

FAMILY LIFE ASSOCIATION OF SWAZILAND (FLAS)
INDUSTRY PROGRAM ASSESSMENT

by

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FLAS Industry Program Assessment

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PROJECT IDENTIFICATION DATA

PROJECT TITLE: Family Health Services

PROJECT NUMBER: 645-0228

GRANT NUMBER: 645-0228-A-00-8021 (FLAS)
645-0228-A-00-8023 (Pathfinder)

CRITICAL DATES: 27 July '88: Effective Date
31 July '91: Amendments 5 & 7
18 Sept. '92: Modification
12 Dec. '93: PACD

PROJECT FUNDING:

FLAS:	\$ 966,271
Pathfinder:	<u>1,734,287</u>
Total:	\$2,700,558

The information above pertains to the funding for the entire Family Health Services Project. This assessment addresses one of the four components of the Family Health Services Project -- the industrial family planning program.

Introduction

The Family Life Association of Swaziland (FLAS), under its Family Health Services project funded by USAID, has initiated a pilot Industry project. The project began in January 1992 (at which time the Resident Advisor was posted) and is presently scheduled to end in December 1993.

USAID contracted with John Snow, Inc. (JSI) to conduct an assessment of the Industry Program with a view to its possible extension and expansion. The assessment was conducted from March 22 to April 7, 1993 by David O'Brien and Eric Krystall.

The assessment team wishes to express its gratitude to the Executive Director and staff of FLAS for their excellent briefing, constant supply of documents and for the hectic but complete schedule of appointments with key informants and field visits that enabled us to cover a great deal of ground in a relatively compressed time frame. Seldom could the logistics of a mission proceed more smoothly. Finally, and most of all, we wish to express our appreciation to FLAS for its active intellectual involvement in this exercise.

I. Summary

A. Overview

The FLAS industry-based family planning and STD/AIDS prevention activities began implementation about a year and a half ago. Since that time, the project has made considerable progress. It is now functioning on a regular basis and well-established as a good project with considerable potential for expansion.

B. Accomplishments

Among the accomplishments that FLAS, in cooperation with *Pathfinder International*, has achieved in this short time are the following:

- Exceeded the target of establishing services with three firms by establishing services with seven industries-- four of which are quite large and three fairly small-- through three service providers.
- Established a network of over 150 trained industry-based distributors (IBD) dispensing condoms and foaming tablets and conducting motivation activities.
- Implemented a system for tabulating acceptors and couple years of protection (CYP) for reporting progress on a regular basis, served over 2,000 new acceptors, generated over 2,000 CYP, and developed useful baseline information for the design of future activities.
- Developed three manuals for (1) *IBD's Family Planning Procedure Manual*, (2) *Trainers Manual for IBD's of Family Planning*, and (3) *Family Planners Training Manual for Clinical Skills*, that are in the process of being field tested.
- Conducted a study tour for eight participants to countries in the region with model private sector family planning programs (i.e., Kenya and Uganda).
- Implemented activities in a cost-effective manner by minimizing recurrent cost support to participating industries and thereby enhancing prospects for future sustainability.

C. Future Considerations

Among the recommendations we offer for future consideration are the following:

Red Cross
+ RSM

Actual
1982

More staff

IE&C
material
etc.

Project activities should be expanded to (1) more large firms; (2) medium size firms through cost-effective service providers; and (3) the market-based private sector service providers, e.g., private physicians and nurses.

The project should continue to pay attention to the method mix of acceptors and develop education and communication strategies to promote use of more effective methods.

The project should aggressively increase access to oral contraceptives and voluntary surgical contraception.

The project should continue to try to emphasize family planning in conjunction with STD/AIDS prevention, rather than simply emphasize STD/AIDS prevention.

To improve implementation, FLAS management and staff should move deliberately to integrate the private sector family planning activities with FLAS' other technical activities.

In the short run, the demographic impact of project activities will be modest. The importance of these activities is in the increased access to high quality, sustainable family planning services and the development of a base of support for family planning within an important segment of the population.

FP mgt for
FLAS industry
managers

Expand
President
Admin

IBD selection
criteria +
incentives

II. Background and Purpose

A. Background to FHS Project

1. Original Authorization Scope - July '88

In July 1988, USAID/Swaziland authorized Cooperative Agreements totaling \$2,400,000 with the Family Life Association of Swaziland (FLAS) and Pathfinder to implement the Family Health Services Project (FHS) over a five-year period. The four components of the project have been: (1) establishing a research and evaluation capability at FLAS; (2) improving service delivery at FLAS' three clinics; (3) strengthening the IEC capability at FLAS; and (4) initiating a comprehensive program of family planning services in at least three large industries.

The project was to be implemented in two phases: the first phase, lasting approximately two years, would emphasize development of FLAS institutional capabilities, i.e., the first three of the components above. Subsequent to the completion of the first phase, a midterm evaluation (conducted in September '90) would provide information on which to base a decision to proceed with phase two, with which the fourth component above is primarily concerned. It is specifically the fourth component with which this assessment is primarily concerned. (Terms of Reference are attached as an Appendix.)

2. FHS Midterm Evaluation - September '90

A midterm evaluation was conducted of the overall FHS Project in September 1990. The evaluation addressed several aspects of the industry-based activities and included the following observations among others:

- FLAS has been implementing industry-based family planning activities since 1987 through the FLAS *Demonstration Private Sector Distribution Program*, initially funded by FPIA.
- While FLAS efforts have initiated the provision of services to a large and currently underserved population, the impact of such efforts is limited, and acceptance and utilization of services could be greatly enhanced through employing a more systematic and comprehensive approach to the provision of services in industrial settings.
- Activities include providing a supply of free condoms at selected workplaces, sometimes accompanied by

motivational talks. To date, FLAS has provided these services in approximately 80 companies; statistics indicate that they have distributed about 88,000 condoms. Each company is visited once every two or three months, at which time they are resupplied with condoms. Commodities are usually not distributed directly to the potential users. FLAS has attempted to recruit industry-based distributors but has met with limited success.

- The midterm evaluation team visited companies, including Usuthu Pulp, Swazican, Mhlume Sugar, and Ubombo Ranches, to assess the level of services and interest. Large companies are already providing family planning services but utilization is low. All had sent at least one nursing sister to the eight-week family planning course offered by the Ministry of Health and UNFPA. However, none of the companies contacted believed that they had adequate resources and information to conduct the kind of health education necessary to significantly increase the utilization of the FP services.

The team recommended that FLAS initiate a pilot industry-based family planning program during Phase II of the FHS Project. The evaluation of the overall FHS Project was generally favorable, and the project was fully funded for implementation in Phase II.

3. Modification in '91

The Cooperative Agreements with FLAS and Pathfinder were modified (separately) in July '91, extending the expiration date to December 31, 1993. As articulated in the July 1991 Modification to the Pathfinder Cooperative Agreement, the goal and purpose of the project are the following.

Goal: To reduce unwanted fertility and improve maternal and child health.

Purpose: To increase the prevalence of modern contraception and the practice of child spacing.

End of Project Status: Compared to 1990 levels, couple years of protection (CYP) provided through FLAS clinics was expected to increase by 50%; CYP provided by the private companies was expected to increase by 75% (according to the Modification with Pathfinder).

This modification also called for Pathfinder to place a Resident Advisor for 12 to 24 months to assist FLAS with the development and implementation of the industry-based component. Programs with three companies were to be operational by the end of 1991. CYP provided by these companies was to increase by 50% by the end of 1992 and 75% by the end of 1993, according to the Modification with FLAS. Programs with three additional companies are to begin by the end of '93.

4. Increase in Funding - September '92

In September '92, project funding was increased by \$300,500 (\$287,000 to FLAS and \$13,000 to Pathfinder), bringing the total LOP funding to \$2,700,558. These funds were budgeted to procure two computers, conduct a final evaluation, and complete planned activities.

B. Purpose of This Assignment

USAID is considering amending and extending the FHS Project until September 30, 1995. The purpose of this assignment is to evaluate the industry-based program and to describe activities which FLAS could implement with private organizations under an extended FHS project.

This assignment has been undertaken by two consultants during the period March 22 to April 6, 1993 through an indefinite quantity contract between AID and John Snow, Inc. Working drafts of this document were shared with FLAS, USAID, and Pathfinder on April 5th and 7th.

III. Program Development

A. Findings

Overview of Industries

The private sector in Swaziland is comparatively large (albeit not enormous) and vigorous for a country its size. Previous assessments during the project development stage of the Family Health Services Project gathered information regarding the size of industries (as provided by the Federation of Swaziland Employers). During this assessment, specific statistics could not be obtained from the FSE, but of the Federation's 450 members, 20 are categorized as employing more than 100 workers.

As the following table indicates, it is estimated that approximately ten companies employ more than 1,000 workers each. There are two firms that employ 5,000 or more workers, four more that employ more than 2,000 workers, and a few more that employ over 1,000. These facts and estimates were provided by the management of firms or by the Swaziland Federation of Trade Unions.

TABLE I

<u>Organization</u>	<u>Permanent</u>	<u>Seasonal</u>	<u>Total</u>
Served by current FHS activities:			
Usuthu Pulp	2,800	N.A.	2,800
Ubombo Ranches	3,500	2,000	5,500
IYSIS*	1,252	1,218	2,470
Mananga Agric.*	109	10	119
Mhlume Sugar*	1,737	320	2,057
Vuvulane Farms*	127	130	257
Not served by current FHS activities:			
Mondi Forests			1,500
Mondi Timber			1,000
Ngonini Estates			500
Shiselwini Forest			600
Tambankulu Estate			2,000
Simunye Sugar			5,000

* Mananga Medical Services provides preventative, primary and secondary care to the employees of IYSIS (Inyoni Yami Swaziland Irrigation Scheme), Mananga Agricultural Management Center, Mhlume Sugar Company, and Vuvulane

Irrigated Farms, as well as to Cargo Carriers and several other small organizations.

Many of Swaziland's medium-size companies operate at one location: the Matsapa Industrial Center. Most of these firms obtain health services from *Occupational Health Services*, an HMO (health maintenance organization) located at Matsapa, which has 54 contracts to serve 60,000 patients, with ten clinic sites, three doctors, 50 nurses, as well as other specialties such as radiography and physio-therapy. (OHS has had previous experience with condom distribution activities which were sponsored by the British ODA.) OHS reports that some of the industries they serve have requested worker STD/AIDS prevention activities.

Although private sector family planning in Swaziland can never attain the scale it has in some larger countries, clearly the role of employer-based family planning and AIDS prevention could be an important one.

The FLAS Industry Based Project has established family planning and STD/AIDS prevention activities with the following firms:

1. Usuthu Pulp Company (UPC)
2. Ubombo Ranches (UBO)
3. Mananga Med. Srv. (MMS): IYSIS
4. Mananga Ag. Mgmt. Ctr.
5. Mhlume Sugar Co.
6. Vuvulane Farms
7. Cargo Carriers

Thus, seven firms--some quite large, others small--are served by three health care providers. Development activities for these services--preparation of instruments for baseline studies, beginning of training, etc.--began in 1991. The Resident Advisor, placed by Pathfinder International, arrived at post in January 1992, after having conducted a consulting mission in August '91.

Services were begun with two other large firms, Swazican and Natex, but have since been discontinued. Swazican has experienced financial problems in general, largely resulting from the conglomerate of which they are a part, and has substantially reduced its workforce. It is, nonetheless, hoped that family planning and STD prevention activities will recommence when these problems have been overcome. With Natex, the project apparently encountered some opposition from health service providers and middle management.

The service structure of the three main participating service providers is as follows:

<u>Organization</u>	<u>Hospitals</u>	<u>Clinics</u>	<u>Mobile Sites</u>
MMS	1	2	39
UBO	1	20	0
UPC	1	3	5

Some of these firms were already providing some family planning and STD/AIDS prevention prior to this particular FLAS/FHS initiative (that is, they had already trained providers and had already been provided with condoms by the Ministry of Health) though family planning was apparently not provided in a programmatic manner. In particular, outreach and the use of industry-based distributors was an initiative of the current project.

CYP

Although the modifications to the Cooperative Agreements (dated July 31, 1991) do not specify "objectives" per se, they do state what is "expected":

"Pathfinder will assist FLAS to have programs installed and operational in three companies by the end of 1991. It is expected that CYP (couple years of protection) provided by these three companies will increase by 50% by the end of 1992 and by 75% by the end of 1993. Pathfinder will also assist FLAS to begin programs in three additional companies by the end of 1993."

Currently, programs are operational in more than three companies; they certainly were at the end of 1992 and had begun to be installed at the end of 1991. It was probably overly ambitious to expect that programs would be operational in three companies in the five-month interim period between July 31 and December 31, 1991, although implementation activities were well underway.

Through the end of February '92, the following CYP for both clinics and IBD's is reported by the project:

<u>Organization</u>	<u>'92 Total</u>	<u>Jan '93</u>	<u>Feb '93</u>	<u>Total</u>
MMS	512	63	57	632
UBO	810	53	55	918
UPC	381	57	113	551
Total	1,703	173	225	2,101

There is apparently no baseline information regarding CYP provided by the industries prior to the beginning of the project in the baseline study or in FLAS documents that we have reviewed. (Perhaps the industries themselves have this information in their archives, although it is not likely that they were maintaining family planning-specific information unless they were reporting this to the MOH.) The pre-project CYP could probably be estimated based on the baseline contraceptive prevalence and method mix, but this estimate would be highly speculative, particularly since condom acceptors comprise such a large proportion of the distribution. (For example, since the baseline study collected information on "acceptors," each acceptor using the condom method would imply 100 condoms for deriving CYP. However, anecdotal information provided by IBD's, their supervisors, and clinicians indicated that condom acceptors use the method very inconsistently, thereby undermining the assumption of 100 condoms actually distributed to condom acceptors.) Therefore, one cannot, with confidence, quantitatively compare current CYP generated for 1992 or for 1993 with that generated in 1990 as a baseline CYP, since accurate 1990 data is not available.

However, the FLAS data indicates that a substantial increase in CYP is currently being generated compared to prior-to-project activities. The FLAS MIS can compare current CYP to that provided a year ago, i.e., at the beginning of 1992, although such a comparison has its limitations:

	2/92	2/93	PCT.
CYP	36	225	625%

Given the sample size of two months, this analysis is simplistic and does not point to a firm quantitative conclusion. It could be repeated continually into the future and also analyzed for larger blocks of time (e.g., three-month, six-month or twelve-month periods), to smooth for factors such as establishing activities with new industries, as more data is generated.

In future years or quarters, CYP achieved could certainly be compared to these earlier periods to monitor progress.

Baseline Study

As alluded to above, the project began a comprehensive baseline study in January '92; data collection was completed in May and the report published in November '92. The study states that, "In the industry-based AIDS/FP project areas, the CPR as of January '92 was 34%." The method mix was as follows:

Condom	45.3%
Injection	23.8%
Orals	11.4%
IUD	5.4%
F. Sterilization	2.4%
M. Sterilization	0.8%
Foaming tabs	0.5%
Other	10.4%

The baseline study did succeed in developing a lot of useful information. Other information that would be useful from the baseline would include information on client satisfaction with their current method of family planning and the number of spouses -- neither of which were included in the previous studies.

The baseline study articulates the "expectation" of the industry-based project differently than the Modifications to the Cooperative Agreements, stating:

"Phase II of the industry-based FP/AIDS project runs from January 1992 to December 1993. Over this period, it is expected that contraceptive prevalence will increase by 20%. Given that the current prevalence rate in the project industries is 34%, a prevalence rate of at least 54% is expected at the end of 1993. Given the 16,550 employees in the seven companies, 5,627 are currently using family planning. The number expected to be contracepting at the end of 1993 is 8,937. Therefore 3310 new acceptors have to be recruited to increase the current prevalence rate by 20%."

Acceptors

At the close of 1992, according to the FLAS MIS reports, the industry based project had generated 1,630 new acceptors. Another 494 new acceptors have been reported for January and February '93, for a total of 2,124 to date. According to the baseline study, the 2,124 cumulative achieved CYP as of February '93 represents 64% of the total targeted for the end of 1993.

There is slight inconsistency between the "expectations" specified in the two Cooperative Agreements (e.g., increases in CYP by 50% by the end of 1992 and 75% by the end of 1993) and the "expectations" articulated in the baseline study (i.e., increase in CPR by 10% per year in each of 1992 and 1993).

It is our understanding that the adjustment in "expectations" was agreed to by FLAS and USAID because the baseline study would not capture baseline CYP information, but would capture baseline CPR.

Although the apparent lack of data makes establishing baseline CYP for 1990 or 1991 for comparative purposes uncertain at this point, the current data being collected (as of the beginning of '92) will serve as useful baseline CYP data for future comparisons. Monitoring CYP is useful-- and will be more so--since, as the programs become more established, this indicator will provide a quick and useful indication of progress.

Nonetheless, since CYP is meant to be a relatively simple and gross administrative tool and not really a surrogate measure for CPR, continuing to monitor acceptors is also important. The two measures can be useful to balance each other and compare to each other for consistency. For example, if CYP generated seems relatively high, the project is distributing a large quantity of contraceptives. But if the number of new acceptors also remains high, this volume of contraceptives might be spread thinly over a large volume of new, but not continuing, acceptors. This, in turn, could be indicative of discontinuation of contraception and, perhaps, quality of the program. Therefore, "active users" might be the best indicator. The private sector program might be able to monitor active users more readily than public sector programs since it is working with a largely stable target population, one that remains employed and living at the estate, generally with fairly low turnover rates. The FLAS Research and Evaluation Unit might be interested in testing the operationalization of this indicator at sample sites.

*

Potential Impact

From all of these comparisons, however, it is clear that the private sector is not going to generate a demographically significant increase in CYP in the short or medium term as it is currently served by the project. Further, while the importance of protection against AIDS and STD's should not be minimized, the validity of counting condom acceptors in CPR calculations as practicing family planning is questionable because anecdotal information undermines the assumption that condom acceptors do, in fact, use this method consistently.

If all of the firms identified in Table 1 previously are included in the project, it would serve approximately 25,000 employees and one might be able to assume 25,000 couples. If one increases this somewhat for the employees at Matsapa and some of the general public in the communities served by the industries, the target population might attain 30,000. If the project is successful in reaching 50% of that population as continuing acceptors (perhaps an overly ambitious assumption), 15,000 acceptors would be served. Although this figure might not seem demographically significant, it is, nonetheless, very worthwhile. In the Swazi context this might mean reaching 8% of the women of reproductive age through this project alone (assuming a population of 850,000, of which 22% are WRA).

Nonetheless, the strength of this project and the role of the industry-based sector is less in generating family planning output, than it is in making high-quality, sustainable, family planning services accessible to a specific population and in building a base of support for family planning among an important segment of the population--workers--which should have effects throughout the rest of the population.

Cost Recovery

FLAS has been very conservative about funding activities for the industries and the industries have been very amenable to participating in the cost of project activities. The industries pay for virtually all provider personnel costs, equipment costs, and some training. FLAS (through USAID funds) finances the cost of project management, development and implementation of systems and technical resources, some training, and some IEC development and materials. Both the industries and FLAS are to be commended for both this level of cooperation and sensible programming. In fact, since so little financial support has been directly provided to the industries, there need be effectively little or no

transitioning or "weaning" of the industries from FLAS financial support.

Nonetheless, the industries' medical budgets have their own constraints. There are some relatively smaller elements (e.g., tee shirts for IBD's, flip charts for IBD's, sphygmomanometers for monitoring hypertension) of the project for which the industries are also willing to participate in the cost. However, funding for these activities may be delayed by the approval processes. Though the cost is not major, these elements could go a long ways towards (1) motivating IBD's and (2) improving program effectiveness--particularly if deployed in a strategic manner to specifically incent performance. For example, tee shirts could be provided to IBD's who attain a certain level of performance such as new acceptors recruited, motivation activities conducted, etc.

With the exception of Swazican, the pilot companies are willing and able to participate in the cost. However, to maximize the effectiveness of the program, FLAS should want to participate in the cost of further activities in order to:

- (1) maintain their relationship with the industries,
- (2) motivate the industries to aggressively pursue the program; and
- (3) enhance program effectiveness by expediting or improving these activities.

If FLAS were not to participate in future costs, the industries would continue to operate the program, although perhaps with a reduction in effectiveness and enthusiasm. The Project thus far has demonstrated that the private sector is willing to play a significant role in providing and paying for STD/AIDS prevention and family planning services on a sustainable basis.

Even considering the fact that some family planning activities preceded this initiative, this project has, in a comparatively short period, made significant, if modest, progress.

Non-Government Organizations

The Assembly of NGO's is a coordinating body that organizes meetings for members. The Assembly's Directory lists about 60 organizations currently operating in Swaziland. They work in various areas of development and many of them have field workers and outreach activities. They range in size from the 300-bed Raleigh Fitkin Memorial Hospital/Nazarene

Health Services with 10 clinics throughout the country to small rural projects. Already the Red Cross and RFMH have preliminarily indicated their interest in strengthening and expanding their FP/AIDS activities with FLAS assistance. There are probably other NGOs that would welcome such assistance and add to urban and rural services.

Market-Based Providers

Market-based providers are those health or family planning providers who participate in the open market, competing to provide services based on supply and demand for services. These might include private hospitals, private physicians, group practices, private nurses, traditional providers.

Unfortunately, in spite of numerous attempts, it was not possible to meet with the head of the Medical and Dental Association nor of the Nursing Council to explore their interest in detail. However, a very encouraging meeting did take place with a prominent doctor in private practice.

Although we understand that the number of nurses or nurse-midwives in private practice is fairly small, the medical and nursing associations could serve as forums for the expansion of family planning provided by private providers. (In fact, the Prime Minister's wife formerly operated a private nursing practice.) Examples of activities could be funding family planning training for nurses and funding a replacement nurse to provide coverage during the training period. Simple family planning equipment could be provided as well as IEC materials. At this point, however, expansion into this area is of relatively lower priority and would need to be further explored more fully.

B. Recommendations

1. Considering the findings regarding the accomplishments of the project to date, potential future project activities, and actual and potential project output, the role of private sector family planning in Swaziland should be to increase access to high quality, sustainable family planning services and to contribute to the development of a broader base of support for family planning activities in general.
2. The role of the private sector should be strongly encouraged and promoted although the importance of other sectors should not be overlooked.

The private sector could grow to provide a substantial amount of family planning services in Swaziland and thus play an important role in the national family planning program. Despite this potential, however, there are inherent constraints on the number of access points offered by the private sector in a country the size of Swaziland and in the particular niche(s) of the market that the private sector can serve. Therefore, it should be acknowledged that the potential for the greatest impact in reducing fertility and increasing contraceptive prevalence remains with more classical providers, such as NGO's, including FLAS clinics, and the Ministry of Health.

3. The project should be expanded, but must be more aggressive if there is to be any significant impact in terms of family planning.

Since the inception of these activities in 1987, FLAS has successfully established FP/STD/AIDS activities in more than three industries. In the most recent phase of the FHS Project, FLAS has done a good job of building on the earlier activities to lay a foundation for future expansion, including (1) developing a cadre of trained distributors, (2) continuing to mobilize the support of management and the private sector community, (3) developing first drafts of training materials and procedures manuals, (4) developing useful baseline information and IEC materials, (5) starting a service statistics system, and (6) continuing to develop FLAS' organizational and human resources in this area.

Nonetheless, though the process of development and implementation of activities has largely been successful, the family planning output has been on a more modest scale than one might have envisioned. This is partly the result of the cautious scope of these activities as specified in

the project paper and its modifications (i.e., specifying three industries as a target, perhaps in an effort to be pragmatic). The project team has been adhering fairly strictly to the terms of these documents in order not to misstep by being overly ambitious during the pilot phase.

Having demonstrated the potential for participation in an industry-based family planning program, FLAS should now move more aggressively into this segment of the family planning market.

4. **Expansion should not be simply in terms of numbers, but in scope and breadth of activities as well: more firms, more types of firms, more variety of activities with firms, and more private sector activities than simply employment-based services (e.g., market based providers).**
5. **The family planning aspect should be re-emphasized through re-orientation activities including seminars with management (mid-level and top-level) of the firms, piloting of re-supply of OC's by IBD's, and development of VSC capability. These activities could entail going so far as to assist the industries by paying for the services of one nurse for a limited period to ensure that her only responsibility is to strengthen family planning services and actively work with the IBD's to promote more effective methods. Within an industry, a strong family planning service can build a critical mass of satisfied users who would be more active recruiters to their peers.**
6. **If the project is to be successful in providing family planning, the method mix should be much more balanced, though the additional use of condoms for protection against STD/HIV should be advocated when other methods are employed. Currently, the method mix for acceptors strongly emphasizes condoms and, to a lesser extent, injectable contraceptives. (Refer to related recommendations regarding IBD re-supply of oral contraceptives in Section VI.)**
7. **The program should develop a capability in female voluntary surgical contraception using the minilap under local anesthesia technique. The existing industry sites have impressive clinical capabilities which could readily integrate this service with the proper training, counseling, and safeguards for informed consent and quality of care. (USAID and FLAS have scheduled a subsequent assessment of the feasibility of establishing clinical capability for providing more effective methods such as VSC and Norplant**

which will presumably analyze this specific issue in sufficient detail.)

8. **The program should attempt to incorporate those organizations that are already providing services in order that the program's significance might exceed the sum of the individual interventions. Several other large employers which would be likely participants (some of which have already embarked on service provision, some not) in the program include Mondi Forests, Mondi Timber, Ngonini Estates, Shiselweni Forest, Tambankulu Estate, and Simunye Sugar Industries. Some of these have already embarked on providing services.**
9. **A mechanism should be developed to service employers cost effectively at the Matsapa industrial area. Occupational Health Services has expressed an interest in playing a leadership role with FLAS in such a system.**
10. **In addition to the industry-based activities, the program should expand activities into market-based family planning channels. Preliminary conversations with hospitals, private physicians, and private nurses have indicated that they are very interested in providing more family planning services and in developing their resources to provide effective STD/AIDS counseling and services.**
11. **A presentation of the program should be prepared by FLAS staff to demonstrate the project at meetings of the NGO assembly. Should a number of NGO's be interested, a FLAS staff member could be assigned part-time to the Assembly to coordinate project activities.**
12. **At NGO's such as the Red Cross and RFM Hospital, which are already providing family planning services, a thorough review of staffing, clinic services, and IEC should be conducted. FLAS should provide necessary upgrading in training. If necessary, IEC and clinic equipment could be supplied. Outreach activities could be strengthened from clinic sites through fielding of CBD's, based on the lessons learned from the current IBD activities in which FLAS is participating.**
13. **In our opinion, the objective of the project should be to increase access to and use of high quality, sustainable family planning services, objectives that would contribute**

FLAS INED, NO ONE KNEW
I DON'T KNOW WHAT THE FLAS INED
SHOULD LOOK LIKE. WAITING FOR THIS

to the achievement of the specified goal and purpose of the project. The existing project has a specified goal and a purpose; however, there are no objectives identified in any of the Cooperative Agreement Modifications to which the assessment team has had access (though the documents do mention "expectations"). This is a flaw in the original project design and should be rectified in the next phase.

It is premature to identify precise objectives in sufficient detail on the basis of two weeks in Swaziland. This document and the discussions that have taken place to develop it have outlined a wide variety of activities in a number of program areas and identify the priorities in the opinion of the consultants.

14. Considering the number and breadth of activities that may be undertaken, the ultimate priority and quantity of activities should be negotiated between the project implementers, FLAS, and the project funders, USAID.

This would contribute to the achievement of the specified goal and purpose of the project.

15. CYP and/or CPR should be the most important indicator(s) for project monitoring and evaluation.

Useful output indicators of the achievement of this objective include CYP and CPR, both of which have pros and cons. CYP is a widely used indicator of family planning performance, is derived from the data most widely available (commodity use and clinical procedures) performed and is understandable for program managers. CYP can be more easily calculated based on more readily accessible data. Although there was not baseline CYP data at the beginning of this phase of the project, as of the beginning of 1992 FLAS has good baseline data on CYP in the industries with which it is working. However, there are a number of limitations to CYP. Most important is that CYP emphasizes quantities dispensed rather than continuation or method effectiveness, and that attempts to link it to fertility reduction (the goal of the project) exceed its intended use.

With increasing number of industries participating, the absolute level of output (CYP, acceptors) should increase substantially simply as a result of increased numbers of service sites, trained clinicians, and IBD's. In addition to counting the absolute amount of output, it would be informative to measure the average output generated per IBD and use this to manage the IBD program. The FLAS system has begun to track output by IBD. Since the historical data for

TRUE. BUT CPR IS HARD TO MEASURE. 22 April 93

EXPENSIVE AND VERY TIME CONSUMING, THUS WE CHOSE CYP.
(IT TOOK FLAS A LONG TIME TO FINISH BASELINE SURVEY)

IBD output is only now being established, this comparison of average output would not be very informative at this juncture, but should be in the future. FLAS has the resources to follow-up on this.

CPR is a proximate determinant to fertility reduction, but usually requires survey data or, at least, small studies. Because of the baseline study conducted by FLAS in '92, FLAS now has good baseline CPR information on the populations covered by the industries. In fact, this data could probably be extrapolated to some of the other industries which might be included in the future and therefore mitigate the need for incurring the time and expense of repeating full-scale, individual baseline studies.

CYP could be the most useful output indicator for monitoring project progress routinely; CPR could be used as an indicator to evaluate project impact over the life of the project.

Alternatively, an analysis to estimate active users from quarterly supply data could be undertaken to estimate program coverage in terms of CPR, but this method would be somewhat less reliable than a survey. Since the industry projects are working with fairly confined, stable, and moderate-size populations, surveying would not be as resource-intensive as a full-scale Demographic and Health Survey, for example. *BUT IT'S STILL A MAJOR UNDERTAKING FOR FLA.* ✓

16. The indicators of achieving this objective should include both output indicators and process indicators.

In addition to CYP and CPR, other informative indicators for this project might include the following, all of which are important to the current and proposed activities:

- Increased use of more effective family planning methods (determined by method mix of all users/clients).
- Number of *functioning* clinic sites established or upgraded to full family planning service capability.
- Number of clinicians *trained and practicing* family planning.
- Number of IBD's trained and actively distributing (and resupplying oral) contraceptives.
- Number of VSC sites equipped, staffed with trained providers, and functioning.

- Continuation rates (which FLAS is already capable of calculating from its three non-industry based clinics).
- Development, pre-testing, and distribution of a specific quantity of specific types of IEC materials targeted specifically to this segment of the population.

Method mix is a particularly important indicator because all protection is not equal: various methods have widely varying failure rates and degrees of effectiveness.

Recommendation #17: Depending on the quantity and range of activities negotiated between FLAS and USAID for the next phase, FLAS and USAID should agree to the specifics (e.g., quantitative targets) of the indicators.

C. Inputs

- VSC: Training for four to six doctor/nurse teams at FPAK/Nairobi or another training program and basic equipment. Several of the industries currently being served have good facilities and would be willing to share the cost of these activities. ✓
- Modest grants or simple budgets (e.g., \$5,000 - \$15,000) to clinic sites be considered, which would be administered by FLAS. *THEY HAVE A HARD TIME WITH THEIR OWN BUDGET.*
- At the Matsapa industrial area, project support for the cost (on a tapering proportion over time) of a nurse coordinator, thus providing FLAS with some leverage over implementation of activities. ✓

IV. Management

A. Findings

Staffing & Structure

In accordance with the Cooperative Agreements and Modifications, the project is staffed by FLAS with a Program Manager and an Industry Nurse, while Pathfinder provides the Resident Advisor and an Administrative Assistant. The Program Manager is a trained nurse experienced in working with industry, albeit without formal training in management and administration. The FLAS Research and Evaluation Unit manages the MIS/Evaluation activities. Interviews conducted with representatives of participating firms and other organizations provided a strong endorsement of the project staff.

Pathfinder International has fielded a highly qualified Resident Advisor with extensive experience in international family planning program development and management and private sector family planning. The Resident Advisor conducted a consulting mission in August '91 to assist in program development and took up her post as Resident Advisor in January '92.

In addition to the industry-based activities, Pathfinder provides assistance to the other FLAS units specified in the FHS Project scope. Project management and implementation assistance for the FHS Project in general is provided approximately quarterly from the Pathfinder regional office in Nairobi. The Pathfinder/Boston Medical Director and regional MIS Advisor had recently conducted technical assistance to the FHS Project, which was well received on the part of FLAS and considered of high quality and useful. Pathfinder assistance also supported the development of the manuals and the baseline study, the development and implementation of the MIS, and the facilitation of training activities.

As mentioned in the sections addressing IBD's and IEC, discussions among staff from the industries and project staff indicate that field activities would benefit from additional education and communications materials specifically addressed to the target population(s). The FHS Project and Pathfinder International have entered into a subcontract with PATH to develop and implement an IEC program. Some fairly generic IEC materials, i.e., pamphlets on family planning and AIDS, have been distributed to the projects.

Organizational Development

The general nature of the IEC materials is indicative of the continuing need for organizational development activities in an organization that continually undertakes new initiatives and must integrate new activities into existing functions. FLAS conducted a strategic planning exercise in July '92 and a team building exercise in January '93. The strategic plan (which is still a draft) indicates that FLAS intends to continue to support its three clinic sites and develop its capability as a technical resource for developing and overseeing family planning and related activities.

Strategy

The FLAS strategy is very consistent with the expansion and implementation of private sector activities--activities to be designed, developed and monitored by FLAS, but implemented by other existing organizations. Having developed and adopted this strategy, it is necessary to articulate the specific programmatic objectives that would achieve the strategy and the priority activities to achieve the objectives, to prioritize the means to achieve it, and to program the resources. For example, if the development of FLAS as a technical resource is to be a priority goal and industry-based activities are to be one of the programs through which this is implemented, one must still determine the priority activities across the organization that need to be accomplished to achieve this goal. Trade-offs may be required in other technical areas. If the strategy is adopted, specific objectives and activities should be identified and governed by specific time frames and specific resources of the organization should be identified and committed to achieve them--activities that are particularly crucial if FLAS redefines the industry-based activities from a "project" to a fully integrated department of FLAS. This is a role that routine, ongoing organizational development activities can play.

Documentation

FLAS and the industry-based project monitor the implementation of activities through the service statistics system, annual workplans, special studies, and other project documents. For each participating organization, the staff of the industry-based program has developed a background paper describing the organization's current related activities, planned activities, required resources, expected outputs and impact. (Since the project does not provide direct funding to the participating organizations, there is

no formal funding document, such as a grant agreement or subcontract, necessary.) Participating organizations mentioned that prior to the development of such a document, the implementation activities were somewhat vaguely implemented and lacked a clear focus. Although these documents are very useful and quite comprehensive in terms of what they attempt to cover, the documents that have been reviewed have not been complete since there were sections awaiting data developed during the baseline studies. Although these documents are not necessary for funding purposes, they are important for planning, organizing, and monitoring activities and should be completed in a deliberate manner and then reviewed with the participating organization.

Information Management

The service statistics system for the industry-based project was implemented in September '92 and the first report was distributed to the managers in mid-December of that year. The service statistics system seems to be functioning relatively well at this point, although the traditional issue of complete reporting by IBD's still poses a problem. FLAS is apparently using CYP conversion factors approved by IPPF (i.e., 100 condoms equals 1 CYP) rather than the AID CYP factors (i.e., 150 condoms equals 1 CYP), since IPPF is their largest financial supporter. The system generates information on new users, revisits, and CYP on a monthly basis according to (1) the implementing organization, (2) clinic-based activities, and (3) industry-based distributors. These reports are widely distributed both within FLAS and to the participating organizations. In the earliest reports, determining the overall performance of the firms was somewhat confusing because IBD performance and clinic performance were in separate reports. To be more concise for the use of the management of the particular industries, it would be more useful to continue to (1) provide detailed information on the achievement of the specific organization, (2) limit the information on the other organizations to summary information and summary comparisons, (3) link the achievement information to "planned" targets for comparisons, and (4) identify, consistent with workplans, specific initiatives to highlight. For example, if oral contraceptive resupply by IBD's is implemented on a pilot basis, it would be very useful to focus on this particular initiative. Subsequently, if the oral contraceptive pilot concept becomes well-established, a useful initiative to track might be the number of VSC referrals if that aspect of the program is pursued. The REU should continue to try to simplify the format of the information presented in the reports so that

it is readily accessible to management. CYP targets have been established for 1993 that aim for a 10% increase over '92 CYP achieved.

The management of the participating organizations referred to the service statistics system and changes in service output in discussions. However, in reviewing project documents (other than MIS reports), there is little evidence of utilization of service statistics for routine program management, such as identification of strengths, high performers, or areas that require improvement interventions.

NOW BEING DONE

Baseline studies have been identified as the means to determine project achievement of the purpose of increasing CYP by 50% by the end of 1992 and by 75% by the end of 1993 (source: Modification to FLAS Cooperative Agreement, 31 July '91). The baseline study was originated in January '92 and completed in November '92. Therefore, although the studies are interesting and useful for program planning, they are not useful for comparing before and after figures at this time (although service statistics can provide a useful similar comparison of CYP). These data and studies should be very useful for doing so later. A follow-up to the baseline study is planned for October-November '93.

The FHS, including the industry-based project, has generated a clear and useful Gantt chart identifying the activities to be conducted in 1993 and their timing according to the components of the project. Although this is a useful tool, its usefulness would be enhanced if the Gantt chart were accompanied by a textual elaboration indicating the rationale for the sequence of activities and responsibility for conducting them and linking the activities to objectives and priorities.

WE TRIED THIS BEFORE

Given the level of FLAS' institutional development, (e.g., staff, management, technical resources), FLAS has the capability to expand the program to other industries and other parts of the private sector if they are provided with the resources and support identified herein.

B. Recommendations

1. The staff is highly competent to perform the tasks involved and very well regarded by the organizations that participate in the program. To take on the recommended additional activities and longer-term objective of integrating these activities into FLAS, the existing human resources base should be maintained and, in fact, strengthened for the medium term future.

2. FLAS should conduct the following priority activities to facilitate their expansion of the private sector program:
 - Create an Industry Department, probably to be renamed the Private Sector Department. ✓
 - Conduct an organizational development workshop to develop a detailed plan for supporting the private sector initiative, including objectives, activities, tasks, and resources, and restructure staff responsibilities.
 - Upgrade the management skills of the Program Manager to enable him to manage the expanded portfolio of activities. ✓
 - Employ additional staff, rent additional office space, obtain equipment.
 - Obtain another vehicle to service other geographic regions and activities and obtain necessary communication equipment.
 - Ensure that team members can function as project developers as well as in their specialty areas.

3. It is recommended that the Program Manager pursue a one-year family planning-related diploma course, e.g., at the University of Connecticut. The Program Manager has an excellent grasp of the industry based program and how to expand it. However, if he is to be the head of the Private Sector Department with expanded staff and additional resources to manage, he will need to upgrade his managerial and administrative skills. In all likelihood, this would have to be an overseas program. Pathfinder/Boston should conduct the research to determine the possible programs for which the Program Manager would qualify, e.g., at the University of Connecticut. If his current credentials do not support his application to a one or one and a half year program, appropriate short-term programs should be identified that would meet this need. ✓

4. The staff of the project will need to be increased in other ways as well, probably by adding two full-time equivalent professionals, such as a program officer, and a small/medium industries nurse coordinator. ✓

5. To support the activities and staffing suggested above, funding requirements and sources of support need to be identified. USAID/Swaziland should negotiate modifications to the Cooperative Agreements with FLAS and Pathfinder to provide the necessary financial support.
6. If the previous recommendations regarding expansion of the pilot project in several aspects are adopted by FLAS and USAID, the term of the Resident Advisor should be extended through the end of the next phase so she can (1) continue to assist in the design, development, and management of a wider variety of private sector family planning activities; (2) provide continuity if the Program Manager is sent abroad for formal training in management; and (3) subsequently effect an orderly transition of the program to the FLAS Program Manager.
7. Other FLAS technical functions, e.g., IEC and MIS, need to continue to be better integrated to service this initiative.
8. In order to effectively mobilize the organization, organizational development activities need to be undertaken on a regular basis, activities such as determining programmatic objectives and priorities, identifying specific resources to implement the priorities, and effectively monitoring the implementation.
9. In addition to organizational development activities, better documentation of activities should continue to be a priority to improve implementation, e.g., more specific work plans for the industry activities, project documents, baseline studies, follow-up studies, etc.
10. The service statistics system seems to function relatively well at this time, although obtaining reports from IBD's remains a problem. However, to make information more useful at the various levels, reports should continue to be streamlined and priority areas highlighted.
11. The project should continue to exercise good judgement in paying for activities, but should implement sustainability policies that best achieve the larger goal of provision of family planning services and STD/AIDS prevention.

12. A constant supply of contraceptives for the life of the project should be assured by interested donor organizations.

C. Inputs

- Training for Project Manager.
- Extension of Resident Advisor position.
- Salary support for two full-time equivalents positions for the following types of skills as needed depending on ultimate program development determinations: program officer, clinical specialist, IEC specialist, NGO coordinator.
- Support for rental of office space, acquisition of furniture/equipment and vehicle and communications equipment if necessary.

V. Training

A. Findings

Training, a major component of the project, has included training of FLAS staff, industry-based clinical staff, supervisory staff and IBDs, as well as management seminars within industries. During the pilot phase much was accomplished:

- The FLAS Industry Nurse was trained for five weeks by CAFS in Kenya in clinical family planning skills.
- Ten nurses were trained in clinical family planning skills, six from industry and four from non-government organizations.
- Six FLAS staff and four industry nurses were trained as trainers of AIDS educators by AIDSCOM.
- Three FLAS staff were trained by AIDSCOM in the development of AIDS IEC materials.
- 157 IBDs have been trained by FLAS staff (in collaboration with Project Hope/TASC) for two weeks in non-clinical contraceptive methods and distribution, and family planning and AIDS education at the village level.
- Orientation seminars for FP/AIDS industry coordinating committees at village level have been held.
- Trainers' manuals for clinical and IBD training and an IBD procedures manual for family planning have been developed, are now being field-tested and will then be reviewed externally. The consultant who prepared the manuals was also involved in both the clinical and IBD training and informed the team that the training was based on the same curriculum and materials. A review of the manuals reveals them to be adequate for the level of training for which they were prepared. A few changes are called for, such as a warning that petroleum-based products (e.g., vaseline) causes a rapid deterioration of latex and should not be used as a lubricant with condoms. In addition, instruction materials (e.g., teaching aids, handouts, and learning exercises) should be included. The forthcoming review will doubtless recommend more detailed suggestions for improvement.

- A study tour for FLAS staff and industry doctors to Uganda and Kenya to meet FP/AIDS program personnel, especially in the private sector, and view programs was organized. This highly successful activity created a team spirit between FLAS and their industry projects, as well as provided a learning experience on the incorporation of FP/AIDS activities in these countries and the possibility of adapting these activities in Swaziland.

The FLAS Industry team has achieved the specified activities for training; indeed they have accomplished more than was designated for this period. But much remains to be done to accelerate family planning acceptance in the industry population. Since clinical staff have only recently been trained, there has been little rise in family planning acceptance. This may be due to the fact that existing staff continue with their regular tasks and that family planning takes a lower priority than the press of curative and preventive care.

Some dissatisfaction has been expressed at the lack of motivation of the IBDs though it must be noted that all agreed that they were highly motivated during training. More attention should be paid to preparing them for the time commitment required of them and the frustrations inherent in such a volunteer activity. (Further discussion of this point is included in the section on IBDs, Section VI.)

B. Recommendations

1. As only refresher training has been scheduled for the remainder of this year, the FLAS staff should immediately prepare estimates of training needs for 1993/4. These estimates will include clinical training and refresher courses for industry nurses; IBD training and refresher courses, including training for IBDs replacing unmotivated IBDs; and training for supervisors of IBDs. Training for various levels of management will also be needed. We recommend that a detailed training assessment be conducted to prepare a detailed work plan and the training resources needed. Pathfinder should provide technical assistance to assist the FLAS staff in preparing this assessment. For immediate needs, the present resources available in Swaziland and consultants used in recent training should be sufficient. It is recommended that during 1993 the following training should take place:

- at least one more clinical training course be held;

- three to four courses for training and retraining IBDs and their supervisors;
- a refresher course for existing IBDs if the resupply of orals by IBDs is introduced; and
- at least one-day seminar for each of top and middle-level management in the participating industries.

Costs for the above training should be shared with industry.

2. A training format and related training materials should be developed for seminars for various levels of management in industry, such as supervisors of field workers and middle and top management, to encourage their understanding of, support for and involvement in family planning and AIDS awareness activities for industry staff.
3. Because the involvement of trade unions can contribute to the success of the program; seminars for union leaders and shop stewards should be scheduled. ILO has excellent Family Life Education for workers which can be adapted for the Swazi context.
4. A specific timetable for testing, external review and finalization of the training and procedures manuals should be specified by FLAS and Pathfinder.
5. As the training requirements for this program and other FLAS activities are extensive, FLAS should consider developing a permanent training unit. The cost of hiring additional staff and consultants can be more than offset by savings accrued from not sending trainees to other countries. The added FLAS training capacity could then be marketed to other local organizations and to surrounding southern African countries. However, if FLAS does pursue this expansion of its training capabilities, it should be done incrementally. The expansion initially should be built around the private sector training activities. If this is successful, other training capabilities can be developed which could be used by some southern African family planning/AIDS training programs.
6. Assuming that a program of IBD resupply of oral contraceptives, as recommended in Section VI, is adopted and aggressively pursued, a training component to implement that activity should be developed.

C. Inputs

- Technical assistance from Pathfinder for training assessment and development of timetable and specification of needed resources.
- Local trainers and consultants to conduct training courses as specified above.
- Rental of training facilities.
- Transport and subsistence for trainees.

VI. Industry-Based Distributors (IBDs)

The IBDs form the backbone of the industry program. No matter how well equipped the family planning clinics are and how well trained the clinic staff, unless clients are motivated and referred to seek family planning services, the increase in family planning will be small. To date, over 150 IBDs have been selected, trained, and are supposedly active in motivating and educating the families assigned to them, distributing non-prescriptive contraceptives, and referring clients who want other contraceptive methods to the company clinics. They also are trained to increase AIDS awareness and to promote condom use as protection against STDs and HIV/AIDS, as well as as a contraceptive method.

Each company decided how to recruit their IBDs. Ubombo Ranches already had village health workers (VHWs), and FLAS gave them additional training so that they could function as IBDs. Some Indunas were included in this training as support for the IBDs because of their high leadership profile in the community and were given the same course as the IBDs. The other companies used varied criteria but, in the main, selected people who had demonstrated leadership skills and were prepared to volunteer their services.

A. Findings

- All interviewed in the industry projects agree that the IBD training provided by FLAS was good and that the IBDs were highly motivated at the end of training. However their performance has gradually fallen off. They are not aggressive enough in recruiting family planning acceptors or in the distribution of condoms; do not spend sufficient time on motivational and educational activities; distribute only a rather small number of non-prescriptive methods; and refer few clients to the clinics for family planning advice and services.
- Except for Ubombo Ranches, who already had full-time VHWs, the other projects agreed that selection needed to be improved and new criteria developed.
- Not surprisingly, there are mixed views on the issue of providing incentives or compensation to IBDs. Currently, arrangements range from pure unrewarded voluntarism at most participating organizations to the full-time, trained and compensated VHWs at Ubombo. The IBD's at Usuthu Pulp and the firms served by Mananga

Medical Services are generally not compensated or specifically incented to provide services, although those IBD's we met seem to be quite highly motivated. The view that it is foolish to expect high performance when there is no compensation was expressed by several informants, while others said that family planning/STD/AIDS activities should be perceived as purely community-based rather than employer-sponsored if they are to be accepted by the community. Nonetheless, it should not be a foregone conclusion that those IBD's currently compensated are all providing a higher volume of family planning and AIDS services than those not compensated--(although they doubtless are providing a greater amount of high quality community health services). A quick review of the activity reported by IBD's indicated a high degree of variability and a substantial number of which were not providing many services at all. On the whole, however, there is agreement that some sort of incentive, either monetary or in kind, is needed as a recognition of the importance of the work they are doing. Various comparisons are possible. The output of the paid versus the unpaid, monetary versus in kind recognition, etc., should be analyzed.

- The gender distribution of the IBDs is not congruent with the populations they are serving. Given the nature of Swazi society it is clear that the most effective interaction when discussing intimate topics such as family planning and AIDS is between people of the same sex.
- The IBDs do not have a sufficient and varied supply of educational and motivational materials on family planning, STDs and AIDS.

B. Recommendations

1. Based on the performance of the present active and inactive IBDs, selection criteria should be revised. (The project MIS has the capability to measure and report the activity of individual IBD's.) Given the urgency this analysis should not take the form of high level operations research. A quick albeit deliberate assessment of performance and reasons for success and failure is recommended. The procedure should be an assessment of (1) the achievements of each IBD in terms of talks given; (2) other motivational and educational activities, particularly creative activity such as the development of simple IEC materials, motivational activities undertaken; (3) condoms and foaming tablets

distributed; and (4) reports completed on time. This need not be a research-intensive nor technology intensive study. This information could be obtained by preparing a check-list for supervisors or from the MIS data already collected. Also to be checked is the average amount of time spent on IBD activities and, if appropriate, reasons for not spending more time. Perhaps this could be done by introducing a diary in which the IBD can record activities undertaken. Additional anecdotal data on performance should be collected from supervisors, though this should be considered against the supervisor's own performance. Data should be collated and a short analysis prepared for each industry. Relevant FLAS staff and representatives of the management of clinic staff of each of the industries currently participating in the project should conduct a short workshop to discuss the findings and prepare standard criteria for selection of IBDs. These criteria would probably include:

- level of education;
- an assessment of commitment;
- time available for IBD activities;
- age;
- ability to complete reports;
- personality; and
- some measure of standing in the community.

Pathfinder can provide technical assistance for the rapid evaluation of this data. This exercise should also be linked to the following recommendation on incentives.

2. An analysis[?] of the incentives that have[?] been provided in the project should be conducted and compared to the MIS data on individual IBD activity. This can be supplemented with information on the incentives provided in other countries where available. The incentive issue was referred to in all meetings with industry, the Federation of Swazi Employers (FSE) and the Swaziland Federation of Trade Unions. It is quite clear that a major factor contributing to the level of activity by IBDs would be the recognition given to their efforts. In the case of Ubombo Ranches, the VHWS are paid. Does this significantly show in the results of their activities or do they continue with their previous tasks and not give added priority to their work on STD/AIDS/family planning? Issues to consider should include (1) whether or not to pay IBDs; (2) if they are paid, at what level; (3) if there is no payment, what other forms of recognition (e.g., uniforms or hats, badges, umbrellas, gum boots, carrying bags for supplies with the FLAS and/or company logo, plaques to be placed outside their homes) can be used. FLAS should prepare a presentation based on the collected data as well as presenting models from other countries and programs. A half-to one-day workshop, preferably in conjunction with the

workshop on selection criteria, should be organized by FLAS to include representatives from industry, FSE, and the trade unions. While no uniform policy would probably be formulated, alternatives could be agreed on and tested for effectiveness.

The industries present good opportunities for small scale, rapid (dare we say it?) operations research-type analyses of factors facilitating and constraining achievement of service delivery goals and objectives. However, this should include the cautionary note that these analyses should not over-emphasize the research and analysis aspects.

3. The FLAS training for the IBDs should specifically develop a module on budgeting time for IBD activities and how to enlist help when necessary. Supervisors should also be trained to advise IBDs who fall behind in their duties.
4. Reporting forms should be simplified to provide the minimum necessary information to compile useful service statistics. *HOW DO WE
THIS DIFF-
FROM WHA
WE HAVE
NOW?*
? A one-write system can be used which specifies employee number, sex, new client or revisit, and method given. Both IBDs and supervisors should be trained in the use of the forms and the necessity for timely reporting. Possibly any recognition decided on should be conditional on reports being received within an agreed deadline.
5. A representative group of IBDs should be brought together with FLAS, Industry and IEC staff to review current IEC materials and determine what additional necessary materials, especially low-cost ones, are needed on family planning/STD/AIDS. Other IEC methods, such as folk media, the painting of murals that will convey relevant messages to the community, and puppet shows, should also be considered, and priorities set and acted upon.
6. At present IBDs only provide non-prescriptive contraceptive methods. However, all interviewed agreed that a large pilot program for the resupply of oral contraceptives by IBDs after an initial examination of the client at the clinic should be started as soon as possible. Not only will this be an advantage to clients who often have long distances to travel to the clinic and to clinic staff whose load would be somewhat lightened, but it also would confer additional status to the IBD. The training would then include a unit on the prescription of oral contraceptives and the recognition of possible side effects. If the concern regarding hypertension is determined to be warranted IBDs would be taught to measure blood pressure and supplied with blood pressure monitors.

C. Inputs

- Provision of non-monetary incentives, e.g., FLAS badges, commodity bags, plaques for advertising services, hats, umbrellas, gumboots. Could also be provided by the company with their logo.
- Design and production of a llihya. -?
- TA for incentive and selection reviews.
- Training and retraining courses

VII. Information, Education and Communication (IEC)

A. Findings

IEC activities and materials are essential for creating understanding and motivating people to accept family planning and to protect themselves against STDs and HIV/AIDS. The project activities call for:

- the development of an IEC strategy;
- the deployment of 160 IBDs to provide family planning/HIV/AIDS education to employees and their dependents;
- the formation of FP/AIDS coordinating committees at village level in each industry; and
- development and distribution of IEC materials such as pamphlets, manuals and a video-tape on family planning.

These activities require close coordination with the FLAS IEC department. The department employs seven IEC officers, making it the best staffed in FLAS. While they work as a team, each person has responsibility for a particular area. Thus, two are in mass media, one for radio and the other for newspapers and TV. Materials are developed both in English and Siswati. One each are in materials development and community mobilization and two are doing family life education in six pilot schools. The Senior Program Officer is in charge of the unit. They have a large stock of films, which are shown by drivers at industry and other sites. A large equipment order including more and replacement films has just been placed with Pathfinder. An assessment of the project is to be conducted next week and will help set objectives for IEC. The unit is involved in the production of a wide range of materials, some of which is specific to the Industry Project including a male motivation video, a folk media video, and pamphlets.

While it is clear that the industry project staff and the IEC unit work together, there is little evidence that the formulation of any industry-oriented IEC strategy and the development and production of IEC materials relevant to the specific needs of workers and other industry target groups has been a priority for the IEC department. This may be because there is no overall IEC work plan for FLAS, though the formulation of an IEC strategy for FLAS is being developed through a Pathfinder sub-contract with PATH. The current IEC workplan contains the rather limited activities discussed above and is being implemented.

Progress has been made in that 157 IBDs have been trained and are equipped to provide education to industry target audiences. FP/AIDS coordinating committees have been formed at the village level in each of the operational industries. Management seminars have been held. One pamphlet has been produced and several others have been developed and are being printed. These are, however, general FLAS materials and not specific to the project. An IBD trainer's manual and IBD procedures manuals have been produced and are to be tested. A videotape on family planning folk media is in production.

B. Recommendations

1. If the private sector activities are to be a high priority, (as has been recommended herein and as would be required to implement the activities recommended herein) an IEC program specific to this target population should be developed if these activities are going to be successful. This should entail developing specific campaigns to equip, on a regular basis, the IBD's and clinicians with new messages which reinforce the overall purpose and means of conveying the message. These could include method specific campaigns and campaigns oriented to specific segments of the population. For example, assuming that a large-scale pilot program of OC re-supply by IBD's is approved and implemented, a campaign to support the launch of this initiative should be implemented. Assuming that VSC capability is developed at several industries, a campaign to support the launch of these activities should be implemented. During another calendar quarter, male involvement could be highlighted, spousal involvement, STD/AIDS issues could be re-emphasized, or household economics issues promoted.
2. FLAS and necessary IEC consultants should hold a strategy session to revise objectives and prepare a workplan for the development, production and implementation of specific industry-related IEC materials and activities. These would supplement the basic materials currently being developed for the overall FLAS program.
3. Employers, trade unions and workers should be involved in formulating relevant family planning/STD/AIDS IEC materials for management and workers and produced by FLAS. These materials would address issues such as the cost/benefit of family planning for both firms and families, health and productivity outcomes from planned families, worker's rights and responsibilities with regard to FP/STD/AIDS issues, and the recognition and counteraction of rumors about FP/STD/AIDS.

4. As Swaziland has one culture with regional variations culturally relevant activities should be strengthened. These activities should include folk media, including drama, dance, poetry and song on FP/STD/AIDS themes through work groups, womens' and church groups, primary and secondary schools, etc. Regional festivals could be held, culminating in a national festival sponsored by the industries. A family planning and/or AIDS llihiya (i.e., cloth) can be designed to be worn by participants and offered for sale. Local artists could design murals on family planning/AIDS themes to be painted on factory walls and other public areas for viewing and discussion by the community. Contact could be made with the South African group "Puppets Against AIDS" about a training workshop for local puppeteers and a tour of industry sites and other public performances sponsored by industry. The group has been well received in countries such as Zimbabwe, Mauritius, Botswana, Sweden and Canada.
5. In addition to the village-level IEC committees, industry-wide IEC committees that include representatives of top- and middle-level management, clinic staff, IBDs, workers, unions, and the community should be formed, unless they already exist, and oriented to the range of IEC activities. They should then, in conjunction with FLAS, plan FP/STD/AIDS activities for their own firms or organizations and specify the technical assistance they would require from FLAS, PATH, or Pathfinder.
6. The IEC unit needs to be strengthened to cope with a massive need for materials relating to FP, STDs and AIDS. Most of the IEC unit should be sent for further training in various IEC methods and techniques. Funds should be made available for local consultant time for the actual production of materials. As can be seen from the description of duties, much time is spent on the actual conduct of lectures and interpersonal communications. The schools project occupies two officers. Members of the unit should see themselves as idea persons developing materials or coordinating the actual production with Swazi consultants and printers, etc. A discussion with the senior program officer elicited many program ideas, from listening forums to marketing of services. Details should emerge from the almost immediate assessment of the IEC unit.

C. Inputs

- **Short courses for staff, e.g., Kenya Institute of Mass Communications.**
- **Funds for production of materials.**
- **Purchase of relevant materials.**
- **Workshop and tour by "Puppets Against Aids."**
- **Regional and national folk media festivals**
- **Rotating fund for developing marketing and packaging techniques.**

APPENDICES

ATTACHMENT 1

SCOPE OF WORK FOR FHS INDUSTRY-PROGRAM ASSESSMENT

General. USAID is planning to amend and extend its Family Health Services (FHS) Project with the Family Life Association of Swaziland (FLAS). The extended project will end on September 30, 1998. A major component of the extended project is likely to include an extension and expansion of industry-based family planning (FP), STD and AIDS activities initiated under FHS in January 1992. In addition, USAID and FLAS may wish to use the approach taken in the industry program to include family planning, STDs and AIDS in the programs of other, non-industrial, private organizations or groups.

FLAS's industry program was planned in 1991 and began implementation in late 1991. It is currently operating in eight private companies (against an original target of three):

- 1) Usuthu Pulp, a large forestry and wood-pulp-manufacturing concern with its own medical department and hospital;
- 2) Ubombo Ranches, a large sugar and livestock operation with its own medical department, hospital and a network of paid community health workers;
- 3) Swazican, a large pineapple growing and canning operation which obtains medical services from Occupational Health Services (OHS), a local, private provider of pre-paid health care;
- 4) Mhlume Sugar, a large sugar estate served by Mananga/Mhlume Medical Services, the medical department and hospital at Mhlume Sugar which also serves the following four smaller companies;
- 5) Inyoni Yami Sugar Irrigation Scheme;
- 6) Cargo Carriers, a trucking company;
- 7) Vuvulane Estate, a citrus plantation; and
- 8) the Mananga Agricultural Center, a donor-funded agricultural research and training center.

USAID supports this program through the provision of a resident advisor provided by Pathfinder International, short-term technical assistance (TA), and local-cost support, including salaries for two FLAS staff: an industry-program manager (a nurse) and an industry nurse.

Under the industry program, it is intended that FLAS act as a technical-assistance resource (i.e., as an outside consultant) to help industries to establish sustainable programs which provide FP services and FP/STD/AIDS education to employees and their dependants. By December 1993, knowledge and attitudes

September 1986 to attain these objectives and (c) long- and short-term TA needed to conduct these activities;

4) Estimate interest in FP among non-industrial, private organizations/groups; and

5) Recommend objectives and costed activities, if any, which FLAS could feasibly undertake to assist such organizations or groups to become active in FP, possibly including STD and AIDS activities.

Specific Requirements. To accomplish the five objectives noted above, the consultants shall:

1) Assess the quality and appropriateness of training materials developed for clinic staff and IBDs and the extent to which the content of training programs has been incorporated into actual practice (clinical practice need not be observed); recommend improvements;

2) Using MIS data, direct observation and key-informant interviews, assess the quality, extent and likely effectiveness of IBD activities, including commodity distribution and IEAC activities related to FP, STDs and AIDS respectively (IEAC materials and their development need not be assessed); describe constraints to improved/expanded IBD activity, and recommend strategies to overcome these constraints;

3) Assess FLAS's management of the industry program, including the extent of effective (a) coordination among FLAS management and staff in pursuit of clearly defined program priorities, (b) FLAS interaction with service providers, IBDs and company management, and (c) FLAS commodity-management (i.e., keeping clinics and IBDs supplied with contraceptives and IEAC materials); recommend improvements;

4) Assess whether accurate and useful program-monitoring data is available from the MIS (e.g., is a running 12-month, graph of monthly CYP distributed, stacked by method, compiled for each industry, clinic, and IBD?); recommend improvements;

5) Assess whether and how data from the MIS is being used by FLAS management and program staff; recommend how use might be improved;

6) Based on MIS data, assess, if possible, whether the use of FP is increasing in the eight pilot companies and the adequacy of the method mix; recommend means to increase utilization of longer-acting methods if so indicated;

7) Assess FLAS's mechanisms for evaluating the industry program, including (a) the quality of the industry-baseline survey and (b) the utility and feasibility of such surveys as FLAS evaluation tools relative to the MIS; if future surveys are recommended, suggest ways to simplify them;

among this group relating to FP, STDs and AIDS are expected to improve, and contraceptive prevalence is expected to increase from 34% to 64%.

The industry program includes the following:

1) FP Service Delivery. Condoms, foaming tablets, pills, IUDs and injectable contraceptives are provided by about 12 nurses (6 trained by the program) at 12 company clinics/hospitals. Condoms and foams are distributed by 159 program-trained community volunteers (Industry Based Distributors - IBDs) who live in company villages. FLAS currently provides AID-funded contraceptives to companies at no charge, but it is hoped that companies will absorb this expense in the future.

2) Information, Education and Communication (IE&C) related to FP/STD/AIDS. IBDs are expected to educate their peers on matters relating to FP, STDs and AIDS and to refer clients to clinics for services other than condoms and foams. IE&C activities include group talks, home visits, distribution of leaflets, and films. Folk media are about to be introduced.

3) Monitoring and evaluation. FLAS has conducted a baseline survey on knowledge, attitudes and contraceptive prevalence in each company and has established a Management Information System (MIS) to gather monthly data on contraceptives distributed and IE&C activities conducted. In addition to monthly FLAS visits to each company, meetings with advisory committees are held quarterly to review implementation at each company.

4) Marketing. Based on experience in the eight 'pilot' companies noted above, FLAS is expected to market its services, for a fee, to other companies. No marketing activities have been conducted to date.

USAID is seeking the services of two experienced consultants from March 22 through April 7, 1993 to evaluate the industry program and to describe specific, costed activities which FLAS could implement with private organizations under an extended FHS project. (Consultants should be in Swaziland ready to work on March 22 and should leave April 8. Two rental cars will be required.) The consultants will:

1) Document the progress and problems experienced by FLAS in the industry program to date;

2) In light of this experience, assess the program's potential as a means of increasing the sustained provision of increased FP services and FP/STD/AIDS education by private industry;

3) Recommend (a) revised objectives for the industry program as appropriate, (b) revised and costed activities (either more or fewer) to be implemented through

- 8) Assess the priority accorded to FP/IDs/AIDs by company management and medical staff, the latter including clinical-service providers;
- 9) Assess likelihood that pilot companies will be able and willing to operate the program with only occasional, cost-reimbursable assistance from FLAS by December 1993;
- 10) Recommend strategies for 'weaning' pilot companies from FLAS assistance and recruiting new companies, on a cost-reimbursable basis;
- 10) In liaison with the NGO COordinating Assembly, assess interest of other private organizations in incorporating FP/AIDs activities into their programs;
- 12) Assess FLAS's capacity to expand the industry-program approach to other industries and to other private organizations or groups; recommend additional resources required.

The consultants will be sent the following documents for review before arrival in Swaziland:

- 1) FHS Grant Agreements with FLAS and Pathfinder
- 2) Industry Workplans for 1992 and 1993
- 3) Semiannual USAID project implementation reports, 1992
- 4) Monthly FLAS industry-project reports, 1992
- 5) FLAS industry-project trip reports, 1992
- 6) Industry-project training manuals (IBDs and nurses)
- 7) IBD procedures manuals
- 8) MIS monthly statistics
- 9) Industry baseline-survey report
- 10) Weekly activities plans for industry-program staff
- 11) FLAS Management Review, 10/92
- 12) KAP studies by Polly McLean, 6/90

Qualifications: Consultants shall combine significant experience in the design, management and evaluation of industry-based family planning programs. Management expertise will be especially important. Experience in community based distribution programs will also be important for assessing IBD activities, and a social scientist with previous FP experience and a good working knowledge of Swazi society may prove well suited to this task.

Reports. The consultants will produce a draft report of their findings and recommendations, which will be discussed with FLAS and USAID prior to finalization. The consultants will provide FLAS and USAID with a final draft report (6 copies and 3 copies respectively) prior to departure.

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Persons Contacted

Family Life Association of Swaziland

A.M. Mkhwanazi, President
G. Gule; Treasurer, Executive Committee
Khetsiwe Dlamini, Executive Director
Harriet Kunene, Industry Nurse
Khanya Mabuza, Program Manager
Musa Mowy, R&E Unit
Nomcebo Manzini, Programmes Director
Musa Mugogo, R&E Unit
Jerome Shongwe, IEC Unit

Pathfinder International

Millicent Obaso, Resident Advisor
Douglas Huber, Medical Director (Pathfinder/Boston)
Tom Fenn, Director of Technical Services (Pathfinder/Nairobi)

USAID

Jay Anderson; Head, Health, Population, Nutrition Office
Anita Sampson, Program Officer, Health & Population Office

Baphalali Swaziland Red Cross

T.S. Dlamini, Executive Director

Federation of Swaziland Employers

Musa Hlope, Executive Director

IYSIS

Bhizen Dlamini, IBD
Jameson Bulunga, IBD Supervisor
Amon Mamba, IBD
Isaac Msibi, Welfare & Recreation Officer/Industry Programme & IBD
Supervisor

Mananga Medical Services

Ian Gilbertson, Medical Director
Dorothy Dlamini, Community Health Nurse and Industry Project Coordinator

Mhlume Sugar Company

Durnsane Dlamini, Personnel Manager
Sipho Dlamini, Personnel Officer, Industry Project Coordinator
Zilpa Gumedze, Nursing Sister

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Ministry of Health

G. Matsebula, Matron
Prisca S. Khumalo, Sister

National AIDS Council

Rudolf Mazya, Program Manager

Nazarene Hospital

Dr. McCoy, Acting Medical Director

NGO Assembly

Sara Dlamini, Director

Occupational Health Services

Geoffrey Douglas, Medical Officer

Private practice physician

Dr. Vilakati

Swaziland Federation of Trade Unions

Jan Sithole, Director

TASC

Thandi Nhlengethwa, Program Director

Ubombo Ranches

Paul Canter, Medical Director
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UNFPA

Rhodes Mwaikombo, Chief Technical Advisor

Usuthu Pulp Company

Beau Dees, Medical Director
Alfred Mndzebele
Thandi Simelane, Nurse
Delu Sengu, Nurse