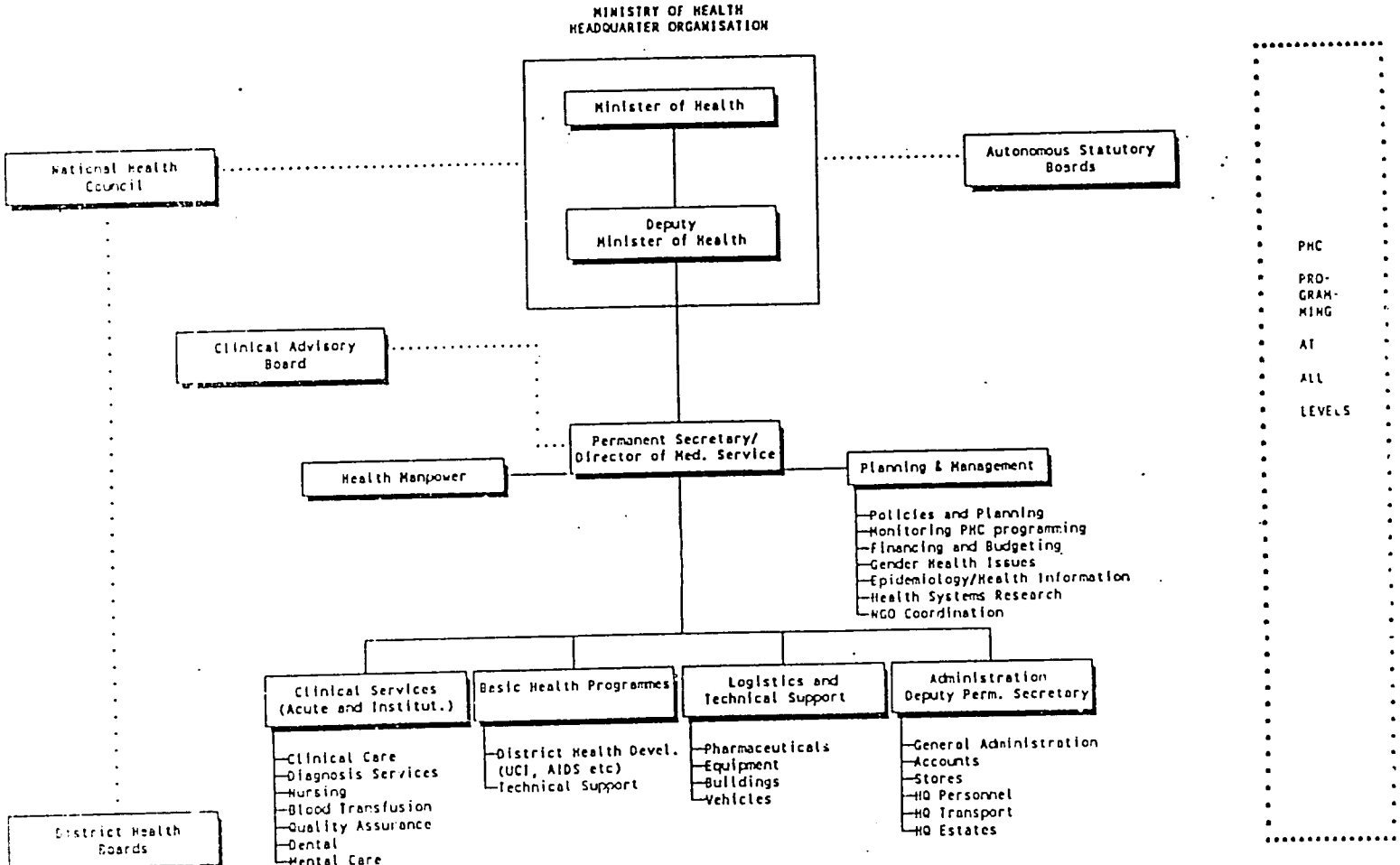
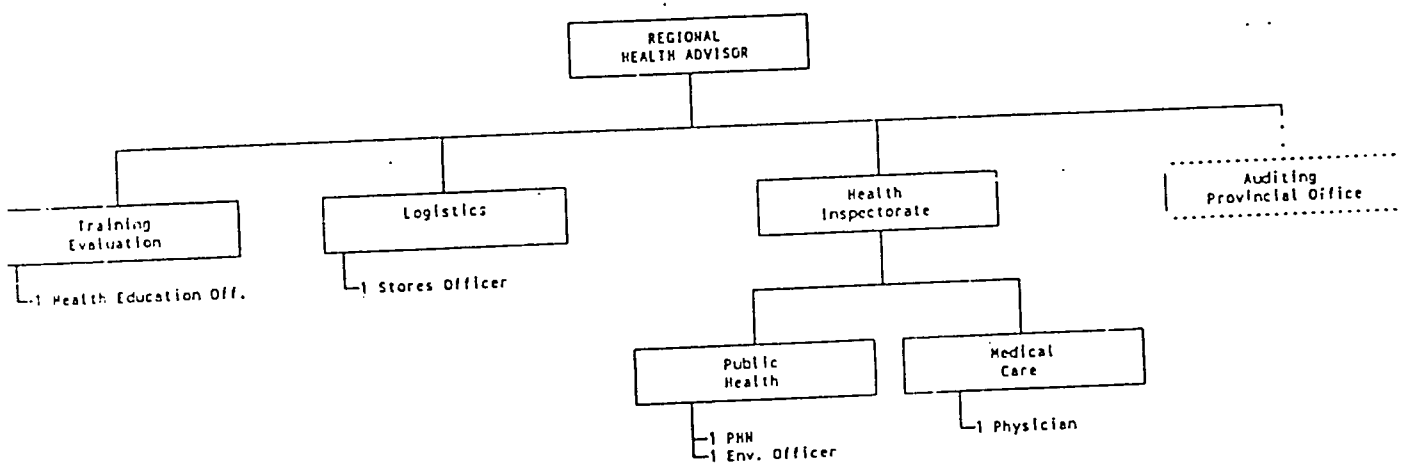
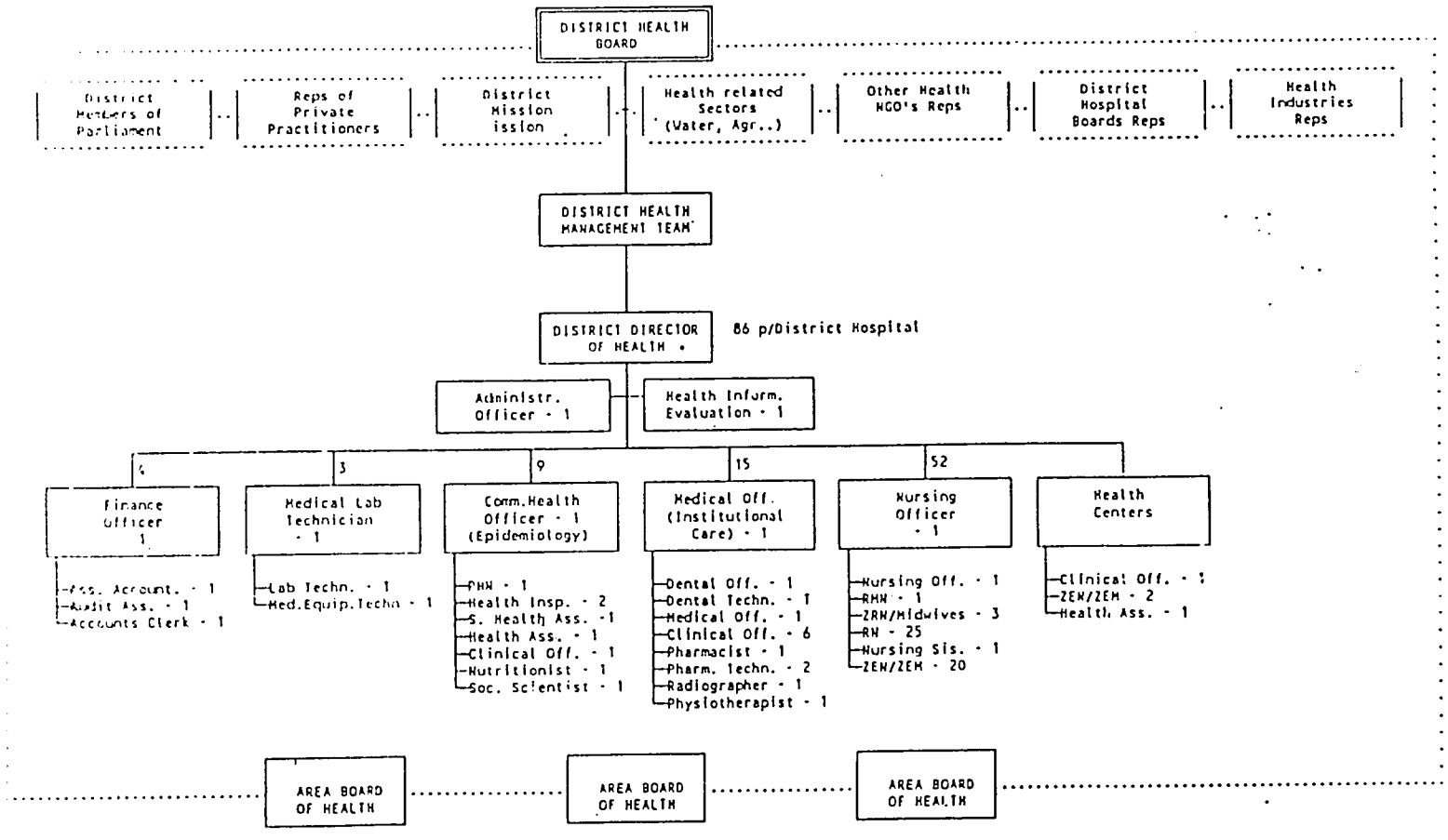
Health Centres
Area Board 1
Area Board 2
Area Board 3


MINISTRY OF HEALTH
HEADQUARTER ORGANISATION
Minister of Health
Deputy Minister of Health
National Health Council
Autonomous Statutory Boards
Clinical Advisory Board
Permanent Secretary/ Director of Med. Service
Health Manpower
Planning & Management
Policies and Planning
Monitoring PHC programming
Financing and Budgeting
Gender Health Issues
Epidemiology/Health Information
Health Systems Research
NGO Coordination
Clinical Services (Acute and Institut.)
Clinical Care
Diagnosis Services
Nursing
Blood Transfusion
Quality Assurance
Dental
Mental Care
Basic Health Programmes
District Health Devel. (UCI, AIDS etc)
Technical Support
Logistics and Technical Support
Pharmaceuticals
Equipment
Buildings
Vehicles
Administration Deputy Perm. Secretary
General Administration
Accounts
Stores
HQ Personnel
HQ Transport
HQ Estates
District Health Boards
PHC PRO-GRAM-MING AT ALL LEVELS

ZAMBIA HEALTH CARE SYSTEM
PROVINCIAL ORGANISATION



ZAMBIA HEALTH CARE SYSTEM
DISTRICT ORGANISATION
(Mission Hospitals not included)



MOH PERSONNEL BY HEALTH FACILITIES, 1993

PROVINCE/DISTRICT FACILITY	DOCTORS/ MEDICAL MGMT.	CLINICAL OFFICERS & INSP.	HEALTH ASST.s	NURSES/ MIDWIVES	OTHER MEDICAL & P.H.	ADMIN., ETC.	TOTAL PERSONNEL
CENTRAL MINISTRY	42	2	0	1	18	274	337
HEALTH DEMO ZONE MWACHISOMPOLA	4	12	5	17	6	12	56
CHAINAMA COLLEGE OF HEALTH SCIENCES	5	26	0	0	26	17	74
UNIVERSITY TEACHING HOSPITAL (UTH)	218	13	0	440	399	176	1246
UTH SCHOOL OF NURSING	1	10	0	7	72	5	95
SUB-TOTAL	270	63	5	465	521	484	1808
CN PROVINCIAL MEDICAL OFFICE	5	9	3	3	2	25	47
KABWE GENERAL HOSPITAL	36	49	0	191	44	42	362
KABWE SCHOOL OF NURSING	0	1	0	29	3	4	37
KABWE RURAL HEALTH CENTERS	1	32	13	51	0	8	105
MUMBWA DISTRICT HOSPITAL	2	33	7	53	5	13	113
SERENJE DISTRICT HOSPITAL	3	32	8	33	6	10	92
CHITAMBO DISTRICT HOSPITAL	2	32	6	28	2	20	90
MKUSHI DISTRICT HOSPITAL	2	12	6	20	3	5	48
TOTAL CENTRAL PROVINCE	51	200	43	408	65	127	894
CB NDOLA CENT HOSP/SCHOOL OF NURSING	138	68	0	375	120	152	853
KITWE CENTRAL HOSPITAL	100	44	0	302	60	115	621
KITWE CENT HOSP SCHOOL OF NURSING	0	0	0	0	23	2	25
PROVINCIAL MEDICAL OFFICE	7	8	1	5	1	32	54
THOMPSON HOSPITAL, LUANSHYA	3	30	1	101	8	12	155
KAMUCHANGA HOSPITAL, MUFULTRA	4	30	0	93	9	12	148
CHINGOLA/CHILILABOMBWE/KALUSHI HCs	4	22	0	120	4	11	161
NDOLA RURAL HEALTH CENTERS (30)	1	29	21	23	1	9	84
TOTAL COPPERBELT PROVINCE	257	231	23	1019	226	345	2101
E PROVINCIAL MEDICAL OFFICE	5	26	3	19	6	31	90
CHIPATA GENERAL HOSPITAL	31	37	0	173	31	57	329
LUNDAZI DISTRICT HOSPITAL	3	31	12	36	8	23	113
PETAUKE DISTRICT HOSPITAL	1	31	19	81	9	26	167
NYIMBA GOVERNMENT HOSPITAL	2	31	0	41	8	26	108
CHIPATA/CHADIZA/LUNDAZI/PETAUKE/ NYIMBA/KATETE RURAL HEALTH CTRS (89)	8	187	96	120	19	0	430
NSADZU REHABILITATION CENTER	0	11	1	0	0	1	13
TOTAL EASTERN PROVINCE	50	354	131	470	81	164	1250
LP PROVINCIAL MEDICAL OFFICE	5	6	2	0	2	27	42
MANSA GENERAL HOSPITAL	21	27	0	120	17	35	220
KAWAMBWA DISTRICT HOSPITAL	2	31	10	37	5	19	104
MBERESHI GOVERNMENT HOSPITAL	3	25	4	36	7	22	97
MWENSE RURAL HEALTH CENTERS	1	12	7	18	0	3	41
SAMFYA HEALTH CENTERS	2	24	10	38	2	7	83
NCHELENGE HEALTH CENTERS	2	16	11	22	1	5	57
TOTAL LUAPULA PROVINCE	36	141	44	271	34	118	644
LS PROVINCIAL MEDICAL OFFICE	2	0	0	0	5	28	35
LUSAKA URBAN HEALTH CENTERS (40)	30	61	0	352	7	25	475
LUSAKA RURAL & LUANGWA HEALTH CTRS (19	2	35	21	51	3	5	117
TOTAL LUSAKA PROVINCE	34	96	21	403	15	58	627

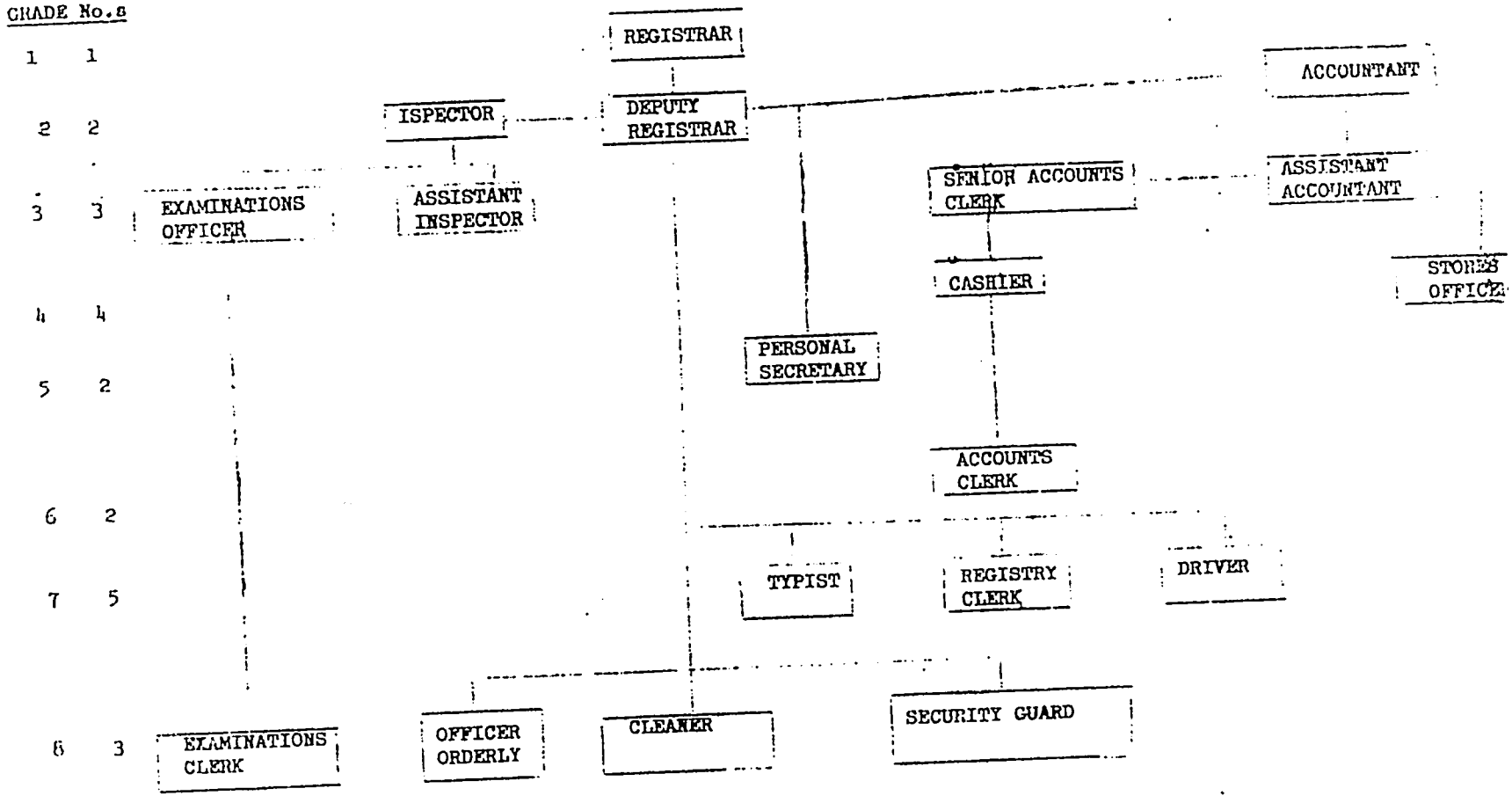
MOH PERSONNEL BY HEALTH FACILITIES, 1993

PROVINCE/DISTRICT FACILITY	DOCTORS/ MEDICAL MGMT.	CLINICAL OFFICERS & INSP.	HEALTH ASST.s	NURSES/ MIDWIVES	OTHER MEDICAL & P.H.	ADMIN., ETC.	TOTAL PERSONNEL
N PROVINCIAL MEDICAL OFFICE	5	7	3	2	2	32	51
KASAMA GENERAL HOSPITAL	24	38	3	153	22	44	284
MBALA GENERAL HOSPITAL	18	28	8	74	15	30	173
CHINSALI DISTRICT HOSPITAL	5	23	10	33	7	23	101
ISOKA DISTRICT HOSPITAL	2	34	10	41	5	24	116
LUWINGU DISTRICT HOSPITAL	2	32	7	33	5	12	91
MPIKA DISTRICT HOSPITAL	3	31	10	36	7	12	99
MPOROKOSO DISTRICT HOSPITAL	2	19	4	30	4	18	77
KAWIMBE REHABILITATION CENTER	0	11	1	0	0	1	13
TOTAL, NORTHERN PROVINCE	61	223	56	402	67	196	1005
NW PROVINCIAL MEDICAL OFFICE	4	6	0	0	2	31	43
SOLWEZI GENERAL HOSPITAL	27	19	11	95	24	42	218
KABOMBO DISTRICT HOSPITAL	4	32	2	44	5	10	97
MWINILUNGA DISTRICT HOSPITAL	3	26	5	38	7	23	102
KASEMPA RURAL HEALTH CENTERS	0	15	1	8	2	0	26
CHIZERA RURAL HEALTH CENTER	0	2	2	4	0	0	8
ZAMBEZI DISTRICT HOSPITAL	4	26	8	43	11	22	114
SOLWEZI/KABOMPO/MWINILUNGA HCs	1	175	98	22	5	0	301
TOTAL, NORTHWEST PROVINCE	43	301	127	254	56	128	909
S PROVINCIAL MEDICAL OFFICE	6	7	3	1	2	32	51
LIVINGSTONE GENERAL HOSPITAL	48	40	0	168	22	44	322
CHOMA GENERAL HOSPITAL	24	27	14	123	22	38	248
GWEMBE DISTRICT HOSPITAL	3	30	16	35	5	13	102
SIAVONGA DISTRICT HOSPITAL	2	10	3	43	6	20	84
KAFUE GORGE HOSPITAL	1	30	1	30	5	21	88
MAZABUKA DISTRICT HOSPITAL	5	23	1	88	13	21	151
NAMWALA DISTRICT HOSPITAL	2	30	16	38	10	17	113
MONZE DISTRICT HOSPITAL	5	29	17	67	6	26	150
ITEZHI-ITEZHI RURAL HEALTH CTR	1	19	8	43	4	3	78
TOTAL SOUTHERN PROVINCE	97	245	79	636	95	235	1387
W PROVINCIAL MEDICAL OFFICE	2	7	2	0	2	29	42
LEWANIKA GENERAL HOSPITAL	24	38	12	147	25	29	275
LEWANIKA GEN HOSP NURSING SCHOOL	0	0	0	0	5	0	5
KALABO DISTRICT HOSPITAL	2	30	9	57	8	20	126
KAOMA DISTRICT HOSPITAL	1	23	7	54	5	16	106
SENANGA DISTRICT HOSPITAL	3	26	15	40	8	17	109
SESHEKE DISTRICT HOSPITAL	3	27	12	63	9	[illegible]	135
LUKULU DISTRICT HOSPITAL	2	6	7	21	6	[illegible]	44
TOTAL WESTERN PROVINCE	37	157	64	382	67	135	842
SPECIAL HOSPITALS							
CHAINAMA HILLS HOSPITAL	24	29	0	54	17	99	223
ARTHUR DAVISON HOSPITAL	30	10	0	124	21	31	226
LITETA LEPROSY HOSPITAL	7	6	0	15	8	29	65
PUBLIC HEALTH LABORATORIES	6	0	0	0	[illegible]	0	[illegible]
RHEUMOCONIOSIS, MED & RSRCH BUREAU	12	0	0	0	0	1	13
FOOD AND DRUG LABORATORY	0	0	0	0	44	[illegible]	51
CHEST DISEASES LABORATORY	0	0	0	0	5		5
MALARIA RESEARCH LABORATORY	[illegible]	0	0	0	4	[illegible]	7
TOTAL SPECIAL HOSPITALS	[illegible]	4[illegible]	0	[illegible]	[illegible]		[illegible]
TOTAL MOH	1016	2056	593	4903	1533	[illegible]	10141

GENERAL NURSING COUNCIL OF ZAMBIA

(The Nurses and Midwives Act,1970)

ORGANISATION CHART



GENERAL NURSING COUNCIL OF ZAMBIA

(The Nurses and Midwives Act 1970)

1993 DRAFT BUDGET

REVENUE	1992 BUDGET	VARIANCE	1993 BUDGET
Government grants	9,000,000	27,000,000	36,000,000
Capital grant	2,000,000	2,500,000	4,000,000
Annual fees	5,250,000	19,950,000	25,200,000
Registration fees	612,000	2,388,000	3,000,001
Examination fees	260,000	-	260,000
Seminar grants	500,000	-	500,000
Accruals and sundries	620,000	1,963,500	2,583,500
fines and levies	2,170,000	8,680,000	10,850,000
Other fees and income	230,000	-	230,000
Sales	4,400,000	84,000,000	88,400,000
	25,042,001	146,481,500	171,523,501
EXPENDITURE			
Staff emoluments	7,571,251	17,905,250	25,476,501
Examination expenses	1,000,000	12,586,000	13,586,000
Education & Inspections	1,061,000	2,009,000	3,070,000
Meetings expenses	399,750	1,821,250	2,221,000
Purchase of goods	1,160,000	1,840,000	3,000,000
Purchase of stock	3,200,000	75,300,000	78,500,000
Purchase of services	2,300,000	7,370,000	9,670,000
Staff loans and advances	1,850,000	4,650,000	6,500,000
Fixed assets	6,500,000	23,000,000	29,500,000
	25,042,001	146,481,500	171,523,501

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ECONOMIC AND FINANCIAL ANALYSIS

I. ECONOMIC ANALYSIS

A. Economic Benefits from Reduced Fertility in Zambia

According to the World Bank report for the Zambia 1993 Consultative Group meeting, the rate of population growth is one of the most powerful elements affecting economic growth in Zambia. The current high 3.2 percent growth rate, together with the high dependency ratio of about 100 percent, makes it very difficult to generate positive per capita growth in Zambia.

The Bank presented two economic growth scenarios, one based on a standard fertility rate decline and the other on a rapid rate of decline (see Table J-1). With the former, total population would double in 25 years; with a rapid decline in the fertility rate, it would take 45 years for population to double.

Table J-1

SCENARIOS BASED ON ALTERNATIVE FERTILITY RATES

	Standard F.R. Decline	Rapid F.R. Decline
Fertility Rate Changes		
1995	6.469	6.469
2000	6.389	5.236
2010	5.629	3.431
2020	4.429	2.552
2030	3.229	2.402
Total Population (in millions)		
2000	10.4	10.1
2010	13.6	11.8
2020	17.3	13.3
2030	21.0	15.0
Dependency Ratios		
2000	100.8	94.3
2010	91.5	66.1
2020	79.8	52.2
2030	64.6	48.1

The impact on average living standards from a rapid decline in

the fertility rate would be considerable. To calculate this, the World Bank had to make an assumption about the impact of population growth on total output. If one envisioned output being constrained by the amount of imported capital, the impact would be negligible. If the image was of extensive agricultural growth responding to more consumers and more potential farmers, the response would be closer to one-to-one in the long-term so long as land was available. In Zambia's case, it would be reasonable to assume no effect on output in the first ten years, because the reduced fertility rate would affect only the number of children, but to assume a 50 percent impact on output after 20 years (which is quite high given Zambia's dependence on copper exports and other fixed sources of foreign exchange).

Achieving the Bank's rapid fertility decline scenario would result in total population being 3 percent lower after 10 years. In terms of per capita income, this is equivalent to having 3 percent more total output or approximately .3 percent per year higher growth rate. The Bank points out that this is the equivalent of having additional investment of 1.5 percent of GDP every year (which in 1992 prices would be nearly 10 billion Kwacha--$30 million at the end of October 1992 open market rate).

The effect over 20 years is even stronger. According to the rapid fertility decline scenario, the total population would be 13 percent smaller. Assuming a 50 percent contribution to increased output, both total and per capita output would be 6.5 percent larger than in the baseline scenario.

The effect of a rapid decline in the fertility ratio is even stronger if we look at dependency ratios. Zambia has a very young population, with almost 50 percent of the population under the age of 15, a familiar feature in countries with a high fertility rate over a long period of time. For every 100 people in the labor force (aged 15-64), there are 106 people (aged <15 and >65) who are dependent upon them. This gives a dependency ratio of 106, in contrast to a ratio of 20 to 40 for developed countries. [The Bank's 106 figure is based on a projection from the 1980 census; the 1992 Demographic and Health Survey (DHS) gives a dependency ratio of 100.]

The decline of 3 percent in total population in 10 years would lower the dependency ratio by 6 percent in the same period. Over a 20-year period, the dependency ratio would be 33 percent lower, which could make a tremendous difference in health and education and in the general level of living standards. Not only would output per person be higher, but services for children and the aged could be enhanced because available resources would be spread over a smaller dependent population.

The number of children between the ages of 5 and 15 was 2.2

million in the 1990 census. The impact of the standard and rapid fertility declines on this age-group is presented in Table J-2 below. These are the school-aged children, and a significant change in their numbers will impact significantly on the number of teachers, school facilities, and school equipment and supplies. Thus, with the rapid fertility decline scenario, the number of school-aged children will be 25 percent less in 20 years. This should mean a somewhat lower but nevertheless quite significant reduction in the amount of money that would otherwise be required to educate the students--a savings to parents and the GRZ budget.

Table J-2

School-Aged Children (in thousands)

Year	Standard Decline	Rapid Decline
1990	2,228	2,228
2000	3,092	3,082
2010	3,863	2,963

High fertility rates contribute significantly to the high rates of morbidity and mortality for both mothers and children. High fertility rates also determine the numbers of females in child bearing ages and the number of children under five, the two segments of the population which make the greatest demand on health services. This demand would translate into different personnel, facilities, and budget needs depending upon the rate of population growth. Table J-3 provides information on the population at risk under the standard and rapid decline in fertility rates scenarios. The difference in mothers to be served does not become significant for 30 years, but the potential savings for services for the under-five group becomes significant within 10 years, numbers being almost 40 percent less under the rapid decline scenario.

Table J-3

Women of Child-bearing Age and Children Under 5

Year	Standard Scenario	Rapid Scenario
Women of Child-bearing Age (15-49)		
1990	1,683	1,683
2000	2,289	2,289
2010	3,106	3,106
2020	4,189	3,768
2030	5,532	4,221
Children Under Age 5		
1990	1,607	1,607
2000	1,942	1,606
2010	2,399	1,492
2020	2,630	1,458
2030	2,600	1,483

An accelerated reduction in fertility can also be expected to have a significant economic and social impact through the demand for urban services. Assuming a rural/urban migration trend of 0.9 percent (a 1985 GRZ estimate), one can extrapolate the demand for urban services using as a proxy the number of new dwellings that will be needed. Currently, about 620,000 dwellings are in place, and an additional 400,000 are expected to be needed under the standard scenario. The requirement under the rapid decline scenario would be somewhat less in 10 years, but about one-third less within 20 years.

Based on its analysis, the World Bank concluded that moving to something like the rapid fertility decline scenario would be the single most powerful step the Zambians could take if they wish to make substantial progress in increasing the standard of living. Without such a change, progress will be frustratingly slow.

It is obvious from the foregoing that there is an extremely high rate of return for any family planning activities in Zambia if they can impact significantly upon the fertility rate. As discussed in other analyses, there are a number of factors that suggest that the timing is right for the Family Planning Assistance project to have a significant impact on the fertility rate. For example, the government has established a population policy and a long-range family planning program. It is in the process of decentralizing the planning and management of health and family planning to districts, which should lead to greater efficiencies

and responsiveness to communities' needs. The DHS findings indicate that there is a large unmet need for contraception. Recent on-the-ground research tends to corroborate the DHS finding: there is a big demand for information about family planning, but there is a limited availability of information and services.

To maximize the chances of impacting significantly upon the fertility rate, the project proposes to target on strategic districts. These districts were chosen by ranking the districts, utilizing the following criteria: total population, population density, unmet need for FP services (available by district in the DHS), and the relative access of the district (measured in driving time from Lusaka). Some further refinement will be required when the implementation team is on board, e.g., to take into account the attitudes of the service providers in the district and the geographical access within the district. A summary of some of the data for the target districts initially selected are included in Table J-4 on the following page.

The data show that the priority areas are Lusaka and the districts in the Copperbelt Province. These highly populated urban areas, already being impacted by rural-urban migration, are the ones that are most vulnerable to a continued high fertility rate--in terms of the potential need for housing, urban infrastructure, employment, health and education facilities. In addition, the high dependency ratios probably impact more heavily on the urban areas than on the rural ones. Usually children can contribute more and earlier to the family welfare in rural areas. Furthermore, in Zambia, where there is still a lot of arable land available, there are greater options for utilizing family members in rural areas than in the urban centers with their high levels of unemployment.

In summary, the World Bank's analysis indicates that the potential benefits from a rapid decline in the fertility rate are very large. The USAID choice of priority target areas is consistent with the WB analysis, concentrating where the chances are greatest for accelerating a decline in the fertility rate. An analysis of the economic aspects of choosing possible interventions is discussed below.

Table J-4

Data on Strategic Districts

B. Economic Analysis of Various Interventions

At the present time, the primary contraceptives available in Zambia are orals and condoms. A major objective of the project is to increase the knowledge of both men and women about the possible contraceptive choices and ensure that there is a more consistent supply of a wider variety of contraceptive methods. The delivered cost in Zambia of a couple year of protection (CYP) of various contraceptives is shown below in Table J-5.

Table J-5

CYP Cost of Various Contraceptives

	CIF Cost Zambia	CYP Conv. Factor	$ Cost Per CYP
Condoms	$ .038	x 150	$ 5.70
Oral Contraceptives	.262	x 15	3.93
Vaginal Foam Tablets	.098	x 150	14.70
IUCD	1.00	- 3.5	0.28
Injectable (1 yr)	5.38	x 1	5.38
Norplant (set)	26.54	- 3.5	7.58
MiniLap/Laproscopy			

The figures understate the costs of all methods except condoms and foam tablets because some additional costs are involved in putting the method into practice, e.g., medical exams, equipment, training of personnel. Even allowing for these extra costs, the most economical contraceptive method is the IUCD. The project intends to train providers at various levels in IUCD insertion and seek appropriate formal action by the MOH to make it clear that such action may be taken by various paramedical personnel, not just doctors.

The next economical method is the use of oral contraceptives and they will continue to be important. Nevertheless, over time it is hoped to move users of orals to methods that give longer term protection. Too many users of orals miss for various reasons, including unreliable supply. The injectable method is more reliable in this sense and has a low failure rate unless subsequent appointments for continuing users are not kept.

Norplant will be promoted, even though of relatively higher cost, because it provides a fairly long period of protection compared to other methods. Condoms will continue to be promoted even though they do not provide long term protection because of their importance in stopping the spread of sexually transmitted diseases, especially HIV/AIDS.

While foaming tablets are more expensive that other methods, the CYP cost is misleading because it is not expected that the method would be used on a regular basis. The tablets provide immediate protection, and they are included in the mix as a back-up to prevent method failure, especially from missed pills.

In addition to looking at the costs and benefits of various interventions, some effort was also made to compare the costs of the different types of programs: clinic-based integrated family planning (IFP), community-based services (CBS), employer-based services (EBS), and contraceptive social marketing (CSM).

It was discovered that there are few reliable data on the costs of these programs. In the first place, most of the methods discussed above are not available in most areas of the country. Furthermore, there is wide variation in costs. In a UNICEF study in Monze district in Southern province, the median recurrent cost for a family planning visit in the 14 rural health centers in the district was 102 Kwacha, but the range varied from 27 Kwacha to 401 Kwacha.

In terms of the outlay of project funds, it is quite likely that the benefit per dollar spent will be greatest in the employer-based services program. This does not mean, however, that greater EBS activity should be undertaken at the expense of other programs. The EBS activity is concentrated in the Copperbelt province, where several of the project strategic sites are located, but it is not a significant potential contributor in other areas. Furthermore, not all methods can be made available at the EBS sites, so support to develop government and mission hospitals as referral sites would also be needed.

The CBS activities should be economical because they will usually be administered by local nongovernmental organizations (NGOs). Their capability, however, is likely to be limited in terms of the methods they can offer. A major contribution of the community worker will be to provide information to men and women about the different methods and referring them to clinics for longer term protection.

The CSM activity is more national in scope than planned activities under the other programs and will be providing evidence of the possibilities of greater private sector participation. A concentration on CSM, to the detriment of other programs, is not desirable because CSM will be concentrating on methods that provide only short-term protection. It is anticipated that the CSM program can provide a back-up supply for a number of contraceptive commodities and will also supply the EBS and CBS sites.

Thus, to get the most cost-beneficial structure, the project

has a mix of activities directed at different providers. It will be important to stress to project implementers the importance of maintaining strong inter-relationships among the programs.

II. FINANCIAL ANALYSIS

The National Family Planning Program of the Government of the Republic of Zambia (GRZ) comprises four components for delivering family planning services:

- integrated family planning through Ministry of Health (MOH) facilities;
- community-based distribution of services;
- employer-based distribution of services; and
- contraceptive social marketing.

Each of the foregoing will be discussed in Sections A - D, with a focus on the funding mechanisms to be used, motivation issues that should be considered, and the sustainability issues involved in each program (including the financing of recurrent costs).

In addition to the above, there are health programs carried out by mission or church groups, and some of them also offer modern family planning services. Usually their programs are clinic-based, but some organizations also support community-based services activities. It is anticipated that any FP Services project support to mission/church family planning providers will be funded through one of the four programs mentioned above. Mission/church activities, therefore, are not discussed herein.

The section concludes with some ideas on ways that the private sector might become involved in expanding the distribution of family planning services.

A. Integrated Family Planning in MOH Facilities

1. Funding Mechanisms

An Integrated Family Planning (IFP) program in the Zambian context is the result of integrating family planning activities into the Maternal Child Health (MCH) program of the MOH. In theory, therefore, one would assume that IFP funding would come from the MOH regular budget. In fact, however, until very recently there was no integrated family planning program. The MCH/FP integration has only recently begun in six pilot centers so there is no budget item for MCH/FP programs. There is, of

course, some MOH funding for MCH and for FP, so one would normally expect that there would be a line item for MCH/FP in future MOH budgets.

These are not, however, normal times in Zambia. Besides general budgetary limitations resulting from overall GRZ deficits, the MOH is in the process of de-centralizing to to-be-created District Health Boards the responsibility for administering health programs (presumably including family planning because the latter is being integrated with MCH). The new system, which is not yet finalized, is likely to involve the provision of block grants to districts based on a long term health strategy for the district and annual budgetary submissions. These block grants are to be supplemented by user fees charged by the district medical facilities in accordance with schedules approved by the District Health Board in consultation with the MOH.

Under the system being installed, the level of financial and other support given to the family planning program will depend in part on the level of the MOH grant to the district. More important, however, will be the priorities of District Health Boards and principal health officers in the district facilities. On the assumption that fees for family planning services will discourage their utilization where the demand is already very small, districts can be expected to charge little, if anything, for family planning services. Thus, there is a built in bias to direct district resources to other health activities where the returns are greater for the facility. Possible ways to deal with this are presented in the next sub-section.

Most FP financing, especially for commodities, has come from donors. Donor funds supported the program during the period of the 1980s when fertility reduction was not a priority of the GRZ and in the early 1990s when GRZ resources have been extremely limited. Presumably, a greater donor commitment will be forthcoming now that the GRZ is committed to fertility reduction.

Adequate funding and good distribution and delivery systems will still not impact on the fertility rate unless there is a demand for the family planning services. The widespread dissemination of effective information, education, communication (IEC) messages--nationally and locally--can help increase the present demand.

In addition, the commodity distribution system, which is currently supply-driven, needs to become demand-driven. The MOH FP supply system has always been dependent upon donor supplies, and these have been inconsistent, intermittent and inadequate. The result has been a proliferation of spermicides and pill brands. As clients became accustomed to products, the supply

would be disrupted, and the next donor would bring in different products.

The MOH has recently taken steps to deal with this supply problem. It has developed a standard list of products, including six different types of pills, an IUCD, condoms, and foams, which it plans to keep in stock. The British ODA has been requested to supply these contraceptives for the next five years.

The MOH also has taken steps to develop an improved internal logistics system. New supply forms, including the standardized product list, were introduced in to districts and health centers in January 1993. More training of district and health center staff is needed before the system can be fully implemented.

The IFP program has the potential to be the most important FP program in the country, because it has the widest geographical distribution network and its facilities have the potential to deliver a wider variety of FP services than other programs. The total coverage of the IFP program can be increased if it establishes collaborative relationships with the community-based and employer-based FP programs.

2. <u>Motivation Issues</u>

Under the new public health financing system, it is anticipated that local health facilities will charge higher fees for curative health services than for preventive services and possibly nothing for promotive activities such as family planning. Under those circumstances, it would be natural for the management of the health facility to give priority to those activities that maximize the income for the facility, especially since curative services are usually of highest priority to the facility's clients. Thus, there is a built-in bias against such activities as family planning.

One way to deal with this bias would be to base the size of the MOH's block grant to a district primarily upon the magnitude of its preventive and promotive programs, with minimal funding provided for curative care (hereafter referred to as Incentive A). In other words, the self-financing (to a considerable degree at least) of curative care would free up MOH resources that could be used to subsidize preventive and promotive services, hopefully at a higher level. This, in turn, should reduce, over time, the demand for curative services, thereby improving the overall viability of the system.

A variation on the foregoing would be to provide payments to providers of FP services for actual delivery of services, with the level of payment being based either on the cost of the services supplied or the couple years of protection (CYP)

provided (Incentive B). For pills and condoms users, one might give a larger incentive for continuing rather than new users. The amount provided, however determined, could be set to be competitive with the fees charged for curative services.

To ensure that the foregoing incentives work as proposed would probably require: 1) an IEC program targeted on MOH officials and health facility managers emphasizing the importance of FP to the country in general and the health system in particular; 2) a reliable information system to document that the programs described in the requests for budgetary grants (or applications for reimbursement under Incentive B) are actually implemented; 3) a supervision program that evaluates on a regular basis the efficacy and efficiency of the FP programs being implemented; and (4) a means of ensuring that the results of 2) and 3) will impact on block grant design and approval or the authorization of Incentive B payments.

The importance of utilizing participatory management techniques is being emphasized in the training of health facility managers who will be implementing the new policy of de-centralizing the management of health care in Zambia. In one health facility in which some user fees have been generated and the employees have been involved in decisions about how to use the new funds, employees of the facility turned down the offer of being paid for overtime (which would have been new) because it would have helped only a few. Rather, they proposed that any funds available for promoting employee morale be used in a way that would generate benefits for all of the facility's personnel, e.g., providing a canteen, supplying uniforms, providing facilities for laundering uniforms, providing transport to and from work, etc.

This suggests the possibility of supplementing either of Incentives A or B with special awards to those facilities that make impressive strides in fostering FP acceptance and continued utilization. It also suggests that the awards should be to the facility, not to individuals. The awards should make it easier to do a good job of providing FP services as well as provide some small benefit to all personnel at the facility.

3. <u>Sustainability Issues</u>

The sustainability of the IFP program in the short to medium term depends primarily upon the MOH's ability to strengthen the distribution network for FP commodities and to improve the capability and motivation of MOH personnel to deliver a high quality of FP services. Donor support for the financing of commodities, training of personnel, and the preparation and distribution of IEC messages appears ensured as long as the GRZ continues its strong support for implementing its national

population policy.

This MOH support does not involve allocating additional budgetary resources in the short to medium term. It involves primarily organizing and allocating better its personnel and financial resources, i.e., using its resources more efficiently and effectively. In some cases, it may involve re-assignment of personnel; recent studies in the Monze district suggest that current personnel staffing in rural clinics is not consistent with the workloads of those clinics. Personnel will need to be made available for training, but this need not have any budgetary implications.

For the longer term, the financial sustainability of the FP program is directly inter-twined with the success of the current effort to de-centralize the management of all health services to District Health Boards and authorize the Boards to charge fees or enact some type of HMO arrangement. Initially, fees are expected to be relatively small, but it is planned that they will be raised over time to approach more closely, or cover in some cases, the actual costs of providing the service.

It is conceivable that fees for the provision of FP services will also eventually approach the cost of providing those services, but this will only occur when the demand for such services has become quite high--to a level not likely to be reached during this project.

During the life of the project, it seems more prudent to maintain minimal or no fees for the provision of most FP services and to concentrate instead on improving the efficiency of the use and the effectiveness of MOH resources devoted to FP planning. This can be done by training of personnel, adopting other motivational incentives, reducing operational costs where feasible, and promoting mutually supporting inter-action between IFP and other FP programs, particularly CBS and EBS.

Given the current poor state of the economy and the uncertainty about the final structures for financing health programs, there is virtually no basis for projecting the MOH's ability to fund fully a family planning program after the FP Services project is completed. As a proxy to hard figures, logic says that current economic plans and policies should result in a growing economy some five years out which should permit a reversal of the decline of recent years in the resources for public health. Furthermore, although the final form(s) of health financing are not yet known, it seems likely that the shifting to districts of the responsibility for the management of health care will have two positive results: 1) better management of financial resources; and 2) an increased contribution by the population to the cost of their health care.

Research indicates that the Zambian population is prepared to pay for quality health care, but not the full price. One UNICEF team estimated that fees could be instituted that would recoup between 6 and 7 percent of MOH recurrent expenditures (80 percent of total expenditures in 1991, higher in other years). Another draft UNICEF study provides information about a number of instances where communities have contributed to health center improvements, particularly capital improvements. Thus, the contribution of individuals and communities to the costs of health care may well exceed the UNICEF team's estimates--particularly over time as the economy begins to recover.

As indicated above, a UNICEF resource use study of health centers in Monze district in Southern province found that there was significant mis-allocation of personnel in relation to workload. When responsibility for management of the health program is de-centralized to district, it is anticipated that the utilization of personnel and financial resources will be more efficient than at present.

Given the policy directions of the GRZ and the importance of a rapid reduction in fertility as discussed in Section I of this Annex, the GRZ should have no trouble finding some continuing donor support for its family planning program should follow-on A.I.D. resources not be available.

B. Community-Based Services

1. Funding Mechanisms

There are community-based workers providing family planning services who have been trained and are being supported by NGOs such as the Family Planning Association of Zambia (PPAZ), Family Life Movement of Zambia, the Makeni Ecumenical Center, and the Adventist Development and Relief Agency (ADRA). In addition, the MOH has social service workers who promote awareness of family planning and refer interested women to health clinics to obtain the appropriate FP services. The primary support for the community-based workers comes from the GRZ and the NGOs. The NGOs get most of their support from donors, but they also generate some financial support from within the country and from parent or affiliate organizations in other countries. It is anticipated that project support for CBS will be channeled through local NGOs.

2. Motivation Issues

According to PPAZ, most of its CBS workers are highly motivated. Nevertheless, some specialized training and authorization to provide additional services would probably

result in additional and more effective action by these workers. Consideration should be given to creating an incentive bonus system that might serve to motivate both CB workers and those women who practice some form of modern family planning.

The incentive system might be started by having the CBS workers do an inventory of the women of child-bearing age in the community, including such information as the woman's age, the number of children, the spacing of the children, those practicing contraception (by type), and those who are not practicing contraception but who have expressed an interest in child spacing or termination of child-bearing. Besides serving as useful base-line data for the project, it could also be used as a base-line for an incentive system.

The data should be provided to a cooperating NGO for entry into a computer for all participating CBS workers. The worker would be provided a printout of the summarized information. He/she would up-date the information on a regular basis. At least annually, a comparison should be made of the progress in obtaining new acceptors and retaining those already practicing. Prizes could be offered for the three CBS programs in each province (or district) showing the greatest improvement during the year. The improvement could be based on the couple years of protection (CYP) provided.

The prizes should be something that could be used by the "Family Planning Club" to generate income for its members. The Club would include the CBS worker, any others who help the CBS worker or otherwise promote the FP program, and those practicing contraception. Prizes might include a sewing machine, yarn, some baby chicks, or other appropriate gift that could be income-producing for the group.

A similar type of incentive system might be appropriate for the MOH CB workers. However, there should be an evaluation made of that effort prior to any USAID involvement with it.

The CBS program should be linked closely to clinic-based services because acceptors may wish to utilize contraceptive services that are available only through the clinics. With the kind of incentive program suggested above, the CBS worker would benefit from encouraging women of the community to take advantage of the services available in the clinic as well as those available from the worker.

The CBS program should also be linked to the Contraceptive Social Marketing (CSM) program. The CBS worker should be offered the opportunity to be the CSM representative in his/her community. The CBS worker would handle, after appropriate training, pills, spermicides and condoms. Club members could

help market the condoms in the community, or find outlets for marketing them, and take a mark-up for the benefit of the Club.

3. Sustainability Issues

Activity at the community should be sustainable under the circumstances described in the previous sub-section. However, the sustainability at the community level assumes that the CSM program will be sustainable. Continued technical support will be important for the effectiveness of the program even though not crucial for sustainability--at least in the medium term. It is assumed that either NGO support or technical support from clinic-based FP programs will be available.

C. Employer-Based Services

1. Funding Mechanisms

This program encourages private firms to offer a variety of family planning services, particularly in company clinics or hospitals. Such facilities are found mostly in urban areas, particularly in the Copperbelt province. About 80 percent of the employees of the firms that have previously participated in an EBS program were men. Most firms do not provide health services to families of their employees. Project support to the EBS program will involve activities through the Ministry of Labor and a local NGO.

2. Motivation Issues

Firms presumably would be motivated to provide such services, particularly those firms with a significant number of female employees. Child spacing should benefit the firm through reduced absences and a reduced call for clinical services related to childbirth. The firm might need specialized training and equipment for its clinical personnel and appropriate IEC materials to motivate its employees (or spouses of its employees) to make use of the FP services available.

It is planned to carry out an Operations Research activity with one or more firms to compare clinic visits, days off the job, and advances of pay made to women practicing child spacing and those that are not. It is expected that the results would demonstrate that providing FP services has a favorable result on firms' bottom line. This could help motivate other firms to provide FP services to their employees and convince firms that they can afford to pay for the family planning training and commodities that have been being provided to the firms at no or minimal charge..

3. Sustainability Issues

The EBS program should be sustainable as long as the firms are able to maintain their clinical services and are convinced of the value of providing FP services to their employees. Once firms are convinced of the value of providing the services, they should be willing to pay for any follow-up training and purchasing FP commodities and equipment.

D. Contraceptive Social Marketing

1. Funding Mechanisms

Contraceptive Social Marketing (CSM) involves providing contraceptives at affordable prices through private channels, primarily established commercial outlets. This has been undertaken for some years, primarily for the sale of condoms, pills and spermicides through the Pharmaceutical Society of Zambia (PSZ). The latter organization is currently involved in a new condom sales program with Population Services International as part of a USAID project for the control of AIDS. It is anticipated that the same mechanism will be used to implement this component of the FP Services project.

2. Motivation Issues

The firm operating the CSM program for condoms for protection against AIDS offers motivation incentives at two levels: (1) to the firm's salesmen who receive a commission for the amount they distribute to commercial outlets; and (2) to the commercial outlets which are authorized a specified mark-up over the price charged to the outlet.

Apparently a number of outlets are selling the condoms substantially over the authorized selling price. This suggests, therefore, that the CSM firm should consider increasing its price and the spread authorized to commercial outlets. A review of the pricing is scheduled to be undertaken and discussed with U.S.A.I.D. This information should be used to guide the pricing policies of the CSM component of the FP Services project.

There are other condoms for sale in Zambia, and it appears that the merchants are free to charge what they will. Therefore, some merchants tend to display the more expensive ones and not the Maximum brand available through the CSM program with its lower authorized selling price. It is possible that enlarging the margin offered to retailers will help change this situation; it is suggested, however, that it would also be useful to prepare some IEC materials for distribution to retailers, particularly the pharmacies, which could emphasize the importance of the CSM activity and the GRZ's support for the activity. In addition, the possibility of adding additional FP products to the CSM line might help convince retailers to promote Maximum condoms more

actively.

3. **Sustainability Issues**

The Cooperative Agreement for the current CSM activity for AIDS control provides that 85 percent of the receipts from sales are to be put into a special account to be used for strengthening the capacity of the Pharmaceutical Society of Zambia (PSZ) to continue the activity after the end of the project. How the funds will be used has not been determined. Furthermore, there are no specific targets related to sustainability of the activity. The commercial viability of the activity is to be reviewed in the annual assessments, but reference is made to PSI/PSZ performance. The implication is that PSI involvement is expected beyond the end of the project; there is no provision for reducing or eliminating the field staff of PSI--which appears to duplicate, in part, PSZ staff.

No doubt less attention has been paid in the Cooperative Agreement for AIDS control to sustainability because the seriousness of the AIDS epidemic in Zambia and nearby countries dictates that the overriding objective must be to increase rapidly the use of condoms in an effort to slow the rate of HIV/AIDS transmission. Furthermore, it is unrealistic to assume that the activity could be made fully sustainable by the end of the grant period, even if it were the primary objective. Under the circumstances, sustainability of the CSM activity is clearly secondary.

The situation with family planning CSM activity is comparable. Given the extremely high rate of population growth in Zambia, the primary purpose of the FP CSM activity must be to increase the number of acceptors as rapidly as possible; sustainability should be of secondary consideration. Effectiveness should take precedence over cost-effectiveness, but the latter should not be ignored. Improved cost-effectiveness can increase the likelihood of support beyond the current five-year period. Furthermore, a fully indigenous operation without long-term expatriate technical assistance may well be more acceptable in the local environment and thus more effective.

It seems appropriate, therefore, that the priority sustainability issue should be creating the local capacity to carry on the activity without long-term technical assistance. This alone would reduce the costs of any follow-on assistance by at least 30 percent. If the current project is channeled through PSI/PSZ with similar arrangements for use of the funds generated from sales of FP commodities, i.e. a high percentage to be used for strengthening PSZ's capability to continue the activity, the donor support for future CSM activities should be further reduced.

Using the PSI proposal for AIDS prevention and the marketing of oral contraceptives (OCs), by year 5 the costs of operations (excluding PSI costs) would be about $1.2 million for condoms alone or $1.4 million for condoms and OCs. The generated sales at that time is projected to be about 8.4 million condoms, which would generate $84,000 at the current price of $.01. Because many retailers are already charging five times and more the suggested retail price, it seems reasonable that the selling price by year 5 should be at least five times the current price. This would yield $320,000.

The projection of sales of OCs is 225,000 cycles with the starting price proposed at about $.33 per cycle, i.e., approximately 1 percent of per capita GNP. GNP growth is expected to be very slow, probably lagging behind population growth most of the project period. Therefore, the sales price at the end of the project is projected at $.30, giving expected sales receipts of $67,500. Thus, by the end of the project, the annual shortfall would likely be in the order of $1 million [$1.4 million less ($320,000 + $67,500)].

This shortfall could be reduced by raising prices, increasing sales and by cutting costs. More experience is needed before consideration should be given to raising prices. Increasing sales could include additional sales of the two products plus adding additional products. It is proposed that the CSM activity attempt to develop sales in both the Community-Based and Employer-Based programs as well as some of the Districts. This activity would probably be able to add some commodities, but the primary source of sales receipts is likely to be the condoms and OCs. More experience is needed to determine whether cost-cutting is likely to be feasible.

It probably would be possible to reduce further the gap between project receipts and expenses by adding to the product line some non-FP commodities which could be distributed through the FP channels, e.g., oral rehydration salts, impregnated bednets, etc. This is unlikely, however, to generate enough funds to subsidize FP activities. To make a significant reduction in the gap probably would require adding to the product line some commodities with high profit margins and/or investing in supplementary profit-making activities.

E. Potential Private Sector Involvement

There are two types of activities that impact on the provision of family planning services which appear to have the potential for private sector involvement: 1) the procurement and distribution of pharmaceuticals, FP commodities, and medical supplies and equipment; and 2) the development of new techniques for financing and delivery of health services, including FP services, e.g., health insurance, health maintenance organizations (HMOs), MCH/FP clinics.

Currently, most of the pharmaceuticals and medical supplies and equipment and family planning commodities which are being distributed to government hospitals and clinics is being procured by Medical Stores Limited (MSL), a separate entity with its own stock and board of directors. However, the stock is owned by the Ministries of Finance and Public Health, and the board of directors, which used to include some non-governmental users such as PSZ, CMAZ and PPAZ, has not been re-constituted since the new government took over.

There has been some talk of privatizing MSL, but it is not on the privatization lists for the first two years. It would make sense to privatize it, even if the MOH and/or MOF continued to be stockholders and some non-governmental users were on the board of directors. Alternatively, with the de-centralization of procurement to districts, a group of pharmaceutical firms might wish to attempt to make procurement contracts with districts and give the MSL some competition.

Concurrent with the de-centralization of the management of the delivery of health care, the GRZ is encouraging experimentation with various types of health financing, e.g., HMOs, health insurance systems, etc. MOH doctors have been authorized to undertake private medical practice outside of their MOH work hours. This could lead to doctor-organized HMOs or MCH/FP clinics. In some countries trained nurses and mid-wives have set up MCH/FP clinics. Grants might be provided to individuals or groups to set up such clinics in under-served areas of Zambia.

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Costing of Project by Inputs and Outputs

Project Inputs	Contraceptive Social Mktg	Service Delivery	IEC	Policy & OR	Project Mgmnt	TOTAL
AID Appropriated						
Technical Assistance	1,269,000	6,879,000	3,080,000	736,000	515,000	12,529,000
Training		435,000	0	0		435,000
Commodities	1,815,000	1,695,000	0	126,000	75,000	3,711,000
Audit/Evaluation					225,000	225,000
Inflation & Contingency					3,100,000	3,100,000
Total	3,084,000	9,009,000	3,080,000	912,000	3,915,000	20,000,000
						0

Contraceptive Social Marketing – See Note 1
IEC – See Note 7
Policy and OR – See Note 8
Project Management – See Note 9

Project Inputs	Service Delivery IFP	Service Delivery CBD	Service Delivery EBD	Service Delivery VSC	Service Delivery MCH/FP	Service Delivery Inst Contractor	TOTAL
AID Appropriated							
Technical Assistance	301,200	2,734,000			154,000	3,690,000	6,879,200
Training	216,000	111,375		108,000	0		435,375
Commodities	1,376,050	0	165,000		154,000		1,695,050
Audit/Evaluation							0
Inflation & Contingency							0
Total	1,893,250	2,845,375	165,000	108,000	308,000	3,690,000	9,009,625
							0

IFP – See Note 2
CBD – See Note 3
EBD – See Note 4
VSC – See Note 5
MCH/FP – See Note 6
Inst Contractor – See Note 9

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NOTE 1 Contraceptive Social Marketing

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
I. Salaries & Fringes	78,200	78,200	78,200	78,200	78,200	391,000
II. Travel & Transportation	60,600	63,100	64,700	67,500	70,400	326,300
III. Equipment & Supplies	115,500	9,200	13,100	17,600	24,200	179,600
IV. Advertising, Promotion, and Research	111,800	109,800	111,800	107,800	110,500	551,700
V. Commodities	44,200	87,100	159,600	348,800	995,400	1,635,100
Total	410,300	347,400	427,400	619,900	1,278,700	3,083,700
						0

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NOTE 1 Contraceptive Social Marketing

I. Salaries & Fringes							
A. U.S. Support Staff based on 260 days per year, increase par year	0%						
CC Marketing Director (10%)		5,932	5,932	5,932	5,932	5,932	29,660
STTA (21,21,14,14 @ $300/day)		6,300	6,300	6,300	6,300	6,300	31,500
Fringe (35%)		4,281	4,281	4,281	4,281	4,281	21,406
Subtotal		16,513	16,513	16,513	16,513	16,513	82,566
							0
B. Field Staff							
Pharmaceutical detailers (8)		10,560	10,560	10,560	10,560	10,560	52,800
Packers (3)		2,970	2,970	2,970	2,970	2,970	14,850
Subtotal		13,530	13,530	13,530	13,530	13,530	67,650
Fringe benefits (25% on sal)		3,383	3,383	3,383	3,383	3,383	16,913
Total Field Staff		16,913	16,913	16,913	16,913	16,913	84,563
							0
C. Indirect Cost							
US Support Staff 1.42		23,449	23,449	23,449	23,449	23,449	117,244
Field Staff 1.26		21,310	21,310	21,310	21,310	21,310	106,549
Total Salaries & Fringes		78,184	78,184	78,184	78,184	78,184	390,921
							(0)
II. Travel & Transportation							
International airfare ($6000/round trip) 1 trip per year STTA		5,000	6,000	6,000	6,000	6,000	30,000
Perdiem (165/day 21,21,14,14,14)		3,465	3,465	2,310	2,310	2,310	13,860
Visa fees & vaccinations ($125/trip)		125	125	125	125	125	625
Local travel – perdiem (4x180 days x $50)		36,000	37,800	39,690	41,675	43,758	198,923
Vehicle maintenance & insurance		4,500	4,725	4,961	5,209	5,470	24,865
Fuel		10,500	11,025	11,576	12,155	12,763	58,019
Total Travel & Transportation		60,590	63,140	64,663	67,474	70,426	326,292

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NOTE 1 Contraceptive Social Marketing

						(0)
III. Equipment & Supplies						
Blood pressure equipment (100 sets)	35,000					35,000
3 vehicles x 25,000	75,000					75,000
Packaging	5,527	9,165	13,059	17,624	24,154	69,529
Total Equipment & Supplies	115,527	9,165	13,059	17,624	24,154	179,529
						(0)
IV. Advertising, Promotion, and Research						
Advertising production costs						
Radio	2,000	2,000	2,000	2,000	2,000	10,000
TV/Cinema/Slides	10,000	10,000	10,000	10,000	10,000	50,000
Press	2,000	2,000	2,000	2,000	2,000	10,000
Billboards	2,500	2,500	2,500	2,500	2,500	12,500
Point of purchase materials	2,500	2,500	2,500	2,500	2,500	12,500
Brochures, pamphlets, & leaflets	10,000	10,000	10,000	10,000	10,000	50,000
Professional Detailing Materials	25,000	25,000	25,000	25,000	25,000	125,000
Design fees	1,000	1,000	1,000	1,000	1,000	5,000
Media Placement						
Radio	8,000	8,000	8,000	8,000	8,000	40,000
Television/Cinema	15,000	15,000	15,000	15,000	15,000	75,000
Press	5,000	5,000	5,000	5,000	5,000	25,000
Billboards	4,000	4,000	4,000	4,000	4,000	20,000
Field Promotion	10,000	10,000	10,000	10,000	10,000	50,000
Research						
Market research	2,000	2,000	2,000	2,000	2,000	10,000
Pricing studies	2,000	2,000	2,000	0	2,000	8,000
Brand name/packaging	2,000	0	2,000	0	750	4,750
Monitoring studies	4,000	4,000	4,000	4,000	4,000	20,000
Qualitative/pretesting	750	750	750	750	750	3,750
Tracking studies	4,000	4,000	4,000	4,000	4,000	20,000
Total Advertising, promotion and research	111,750	109,750	111,750	107,750	110,500	551,500
						0
V. Commodities						
Oral Contraceptives (cif Lusaka)	26,775	42,997	60,775	82,046	110,763	323,356
IUCDs (cif Lusaka)	3,599	5,523	8,183	11,074	17,508	45,888
Injectibles (cif Lusaka)	11,056	25,134	35,700	40,075	29,302	141,268
Implants (cif Lusaka)	2,764	13,472	54,947	215,597	837,862	1,124,642
	44,195	87,126	159,605	348,793	995,435	1,635,153

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Year	1994	1995	1996	1997	1998	1999	2000
Total Population	8,593,290	6,851,089	9,116,621	9,390,120	9,671,624	9,961,978	10,260,838
Women Rep Age	22.00%	22.00%	22.00%	22.00%	22.00%	22.00%	22.00%
Women Rep Age	1,890,524	1,947,240	2,005,657	2,065,826	2,127,801	2,191,635	2,257,384
Method mix %							
Pills	4.00%	4.76%	5.66%	6.73%	8.00%		
IUDs	0.50%	0.59%	0.71%	0.84%	1.00%		
Injectibles	0.30%	0.53%	0.95%	1.69%	3.00%		
Implants	0.01%	0.02%	0.07%	0.27%	1.00%		
Sterilization	2.10%	2.33%	2.59%	2.86%	3.20%		
Condoms	1.80%	1.80%	1.80%	1.80%	1.80%		
	8.71%	10.04%	11.78%	14.20%	18.00%		
Individuals using contraceptives							
Pills	75,621	92,627	113,457	138,972	170,224		
IUDs	9,453	11,578	14,182	17,371	21,278		
Injectibles	5,672	10,388	19,027	34,851	63,834		
Implants	95	366	1,418	5,493	21,278		
Sterilization (cum)	39,701	45,433	51,993	59,499	68,090		
Condoms	34,029	35,050	36,102	37,185	38,300		
Modern meth CYPs	164,570	195,443	235,179	293,372	383,004		
Demand in units by method							
Pills (13 cycl/person)	983,072	1,204,149	1,474,942	1,806,632	2,212,913		
IUDs	9,453	11,578	14,182	17,371	21,278		
Injectibles (4/persor	22,686	41,553	76,109	139,404	255,336		
Implants	95	366	1,418	5,493	21,278		
Commodities provided by ODA							
Pills	2,290,000	2,485,000	2,625,000	2,750,000	2,885,000		
IUDs	6,500	10,000	12,000	15,000	16,000		
Injectibles	100,000	140,000	150,000	170,000	180,000		
Implants	0	0	0	0	0		
Commodity Inventory Balance							
Pills	1,306,928	2,587,779	3,737,837	4,681,205	5,353,292		
IUDs	(2,953)	(4,531)	(5,713)	(9,085)	(14,353)		
Injectibles	77,314	175,761	249,652	280,248	204,911		
Implants	(95)	(461)	(1,879)	(7,372)	(28,650)		
Commodities provided by USAID for Social Mktg, back-up supply, or fill gap							
Pills	89,250	143,325	202,583	273,488	359,209		
IUDs	3,396	5,211	7,720	10,447	16,517		
Injectibles	7,731	17,576	24,965	28,025	20,491		
Implants	109	530	2,161	8,478	32,948		
CIF costs - CPSD							
Pills	0.30	0.30	0.30	0.30	0.30		
IUDs	1.06	1.06	1.06	1.06	1.06		
Injectibles	1.43	1.43	1.43	1.43	1.43		
Implants	25.43	25.43	25.43	25.43	25.43		
Project Commodity Costs							Total
Pills	26,775	42,997	60,775	82,046	110,763		323,356
IUDs	3,599	5,523	8,183	11,074	17,508		45,888
Injectibles	11,056	25,134	35,700	40,075	29,302		141,268
Implants	2,764	13,472	54,947	215,597	837,862		1,124,642
Commodity Costs	44,195	87,126	159,605	348,793	995,435		1,635,153
							0

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Note 2: Integrated Family Planning Clinics

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Strategic Clinics – Facilities										
Health center facility improvements	60	5,000	C	N		200,000	100,000			300,000
Health center FP equipment	60	3,300	C	Y		132,000	66,000			198,000
Health center FP expendable equip	60	900	C	Y		36,000	54,000	54,000	54,000	198,000
Health center FP supplies	60	1,200	C	N		48,000	72,000	72,000	72,000	264,000
40 clinics yr 1; 60 clinics yr 2–5										
Health center comm back-up fund	1	300,000	C	N		150,000				150,000
capable of filling strategic sites OC need for 3 to 5 mds.										
Pre-Service Training										
ST TA – Curriculum	2	26,000	TA	Y	52,000					52,000
Equipment & Supplies:										
AV Equipment	11	5,000	C	Y	55,000					55,000
Reproductive models	11	500	C	Y	5,500					5,500
Flip Charts & other	11	250	C	Y	2,750					2,750
Textbooks & publications	11	1,000	C	Y	11,000					11,000
In-Service Training										
ST TA Guidelines	1	26,000	TA	Y	26,000					26,000
Guidelines: print & distribute	1	15,000	C	N	11,250	3,750				15,000
Master trainers program (CAFS)	12	6,000	TR	Y	72,000					72,000
ST TA – Community Mobilization	2	26,000	TA	Y			52,000			52,000
Contraceptive tech courses (CAFS)	24	6,000	TR	Y			144,000			144,000
ST TA – Eval TCT in-service trng	3	26,000	TA	Y			78,000			78,000
ST TA – Eval FP trng plan	1	26,000	TA	Y					26,000	26,000
Lusaka Central Trng Unit – GoC										
Training coordinator	1	4,800	TA	N		4,800	4,800	4,800	4,800	19,200
Training staff	2	3,600	TA	N		7,200	7,200	7,200	7,200	28,800
Secretary	1	1,200	TA	N		1,200	1,200	1,200	1,200	4,800
Training materials	1	5,000	C	Y		5,000	5,000	5,000	5,000	20,000
Publications	1	1,000	C	Y		1,000	1,000	1,000	1,000	4,000
Utilities	1	1,200	C	N		1,200	1,200	1,200	1,200	4,800
Communications	1	1,200	C	N		1,200	1,200	1,200	1,200	4,800
Postage & Courier	1	1,200	C	N		1,200	1,200	1,200	1,200	4,800
Computers w/printers & software	3	6,000	C	Y	18,000					18,000
Office furniture	4	5,000	C	Y	20,000					20,000
Office supplies	1	1,200	C	N		1,200	1,200	1,200	1,200	4,800
Repairs & Maintenance	1	2,400	C	N		2,400	2,400	2,400	2,400	9,600
Vehicle	1	25,000	C	Y	25,000					25,000
Vehicle maintenance & insurance	1	1,500	C	N		1,500	1,500	1,500	1,500	6,000
Fuel	1	3,500	C	N		3,500	3,500	3,500	3,500	14,000
Local travel perdiem (180 days x $50)	180	50	C	N		9,000	9,000	9,000	9,000	36,000
Accountant	1	3,600	TA	N		3,600	3,600	3,600	3,600	14,400
Photocopy machine	1	5,000	C	Y	5,000					5,000
Total					303,500	613,750	610,000	170,000	196,000	1,893,250
										0

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Note 2 Integrated Family Planning Clinics

Category	Qty	Cost	TypeFX	Year 1
Equipment List – Durable				
Exam tables	1	750		750
Sterilizer	1	535		535
Sphygmomanometer	2	31		62
Adult weighing scales	1	22		22
Stethoscopes	2	11		22
speculia Graves, medium size	4	25		100
speculia Graves, large size	2	25		50
speculia Graves, small size	2	25		50
IUD insertion removal kits	2	160		320
Cheatle forceps (other instrument forceps)	1	8		8
Jar for holding forceps	1	10		10
Instrument tray	1	48		48
Covered instrument pans	2	7		14
Kidney dishes	2	11		22
Exam lamps – Anglepoise (with extra bulbs)	1	80		80
Torch	1	10		10
Test tube stand	1	10		10
Female Pelvic Model	1	233		233
File Cabinet (S A price)	1	105		105
Lockable cabinets(1 sterile equipment, 1 cc	2	125		250
Desk (S A price)	1	289		289
Stools	2	52		104
Table	1	100		100
Chairs (S A price)	2	48		96
Total				3,290
Equipment List – Expendable				
Test tubes	12	3		30
Thermometers	2	4		8
Disposable gloves – large	1	54		54
Disposable gloves – med	1	54		54
Sterile gloves – large	2	27		54
Sterile gloves – med	2	27		54
Other minor equipment	1	600		600
Total				854

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Note 3: Community Based Distribution

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Orientation/Training Workshop										
Per diems (person days)	175	165	TR	N	28,875					28,875
Facilities	5	500	TR	N	2,500					2,500
ST TA	1	26,000	TA	Y	26,000					26,000
International Conferences	8	10,000	TR	Y		20,000	20,000	20,000	20,000	80,000
Grants for CBD programs:	11	246,000	TA			938,000	590,000	590,000	590,000	2,708,000
Total					57,375	958,000	610,000	610,000	610,000	2,845,375
Wages & Salaries										
Project Manager	1	1,350		N		1,350	1,350	1,350	1,350	5,400
Service Delivery Nurse/Mobile C	1	1,200		N		1,200	1,200	1,200	1,200	4,800
CBD Supervisor	2	1,200		N		2,400	2,400	2,400	2,400	9,600
CBD Workers	20	900		N		18,000	18,000	18,000	18,000	72,000
Driver	1	900		N		900	900	900	900	3,600
Fringe Benefits	25%			N		5,963	5,963	5,963	5,963	23,850
Operating Expenses										
Telephone, Postage	1	1,200		N		1,200	1,200	1,200	1,200	4,800
Utilities	1	1,200		N		1,200	1,200	1,200	1,200	4,800
Office Supplies	1	1,200		N		1,200	1,200	1,200	1,200	4,800
Travel & local transportation	1	3,600		N		3,600	3,600	3,600	3,600	14,400
Clinic supplies	1	500		N		500	500	500	500	2,000
CBD equipment	20	50		N		1,000	1,000	1,000	1,000	4,000
Uniforms	20	30		N		600	600	600	600	2,400
Professional fees (medical)	1	1,500		N		1,500	1,500	1,500	1,500	6,000
External auditor	1	600		N		600	600	600	600	2,400
Bookkeeper	1	600		N		600	600	600	600	2,400
Rent	1	1,200		N		1,200	1,200	1,200	1,200	4,800
Printing educational materials	1	120		N		120	120	120	120	480
Training materials CBD workers	20	40		N		800	800	800	800	3,200
Perdiem CBD workers	20	15		N		300	300	300	300	1,200
Travel to workshops CBD worke	20	70		N		1,400	1,400	1,400	1,400	5,600
Bicycles	20	200		N		4,000				4,000
Motorbikes	2	1,000		Y		2,000				2,000
Spare parts	2	300		Y		600				600
Fuel for motorbikes	2	1,250		N		2,500	2,500	2,500	2,500	10,000
Vehicle	1	25,000		Y		25,000				25,000
Vehicle insurance	1	1,200		Y		1,200	1,200	1,200	1,200	4,800
Vehicle maintenance	1	1,800		N		1,800	1,800	1,800	1,800	7,200
Fuel for vehicle	1	2,500		N		2,500	2,500	2,500	2,500	10,000
					0	85,233	53,633	53,633	53,633	246,130

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Note 4: Employer Based Distribution

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Employer FP equipment	50	3,300	C	Y	99,000	66,000				165,000
										0

Note 5: Volutary Surgical Contraception

Training in minilap/lap (MD/RN 2 pers	1	6,000	TR	Y	12,000	24,000	24,000	24,000	24,000	108,000
										0

Note 6: MCH/FP Unit

ST TA Management review	2	26,000	TA	Y	52,000					52,000
ST TA Logistic MIS	2	26,000	TA	Y	26,000	26,000				52,000
Male awareness survey	1	25,000	TA	N	25,000					25,000
Female awareness survey	1	25,000	TA	N	25,000					25,000
Office supplies and materials	1	1,200	C	N	1,200	1,200	1,200	1,200	1,200	6,000
Training materials	1	5,000	C	N	5,000					5,000
Publications	1	1,000	C	Y	1,000	1,000	1,000	1,000	1,000	5,000
Computers w/printers & software	3	6,000	C	Y	18,000					18,000
Office furniture	4	5,000	C	Y	20,000					20,000
Vehicle	1	25,000	C	Y	25,000					25,000
Vehicle maintenance & insurance	1	1,500	C	N	1,500	1,500	1,500	1,500	1,500	7,500
Fuel	1	3,500	C	N	3,500	3,500	3,500	3,500	3,500	17,500
Local travel perdiem (180 days x $50)	180	50	C	N	9,000	9,000	9,000	9,000	9,000	45,000
Photocopy machine	1	5,000	C	Y	5,000					5,000
					217,200	42,200	16,200	16,200	16,200	308,000

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Note 7: Information, Education, and Communication

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Audience research:										
BASELINE										
Senior expatriate TA	2	26,000	TA	Y	52,000					52,000
Senior local TA	3	2,000	TA	Y	6,000					6,000
Local research assistants	6	1,000	TA	Y	6,000					6,000
Communications	1	1,000	TA	Y	1,000					1,000
Supplies & Printing	1	1,000	TA	Y	1,000					1,000
Institutional overhead		45%	TA	Y	29,700					29,700
Follow-up audience research	1		TA	Y			95,700			95,700
Three mo mass media campaign - men										
Radio		8,000	TA	N		8,000				8,000
TV		15,000	TA	N		15,000				15,000
Press		5,000	TA	N		5,000				5,000
Billboard		4,000	TA	N		4,000				4,000
Three mo mass media campaign - youth										
Radio		8,000	TA	N		8,000				8,000
TV		15,000	TA	N		15,000				15,000
Press		5,000	TA	N		5,000				5,000
Billboard		4,000	TA	N		4,000				4,000
Three mo mass media campaign - women										
Radio		8,000	TA	N		8,000				8,000
TV		15,000	TA	N		15,000				15,000
Press		5,000	TA	N		5,000				5,000
Billboard		4,000	TA	N		4,000				4,000
Promotional materials		35,000	TA	N		35,000				35,000
Radio social drama		25,000	TA	N		25,000				25,000
LT TA IEC Specialist	1	557,800	TA	Y		278,900	278,900			557,800
ST TA	4	26,000	TA	Y		26,000	26,000			52,000
District - Small Grants	20		TA	Y		376,000	207,000			583,000
Institutional Overhead		40%	TA	Y	95,700	836,900	607,600			1,540,200
					191,400	1,673,800	1,215,200	0	0	3,080,400

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Note 7: Information, Education, and Communication

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Illustrative Grant details										0
Theater performances	10	100	TA	N		1,000	1,000			2,000
Video shows	50	50	TA	N		2,500	2,500			5,000
Community leader workshops	40	75	TA	N		3,000	3,000			6,000
FP IEC Material & Supplies	1	2,500	C	N		2,500	2,500			5,000
Pre-recorded videos	8	150	C	N		1,200	1,200			2,400
Blank videos	10	10	C	N		100	100			200
Blank audio cassettes	10	5	C	N		50	50			100
Generator	1	6,000	C	Y		6,000				6,000
AV Equipment	1	2,000	C	Y		2,000				2,000
Video Camera	3	150	C	Y		450				450
Tape recorders					0	18,800	10,350			29,150

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Note 8: Policy & Operational Research

Category	Qty	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
ST TA Legislation	3	26,000	TA	Y	52,000	26,000				78,000
Local TA	3	2,000	TA	N	4,000	2,000				6,000
										0
Operations Research (OR)										0
Local TA - research coordinator	1	24,000	TA	N		24,000	24,000			48,000
Secretary	1	1,200	TA	N		1,200	1,200			2,400
Rent	1	6,000	C	N		6,000	6,000			12,000
Utilities	1	1,200	C	N		1,200	1,200			2,400
Communications	1	1,200	C	N		1,200	1,200			2,400
Postage & Courier	1	1,200	C	N		1,200	1,200			2,400
Computers w/printers & software	2	6,000	C	Y		12,000				12,000
Office furniture	2	5,000	C	Y		5,000				5,000
Office supplies	1	1,200	C	N		1,200	1,200			2,400
Repairs & Maintenance	1	1,200	C	N		1,200	1,200			2,400
Vehicle	1	25,000	C	Y		25,000				25,000
Vehicle maintenance & insurance	1	1,500	C	N		1,500	1,500			3,000
Fuel	1	3,500	C	N		3,500	3,500			7,000
Local travel perdiem (180 days x $50)	180	50	C	N		9,000	9,000			18,000
Accounting & Bookkeeping	1	3,600	TA	N		3,600	3,600			7,200
Photocopy machine	1	5,000	C	Y		5,000				5,000
										0
OR - Fee for Service										0
Research assistants	4	1,000	TA	N		4,000				4,000
Local travel perdiem	120	50	C	N		6,000				6,000
ST TA Baseline & selection	2	26,000	TA	Y		52,000				52,000
Claims processing	1	5%	TA	N		2,000	2,000			4,000
Audit	10	1,000	TA	N		10,000	10,000			20,000
Claims for services rendered	10	10	TA	N		40,000	40,000			80,000
400 CYPs per site										0
ST TA Evaluation	2	26,000	TA	Y			52,000			52,000
Research assistants	2	1,000	TA	N			2,000			2,000
Local travel perdiem	60	50	C	N			3,000			3,000
										0
OR - Provider incentives										0
										0
Research assistants	2 12	1,000	TA	N		12,000	12,000			24,000
ST TA Baseline & selection	2	26,000	TA	Y		52,000				52,000
Local travel perdiem	180	50	C	N		9,000	9,000			18,000
Incetive payments for awareness	5	1,600	TA	N		8,000	8,000			16,000
ST TA Evaluation	1	26,000	TA	Y			26,000			26,000
										0
OR - FP Venture Capital										0
Equity investments	10	5,000	TA	N		10,000	15,000	25,000		50,000
ST TA Evaluation	2	26,000	TA	Y		26,000				26,000
										0
Institutional overhead	40%		TA		0	133,120	93,520	10,000		236,640
Total					56,000	493,920	327,320	35,000		912,240

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Note 9: Institutional Contractor

Budget Analysis for Institutional Contractor – FPS

Category	Year 2	Year 3	Year 4	Year 5	TOTAL
I. Salaries & Fringes	660,997	660,997	660,997	660,997	2,643,987
II. Allowances	103,272	65,522	65,522	81,772	316,088
III. Travel & Transportation	62,000	62,000	62,000	62,000	248,000
IV. Equipment & Supplies	107,500	20,340	21,327	22,363	171,530
V. Other Direct Costs – Operations	73,200	75,600	79,380	83,349	311,529
Total	1,006,969	884,459	889,226	910,481	3,691,135
					(0)

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Note 9: Institutional Contractor

Budget Analysis for Institutional Contractor – FPS

Category	Year 2	Year 3	Year 4	Year 5	TOTAL
I. Salaries & Fringes					
A. U.S. Support Staff based on 260 days per year, increase per year 0.00%					
Project Director 25%	20,000	20,000	20,000	20,000	80,000
Secretary 100%	20,000	20,000	20,000	20,000	80,000
Subtotal	40,000	40,000	40,000	40,000	160,000
Fringe benefits (24%)	9,600	9,600	9,600	9,600	38,400
Total US Support	49,600	49,600	49,600	49,600	198,400
B. Field Staff					
Chief of Party – Management/Logistics Specialist	80,000	80,000	80,000	80,000	320,000
Training Advisor	72,000	72,000	72,000	72,000	288,000
Subtotal	152,000	152,000	152,000	152,000	608,000
Fringe benefits (24% on sal)	36,480	36,480	36,480	36,480	145,920
Total Field Staff	188,480	188,480	188,480	188,480	753,920
C. In-Country Staff (Zambian)					
Training Consultant	24,000	24,000	24,000	24,000	96,000
CBD/EBD Advisor	18,000	18,000	18,000	18,000	72,000
Management Advisor	18,000	18,000	18,000	18,000	72,000
Assistant Financial Officer	12,000	12,000	12,000	12,000	48,000
Secretary (2)	8,000	8,000	8,000	8,000	32,000
Driver (6)	12,000	12,000	12,000	12,000	48,000
Subtotal	92,000	92,000	92,000	92,000	368,000
Fringe benefits (25%)	23,000	23,000	23,000	23,000	92,000
Total In-Country Staff	115,000	115,000	115,000	115,000	460,000
D. Indirect Cost					
US Support Staff 1.42	70,432	70,432	70,432	70,432	281,728
Field Staff 1.26	237,485	237,485	237,485	237,485	949,939
Total Salaries & Fringes	660,997	660,997	660,997	660,997	2,643,987
					0

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Note 9: Institutional Contractor

Budget Analysis for Institutional Contractor – FPS

Category	Year 2	Year 3	Year 4	Year 5	TOTAL
II. Allowances					
Post Differential	28,272	28,272	28,272	28,272	113,088
Shipping/Storage of Household Effects	15,000			15,000	30,000
Consumable Shipment (2,500 x $4.30)	21,500				21,500
Annual Medical Exam/SOS insurance	2,500	1,250	1,250	2,500	7,500
Education Allowance	32,000	32,000	32,000	32,000	128,000
DBA insurance	4,000	4,000	4,000	4,000	16,000
Total Allowances	103,272	65,522	65,522	81,772	316,088
III. Travel & Transportation					
To and From Post ($3000 per trip)	24,000			24,000	48,000
Management Trips (5 trips per year @ $6,000 per trip)	30,000	30,000	30,000	30,000	120,000
R&R ($3,000 per trip)		24,000			24,000
Home Leave			24,000		24,000
Local travel – perdiem	8,000	8,000	8,000	8,000	32,000
Total Travel & Transportation	62,000	62,000	62,000	62,000	248,000

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Note 9 Institutional Contractor

Budget Analysis for Institutional Contractor – FPS

Category	Year 2	Year 3	Year 4	Year 5	TOTAL
IV Equipment & Supplies					
Equipment					
486 Computer @ 2,700	10,800				10,800
HP Laser printer 1 @ $1,300	1,300				1,300
Office Equipment	4,000				4,000
Typewriter	900				900
FAX	1,400				1,400
Modem	600				600
Subtotal Equipment	19,000				19,000
Field Office Equipment					
Furniture	10,000				10,000
Copier	12,000				12,000
FAX	2,000				2,000
Computers	35,000				35,000
VCR & TV	1,500				1,500
Taperecorder	500				500
Adding Machines	200				200
Subtotal Zambia Equipment	61,200				61,200
Supplies					
Maintenance contract	600	600	600	600	2,400
Computer software	3,900				3,900
General supplies	800	840	882	926	3,448
Office Supplies	1,000	1,050	1,103	1,158	4,310
Photocopying & printing	4,000	4,200	4,410	4,631	17,241
Subtotal Supplies	10,300	6,690	6,995	7,314	31,299
Field Supplies					
Office Supplies	5,000	5,250	5,513	5,788	21,551
Photocopying & Printing	8,000	8,400	8,820	9,261	34,481
Computer software	4,000				4,000
Subtotal Field Supplies	17,000	13,650	14,333	15,049	60,032
Total Equipment & Supplies	107,500	20,340	21,327	22,363	171,530

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Note 9: Institutional Contractor

Budget Analysis for Institutional Contractor – FPS

Category	Year 2	Year 3	Year 4	Year 5	TOTAL
V. Other Direct Costs – Operations					
US Support					
Communications	3,000	3,150	3,308	3,473	12,930
Modem lines	1,200				1,200
Subtotal	4,200	3,150	3,308	3,473	14,130
Field Support					
Rent	45,000	47,250	49,613	52,093	193,956
Utilities	2,000	2,100	2,205	2,315	8,620
Communications	12,000	12,600	13,230	13,892	51,722
Postage & Courier	6,000	6,300	6,615	6,946	25,861
Repairs & Maintenance	4,000	4,200	4,410	4,631	17,241
Subtotal	69,000	72,450	76,073	79,876	297,399
Total Other Direct Costs	73,200	75,600	79,380	83,349	311,529

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Category	Qt.	Cost	Type	FX	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PSC Project Manager	2	515,000	TA	Y	257,500	257,500				515,000
PSC Project Support (Vehicles, Office furniture, Supplies)		75,000	C	Y	37,500	37,500				75,000
Project Evaluation #1	1	75,000	AE	Y			75,000			75,000
Final Evaluation	1	75,000	AE	Y					75,000	75,000
Project Audit	1	75,000	AE	Y				75,000		75,000
					295,000	295,000	75,000	75,000	75,000	815,000

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SUMMARY TABLE - PROCUREMENT PLAN

			PROBABLE SOURCE/ORIGIN		
			941	935	000
Contraceptive Social Marketing		3,084,000	1,095,000	0	1,989,000
Integrated Family Planning - PVO	1,893,000		486,000	763,000	644,000
selected from IFA					
Community Based Distribution	2,845,000		2,391,000	73,000	381,000
Employer Based Programs	165,000		0	0	165,000
Voluntary Surgical Sterilization	108,000		0	108,000	0
MCH/FP Unit	258,000		70,000	41,000	147,000
Institutional Contract	3,691,000	8,960,000	1,767,000	103,000	1,821,000
IEC		3,080,000	584,000	49,000	2,447,000
Operations Research		912,000	342,000	10,000	560,000
Project Mgmt, Eval, & Audit		815,000	25,000	25,000	765,000
Inflation & Contingencies		3,149,000	1,263,000	219,000	1,667,000
TOTAL		20,000,000	8,023,000	1,391,000	10,586,000
		0			

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Contraceptive Social Marketing	3,084,395	USAID/ZAMBIA			
Salaries					
OC Marketing Director (10%)	29,660	PSI/PSZ			29,660
STTA (21,21,14,14 @ $300/day)	31,500				31,500
Fringe (35%)	21,406				21,406
Pharmaceutical detailers (8)	52,800		52,800		
Packers (3)	14,850		14,850		
Fringe benefits (25% on sal)	16,913		16,913		
Indirect Cost					
US Support Staff 1.42	117,244				117,244
Field Staff 1.26	106,549		106,549		
Travel & Transportation					
International airfare ($6000/round trip)	30,000				30,000
1 trip per year STTA					
Perdiem (165/day 21,21,14,14,14)	13,860				13,860
Visa fees & vaccinations ($125/trip)	625				625
Local travel – perdiem (4x180 days x $	198,923		198,923		
Vehicle maintenance & insurance	24,865		24,865		
Fuel	58,019		58,019		
Equipment & Supplies					
Blood pressure equipment (100 sets)	35,000				35,000
3 vehicles x 25,000	75,000				75,000
Packaging	69,529		69,529		
Advertising, Promotion, and Research					
Advertising production costs					
Radio	10,000		10,000		
TV/Cinema/Slides	50,000		50,000		
Press	10,000		10,000		
Billboards	12,500		12,500		
Point of purchase materials	12,500		12,500		
Brochures, pamphlets & leaflets	50,000		50,000		
Professional Detailing Materials	125,000		125,000		
Design fees	5,000		5,000		
Media Placement					
Radio	40,000		40,000		
Television/Cinema	75,000		75,000		
Press	25,000		25,000		
Billboards	20,000		20,000		
Field Promotion	50,000		50,000		
Research					
Market research	10,000		10,000		
Pricing studies	8,000		8,000		
Brand name/packaging	4,750		4,750		
Monitoring studies	20,000		20,000		
Qualitative/pretesting	3,750		3,750		
Tracking studies	21,000		21,000		
Commodities					
Oral Contraceptives (cif Lusaka)	323,356				323,356
IUCDs (cif Lusaka)	45,888				45,888
Injectibles (cif Lusaka)	141,268				141,268
Implants (cif Lusaka)	1,124,642				1,124,642
Total	3,084,395		1,094,947	0	1,989,448
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Integrated Family Planning – PVO selected from IFA		REDSO/ESA/RCO			
Strategic Clinics – Facilities		FPSPMT			
Health center facility improvements	300,000		300,000		
Health center FP equipment	198,000				198,000
Health center FP expendable equip	198,000			198,000	
Health center FP supplies	264,000			264,000	
40 clinics yr 1; 60 clinics yr 2–5					
Health center comm back–up fund	150,000				150,000
capable of filling strategic sites OC need for 3 to 5 mos.					
Pre–Service Training					
ST TA – Curriculum	52,000				52,000
Equipment & Supplies:					
AV Equipment	55,000			55,000	
Reproductive models	5,500				5,500
Flip Charts & other	2,750				2,750
Textbooks & publications	11,000				11,000
In–Service Training					
ST TA Guidelines	26,000				26,000
Guidelines: print & distribute	15,000		15,000		
Master trainers program (CAFS)	72,000			72,000	
ST TA – Community Mobilization	52,000				52,000
Contraceptive tech courses (CAFS)	144,000			144,000	
ST TA – Eval TOT in–service trng	78,000				78,000
ST TA – Eval FP trng plan	26,000				26,000
Lusaka Central Trng Unit – GNC					
Training coordinator	19,200		19,200		
Training staff	28,800		28,800		
Secretary	4,800		4,800		
Training materials	20,000		20,000		
Publications	4,000		4,000		
Utilities	4,800		4,800		
Communications	4,800		4,800		
Postage & Courier	4,800		4,800		
Computers w/printers & software	18,000				18,000
Office furniture	20,000			20,000	
Office supplies	4,600			4,800	
Repairs & Maintenance	9,600		9,600		
Vehicle	25,000				25,000
Vehicle maintenance & insurance	6,000		6,000		
Fuel	14,000		14,000		
Local travel perdiem (180 days x $50)	36,000		36,000		
Accountant	14,400		14,400		
Photocopy machine	5,000			5,000	
	1,893,250		486,200	762,800	644,250
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Community Based Distribution		FPSPMT			
Orientation/Training Workshop					
Per diems (person days)	28,875		28,875		
Facilities	2,500		2,500		
ST TA	26,000				26,000
International Conferences	80,000				80,000
Grants for CBD programs:	2,708,000		2,359,830	73,170	275,000
	0				
Total	2,845,375		2,391,205	73,170	381,000
Wages & Salaries					
Project Manager	5,400		5,400		
Service Delivery Nurse/Mobile Clinic	4,800		4,800		
CBD Supervisor	9,600		9,600		
CBD Workers	72,000		72,000		
Driver	3,600		3,600		
Fringe Benefits	23,850		23,850		
Operating Expenses					
Telephone, Postage	4,800		4,800		
Utilities	4,800		4,800		
Office Supplies	4,800		4,800		
Travel & local transportation	14,400		14,400		
Clinic supplies	2,000		2,000		
CBD equipment	4,000		4,000		
Uniforms	2,400		2,400		
Professional fees (medical)	6,000		6,000		
External auditor	2,400		2,400		
Bookkeeper	2,400		2,400		
Rent	4,800		4,800		
Printing educational materials	480		480		
Training materials CBD workers	3,200		3,200		
Perdiem CBD workers	1,200		1,200		
Travel to workshops CBD workers	5,600		5,600		
Bicycles	4,000			4,000	
Motorbikes	2,000			2,000	
Spare parts	600			600	
Fuel for motorbikes	10,000		10,000		
Vehicle	25,000				25,000
Vehicle insurance	4,800		4,800		
Vehicle maintenance	7,200		7,200		
Fuel for vehicle	10,000		10,000		
	246,130		214,530	6,600	25,000
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
		FPSPMT			
Employer Based Services					
Employer FP equipment	165,000				165,000
Training in minilap/lap (MD/RN 2 perso	108,000			108,000	
ST TA Management review	52,000				52,000
ST TA Logistic MIS	52,000				52,000
Office supplies and materials	6,000			6,000	
Training materials	5,000			5,000	
Publications	5,000			5,000	
Computers w/printers & software	18,000				18,000
Office furniture	20,000			20,000	
Vehicle	25,000				25,000
Vehicle maintenance & insurance	7,500		7,500		
Fuel	17,500		17,500		
Local travel perdiem (180 days x $50)	45,000		45,000		
Photocopy machine	5,000			5,000	
	258,000		70,000	41,000	147,000
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
IEC		USAID/ZAMBIA			
Audience research:		JHU			
BASELINE:					
Senior expatriate TA	52,000				52,000
Senior local TA	6,000		6,000		
Local research assistants	6,000		6,000		
Communications	1,000		1,000		
Supplies & Printing	1,000		1,000		
Institutional overhead	29,700				29,700
Follow-up audience research	95,700				95,700
Three mo mass media campaign – men					
Radio	8,000		8,000		
TV	15,000		15,000		
Press	5,000		5,000		
Billboard	4,000		4,000		
			0		
Three mo mass media campaign – youth			0		
Radio	8,000		8,000		
TV	15,000		15,000		
Press	5,000		5,000		
Billboard	4,000		4,000		
			0		
Three mo mass media campaign – women			0		
Radio	8,000		8,000		
TV	15,000		15,000		
Press	5,000		5,000		
Billboard	4,000		4,000		
			0		
Promotional materials	35,000		35,000		
Radio social drama	25,000		25,000		
LT TA IEC Specialist	557,800				557,800
ST TA	52,000				52,000
District – Small Grants	583,000		414,000	49,000	120,000
Institutional Overhead	1,540,200				1,540,200
Total	3,080,400		584,000	49,000	2,447,400
Illustrative Grant details					
Theater performances	2,000		2,000		
Video shows	5,000		5,000		
Community leader workshops	6,000		6,000		
FP IEC Material & Supplies	5,000		5,000		
Pre-recorded videos	2,400		2,400		
Blank videos	200		200		
Blank audio cassettes	100		100		
	0				
Generator	0				
AV Equipment	6,000				6,000
Video Camera	2,000			2,000	
Tape recorders	450			450	
	29,150		20,700	2,450	6,000

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Policy & Operations Research		USAID/Zambia (buy-in)			
ST TA Legislation	78,000	Contractor			78,000
Local TA	6,000		6,000		
	0				
Operations Research (OR)	0				
Local TA – research coordinator	48,000		48,000		
Secretary	2,400		2,400		
Rent	12,000		12,000		
Utilities	2,400		2,400		
Communications	2,400		2,400		
Postage & Courier	2,400		2,400		
Computers w/printers & software	12,000				12,000
Office furniture	5,000			5,000	
Office supplies	2,400		2,400		
Repairs & Maintenance	2,400		2,400		
Vehicle	25,000				25,000
Vehicle maintenance & insurance	3,000		3,000		
Fuel	7,000		7,000		
Local travel perdiem (180 days x $50)	18,000		18,000		
Accounting & Bookkeeping	7,200		7,200		
Photocopy machine	5,000			5,000	
OR – Fee for Service					
Research assistants	4,000		4,000		
Local travel perdiem	6,000		6,000		
ST TA Baseline & selection	52,000				52,000
Claims processing	4,000		4,000		
Audit	20,000		20,000		
Claims for services rendered	80,000		80,000		
400 CYPs per site	0				
ST TA Evaluation	52,000				52,000
Research assistants	2,000		2,000		
Local travel perdiem	3,000		3,000		
	0				
OR – Provider incentives	0				
	0				
Research assistants	24,000		24,000		
ST TA Baseline & selection	52,000				52,000
Local travel perdiem	18,000		18,000		
Incetive payments for awareness	16,000		16,000		
ST TA Evaluation	26,000				26,000
	0				
OR – FP Venture Capital	0				
Equity investments	50,000		50,000		
ST TA Evaluation	26,000				26,000
	0				
Institutional overhead	236,640				236,640
	912,240		342,600	10,000	559,640
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Institutional Contract		FPSPMT			
U.S. Support Staff					
based on 260 days per year, increase per year					
Project Director .05	80,000				80,000
Secretary 100%	80,000				80,000
					0
Fringe benefits (24%)	38,400				38,400
Field Staff					
Chief of Party – Management/Logistics Sp	320,000				320,000
Training Advisor	288,000				288,000
Fringe benefits (24% on sal)	145,920				145,920
In-Country Staff (Zambian)					
Training Consultant	96,000		96,000		
CBD/EBD Advisor	72,000		72,000		
Management Advisor	72,000		72,000		
Assistant Financial Officer	48,000		48,000		
Secretary (2)	32,000		32,000		
Driver (6)	46,000		48,000		
Fringe benefits (25%)	92,000		92,000		
Indirect Cost					
US Support Staff 1.42	281,728				281,728
Field Staff 1.26	949,939		949,939		
Allowances					
Post Differential	113,088				113,088
Shipping/Storage of Household Effects	30,000				30,000
Consumable Shipment (2,500 x $4.30)	21,500				21,500
Annual Medical Exam/SOS insurance	7,500				7,500
Education Allowance	128,000				128,000
DBA insurance	16,000				16,000
Travel & Transportation					
To and From Post ($3000 per trip)	48,000				46,000
Management Trips (5 trips per year @ $6,0	120,000				120,000
R&R ($3,000 per trip)	24,000				24,000
Home Leave	24,000				24,000
Local travel – perdiem	32,000		32,000		
Equipment & Supplies					
Equipment					
486 Computer @ 2,700	10,800				10,800
HP Laser printer 1 @ $1,300	1,300				1,300
Office Equipment	4,000			4,000	
Typewriter	900			900	
FAX	1,400			1,400	
Modem	600			600	
Field Office Equipment					
Furniture	10,000			10,000	
Copier	12,000			12,000	
FAX	2,000			2,000	
Computers	35,000				35,000
VCR & TV	1,500			1,500	
Taperecorder	500			500	
Adding Machines	200			200	
Supplies					
Maintenance contract	2,400		2,400		
Computer software	3,900				3,900
General supplies	3,448		3,448		
Office Supplies	4,310		4,310		
Photocopying & printing	17,241		17,241		
Field Supplies					
Office Supplies	21,551			21,551	
Photocopying & Printing	34,481			34,481	
Computer software	4,000				4,000
Other Direct Costs – Operations					
US Support					
Communications	12,930			12,930	
Machine lines	1,200			1,200	
Field Support					
Rent	193,956		193,956		
Utilities	8,620		8,620		
Communications	51,722		51,722		
Postage & Courier	25,861		25,861		
Repairs & Maintenance	17,241		17,241		
	3,691,135		1,766,737	103,262	1,821,136
	0				

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Item	Total	PROCUREMENT AGENT	PROBABLE SOURCE/ORIGIN 941	935	000
Project Management		USAID/Zambia			
PSC Project Manager	515,000				515,000
PSC Project Support (Vehicles, Office furniture, Supplies)	75,000		25,000	25,000	25,000
Project Evaluation #1	75,000				75,000
Final Evaluation	75,000				75,000
Project Audit	75,000				75,000
	815,000		25,000	25,000	765,000

MONITORING & EVALUATION PLAN

The USAID/Zambia Country Program Strategic Plan (CPSP) for FY 1993-1997 goal statement--"socially stable, economically productive and politically active population"--is supported by two subgoals: a market-oriented economy with broad participation; and, sustainable improvements in general health status. Two strategic objectives for the health sector were also defined in the CPSP: increased use of modern contraceptives; and, improved HIV/AIDS control practices. The Family Planning Services Project joins the HIV/AIDS Prevention Project as the Mission's principal vehicles for achieving the health sector strategic objectives.

1. Project Goal

The FPS project goal is identical to the overall Zambia Mission goal statement of a socially stable, economically productive and politically active population. Indicators which will be tracked for assessing achievement of this goal include:

- -- increase in real GDP per capita
- -- decrease in percentage of Zambians living below the poverty datum line, and
- -- increase in percentage of registered voters.

The sources of information for monitoring achievement of these objectives will include reports from the Central Statistics Office of the Government of the Republic of Zambia (GRZ) and the Registrar.

2. Project Sub-Goal

The project sub-goal corresponds to the overall Zambia Mission sub-goal of sustainable improvements in general health status. Indicators which will be tracked on a regular basis to measure progress in achieving this sub-goal are:

- -- total fertility rate declines from 6.5 in 1992 to 6.0
- -- 1992 prevalence rates of diarrheal disease, ARI and malaria decreases
- -- HIV prevalence rates of women attending antenatal clinics declines
- -- HIV incidence rates decline among targeted populations:

workers, traditional healers, out-of- school youth, counselling center clients

The sources of information for monitoring achievement of these indicators will include the 1996/97 ZDHS, WHO/MOH epidemiological records and the HIV/AIDS Prevention Project monitoring reports.

3. Project Purpose

The project's purpose, **to increase the use of modern contraceptives**, is also the CPSP Strategic Objective No. 2. Three indicators will be tracked on a regular basis to ensure that the project is having its intended impact:

-- couple years of protection increases from an estimated 160,000 in 1992 to 380,000

-- contraceptive prevalence rate for modern methods increases from 9% in 1992 to 20% among married women and from 7% to 18% among all women, and

-- family planning services delivered at 80 strategic sites increases by 75% from base period.

The sources of information for monitoring achievement of these objectives will include the 1996/97 ZDHS, MOH and PSZ logistics management reports on numbers of acceptors and supplies distributed, baseline and follow-up surveys at strategic sites and periodic special surveys to monitor condom use.

4. Project Outputs

The outputs which are described for each of the FPS project components correspond to the CPSP targets listed for Strategic Objective No. 2. The components are: a) social marketing; b) IEC; c) service delivery at strategic sites; d) policy and operations research; and e) project management.

a. Social Marketing

Outputs for the social marketing component include the **expansion of distribution points and the increase of the private sector share of FP financing.** This is done by expanding the existing condom social marketing activity into a comprehensive contraceptive social marketing program that includes the sale of oral contraceptives, spermicides, IUCDs, injectables and implants, in addition to the present marketing of condoms.

Indicators which will measure success in achieving the objective include:

-- number of distribution points for oral contraceptives (combined and progesterone only pills) expands from 0 to 500 including pharmacies, employer-based services (EBS), community-based distributors (CBD) and NGO and private health providers

-- number of distribution points for injectable contraceptives (Depo Provera) expands from 0 to 250 including pharmacies, EBS, NGO and private health clinics

-- number of distribution points for hormonal implants (NORPLANT) expands from 0 to 40 including public and private hospitals and clinics

-- number of commodities supplied through the private sector increases from 0 to:

* 710,000 cycles of orals
* 100,000 vials of injectables
* 43,000 IUCDs
* 43,000 sets of implants (and trocars)

-- Percentage of FP users using pharmacies and private sector for services increases from 16% in 1992 to 25%

Sources of data will include monthly marketing sales and distribution reports from PSZ as well as stock control and acceptor reports of EBS and CBD implementing agencies, and the 1996/97 ZDHS.

b. Information, Education and Communication (IEC)

The outputs of the IEC component include **increased demand for FP services, increased knowledge of FP and increased motivation to use FP.** This is done by carrying out three mass media campaigns (TV, radio, newspapers, billboards, bus ads, posters, t-shirts) targeting men, youth and women; training in FP motivation for community level health workers and change agents; development and production of health center materials (FP logo, posters, calendars, flip charts, method brochures) and community materials (pamphlets for non-literates, drama, presentations, meetings).

Indicators which will measure success in achieving the objectives:

- percentage of women/men who have heard a FP message on radio or TV increases from 13%/-- in 1992 to 40%/50%

-- percentage of women/men who have heard a FP message from someone in their community is reported at 40%/60%

-- 80% of people interviewed can name more than two FP methods and identify a source for modern methods

-- ideal number of children decreases from 5.8 in 1992 to 4.7

-- percentage of couples who discuss FP increases from 58% in 1992 to 74%

-- percentage of women who want to limit or space next child two years or more increases from 33% in 1992 to 55%

Sources for assessing progress toward meeting these targets will be the 1996/97 ZDHS, data collected in baseline and follow-up surveys, and periodic surveys of health center FP clients.

c. Service Delivery--Strategic Sites

The two outputs of the service delivery--strategic sites component are **improved access to FP services and improved quality of FP services.** This is accomplished by establishing integrated family planning services at 3-4 facilities in 20 strategic sites, supporting 11 community-based distribution services and 40-50 employer-based services, expanding the provision of long-term FP methods (IUCD, implants, ML/LA and NSV), strengthening FP pre- and in-service training activities and the management capacity of the MOH MCH/FP unit. To accurately assess progress towards achieving these objectives, the project will assess:

-- number of hours per week that MOH hospitals and health centers in strategic sites offer FP services increases from 2-4 to 30-35 per week;

-- number of health centers in strategic sites offering more than three modern methods of FP increases from baseline to 57;

-- number of hospitals and health centers in strategic sites offering long-term FP methods (IUCD, implant, ML/LA, and/or NSV) increases from baseline to 36;

-- number of companies in strategic sites offering at least 3 modern FP methods increases from baseline to 45;

-- number of CBD agents in strategic sites providing information and contraceptives to members of their communities increases from baseline to 220;

-- average amount of time provider spends on counseling client increases from baseline to 15 minutes;

-- number of FP acceptors who discontinue use of modern methods decreases from 16% in 1992 to 10%

The sources of information for monitoring achievement of these objectives will include: periodic inventories, survey data collected by District Health Management Teams, and patient flow analyses; progress and implementation reports provided by the technical assistance management team, participating MOH District Health Boards, NGOs implementing CBD activities and companies offering employer-based services; service statistics; and, the 1996/97 ZDHS.

d. Policy and Operations Research

The outputs of the policy and operations research component are **improved availability of services and establishment of appropriate incentive-based systems.** This will be accomplished by providing technical assistance to the MOH to enhance legislation that supports a positive FP environment, and conducting operations research studies to explore cost-reimbursement systems of financing FP services.

Indicators which will measure success in achieving these objectives include:

-- passage of the new Nurses and Midwives Act allowing them to insert IUCDs and prescribe hormonal contraceptives

-- advertisements for contraceptive social marketing products aired

-- incentive-based service providers proves feasible

5. Evaluation

Two project evaluations will be conducted during the life of the project. A midterm evaluation is schedule for 1996 and a final evaluation for 1998. A Demographic and Health Survey, presently scheduled for 1996/97 will provide essential data for the final evaluation.

The purpose of the midterm evaluation is to assess program impact and progress toward achievement of the major project outputs and purpose, identify problems likely to affect successful achievement of the project purpose, and recommend mid-course corrections in project strategy, componentry and or project objectives.

The midterm evaluation will require four outside consultants for a minimum of four weeks each. The team should include a family planning clinic specialist, a contraceptive social marketing specialist, an IEC/training specialist and a management specialist. The USAID HPN Officer, USAID personal services contractor, Technical Assistance Management Team (TAMT) and grantee representatives will also participate.

Prior to the arrival of the evaluation team, project staff will compile all pertinent data for their assessment. The team will also have available all reports prepared in developing IEC materials from focus groups and KAP studies, operations research study reports, and other research and analyses.

Specific areas to be assessed in the midterm evaluation include:

a. the effectiveness of the TAMT in providing training and technical support; the extent to which trained personnel are able to function on their own; their ability to sustain their operations; and the adequacy of support services being provided to the subgrantees by the TAMT;

b. the effectiveness and efficiency of the TAMT mechanisms in developing and awarding subgrants and monitoring their implementation;

c. the number of IEC and service delivery grants awarded and the effectiveness of the subgrantees in expanding high quality FP services and increasing numbers of modern method users;

d. the number of service delivery points added by public and private sector organizations and the effectiveness of these entities in providing services and identifying mechanisms for future, rapid service expansion;

e. the extent to which project or other external resources will be required to maintain levels of service delivery being provided by subgrantees;

f. the potential for addition or expansion of strategic sites to larger geographical areas and numbers of clients;

g. the costs of grants award and monitoring mechanism and potential for sustainability of subgrantee activities in the medium and long term.

The evaluation team will identify problems and issues and recommend

solutions. The team will also make a preliminary recommendations regarding a follow-on project and its proposed structure. These recommendations will be discussed with the evaluation committee and plans made for implementation of those recommendations agreed to by USAID and Zambian counterparts.

The final evaluation will assess overall project impact, progress towards achievement of project objectives, and sustainability of sub-projects. Specific issues, team composition, and duration will be similar to the midterm evaluation. However, the team will make recommendations regarding a follow-on project and suggestions for its design.

Planning for the final evaluation will start at least one year in advance of the PACD. ZDHS survey data should be available for assessing the impact of the project activities on contraceptive prevalence and access to modern contraceptives. In addition the TAMT will be responsible for ensuring that the following are completed and made available to USAID: grant award and monitoring documents for all subgrantees; reports for all operations research and other studies financed under the project; comprehensive, up-to-date progress reports; and data from the logistics management information system.

6. Audit

Given the number of grants under this project, effective financial management, accountability and audit will be a primary concern. The TAMT will be required to have a well-established track record in administering and managing USAID-financed projects and subgrants. The TAMT will be expected to ensure that subgrantees possess adequate administration and financial control systems to meet USAID's accountability requirements. Audit firms will be engaged to conduct annual financial and compliance examinations of subgrantees. In addition, the TAMT must comply with Standard Provisions for grants to NGOs which include requirements for submission of annual independent CPA-audited financial statements to USAID.

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

SEP 22 1993

ACTION MEMORANDUM FOR THE ACTING DEPUTY ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: Keith E. Brown, AFR/SA

SUBJECT: Family Planning Services Project (611-0235)

Problem: Approval is requested to waive the requirement of Section 110 of the Foreign Assistance Act of 1961, as amended (Act), calling for a host country contribution of at least twenty five per cent of program or project costs for the Zambia Family Planning Services Project (611-0235).

Background: Zambia's population of approximately 8.2 million is growing at an annual rate of approximately 3.2 percent. If this rate continues the population is expected to double in just 22 years. Though reduced to 6.5 from 7.2, the high fertility rate in Zambia is a major factor exacerbating the country's economic problems.

USAID/Zambia proposes to assist the GRZ with a project designed to increase the use of modern contraceptives. The project will assist with activities in five areas: Contraceptive Social Marketing; Information, Education, and Communication (IEC); Services Delivery; Policy and Operations Research; and Project Management and Administration.

Host country contributions will be limited to in-kind goods and services, and user fees initiated by the GRZ. The GRZ contributions will be staff and office space in the Ministry of Health associated with the project. While the host country will make a contribution for all components of the Project, the in-kind and cost recovery contributions will fall far short of the 25 percent threshold.

Discussion: Section 110 of the FAA provides that: "No assistance shall be furnished by the United States Government to a country under sections 103 through 106 of this Act until the country provides assurance to the President, and the President is satisfied, that such country provides at least 25 percent of the costs of the entire program, project or activity with respect to which such assistance is to be furnished, except that such costs borne by such country may be provided on an 'in-kind' basis."

FAA Section 124 (d) authorizes a waiver, on a case-by-case basis, of the requirement of FAA Section 110 in the case of a program,

project or activity in a relatively least developed country. Considerations relating to financial constraints, host country commitment, nature of the project, and phased contribution form the basis for such determination. These items are discussed below.

Financial Constraint: Zambia is on the Development Assistance Committee (DAC) list of low income countries and is reported by the World Bank to be in severe budgetary and balance of payments difficulties. In view of this situation, special consideration is merited with regard to the required level of the contribution of the Government of the Republic of Zambia in support of the activities of the FPS Project. Since 1989 Zambia has been attempting to stabilize its economic circumstances with the assistance of the IMF and the World Bank. The impact of economic restructuring in Zambia has been complicated by the need to cope with drought-induced agricultural difficulties. This has imposed a severe burden upon available budgetary resources which are already limited. With the assistance from the World Bank, the GRZ is attempting to allocate more resources for social sectors, including health and family planning. Even with a greater allocation of funding to the social sectors, spending is only expected to reach the level allocated in 1984 which limits the GRZ's capability to assist in funding the start-up costs of an expanded family planning program.

Country Commitment: The GRZ recognizes the negative impact of rapid population growth on socio-economic development and the consequent need to systematically integrate population issues into the nation's development planning and implementation process. The GRZ's National Family Planning Program: 1992-2000 describes the activities the GRZ endorses which will achieve national family planning goals, objectives, and targets. Its well defined strategy covers: service delivery; information, education, and communication (IEC), commodity and equipment logistics; and training. The GRZ considers information as well as access to family planning services a fundamental human right. To improve access and availability of family planning services, the National Program has deliberately chosen to promote family planning services via a variety of services providers: Community Based Services (CBS), Employer Based Services (EBS), Contraceptive Social Marketing (CSM), and the more traditional clinic-based Integrated Family Planning services (MCH/FP). Because of the financial constraints, the GRZ is encouraging greater private sector participation in the provision of health care and family planning services.

Nature of the Project: USAID/Zambia assistance for this Project merits special consideration for a waiver of the counterpart requirements, as it is a special concern with more than just bi-lateral importance. A.I.D. assistance for family planning is an essential element of U.S. development assistance. The Family

Planning Services Project supports the basic A.I.D. premises that: individuals and couples have a right to decide freely the size of their family; family planning programs are in line with U.S. strategic as well as humanitarian interests; and the U.S. needs to be pro-active in the area of family planning since the U.S. has unique strengths in this area of international assistance. The Family Planning Services Project meets special concerns of the U.S., and also falls within one of the four strategic areas established by the Administrator as a focus for the Agency.

Phased Contribution: This option was deemed not viable for the FPS Project because Zambia's financial constraints are likely to remain throughout the life of the project. Consequently, the GRZ's ability to financially participate in the project is not expected to show appreciable improvement over this period. While all efforts will be made to have the GRZ make whatever contributions possible, this contribution will fall short of the 25 percent threshold.

Authority: Section 124(d) of the Act permits a waiver of the Section 110 cooperating country cost-sharing requirement of 25 per cent on a case-by-case basis for programs, projects or activities in relatively least developed countries. AID Handbook 3, Chapter 2, App. 2.G, Section E2b, indicates that the DAC list of low income countries is an acceptable starting point for considering whether a country is eligible for a waiver of the Section 110 requirements. As indicated above, Zambia is on the DAC list. Zambia is also on the United Nations General Assembly list of "least developed countries." Delegation of Authority 403 delegates authority to Assistant Administrators to approve Section 110 waivers, but does not permit it to be redelegated to field posts. You may exercise the authority under DOA 550 "alter ego" delegation.

For the reason, described above, USAID/Zambia believes that the initiation and execution of the "Family Planning Services Project (611-0235) would be handicapped by the 25 percent contribution requirement.

Recommendation: That you approve a waiver of the 25 percent costs sharing requirement contained in Section 110 of the Foreign Assistance Act of 1961, as amended, for the Family Planning Services Project, provided that the GRZ makes the contribution as indicated above.

Approved: _____

Disapproved: _____

Date: 9/27/93

Drafted:USAID/Zambia/PDO:DStraley;AFR/SA:SCAnderson:8/26/93:fpspa
ct.mem

Clearances:

USAID/Zambia/CONT: MGweshe	(draft)	date	8-26-93
USAID/Zambia PDO:DStraley	(draft)	date	8-26-93
REDSO/ESA/RLA:RSarkne	(draft)	date	8-26-93
REDSO/ESA/HPN:JLarosa	(draft)	date	8-26-93
AFR/SA:RHarber		date	8/30/93
AFR/SA:LTaylor		date	3 Sept 93
AFR/DP:JGovan		date	8/2/93
GC/AFR:ESpriggs		date	9/21/93

CONTRACEPTIVE SOCIAL MARKETING

I. Activities of PSI/PSZ

In October of 1992, USAID/Lusaka signed a cooperative agreement with Population Services International (PSI) for a five year project entitled HIV/AIDS Prevention Project, an activity to be carried out jointly with the Pharmaceutical Society of Zambia (PSZ). Its goal is the promotion of condoms as the primary preventive measure against the spread of HIV/AIDS and has a minimum sales objective of 30.6 million condoms to be sold in urban and periurban areas over the five year period . By September of 1997, the program plans to reach 95% of all pharmacies and private health clinics, 90% of all wholesalers, 80% of state stores and 75% of all hotels, major bars and clubs. Furthermore, the project is to create brand awareness of the specific condom in 80% of the public. Finally, it will strengthen sustainability of PSZ to operate a marketing infrastructure to distribute other health care products.

By pretesting names with 16 focus groups in Lusaka, Copperbelt, and Livingstone prior to agreement signing in April 1992, the name "Maximum" was selected, implying maximum protection and pleasure. The price for a pack of four was priced at K20, approximately $0.10, but since the fall in the value of the Kwacha to the range of 500-550/$1, the advertised price of K20 is effectively lowered to $0.04. Funds generated by the sales are to be maintained in a separate account with 85% to be reinvested to build sustainability, 10% applied to operating/administrative expenses and 5% retained by PSZ.

The sales program was launched on December 1, 1992 and by the end of June 1993, a 7 month period, a total of 2.9 million condoms were sold, easily above pace to reach the first year target of 4 million. 391 outlets have been established, again ahead of schedule in reaching the LOP target of 800 outlets, and consist of:

23%	pharmacies
25%	workplaces - factories, breweries, barracks, mining companies
20%	wholesalers
17%	supermarkets
15%	shops, bars, restaurants

The uptake by the public of condoms in this program is quite astounding, given the fact that there has been no advertising. Such campaigns are currently in the preparatory stage, with radio spots being produced and pretested by Young & Rubicon, a local firm, for broadcast on the three radio stations. Television ads are being considered, using well-known sports and singing figures, but

more research into audience reach must be conducted.

Ads will be targeted at three groups: urban youth, workers and certain high risk populations. Both brand name and generic condom promotion campaigns are being considered, although current thinking of PSI advisors favors the former as first priority.

II. Pharmaceutical Society of Zambia (PSZ) and its Role in CSM

The Pharmaceutical Society of Zambia is a private organization, founded in 1982 as a trade association and lobby for both public sector and private pharmacists. It has 100 dues-paying members, who work in government, mining and mission clinics as well as in private drug producing companies and is governed by a six person board elected by its members. An illustration of its lobbying activities is its introduction of a law into parliament to grant the PSZ Board authority to register (certify) new pharmacists.

PSI chose PSZ as its in-country collaborating partner since the Society had experience implementing a contraceptive retail sales program dating from 1985, with assistance originally from Family Planning International Assistance. FPIA-supplied, central AID-funded contraceptives were channeled to 106 outlets until 1990 when FPIA support terminated due to the loss of an AID grant. Subsequently, PSZ received a commodity grant from Pathfinder to continue the retailing program.

It presently maintains a modest sales effort, parallel to the PSI-organized program, selling IUCDs and oral contraceptives provided by Pathfinder to mining clinics and private hospitals and pharmacies, but not to Ministry of Health clinics. IUDs are priced at K150 (approx. $0.30) and orals at K30 ($0.06).

PSZ's comparative advantage as social marketer in Zambia is that it is the most legitimate liaison with the government as the recognized representative of the pharmaceutical industry. Furthermore, one of its charter mandates is to increase public awareness about general health issues, with pointed reference to family planning, and the role that proper use of medications and contraceptives can play in ensuring the physical well-being of Zambians.

Its successful development of the distribution network of pharmacies for contraceptives over the last several years with FPIA and Pathfinder, combined with the rapid and extensive outreach achieved in 1993 with the PSI condom project, validates the government's designation of PSZ in the "National Family Planning Program 1992 - 2000" as the main collaborator in its effort to

encourage contraceptive social marketing. Some donors have cited PSZ's use of public transportation (railway, buses and postal system) when other means are unavailable to reach outlets and its small core staff as indicators of its efficiency and cost-effective "appropriate technology" approach.

On the other hand, it is obvious that the distribution and delivery capacity of PSZ must be strengthened if it is to greatly expand its CSM program beyond the condom line for AIDS control and current contraceptive sales to pharmacies and clinics that has remained constricted due to irregular commodity supplying. The President and Executive Director of PSZ have acknowledged this potential threat to the viability of a broadened marketing and distribution function of the Society and recognized two options: to purchase more vehicles to be the direct property of PSI, or to lease trucking services on a consignment basis.

III. Market Expansion

The existing CSM structure being put into place by PSI lends itself well to a series of product add-ons to the on-going program for social marketing of condoms for HIV prevention.

Most CSM programs initiate business by launching condoms, then move to sales of oral contraceptives. This sequencing is appropriate for the Zambian situation as well. Moreover, such expansion can take advantage of PSZ's experience in retailing of oral contraceptives to pharmacies by systematizing the process and guaranteeing, through the bilateral funding of this Project, a steady supply of commodities and the resources needed for advertising, training and storage/delivery facilities, elements that have been missing in the past.

The pricing of the combined estrogen-progesterone OC should be consumer-tested, but could potentially adopt the already established price of K30 being charged by PSZ.

Opportunities now exist for enriching the contraceptive mix of methods that can be made available through CSM with the advent of U.S.FDA approval of the highly effective injectable, Depo-Provera. This product would require an concerted educational effort directed at both professional providers as well as the general public, to dispel fears of injectables, based on rumors of severe side effects and permanent infertility. Furthermore, great care must be exercised in the Zambian health environment to avoid the spread of HIV through the use of needles contaminated with infected blood products.

Depo-Provera and other injectables share the benefits of being

relatively long-lasting, one injection of Depo providing coverage for three months, and of being identified as culturally acceptable "good medicine."

A fourth product that can be seriously considered as a candidate for the expanded CSM portion of this Project is NORPLANT. This implant has enormous potential for making a significant impact on contracepting behavior worldwide and Zambia's family planning program is poised to participate in exploiting that potential to help achieve the Government's population policy goals.

The high expectations technically for NORPLANT are based on its extremely long effectiveness, usually calculated at 3.5 to 5 years, the infrequency of attention required in administering and doing check-ups of the method---one implantation, a follow-up shortly after and annual inspections--- and its reversibility. Equally attractive is the fact that the method is not easily perceived by anyone besides the user herself. In Zambia, where beliefs that women using family planning may be promiscuous are common, this method may be highly desired.

The CSM program can contribute to increasing CYPs by adding NORPLANT to its sales line targeted exclusively to hospitals and larger clinics dealing with the public traditionally served by the government, and to private clinics whose clientele possess greater purchasing power. Prices charged by PSZ should vary accordingly. A carefully designed and implemented training program for nurse-midwives and physicians is an essential element of the NORPLANT method diffusion and resources should be in included in the training component of the Project for this purpose.

Thought and consideration should be given to achieving a thematic linkage of all products sold in the CSM program, using the same color (yellow) in packaging, slogans and names if appropriate, and advertising to clearly identify CSM as a public service of the PSZ.

IV. Policy and Regulatory Implications

Numerous assessments have reported that according to law, condoms can be sold in non-pharmaceutical outlets---supermarkets, drugstores, shops and kiosks--- but that oral contraceptives are to be distributed only in pharmacies. In theory the Pill is sold upon presentation of a prescription; in practice, it is known that OCs are sold, more often than not, without the prescription requirement in Zambia, as well as elsewhere in the world.

Although the law is ambiguous, stating that IUD insertion procedures are part of the physicians' protocol but remaining mute over whether nurses are prohibited from this practice, there are

exceedingly few nurses in the entire country who are indeed inserting IUDs.

Until recently, it was believed that all injectables were banned for use as contraceptives, but the Government through Medical Stores Limited has requested a supply of Noristerat, an injectable of two months' duration, as a donation from the ODA. Still, it appears that the general public and many service providers consider injectables, and particularly Depo-Provera, as illegal.

Finally, although there are no restrictions on the advertising of "non-ethical" products such as condoms, mass media advertising of ethical pharmaceutical products, of which oral contraceptives are one, is not permitted.

All of the above restrictions impinge heavily on the prospects of success in expanding the PSI/PSZ social marketing program to include contraceptives besides condoms.

The USAID Mission has begun a policy dialogue over these issues with the Government, represented principally by the Ministry of Health. From recent discussions by Mission personnel and consultants with MOH leadership, it seems clear there is a disposition at the highest levels to reform and liberalize regulations that at the moment stand in the way of effective contraceptive social marketing and an improved performance of the national family planning program as envisaged by the new Zambian administration.

There is a realization in the MOH that it must take a more proactive role in policy matters in order to increase access to family planning services. Specifically, the MOH plans to facilitate the passage of the Nurse-Midwife Act, now being reviewed by a Task Force, which will officially broaden the scope of functions permitted to this personnel, including IUD insertions, keyed to a requisite of training. Legislation will be proposed in 1994 with an expectation that the Act will become law by January 1995, when the Ministry-wide decentralization plan is to take full effect. In the meantime, the MOH would issue policy guidelines clarifying and, in effect, legitimizing the behavior of nurses now inserting IUDs and permitting the training of others during the interim.

Coming out equally clear from these policy discussions is the shared view that the physician-issued prescription as a prerequisite to accessing oral contraceptives is a severe limitation on broadening OC use in Zambia, a country with a 1/13000, doctor to population ratio. Correspondingly, there is a willingness on the part of MOH leadership to consider authorizing

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alternative approaches such as contra-indication checklists for use by non-pharmaceutical personnel, as long as it was accompanied by appropriate training.

Regarding the prohibition of advertising, it was stated by Ministry authorities that the MOH has the power to exempt oral contraceptives if they are part of a sales promotion with a social welfare purpose.

In the case of injectables, the MOH adheres to the principle of international recognition of the safety and efficacy of drugs, following the guidance of WHO and the U.S.FDA. As long as the drug is registered and used in the country of origin, it is eligible for registration in Zambia. Action required here would be that the Pharmaceutical Division of the MOH submit a request for registering Depo-Provera to the Pharmacy Board.

It is suggested that the elimination of many, if not all, of the above policy constraints form part of the conditionality of this Project.

V. Competitive Influence of Contraceptive Social Marketing on Medical Stores Limited

Medical Stores Limited (MSL) is wholly owned by the MOH and headed by a Managing Director, but at present is an independently operated organization with a governing board chaired by the MOH. According to the Managing Director, it has multiple functions. It was set up to serve as a central procurement center for generic drugs and other pharmaceuticals, medical supplies and equipment, and in this function procures and distributes essential drugs on the WHO-approved Essential Drugs Program list. Operating a fleet of 17 trucks, it delivers commodities, mainly in the form of kits, monthly to the province and district levels where the responsibility for distribution to health centers rests with the districts and to hospitals by the provinces. The kits are assembled by MSL and consist of 77 essential drugs, including condoms, calculated to serve 1000 patients for a month. In addition, it also manufactures 35 products.

Beyond the condoms in the kits, MSL also is responsible for storage and distribution of other family planning supplies, donated somewhat sporatically by IPPF through PPAZ and by UNFPA through the MOH, commodities which are handled separately from the kits. Unfortunately, there is no comprehensive, long-term plan for the management of contraceptive logistics. In fact, the lack of such a plan and specialized personnel, combined with the irregularity of contraceptive supplies, have contributed to the frequent stock-outs and problems with expired contraceptive products at service

outlets.

It is clear that MSL has the mandate, facilities and staff to continue to be the main agency for procuring, storing and delivering medical supplies, including contraceptives, to public sector health service points. It is equally clear, if past is prologue, that there will continue to be supply/resupply problems. The inventory of all goods in the warehouse was characterized by the Managing Director as "very low" (July 1993), who also stated that the MOH owed the MSL 2 billion Kwacha (approximately $4 million).

With only condoms routinely supplied in the assembled kits, other contraceptives are delivered to the MCH/FP Divisions, rather than the Pharmaceutical Units, at the provincial and district levels and often are omitted in the regular delivery schedules to outlying clinic points. Being basically a "push" system from the top down with no systematic return of feedback from the field, there is relatively little flexibility in adjusting quantities in the kits or other supply lines based on the actual utilization experiences of service points.

The National Family Planning Program has identified the contraceptive logistics system as a major problem in the delivery of services and in June of 1993 requested assistance from the ODA. The request took the form of an emergency supply of contraceptives for the Government and PPAZ, to cover needs during the November 1993 to December 1994 period; and a five year plan of estimated contraceptives, technical assistance and ancillary support costs. Valued at K600,000 (approximately $1 million), the emergency shipment consists of six brands of OCs, injectables (Noristerat), foaming tablets and IUCDs. ODA has also provided its procurement plan indicating that it will provide more than enough OCs and injectibles to cover the public sector need over the next five years.

With many parastatals undergoing privatization under the Government's economic reform program, the future of MSL is unclear. The expectation of the Managing Director is that MSL will not be privatized for three years. It does have a broad outreach through its fleet of vehicles. However, gross resource scarcity, carry-over of major debt from the MOH and lack of tight logistics management and information control most likely will continue. The recent reduction in MSL personnel from 500 to 390 may lead to greater efficiencies. On the other hand, it may also lead to even less capacity to distribute commodities consistently.

In light of this prognosis, it certainly is in the best interest of the CSM program to be poised to fill in any supply gaps of

contraceptives in the "natural" market of the MSL, i.e. the MOH districts and their clinics. The entree into this market already exists through the FPIA/Pathfinder-initiated sales program with clinics, mining company dispensaries and mission hospitals.

PSI/PSZ should probe the potential market represented by the District Boards which will have autonomy to procure needed medications with the block grants provided by the central MOH authority and revenues generated from fees for services rendered. If MSL cannot respond to the needs for contraceptives of the MOH system, the CSM program should serve as an immediate back-up source of supply.

VI. Conclusions

1. The Contraceptive Social Marketing program forms an important part of the new Family Planning Services Project.

2. The current activity with PSI of condom sales should be expanded as quickly as possible to include a broader array of contraceptive products, beginning with the oral contraceptive and IUDs, and eventually include injectables and NORPLANT.

3. Continue the relationship with the Pharmaceutical Society of Zambia (PSZ) to take advantage of the on-going CSM activity with PSI and a modest sales effort, outside of the formal social marketing structure with PSI, already in operation retailing IUDs and OCs. This continuation can capitalize on the natural and collaborative relationship with the GOZ of the PSZ as the recognized representative of the pharmaceutical industry and on the fact that it is distributing CSM condoms to nearly 400 retail outlets at present.

4. SMC should probe the market being created by the establishment of district boards with their own purchasing power and discretionary decision-making in procuring drugs by being proactive in pursuing this potential market. Provincial and district hospitals are included in this category. In this way, the CSM program can serve as a secondary or fall-back source of supplies to "graduated" MOH health facilities which will with high probability experience commodity supply problems with Medical Stores Limited (MSL), the official distribution agent under the current Government plan.

5. The distribution/delivery capacity of PSZ is of concern and, being critical to the viability of the CSM program, merits great attention by PSI/PSZ and close monitoring by the AID Mission. Two options to strengthen this aspect of the program are (a) provide a small fleet of trucks to PSZ or (b) contract or lease trucking

services on a consignment basis.

6. It is essential to include training seminars for members of the PSZ and other non-affiliated pharmacists in family planning motivation and information on methods. These can be organized and funded by PSI under its amended agreement.

7. As CSM expands to bring other contraceptive products on line, the Project through PSI/PSZ should develop brand names for them, ideally with a common linkage that identifies them as being part of the same marketing campaign, all the while adhering to principles of pre-testing of consumer preferences.

8. PSI/PSZ should develop two lines of advertising: (a) brand-specific that identifies individual products by name; and (b) generic family planning messages, coordinated in close collaboration with the national IEC campaign to be managed by either the MOH (MCH/FP) or the Ministry of Information and Broadcasting.

9. It is suggested the yellow colored packaging of the MAXIMUM condom be continued for all CSM products to clearly identify the sales effort as a public service of the PSZ. The linkage to the condom product currently being sold could be achieved by adding two heads between the silhouetted male/female figures, the condom logo, to identify contraceptives as family planning rather than AIDS/HIV pr[illegible]ion products.

10. The addi[illegible]n of the injectable, Depo-Provera, and NORPLANT to the sales line should be exclusively targeted to clinics, those serving the public on a subsidized price basis, and private clinics---"surgeries"--- paying higher prices. It is important to ensure that Depo be sold as a vial-nonreusable syringe (combined unit) in a sterile package to avoid potential blood product contamination from reusable needles.

11. It goes without saying that the funds being deposited in a special account, representing 85% of revenues generated, be devoted to building the sustainability of the CSM program after the withdrawal of PSI technical assistance and AID financial support. The Mission should request that PSZ with technical assistance from PSI submit a plan for investing in CSM activity sustainability.

12. Policy dialogue between the Government and the USAID mission should continue regarding removal of regulatory constraints over oral contraceptives to authorize over-the-counter sales, with proper safeguards of training in the use of contra-indication checklists; liberalization of clinical protocols to allow nurse-midwives to insert IUDs; legalization of advertising of OCs; and

the issuance of Ministerial guidelines authorizing the use of injectables and implants. Elimination of policy constraints may be the subject of conditionality of the Project.

TRAINING ANALYSIS

PRE-SERVICE TRAINING

1. Nurse/Midwives

Zambian Registered Nurses (ZRNs) are trained at three Government schools (Lusaka, Kitwe, and Ndola) and one mining industry supported school in Mufirala. Together they graduate approximately 200 students per year in a three year program. ZRNs are usually employed in the larger hospitals and work at the administrative level. ZRNs who attend an additional year of training in midwifery are qualified as Zambian Registered Nurse Midwives (ZRNM).

Zambian Enrolled Nurses (ZENs) are trained in a 2 year nursing program. Qualified students attend an additional year to receive a certificate as a Zambian Enrolled Midwife (ZEM). Training institutions for ZENs/ZEMs are located in each province with the exception of the Western province where there is no ZEM training. ZENs/ZEMs are usually the front line service providers in the rural areas and provide direct patient care in hospitals. The Post-Basic School of Nursing, located in Lusaka, provides a Bachelor of Science degree in Community Health, Medical/Surgical Nursing, Psychiatric Nursing or Midwifery for qualified ZRN/ZRMs who have had at least 2 in clinical practice. There are approximately 20 graduates per year who attend the 3 year program.

With technical assistance from the General Nursing Council (GNC), family planning was incorporated into basic MCH and Community Health Nursing sections of the curriculum in the ZEN schools and strengthened in the ZRN, ZEM, and ZRNM schools. The first class to graduate from the revised curriculum will be in July, 1994. In 1992, 41 tutors from 34 provincial/district nursing schools, were trained to present the new curriculum. There has been no follow-up evaluation of the tutors since training.

2. University Teaching Hospital (UTH) Medical School

FP planning training is incorporated into the basic curriculum during the OB/GYN and MCH components. UTH, in the past, has worked with AVSC to train doctors and nurses in VSC using minilaparotomy under local anesthesia (ML/LA). In 1990 UTH provided counseling for 395 clients of which 230 underwent a VSC procedure (93 under general anaesthesia and 137 under local). The program was never fully developed and training was suspended when the dedicated operating theatre was re-opened for general surgical use and half the trained people left the country.

3. Clinical Officers/Health Assistants

The Chainama College of Health Sciences prepares two cadres of health workers, Clinical Officers (CO) and Health Assistants (HA). While varying degrees of family planning is incorporated into their programs, it is limited by time constraints. The training program for COs and HAs are both 3 years with men making up the majority of the classes. Approximately 60 COs are trained each year (30 admitted in January and 30 in July) and 75% to 80% graduate. 35 to 40 entrants are admitted for HA training and graduate approximately 65%. CO and HA training includes 8 months of practical training at rural project areas throughout the country. These 2 cadres of workers are the front line and sometimes only health providers in rural districts.

The Health Assistants curriculum is not well developed in providing basic training in the reproductive system as well as family planning. It is slightly improved in the CO curriculum and includes counseling in both short and long term methods of family planning. The school lacks adequate instructional materials and models for teaching.

(a) Clinical Officers are trained to manage/supervise health centers as well as to diagnose and treat both in-patients and out-patients. They plan, organize, implement, and evaluate preventive, promotive and rehabilitative health programs in their catchment areas. In addition, they participate in the training and supervision of community health workers, traditional birth attendants and other persons involved in primary health care activities.

The 10 hours of instruction that COs receive in family planning includes record keeping, use/practice of temporary methods ccs., spermacides, condoms, coitus interruptus and NFP methods as well as information in male and female sterilization and IUCDs. They are also taught to manage high blood pressure, pelvic infection, pregnancy, abnormal uterine bleeding, amenorrhea, and dysmenorrhea.

(b) The Health Assistants curriculum (last revised March 1992) encompasses a multi-disciplinary field of Environmental Health and Hygiene. Because of the shortage of COs the Health Assistants often take on the additional responsibilites related to supervision and the management and delivery of health care. Course content includes:

Malariology and Malaria control
Meat inspection
Tuberculosis and Leprosy investigation and control
Mental Health
Appropriate Technology
Occupational Health and Safety

Entomology, parasitology, and microbiology
Maternal and child Health
Immunology, Immunizations, and injections
Disposal of the Dead
Primary Health Care

Family planning is incorporated in the MCH section. Information on counseling, anatomy and physiology of the reproductive system, and method mix needs to be strengthened to provide HAs with a better understanding of FP servi

C. In-Country, In-Service Training

1. Public Sector

The MOH Family Health Unit (MCH/FP) has developed and conducts a MCH/FP course one to two times a year, depending on financial resourses and time constraints on staff, for health service providers (ZENs, ZEMs, COs, and later ZRNs). The 14 week MCH/FP program (7 weeks didactic/7weeks practical training) qualifies these practitioners as Family Health Nurses (FHNs). The training is conducted at Mwachisompola Health Demonstrtion Zone which is located 18 Km. from Lusaka. In previous years the training site was provided free of charge, but beginning in 1993, the MCH/FP Unit was required to rent space which has proven to be a financial constraint. The coarse curriculum has recently been revised and further developed with technical assistance from the General Nursing Councils. Family planning services take up 2 weeks of the course outline with the remainder of time spent with health education and communication skills, sexually transmitted diseases, infertiltiy, MIS, logistics, nutrition, child health and management skills. Supervision during the practicum is loosely coordinated and it is not clear what competency level is attained by trainees before completion of the program. Approximately 1180 persons have been trained through this MCH/FP course.

The following Table provides numbers of Family Health Nurses (FHN) trained by the MCH/FP Unit of the MOH since inception of the program in 1981. The MCH/FP Unit is attempting to update the number of trained FP service providers (physicians, nurses, clinical officers) and still practicing in each province.

TABLE 1: Approximate Number of Trained Family Health Nurses by Province (Government)

Province	FHN	Total # of Nurses/ Midwives	% Trained in FP
North West	90	254	35%
Northern	116	403	29%
Luapula	85	271	31%
Western	120	382	32%
Central	130	408	32%
Eastern	135	470	29%
Lusaka	130	403	32%
Southern	150	627	24%
Copperbelt	170	1019	17%
Total	1120	4237	

Source: MCH/FP Unit Statistical Report: 1993

2. Private Sector

Various NGOs (PPAZ, YWCA, Makeni Ecumenical Center, Family Life Movement of Zambia (FLMZ) provide a variety of services and training. PPAZ, has recently completed a strategic planning exercise which identifies expansion of its' CBD activities. A "model" curriculum, used by the Pathfinder supported ADRA CBD projects will form the basis of a standardized curriculum. PPAZ is also participating in a joint project with the Japanese Organization for International Cooperation in FP (JOICFP). This project integrates nutrition, IEC and FP (foam and condoms) delivered through CBDs.

in 1990, the USAID sponsored Enterprise Project through PPAZ, designed and developed a curriculum for a 6 week FP course for 11 industry-based nurses. PPAZ has followed up with one field assessment after training.

D. Participant Training (U.S. and Third Country)

Through the UNFPA project, the MOH has been able to send approximately 50 nurses to family planning training courses in Mauritius, Zimbabwe and Kenya. The training includes IUD insertion but includes no follow-up training or evaluation after the nurses return to Zambia. The practice of IUD insertion has not been supported after completion of the course.

E. Conclusions

Pre-Service Training

In 1992, technical assistance was provided by the GNC, to incorporate/strengthen the FP component in the curricula of all schools of nursing (see detailed description in Annex P). To date, there has been no formal evaluation of the new curriculum. Review and revision of the curriculum will serve as the basis for strengthening pre-service FP training in all health providers educational institutions. Expansion of FP training during pre-service education is constrained in that these programs provide for comprehensive training in general health service delivery and therefore limited by specific time allocated to each subject. Therefore, the FPS Project will focus attention on development/strengthening of the pre-service FP component in curricula, in order to serve as a framework and strong basis for the more specialized in-service courses.

In-Service Training

The training section of the MCH/FP Unit is presently stretched beyond their capacity to adequately provide all in-service training resources required for the implementation of the National Family Planning Program (NFPP). MCH/FP Unit includes a person in research and Evaluation, a demographer/statistician, 3 trainers and 2 MCH staff. The Unit, in addition to providing training personnel to FP courses provided through various NGOs and schools of nursing, is also responsible for the storage and distribution of contraceptives and service statistics collation, recording and reporting. The present training site at Mwachisompola Health Demonstration Zone is less than ideal due to the distance from Lusaka and the increase in rental costs. It is not clear what role the MCH/FP Unit will continue to play as decentralization occurs and the districts take on the role of planning and implementation of health programs.

In-service training is sporadic and uncoordinated in terms of the overall national FP training needs as well as establishing the link between pre-service, in-service and service delivery training. There has also been no development of standards for certification as a family planning trainer/instructor. Trainers interviewed at the MCH/FP Unit, GNC, and PPAZ have all had varying degrees of training and clincal practice as family planning service providers. Competency-based training is a weak component in all family planning programs presently provided through pre-service and in-service training.

Supervision, monitoring and training follow-up of FP service providers requires strengthening. In speaking to nurses, COs, and HAs providing FP services at several rural health centers and district hospitals, their lack of understanding regarding the

advantages and side effects of different oral contraceptive (OC) formulations was identified. Furthermore, several had been trained in IUCD insertions but had never performed the procedure either during or after training. Refresher training (training for those already trained) is rarely provided and needs additional focus in the FPS project and developed at the District Level.

Training institutions (pre-and in-service) lack adequate training materials such as flip charts, reproductive models, resource text, training manuals, and a.v. equipment. Most reference texts found in the various institutions, were from the 1970's and '80s. Students competence is almost exclusively dependent on the quality of instruction given by the individual tutor as they lack additional resources and materials/texts from which to supplement and reinforce their learning.

While lack of adequately trained nurses and clinical officers has constrained FP service delivery at health centers, the lack of hospital based physicians, who are trained to provide FP services and offer backup support to lower level workers for patient referral, has also been identified as a human resource constraint. There are few physicians available to meet the demand for permanent surgical contraception to limit births. In a like manner, since few physicians have been trained to insert IUCDs, this method is virtually unavailable to FP clients.

F. Implementation with Illustrative Budget

In order to address the large unmet need for family planning (62%, ZDHS;1990) and to support the National Family Planning Program of Zambia, the training of family planning personnel will be an essential component of USAID's FPS Project strategy. Trained service providers, trainers, and master trainers should be skilled and knowledgeable, sensitive to the human and social factors in family planning, motivated and confident in their abilities to deliver services. Efficient supervision and management should serve to support the service delivery system which ultimately impacts at the level of provider and client and the quality of services. Many health personnel previously trained in family planning have relocated to other countries where the economic compensation and living conditions are of a higher caliber.

The goal of the training component is the achievement by Zambia pre-service and in-service institutions of improved and sustainable capabilities to train increased numbers of medical, paramedical and support personnel as skilled, knowledgeable and active family planning service providers and the expansion of the number, variety, distribution and accessibility of the service outlets in which those trained personnel are employed.

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1. Support of Pre-Service Training

Review of the FP curriculum, teaching and resource materials available for instruction as well as the training of the FP instructors in Lusaka School of Nursing (ZRN), Post-Basic School of Nursing, Chianama College of Health Sciences has identified the following areas which need assistance from the FPS project:

Year 1

- Short-term TA to review, develop and standardize competency based FP curriculum in all pre-service institutions. Revision should include, in addition to basic FP counseling/service delivery, focus areas in (a) adolescent counseling/FP information; (b) integration of sexually transmitted diseases (STDs) & HIV/AIDS and (c) guidelines for counseling and referral of infertile women. (2p/m)

- Equipment and supplies to support training and supervision for pre-service institutions: a.v. equipment, reproductive models, charts, up-dated textbooks, resource documents. ($100,000)

Year 2, 3 and 4

- years 2,3 and 4 the FPS Project will follow up activities and link practical training with FPS Project services at strategic sites.

Project will support local costs support for travel, per diem, office and teaching supplies related to training, evaluation and follow up activities ($100,000).

2. Support of In-Service Training

Under grants to PPAZ and other NGOs, the CBD training program will be developed and over-all management and supervision will be carried out by the MCH/FP Unit CBD Consortium.

Year 1

- Provide a Master Trainers Program (CAFS) in-country, for 12 participants from MCH/FP Unit, GNC, PPAZ and pre-service training institutions with training and supervisory responsibilites in MCH/FP. ($70,000)

Year 2

- Provide long-term Technical Advisor to assist the MCH/FP Unit/GNC with the development of a comprehensive training implementation plan for in-service training. (1p/60m)

- Short-term TA will also assist the MCH/FP Unit/GNC to review and finalize standards/guidelines for service delivery (to include adolescent FP counseling/information). (1p/m)

- Long-term TA toassist with development of a comprehensive family planning training plan, monitor progress of training programs, act as technical resource person. The comprehensive FP training plan should be clearly defined to include materials development, trainer preparation, geographic phasing of training, training follow-up, course schedule, and evaluation schedule for both government and private sectors.

- Print and disseminate standards/guidelines nationally to DMOs, hospitals, clinics, employer-based clinics, health centers, NGOs, mission hospitals. ($15,000)

- Support development of a Central Training Center in Lusaka, including support of a local Pre-service Training Coordinator and 2 additional training personnel, office supplies, equipment, training materials.

- Support from Short-term TA to design and provide community mobilization workshops in each province for strategic District Health Educators or appropriate FP program planners. These workshops will provide training in FP promotion, assist with the design of local FP campaigns, and methods to conduct seminars for community leaders and community groups. (2p/2m)

Year 3

- Provide 2 short-term contraceptive technical courses (CAFS), in-country, to 12 (each course) participants from strategic sites, including Drs., C.Os, ZRNs, ZRMs, and ZEMs. ($144,000)

- Train physician/nurse/CO teams in long-term family planning methods and management of complications (see Section III.3.d). ($70,000)

- Short-term TA will be provided for follow supervision/evaluation to Master Trainers to plan/conduct a 4 week training course for provincial and district Health Educators/PHN. Teams of 3 Master Trainers (4 teams) will train participants from each strategic site. The course will include service delivery skills management and IPC/C components. (2p/6w)

- Provide out-of-country training to managers, supervisors, and/or program officers identified from the CBD consortium, in a Management of Community Based Family Planning program offered by CAFS. (2 persons) ($12,000).

Years 4

- Provide out-of-country training to managers, supervisors, and/or program officers identified from the CBD consortium, in a Management of Community Based Family Planning program offered by CAFS. (2 persons) ($12,000).

Years 5

- Evaluation of comprehensive FP training plan and make recommendations for changes. (1p/m)

Project will support local costs, for travel, per diem, office and teaching supplies related to training, evaluation and follow-up activities at the district training centers. ($100,000)

INFORMATION, EDUCATION, AND COMMUNICATION ANALYSIS

I. ANALYSIS OF CURRENT SITUATION

The 1992 Zambian Demographic Health Survey (ZDHS) indicates that a high proportion of currently married women reported knowing a modern method of family planning (91 percent) and 78 percent of them have some knowledge about a traditional method. No doubt, the population and family planning IEC efforts of the Planned Parenthood Association of Zambia (PPAZ), Ministry of Information and Broadcasting Services (MOIBS), Pharmaceutical Society of Zambia (PSZ), Ministry of Health's Maternal and Child Health/Family Planning Unit (MOH MCH/FP Unit), Ministry of Education (MOE), and Ministry of Labor (MOL) have contributed to the almost universal awareness of family planning in Zambia. Mass media programs involving radio, television, newspapers, and sensitization seminars and workshops for influentials (political, traditional, and religious leaders at national and provincial levels; pharmacists; teachers; journalists; song writers; and play writers) have been the main population/family planning IEC activities undertaken since 1983, and are thought to have played an integral role in the adoption of the National Population Policy in 1989. In addition, PPAZ field educators, Makeni Ecumenical Center and the Adventist Development and Relief Agency (ADRA) CBD agents, and MOH field workers are promoting modern methods of family planning, while Family Life Movement of Zambia (FLMZ) teachers are promoting natural family planning including lactational amenorrhea method (LAM), using interpersonal communication.

Radio continues to be the major source of news and entertainment with over 3.5 million regular listeners to the three channels (1,2 and 4) of Zambia National Broadcasting Corporation's (ZNBC's) national network. Media access for rural dwellers is constrained by inconvenient program schedules, poor signal quality, as well as faulty or unavailable receivers. Television, which is largely an urban medium of the more affluent, has about 900,000 viewers. The two daily English newspapers have an estimated readership of 675,000, while the three weekly newspapers and the monthly Mining Mirror have a readership of 500,000 and 80,000 respectively. Government publicity and development-oriented communication is undertaken by the Zambia Information Services (ZIS) through a network of provincial and district offices and correspondents, the (irregular) publication of six vernacular newspapers, and public address systems.

Although the family planning awareness that has been created is almost universal, the "Knowledge, Attitude, and Practice (KAP) Gap", i.e., the gap between family planning knowledge and practice (only 19.1% current users), remains wide. This is despite the high unmet need, i.e., women who say they want to use

family planning, of 63% or approximately 350,000 married women. Some reasons for this gap include the unavailability of quality family planning services (i.e., an inadequate contraceptive method mix, a poor contraceptive logistics management system resulting in frequent stockouts, a lack of trained family planning service providers), a lack of detailed information on methods and where to obtain family planning services, and the fear of methods, particularly the possibility of becoming infertile (see Social Soundness Analysis). In addition, target groups that influence married women's reproductive decision-making, specifically men, service providers, and community elders such as grandmothers and mothers-in-law, have not been targeted with family planning information. Nor have youth--a group particularly ill-equipped to deal with their sexuality and consequently vulnerable to unwanted pregnancy and STD/HIV infection--been linked to appropriate family planning/reproductive health services through targeted IEC interventions.

Studies reveal that many teenage girls who are sexually active see abortion as the easiest form of family planning as 75% of women who resorted to induced abortion at a particular health facility were between the age of 14-19. They are reluctant to use contraception because they are afraid of being treated badly by service providers or fear being found out by their parents. Focus group discussions (FGDs) reveal that while school is one source of information on the facts of life, it is secondary to friends, films, and family elders. (See Social Soundness Analysis.) The youth, those aged 15-25, account for 21 percent of the total population of Zambia and at the time of the ZDHS, more than one quarter of teenage women had already had a child and another 7% were pregnant with their first child.

The United Nations Fund for Population Activities (UNFPA) has been the main supporter of population and family planning IEC, providing approximately three million US dollars. Even though these IEC efforts have been instrumental in influencing the adoption of a National Population Policy in 1989, and generating almost universal family planning awareness, Zambian men and women, nevertheless, lack detailed information on contraceptive methods and where to obtain them. (See Social Soundness Analysis.)

Some identified constraints that limit the effectiveness of family planning IEC include:

- lack of trained IEC personnel;
- development of IEC materials in an ad hoc fashion without the guidance of a clearly defined strategy;

- lack of targeting specific groups and pretesting of materials to enhance understanding, relevance, and appropriateness;
- lack of audience research to identify informational gaps and mechanisms of bridging these gaps;
- lack of funds to repeat mass media campaigns;
- lack of financial resources to develop adequate numbers of posters, pamphlets, and other materials in major languages;
- grossly inadequate numbers of field workers to reach women with family planning information using interpersonal communication;
- poor transportation and weak follow-up, supervision and back-up support systems, which hamper interpersonal communication activities in the field;
- minimal coordination of IEC efforts which has resulted in the absence of any common theme(s); and
- negative attitudes of service providers.

With the establishment of the Inter-Agency Technical Committee on Population's (ITCP's) IEC subcommittee in 1992, and the development of a national population IEC strategic plan, some of these problems are being addressed.

II. IEC STRATEGY

A. Overall Strategy

The objective of the FPS Project is to increase the use of modern contraceptives from 9% to 20% among married women and from 7% to 18% among all women by the end of the five year project. Because an increase in contraceptive prevalence is conditional on generating and maintaining a strong demand for family planning services, the overall strategy is three-pronged:

1) To channel existing demand to family planning services;

2) To continuously stimulate a strong and durable demand among consumers for family planning services; and

3) To enhance the overall quality of care offered by family planning service providers;

Offering quality services not only maintains demand for services, but often stimulates demand as satisfied clients are invariably

the best family planning promoters.

Interpersonal communication is important because it allows the service provider to respond with empathy to a client's questions, needs, and concerns. Because health providers' interpersonal communication and counseling (IPC/C) skills can have a strong impact on individuals' decisions to use or keep using family planning, the IEC strategy emphasizes building the service providers' IPC/C skills through training and providing them with good educational support materials so that they impart accurate information. While this is a key aspect of the IEC strategy, the provider training activities are included under the training section of the service delivery component.

While greater access to services is essential for expanding contraceptive use, access alone is not enough. Individuals must be informed and motivated to seek out these services. From a marketing perspective, a prospective client or customer is more likely to act when s/he has a very clear sense of where the service or product can be obtained, at what costs, and with what quality. In addition, demand for family planning needs to be sustained. Since well-designed multi-media campaigns can translate need for family planning into demand and also maintain the created demand, the FPS Project's IEC component will emphasize:

1) designing messages and campaigns for specific, priority audiences; and
2) expanding use of both traditional and mass media to transmit these messages.

In the same manner, the social marketing component will include an IEC program that informs prospective clients about the products being offered and the location of product outlets.

B. <u>IEC Component's Focus</u>

1) The main focus of the IEC component will be to link the 350,000 married women in Zambia who want to practice family planning to quality services (i.e., clinic-based, community-based, employer-based, or the contraceptive social marketing program) with appropriate information

   Targeting these women alone, however, will not suffice. To succeed, it is imperative that the following be done in conjunction with reaching the women (see Social Soundness Analysis):

   i) Obtaining men's commitment to family planning so that they support their wives in obtaining family planning services or use a method themselves;

ii) Enlisting the commitment of community elders who are influential in women's reproductive decision-making to family planning;

iii) Enhancing service providers' attitudes toward family planning and provision of family planning services;

iv) Enlisting support of community influentials' (including traditional, political, and religious leadership);

v) Seeking District Health Management Team members' commitments to family planning.

2) The second focus will be on linking youth aged 15-25 (both male and female) to reproductive health information and services.

III. PROGRAM OF ACTION

During the five year FPS Project, the program activities in the IEC component will include 1) a mass media program including audience research and development of radio and television spots and a logo for FP service providers; and 2) a district level program including development of print materials, community mobilization, clinic-based and outreach activities, and strengthening of provider counselling skills.

The FPS Project will issue a PIO/T or an OYB transfer to the Johns Hopkins University/Population Communications Services Project (JHU/PCS) to fully develop and implement this IEC component. JHU/PCS will work directly with the ZIS on the mass media program and the MOH District Health Management Teams on the district level program.

A. Mass Media

Since the FPS Project's strategic service delivery sites will be concentrated in urban districts with the highest population density and greatest unmet need for FP services, the mass media, which reaches a predominantly urban audience, will be an important channel of communication in the dissemination of family planning information, the marketing of family planning services and the dissemination of information on the socially marketed contraceptives.

The ZDHS reveals that while nearly 57 percent of Zambian women listen to the radio weekly, 42 percent read a newspaper and only 22 percent watch television at least once a week. In fact, media access is higher among younger women (i.e., age 15-39), educated women, women in urban areas, and women in the Copperbelt and Lusaka Provinces as they tend to read newspapers, watch

television, and listen to radio. Unfortunately, current media access figures for men are not available.

The campaigns likely to be conducted include: (1) men; (2) youth; and (3) women with a focus on: (i) promoting family planning services, including the positive portrayal of the service provider; and (ii) allaying fear of methods. In order to develop these campaigns several research activities will be conducted to provide baseline information for valuative purposes and in-depth knowledge and attitude information to develop specific messages for radio and television spots.

Audience Research

To identify and guide IEC interventions, JHU/PCS and ZIS will identify and contract a company or group of researchers to conduct a baseline survey, FGDs and in-depth interviews to obtain qualitative information on family planning KAP of urban and rural men and women.

The baseline survey will be conducted in a sample of the strategic sites that have been identified under the FPS project. It will provide baseline KAP data and will point the researchers toward the specific topics that need to be explored in the FGDs and interviews.

The specific groups that will be included in the FGDs and interviews will be:

- urban and rural women of reproductive age (15-49)

  Audience Segmentation:

  - women who have not had a child yet (delay pregnancy);
  - women who have had children but want to wait before having the next (child spacing);
  - women who have completed their families (family limitation)

- urban and rural men aged 15-65

  Audience Segmentation:

  - men who have not had a child yet (delay partner's pregnancy);
  - men who have not had their ideal number of children (child spacing);
  - men who have had their ideal number of children (family limitation)

- urban and rural youth

Audience Segmentation:

- in-school youth;
- out-of-school youth

o community influentials in reproductive decision making

- leaders (chiefs, religious leaders, etc.)
- grandmothers, mothers-in-law, etc.

o service providers

o District Health Management Teams (DHMTs)

The audience research data may necessitate modifying the audience segmentation and the channels of communication to be used.

The baseline survey and this qualitative data, along with existing quantitative data from the ZDHS, will provide the information necessary to design the specific mass media messages and IEC materials that will be developed.

Illustrative Campaigns

An illustrative mass media program is presented below, but this plan will be modified according the results of the research activities.

Two three-month campaigns targeting men and youth will be designed and implemented. Both campaigns will have five main messages which will be disseminated by means of six 30-45 second radio spots (two in English and four in vernacular), three 60 second TV spots (one in English and two in vernacular), newspaper inserts (five English and two vernacular for each campaign), billboards (2-5 per district), bus advertisements (10-30 per district), and posters (five for each campaign; 5,000 of each poster). A 52 week radio social drama in Bemba that deals with such issues as family planning, STDs including HIV/AIDS, gender issues and concerns, youth's concerns, etc. will be launched at the beginning of the campaign for men. In order to maximize resources, this drama will be produced in collaboration with the AIDS Project. Sponsors of the air time after the 39th week will be sought. Radio and TV hosts of current chat and call-in shows will be encouraged to include the different aspects of each campaign's five messages. Promotional materials such as T-shirts, key chains, stickers, etc. and activities, such as competitions, to support the radio social drama and both campaigns' messages will also be developed and distributed. Also in order to engage both men and youth in a national discussion of sexual responsibility, debates with two teams taking opposite stands on topics such as "Zambian men (substituted with

teenagers) are sexually irresponsible" will be conducted on radio.

The campaign targeting women will be three-pronged and therefore considerably different from the campaigns for men and youth. Initially, the family planning logo will be promoted and the service provider will be portrayed in a positive light, i.e., someone who cares and treats you with kindness, understanding, and respect. To support this, radio and TV spots, newspaper inserts, billboards, handbills (single sheet flyers), and bus signs will be used. Five catchy 30-45 second radio spots (two in English and three in vernacular) that advertise quality family planning services will be developed and aired for a year (i.e., each radio spot will be aired 10 times a day alternatively for five days a week for three months [Phase I] with a break of one month; aired 8 times a day for five days a week for three months [Phase II] with another break of two months; and aired 10 times a day for five days a week for the final three months [Phase III]). Three appealing 60 second TV spots (one in English and two in vernacular) will be produced and aired twice a night during the same months that the radio spots are on. Billboards (2-5 per district), bus signs (10-30 per district), and five newspaper inserts (three in English and two in vernacular) promoting the family planning logo and positive image of the service provider will also be used.

During Phase II of promoting family planning services, ten 60 second radio spots (five in English and five in vernacular) and five TV spots (two in vernacular and three in English) on method-specific information highlighting advantages and disadvantages will be produced and aired. Also, five posters will be produced and 7 newspaper inserts (five in English and two in vernacular) will be published in the English daily newspapers and the ZIS vernacular publications at the same time to support the radio and TV spots. Similarly, the third campaign component will specifically deal with fears about methods (side effects and rumors and misconceptions) and will include ten 60 second radio (five in English and five in vernacular) and five TV spots (two in vernacular and three in English), ten 15-minute radio features on family planning methods (five in English and five in vernacular), five posters, and seven newspaper inserts (five in English and two in vernacular). The 15-minute radio features will have a nurse or doctor being interviewed about the safety and effectiveness of a specific method, the various side-effects, and the rumors and misinformation associated with that particular method. Each program will also feature short inserts from satisfied users of the particular method being discussed. One English and vernacular radio feature will be aired every day for one week once a month for the three months of Phase III of the promotion of services.

In addition to promoting family planning services, women in districts without family planning services will be encouraged to approach their DHMTs and advocate for such.

Family Planning Logo

A logo to identify family planning service delivery sites will also be developed as a part of this mass media program. GRZ agencies and NGOs that deliver FP services will participate in the development and testing of the logo and will receive flags, poster, buttons and t-shirts with the logo that they can use to promote the location of FP services. This activity will also be undertaken in coordination with the social marketing component of the FPS project.

Zambia Information Services

The Zambia Information Services (ZIS) qualifies to coordinate all mass media activities because: (1) it is a department of the MOIBS and has been given the mandate to execute the Population Communication Project previously funded by UNFPA; (2) it has the requisite materials development facilities; (3) it has representation at the district level; and (4) the Assistant Secretary for Press, MOIBS, is the head of the ITCP's IEC subcommittee. Given that ZIS lacks technically trained staff, JHU/PCS will provide a mass media expert will be assigned to ZIS for two years to provide training and technical assistance to ZIS staff. In addition, a research and an advertising agency will be identified through a competitive process to assist in the planning and implementation of the three campaigns. ZIS will be encouraged to contribute to the campaigns by mobilizing journalists who were previously trained under the Population Communication Project to write feature articles in English and vernacular on the campaigns' themes and messages.

B. District Level IEC Program

The district level IEC activities will include materials development, community mobilization, clinic-based and outreach activities. Training of service providers to strengthen their counselling skills is also an important element in the IEC strategy. While the training is included in the service delivery component, a detailed description is also included in this annex.

1. Materials Development

The World Bank (1993), UNFPA (1993), and SEATS (1991) assessments identified the need for training key IEC personnel in materials development including audience research. JHU/PCS, therefore, will conduct materials development workshops for IEC personnel at the national level and district levels. Even though the IEC

component will contract trained researchers to conduct audience research, an understanding of qualitative research techniques is essential for asking the correct questions and knowing if the data are valid.

It should be noted that JHU/PCS personnel will closely coordinate all materials development with those the implementers of the AIDS Program so as to avoid any duplication of effort. This is important because many of those who will be involved in developing AIDS IEC materials at the national level will also be those to develop FP materials.

2. Community Mobilization

As part of the MOH decentralization effort, the Health Education Unit has provided guidelines to the DHMTs for MCH/FP social mobilization. In order to make this initiative viable, JHU/PCS will administer small grants to the participating DHMTs. Depending on the size of the district, forty meetings and group talks a year with community leaders (political, traditional, and religious), social influentials (grandmothers and other elders who influence reproductive decision-making) will be conducted by identified members of the DHMTs. Powerful social networks and groups like women's groups, church groups, clubs (particularly youth clubs), political organizations, and development committee groups will be identified and mobilized to promote family planning to community members. Community theater, which is a popular traditional medium, will be used for promoting family planning and STD/HIV/AIDs prevention especially among the youth. Approximately 200 performances a year in each FPS Project strategic site district will be the target. Since the project design research indicates that video shows would be a well-received channel of communication, there will be at least 50 showings in each FPS Project district. All community activities will be linked to and support the three mass media campaigns and the AIDS Project initiatives.

3. Clinic-Based and Outreach

A flag with the national family planning logo will be produced and mounted outside all family planning service outlets, including the homes of CBD agents and social marketing outlets, for easy identification. IEC materials such as pamphlets (including ones for low-literate clients) on each method and one on all methods (30,000 copies of each), posters (see Mass Media section), flip charts (500 large ones and 750 small ones), calendars (5,000 copies each year), and other IEC materials that will be used in the clinic-based and outreach activities will be developed involving the target audience in all stages of the materials development process.

JHU/PCS will work with the FPS Project Management Team to assist

each strategic service delivery site to design and implement plans to market its family planning services. The first likely event will be an "inauguration" to recognize the staff's ability to provide "quality" family planning services. This event could be attended by a GRZ official like the Minister or Deputy Minister of Health and receive media coverage. Handbills, notices, and the ZIS public address system should be used to advertise the event within the district.

Low-literate manuals for CBD agents and other identified family planning promoters will also be developed. All FP/IEC outreach activities will be closely coordinated with the AIDS program to ensure the promotion of reproductive health.

Competitions for CBD agents and other cadres of family planning promoters within districts will be instituted. The winners of these competitions will be lauded at community gatherings and will also be given prominence, if possible, on radio talk shows.

Community-based, outreach, and clinic-based activities will play an integral role in linking youth to family planning information and services. Programs that include peer counselors, parent education, and CBD agents and service providers who specifically meet the needs of the youth will be designed and implemented. In addition, community-based outreach IEC interventions, particularly the IEC efforts of the CBD agents and family planning promoters, and clinic-based and outreach IEC efforts of the service providers, will play an integral role in maintaining the demand for family planning services by allaying fears about side effects and addressing attitudinal barriers to the continued use of family planning.

4. Training of Service Providers and FP Promoters

Research and discussions conducted in conjunction with project design, indicated that service providers' negative attitudes and poor IPC/C skills are a major barrier to increased adaption of family planning. FGDs revealed that people preferred to go to traditional healers because they did not have to wait in line for services, they were given holistic treatment, and found their encounters with the traditional healers psychologically soothing. (See Social Soundness Analysis.) FLMZ trainers also said that community members preferred to get their information outside the clinic setting because they did not feel comfortable with service providers' attitudes. It is clear that in addition to enhancing family planning knowledge and skills, major attitudinal problems among staff need to be corrected through training.

The IPC/C component in the family planning skills training curriculum for service providers will be strengthened with assistance from government agencies and NGOs involved in FP

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IPC/C, i.e., MOH MCH/FP Unit, FLMZ, PPAZ, ADRA, and Makeni Ecumenical (see Training Annex). The FPS Project will train approximately 300 service providers in family planning clinical skills and IPC/C. IPC/C refresher training will be conducted every six months during the first two years after initial training and every year after that until the end of the project.

A video that documents short interviews with community members and other community health professionals (i.e., traditional healers, FLMZ trainers, etc.) could be produced to highlight what people think of service providers and how this affects their health seeking behavior. The examples in the video should include both positive and negative experiences. This video can be used at training workshops to give service providers an impression of what community members think of them and to discuss the importance of good IPC/C skills for the provision of family planning and other health services.

JHU/PCS and the FPS Project Management Team members will work with the FP Master Training Team to review and strengthen existing IEC training curricula for CBD agents. (See Training Annex for details on CBD training.) Since other cadres, besides the CBD agents, will be identified to do family planning promotion and community outreach, a job description will be outlined for each cadre and a family planning IEC curriculum that is based on each cadre's roles and responsibilities will be developed (see Training Annex).

The FP Master Training Team will conduct FP promoter training-of-trainers (TOT) workshops which will include trainers from each of the FPS Project strategic sites districts. District trainers will be assisted by members of the Master Training Team to plan and conduct FP promoter workshops in their districts. After this, the district FP promoter trainers should have the requisite confidence and skills to carry out training workshops (including refresher training workshops) on their own. The actual number of workshops will depend on how many FP promoters are identified.

C. Program Managment

A scope of work will be finalized and technical services will be obtained from JHU/PCS. They will establish a relationship (possible through a memorandum of understanding) with ZIS to carry out the mass media program activities. JHU/PCS will contract a research group and an advertising agency, through a competitive process, to carry out the research and place the media spots. JHU/PCS will also provide long-term and short-term technical advisors. The World Bank has recommended ZIS staff be provided training and technical assistance for two years.

In order to implement the district level program, JHU/PCS will work closely with the FPS Project Management Team and the MOH MCH/FP Unit health educator, who initiated the MCH/FP social mobilization effort. JHU/PCS will also issue small grants directly to the strategic sites districts to implement community mobilization activities as well as clinic-based and outreach activities.

The short-term technical assistance to be provided by JHU/PCS will be mainly in the area of IPC/C and development of print materials.

D. Monitoring and Evaluation

A formal monitoring and evaluation plan will be developed prior to the onset of activities and will include the gathering of baseline data and a final evaluation.

1. Impact Evaluation

The IEC component of the FPS Project will be evaluated at three levels: impact, outcome, and process. The impact evaluation has to be done within the context of the entire FPS Project as other factors, such as the availability of equipment and contraceptives and clinically trained service providers, are integral to increasing the contraceptive prevalence rate (CPR) of modern methods. The main indicator for the impact of the Project will be the increase in CPR of modern methods which can be measured by comparing the CPR of modern methods at the beginning of the project with the CPR at the end. Another impact indicator is the decline in birth rates both nationally and in the specific FPS Project districts since project initiation. A possible third indicator of impact is change in family planning attitudes (i.e., attitudes become more favorable) and this attitudinal change can be measured by comparing the final evaluation results with the baseline data.

2. Outcome Evaluation

To assess outcome, calendar cards at the clinics will include data such as where family planning information was obtained (i.e., what medium or media), what prompted client to come to clinic, etc.

After each campaign, a selected sample of target audience will be interviewed to assess recall, message appeal, appeal of presentation, any action taken, etc.

Specific indicators for measuring outcome include:

- Percentage of target audience exposed to family planning

messages based on respondent recall

- Percentage of the target audience exposed to a specific message and liking it
- Percentage of target audience that correctly comprehend a given message
- Percentage of the target audience that acquire a skill to complete a particular task as a result of exposure to a specific communication
- Number/percentage of target audience who discuss message(s) with others, by type of person
- Percentage of target audience that take action, i.e., go to family planning clinics for services, because of exposure to a specific or combination of communication(s)
- Percentage of target audience that advocate family planning practice

3. Process Evaluation

To measure process, the following indicators can be used:

- Number of communications produced, by type, in a reference period (e.g., one year)
- Number of communication(s) disseminated, by type, in a reference period (e.g., one year)
- Number of IEC courses conducted, by type, in a reference period (e.g., one year)

APPENDIX A

UNFPA's Expenditure on IEC Projects and IEC Components of Projects Including Training Support to IEC Personnel in Zambia

Project No.	Title	Amount
ZAM/86/PO1	Population Communication Project	$462,192
ZAM/85/PO3	In-School Population Education	$435,736
ZAM/89/PO1	MCH/FP Services	$136,312
ZAM/91/PO1	Zambia's Population Policy	$247,275
ZAM/89/PO2	Population IEC and Family Services in Organized Sector	$562,274
ZAM/88/P50	Umbrella Project	$ 72,410
	TOTAL	$1,916,199

Family Life Movement, which concentrates on IEC activities, have had the following operational budgets:

Year	Budget
1983-84	$101,815
1985-86	$131,700
1986-88	$274,875
1988-1991	$169,850
1992-1995	$ 53,616
TOTAL	$731,856

Planned Parenthood Association of Zambia has spent the following on IEC since 1986. Unfortunately, no figures for any time prior to this are available.

Year	Budget
1986	$11,797
1987	$23,880
1988	$13,612
1989	$ 6,606
1990	$ 9,996
1991	$ 2,309
1992	$ 7,225
1993	$10,895
TOTAL	$86,320

PATHFINDER FUND supported CBD projects have approximately $225,000 committed specifically for IEC.

 Annex R

ACT: AID-3 INFO: AMB DCM

28 SEP 1993

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DE RUEHC #5735/01 2710404
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TO RUEHLS/AMEMBASSY LUSAKA IMMEDIATE 5651
INFO RUEHNR/AMEMBASSY NAIROBI IMMEDIATE 3334
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LOC: 157 585
28 SEP 93 0457
CN: 49483
CHRG: AID
DIST: AID

ACTION	DUE DATE
DS	9/29
TRANSFER	INFO
ACTION TAKEN	
PP revised accordingly	
DATE 9/29	INITIALS

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: ZAMBIA FAMILY PLANNING SERVICES PROJECT PAPER REVIEW

REFS: A. LUSAKA 2750 B. STATE 253063

1. SUMMARY. THE SUBJECT PROJECT PAPER WAS REVIEWED BY THE EXECUTIVE COMMITEE FOR PROJECT REVIEW (ECPR) ON MONDAY, SEPTEMBER 20, 1993. THE MEETING WAS CHAIRED BY KEITH BROWN, DIRECTOR, OFFICE OF SOUTHERN AFRICAN AFFAIRS. AND WAS ATTENDED BY AFR/SA, GC/AFR, AFR/ARTS POL/CDIE, AFR/DP, AND RD/POP. THE ISSUES CONSIDERED AT THE MEETING WERE IDENTIFIED AT THE WEDNESDAY, SEPTEMBER 15, 1993 ISSUES MEETING. THE ECPR DECIDED TO APPROVE THE PROPOSED ZAMBIA FAMILY PLANNING SERVICES (FPS) PROJECT PAPER (PP) AND CONCUR IN AUTHORIZATION OF THE PP IN THE FIELD BY THE USAID/ZAMBIA MISSION DIRECTOR UNDER DOA 551 SUBJECT TO MISSION COMPLIANCE WITH THE SPECIFIC CLARIFICATIONS AND MODIFICATIONS RECOMMENDED IN PARA. 2 BELOW.

2. THE ECPR RECOMMENDED THE FOLLOWING MODIFICATIONS OF THE FAMILY PLANNING SERVICES PROJECT PAPER:

A. ADDRESSING POLICY CONSTRAINTS TO PROJECT

IMPLEMENTATION

ECPR MEMBERS INITIALLY EXPRESSED CONCERN REGARDING THE ENABLING ENVIRONMENT FOR IMPROVING FAMILY PLANNING IN ZAMBIA. THEY QUESTIONED THE APPEARANCE OF RELIANCE ON ADMINISTRATIVE/REGULATORY ACTION BY THE GRZ IN THE IMMEDIATE TERM AND PROMISES OF FUTURE LEGISLATION TO REMOVE POLICY CONSTRAINTS SUCH AS RESTRICTIONS ON THE TYPE OF PROVIDER ALLOWED TO INSERT IUCDS AND PRESCRIBE ORAL CONTRACEPTIVES AND THE PROHIBITION AGAINST ADVERTISING ORAL CONTRACEPTIVES. THE FEELING WAS THAT A MORE DEFINITE AND URGENT COMMITTIMENT ON THE PART OF THE GRZ TO LEGISLATION THAT WOULD ENSURE A FAVORABLE ENVIRONMENT FOR FAMILY PLANNING OVER THE LONG TERM UNDER OTHER GRZ

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ADMINISTRATIONS MIGHT BE REQUIRED.

HOWEVER, AFTER FURTHER REVIEW, THE ECPR CONCLUDED THAT GRZ ADMINISTRATIVE/REGULATORY ACTIONS PROPOSED IN THE PP WERE SUFFICIENT FOR PROJECT IMPLEMENTATION OVER THE FIVE YEAR LIFE OF PROJECT AND THAT LEGISLATION IS NOT NECESSARY TO ACCOMPLISH PROJECT OBJECTIVES. IT IS RECOMMENDED THAT THE PP BE MODIFIED TO MAKE EXPLICIT: (1) THE STATUS OF PROPOSED LEGISLATIVE CHANGES IN LIGHT OF SEC 611 (A) (2), AND (2) THAT PROPOSED LEGISLATION IS NOT NECESSARY TO ACCOMPLISH PROJECT OBJECTIVES, BUT RATHER THAT THE REQUIRED CHANGES CAN BE EFFECTED ADMINISTRATIVELY WITHOUT LEGISLATION, THOUGH LEGISLATION IS USEFUL AS A MEDIUM TO LONG-TERM GOAL.

B. ADEQUACY OF THE PROPOSED CONTRACEPTIVE LOGISTICS AND SUPPLY SYSTEM

THE PROPOSED CONTRACEPTIVE LOGISTICS/SUPPLY SYSTEM RELIES PRIMARILY ON THE UNCERTAIN CAPACITY OF THE GOVERNMENT PARASTATAL, MEDICAL SUPPLIES LIMITED (MSL) TO SUPPORT THE PROJECT'S AMBITIOUS GOALS FOR IMPROVING FAMILY PLANNING SERVICE DELIVERY. IT IS NOT CLEAR IN THE PP THAT THERE WILL BE EFFORTS TO STRENGTHEN MSLIS OPERATIONAL CAPACITY, THOUGH THE PP INDICATES THAT THE BRITISH ODA PROGRAM WILL PROVIDE CONTRACEPTIVE COMMODITIES FOR DISTRIBUTION THROUGH MSL. THE SUPPLY BACK-UP ROLE TO THE MSL ENVISIONED FOR THE PROJECT'S CONTRACEPTIVES SOCIAL MARKETING PROGRAM (CSM) SEEMS FEASIBLE IF THAT ROLE IS TO FILL OCCASIONAL SUPPLY GAPS LEFT BY A STRENGTHENED, ADEQUATELY FUNCTIONING MSL. SOCIAL MARKETING PROGRAMS SHOULD NOT BE SET UP AS BACK-UP SYSTEMS FOR THE PUBLIC SECTOR. THE MSL SHOULD BE STRENGTHENED IN ORDER TO AVOID STOCK-OUTS AND NOT RELY ON THE CSM PROGRAM. THE CSM PROGRAM COULD PROVIDE COMMODITIES TO THE PUBLIC SECTOR ON AN INDIVIDUAL BASIS WHEN AN ORDER IS PLANNED AND PAID FOR BY THE INDIVIDUAL

FACILITY OR ENTITY.

IT IS RECOMMENDED THAT THE PP BE MODIFIED TO INDICATE THAT THE PROJECT WILL PROVIDE FOR TECHNICAL ASSISTANCE TO THE MSL IF ODA PROGRAM SUPPORT IS DETERMINED TO BE INSUFFICIENT TO STRENGTHEN MSL CAPACITY. THE AID POLICY PAPER ON PRIVATE ENTERPRISE DEVELOPMENT (PG. 15, PARA. F) SUPPORTS PROVISION OF ASSISTANCE TO OR THROUGH A PARASTATAL IN THE CONTEXT OF EXPOSING THE PARASTATAL TO

MARKET FORCES. IF THE MISSION HAS CONCERNS REGARDING WHETHER TECHNICAL ASSISTANCE TO THE MSL IS IN ACCORD WITH THE POLICY PAPER, IT MAY WISH TO CONSULT WITH POL. THE PP SHOULD ALSO INDICATE THAT THE CSM COMPONENT OF THE PROJECT WILL BE EXPECTED TO FILL CONTRACEPTIVE SUPPLY GAPS ONLY AND WILL NOT BE RELIED ON FOR OTHER THAN OCCASIONAL BACK-UP SUPPLY SUPPORT. IF TA TO MSL IS REQUIRED, THE MISSION SHOULD CONSIDER PROCUREMENT THROUGH A BUY-IN TO THE RD/POP FPLM PROGRAM. OPTIONS SHOULD BE DISCUSSED WITH RD PERSONNEL (SEE PARA. 4, BELOW, REGARDING BUY-INS).

C. OPERATIONS RESEARCH

THE ECPR FOUND THE SECTION OF THE PP ON OPERATIONS RESEARCH (OR) UNCLEAR WITH RESPECT TO THE PURPOSE AND PROPOSED AGENDA FOR THE RESEARCH. FOR EXAMPLE, THE SECTION DESCRIBING PROPOSED RESEARCH INTO FEE-FOR-SERVICE REIMBURSEMENT DOES NOT INDICATE HOW THE REIMBURSEMENTS WOULD BE HANDLED OR HOW SUCH A SCHEME WITH ALL ITS INHERENT COMPLEXITY COULD BE FEASIBLY MANAGED AND REPLICATED IN THE ZAMBIAN CONTEXT. SIMILARLY, THE PROPOSED RESEARCH INTO PROVIDER INCENTIVES IS UNCLEAR AND RAISES AGAIN THE QUESTION OF REPLICABILITY. IT WAS FURTHER NOTED THAT THE PP DOES NOT ESTABLISH A RELATIONSHIP BETWEEN POLICY AND OR THOUGH THEY ARE COUPLED IN THE PRESENTATION.

THE PP SHOULD BE MODIFIED TO INCLUDE OR AS PART OF THE INSTITUTIONAL CONTRACTOR'S SCOPE-OF-WORK, EITHER DIRECTLY OR UNDER A SUB-CONTRACT WITH THE CENTRALLY-FUNDED OR CONTRACTOR FOR AFRICA. THE SPECIFIC TOPICS AND APPROACHES ARE BEST LEFT TO THOSE WHO IMPLEMENT THE OR PROGRAM, WHILE THE PP SHOULD SPECIFY OBJECTIVES TO BE ACHIEVED UNDER THE OR AND POSSIBLY SPECIFY CRITERIA FOR SELECTION OF TOPICS. THE ECPR CONCLUDED THAT THE OR COMPONENT SHOULD INVESTIGATE COST-RECOVERY AS WELL AS REIMBURSEMENT SCHEMES AND AN ASSESSMENT OF ALTERNATIVE APPROACHES TO SERVICE DELIVERY UNDERTAKEN AT THE DISTRICT LEVEL.

D. FP SERVICES FOR ADOLESCENTS

CONCERN REGARDING TEENAGE MARRIAGE AND PREGNANCY IS EXPRESSED SEVERAL TIMES IN THE PP, BUT ADOLESCENTS ARE NOT TARGETED SPECIFICALLY IN THE DISCUSSION OF SERVICE DELIVERY. THE ECPR AGREED THAT FAMILY PLANNING SERVICES SHOULD BE SPECIFICALLY DEVELOPED TO MEET THE NEEDS OF TEENS IN TERMS OF TRAINING, COUNSELING, SERVICE DELIVERY, ETC. THE TEEN SUB-GROUP OF FAMILY PLANNING RECIPIENTS IS ALSO A PROPER FOCUS FOR OR TO TEST ALTERNATIVE SERVICE DELIVERY STRATEGIES.

THE PP SHOULD BE REVISED TO INCLUDE A DESCRIPTION OF THE PROJECT'S FOCUS ON PROVISION OF FAMILY PLANNING SERVICES TO THE ADOLESCENT SUB-GROUP. RD/POP HAS PROVIDED SUGGESTED LANGUAGE TO IMPROVE THE DISCUSSION ON TARGETING

THIS SUB-GROUP. THIS LANGUAGE WILL BE FAXED TO THE MISSION FOR CONSIDERATION FOR INCORPORATION INTO THE PP.

E. INTRODUCTION OF IMPLANT AND INJECTABLE CONTRACEPTIVES

THE ECPR DECIDED THAT BECAUSE OF PREVIOUS CONTROVERSY SURROUNDING THE IMPLANT CONTRACEPTIVE NORPLANT, ANY STRATEGY FOR ITS INTRODUCTION IN ZAMBIA MUST BE CAREFULLY THOUGHT OUT IN TERMS OF TRAINING AND APPROPRIATE INTRODUCTION, IEC STRATEGY, PROCUREMENT AND OTHER CONSIDERATIONS. THE OFFICE OF POPULATION WILL NOT BE FUNDING NORPLANT AFTER 1993, RAISING QUESTIONS ABOUT FUNDING FOR NORPLANT SETS, AND IS REVIEWING ITS OVERALL POLICY ON THE CONTRACEPTIVE. NORPLANT MAY HAVE TO BE INTRODUCED AT A LATER POINT THAN CURRENTLY PLANNED (I.E., YEAR 3 OR 4 OF THE PROJECT) TO ENSURE THAT ADEQUATE PREPARATION HAS BEEN MADE. WITH REGARD TO DEPOPROVERA AND NORISTERAT, THE PP IS NOT CLEAR ON WHETHER ODA WILL PROVIDE NORISTERAT TO THE PUBLIC AND THE PROJECT PROVIDE DEPO TO THE PRIVATE SECTOR ONLY. IF BOTH ARE TO BE INTRODUCED IN THE PUBLIC SECTOR, THERE WILL NEED TO BE INTENSIVE TRAINING OF PROVIDERS.

THE ECPR CONCLUDED THAT IF AT ALL FEASIBLE, ONLY DEPOPROVERA SHOULD BE INTRODUCED IN ZAMBIA. DEPO IS EFFECTIVE FOR A LONGER PERIOD OF TIME (3 MONTHS) THAN NORISTERAT (2 MONTHS) AND HAS FEWER SIDE EFFECTS. SUPPLYING BOTH INJECTABLES TO A COUNTRY IS CONFUSING FOR PROVIDERS AND CLIENTS AND HAS RESULTED IN INAPPROPRIATE SUBSTITUTION OF ONE FOR THE OTHER (PARTICULARLY WHEN THERE ARE STOCK-OUTS). THE BEST SOLUTION IS FOR ODA TO SUPPLY DEPO FROM BELGIUM SO THAT THERE IS ONLY ONE INJECTABLE CONTRACEPTIVE IN THE SYSTEM.

THE ECPR RECOMMENDS THAT THE PP BE MODIFIED TO INDICATE THAT THE MISSION WILL BEGIN A DIALOGUE ASAP WITH THE GRZ

MOH AND ODA TO WORK OUT A PLAN AND APPROPRIATE TIME-TABLE FOR PROMOTION OF STANDARDIZATION ON DEPOPROVERA. THE PP SHOULD INDICATE THAT ISSUES WITH RESPECT TO NORPLANT WILL NEED TO BE RESOLVED AND A CAREFUL STRATEGY DEVELOPED PRIOR TO ITS INTRODUCTION.

F. FEASIBILITY OF OUTPUT AND IMPACT INDICATORS

THE PP PROJECTS THAT, IN ZAMBIA, BY THE END OF THE PROJECT: COUPLE YEARS PROTECTION WILL REACH 380,000; THE MODERN CONTRACEPTIVE PREVALENCE RATE WILL INCREASE FROM 9 PERCENT TO 20 PERCENT AMONG MARRIED WOMEN, AND FROM 7 PERCENT TO 18 PERCENT AMONG ALL WOMEN; AND FAMILY PLANNING SERVICES DELIVERED AT STRATEGIC SITES THROUGHOUT ZAMBIA WILL INCREASE BY 75 PERCENT FROM THE BASELINE PERIOD. THESE PROJECTIONS OF END-OF PROJECT ACHIEVEMENTS SEEM OVERLY AMBITIOUS, PARTICULARLY IN VIEW OF THE FORMIDABLE TECHNICAL, INSTITUTIONAL, POLICY AND LEGAL AND SOCIAL CONSTRAINTS ALSO DESCRIBED IN THE PP.

THE ECPR RECOMMENDS THAT THE EXPECTED END-OF-PROJECT ACHIEVEMENTS BE REVIEWED AND REVISED AS NECESSARY DURING THE MER EXERCISE. GIVEN THE MISSION/AFR/W CONTRACT PER THE APPROVED CPSP, THE OUTPUT/IMPACT FIGURES SHOULD BE ESTABLISHED FOR THE LIFE-OF-THE PROJECT AND NOT REVISED ANNUALLY.

G. PROJECT SUSTAINABILITY

STATEMENTS IN THE PP, PGS. 42 AND 43 SUGGEST THAT THE PROJECT MAY NOT BE SUSTAINABLE AND THAT ITS SUCCESS MAY DEPEND ON THE PLANNED MCH PROJECT TO BE INITIATED IN FY 1994. THE MISSIONIS ASSESSMENT OF THE OVERALL SUSTAINABILITY OF THE ELEMENTS OF THE PROJECT DOES NOT COME THROUGH CLEARLY IN THE PP. A MUCH CLEARER STATEMENT OF THE MISSION'S ASSESSMENT OF PROJECT SUSTAINABILITY SEEMS INDICATED IN ORDER TO MEET THE DFA REQUIREMENT REGARDING LONG-TERM DEVELOPMENT IMPACT OF PROJECTS FUNDED FROM THE ACCOUNT.

THE PP SHOULD BE REVISED TO CLARIFY THE ASSESSMENT OF THE PROJECTIS SUSTAINABILITY.

3. IN ADDITION TO THE ISSUES ADDRESSED IN PARA. 2 ABOVE, THE ECPR ALSO ADDRESSED THE FOLLOWING CONCERNS:

A. THE PP ECONOMIC ANALYSIS

THE ECONOMIC ANALYSIS PROVIDED IN THE PP COULD BE STRONGER. THE PRESENTATION AND DISCUSSION OF THE WORLD

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BANKIS EXAMINATION OF SOME OF THE POSSIBLE EFFECTS OF A REDUCED POPULATION GROWTH RATE GIVE A HINT OF THE POSSIBLE BENEFITS DERIVING FROM THE PROJECT. THE ANALYSIS SHOULD CLEARLY LINK THE PROPOSED INTERVENTIONS AND THEIR EXPECTED IMPACTS TO QUANTIFIABLE INDICATORS. FROM THIS FOUNDATION, A STRONGER ANALYSIS WOULD DERIVE ESTIMATES OF THE ECONOMIC BENEFITS TO BE EXPECTED OVER TIME. THESE BENEFITS WOULD THEN BE USED IN CONJUNCTION WITH THE FULL COST DATA TO DEVELOP VARIOUS MEASURES OF THE NET ECONOMIC IMPACT OF THE PROJECT.

THE MISSION IS ENCOURAGED TO MAKE SURE THAT FUTURE PPS HAVE STRONGER ECONOMIC ANALYSES.

B. CONTRACTING MODE

THE PP APPEARS TO BE CONTRADICTORY WITH RESPECT TO WHETHER THE PRIME SERVICE DELIVERY ENTITY WILL BE A GRANTEE (PG.23) OR AN INSTITUTIONAL CONTRACTOR (PGS. 46 AND 49-50). A CONTRACT IS A.I.D.'S NORMAL RELATIONSHIP FOR IMPLEMENTING A PROJECT AND IS APPROPRIATE WHERE A.I.D.'S OBJECTIVE IS TO PROCURE SERVICES, WHILE AN ASSISTANCE INSTRUMENT, SUCH AS A GRANT, IS APPROPRIATE WHERE THE PURPOSE IS TO SUPPORT THE GRANTEEIS OWN PROGRAM (HB 13). ON THE SURFACE, A CONTRACT WOULD APPEAR MORE APPROPRIATE IN THIS CASE.

SINCE THE MISSION HAS INDICATED BY FAX MESSAGE THAT IT WILL USE A CONTRACTOR, THE PP SHOULD BE REVISED TO CLEARLY

Annex R

INDICATE THIS CHOICE OF IMPLEMENTATION INSTRUMENTS AND JUSTIFY THE CHOICE BASED ON ACTUAL PROJECT REQUIREMENTS. IN THE CASE OF A CONTRACT, COMPETITION CAN NOT BE LIMITED TO PVOS (PG. 23 OF THE PP). IF PARTICULAR CHARACTERISTICS THAT PVOS USUALLY HAVE ARE CRITICAL, THESE PARTICULAR CHARACTERISTICS COULD BE INCLUDED IN THE EVALUATION CRITERIA.

WHILE CONTRACTORS CAN MAKE SUBGRANTS IN CERTAIN CIRCUMSTANCES, PROBABLY MET IN THIS CASE, THIS REQUIRES SPECIFIC APPROVAL FROM THE MISSION DIRECTOR, WITH PRIOR COMMENT BY FA/PPE (SEE CONTRACT INFORMATION BULLETIN 92-7, DATED MARCH 8, 1992). SINCE A CONTRACTOR WILL BE SELECTED, THE PP SHOULD NOTE THIS REQUIREMENT. THE PP SHOULD PROVIDE FOR AN ALTERNATIVE ARRANGEMENT IN CASE THE APPROVAL IS NOT GIVEN. PPE HAS GENERALLY PROVIDED FAVORABLE COMMENTS SO LONG AS THE SUBGRANTEES ARE NOT U.S. ORGANIZATIONS. ALSO, PPE CAN PROVIDE USEFUL PROVISIONS FOR THE CONTRACT.

4. THE FOLLOWING MISCELLANEOUS RECOMMENDATIONS FOR IMPROVING THE PP ARE OFFERED FOR MISSION CONSIDERATION:

-- PROJECT PURPOSE. THE STATEMENT OF PROJECT PURPOSE SHOULD BE CONSISTENT THROUGHOUT THE PP AND THE PROJECT AUTHORIZATION AND GRANT AGREEMENT AS WELL. THE PURPOSE STATEMENTS ON THE FACESHEET AND PG. 21 DIFFER SLIGHTLY. THE ECPR RECOMMENDS THAT THE PURPOSE ON PG. 21 BE USED.

-- SECTION 110 WAIVER. SEC. 110 WAIVERS HAVE GENERALLY NOT BEEN ABSOLUTE, BUT RATHER ARE CONDITIONAL ON THE HOST COUNTRY'S MAKING THE SPECIFIED CONTRIBUTION THAT IT IS ABLE TO MAKE. THE PP AND PROJECT AGREEMENT SHOULD REFLECT THE GRZIS CONTRIBUTION, ALBEIT LESS THAN 25 PERCENT.

-- NON-COMPETITIVE GRANTS. THE PP SHOULD EXPLAIN THE BASIS FOR NON-COMPETITIVE AWARD OF A GRANT FOR THE COMPETITIVE SOCIAL MARKETING COMPONENT, EXPLICITLY IN TERMS OF THE APPLICABILE HB. 13, CH. 2 CRITERIA (FOLLOW-ON OR AMENDMENT).

-- BUY-INS. WITH RESPECT TO TECHNICAL ASSISTANCE FOR IEC, CONTRACEPTIVE LOGISTICS MANAGEMENT, AND POSSIBLY OPERATIONS RESEARCH, THE MISSION SHOULD CONSIDER WHETHER CENTRALLY FUNDED PROJECTS WILL PROVIDE ADEQUATE IMPLEMENTATION MECHANISMS. SOME CONCERN HAS BEEN EXPRESSED ABOUT THE PACDS AND CEILINGS FOR THESE PROJECTS.

IN THE CASE OF PCS/JOHNS HOPKINS UNIVERSITY FOR IEC, THE CURRENT AGREEMENT HAS A PACD OF JULY 1995. HOWEVER, THERE WILL BE AN OVERLAPPING FOLLOW-ON AGREEMENT BEGINNING JULY 1994. THE RD/POP CTO INDICATES THAT FUNDS FOR THE WORK IN ZAMBIA WILL BE SPLIT BETWEEN THE TWO AGREEMENTS IF NECESSARY, DEPENDING ON WHEN THE ZAMBIA PROJECT IS READY TO NEGOTIATE A BUY-IN.

UNDER THE PBLM PROJECT, THERE ARE TWO AGREEMENTS: ONE

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WITH JOHN SNOW, INC., WHICH HAS A PACD OF SEPTEMBER 1995 AND THE OTHER A PASA WITH THE CENTER FOR DISEASE CONTROL THROUGH AUGUST 1996. RD/POP EXPECTS THERE TO BE A FOLLOW-ON ACTIVITY, BUT OF COURSE CANNOT GUARANTEE THAT JSI WOULD BE THE COOPERATING AGENCY. NEVERTHELESS, RD/POP STAFF BELIEVE THAT, ASSUMING THERE IS NO NEED FOR A LONG-TERM, IN-COUNTRY ADVISORS, THERE SHOULD BE NO DIFFICULTY ACCOMODATING ANY TECHNICAL ASSISTANCE NEEDS FOR ZAMBIA. AN FPLM TEAM IS SCHEDULED TO VISIT ZAMBIA IN OCTOBER, 1993, AND IT IS SUGGESTED THAT PROJECT REQUIREMENTS AND A POTENTIAL SCHEDULE BE DISCUSSED AT THAT TIME.
IF A SUB-CONTRACT IS TO BE NEGOTIATED WITH THE AFRICA OR/TA PROJECT FOR OPERATIONS RESEARCH TECHNICAL

ASSISTANCE, THERE SHOULD BE NO PROBLEM WITH THE PACD. A FOLLOW-ON PROJECT WILL BE SIGNED BEFORE THE END OF FY 1993 FOR FIVE YEARS, WHICH WOULD COVER THE PERIOD OF THE PROJECT IN ZAMBIA. THE CONTRACTOR IS NOT KNOWN AT THIS TIME.

ALTHOUGH THERE DO NOT APPEAR TO BE PROBLEMS WITH EITHER THE IEC BUY-IN OR A POSSIBLE SUB-CONTRACT, FPLM DOES PRESENT SOME DIFFICULTY. THE MISSION SHOULD CONSIDER THIS ADVICE REGARDING THE AVAILABILITY OF APPROPRIATE BUY-IN MECHANISMS AND DETERMINE WHETHER IT WISHES TO PURSUE THE BUY-IN OPTION OR DO ITS OWN PROCUREMENT WAIVER.

-- GRAY AMENDMENT. THE LAST SENTENCE OF THE PARAGRAPH ON PG. 50 SHOULD BE REVISED AS FOLLOWS: QUOTE IN ACCORDANCE WITH AIDAR 726.301(B), THE CONTRACTOR WILL SUBCONTRACT WITH DISADVANTAGED ENTERPRISES FOR AT LEAST 10 PERCENT OF THE VALUE OF THE CONTRACT. UNQUOTE. THE DFA LEGISLATION

UNCLAS SECTION 05 OF 05 STATE 295735

IS NOT THE BASIS FOR THIS REQUIREMENT.

-- CONDITIONS PRECEDENT. ALL CPS SHOULD BE PRECEDED BY QUOTE EXCEPT AS A.I.D. MAY OTHERWISE AGREE IN WRITING. UNQUOTE. TO ELIMINATE REDUNDANCY AND PLACE REQUIRED ACTIONS CLEARLY IN THE PAST TENSE, THE CP FOR CONTRACEPTIVE SOCIAL MARKETING SHOULD BE REVISED ALONG THE FOLLOWING LINES:

QUOTE PRIOR TO THE DISBURSEMENT OF FUNDS FOR THE CONTRACEPTIVE SOCIAL MARKETING COMPONENT, OR TO THE ISSUANCE OF DOCUMENTATION PURSUANT TO WHICH SUCH DISBURSEMENT MAY OCCUR, THE GRANTEE SHALL SUBMIT TO A.I.D., IN FORM AND SUBSTANCE SATISFACTORY TO A.I.D., EXCEPT AS A.I.D. MAY OTHERWISE AGREE IN WRITING, EVIDENCE THAT THE MINISTRY OF HEALTH HAS AUTHORIZED 1) ADVERTISING OF ORAL CONTRACEPTIVES AND 2) DISPENSING OF ORAL CONTRACEPTIVES BY APPROPRIATELY TRAINED INDIVIDUALS WITHOUT THE NEED FOR A PHYSICIANIS PRESCRIPTION. IT IS ANTICIPATED THAT THE MOH WILL AUTHORIZE THIS WITHIN THE FIRST SIX MONTHS OF THE PROJECT. UNQUOTE.

-- VENTURE CAPITAL COMPONENT. THE PP NEEDS TO CLARIFY WHETHER THIS COMPONENT INVOLVES PVO INVESTMENT IN (I.E., OWNERSHIP OF SHARES IN) SELECTED MEDICAL PRACTICES, OR AN OUTRIGHT GRANT (EQUIPMENT, ETC.,) TO THE MEDICAL PRACTICE. THE ISSUE OF WHETHER OUTRIGHT GIFTS TO PROFIT MAKING VENTURES IS PERMISSIBLE UNDER A.I.D. REGULATIONS WILL NEED TO BE RESOLVED IN THE LATTER CASE. THE RLA'S ASSISTANCE SHOULD BE SOUGHT IN RESOLVING THIS POINT.

-- STATUTORY CHECKLIST. SINCE THE FINAL AUTHORIZATION

WILL TAKE PLACE IN THE FIELD, THE RLA SHOULD REVIEW THE STATUTORY CHECKLIST.

5. THE MISSIONIS HARD WORK AND DILIGENCE IN DEVELOPING THE FPS PP WORKING AGAINST A VERY TIGHT DEADLINE IS APPRECIATED.

WHARTON
BT
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