FAMILY PLANNING SERVICES PROJECT

660-0094

SUMMARY

The following Project Paper (PP) developed in accordance with STATE 213510, is for a project of family planning service delivery to be carried out in Zaire. by the Department of Public Health (DPH) in collaboration with the National Committee for Desired Births (CNND) and several private-sector institutions such as the National Workers Union (UNTZA) through CASOP (the union's social service arm), the Church of Christ of Zaire (ECZ) and selected industry health services. It is a five-year project with an estimated AID contribution of $3,940,000; a Government of Zaire (GOZ) contribution of $3,907,000 (local currency equivalent a CNND contribution of $358,000 (local currency equivalent); and $1,715,000 to be contributed by other donors (Total - $6,920,000).

The PP draws its rationale from the CDSS which provides the basic analysis of the impact of demographic factors on the development of Zaire, the fourth largest country[1] on the African continent. Zaire's population of approximately 30,000,000 is growing at about 3% per year. This rate of growth implies critical family health problems stemming from short birth intervals and high parity. It also places a substantial burden on a society that, with a presently stagnant or deteriorating economy, is not able to employ productively many of its human resources or to afford the social investments needed to improve the quality of life of its growing population. The CDSS concludes that, through the informational/educational activities of various institutions, particularly the CNND, a demand for family planning services has been created that at present exceeds the supply.

Family planning is not new to Zaire. Child spacing is traditional, but with modernization many of the traditional methods have fallen into disuse. Consequently, induced abortion is increasing (according to reports by health sector officials) and there is a growing demand for family planning (as documented by Tulane's AID-financed research in Zaire). Zaire's family planning program has its political and legal foundation in the 1972 pronouncements of President Mobutu and the 1973 "Ordonnance 73" (Presidential decree), which created the National Committee for Desired Births to carry out a program of family planning information and services. The progress that has been made since 1973 is unique in Francophone West Africa.

The objective of the proposed project is to assist the GOZ in coordinating the efforts of those who have initiated family planning activities, in strengthening and expanding the efforts to include family planning in ongoing maternal and child health programs, and in increasing effective access of the population to family planning information and services in 14 major cities where 25% of the population resides. The project purpose is to increase contraceptive use in these 14 cities from approximately 3-5% of couples of fertile age to 12% by 1987.

1. In terms of population.

The major activities to be carried out are:

a) to improve coordination through a national advisory council and a management/coordination unit. This unit will combine the personnel of the CNND and DPH for coordinated management while still depending on the separate institutions (CNND, DPH, ECZ, CASOP, etc.) to carry out discrete, independent implementation functions. The council will provide the means for coordinating donor input. It will ensure coordination with such other USAID-supported efforts in family planning as the Basic Rural Health Project, the Tulane Operations Research Project, and such other centrally-funded projects such as F.P.I.A., Pathfinder, JHPIEGO, and IPAVS;

b) to transfer skills through the provision of 30 person-months of short-term technical assistance, 60 person-months of long-term assistance, and Peace Corps volunteer assistance;

c) to improve training through 72 person-months of short-term and 75 of long-term training outside of Zaire, development of CNND training courses for 200 service providers in Zaire, and development of curricula in reproductive health and family planning for medical and nursing students;

d) to improve contraceptive availability, logistics and service statistics through technical assistance to CNND and increased shipments of contraceptives;

e) to improve supervision and evaluation through technical assistance and support for a supervision unit in the CNND;

f) to increase service delivery primarily through the hospitals, clinics and dispensaries of the DPH but also through those of the ECZ, CASOP, and industry health systems. Modest improvements will be made to initiate or upgrade services in 75 centers and 15 satellite community-based distribution programs. Information and counseling will be provided to clients and a full range of contraceptive services, including sterilization, IUD, oral contraceptives, natural methods, condoms, and foam. Medical standards are established by the GOZ through its relevant institutions. However, it is agreed they will be consistent with international standards of IPPF, WHO and IPAVS. Where sterilizations are performed, the policies governing USAID's world-wide support of these activities will be followed with especial emphasis on the quality of training, equipment care, patient care and the requirements for informed voluntary consent of the patients. By the end of the project 250,000 new acceptors will have been provided services (125,000

continuing users, and 300,000 couple years of protection).[2] This will increase contraceptive prevalence in the target areas from 3-5% at present to approximately 12%, not enough to substantially influence the birth rate/growth of the country immediately, but a nevertheless significant step forward.

At the end of the project a structure for coordinating, facilitating and evaluating family planning services will be in place. Improved logistics, reporting and supervision systems will have been established and a cadre of trainers and service providers will be available for program continuity and expansion.

Recurrent cost requirements (other than for contraceptives) will be relatively low inasmuch as this project will focus on using and strengthening present structures and personnel, and on introducing concepts of self-financing. GOZ contributions from its Ordinary Operating Budget will gradually increase and future projects will plan for local currency contributions to match the value of donated commodities.

The PP addresses the issues raised in STATE 213510 as follows (paragraphs cited as those of 213510):

Para A: Duration of Commodity Supply - See Section IV (F), Contraceptive Supplies (page 20)

Para B: Medical Standards and Depo-provera - See Section IV (H) Service Delivery (page 22) and Section I (D) Family Planning Policy and Status (page 7)

Para C & D: Social and Economic Analysis - See Annex E and page 34

Para E: Evaluation - See Section VIII (B) Monitoring and Evaluation Plan (page 39)

Para F: Goal and Purpose - See Section II - Goal and Purpose (page 10) and Log Frame - Annex A

2. Couple/Years of Protection - the cumulative total in years of the total number of acceptors x the length of time actively using a contraceptive method.

I. PROJECT DESCRIPTION

A. Demographic and Related Socio-Economic Conditions

The population of Zaire, currently estimated at approximately 30 million is the largest in Central Africa and ranks fourth on the continent. Only Nigeri is larger in West Africa; Zaire having three times the population of the next largest country, Ghana. The growth rate, estimated at 3% or more, ranks with the highest in the world. Urbanization is rapidly increasing. In 1970, it was estimated that the population of the 11 largest cities constituted nearly 15% of the population. Today, the population of Kinshasa exceeds three million; Lubumbashi, Kisangani, M'buji Mayi, and Kananga have approximately half a million each. At present, the urban population is 7.5 to 9.0 million or 25-30% of the total. Among problems related to urbanization is the breakdown of traditional child spacing practices leading to increases in fertility.

The conditions associated with rapid population growth in other countries are also apparent in Zaire. The percentage of the population under 15, dependency rates, infant mortality rates, the level of malnutrition and the rate of unemployment in the cities are all high. Appropriate pre-natal and obstetric care is limited and a high percentage of births are of high parity. Birth interval is decreasing, and many births are to adolescents or to women beyond the safer ages of child bearing. Although maternal mortality rates are estimates, they are reported to be high. It is clear that pregnancies are occurring under conditions of high health risk. The incidence of illegal induced abortions is reported to be increasing rapidly in the cities, particularly in the younger age groups.

Current accurate population data are lacking, although demographers have attempted to construct reasonable estimates from small-scale surveys conducted since the administrative census of 1970. Following are selected socio-economic indicators compiled by CDC and APHA (CCMD Evaluation, 1981) from various Zaire, U.S. and World Bank sources:

1) Population (mid-1981 estimate): 30.1 million

2) Population Growth Rate (includes immigration): 3.2%

3) Percent Urban (1975 estimate): 28.7%

4) Migration -- Rural to Urban (1975-79): 8.4%

5) Vital Rates and Other Demographic Information:

   Crude Birth Rate: 46/1,000 population

   Crude Death Rate: 18/1,000 population

   Natural Increase: 3%

   Number of Years to Double Population: 25

5) (Continued)

Infant Mortality Rate: 171 per 1,000 live births

Child Mortality Rate (0-5 years): quoted as high as 500 per 1,000, but regarded as unreliable.

Life Expectancy at Birth: Male - 45.2; Female - 47.8

Population Under 15 (1979): 11,796,000 (46%)

Population Over 65 (1979): 642,400 (2.5%)

Females 15-44 (1979): 5,444,400

Married Females 15-44: Not available

Literate Population: Estimated between 32-65%

B. GOZ Population Policy

Although the GOZ has no enunciated demographic policy, there has been a slow evolution of the recognition of the impact of demographic factors on development and the importance of child spacing to maternal and child health.

In 1972, the elements in the old colonial law related to contraception were superceded by actions of President Mobutu. On December 5, 1972 in a speech before the Legislative Council, President Mobutu stated that, while the ultimate objective of marriage is procreation, procreation itself should not be unlimited. He spoke of the older times when high infant mortality required high fertility, noting that today, families need less births because there are less deaths, hence the need to bring the actual number of births to correspond with the number desired. President Mobutu also called attention to the prevalence of induced abortions as an inappropriate method to avoid unwanted births. He stated the need to explain and facilitate the use of contraceptives to alleviate this undesirable situation. This established the philosophy and policy of Desired Births.

On February 14, 1973, Ordonnance No. 73 was signed by the President establishing the National Committee for Desired Births (CNND) and providing the legal authority for promoting and providing family planning services.

Article 1 creates a national council attached to the Office of the Presidency for promotion of the principle of desired births.

Article 2 states the council's mission to plan the national program to promote the information and services to the population related to desired births and to coordinate the activities for the accomplishment of the program.

Later development of a population consensus, if not policy, can be seen in the January, 1982 document of the DPH, "Plan of Health Action, 1982-86".

In its initial paragraph describing the health problems of Zaire, it calls attention to the "explosive growth of the population (growth rate of 3% for a population estimated at 29,000,000 in 1981)... and the rapid rate of urban growth of the large cities, particularly Kinshasa as well as lead cities in other Regions." In other sections, the Plan calls attention to high birth rates and the high percentage of the population under 15. Its policy statement reflects the Declaration of Alma Ata and specifically includes family planning among the activities of maternal and child health.

C. USAID Development Objectives

The CDSS calls attention to the impact of rapid population growth as the increase is outstripping present allotments for social services provided to the population and could erode or even cancel future gains in economic development. Transport, utilities, health, social services, and education are suffering under the burden of the present rapid population growth. More importantly, the labor force will double before the end of the century, thus creating an extremely difficult situation for a country where unemployment and under-employment is already a serious social and economic problem. The rapid population growth rate with its high fertility and close birth intervals plays a significant role in the widespread malnutrition in Zaire. Chronic malnutrition of children under the age of five is considered the most serious public health problem. The National Center of Human Nutrition Planning (CEPLANUT) recently found that the two most significant variables impacting on the malnutrition of this group were socio-economic status and family size. The Center has concluded that the most feasible short-term strategy to combat the problem of chronic malnutrition is to provide child spacing service to those women in need.

The Mission has noted that since 1973, various groups have been involved in educating the population on the acceptability and advantages of child spacing. As a result, there exists in Zaire an unmet demand for services. Therefore, the 1983 CDSS for the population sector concentrates on meeting this presently unmet demand. This strategy includes the following specific activities:

-- Expansion of family planning service delivery through those organizations that already are providing services or are capable of initiating services with relatively little assistance.

-- Attempt to modify GOZ policy towards provision of family planning services to unmarried women and teenagers.

-- Modification of medical school, nursing school and in-service training curriculum to include family planning.

-- Making family planning services a part of all GOZ health delivery systems.

This project, together with the Basic Rural Health Project (086), will deal directly with the first, third and fourth objectives. In practice, the

project will influence policy (objective two) but it is expected that other efforts of the International Planned Parenthood Federation (IPPF) will take a more direct approach through the CNND.

From March 1 through 8, 1982, a PID review team of 12 persons, representing the National Committee for Desired Births (CNND), the Department of Public Health (DPH), the Mutual Fund for Workers and Peasants of the National Union (CASOP), the Eglise du Christ au Zaire (ECZ), Johns Hopkins University (JHPIEGO), International Project Association for Voluntary Sterilization (IPAVS), USAID and REDSO/WA visited a total of 56 health institutions in nine major cities of Zaire. The visit provided opportunity for observation of economic conditions in the country, the visible population pressure in several areas where such pressure on the land is producing erosion and environmental deterioration, rapid urbanization, slum conditions and unemployment. These observations and interviews with social and health leaders confirmed the basic premise of the CDSS that there are sound economic and social development reasons for concern about rapid population growth and that these issues are beginning to be recognized more clearly by leaders of the Zaire society.

The concern articulated in the CDSS for malnutrition as related to population growth is well placed and could be expanded to include other family health issues related to family size and birth interval. Concerns for employment and the impact of rapid urbanization were frequently expressed in interviews of the review team. The difficulties of meeting social requirements were summed up by one medical director..."Every day two classrooms of children are born at Mama Yemo Hospital; how can we build schools that fast?" Interviews with health staff and community leaders confirmed the CDSS assumption that there is, at present, an unmet demand for family planning services. Additionally, however, the review suggested that continuing emphasis on informational/educational services may be more important than implied in the CDSS.

D. Family Planning Policy and Status

(See Annex B for more detail)

Although the legal basis and principle of family planning was established in 1972 and 1973, the strategy for implementing it has evolved slowly. Various efforts of local organizations supported by such international organizations as IPPF, USAID, FPIA, Pathfinder and JHPIEGO, as well as by Tulane University have produced a widespread recognition of the concept of "Desired Births". In many rather unconnected small project activities, largely in the private sector, some contraceptive supplies are being made available.

To date, actions of the DPH have been limited in the area of family planning. However, recently in developing its health policy to lead to Zaire's goal of "health for all by the Year 2000", it has recognized the important contribution child spacing can make to improve maternal and child health. Thus, the GOZ has requested USAID assistance in developing a project to coordinate the activities of various organizations providing family planning services and to strengthen this aspect of maternal and child health within the health services of the DPH in the major urban areas of Zaire.

A recent evaluation of the CNND (conducted by A.P.H.A.) identified the basic soundness of this organization. It recognized the considerable accomplishments in training and informational programs. It recommended changes in organizational emphasis so that CNND could play a more effective role in coordinating family planning activities in the country and improve its performance in contraceptive supply, reporting and evaluation. This project design is consistent with these recommendations.

All methods of family planning; sterilization, hormonal, IUD, condoms, foams and natural are being provided in the services delivered in Zaire. The CNND, together with the DPH, are responsible for medical standards which follow the guidance of the international standards of IPPF, WHO and IPAVS. The position of WHO is also followed with regard to the use of Depo-provera, a product which USAID does not provide. Initially, surgical contraception will be provided only by physicians. Other methods will be provided by nurses and paramedical personnel under extended medical supervision. Later in the project, the use of para-professionals will be studied. It is expected that more community personnel will be involved in the provision of family planning information and non-clinical contraceptives, a procedure that is presently being utilized in the Tulane Operations Research project and an FPIA-supported project with the CNND. The principle of the voluntary nature of family planning is well established in Zaire and will be supported in the project with especial emphasis in ensuring that sterilization activities are performed with informed, voluntary patient consent.

As noted above the Project review team of DPH, CNND, CASOP, ECZ, JHPIEGO, IPAVS, and USAID visited 56 health institutions in nine of the major cities of Zaire. The findings are summarized in Annex B. In brief, a demand for family planning was confirmed, the need for training health personnel in family planning was underscored, health facilities were identified as capable of adding family planning to existing maternal and child health services and health personnel were interested in so doing.

Surveys carried out in Kinshasa and urban and rural areas around Matadi, as well as information from the project review visit, confirm the widespread practice of traditional means of child spacing and consequent acceptance of the program of "Desired Births." While as many as 30% of the women surveyed in Kinshasa and 50% of those in the Matadi area reported they were practicing some method to postpone another pregnancy, only 3-7% of them were using modern contraceptives. This suggests considerable potential for acceptance of family planning services if they are made more readily available in a geographically, economically, and culturally acceptable fashion.

- Project Specific Environment

The last few years has seen a general decline in the GOZ's capacities to implement development projects. This has been due to a myriad of economic and organizational problems that have afflicted all GOZ departments, including the DPH. These problems have been set forth and analyzed in the CDSS for Zaire. They will not be discussed in detail here. The most important of these problems, constraints that impinge upon this project are:

1) Low morale of DPH employees resulting from poor working conditions (lack of material resources), low salaries, and particularly the frustration of not being able to provide many routine services to the public.

2) A large, centralized, inertia-bound and generally ineffective bureaucracy.

3) Weak managers and poor management practices at all levels.

4) Poor transport, communications, and consequently logistics support and supervision due to a deterioration of basic infrastructure.

5) Inadequately trained and experienced personnel; in the case of this project, a body of personnel generally unfamiliar with family planning service delivery.

The project does not plan to address all of these constraints but has been designed to work around them and to build on the opportunities for strengthening those functions critical to accomplishment of project objectives.

The project will do this in two ways. The first will be by addressing, within its means, the constraints of the DPH medical facilities as they impinge upon family planning service delivery. The second will be by utilizing the relatively well-developed and well-functioning non-governmental health care delivery system.

In the first approach the project will upgrade the training of DPH clinical employees and will provide some basic medical supplies and contraceptive commodities with which to provide services. While this will not resolve all morale problems, it will help alleviate the first and last cited above. On the management side the project will recycle DPH administrators and planners in the basics of family planning management. Regarding communications, logistics and supervision the project has been designed to minimize these constraints by limiting activities to those urban areas to which regular air transport is routinely available and in which ground transportation is feasible.

In the second approach the project will initiate service delivery through selected non-governmental health care facilities that have traditionally had well-motivated personnel, good logistics and effective management. In these facilities, which will comprise half of the total, the project will provide training plus some medical commodities and contraceptives. All of these private sector organizations have central offices in Kinshasa that are capable of expediting personnel and material to other urban centers using their own internal distribution systems.

In the public and private systems it is planned that the ongoing logistical support needed to sustain the systems will be minimal. After training has been completed, supplies provided, and the clinics become operational, there will be a period during which frequent visits by supervisory personnel will be needed.

After the initial breaking-in period, these frequent visits will no longer be necessary. Since it is planned that all activities will be in urban areas with adequate roads, the project vehicles will easily last through this break-in period.

Resupply of initial stacks of contraceptives will be required infrequently (perhaps once a year). Since contraceptives are light in weight, dense in volume, and have a relatively long shelf life, they can be stored easily for long periods.

In sum, the general constraints to development activities in Zaire, and specifically those that characterize the health sector, are not seen as insuperable obstacles given the design of the project.

II. PROJECT GOAL AND PURPOSE

The goal of the project is to increase the use of voluntary family planning services among Zairian families, assisting them to space their children and to have the number of children they desire.

The project purpose is to increase contraceptive use in 14 urban areas from approximately 3-5% of couples of fertile age to 12% by 1987.

The project will complement the activities of the Basic Rural Health Project (660-0086), that will provide family planning services in 50 rural areas of Zaire. Together these projects will provide at least some access to modern contraceptive services to approximately 40% of Zaire's population. Presuming 1,050,000 women of fertile age exposed to pregnancy in these areas a continuing user level of 125,000 in the last year of the project will be a prevalence rate of approximately 12%. This only begins the process of fertility reduction, nevertheless it is an important gain over the present 3-5% prevalence of modern contraceptive use in urban areas. The levels of users to be reached in these projects are not such as to dramatically influence Zaire's fertility rate in the short run, or to impact substantially on family health and welfare in global terms. However, individual families will be benefited substantially during the project, and the actions of this project will initiate a process that can be expected to gain momentum during and beyond the life of the project. Benefits of this project, which are keyed to its implementation and are essential components of future growth are:

-- the involvement of the Ministry of Health in the provision of family planning as part of maternal child health;

-- the further legitimizing of family planning as part of official government health policy;

-- focusing the efforts of the CNND to lend a more effective role in coordination of national family planning activities, closer working relations with the DPH; more effective handling of contraceptives:

-- the development of key elements of family planning program, i.e.:

a) basic policy decisions such as to initiate the integration of family planning into health services, to employ community workers outside fixed facilities in service delivery, and to provide a full range of contraceptive services;

b) training programs and a cadre of trained trainers;

c) basic communication and information materials and program;

d) a system for planning, ordering, receiving, warehousing and delivering contraceptives;

e) a framework for experimenting with new approaches and evaluating results;

f) a collaborative relationship between public and private sector agencies that can utilize efficiently the comparative advantages of each..

III. BENEFICIARIES AND THEIR PARTICIPATION

The project will benefit directly the at-risk women who will enjoy new access to family planning services. It will benefit indirectly those women's families that will have more time and resources devoted to their care because of child spacing and avoidance of unwanted births. The most accurate predictor of beneficiary reaction to family planning programs is actual practice when modern methods are made readily accessible in culturally acceptable ways. This has been the case only in limited areas of Zaire to date, and reporting and evaluating of these activities is not definitive. However, there have been indications of acceptance of all methods (sterilization, pills, IUDs, Depo-provera, condoms and foam products and natural methods) in varying degrees.

As discussed elsewhere, child spacing is not a new concept to the Zairian family. As urbanization has occurred and some of the living arrangements that supported prolonged sexual abstinence following childbirth are less the custom, families are faced with seeking different methods of birth spacing. The evidence is in the increased incidence of induced abortion, the growing demand for family planning services in the various health systems, the results of several surveys and the community response to the service delivery in the Tulane Operations Research project in Bas Zaire.

Although potential clients have not been directly involved in the development of this project, per se, some have been interviewed as to their interest. There has been very substantial participation in project development by members of the CNND, the DPH, church groups, the labor union and various service providers. To some degree, they represent the point of view of the beneficiary, but additional efforts will be made to move the project toward more community

participation. The issue of the degree of medical supervision required for family planning enters any consideration of how much of the planning and service delivery can be placed in the hands of community personnel. However, they clearly can be involved in providing information to their neighbors. They will be involved more as the project information component provides for more client education/information. As in some locations, funds generated from charges for services are used to improve clinical services, the community can be involved in decisions and implementation.

IV. PROJECT ACTIVITIES

As indicated previously, the focus of this project is to develop and carry out those activities essential to expand access of the populace to contraceptive information and service. All the concerned organizations agree that, for the moment, the process of education and information has created a demand that, in many cases is not being met. The emphasis therefore over the next five years will be on service delivery although information and education programs will be continued. The major project activities will be as follows:

1) actions to improve coordination[3]

2) transfer of technical skills[3]

3) training

4) production of didactic and informational materials

5) improving facilities through refurbishing and provision of equipment

6) contraceptive supply

7) service delivery

8) supervision, data collection and evaluation.

The activities will be described in this Section; the particular institutions and arrangements will be discussed further in the Section on Implementation.

A Action to Improve Coordination

As stated above, there are a host of institutions (national and international) in Zaire interested in and some already providing family planning services. One must guard against an organizational structure or coordination formula that stifles the initiative of these various institutions. Excessive coordination could be as damaging to program growth as would be the complete lack of coordination. The program will seek to avoid the pitfall of stifling initiative while developing ways to share information, skills and resources, avoid duplication, fill necessary program gaps and create mechanisms to facilitate the work of separate service networks.

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3. In one sense these are ways to achieve the other activities rather than activities themselves, but they are included here to identify them and emphasize their importance.

The process has already begun in the development of the Project Paper. One of the early meetings in October, 1981, between CNND, DPH and USAID identified, among other constraints to the expansion of family planning services in Zaire, "insufficient coordination among concerned organizations."

The local site review visit which had the participation of DPH, CNND, CASOP, ECZ, IPAVS, JHPIEGO, and USAID was an excellent step toward improved understanding among these groups. All stages in project development have been produced as a result of meetings between DPH, CNND, and USAID. Perhaps the most significant in this regard is the establishment of a project advisory council made up of all the participating agencies, an operational management unit composed of CNND, DPH, and USAID personnel, and identification of discrete and independent but interrelated actions of all agencies in the project implementation. Project management will continue to focus on this facilitative type of coordination as one of its significant activities. In this connection the project will investigate distribution of non-clinical contraceptives via the PEV network.

In designing the management structure, a model emphasizing efficiency and tight management control was rejected in favor of a model designed for more institutional involvement and responsibility by the present institutions (DPH and CNND). This is expected to enhance their sense of responsibility and be a more sustainable approach over time and following the project.

B. Transfer of Technical Skills

Through eight years of experience in developing and implementing family planning programs, through the assistance of IPPF and other international donors, and by taking advantage of international and national training opportunities, CNND has built up a substantial body of technical expertise in family planning in the country. However, certain areas have been identified where additional skill transfers would be of assistance. Some of this will be accomplished by training, but there will also be need for technical assistance. Most of the technical assistance needs can be met through short-term assistance. These will be specifically in the areas of:

1) planning and organizing training programs in country;

2) development of short course and medical and nursing curricula and didactic material;

3) development of informational materials;

4) development of a simplified system of service statistics and utilization of service statistics and surveys in evaluation;

5) development of an improved commodity supply system;

6) development of medical standards and a system of medical supervision.

The long-term technical assistance envisioned in the project will be focused on the transfer of planning and management skills. Peace Corps participation will have some skill transfer component but will generally be more directed to assistance with implementation.

C. Training

1. General

One of the most significant and pervasive needs identified by the PID review team was that of upgrading the skills and knowledge of health service providers in family planning. In-country training in this project will be designed for that purpose. It will also be a key mechanism for securing the identification of these local providers with the "coordinated system" of family planning delivery planned in this project (this is not to take these providers outside their own system of DPH, CASOP, or ECZ, but to help them to relate also to the principles and organization of "desired births"). Another in-country training activity will be directed toward management personnel through the several delivery networks. The objective will be to gain their authority and support for the project activities and to upgrade their management skills related to specific needs of the project.

Project leadership and those engaged in training and supervision will benefit from occasional short-term training opportunities outside the country, preferably in Africa. Although not a large part of the project's training emphasis, provision is made for observation visits to family planning programs in other countries; courses and seminars on management; new approaches to family planning delivery, curriculum development and training methodology, evaluation, communication skills; and special concerns such as women in management, adolescent fertility and natural family planning. Project training activities will be supplemented by centrally-funded programs of this same nature.

With the primary objective of strengthening Zaire's long-term capacity to plan and manage its own family planning/population programs, provision will be made for long-term post graduate training principally at the Masters of Public Health level. Candidates who are assured of continuing employment related to family planning in the CNND, DPH or medical or nursing faculties will be provided scholarships for training in Francophone African institutions or as appropriate in the U.S.

Since the training activities in-country will require the preponderance of project training manager's attention, further discussion of this aspects follows.

In-country training for clinical service providers will be carried out primarily in three locations: Kinshasa, Lubumbashi, and Kisangani. Community workers will generally be trained in the cities where they live although initially a few may be trained in on-going projects elsewhere in Zaire. Management training will be concentrated in Kinshasa. On-the-job, follow-up training of clinical personnel will be carried on by project supervisor/evaluators in the service delivery locations; clinic personnel will provide

this follow-up training to community workers in their clinic area. In addition to assisting with these "post graduate" retraining courses, medical and nursing faculties will provide family planning/reproductive health training as part of their basic curricula to all medical and nursing students.

In the three major centers (Kinshasa, Lubumbashi, and Kisangani) it is not the project's intention to create any large new training infrastructure. Rather, the intent is to build on, knit together and strengthen existing infrastructure to provide a didactic and practical training in clinical and non-clinical family planning. The component parts may be carried out in separate facilities or locations in the urban area, but all will be linked together as one unified training system -- thus the term "Center" has been used. The pattern will vary in each city but the essential elements will be the same:

-- medical and/or nursing school faculty together with CNND and DPH personnel providing the basic didactic information;

-- an on-going family planning clinic program (generally in the context of other maternal and child health service) staffed by DPH, CNND, medical or nursing faculty personnel and students. The clinic (or clinic and hospital) should provide all clinical methods, including sterilization;

-- dispensaries (public and/or private) where non-clinical methods are provided;

-- community-based outlets (or workers) for the distribution of non-clinical family planning information and methods;

-- an active patient/client/community education program for explaining all family planning methods, where to obtain them and how to use them;

-- each "Center" will have a designated director of training.

2. Course Material

(a) Clinic Personnel

There will be specialized training for physicians, nurses, anesthetists involved in surgical service. However, all clinic program trainees will receive classroom training (2 weeks) in the following:

(1) Review of basic elements of maternal and child health

-- pre-natal care
-- simple obstetrics - need for medical attention
-- post-partum care

-- vaccination schedule
-- malnutrition
-- diarrhea - oral rehydration.

(2) Relationship of child spacing to maternal and child health

-- infant and maternal mortality and morbidity, prematurity, neo-natal mortality, malnutrition; problems associated with adolescent pregnancy, short birth interval, high parity and births to older women;
-- recognition of high reproductive health risks.

(3) Zairian culture and traditional methods of child spacing. Recognition of changes; demand for contraceptives.

(4) Elements of reproductive physiology and reproductive health

-- physiology
-- infertility
-- sexually transmitted diseases.

(5) Contraception

-- Explanation of all methods (sterilization, IUD, orals of several kinds, Depo-provera, new methods of "natural" family planning, condoms, foam and foaming tablets, diaphragms) how they function and information needed by client to understand how to use.
-- Benefits and appropriateness of various methods related to costs, ease of delivery, ease of client use, effectiveness; health and other considerations related to age, parity, education and life style of the client; availability of medical supervision; relation to specific health conditions such as protection of lactating mothers, assisting anemic conditions, protection against sexually transmitted disease, protecting the very high risk patient.
-- Contraindications, relative health risks, specific conditions requiring medical intervention, how to deal with problems.

(6) Program standards

-- clinical methods
-- non-clinical methods

(7) Management and Administration

-- Explanation of national program of desired births, service and supplies available and how various service networks such as DPH, CASOP, ECZ fit in. What can they expect from CNND, what should they expect from their own institution; requirements for affiliation with CNND.

-- concepts of self-financing and local participation
-- possibilities of assistance in refurbishing of local facilities
-- how to order supplies and equipment
-- proper care of material
-- reporting on receipt and use of equipment and materia
-- service statistics
-- expectations of supervisory assistance.

(8) Clinic organization and patient attention

-- delegation of responsibilities
-- patient flow
-- interpersonal relations.

(9) Communication Skills

-- with clients
-- with community
-- use of available informational materials
-- techniques of supervision.

Trainees will also receive practical experience in the clinic (two to three weeks) and community-based distribution setting (three days to a week).

They will participate in the screening of patients, taking of health histories, counseling in family planning methods and explanation of how to use methods, dealing with side effects, distribution of supplies and record keeping. For those who have been selected to receive training in IUD insertion, more time will be required to do a more thorough pelvic exam, recognition of conditions requiring medical intervention and adequate supervised insertions to be competent in this procedure.

In the community practice they will participate in community education sessions, training or follow-up training of community workers, supervision of community-based distribution posts and record keeping.

(b) Community-Based Personnel

Training will be organized by clinic personnel for community workers so as to require as little dislocation as possible in distance and time. Material and approach will be greatly simplified in recognition of the trainee's probable low level of formal education, limited literacy skill and little experience with formal pedagogic approaches. Initial training sessions should not be more than two to three half days with plans for considerable follow-up and "in-service" training.

Basic materials will be a very simplified approach to the subjects of 2, 3, 5, and 9 above, with a "management" component designed for the simple requirements of non-clinical programs. The need for community involvement

and participation will be included. Practical aspects will be dealt with in role playing. A short visit will be made to the clinic to acquaint the workers with the referral/supervision point and to understand the support available for the worker and for patients referred. Most of the practical training will be in the community itself as assisted by the supervisor in initial activities.

(c) Management Personnel

Supervisors/management at various levels of CNND, DPH, CASOP, ECZ and others will receive training in one or two day seminars and workshops. For those more directly involved in the program, a one week course will be developed. The courses will be tailored to the specific objectives for particular participants. For one group the objective will be primarily to explain the program and its procedures and gain their support. For these a simplified version of 2, 3, 6 and 7 above will be the approach.

The group engaged with direct management responsibilities will receive a more in-depth course using some of 2, 3, 5, 6, 8 and 9 above but focusing primarily on more detailed attention to 7.

(d) Medical and Nursing Students

Curricula will be developed similar to the reproductive health/nutrition/maternal child health curricula developed by Johns Hopkins in cooperation with Brazilian medical faculties.

It will have much of the same focus as the refresher course outlined for clinic personnel above. Obviously it will be in more detail and the skill levels to be developed in the practicum will be greater. The curriculum design effort will determine how this can best be integrated into existing courses and how much should be dealt with as a separate reproductive health course.

In carrying out the training action described above, there will be full collaboration with the training activities of the Basic Rural Health project. With the technical assistance to be provided, the number of trained personnel already in country and CNND's experience in training, this activity can be carried out effectively.

D. Production of Didactic and Informational Materials

Considerable material of this nature has been provided to CNND by IPPF, Pathfinder, ECZ and received in various training programs. A Zairian institution supported from Belgium and by WHO, the Bureau of Studies and Research for the Promotion of Health, has produced a substantial series of well illustrated materials on various health subjects. Many of their published brochures contain excellent material on family planning and its place in maternal and child health. The material is presented in a somewhat more sophisticated way than needed for the refresher courses. It is also overbalanced in its emphasis on the IUD as much more desirable than other methods. However, these brochures

can be quite helpful as part of the didactic material for the training program. Personnel of the DPH have prepared a simple family planning syllabus for training nurses in the USAID-supported Health Systems Development project. Course materials are being developed for the USAID-supported Basic Rural Health Services project. Much of the task of producing didactic material for the refresher courses is one of collating and adapting. A supplement will be developed dealing with the administrative aspects of the urban family planning service project. CNND training personnel are experienced and can handle this adaptation with some short-term assistance.

Some of this same material can be utilized in the nursing and medical courses. The AHTIP (University of North Carolina) training modules and the Strengthening Health Delivery Systems (SHDS) training modules will be useful even though family planning aspects will require strengthening. Johns Hopkins material can provide a helpful framework for adaptation. Simple informational bulletins and flipcharts for use in the clinic as a guide for discussions with clients are particularly meager. Both Tulane University and PIACT can be consulted for useful models of communication materials. The Bureau for Studies and Research for the Promotion of Health has the technical capacity for design and printing.

We know of no evidence that posters have much influence in "motivating" people toward smaller family size or toward family planning. However, when placed in appropriate locations, they do convey the idea that family planning is accepted by authorities and by society. Probably more important, they help to inform prospective users that family planning information and service is available and where. All this material should be written and designed in Zaire. Due to local costs of paper and printing, some may be printed elsewhere.

E. Improved Facilities

1. Refurbishing

A substantial infrastructure of health facilities was built up during the time of colonial influence. Many of the physical facilities remain in use, but most have deteroriated somewhat or greatly over the years. It will not be necessary to build any facilities to achieve the objectives of the project However, in most facilities, some simple refurbishing will be needed to provide the clean, attractive surroundings appropriate for maternal and child health and family planning. Reasonable judgement will have to be exercised in each case to make appropriate improvements so family planning fits into the whole MCH outpatient or OB/GYN department. In any event, these will not be costly repairs. They will entail such things as painting, window repair, drapes for examining rooms, floor and roof repair, electrical and sanitary facility repairs, benches, and general clean up. In most cases the labor will be provided locally and materials will be provided by the project.

In the training centers and in the facilities providing surgical services, somewhat more extensive refurbishing remodeling will be needed but this will be well within the capability of local workmen.

2. Medical Equipment

The facilities of each location will be reviewed in terms of the family planning services to be provided -- surgical, clinical (including IUD), and non-clinical. Specifications have been drawn up by IPAVS consultants and the medical supervisor of CNND. These specifications will be followed in providing the necessary lights, tables, surgical equipment, medical kits and ancilliary equipment necessary for complete and safe services. A large supply of expendables will be made available at the initiation of the program (soap, catgut, gloves, towels, sterilizing solution, surgical drapes, etc.). It may be necessary to resupply some of them during the program since commercial suppliers in Zaire at this time handle limited quantities at high prices. However, efforts will be made to shift the responsibility for expendables to the local institutions as part of the objective of eventual self-financing.

F. Contraceptive Supplies

Annex C discusses the economic and programatic rationale for the particular mix of contraceptives to be provided in this project. It is concluded that there is no overriding economic reason for selecting one or more contraceptives over others. For example, although in many countries sterilization is considerably less expensive than other contraceptives in terms of cost per couple/years of protection, this will not be the case in Zaire for some years to come. Start up costs will be high initially for low case loads. There are also programmatic reasons for not focusing a great deal of emphasis on this method. Although there are good health reasons for sterilization being the method of choice for many older high parity women, this is not yet within the cultural tradition of many. Also, for a program in which the primary focus is child spacing, sterilization would be an inappropriate initial emphasis. Both sterilization and the use of the IUD have more stringent requirements as to the level of physician involvement and the standards of facilities and equipment. Even the apparently simpler approaches of natural methods have substantial personnel requirements for effective client education.

Experience around the world (and in Zaire) suggests that a variety of contraceptive methods are needed to meet the health, age, lactational state, personal preferences and fertility regulation objectives of prospective users.

Another element that influences program cost and contraceptive mix is the type of program being developed. As noted, a heavily clinic-oriented approach with substantial physician involvement can place more emphasis on the IUD and sterilization. On the other hand, the less expensive CBD and commercial retail sales approaches would place more emphasis on non-clinical methods. The present attitude of health leadership in the country suggests that experimentation with these community-based approaches is possible, but there is not readiness as yet for a broad programmatic emphasis of this nature.

Thus, a mix of contraceptives was selected generally consistent with present programming and oriented largely toward clinic delivery where major responsibility is given to paramedical personnel under extended medical supervision.

All methods are included in the program. Although Depo-provera is used in Zaire following IPPF and WHO standards, USAID does not provide this product. It is expected that as the project develops, there will be some increase in the percentage of sterilization and that the non-clinical methods will increase as the service moves more toward community-based activities.

Initial projections are for a contraceptive mix as follows:

Contraceptive Method	Percent of Users
Oral	30%
Depo-provera (not supplied by USAID)	25%
IUD	15%
Natural Methods	6%
Sterilization	4%
Condom	10%
Foam Tablets	10%

Projecting 250,000 cumulative new acceptors, 125,000 continuing users at EOP and approximately 330,000 couple/years of protection, the following supplies will be required from USAID (including inventory) for the life of the project:

Orals	1,424,000 cycles
IUDs	164,000 units
Condoms	3,650,000 units
Foam Tablets	3,650,000 units

The estimated cost C.I.F. is $1,183,000.

One of the key elements determining the success of family planning programs around the world has been a full supply of contraceptives. Where a scarcity mentality prevails, counterproductive controls are built around distribution, stock outs occur at clinics and services are withheld from patients. According to Dr. Hatcher in his book, Contraceptive Technology, one of the major reasons for patient drop-out in programs is breakdown in commodity supply. For this reason he recommends distribution of as high as six cycles to a user at one time.

At the same time programs must develop self-sufficiency and the supply of commodities from external sources must have some limits. During the life of this project, the GOZ will be expected to increase its budgetary contributions. In any follow on project, a trust fund account will be required for local currencies for project support which gradually matches the value of imported commodities.

G. Improved Logistics

A major emphasis in the project technical assistance is to develop and then to implement an improved logistics system for contraceptives and medical equipment and supplies. The CDC/APHA evaluation provides the basic diagnosis of the problem. Warehousing at the national level is excellent and the CNND has a good supply manager who is making important improvements. As he is provided additional assistance, as he is permitted to focus more attention on this particular task, as a simplified reporting system is developed, and as increased supervision is maintained at the local level, substantial improvements can be made in project logistics. Emphasis on more advance planning for contraceptive orders, a larger buffer on inventory and a limited "push" system to supply distributors regularly with minimum stocks should ensure against stock-outs at the national and local level.

The involvement of the DPH, CASOP and ECZ in the shipment of supplies for their local health service delivery centers should facilitate much of CNND's work.

Recently IPPF has increased their shipments to CNND and additional supplies through the USAID bilateral project should resolve what has been at times a major bottleneck in increased contraceptive availability in Zaire.

H. Service Delivery

Presently there are approximately 180 outlets in Zaire that are providing family planning services. While many of these are related to the DPH, the more effective appear to be ECZ hospitals and other private groups. The most active family planning delivery systems are in the ECZ network, the majority of which are in the rural areas. Family planning services in the urban areas outside Kinshasa have been neglected and, with a few noteworthy exceptions, are inadequate. To date, the DPH, due to limited resources, has not been able to effectively integrate family planning services in its health delivery system (which practically is limited to the urban areas). Thus, the largest provider of health services has yet to be effectively utilized as a vehicle for family planning services in urban Zaire. As a result, the CNND and other organizations can claim only 20,000-25,000 continuing users in Zaire at this time. USAID currently estimates that there are some three million women of reproductive age in Zaire desiring family planning service. All concerned agencies agree that present demands for services are not being met. The GOZ, ECZ, CNND, and USAID are in agreement that conditions are favorable for a significant expansion of family planning services. The project will establish service outlets in all 14 major urban areas of Zaire. While particular attention will be given to ensuring that these services are available in DPH facilities, other basic health service providers affiliated with the union (CASOP), churches (ECZ), and industry will be assisted.

The target areas for this expansion are as follows:

City	Population Estimated in 1987
Matadi	250,000
Boma	150,000
Goma	100,000
Kikwit	200,000
Mbandaka	225,000
Kisangani	474,000
Bukavu	250,000
Lubumbashi	770,000
Likasi	296,000
Kolwezi	235,000
Mbuji-Mayi	450,000
Bandundu	100,000
Kananga	500,000
Kinshasa	3,600,000
TOTAL	7,600,000

These figures represent estimated census projections for the cities proper; suburban/fringe areas may add an estimated 15% to the total.

The map on the following page identifies the project locations.

14 URBAN AREAS OF ZAIRE TO BE INCLUDED
IN THE REVISED OR NEWLY PLANNED PROJECT

CITY	POPULATION/1987	CITY	POPULATION/1987
[illegible]	[illegible]	[illegible]	[illegible]
Boma	[illegible]	Kolwezi	225,000
Kikwit	[illegible]	[illegible]	450,000
Mbandaka	[illegible]	[illegible]	150,000
Kisangani	[illegible]	[illegible]	[illegible]
Bukavu	243,000	Kinshasa	3,000,000
Lubumbashi	770,000	Goma	100,000

Both AID/W and REDSO/WA have inquired whether this project is integrated adequately with other elements of maternal child health. The objective of the project is to maintain an emphasis on family planning services and the vast majority of the inputs will be directed to making family planning services known, understood and available. At the same time, the major rationale for this family planning service is that it is a basic health service, a very needed one, especially in the present conditions of reproductive health and infant and maternal mortality in Zaire. However, at present, this service is generally lacking in the private and public health systems, which, with all of their shortcomings, are providing a surprising amount of other medical attention to the population. The members of the review team were impressed by the number of daily consultations in hospitals and dispensaries, which clearly had serious resource limitations, but had personnel who worked within these constraints to provide curative and often preventive service. This project cannot hope to solve all (or even many) of the problems facing the health system, but it can support what does exist with a needed additional component to make it more balanced and more preventive in its policy and application. The management, technical assistance, supervision, logistics and evaluation components of this project will be focused on assuring delivery of family planning services within the system. However, in doing so, important improvements will be made in the system itself.

Additionally, this project will provide some of the basic gynecologic equipment and supplies needed by the centers, such as examining tables, lamps, scales, equipment and supplies for simple laboratory tests, blood pressure, etc. Where the laparoscopes are provided they will make an important contribution to diagnostic capabilities for gynecologic problems.

Training and supervision will encompass a reasonably broad spectrum of maternal and child care. Thus, there will be some upgrading of these health care areas, which are closely related to the provision of family planning and are of key importance to family health.

If in the second or third year of the project it is clear that additional components can be handled, particularly to deal with pre-natal care, diarrhea (oral rehydration), and nutrition education, this will be considered in conjunction with other USAID-assisted projects in health and nutrition.

Service delivery will be carried out in several different types of facilities. For most urban areas, the leading service delivery center will be the General Hospital maintained by the DPH. In three cities these are very substantial hospitals having over 1000 bed capacity, with 100 or more births a day in the maternity department and more than 500 daily outpatient consultations. In most places the size of the hospital and case load is more modest (but generally exceeding 200 outpatient consultations per day). However, even in the moderate sized locations there are several physicians, thirty or more nurses and as many other employees. All hospitals have surgical facilities. In these hospitals it is expected that all methods of family planning will be provided. Most will be on an outpatient basis, contacting a clientele which uses the hospitals for pre-natal, obstetric, vaccination, and curative care.

In all these hospitals, tubal ligations will be performed mostly by mini-lap procedure In selected hospitals, laparoscopy will be available both for tubal ligation and for diagnostic purposes. In several cities the major hospital is the university hospital or a hospital maintained by the mining company or the railroad. These also will be included.

In most cities, there are intermediate size facilities of an outpatient, polyclinic nature serving a variety of curative, pre-natal, maternity, post-natal and well-child vaccination needs. These are run by such industries as coffee, breweries, mines and railroad, by church-related organizations or by the unions. They are generally staffed by 3-10 nurses (predominantly male) with medical supervision one or more times a week. They have as many as 100 to 200 consultations per day. In these centers all non-clinical family planning methods (pill, condom, foam and natural) will be available, and IUDs will be inserted. In a selected few with adequate facilities and immediate access to hospitals, mini-lap tubal ligations may be performed. Although not provided by USAID, many facilities will utilize Depo-provera, generally for high parity women.

In all urban areas there are three or more small dispensaries situated in the heart of densely populated zones. Some are related to the DPH's hospitals, but most are supported by the private sector (church or union), using the hospital for patient referral. The dispensaries are staffed by one to three nurses (predominantly male). They receive back-up supervision by a physician with infrequent on-site involvement. These dispensaries serve 50-150 clients per day.

In later stages of the project, community leaders (probably women) will be more directly involved in the distribution of family planning information and non-clinical methods. However, initially it is the community-based, nurse-staffed dispensaries which will provide the community outreach. In these dispensaries, all non-clinical family planning methods will be available; in a select few with adequately trained personnel, physical facilities and medical supervision, IUDs will be inserted; availability and use of Depo-provera will vary according to training and supply; referrals will be made to the hospital for tubal ligations. Client and community information programs will be encouraged.

Each of the major service providing networks (DPH, ECZ, CASOP, industries) will provide the basic personnel for service delivery and supervision (generally using staff presently available by shifting some responsibilities). They will also be responsible for most of the commodity logistics within their system from Kinshasa to the local posts. They will have a primary responsibility for supervision within their own network but as described later, there will be a supplementary project supervision established.

More precise medical standards will be established as part of the project activities and a system of medical supervision will be developed to ensure adequate quality of service appropriate to Zairian conditions.

It is recognized that it is the Government of Zaire through its relevant institutions that is responsible for establishing and maintaining medical standards. These will be developed in Zaire in keeping with standard medical practice. However, it is agreed that they will be generally consistent with such international standards as those developed by IPPF, WHO, JHPIEGO and IPAVS. In the case of any sterilization supported by the project, it is agreed that the policies governing USAID's world-wide support of sterilization activities will be followed. In summary these require that appropriate quality of medical care, training, equipment and medical supervision be maintained. They especially emphasize the requirements that this activity be voluntary, that patients are fully informed in their own language of the risks and consequences of the method, that other methods of contraception be explained and available, that no enticement or coercion be used and that a form indicating informed consent be signed by the patient and maintained on file in the institution performing the surgery.

In sum, the objectives are as follows:

1) To develop quality standards for service delivery consistent with appropriate medical care and the coverage objectives of a public health program. Relative risks to the patient entailed in utilizing a particular product on the one hand or in being exposed to pregnancy on the other will be analyzed in keeping with practical realities of Zairian conditions.

2) To improve attention to training, facilities, equipment, and patient care in surgical procedures. This requires some upgrading of present facilities and skills to expand the program as well as the establishment of a medical surveillance capability in the CNND and/or DPH. There is agreement that the JHPIEGO and IPAVS international standards are applicable and to be utilized.

3) To give attention to training, equipping, and supervising personnel inserting IUDS. Gynecologic examinations will establish protocol and referral to physicians for problem cases will be emphasized.

4) To provide medical supervision within the system for non-clinical contraceptives, focusing careful attention on training service providers to understand the different contraceptive methods, their pros and cons and to be able to counsel clients in their use. A simple checklist for health contra-indications will be utilized. Training will be upgraded in the newer approaches to natural family planning methods. The Tulane Operations Research project will provide valuable experience and data for the use of the DPH and CNND in further evolution of standards in non-clinical distribution.

Efforts are beginning throughout these health systems to establish mechanisms for self-finance. In some, modest charges of U.S. $0.25 to $1.00

are made for consultations and drugs are sold at cost. In others that are well supplied by the union, missions, industry or public sources, drugs and some services are provided free or at substantially less cost. There has been a general policy toward providing family planning services free of charge, but this project will seek to introduce the concept of local self-finance as much as possible. Obviously, attention must be paid to reasonable controls to avoid abuse but it is expected that full supply and increased availability of contraceptives will do much to lessen the possibility of "profiteering" or monopoly pricing. Although supervisors will be required to review this situation locally, it is not intended that the project will set up a system for remitting any of this money to higher levels. Whatever funds are generated locally will be utilized there as a way to develop local self-sufficiency.

In later stages of the project the possibility will be reviewed of assisting the private commercial retail sector to increase sales of contraceptives.

I. Supervision, Data Collection and Evaluation

A major problem identified by the CDC/APHA evaluation was the inadequacy of service statistics that made progress impossible to measure and supply management extremely difficult. Inadequate information is being provided management for program planning purposes. Part of the difficulty appears to stem from a service statistics system which, in trying to gather too much (albeit important) information, breaks down in practice. Several actions have been identified to improve this situation:

1) Technical assistance will be provided to develop a service statistics system to gather only that minimum information essential to project managers. This system will place considerable emphasis on contraceptive flow as a basis for measuring project progress.

2) Utilization of survey methodology to gather more detailed information when considered essential for project evaluation and/or program planning.

3) Inclusion of records keeping and reporting in the training program.

4) Involvement of administrative and supervisory personnel of the major services networks in general supervision.

5) Establishment of a special cadre of project personnel to provide a supplementary supervision of the various local or in service centers involved in family planning delivery. Each center will be visited periodically (at least quarterly, initially) and service statistics will be collected and reports produced at that time.

6) The supervision cadre will participate in each of the training courses both to present specific course material and to initiate contact with the trainees who will be the local implementors.

7) The supervisors' job description will stress the aspect of assistance to local personnel as opposed to a "police" function. The supervisor will assure that training opportunities are made available, that medical equipment, contraceptives and informational materials have been delivered and that building refurbishing is being provided. For selected locations the supervisor will assist the local personnel in establishing, training for, supplying, and supervising community-based activities.

8) The special project supervisory cadre will be responsible for analyzing the service statistics, comparing them with contraceptive logistic information and producing a quarterly management report. These reports, together with reports from the training program and contraceptive prevalence or other surveys will be the basis for the annual evaluation and annual report to be produced by this special cadre.

V. OUTPUTS

The following minimum outputs are planned:

A. An effective management system will be put in place to coordinate, facilitate and evaluate the activities of the various institutions in providing family planning services. This system is to manage the project in such a way as to strengthen the capacity of each separate institution to continue to provide these services in the future in a self-reliant, independent but coordinated fashion.

B. Three training "centers" will be established, capable of providing didactic and practical training for medical, paramedical and community-based distributors in family planning, reproductive health and surgical, clinical and community-based distribution (CBD) skills. In addition to these training functions, these centers will be major service providers in three major cities where they will be established -- Kinshasa, Kisangani and Lubumbashi. The centers will be one of the key project links with the medical and nursing faculties as these faculties assist in developing curriculum, provide some of the teaching staff and use the centers for practical experience for nursing and medical students.

C. Through project actions and technical assistance by, inter alia, centrally-funded projects as JHPIEGO and INTRAH, curricula will be developed in reproductive health and family planning for medical and nursing faculties.

D. A minimum of two hundred family planning service providers in the DPH, CASOP, ECZ and other systems will have been trained in understanding the relation of child spacing to maternal and child health and nutrition; various contraceptives methods, the advantages and disadvantages of each, how they are to be used, basic clinic skills, communication skills and administrative aspects of the family planning program.

E. An improved and simplified service statistics system will be developed and put in place. This will be supplemented by occasional surveys to provide adequate data for periodic project progress reports and evaluations.

F. Basic informational material will be produced in French and at least one local language for use in client education explaining each of the contraceptive methods.

G. An effective system of contraceptive logistics will have been established which provides for coordinated planning, ordering and receiving of contraceptive supplies; effective logistics in-country; ensures minimum/maximum supplies with no stock-outs at the local level; and a simplified system of commodity reporting that ensures accurate and timely reporting to project management and donors of the receipt and distribution of contraceptives.

H. Seventy-five urban service sites with 15 satellite community-based programs will be upgraded or established and functioning on a self-financing basis.

I. By the end of year five, 250,000 new acceptors will have been reached. In that year there will be 125,000 continuing users being provided contraceptives services by the project.

VI. INPUTS AND SOURCES OF FUNDING

	U.S. $ (Equivalent) (000)
A. DPH	
- Personnel costs for DPH management and supervisory personnel in project (7 x $4,143/year x 5)	145[1]
- Personnel costs and operating costs for centers (100 employees at $3,120 salary and costs x 5)	1,560[1]
- Repairs and refurbishing of centers (75 x $5,200/center)	390[2]
- Local costs (per diem, fuel, supervisory and other travel, shipping)	100[2]
- Other costs	100[3]
TOTAL	2,295

1. From annual DPH budget of GOZ (1705)
2. From counterpart funds (490)
3. From ordinary DPH budget (100)

	U.S. $ (Equivalent) (000)
B. CNND	
- Personnel costs for CNND management and supervisory staff in project (10 at $4,160 x 5 years)	208[1]
- Personnel costs for secretary and partial salary for 6 part-time project personnel (4 x $3,100 x 5)	62[2]
- Receipt and warehousing contraceptives	150[1]
- Training costs	700[2]
- Local costs (administrative; travel and per diem for supervisors, transport commodities)	500[2]
- Informational materials	200[2]
- Support for evaluation	100[2]
- Other costs	50[2]
TOTAL	1,970

1. From annual budget CNND and in-kind value of warehousing (358).
2. From counterpart funds (1612). These funds are made available by the GOZ to the project from counterpart accounts. They will be managed in the project by CNND assistance to PMCU.

C. Private Sector Service Providers (CASOP, ECZ, etc.)	
- Personnel at centers (40 x 2,075 x 5)	415
- Local Costs (shipping, clinic costs, administration)	100
TOTAL	515
D. USAID	
- Personnel	
Short-term technical assistant (30 PM)	450
Long-term technical assistant (60 PM)	600
- Training	
Six long-term participants (72 PM)	200
Twenty-five short-term participants (90 PM)	250

	U.S. $ (Equivalent) (000)
D. USAID (Continued)	
- Commodities	
Vehicles (up to 15)	200
Motorcycles (up to 20)	40
Bicycles (up to 100)	20
Medical Equipment	
- 15 surgical centers	300
- 40 full clinic centers	80
- 20 partial clinic centers	20
Contraceptive supplies	1,180
Expendable medical supplies	200
Miscellaneous other materials (office equipment, educational materials, audio visual equipment)	200
- Other Costs	200
TOTAL	3,940
E. IPAVS	300
- Technical assistance for medical supervision/standards	
- Basic equipment/supplies for clinics offering sterilization	
TOTAL	300
F. JHPIEGO	300
- Technical assistance for curricula in medical/nursing schools	
- Training in reproductive health	
- Training for physician/nurses in laparoscopic procedures	
- Commodities - laparascopes	
TOTAL	300
G. IPPF[1]	300
- Contraceptives/training	
TOTAL	300

1. It should be noted that IPPF is the major funder of CNND but for purposes of this document their contribution in staff support has been identified as CNND participation in the project.

	U.S. $ (Equivalent) (000)
I. Peace Corps[1]	100
- Technical assistance (48 PM)	
TOTAL	100
PROJECT TOTAL	$9,920

1. Peace Corps will place one volunteer in Kisangani Training Center; as the project progresses, Peace Corps, DPH, USAID and the other participating agencies will explore the possibility of assigning Peace Corps Volunteers to service delivery centers.

All the above inputs are the normal components of a family planning pr--- with requirements for technical assistance, informational and educational materials (printed and audio-visual), transportation, commodities (medical equipment and contraceptives), training, personnel, supervision and evaluation All of these have been discussed in the project description or implementation plan with the exception of vehicles.

Vehicles will be provided as follows:

Program Management and Coordination Unit

-- For administration, coordination and supervision

1 small sedan
1 station wagon

CNND

-- For logistics of contraceptives and medical equipment

1 chree-quarter ton truck

Training Centers

-- For transport of staff and students and for coordination

3 mini-buses

Selected CBD Programs and Urban Centers

-- Where supervision requires vehicles to be considered.

Motorcycles and bicycles will be for local level supervision of community activities. Vehicles imported will be those for which spare parts and maintenance are available in Zaire (since projects are in the major urban areas this is not a particular problem). Costs of fuel and maintenance will be provided from

Zaire currency available to the project to ensure full mobility of project personnel, considered a key element especially of the logistics, training and supervision components.

VII. SUMMARY OF PROJECT ANALYSES

A. Technical Feasibility

This project takes an approach consistent with successful actions in Zaire and other countries to achieve fertility regulation. It builds on public and private sector institutions and programs already in place. It is consistent with the DPH and medical faculty's growing emphasis on primary health care. It will utilize the type of personnel most available to the system providing them skills that are within their demonstrated capacity. It is designed to minimize the burden on the government for the cost of extension, replicability and continuity. It does not introduce sophisticated technology or any approaches that have not already been demonstrated feasible in Zaire. The major issue of project feasibility, that of proper organizational arrangements to assure collaborative and effective implementation actions of participating institutions has been dealt with in consultation with all parties. The proposed system is determined feasible but must receive constant review. Annex F discusses at greater length concrete examples of the feasibility of each proposed project action.

B. Economic Analysis

The following analysis presents in a descriptive fashion the benefits and costs associated with the project. For reasons cited below, it is not appropriate or possible to quantify these benefits and costs.

The major benefit of the project is the improvement of maternal health care to project participants. It is important to note that this benefit is a result of the improvement of the clinical health delivery system. In other words, the family planning component provided by the project is designed to complement the maternal health services currently offered by the participating clinics. The isolation of the impact of the family planning component upon maternal health care would not be possible at this stage. There is insufficient data on the impact of current clinical services on maternal health care. Also, there is insufficient data on the impact of family planning services on maternal health care in Zaire.

A secondary benefit to the society as a whole is a reduction in the birth rate. It should be clarified that this represents an indirect benefit of the project and cannot be quantified. The goal of the project is to increase the prevalence of family planning services. It is recognized that the success of this goal would lead to some degree of reduced births. Currently, Zaire's growth rate is 3.2%. This can be considered relatively high in the face of a stagnant growth rate in economy which has persisted for the past few years. It is recognized that it is not possible to draw a direct relationship between a reduced birth rate and an improvement in per capita GDP. Nevertheless, it

is fair to say that if a stagnant economy continues, Zaire will not be capable of productively employing or improving the current welfare of all its citizens except at the expense of others in the society.

The economic costs of this project to society are not possible to quantify for the following reasons. The family planning services represent only one component of the maternal health services offered by the clinical system. In order to measure benefits and costs accurately, total benefits and costs of maternal health care and improvement must be estimated. There is insufficient data on the current costs and benefits of maternal health care services by the clinics as well as the projected costs and benefits of a family planning component to accurately carry out a benefit/cost analysis.

The costs of the family planning component can be compared to other projects only with a great deal of caution and reservation. First of all, there is very little precise data on family planning projects in comparable circumstances. Some studies exist for countries in Africa; however, the programs are quite different in approach and substance from this one. Most of these programs are offering only family planning services, rather than family planning services in conjunction with other components of maternal health care. Also, these programs utilize different delivery systems than the proposed project. For example, community-based distribution or retail marketing delivery systems cannot be compared with a clinical-only means of delivery service because of the inherent cost differences. REDSO/WA has estimated a range of average costs for providing family health services in Africa. The data is based on a survey of existing programs in Africa and abroad; however, the estimates were adjusted to compensate for the conditions in Africa. These estimates are measured according to the cost per couple/year of protection (CYP). For the clinical-only method of service distribution, the average cost range is $30-$50 per CYP. The estimated cost per CYP of the proposed project is $30. This estimate includes all local and external financing of the project. Therefore, the average cost per unit of output for the proposed project falls at the low end of REDSO's estimate.

C. Social Soundness Analysis

The proposed project has strong potential for realizing its objectives because there is almost no organized opposition to family planning in Zaire. The 1973 declaration of the President in favor of "Desired Births" opened the door to active family planning efforts, of which the proposed project is a key component.

In considering the potential for the adaption of modern contraceptives, recent data from the Tulane Operations Research project in Bas-Zaire provides support for the acceptability of modern contraceptives by the populace. The project has found that 55% of the eligible population contacted becomes initial acceptors. Furthermore, it was found that 79% of those acceptors tried the method and 51% were still using it six months later.

A related issue is the acceptability of the service locations to be used in this project: DPH hospitals and dispensaries. The vast majority of the population relies on these facilities and thus they are familiar to the target population. It is appropriate to introduce widespread family planning in the urban areas as part of the existing health services, since the motivation of the target population for family planning is health-related. This factor outweighs the associated cost of clinical-only method of delivery.

It is also expected that the proposed project will produce spread effects among various sub-groups of the population and beyond the urban areas. The initial women using the family planning services successfully will become role-models for the remainder of the population.

The social consequences are expected to be most significant for those women who participate in the program and are able to achieve their fertility ideals using efficient contraceptive methods.

VIII. IMPLEMENTATION PLAN

A. Organizational Plan

The basic organizational structure has been developed to provide a centralized planning and supervisory unit, placing discrete implementation responsibilities in the existing Zairian institutions (CNND, DPH, ECZ, CASOP, etc.). This structure evolved as a result of the lengthy process of discussions and work sessions in project design by CNND, DPH and USAID. It responds to the review of the tasks to be accomplished, the interests and capabilities of the several institutions and the particular interest in developing a type of coordination that facilitates independent initiative and builds the program into the present structures as much as possible. In these discussions a more operationally independent structure was considered that initially probably would have been more efficient and fast moving. This was rejected by the project design team in favor of the present system which seeks to build the functions of the project into the existing institutional structures.

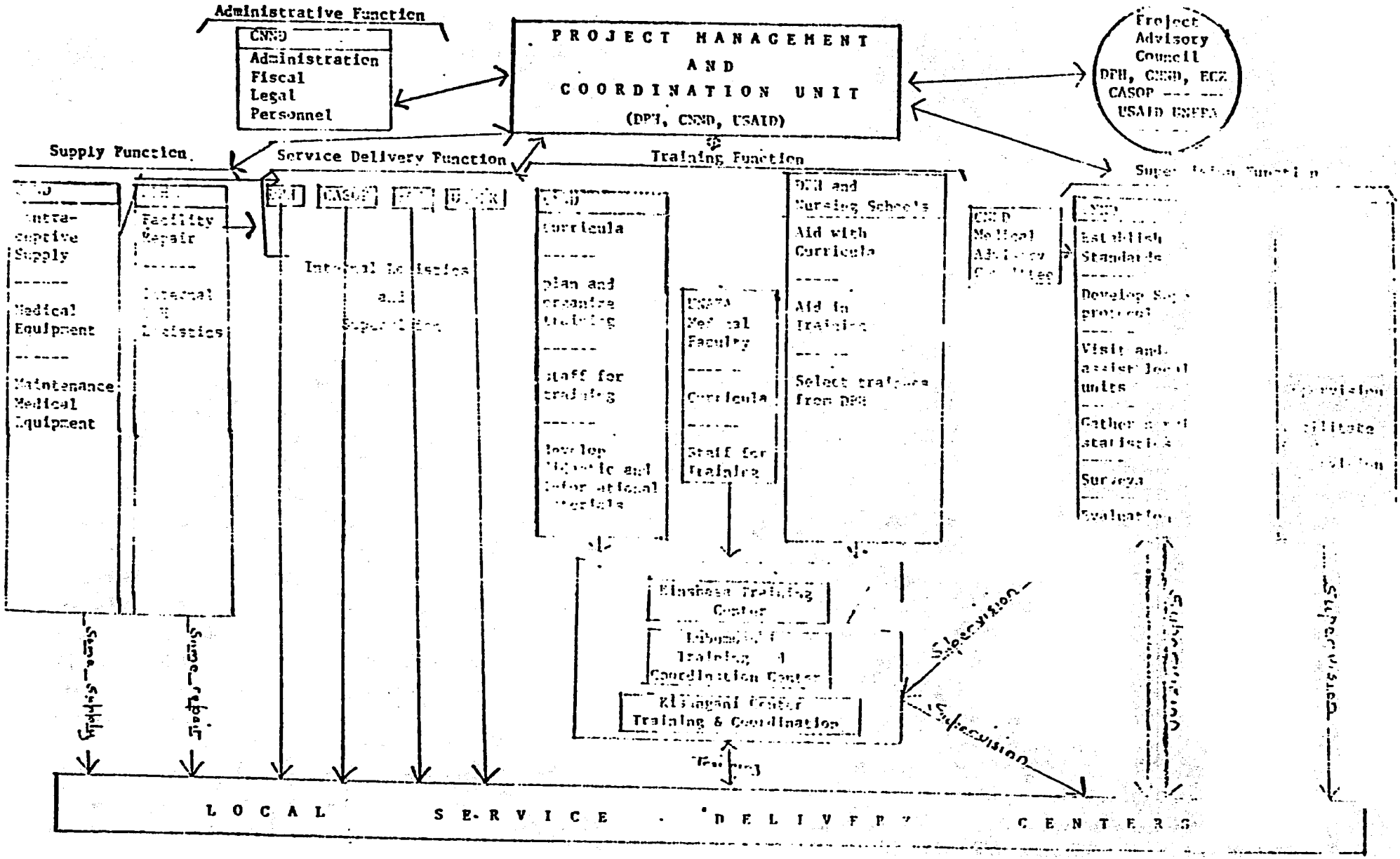
The attached organizational chart provides for:

1) A Project Advisory Council (PAC) to provide a forum for top leadership of the participating agencies to discuss and review the program and assure the fulfillment of their institutional responsibilities.

2) A Project Management Coordinating Unit (PMCU) comprised of a Director provided by the DPH, two Assistant Directors provided by CNND and an Assistant Director who is the USAID-provided long-term consultant. This unit handles the day-to-day project planning and supervision.

3) Administrative, supply, service delivery, training and supervisory functions are assigned to the several institutions with specific responsibilities identified. Staff needs have been identified for each function which has provided for some strengthening of these agencies' capacities to carry out the responsibilities identified.

(See Annex D for more detail)


Administrative Function
CNSD
Administration
Fiscal
Legal
Personnel
PROJECT MANAGEMENT
AND
COORDINATION UNIT
(DPH, CNSD, USAID)
Project
Advisory
Council
DPH, CNSD, ECZ
CASOP
USAID
Supply Function
Service Delivery Function
Training Function
Facility
Repair
Medical
Equipment
Maintenance
Medical
Equipment
Curricula
plan and
organize
training
staff for
training
Develop
DCH and
Nursing Schools
Aid with
Curricula
Aid in
Training
Select trainees
from DCH
Curricula
Staff for
Training
Establish
Standards
Visit and
assist local
units
Surveys
Evaluation
Supervision
Supervision
Supervision
Supervision
Kinshasa Training
Center
Training &
Coordination Center
Kilangani Center
Training & Coordination
LOCAL SERVICE DELIVERY CENTERS

B. Monitoring and Evaluation Plan

1. Ongoing Monitoring and Evaluation

The overall project monitoring will be provided by USAID, DPH and CNND through their representative on the Project Advisory Council (PAC). They will receive and review reports prepared by project staff as well as review internally the reports of their personnel assigned project responsibilities.

Day-to-day management and monitoring the project activities will be provided by the Project Management and Coordination Unit (PMCU) with three professional full-time (USAID, CNND and DPH) and one half-time. Monitoring of specific project functions will be carried out by the chiefs of the various functional units of administration, supply, training, and supervision. Their capabilities will be supplemented by Peace Corps Volunteers where appropriate.

There is special provision made for a supervisory team to carry out the ongoing monitoring and evaluation functions. There will be several basic sources of information for evaluation:

(a) Commodity flow reports from the supply function group of CNND.

(b) Evaluation reports of each of the training courses.

(c) Service statistics prepared by the local service providers with the assistance of the supervisory team.

(d) Regular field reports of the supervisory team.

(e) Specific surveys from time to time.

Based on this information, the staff of the supervisory function under the CNND will develop a quarterly and annual report for the PMCU to use in reporting to the PAC and the several donors and participating institutions.

2. Periodic Evaluations

(a) Two Year Evaluation

At the end of the second year of project operations, there will be an internal evaluation carried out by a joint commission of CNND, DPH, USAID, IPPF, and other donors to the degree they have been involved. Local costs are budgeted. The purpose of this evaluation will be to identify the degree to which the necessary systems are in place and effectively operational. Attention will be given to quantitative measures of specific project objectives, but these measures will be used largely to evaluate the functionality of the systems rather than evaluate project achievements. The major questions to be answered will include the following:

(1) Has the organizational structure (including PAC, PMCU and functional areas) provided for appropriate collaboration between various institutions, organizing and managing this program in an effective and efficient fashion?

(2) Have the appropriate implementation systems been developed and are they operational in the several functional areas?

(a) Is the administrative support organized to provide adequate program budgeting and control, legal advice and personnel standards?

(b) Is the supply function appropriately organized and operational to provide advance planning, commodity ordering and receipt, warehousing, internal logistics and commodity flow reporting? Are proper procedures in place and functioning to assist local institutions in facility repair and refurbishing? Has a capability been developed for repair and maintenance of family planning medical equipment? Are DPP, CASOP, ECZ, and industry supply channels being utilized effectively for commodity supply?

Are the proposed training systems in place and functioning? Are there one to three training "centers" where in cooperation with medical nursing faculties, didactic training and practical experience at the clinical and community level are available? Are courses being held and evaluated? Have didactic and informational materials been prepared? Are procedures established and progress being made on developing pre-service medical and nursing curricula in family planning?

Are clinical services being provided in several locations in each of the cities? Is there at least one community-based distribution organized in several of the cities? Some measure of users should be taken but this will not be the major focus at this time.

Have the supervisory protocols been developed, utilized and proven useful? Has the medical advisory committee been involved in reviewing standards and performance? Are adequate supervisory visits being made and appropriate assistance being given to local institutions to identify trainees and arrange for their training? Are arrangements being made for other institutional needs of equipment, repair and commodities? Is the

service statistics system in place, utilized by local institutions and are supervisors assisting local personnel to produce information for a complete quarterly report of family planning users?

(f) Have effective actions been taken to involve and keep informed the appropriate institutional and society leaders to assure project success, i.e., DPH leadership, regional medical inspectors, governors, CASOP, industry, city authorities and private organization leaders?

(3) How well has the project been coordinated with other population/family planning activities such as the Basic Rural Health project, Tulane Operations Research, FPIA and Pathfinder supported activities?

(4) Have the participating institutions made adequate arrangements for their financial support at this stage and for growth to cover future needs for expansion and continuity?

(5) What changes are necessary in organization and policy, or in the functional areas to assure the most effective project implementation?

3. Fourth Year Evaluation

(a) Contraceptive Prevalence Survey

It is expected that the Westinghouse Health Systems health and contraceptive prevalence survey which is presently in the data collection phase of operations in Zaire can be repeated during the fourth or fifth year of this project to provide, inter alia, a measure of the increase in contraceptive prevalence in the urban areas. This increase would be largely as a result of project efforts since we do not foresee much growth of other channels of contraceptive supply during this period.

(b) A Comprehensive Project Evaluation

This will be completed in the third quarter of the fourth year, in time to provide guidance for program planning and budget for the last year and plans and decisions for project follow-on.

This evaluation will be a joint GOZ/USAID review with the participation of a local professional and of consultants provided by REDSO/WA, USAID/W, and/or centrally-funded evaluation contracts. Local costs are budgeted in the project.

The evaluation will review the issues of the year two evaluation protocol but it will also measure the effectiveness and efficiency of the use of project inputs to achieve the objectives specified in the Project Design.

(c) Personnel Requirements

The personnel required by CNND and DPH are identified in Annex D. These are almost all staff who are presently employed, but whose responsibilities will be shifted to carry out the functions of this project.

USAID personnel requirements are limited but it is essential that they be provided. USAID's U.S. direct-hire staff has recently been brought to full strength in the Public Health Office with a Public Health Officer, a Population Officer who is directly responsible for this project, a secretary and two FSN professional staff. As the project gets into its first year of implementation, it may prove necessary to add an additional FSN for monitoring of field activities.

Much of USAID's day-to-day management responsibilities will be handled by the person contracted by the project to work full time as part of the PMCU.

C. Implementation Schedule

As noted in the timing chart, the first year of project activities will be devoted to organizing the PMCU, procurement of project commodities, orienting key ministry officials re project activities, preparation of a detailed work plan and development of training cirricula. In addition to this preparatory work, two training sessions will be held for 30 service providers and 15 centers will initiate family planning services.

During this first year of project activities it is not planned that a percentage of the total of new acceptors expected will be attained nor will the data system be completely established.

During the first year, the project will identify those centers in need of physical refurbishment and will prepare, plan and budget for this work. Actual work on the first center will begin towards the end of the first year of project activities.

At the end of the first year of project activities the PMCU will prepare a detailed work plan and schedule for years two through five.

Timing of Planned Activities for First 12 Months

Date	Action	Primary Responsibility
August 31, 1982	- Approval of PP	USAID
September 30, 1982	- Pro-Ag Signed - First tranche of Project Funding obligated (FY 82)	USAID-GOZ
October 1982	- Vehicles and first group commodities ordered	USAID-GOZ
	- Recruiting for long-term TA begins	USAID
November 1982	- Project Office established; project personnel lined up	DPH-CNND-USAID
	- Ministry (CNND) identifies personnel to work on project	DPH-CNND
December 1982	- Preparation of Counterpart Fund request for 1983	PMCU
	- Preparation of Work Plan for 1983	PMCU
	- Long-Term TA selected	PMCU-USAID
January 1983	- Long-Term TA arrives	USAID
	- Detailed Work Plan for 1983 finalized	PMCU with TA input
	- All personnel in-place in project	USAID/DPH/CNND
	- Counterpart Fund account established	PMCU
	- FY 1983 funding obligated	USAID-GOZ
February 1983	- Second group of commodities ordered	USAID-GOZ
	- First seminar of orientation held for medicine inspectors and other opinion leaders	PMCU Training Unit/DPH/CNND
	- Seminar for curriculum development and training of trainers	PMCU/CNND/UNAZA Consultants
	- Arrangements for training center completed	PMCU/Training Centers/ Participating Agencies

Timing of Planned Activities for First 12 Months

(Continued)

Date	Action	Primary Responsibility
March 1983	- First group of participants selected for training (15)	PMCU
April 1983	- First training session held for service providers in first training center	PMCU/Training Center
	- Short-term experts begin work in statistics data gathering	PMCU/USAID
	- Data collection system revised	PMCU/USAID/Short-Term TA
	- First meeting of Project Advisory Council (PAC) held	PMCU/PAC/USAID
May 1983	- First group of participants for masters level training identified	PMCU
	- Contraceptive commodities placed in first group of service centers	PMCU/Participating Agencies
	- Service-related medical commodities arrive and placed in service centers	PMCU/Participating Agencies
June 1983	- First group of service centers begin offering services	PMCU/Participating Agencies
	- Vehicles arrive	USAID
July 1983	- First semi-annual report prepared	PMCU
	- In-house review of project	PMCU/PAC/USAID
August 1983	- Second group of commodities arrive	USAID
	- Second training seminar held for group of 15 service providers	PMCU/Participating Agencies
	- First group of master's level training candidates begin training	PMCU
	- Centers identified for refurbishment	PMCU

D. Financial Analysis and Plan

The project's service delivery system will generate funds from user fees. These funds will be used to offset the costs of providing the services and replenishing clinic and other consumable supplies. Since the family planning services will be delivered in already established clinics, the additional cost of these services and the fees charged will be minimal and within the financial means of the target group.

As a result of using existing facilities and charging fees for service, the recurrent operating costs of the project to be borne by the participating clinics will be minimal. The majority of the project's inputs will be used for the organizational training and supervisory functions necessary to initiate the service delivery system. Once this has been done, it is planned that the key external project inputs viz. FX and counterpart funds will be terminated without damaging the system that has been set up. However, given the cost of the contraceptive commodities, their unsubsidized sale to users will probably be beyond their present economic capacity. It is also highly unlikely at this time that the GOZ will be able to provide the necessary foreign exchange to provide contraceptive commodities anytime in the foreseeable future. Therefore, it will be necessary for the system to explore alternative sources for continuing contraceptive supply after the PACD. There are several possibilities. First, USAID could continue to supply dollar funded contraceptives on a bilateral basis after PACD. A second option would be to resupply via centrally funded intermediaries. A third possibility would be through international organizations working in family planning. Regarding option two, Pathfinder and FPIA have been providing contraceptives to Zaire for several years. They have stated their willingness and ability to increase contraceptive supplies to Zaire if there is a need. They have also increased their Zaire budgets considerably over the last few years and have expressed a willingness to continue this trend.

Regarding option three, UNFPA has not yet provided contraceptives as part of their program. They have, however, expressed their total commitment to do so if the GOZ requests assistance. IPPF has been providing contraceptives to Zaire since 1973. Their overall contribution as well as the flow of contraceptive commodities has increased regularly and substantially. The value of their contribution to Zaire in 1981 totaled US$274,000. Because Zaire is considered an IPPF priority, funding for 1982 is planned at US$452,000 and is expected to continue to increase. IPPF has expressed its willingness to increase contraceptive supplies to meet the demand for services that will be created by, inter alia, the Family Planning Services project. In this connection, IPPF and UNFPA have been involved in all aspects of the conception and design of this project.

In summary, while USAID is preparing to supplement commodity provision to assure timely attainment of project objectives, various other donors are already aware of the resulting increased demand and are prepared to pick up the shortfall after the USAID project commodity inputs end in 1987.

At the same time programs should be designed to develop self-sufficiency. During the life of the project, the GOZ will be expected to increase its budgetary contributions for operational support. In any follow-on activity, a trust fund account will be considered for local currencies for project support, generated by and matching the value of imported commodities.

On a larger plane the project will be providing maximum benefit to the most beneficiaries at the lowest cost possible for a clinic-based system. The design team has looked carefully at the funds necessary for project implementation, especially training and supervision, and believes that adequate funding in both local currency and foreign exchange has been provided for. The following tables present the summary financial plan.

TABLE I

Illustrative Budget for USAID Contribution ($000)

	Year 1	Year 2	Year 3	Year 4	LOP[1]
Technical Assistance	294)	(84)	(474)	(198)	(1,050)
Long-Term (60PM)[2]	216 (24PM)		384 (36PM)		600
Short-Term (30PM)[3]	78 (6PM)	84 (6PM)	90 (6PM)	198 (12PM)	450
Training		(149)	(150)	(151)	450)
Long-Term Out of Country (75PM)		83 (25PM)	83 (25PM)	84 (25PM)	250
Short-Term Out of Country (72PM)		66 (24PM)	67 (24PM)	67 (24PM)	200
Commodities	(1,030)	(830)	(380)		2,440)
Vehicles	200				200
Motorcycles	20	20			40
Bicycles	10	10			20
Medical Equipment	200	200			400
Contraceptives	400	400	380		1,180
Medical Supplies	100	100			200
Other - AV Aids, Office Equipment, Spare Parts	100	100			200
Other Costs	40	47	55	58	200
TOTAL	1,364	1,110	1,059	407	3,9 0

1. Total Life of Project
2. Long-Term Technical Assistance estimated at $9,000 per PM for first two years and at $10,666 per P for last three years of project activity.
3. Short-Term Technical Assistance estimated at $13,000 per PM for year one, $14,000 per PM for year two, $15,000 per PM for year three and $16,500 per PM for years four and five.

TABLE II

ILLUSTRATIVE BUDGET GOZ CONTRIBUTION VIA COUNTERPART AND REGULAR BUDGET DPH

Item	Year 1 (000 £)	Year 2 (000 £)	Year 3 (000 £)	Year 4 (000 £)	Year 5 (000 £)	Total Life of Project (000 £)
1) PERSONNEL	(72)	(72)	(72)	(72)	(72)	(360)
Salary and benefits for administrative personnel paid partially or in full by project	72	72	72	72	72	360
2) TRAINING IN-COUNTRY	(450)	(945)	(965)	(910)	(780)	(4050)
Travel and per diem of trainers and participants, materials, locale, institutional reimbursement for didactic and practical training, honoraria, POL						
a) Curriculum development seminar and training of trainers	100	100	-----	-----	-----	(200)
b) Five week (average) courses for nurses and paramedical service providers	300	700	800	750	600	3150
c) Three day (average seminars and workshops for managers, supervisors, public and private sector leaders	50	125	125	100	100	500
d) Local training for community workers	-----	20	40	60	80	200

TABLE II

ILLUSTRATIVE BUDGET GOZ CONTRIBUTION VIA COUNTERPART AND REGULAR BUDGET DPH

(Continued)

Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total Life of Project
	(000 Z)	(000 Z)	(000 Z)	(000 Z)	(000 Z)	(000 Z)
3) COMMODITIES	(200)	(975)	(1300)	(600)	(335)	(3410)
a) Informational and didactic materials, booklets, brochures, posters, flipcharts	200	350	300	200	110	1160
b) Materials and supplies for refurbushing and equipping clinics - paint, plumbing and electrical materials, roofing, glass, curtains, tables, benches, initial supplies of locally available expendables	-----	625	1000	400	225	2250
4) OTHER COSTS	(490)	(1240)	(910)	(1370)	(910)	(4920)
a) Administrative Costs - Office PMCU, utilities, paper, forms, POL for PMCU and functional units	90	150	210	210	210	870
b) Supervision - travel and per diem PMCU central supervisory team, and regional coordinators Kisangani, Lubumbashi, POL for supervision, local costs of surveys	300	850	580	580	580	2890
c) Evaluation - local costs, travel and per diem, honoraria local consultant, secretarial support, local costs of surveys	-----	120	-----	460	-----	580
d) Miscellaneous - Supplementary transport of commodities and supplies, mass media communication	100	120	120	120	120	580

TABLE II

ILLUSTRATIVE BUDGET GOZ CONTRIBUTION VIA COUNTERPART AND REGULAR BUDGET DPH

(Continued)

Item	Year 1 (000 £)	Year 2 (000 £)	Year 3 (000 £)	Year 4 (000 £)	Year 5 (000 £)	Total Life of Project (000 £)
5) TOTAL	(1,212)	(3,232)	(3,247)	(2,952)	(2,097)	(12,740)
a) Regular DPH Budget	80	80	120	140	160	580
b) Counterpart	1,132	3,152	3,127	2,812	1,937	12,160

NOTES: 1) No allowance for inflation - years two through five will require additions for inflation.

2) This does not include the in-kind contribution of DPH for clinic personnel and clinic operations estimated at 9,840,000£.

TABLE III

ILLUSTRATIVE BUDGET FOR CNND CONTRIBUTION

Item	Year 1 (000 $)	Year 2 (000 $)	Year 3 ())) $)	Year 4 (000 $)	Year 5 (000 $)	Total Life of Project (000 $)
1) PERSONNEL						
Management, personnel, trainers, supply and supervision	40	42	42	42	42	208
2) OTHER COSTS						
Receipt and warehousing contraceptives	10	25	35	40	40	150
3) TOTAL	50	67	77	82	82	353

ANNEX A

AID 1020-25 (5-79)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

Life of Project:
From FY 83 to FY 87
Total U.S. Funding 3,940,000
Date Prepared: August 1982

Project Title & Number: Family Planning Services 660-0094

PAGE 1

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) To increase the use of voluntary family planning services among Zairian families, assisting them to space their children and to have the number of children they desire.	Measures of Goal Achievement: (A-2) Contraceptive prevalence in Zaire will increase from approximately 2% to 6% by 1987 increasing thereafter to expected levels of approximately 30% by the year 2000.	(A-3) Contraceptive prevalence survey; service statistics; reports from commercial suppliers	Assumptions for achieving goal targets: (A-4) Basic Rural Health services project implemented, adding to Rural F. P. service; policies/activities that support CNND continue GOZ makes increasing financial support available for family planning program.
Project Purpose: (B-1) To increase contraceptive use in 14 urban areas from approximately 3-5% of couples of fertile age to 12% by 1987.	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2) Approximately 12% of the couples of fertile age will be using modern contraception in the 14 urban areas included in the project. At least 80% of the couples will know about one or more methods of modern contraceptives and will know where to obtain supplies	(B-3) Contraceptive prevalence surveys; service statistics; reports from commercial suppliers	Assumptions for achieving purpose: (B-4) CNND reorientation and realignment of functions occurs; Project Advisory Council with all donors and Zaire participating agencies established and functioning; health delivery networks provide expected policy and material support to enable appropriate quality service delivery including extension of services to community. DSP and CNND develop and maintain an effective collegial working relationship.

AID 1240-20 (11-7-)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 81 to FY 87
Total U.S. Funding 3,940,000
Date Prepared: August 1982

Project Title & Number: Family Planning Services 660-0094

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1) 1. Management/coordination system 2. National training centers 3. Re-trained personnel for service delivery 4. Family planning service sites established 5. Family planning introduced into curricula for medical and nursing schools. 6. New family planning clients and continuing users. 7. Improved data collection system functioning adequately. 8. Commodity distribution system functioning adequately. 9. Informational materials for use in client education.	Magnitude of Outputs: (C-2) 1. One system involving three or more Zaire service networks. 2. Three training centers. 3. 200 family planning service providers retrained. 4. 75 urban service sites established, 15 providing elective sterilization and 15 with satellite community-based distribution. 5. One curriculum for medicine, one for nursing schools. 6. 250,000 new acceptors by 1986; 125,000 continuing users by 1987 7. One comprehensive national system. 8. No stock outs; minimum one year supply on hand in national warehouse; minimum of 6 months supply on hand in service sites. 9. French language and at least one local language materials.	(C-3) 1. CNND project reports, USAID observations; 2nd year evaluation. 2&3. Training center records. 4. Supervisory Reports and annual evaluation. 5. Published curricula 6. Service statistics collected by CNND. 7. Project evaluation; compare published service statistics with clinic records; one system in use by all FP service providers. 8. Warehouse and clinic records 9. Published material. 1-9. 4th year evaluation.	Assumptions for Achieving Outputs: (C-4) 1. Continuing DPH favorable policy evolution and harmonious CNND/DPH relations. 2. Resources made available to project in a timely fashion. 3. Qualified candidates recruited. 4. Schools accept proposed curriculum. 5. Services provided respond to demand (in terms of accessibility). 6. Participating organizations accept standardization. 7. Donors make contraceptive commodities available on a timely basis. 8. Resources available and contractor can be secured.

AID 1020-20 (5-73)
SUPPLEMENT A

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Family Planning Services 660-0094

Life of Project:
From FY 83 to FY 87
Total U.S. Funding 3,940,000
Date Prepared: August 1982

NARRATIVE SUMMARY	Cost (000)	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)		Implementation Target (Type and Quality (D-2)	(D-3)	Assumptions for providing Inputs: (D-4)
. AID				
ST Technical Assistance (30 PM)	450			
LT Technical Assistance (60 PM)	600			
ST Training (72 PM)	200			
LT Training (75 PM)	250			
15 Vehicles - Pick-Ups	200			
25 Motorcycles	40			
100 Bicycles	20			
Medical Equipment for 75 Centers	400			
Contraceptive Supplies	1,180			
Expendable Medical Supplies	200			
Misc. Materials (Office equipment, Educational aids)	200			
Other costs	200			
TOTAL	3,940			
II. GOZ				
Personnel Costs for DPH Management & Supervision	145			
Personnel Costs and Operating expenses for 75 centers	1,560			
Repair/Refurbishing of 75 Centers	390			
Local DPH costs (fuel, per diem, travel, training, shipping)	200			
Local project costs provided from counterpart to be administered by CNND:				GOZ DSP receives budget request; DCMF air freight works well and is continued.
Supplementary project personnel costs	62			

AID 1220-30 (1-82)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 87
Total U.S. Funding 3,940,000
Date Prepared: August 1982

Project Title & Number: Family Planning Services 660-0094

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quality) (D-2)	(D-3)	Assumptions for Providing Inputs: (D-4)
	Cost (000)		
II. GOZ (Continued)			
Local project costs provided from counterpart to be administered by CNND:			
Training Costs	700		
Local Costs (travel, supervision, shipping)	500		
Informational materials	200		
Evaluation	100		
Other	50		
TOTAL	3,907		
III. CNND			
Warehousing for contraceptives	150		
Personnel Costs	208		
TOTAL	358		
IV. PRIVATE SECTOR-Zaire			
Personnel & local costs	515		
V. UNFPA			
Technical Assistance Contraceptives	200		UNFPA receives requested budget
VI. IPAVS			
Technical Assistance Commodities	300		IPAVS receives requested budget IPAVS approves increased allocation for Zaire
VII. JHPIEGO			
Technical Assistance Training & Commodities	300		JHPIEGO receives requested allocation for Zaire
VIII. IPPF			
Contraceptives	300		
IX. Peace Corps			
350 PM of 6 plus technical assistance	100		Peace Corps can recruit PCVS and receives budget necessary to support them.
TOTAL ALL DONORS	9,920		

ANNEX B

FAMILY PLANNING POLICY AND STATUS

1. General

Although the legal basis and principle of family planning was established in 1972 and 1973, the strategy for implementing it has evolved rather slowly. From 1973 to 1981, the CNND worked with various private (church) organizations and some GOZ medical facilities to initiate family planning within the context of Maternal Child Health programs. USAID assisted with this effort through its MCH/FP Project 660-0049. This project integrated the full range of non-surgical family planning activities into two DPH health centers in Kinshasa. Other USAID-funded donors expanded this effort to more clinics in other geographical areas in the late 1970s. These included Pathfinder, FPIA, and the International Project, Association for Voluntary Sterilization (IPAVS).

Recently, the DPH has increased the attention of its own program to the issue of ready availability of family planning services to the general public. In February, 1981, the GOZ elaborated its Public Health Policy that would lead to Zaire's goal of "health for all by the year 2000." This policy focused on providing prevention and cure for the ten most prevalent serious health problems. One of the principal strategies for combatting the problems is provision of the full range of family planning and education and services in all GOZ health care delivery systems. To this end, the USAID bilateral project "Basic Rural Health" (660-0086) is expanding primary health care including family planning through 250 rural Protestant Missions (ECZ) and GOZ health centers in 50 rural zones. It is planned that this project will have 150,000 new acceptors by 1987.

In a series of meetings and planning conferences in late 1981, the GOZ DPH recognized that urban life was creating some serious health and social problems. These included:

-- lack of access to basic health services

-- rise in malnutrition

-- increase in induced abortions to terminate unwanted pregnancies

-- incapacity of many families to provide adequate food, lodging and education for their children

-- increased incidence of infant/child abandonment.

As a result of these observations, the DPH has recognized the special need for an effective program of 'Naissances Desirables' in the urban areas. The GOZ has approached USAID for assistance in this task.

The CNND has collaborated during the last seven years with various organizations in providing information and education on the use of family planning services. In approaching this task, CNND has relied on establishing clinics in the DPH, private companies, and especially the Eglise du Christ au Zaire (ECZ).

CNND also has called on the assistance of various international organizations. Many of these, such as FPIA, Pathfinder, IPAVS, have collaborated with IPPF to assist with both the procuring and delivery of family planning commodities and services to Zaire. These organizations have assisted with small grants for training and start-up of service delivery. While these small projects have been valuable in initiating services, and in demonstrating the need for and receptivity to services in Zaire, they have the following limitations:

-- limited impact (small scale);

-- lack of coordination with other groups working in health and family planning, especially DPH;

-- high per unit of services cost of supervision; and

-- limited resources.

As noted elsewhere, the Tulane University Operations Research project is providing services in urban and rural areas of Bas-Zaire. Its more important contribution will be the lessons to be learned for national planning.

UNFPA assistance to date has been largely for demographic statistics collection and planning. We expect that through collaboration with this project they will be increasing their emphasis on service delivery, specifically through assistance to training programs and provision of some contraceptive commodities.

The report of the CDC/APHA evaluation of CNND indicates that there are at present 95 "antenna" affiliated to CNND which deliver all family planning methods and 83 centers which are only supplied with non-clinical methods. Their organizational affiliation is as follows:

DPH	ECZ	Catholic Church	Other	Total
130	32[1]	3	13	178

1. There are a number of "Satellites" to ECZ "antenna" which are not recorded in the CNND listing (field visits by PID review suggest many of the DPH, while potential providers, are presently offering little, if any, services On the other hand, the ECZ and Catholic Church involvement appears stronger than these figures suggest).

The following simple criteria must be met with the health facilities which request affiliation:

a) that there is a stated interest to delivery family planning services by a health facility and/or organization. Individuals are not eligible;

b) that the personnel of the health facility have appropriate training before they begin providing "clinical" contraceptive methods, which are defined as IUDs and Depo-Provera. The CNND provides other methods, including the Pill, immediately upon receiving the original request for affiliation; and

c) that regular service statistics and supply management reports be submitted to CNND.

In addition to those formally recognized affiliates of the CNND, many distributors (churches, private clinics, hospitals) have initiated family planning services on their own. No definitive data is available but the recent PID review team estimated that there may be as many as 50 service providers that have no direct contact with CNND. Despite this initial progress in family planning delivery that is unique in Francophone West Africa, improvements are needed in processing applications, the organization of training, the provision of contraceptives, supervision, gathering of service statistics and evaluation.

These problems (along with potentials) are identified in the CNND evaluation. This project expects to provide the technical assistance and material support to alleviate the difficulties, which are discussed in the following paragraphs.

2. CNND Evaluations Findings

At USAID/Zaire's suggestion, the CNND was evaluated in February, 1982 by a team of family planning specialists.[4] Their findings are summarized as follows:

-- CNND has a core staff of well trained, energetic workers who have been making an important contribution to family planning in Zaire.

-- CNND's limited resources and small staff were being used in a myriad of activities; as a result, the CNND has not concentrated on or been an effective coordinator of family planning services in Zaire.

-- CNND statistics reflected only a small portion of service providers and that present reporting is cumbersome and of limited use for planning and evaluation.

-- Information and Education Programs have consumed the largest part of CNND's budget and staff time; as a result there is presently a demand for services that is not being met.

A summary of the evaluation team's recommendations follows:

-- That CNND devote its limited staff and resources to coordinating activities of other organizations working in family planning.

-- That the CNND concentrate on training, statistics gathering, evaluation and ordering, stocking of contraceptive supplies.

-- That IPPF review its assistance package to CNND with an eye to increasing contraceptive commodities and to decreasing allocations for Information and Education activities.

-- That short-term technical assistance be made available to CNND in the areas of supply, logistics, service statistics and record keeping.

4. Zaire: Program Evaluation of the Comite Nationale des Naissance Desirables (CNND), January 20 - February 10, 1982 (Center for Disease Control, March 12, 1982).

The mission has reviewed the CNND report and concurs in the recommendations as does the CNND. Apparently, there was some underestimation of the value of contraceptives donated "in-kind" and the imbalance between contraceptives and information and education activities is not as great as the report suggests. However, the point is still well taken. Demand is ahead of supply and it is appropriate to focus more attention on supply. Shortages of contraceptives have been a problem and stock-outs have occurred. A major objective of this project is to resolve those problems.

The PID review team findings are consistent with this report with the caveat that, while increased relative emphasis should be given to service delivery, within these service delivery programs, appropriate attention should continue to be given to informational communication.

3. Standards for Health and Family Planning Service Delivery

In reviewing the policy direction and standards of health care to be pursued in Zaire, there is guidance in the DPH's diagnosis of the problem (Page 2 of the Plan of Health Action 1982-86). "At the time of Independence our country inherited a group of well developed services that was able to provide promotion, prevention and curative services to a significant portion of the population. We were not able to maintain that system due to financial, equipment and personnel shortages. The system has progressively developed into a model based on western medical structures which, despite their undenied good intentions have come to provide very costly curative care to a minority of the population."

The Plan of Action seeks a more cost effective, preventive emphasis, more relevant to the conditions of Zaire and more accessible to the majority. This is articulated (page 9) as follows:

> "The principle objective is to make health care geographically, economically, and culturally accessible...saving the community the great distance necessary to receive health care must be considered an absolute priority...the service must be designed so the community or individual can afford it...the services must be acceptable to those for whom it is provided, must be adapted to their priority needs and of satisfactory quality."

The implications of this intent to develop a system of care and standards of service relevant to Zairian conditions are reflected in the project proposed in this document.

The CNND has been given a policy development, standard fixing role vis-a-vis family planning. The DPH provides some regulatory oversight. There is dependence on the certification and qualification of physicians at the implementation level to utilize accepted medical practice. CNND basic standards are those of IPPF; in case of sterilization those of IPAVS.

Current medical standards are in the process of development as service providers are gaining more experience with a young program.

Oral contraceptives can be purchased in pharmacies without a prescription, although accepted medical practice is that they should be dispensed under medical supervision. Medical supervision is interpreted by CNND instructions to mean by a trained person (usually a nurse) working in a system which has access to medical supervisors. Frequently, but not always, a simple gynecologic exam is involved as well as blood pressure. A check list of possible contra-indications is applied. IUDs are inserted by physicians or by trained nurses under medical supervision. Tubal ligations are only performed by surgeons, under the same standards applicable to other abdominal surgery. Where laproscopes have been provided by JHPIEGO or other equipment by IPAVS, the standards for training and ancilliary equipment have been upgraded and informed consent has been regularized and documented. These forms meet the requirements of USAID policy determination No. 70.

There are some additional standards, which reflect present cultural and religious attitudes. For example, the policy is generally applied to provide contraceptives only to couples where both parties have indicated their consent. Generally, the contraceptives are provided to adolescents only with parental consent. Age, parity and spousal consent requirements related to tubal ligation are conservative and restrict service availability. As an indication of non-pregnancy, it is frequently required that women come for an initial supply of contraceptives during their menstrual period.

Both the DPH and the CNND have been involved in establishing and reviewing these standards as well as supervising their compliance. An indication of care in this regard is the high number of physicians, nurses and administrator who have been sent to JHPIEGO to improve their skills (43 to date). Additionally, there have been twenty or more nurses sent to other international training such as that at Downstate Medical Center to improve their clinical and training skills.

There are qualified physicians in the DPH reviewing the issue of standards. The Vice President of CNND, who is particularly involved, is a past director of the huge Mama Yemo Hospital in Kinshasa which has the largest family planning center in the country. There are a substantial number of expatriate physicians throughout the system who assist in developing standards and supervising performance.

The project itself is designed to result in further development of standards, but above all to provide the training, commodities, and supervision so that "standards" can become practice rather than empty policy statements.

Summary of Institutions and Potential for Family Planning at the Local Level

Following is a summary of the findings and conclusions of a twelve-person review team which visited 56 health institutions in nine of the major cities of Zaire.

SCOPE

On March 8-15, 1982, a twelve person team visited 9 of the major cities of Zaire to observe conditions of physical facilities, program and personnel in the health institutions. The objective was to assess their potential participation in the proposed urban family planning program.

The group was composed of:

Dr. Moucka, Director of Epidemiology, DPH, and Director of Institute of Medical Education

Chirwisa Chirhamocekwa, Director of Health Education, DPH

Dr. Miatudila Malonga, Vice President of CNND

Misamu Kam-mitondo, Supply Officer, CNND

Indumany Kambang, Assistant Director Secretary, CASOP

Rev. Ralph Galloway, Population Advisor, ECZ

Mrs. Florence Galloway, Nurse Midwife, ECZ

Joyce Holfeld, Consultant, IPAVS, New York

Beverly Foster, Program Officer, Africa/Middle East Regional Office, IPAVS/Tunis

Wilbur Wallace, Regional Director, JHPIEGO

Richard Thornton, Public Health Officer, USAID/Zaire, and

William Bair, Regional Population Advisor, USAID, REDSO/WA, Abidjan, Ivory Coast

In each city visited, the PID review team was divided into 3 or 4 groups to visit the major hospitals and other health centers and dispensaries. Each group had a rapporteur who completed a standard questionnaire. Following the visits, the rapporteurs summarized the basic information on a matrix that was then synthesized for each city and summarized. A copy of the city synthesis and the overall summary is attached.

SALIENT OBSERVATIONS

1) Nine cities were visited covering a total population of about 6.5 million.

2) Fifty-five facilities were visited of which 20 were hospitals and 36 were health centers or dispensaries (two were under construction).

3) Of the centers visited, 29 were state-sponsored, 12 church, 9 union, and 6 industry for a rough proportion of 50% public sector and 50% private. It was apparent that all systems had some problems, but an infrastructure does exist which could be utilized for family planning.

4) An indication of client use was determined by number of consultations per day. Eleven institutions had 0-50 consultations per day; ten had 50-100; and thirty-three had 100 or more. Of the 33 (100 or more), one was a 1700 bed hospital, one was a 1200 bed hospital, and seven had between 300-500 beds. These larger institutions had in excess of 300 outpatient consultations daily. The team was impressed with the substantial number of outpatient consultations even in the smallest centers.

5) The 56 institutions were staffed with 216 physicians, 1402 nurses of various levels, and 973 other personnel. (In the largest hospitals, this number includes only the OB/GYN department, the most relevant to family planning.).

6) While the primary focus was curative (53 facilities), a substantial number had pre-natal (38), vaccination (39), pre-school (26), and obstetric services (31).

7) Family planning services were being provided in twenty-six institution Eighteen institutions were providing surgical contraceptive service (sterilization), twenty-two were inserting IUDs, and twenty-six were providing non-clinical methods (pill, condom, Depo-provera, foam and/or counseling in natural family planning). The most frequently used method was the pill followed by Depo-provera or IUD with condoms, foams; sterilization and natural methods substantially less. Records were often not kept in a consistent, complete or up-to-date manner, and in most centers, the actual numbers were low. However, where there was an organized service with specific persons responsible and facilities available (e.g., CNND center in Mama Yemo Kinshasa - (1300 F.P. consultations/month), CNND center Bukavu Hospital and Clinique (400/months), and CNND center N'djili Kinshasa (120/month), and the CNND Matonge clinic (90/month in initial stage), the user level was demonstrably higher.

8) A subjective judgment was made of interest of the service providers and expressed patient demand. Only one center was considered to have no interest; some interest was demonstrated in 19 facilities and thirty six centers expressed considerable interest, several being particularly enthusiastic. In all locations there was no problem or reticence encountered in discussion of family planning. The Concept of "Desired Births" had been broadly disseminated and was generally viewed as a positive health measure.

9) A judgment was made of the potential for family planning consultation and it was estimated that in the centers visited, 26 could ultimately provide sterilization services; 42 could provide IUD services, and 54 could provide non-clinical services. In these centers it is estimated

that with proper training, equipment, educational material and contraceptive supplies, potential could reasonably soon reach approximately 69,000 F.P. consultations per year (25,000 to 30,000 new acceptors).

10) Forty-two out of the fifty-six centers were already average or good in their equipment, suggesting the need for less capital investment in facilities and equipment than might have been expected. However, it was also noted that expendable supplies were universally lacking, suggesting the need for attention to this element. Provision for small repair and refurbishing would add dignity, attractiveness, and cleanliness.

11) The most pervasive need, in addition to contraceptives, was that of personnel training. Personnel are in place and interested in family planning. Many stated (and demonstrated by their conversation) that their family planning knowledge needs to be expanded and their technical skills up-graded. However, it should also be noted that the team interviewed a significant number of personnel who were well trained and well qualified in family planning and able to transmit their skills to others.

12) Informational materials were generally lacking for provider instruction as well as patient information.

13) Surgical procedures were carried out in the same conditions as general abdominal surgery and Caesarean sections, mostly for medical reasons and using old techniques. Laparoscopy and mini-lap can up-grade the service if proper training, facilities and medical supervision are assured. In several locations, more procedures could be performed for contraceptive purposes if more operating room time could be made available for elective surgery.

14) No uniform record system exists for family planning and that which does is encumbered by complicated reporting requirements.

15) Evidence was seen of immediate potential for the classic "community-based distribution" approach in only three or four centers. The heavy outpatient case load of small dispensaries in heavily populated residential zones provides an initial substitute for this as an out-reach program.

CONCLUSIONS:

1) There is an unmet demand for family planning services and basic infrastructure to deliver them consistent with the PID plan and projections.

2) Adding family planning to the present services will not create an "unbalanced" or disproportional attention to family planning. These are on-going MCH activities that family planning will complement and improve. A reasonably narrow focus on family planning in service

delivery is appropriate. The training and informational materials should deal with family planning in the broader context of maternal child health and nutrition.

3) Training at all levels is needed.

4) Informational materials are needed for service providers and patient education.

5) All public and private delivery networks examined are capable of providing service if given supplies, materials, and training. It will be important to maintain multiple networks, outlets, and approaches if significant increases in access and coverage are to be achieved.

6) Many individual centers will have modest case loads. With special attention, lead centers could provide heavy case loads in each city. Both approaches could assure access to a wider population. Future programming should explore community-based distribution (CBD) and social marketing if expanding numbers are to be reached.

7) Logistics systems must be strengthened and record keeping simplified. A mechanism must be found to maintain contact with the local level to improve communication, support problem solving, and reporting as an assistance to the major networks to carry out the program under their responsibility.

8) A medical supervision system is needed to ensure the delivery of high quality service. In addition, protocols for training, facilities, personnel and services must be developed and monitored so that uniform standards can be met. The present emphasis on quality training and equipment for surgical procedures and use of para-medical personnel under medical supervision for non-clinical methods is sound.

INSTITUTIONAL VISITS, REGION ITEM	Number of visits			Type of Institution				Number Personnel			Total Number Consultations Per day			Health Activities				Have Family Plan. Service now			Would Have F.P.			Interest in F.P.			Equipment			Number of Family Planning Consultations	
[illegible] 13, 1982	Total Hospitals		Clinics or Dispensaries	State (official)	Church	Union	Industry	Doctors	Nurses	Other	0 - 50	50 - 100	100 plus	General Curative	Vaccination	Pre-natal	Pre-school	Obstetric	Sterilization	IUD	Non-clinic	Sterilization	IUD	Non-clinic	No	Little	Much	Good	Average	Poor	(Per Month)	(Per Year)
Figures denote numbers of institutions, except under "Personnel". Classification Size (Est. 1 PID for 1984)																														
1. Kinshasa (3,600,000)	8	4	4	7	0	1	0	35	308	131	0	0	8	8	5	7	4	6	3	5	6	5	7	8	0	1	7	6	2	0	2600	31,200
2. [illegible]ndundu (100,000)	5	1	4	1	3	1	0	6	52	113	3	2	0	5	2	2	1	2	1	1	1	1	3	5	0	1	4	0	3	2	235	2820
3. [illegible]bendaka (325,000)	7	1	6	4	2	1	0	16	19	26	3	0	2	5	5	3	3	2	1	1	2	2	4	7	0	2	5	1	4	0	315	3780
4. Kisangani (474,000)	8	4	4	4	1	2	1	51	266	[illegible]	1	3	4	8	5	7	3	5	1	2	1	2	6	7	0	3	5	3	3	2	615	7380
5. [illegible]ma (85,000)	3	1	4	2	1	1	1	13	32	28	1	2	2	5	3	1	1	3	3	2	2	3	3	4	1	2	2	0	1	4	100	1200
6. Bukavu (250,000)	8	1	7	4	3	1	0	18	69	198	2	1	5	0	7	5	4	3	3	4	6	3	5	8	0	4	4	4	3	1	825	9900
7. Lubumbashi (770,000)	8	3	5	5	0	1	2	34	133	155	0	2	6	8	6	6	5	6	3	3	4	5	7	8	0	4	4	6	0	2	515	6180
8. Mbuji Mayi (450,000)	3	2	1	1	1	0	1	15	203	98	0	0	3	3	2	3	2	2	1	2	2	2	3	3	0	1	2	1	2	0	200	2400
9. [illegible]nga ([illegible])	4	3	1	1	1	1	1	19	285	178	1	0	3	4	4	4	3	2	2	2	2	3	4	4	0	1	3	1	2	1	230	2760
TOTAL	56	20	36	29	12	9	6	216	1402	982	11	10	33	54	39	38	26	22	18	22	26	26	42	54	1	19	36	22	20	12	5535	66,420

Some units consult [illegible]

5. Kinds of Contraceptives Being Used

Information is imprecise and unfortunately it appears that in many circumstances contraceptive method has been as much determined by availability as conscious choice. The 1981 evaluation of CNND provides the following:

Percentage Distribution of Family Planning Acceptors, by Method
CNND, Zaire, 1976-1981

Method	1976	1977	1978	1979	1980	1981§
Pill	34.0	29.8	40.8	67.7	36.6	32.3
Depo-provera	41.0	37.0	26.1	7.9	25.6	42.9
Condom	4.9	10.1	13.9	13.9	19.0	8.1
IUD	19.5	20.5	16.5	8.6	13.7	12.6
Tubal Ligation	0.6	1.8	1.9	1.5	1.6	2.8
Vasectomy	0.0	0.0	0.9	0.0	0.0	0.0
Other§§	0.0	0.8	0.0	0.5	3.5	1.2
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
No. of Acceptors	8,542	14,088	17,344	23,147	27,028	5,872

§ January through June only.
§§ The CDC report does not clarify how much of "other" is natural family planning but training materials reviewed and interviews indicate that it is a part of the program. There is provision for its reporting (which is done with no more precision than other reporting).

(Reports from about 40% of family planning outlets)

The most striking conclusions to be drawn from these data are that Depo-provera and the pill use is roughly equal and between them account for between 60% and 70% of contraceptive use each year among acceptors. Also, condom use seems to be higher than in other African countries familiar to the evaluation team. It will be interesting to compare these figures with the results of the Contraceptive Prevalence Survey presently being conducted by Westinghouse Health Systems in certain urban areas.

6. Attitude at the Community and Personal Level

Anecdotal and some statistical indications throughout the field visit of the PID review team suggest a growing acceptance of the concept of "Desired Births" and a growing demand for family planning services. Several efforts have been and are being made to get more statistical measures.

An operations research project conducted by Tulane University has been functioning in Bas-Zaire since 1980. The initial field experience and baseline research from the rural areas suggest:

-- widespread acceptance of a strong emphasis on family planning in the context of maternal and child health;

-- little adverse reaction to the distribution of contraceptives to women in their homes;

-- interest in contraceptive use primarily as a means of child spacing, as indicated by the fact that a substantial percentage of acceptors have been lactating mothers;

-- a preference for foam as a contraceptive method, especially in the above cases;

-- interest in sterilization, as suggested by the number of women who have requested this service.

Since November 1981, the home visitors have been instructed to record the reason for refusal in those cases where the woman does not accept the contraceptives during the home visit, given that this occurs in over half the cases. This information was hand-tabulated initially, with the following results (percentages are based on 1,130 women who refused during the first round of visits and who gave a reason):

-- Husband was absent at time of visit[1]	25.8%
-- Woman is currently pregnant	21.9%
-- Woman desires another child	9.6%
-- Woman is opposed to family planning	8.7%
-- Woman has reached menopause	3.3%
-- Husband is opposed to family planning	2.3%
-- Other (including subfecundity, no exposure to intercourse, preference for traditional methods, etc.)	28.4%
	100.0%

1. Women whose husbands weren't home weren't offered contraceptives.

It is interesting to note that "fear of side effects", which is one of the precoded answers, was not mentioned during Round I.

Similar findings from that project in the urban area of Matadi will be forthcoming in 1982. Some of the preliminary findings follow:

Contraceptive Use Among Women, 15-49, in Matadi, Zaire, March 1982

	n	%
Uses no methods	847	47.3
Uses traditional method(s)	853	47.7
Withdrawal	428	23.9
Abstinence, separate beds	241	13.5
Rhythm	140	7.8
Other	13	0.7
Two or more traditional methods	31	1.7
Uses a modern method	89	5.0
Pill	49	2.7
Female sterilization	20	1.1
Condom	10	0.6
Injection	10	0.6
IUD	0	0.0
Vaginal methods	0	0.0
TOTAL	1,789	100.0

Preliminary information is available from a survey in Kinshasa of 2,459 fertile-aged women who have a child under five, and 1,747 women of reproductive age surveyed in a rural area of Bas-Zaire. Results of these surveys suggest a remarkable level of use of traditional means of contraception, primarily for the expressed purpose of child spacing. In Kinshasa 80% of the women surveyed stated that they were using some child spacing technique, and in the rural area of Bas-Zaire this figure was nearly 50%. At the same time the use of modern contraception was quite low in each group (about 7% in Kinshasa and little more than 3% in the rural area). This suggests a considerable potential demand for contraceptives if information and commodity delivery systems can be developed to make modern contraceptives more accessible (economically and culturally as well as geographically). Initial results of community-based distribution in rural Bas-Zaire suggest cultural acceptance of the practice and substantial interest in modern contraception. Anecdotal information from the FPIA-supported community-based distribution projects suggest the same.

ANNEX C

CONTRACEPTIVE SUPPLY

Contraceptive supplies required are determined by the particular program being developed, the level of users and couple years of protection to be provided, and estimates of inventory requirements to cover warehousing and delays.

1. Contraceptive Mix

Although PID guidance suggested a review of cost effectiveness in method mix, this may not be the most relevant consideration in most family planning programs. In terms of cost effectiveness the signal contribution of USAID has been its centralized purchase of contraceptives, keeping costs of pills and condoms remarkably below retail costs in the developed world. Population Council and USAID efforts have restrained costs of IUD and we expect a similar influence on foaming tablets. The newer methods of female sterilization developed with USAID support have made this method by far the most cost effective where levels of use are substantial. (This economy of scale will not be achieved in Zaire for sterilization in the near future and start-up costs for sterilization will be high; however, sterilization will be introduced largely for health reasons.)

If it were clear that one method were substantially less expensive than another, the issue of costs would be more determinent. However, this does not seem to be the case as suggested by the following cost comparisons:

Contraceptive Costs - 1981

(approximate net FAS)[1]

Condoms (100/couple year protection (CYP))	
Packaged in individual wrap in boxes of 100	$4.10/100 ($4.10 CYP)
Orals (13 cycles/CYP)	
Packaged 3 cycles to package	$0.18/cycle ($2.50/CYP)

1. Note: This is just the contraceptive costs. It may appear, e.g., that condoms and foam tablets are more expensive. However, one must remember that the associated distribution/application/clinic costs may be considerably higher for the IUD and orals than for condoms and foams. Similarly, the costs for natural family planning methods are negligible, but the training, counseling, informational service costs are significant. Depo-provera is not listed since it is not provided by USAID but approximately $8.00 per 10 injection flask, the price per CYP is about $4.00.

Contraceptive Costs - 1981

(Continued)

Lippes Loop (IUD) (1 provides 2 1/2 years protection but logistics require 3-5/CYP)	
Bag of 100 accompanied by 10 inserters	$37.95 ($2.00/CYP)
Copper T (IUD)	$0.80 ($4.00/CYP)
Vaginal Foaming Tablet (100/CYP)	$6.00/100 ($6.00/CYP)

A review of costs including program administration and effectiveness in averting birth suggests that costs will be relatively similar by method (except for sterilization which can eventually be particularly cost effective). Note the following example from the program in the Phillipines:

Average Annual Cost Per Acceptors - Beginning and Continuing and Per Births Averted, by Method Philippines Family Planning Program. CY 1977

Method	Cost per Beginning Acceptor (U.S. $)	Cost per Continuing Acceptor (U.S. $)	Cost per Birth Averted (U.S. $)
Rhythm	11.68	10.42	52.78
IUD	11.95	9.49	37.35
Condom	12.17	11.62	49.31
Pill	12.74	11.57	38.13
Sterilization	20.34	-----	7.38

Source: Pernia, E.N. and Danao, R.A., Cost-Effectiveness Analysis and Optimal Resource Allocation: The Philippine Family Planning Program (Diliman, Quezon City), University of the Philippines School of Economics, December 1978, pp. 38-39.

In terms of cost efficiency, experience around the world has indicated that the type of distribution system organized (which obviously is not independent of methods used) has more influence on cost than methods per se. REDSO/WA's population advisor in a January 11, 1982 paper for the Family Health Task Force reviewed these issues and made some estimates of program costs summarized as follows:

"Rough Rules of thumb for costs of couple year of protection (ideas of how African programs might develop. These are high figures -- all efforts must be taken to get lower.)

Clinic-Based program (orals, IUD, natural, condom) $30-50/CYP (They are cheaper -- should be; there are many more expensive, but difficult to justify.)

Community-Based Distribution (CBD) program (orals, condom, natural, foam) $15-20/CYP)

Commercial Retail Sales Program (orals, condom, foam) $10-15/CYP

Sterilization $50-75 provides 10-15 couple years of protection."

Thus, we conclude that for cost consideration (to say nothing of coverage and accessibility advantages), moving toward the community-based distribution as soon as feasible and eventually to commercial retail sales when appropriate will be most efficient.

As constraints to sterilization efforts can be broken down, this will become a cost effective method.

Considerations other than cost will likely have more influence on the program mix. Successful programs around the world have made a variety of methods available. We will not attempt to explain the medical rationale here of why at different times in the reproductive life cycle of women, with different health status, different access to medical supervision; different contraceptive regimes are to be recommended. This paper will not discuss the pros and cons of the use of Depo-provera which has been explored at length in the recent medical literature. We do not believe it inappropriate for the CNND to have followed IPPF, UNFPA and WHO guidance in choosing to include this product particularly for the older, higher parity women who don't have the access to sterilization. We don't think it appropriate to set up any financial or other mechanisms - (except not to buy the product) to disassociate USAID from this.

Certainly personal preference is not to be ignored. This is often influenced by the users' own physical characteristics. However, just as often it is determined by rumors or attitudes in the community or a particular preference by the service provider. Moral and personal considerations will cause some to prefer natural methods. Natural methods as well as condoms are the more likely ways to involve the male partner more effectively.

Logistics considerations are also involved. A case can be made, for example, for a variety of oral formulations to meet the specific needs of individual patients. However, there is a limit beyond which more potential confusion is introduced by additional methods than the benefits gained.

The medical skills and equipment available as well as the conditions of the clinics determine how many locations should provide sterilization and IUD services.

Past practice is a useful guide in considering contraceptive mix. Data is less than precise and we suspect that practice has been influenced by contraceptive supply availability as much as by conscious choice.

Present Contraceptive Use

Partial data from Kinshasa clinics March 1982

Mama Mobutu (N'djili) and Barumbu Clinic

Contraceptive Method	Percent of Users
Depo-provera	35% (or more)
IUD	15%
Condom	5-10%
Foam	5-10%
Pill	35%

Percentage Distribution of Family Planning Acceptors by Method

CNND, Zaire, 1976-81 (40% of distributors reporting)

APHA/CDC EVALUATION 1982

Method	1976	1977	1978	1979	1980	1981§
Pill	34.0	29.8	40.8	67.7	36.6	32.3
Depo-Provera	41.0	37.0	26.1	7.9	25.6	42.9
Condom	4.9	10.1	13.9	13.9	19.0	8.1
IUD	19.5	20.5	16.5	8.6	13.7	12.6
Tubal Ligation	0.6	1.8	1.9	1.5	1.6	2.8
Vasectomy	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.8	0.0	0.5	3.5	1.2
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
No. of Acceptors	8,542	14,088	17,344	23,147	27,028	5,872

§January through June only

Where Depo-provera is readily available it is used in higher percentages. We expect as foaming tablets are made available, they will increase rapidly in acceptance as in other countries. (Reports from the Tulane Research suggests substantial preference for foam.) As the program shifts to a more "outreach",

community- (or community facility) based approach, there will be more use of the pill, foam and perhaps condom, which might allow less dependence on Depo-provera. Sterilization will increase as adequate surgical facilities become available.

For purposes of project planning at this time, we have projected the following percentages: (These will be adjusted with shifts in use.)

Contraceptive Method	Percent of Users
Oral	30%
Depo-provera	25%
IUD	15%
Sterilization	4%
Natural Methods	6%
Condom	10%
Foam Tablets	10%

2. Program Users and Couple Years of Protection

As stated in the PID, the achievement of 250,000 new acceptors during the life of the project produces approximately 300,000 couple years of protection. This is a figure subject to substantial variations depending on:

-- the rate at which new acceptor per year figures grow (i.e., a faster start-up and more regular progression will produce more CYP for the same total acceptors as compared to a slower start-up and relatively higher numbers of new acceptors in the later years). The calculations which follow used a straight line growth starting from slightly higher than present levels.

-- method mix and continuity. We don't know the drop-out rate at all, let alone by method, in Zaire. Although this would affect CYP, the calculations which follow use a "standard" rate with no variation for mix or changes.

The way this is calculated to include drop-out is based on the experience of the Colombia program where good service statistics were available in the private association clinics, where surveys were carried out to examine patient characteristics and continuity, and a "drop-out rate" was estimated. The average rate established with 50% discounted in the initial year. This procedure was reviewed in some depth by CDC; their conclusion was that 48% could have been used and that this was a conservative but practical basis for calculating continuing users.

Thus to arrive at continuing users, one should discount new acceptors by 50% in the year of their entry into the program and carry the discounted figure forward through the life of the program (presuming we are talking about 4 or 5 year programs -- longer programs would require some additional discounting)

To arrive at Couple Years of Protection (CYP), one must additionally discount the New Acceptors to account for their coming into the program at various times during the first year of their participation. The new acceptors are discounted by 50% to get continuing users in the first year of their entry. That figure is then discounted an additional 25% to account for late entry.

Couple years of protection provides a good basis for projecting contraceptive needs as well as one of the better common denominators for comparing parts of the program or comparing the program with others for a measure of cost effectiveness.

Following is an estimate of the numbers of New Acceptors, Continuing Users and Couple Years of Protection from the Program[1]:

		Year 2	Year 3	Year 4	Year 5	TOTAL
1.	New Acceptors (000)	30	40	50	130	250
2.	Continuing Users from this Year N.A. (50%)	15	20	25	65	
3.	Previous Year's Continuing Users	--	15	35	150	
4.	Total Continuing Users (000)	15	35	60	125	125
5.	CYP from this year's (000) Acceptors (discount line 2 by 25%)	11.2	15	18.75	48.75	
6.	CYP from previous year (line 3)	--	15	35	185	
7.	Total CYP (000)	11.2	30	53.75	233.75	328.75

1. Note that no acceptors are planned for the first year of project activities; during first year project will be involved in training, commodity procurement and other start-up activities.

3. Inventory Requirements

There will be inventory provision for slippage and delays in the logistics and likelihood that some supplies (especially IUDs and also Depo-provera)

can't be targeted as well as others to place small numbers exactly where they are needed. The following quantities were estimated for amounts needed for a CYP.

13 cycles of pills

3 IUDs (at least in beginning)

5 Depo-provera injections

100 Condoms

100 Foaming tablets

Plans will be made for double the first year's needs to provide inventory and maintain this buffer in the system. This will be reviewed annually for actual shipments. However, for program planning purposes, year three will include an additional 50% to increase the buffer stock for the expected program expansion.

4. Contraceptive Requirements

The following table provides the estimates of quantity and cost (CIF) for the five years of the project. The cost figures were based on most recent USAID/W projection of commodity costs plus freight using the 1986 estimates to provide for inflation. (IUDs allow a mix of Lippes and Copper T.)

CONTRACEPTIVE REQUIREMENTS

	Units/ CYP	COST/ UNIT CIF	% OF PRO-GRAM	YEAR I 22000 CYP (including inventory)		YEAR II 30000 CYP		YEAR III 80000 CYP (including inventory)		YEAR IV 82000 CYP		YEAR V 151,000 CYP		FIVE YEAR TOTAL	
				Units (000)	Cost CIF (000)	Units (000)	Cost (000)	Units (000)	Cost (000)	Units (000)	Cost (000)	Units (000)	Cost (000)	Units (000)	Cost CIF (000)
ORALS	13	.28	30	86	24	117	33	312	87	320	90	589	165	1424	399
IUD	3	1.00	15	10	10	13	13	36	36	37	37	68	68	164	164
CONDOMS	100	.09	10	220	20	300	27	800	72	820	74	1510	134	3650	327
FOAM TABLETS	100	.08	10	220	18	300	24	800	64	820	66	1510	121	3650	293
ALL AID					72		97		259		267		488		1183
DEPO PROVERA	1/2 Flask	9.00	25	3	27	4	36	10	90	10	90	19	171	46	414

ANNEX D

ORGANIZATIONAL PLAN

This is a bilateral project between the Government of Zaire (GOZ) represented by the Ministry of Health and the government of the United States represented by USAID. It will be carried out in collaboration with the CNND, the institution in Zaire charged with the responsibility of coordinating activities of "Desired Births" in the country. Other institutions who will participate in service delivery will be such private sector organizations as CASOP, ECZ, and industries which wish to include family planning in their ongoing health activities.

The Ministry of Health will be represented in a project advisory council, will provide the director of a central project management unit and will provide staff for supply, supervision and training programs. The bulk of the family planning services will be provided in facilities of the Department of Health (DPH).

The CNND will also be represented in the project advisory council and will provide key staff for the central project management unit. In addition to its general coordinating role, the CNND will be responsible for project administrative support, supply management, training and supervision. It will carry out these roles with its own staff augmented by staff provided by the DPH.

Medical and nursing faculties will cooperate with the program in training activities. The actual transport of commodities, service delivery and internal supervision will be carried out by the organizations which are presently providing health services in Zaire, that is the DPH, ECZ, CASOP and various industries and private organizations.

The project is to coordinate, manage and evaluate these various implementation responsibilities through an organizational structure which was developed in discussions between CNND, DPH and USAID. It provides for centralized planning and supervision with discrete implementation responsibilities assigned to the participating Zairian institutions (CNND, DPH, ECZ, CASOP, etc.).

The organizational structure provides for:

A) A Project Advisory Council (PAC) to provide a forum for top leadership of the participating agencies to discuss and review the program and assure the fulfillment of their institutional responsibilities.

b) A Project Management and Coordination Unit (PMCU) comprised of a staff provided by the DPH, CNND and a long-term consultant provided by USAID. This unit handles the day-to-day project planning and supervision.

C) Administrative, supply, service delivery, training and supervisory functions are assigned to the several institutions with specific responsibilities identified.

The composition and responsibilities of the PAC, PMCU and the participating agencies in carrying out the project functions are as follows:

A) Project Advisory Council (PAC)

The PAC will be composed of representatives at the Director or Director of Division level of DPH, CNND, ECZ, CASOP, UNAZA, other Zaire institutions, USAID and UNFPA.

The Council will be chaired on a rotating basis and will meet at least quarterly to carry out the following responsibilities:

1) Coordinate donor input to the project
2) Coordinate Zaire input to the project
3) Recommend policy for the project
4) Recommend program for the project
5) Recommend standards for the project
6) Review role and progress of the participating institutions in carrying out their responsibilities for project implementation
7) Review annual evaluation reports of the PMCU and arrange for the overall project evaluation of years two and four.

B) Project Management and Coordination Unit (PMCU)

This unit is charged with the overall responsibility of project management. Offices and operating expenses will be provided from counterpart fund and GOZ Ordinary Budget funds assigned to the project.

The staff will be composed of the following:

1) Director - This person, provided by the DPH, will be a physician, nurse or public health administrator with advanced training in the organization and management of family planning service delivery programs or in public health training programs. He or she will be assigned full-time to the project.

2) Assistant Director for Management - This staff member will be a long-term consultant by USAID as part of the project. He or she will be a qualified public health professional with academic training at least to the Master of Public Health level. He or she will be competent in French language conversation and will have experience in health programs in Africa. Primary skills will be in the planning, management and evaluation of maternal and child health and family planning programs. He or she will be assigned full-time to the project.

3) Assistant Director for Program - This person, assigned full-time to the project by the CNND, will have university level training in education, health or social sciences and at least three years experience in a supervisory, planning or management role in health and family planning programs. Preferably he or she will have advanced training in one of the international short courses in family planning.

4) Assistant Director for Training - This person, who is the Director for Training of the CNND, will be assigned half-time to the PMCU by the CNND. He or she will have university level academic training in the field of health or education and will have had several years of experience in organizing family planning training programs. If he or she has not attended one of the international trainer of trainers courses, this training will be provided early in the project.

5) Bilingual Secretary - This person will be financed by counterpart funds available to the project and will have the qualifications of a professional bilingual secretary with several years of experience in a responsible position in a private or public sector institution. He or she will serve full-time in the project.

The responsibilities of the PMCU will be as follows:

1) Establish policy and program in consultation with PAC
2) Develop detailed program plans, schedules, budgets and operational procedures
3) Enter into agreements with national and local institutions for project implementation
4) Coordinate and monitor implementation by participating institutions (i.e., CNND, DPH, ECZ, CASOP and private institutions)
5) Assist participating institutions in administration, supply, training service delivery supervision and evaluation
6) Plan and monitor training outside Zaire
7) Plan and monitor short-term technical assistance
8) Report to advisory council and to DPH, CNND, USAID ...

C) Functional Areas of Project Implementation

The functional areas of administration, supply, training, service delivery, supervision and evaluation have been assigned to the participating institutions for implementation.

1) Administrative Function

The CNND will be responsible for providing the necessary administrative services to assist the PMCU in managing the project. These responsibilities will be carried out by the following staff:

a) Controller - part-time provided by CNND

b) Accountant - part-time provided by CNND

The responsibilities of this staff will be the following:

a) Assist the PMCU to prepare annual program budget

b) Manage all aspects of fiscal management and control

c) Report to PMCU on progress in fulfilling objectives of program budget

d) Recommend personnel policy to PMCU

e) Prepare and execute for PMCU agreements with national and local institutions related to project implementation

f) Handle all legal aspects of project implementation.

2) Supply Function

The major supply function of the project for contraceptives and medical equipment will be the responsibility of the CNND. They will carry out this responsibility with their own staff augmented by staff provided by the DPH.

There will also be a supply unit within the DPH to handle the internal logistics of contraceptive delivery within the DPH health system and to plan, organize, supply and monitor the supply of materials to local health facilities for repair and refurbishing.

The staff assigned to these two units and their responsibilities is as follows:

2) SUPPLY FUNCTION

A) CNND

1. Staff:

Supply Chief, part-time provided by CNND
Assistant, full-time provided by DPH
Clerk, full-time provided by DPH

2. Responsibilities:

a) Plan, order, receive and warehouse all contraceptives and medical equipment for the project.

b) Deliver contraceptives and medical equipment for DPH, CASOP, ECZ, Training Centers, etc.

c) Deliver materials to local centers as necessary.

d) Minor repairs and maintenance of medical equipment

e) Maintain warehouse records and records of distribution of material

f) Monitor supply levels.

g) Report to supervision unit of CNND and to PMCU

B) DPH

1. Staff:

Supply Manager, provided by DPH

2. Responsibilities:

a) Detach two staff members to CNND.

b) Review, plan, organize, supply facility repair/refurbishing for all service delivery and training centers in project.

c) Internal logistics of contraceptives, informational materials and medical equipment within DPH system.

d) Maintain records consistent with CNND.

e) Report to CNND on distribution of contraceptives, informational materials and medical equipment.

f) Report to PMCU on facility improvement.

3) Service Delivery Function

The actual delivery of family planning services will be carried out by the cooperating service institutions (DPH, ECZ, CASOP and others). Responsibility to organize, monitor, supervise and supply this activity and report on its progress will reside ultimately with these institutions. However, they can expect assistance from the CNND and the PMDI particularly in contraceptive ordering and central warehousing, training and supervision/ reporting.

Each of the cooperating institutions will provide a Director of Family Planning Services, preferably a nurse, or public health or social services administrator, who will be available adequate time to handle the work responsibilities. These health systems will utilize their present supervisory, clinical and community workers to carry out their service delivery and supervision responsibilities under this project.

The staff and responsibilities of the several organizations is as follows:

3) SERVICE DELIVERY FUNCTION

A) DPH

1. Staff:

Director of Family Planning Services, part-time, Nurse A (same person as DPH supervision)
Clinic Staff at local level, part-time

2. Responsibilities:

a) Plan and monitor Family Planning Service Delivery within DPH

b) Supervise internal logistics and supervision

c) Delivery of services at local level

B) ECZ

1. Staff:

Director of Family Planning Service Delivery - part-time by ECZ
Clinic Staff at local level

2. Responsibilities:

a) Plan and monitor Family Planning Service Delivery within ECZ in urban areas

b) Identify facility improvement needs in ECZ project area; work with DPH to accomplish improvements

c) Identify contraceptive, medical equipment and informational material needs for ECZ in project area; request and receive from CNND and distribute; report to CNND

d) Select trainees and arrange training with CNND

e) Service delivery at local level

C) CASOP

1. Staff:

Director of Family Planning Service Delivery part-time by CASOP
Clinic Staff, part-time at local level

2. Responsibilities:

a) Plan and monitor Family Planning Service Delivery within CASOP

b) Identify facility improvement needs in CASOP, work with DPH to accomplish improvements

c) Identify contraceptive, medical equipment, and informational material needs in CASOP; request and receive from CNND and distribute; report to CNND

d) Select trainees and arrange training with CNND

e) Service delivery at local level

D. OTHERS

1. Staff:

Director of Family Planning Service Delivery, each has part-time person provided by their institution
Clinic Staff, at local level

2. Responsibilities:

a) Same as for ECZ, substitute name of own institution for ECZ

4) Training Function

The primary responsibility for organizing and monitoring in-country training programs will reside with the CNND. They will carry this out with their own staff augmented by personnel provided by the DPH. They will enter into contracts with medical and nursing faculties and local health facilities who will cooperate with them in developing the curricula and provide the didactic and practical training for specific courses.

The training will be carried out in three "centers" - Kinshasa, Kisangani, and Lubumbashi. "Center" means a network of facilities (university, hospital, clinic, social service, etc.) which will collaborate to provide the didactic and practical training required.

As part of the overall training objective the CNND training unit will also assist the medical and nursing faculties to develop reproductive health and family planning modules for their basic pre-service curricula.

The staff and responsibilities of the several institutions for the training function are as follows:

A) CNND

1. Staff:

Chief of Training, part-time provided by CNND (same person at Assistant Director for Training in PMCU)
Assistant for Training, full-time provided by DPH
Part of staff in three training centers

2. Responsibilities:

a) Review training needs

b) Plan training program and arrange with training centers

c) Develop curricula for post grad refresher courses with assistance of medical and nursing faculties

d) Assist medical and nursing faculties in developing curricula for basic courses

e) Develop didactic and informational material

f) Assist in training

g) Monitor and Evaluate training

h) Report to PMCU

B) UNAZA MEDICAL FACULTY

1. Staff:

Faculty, part-time
Students, part-time

2. Responsibilities:

a) Develop medical curricula

b) Assist with other curricula

c) Train medical students

d) Assist with post graduate refresher training

C) TRAINING CENTERS (Kinshasa, Kisangani, Lubumbashi)

1. Staff:

Director Kinshasa[1], part-time
Director Lubumbashi, part-time training[1]
Director Kisangani, part-time training[1] and part-time Coordinator
Clinic Staff from DPH and students
Peace Corps Volunteer, each center

2. Responsibilities:

a) Training for project

b) Practical training for medical/nurse students

c) Supervise trainees

d) Deliver service

D) DPH

1. Staff:

(The training assistant detached to CNND will coordinate with DPH Family Planning Service Delivery Director to carry out these responsibilities)
Nursing faculty, part-time
Nursing students, part-time

2. Responsibilities:

a) Assist in curriculum development

b) Provide faculty for training programs

c) Select trainees from local DPH Service Delivery Centers

d) Organize courses/seminars for DPH supervisors

1. Part-time paid by CNND, part-time paid by project for actual teaching.

5) Project Supervisory Function

Each of the service delivery networks (DPH, ECZ, CASOP, industry) will be responsible for their own internal supervision of service delivery. However, it was determined necessary to create a supplementary supervisory capability to facilitate project implementation, identify problems and assist in their resolution, assure uniformity in the quality of service delivery, assist in the preparation of service statistics reports and evaluate project progress.

Direction of this supervisory unit will be the responsibility of the CNND. It will be staffed by personnel of the CNND augmented by personnel provided by the DPH. The CNND Medical Committee will serve as consultants to the unit. The unit will be based in Kinshasa and will be expected to travel frequently at project expense to visit each local service delivery outlet (at least quarterly initially). In carrying out these functions, the supervisory unit will coordinate with the supervisors of the service networks, especially the regional medical inspector of the DPH. They will also work with the Training Directors of the "centers" in Kisangani and Lubumbashi who will be provided half-time to the project by the CNND to serve as coordinator/supervisor in their respective areas.

The staff and responsibilities for the supervisory function are as follows:

5) PROJECT SUPERVISORY FUNCTION

A) CNND

1. Staff:

Chief, full-time provided by CNND
Assistant, full-time provided by DPH
Assistant, full-time provided by CNND
Two Regional Coordinators, part-time by CNND
(CNND Medical Advisory Committee as part-time consultant)

2) Responsibilities:

a) Establish standards for service delivery
b) Develop supervision protocol
c) Assist Regional Coordinators in two regions
d) Supervise Family Planning Service Delivery in the other regions
e) Assist in training
f) Develop standard, simplified system of service statistics
g) Assist local units in producing service statistics report
h) Gather service statistics
i) Assure that training, medical equipment, contraceptives, informational material, building refurbishing has been provided
j) Assist in organizing, training for supplying and supervising community-based activities
k) Arrange surveys
l) Quarterly report to PMCU
m) Carry out annual evaluation and report to PMCU

B) DPH

1. Staff:

Director of Family Planning Service, part-time, Nurse A, provided by DPH (same person as responsible for Service Delivery in DPH)
Regional Medical Inspection Staff, part-time

2. Responsibilities:

a) Inform and involve regional medical inspection
b) Provide for internal DPH medical supervision
c) Facilitate CNND supervision

Every effort has been made to keep staff requirements at a minimum to ensure that national institutions can continue to carry out this activity when international support is no longer necessary. It will be essential that highly qualified personnel are assigned to this project to manage the activities within their own institutions. It is especially important that the persons assigned by the DPH to direct the PMCU and to be attached to the CNND to carry out supply, training, and supervisory functions be well trained and experienced.

Following is a summary of the CNND and DPH staff requirements for this project:

Summary of CNND and DPH Staff Requirements for Project and Project Contribution to Staff

1) CNND

A) Representation on PAC - Director - part-time

B) Members of PMCU

-- Assistant Director of Training, part-time

-- Assistant Director for Program, full-time

C) Administrative Function

-- Controller, part-time

-- Accountant, part-time

-- Legal Consultant, part-time

D) Supply Function

-- Supply Chief, part-time

E) Training Function

-- Chief of Training, part-time

-- Three Directors of Training Center, part-time by CNND; and part of clinic staff of training centers

F) Supervisory Function

-- Chief, full-time

-- Assistant, full-time

2) DPH

A) Representation on PAC - Director General, Chief of Third Direction and/or Chief of Epidemiology, part-time

B) Members of PMCU

-- Director, full-time

C) Supply Function

-- Assistant, full-time (detached to CNND)

-- Clerk, full-time (detached to CNND)

-- Supply Manager (within DPH)

D) Service Delivery Function

-- Director of Family Planning Service Delivery (within DPH), part-time, Nurse A (same as nurse indicated for Supervisory Function)

-- Clinic Staff at local level, part-time

E) Training Function

-- Assistant for Training Function (detached to CNND)

-- Nursing Faculty

-- Nursing Students

F) Supervisory Function

-- Director of Family Planning Service Delivery, part-time, Nurse A (see Service Delivery) (detached to CNND)

-- Regional Medical Inspection Staff, part-time

3) Summary of Project Contribution to Staff

A) Donor representatives in Project Advisory Council, part-time

B) To PMCU

-- Bilingual secretary, full-time

-- Full-time consultant from USAID

C) To Functional Areas

-- Short-term technical assistance

-- One Peace Corps Volunteer

-- Per diem and travel to assure mobility and efficiency especially of training and supervision staff

-- Payment to trainers on a per student or per hour basis

4) Summary of Responsibilities of the Cooperating Institutions

A) DPH

The responsibilities of the DPH are as follows:

1) Represent the GOZ as the Agency responsible for overall progress and fulfillment of project objectives; providing personnel to the Project Advisory Council to recommend policy and review

progress, providing the Director for the Project Coordination and Management Unit to plan and oversee project implementation, and providing personnel for the functional areas of supply, training and supervision to cooperate with CNND in planning and overseeing necessary implementation actions.

2) Assure that direct DPH budget allocations are made to enable project implementation and to secure such counterpart funds required in addition to these budgetary provisions.

3) Plan, manage and evaluate the repair and refurbishing of local medical facilities where family planning services will be delivered.

4) Plan, organize and supervise the delivery of family planning information and service within the health facilities of the DPH, financing costs of personnel, commodity logistics, and clinic operation.

5) Provide DPH staff and faculty of nursing schools to assist with training..

6) Participate in periodic evaluations.

B) CNND

The responsibilities of the CNND are as follows:

1) As the institution in Zaire responsible for coordinating activities of family planning, the CNND will be represented in the PAC, and as executive secretary for the PAC will take the lead role in organizing the agenda, preparing reports for review and providing the necessary follow-up documentation.

2) Through provision of staff for the PMCU, the CNND will participate with the DPH in planning and overseeing project implementation.

3) The CNND will be responsible for administrative support (fiscal management, personnel policy, legal services) to the project. This will include management of counterpart funds made available to the project for office rental and expense, local training costs, travel and per diem, supervision, and limited personnel costs.

4) The CNND will be responsible for ordering the contraceptive supplies and medical equipment for the project, receiving them in country, warehousing them, delivering them to DPH, CASOP and ECZ, and establishing a system of commodity flow control and reporting.

5) The CNND will be responsible, with the DPH and medical faculty collaboration, for developing and supervising the training program for service providers throughout the country. The CNND will contract with training institutions and medical facilities to provide both didactic and practical training.

6) The CNND, in collaboration with DPH and medical faculties, will be responsible for development of didactic and informational material and pre-service training curricula.

7) The CNND will be responsible for the organization and direction of the cadre of supervisory personnel (from CNND and DPH) who will supplement the primary supervision of DPH, CASOP and ECZ.

8) The CNND will participate in periodic evaluations.

C) Other Service Providers

Organizations such as ECZ, CASOP, and industry health systems will have the following responsibilities:

1) Participate in policy development and project review through membership in PAC,

2) Plan, manage and supervise the delivery of family planning information and services within their health systems.

3) Finance the cost of commodity logistics from Kinshasa, clinic expenses and clinic personnel.

4) Make clinic personnel available for training and provide suitable authority, clinic conditions, and supervision for them to put into practice the skills they have learned.

5) Make periodic reports to PAC on progress.

D) USAID

The responsibilities of USAID are as follows:

1) USAID will represent the U.S. Government in its responsibilities to supply agreed upon inputs and to participate in policy development and program management.

2) USAID will participate in policy development and program review through its membership in the PAC.

3) USAID will participate in project management by providing a long-term consultant for the PMCU and short-term consultations for diverse project functions.

4) USAID will assist with the planning and ordering of overseas training and commodities through its normal project implementation orders.

5) USAID will review project progress from time to time through visits to training and service delivery sites.

6) USAID will participate in periodic project evaluations.

ANNEX E

SOCIAL SOUNDNESS ANALYSIS

A. Socio-Cultural Feasibility

Initially, one might question the feasibility of a family planning program for a country such as Zaire with a strong pronatalist tradition. The social structure, with strong reliance on the extended family, both creates pressures on the individual couple to reproduce and also provides a support mechanism which reduces the burden of a large family. Children are viewed as an investment in the future. To many, having a large family improves the odds that at least one or two of the children will be successful and be able to support the rest. Indeed a 1981 survey carried out in the urban area of Matadi in Bas-Zaire showed ideal family size to be 6.3 children, among those who gave a specific numerical response.[5]

1. Background on Current Practices of Fertility Control

On the other hand, there is a deeply ingrained tradition of child-spacing in sub-Saharan Africa in general and Zaire in particular. In comparison to many other developing countries in which family planning programs begin by trying to teach the importance of child-spacing, this is widely understood and accepted throughout Zaire. The occurrence of a second pregnancy too soon after birth of one child results in premature weaning of that infant and in fact, greatly threatens his chance of survival. Parents who allowed this to happen were traditionally ostracized or were made the object of ridicule by the community. The purpose of the practice of child-spacing was not to limit family size, but rather to enhance the survival chances of each child.

The traditional means of achieving child-spacing was post-partum abstinence,[6] a nearly universal practice in traditional societies in tropical Africa. This took a number of forms, including the return of the woman to her parents' home until another pregnancy would be appropriate; polygamy, whereby the husband took on two or more wives to satisfy his physical needs and desire for numerous children; and abstinence from sexual relations while living under the same roof, which is often referred to (even in recent surveys) as "separate beds."

2. Problems with the Traditional Practice of Abstinence

While the desire for spacing remains strong, the traditional means of achieving this objective are becoming increasingly difficult. Especially in urban areas, it is rare for the wife to return to her village for extended

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5. Hillary J. Page and R. Lesthaeghe (eds.) 1981. Child Spacing in Tropical Africa: Traditions and Change. London: Academic Press.

6. Ibid.

periods of time. Women, especially those with some education, are less tolerant of arrangements which would threaten the husband-wife dyad. Polygamy is on the decline, in part because of the economic difficulty of supporting several families, in part because of higher levels of education and exposure to Western ideas.

The response to this situation has been a gradual shift from the traditional practice of post-partum abstinence (sometimes for a long as three years) to traditional methods which do not require abstinence, such as withdrawal and rhythm. A recent study in Kinshasa (1980)[7] shows withdrawal to be the most widely practiced method of fertility control. Among low income women, 15 to 44, married or living in union and with at least one child under five, an astonishing 44 percent reported to be using withdrawal at the time of the interview; this was followed by abstinence (31 percent) and rhythm (19 percent). Overall, 73 percent of the women reported to be attempting to control their fertility by one or more traditional methods, in comparison to 7 percent who were using a modern contraceptive.

3. Current Levels of Motivation for Fertility Control in Zaire

Given that sub-Saharan Africa is generally considered a family planning frontier where there is relatively little interest in "population activity these findings provide striking evidence to the contrary. To put these percentages in perspective,[8] contraceptive prevalence in developing countries is considered to be high when over 60 percent of women, 15 to 44, married or livin in consensual union, are using some means of fertility control. If one accepts the use of traditional methods as a means of fertility control, Zaire would emerge as a country with a very high level of interest in family planning. The difference, of course, is that the current means of achieving this goal in Zaire is with traditional methods, whereas the great majority of contraceptive users in other developing countries rely on modern methods.

The primary conclusion to be drawn from the above data is that there is a strong motivation for fertility control which already exists within the target population. The proposed project, then, would not be attempting to create motivation, but rather to provide a solution to a problem widely felt by members of the target population.

4. Potential for the Adaption of Modern Contraceptives

It can be hypothesized that the very limited use of modern contraceptives among this population is due to:

(1) relative nonavailability of these products in the past at an affordable cost,

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7. Jane T. Bertrand, William E. Bertrand and Miatudila Malonga, "The Use of Traditional and Modern Methods of Fertility Control in Kinshasa, Zaire," Population Studies (in press, for March 1983 publication.)
8. It should be mentioned that the percentages are not strictly speaking comparable, since the denominations differ. However, the conclusions remain the same.

(2) lack of knowledge about these methods, and

(3) possible preference for traditional practices of fertility control.

The proposed project would effectively eliminate the first two obstacles mentioned above, by making contraceptives readily accessible at low cost and providing information/education on their availability and use. The third question -- of key importance in this social analysis -- is the cultural acceptability of these methods.

Data from several sources suggest that the potential for acceptance is good. One of the few published articles on family planning in Zaire reports that when contraceptive methods are delivered in a culturally acceptable manner, the target population is open to adopting them (data from a rural area in the West Kasai region).[9]

More recent data from the Tulane Operations Research Project in Bas-Zaire provide further support for the acceptability of modern contraceptives. This project employs what might be considered the most "aggressive" strategy for delivery of family planning services: free household distribution of contraceptive products. In the first two weeks of home visiting in the urban area of Matadi, 41 percent of the women, 15 to 49, who were visited accepted a free contraceptive method. If one excludes those women who were ineligible due to a current pregnancy, the absence of the husband who must give his consent, secondary sterility or previous sterilization, the percentage of acceptors rises to 55 percent.[10]

Furthermore, there is evidence to suggest that the majority of women who accept a method actually use it, according to data from the rural area of the Bas-Zaire project (where adoption of a given innovation would be expected to be more difficult). Among those who had previously "accepted" a method and were subsequently revisited, 79 percent had tried the method and 51 percent were still using it six months later. These percentages were substantial, considering that this is a population with relatively little previous experience with modern contraceptives.

5. Service Locations To Be Used

A related issue is the acceptability of the service locations to be used in this project: DPH hospitals and dispensaries. The vast majority of the population rely on these two types of healty facilities for the majority of their health care. Thus, these are familiar to the target population. There are frequent stock-outs in many of these facilities, which tend to lower their prestige among the population; however, the very fact that the project will be providing contraceptives through these outlets will help to strengthen them in the eyes of the community.

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9. Judith Brown and Richard C. Brown, 1980 "Characteristics of Contraceptive Acceptors in Rural Zaire." Studies in Family Planning 11: 378-384.
10. "Bas Zaire Family Planning Project." Trip Report: Jane J. Bertrand, July 7-28, 1982.

"Clinic-based" family planning projects in other countries have been gradually supplemented with other types of delivery systems, including community-based distribution and contraceptive retail sales, because of the barriers related to clinic-based delivery: inconvenience and cost involved in getting to the clinic; time lost en route and in the waiting room, discourteous treatment from clinic staff, especially to lower class clients, etc. However, with the systematic introduction of family planning for the first time on a widespread scale in the urban areas, it is appropriate that it be established as part of the existing health services, since the motivation of the target population for family planning is health-related. For those who are truly motivated to practice family planning, the descretionary time necessary to visit the service outlets should not represent a barrier to seeking out this service provided that the required papers and procedures in the dispensaries are kept to a minimum.

6. Profile of the Project Participants

The participants in this project are expected to be the men and women (though primarily women) from the lower and lower-middle classes that constitute the overwhelming majority of the Zairian urban population. While it is probable that those who have received some education (e.g., have gone past the sixth grade) will more readily accept modern contraceptives than others (as shown in the Kinshasa study, cited above), this would not be unusual, and with time, the program is expected to attract others. In contrast, certain countries (examples can be found throughout Latin America) where women tend to become interested in family planning only after they have had 2, 3 or 4 children in a row, it is probable that in Zaire, family planning will be sought out by women of all parity levels for the purpose of spacing.

It is expected that in the beginning, the majority of couples will adopt family planning for the purposes of spacing rather than family limitation. There will be a small group of women who will be interested in family limitation. (This has already emerged in both urban and rural areas of Bas-Zaire.)

However, one should not underestimate the importance of the initial acceptance of family planning for the purposes of spacing. There is evidence from many developing countries that this serves as a means of legitimizing the use of contraceptives and allowing for experimentation with the different methods. With the means available, many women gradually move from the category of "spacers" to "limiters".

Obstacles

One of the reasons that the proposed project has strong potential for realizing its objectives is that there is almost no organized opposition to family planning in Zaire. The 1973 declaration of the President in favor of "Naissances Désirables" has opened the door to active family planning efforts, of which the proposed project is a key component.

This is not to say that one can or should expect strong support from local politicians for population activities, especially for demographic reasons. Whereas many local authorities would support family planning as a DPH intervention,

the time has yet to come for an aggressive campaign for "population awareness" (demographic issues). In summary, the program should not run up against political obstacles as long as the emphasis of the program is on health.

In terms of religious opposition, a certain amount can be expected from fundamentalist groups. However, these sects constitute a very small minority of the population. In general, the Protestants are supportive of family planning, and certain missionary groups have been pioneers in family planning in Zaire. The Catholics cannot openly support the use of modern contraceptives except for natural methods; however, there is considerable tolerance on the part of many local religious leaders such that there is no major source of opposition here. The Kimbanguistes, another sect important in certain areas of the country, have no opposition to family planning. In brief, it is not expected that there will be any organized religious opposition to this project.

Perhaps the largest obstacle to family planning in Zaire is economic. Even at very nominal costs, modern contraceptives are a luxury item for the lowest income groups. However, in the long run, a paying program is more visible than one in which the products are given free of cost.

B. Spread Effects

This urban family planning project is likely to have spread effects for several reasons.

First, it is in the nature of innovations that there is a differential rate of adoption among subgroups within a population. For example, the better educated women who have close access to the services are likely to be the early adopters. A number of these women will prove to be satisfied users, who in turn communicate their experiences with others. Those women who are perceived to be knowledgeable about the methods will be opinion leaders among their peers and will ultimately exert considerable influence in the further acceptance of the innovation, more so perhaps than political leaders or elected local authorities.

Second, although the project will be based in the urban areas, it is likely to have spillover effects elsewhere. Since the urban population is often viewed as trend-setters, it is likely that the use of contraceptives among this population will have an influence on family members and friends in areas not served by the program, who will indirectly be affected by this effort.

It should be stressed that once the program is in place, it will be able to serve additional clients at marginal cost. While the spread effect among the target population will be limited geographically, because of the size of the country and the communication/transport barriers between regions, the amount of mobility found within a given region (between the urban areas and surrounding rural zones) favors the spread effect. Indeed, this will be reinforced by the existence of the Rural Health project in various areas of the country.

Finally, one should not overlook the implications of the spread effect at the international level. At present, there is little systematic effort to make contraceptives readily available to the populations of Francophone sub-Saharan Africa. Yet the initial efforts at doing so in Zaire suggest that the potential acceptance for this is considerable. Given that Zaire is the largest Francophone sub-Saharan country (in population), it would serve as an example to other leaders in the region that this is a politically visible program with acceptance at the grass roots level.

C. Social Consequences

The groups to be helped by this project are those women--from any tribal group, any religious sect, and education level--who choose to participate in the program and thus are able to achieve their fertility ideals using efficient contraceptive methods. By extension, their families are the indirect beneficiaries of this program, given that scarce resources for food, education, clothing and shelter will be divided among fewer people.

Who will be adversely affected by the more widespread availability of contraceptives? At present, there are some pharmacies and private doctors who carry these products; however, they serve a middle-to-upper class population which is unlikely to seek out the services provided through state dispensaries and hospitals. Indeed, the current levels of contraceptive use are sufficiently low that this project will be creating a new market (satisfying a demand which already exists but for which low cost methods have not been previously available), rather than luring clients away from other services.

A program of this type is not likely to affect the distribution of wealth in the short run. Within a given family, the use of contraceptives which leads to fewer children will result in a larger share of the family's resources for each child; in the long run, the program will yield certain economic benefits (or act to stave off a deterioration of the economic situation) for those who adopt. However, the effects of this process will not be felt in the short run, and thus do not represent a potential source of social disruption.

Likewise, the program is not expected to cause any type of displacement or migration. On the other hand, it should help to reduce the pressures caused by rapid population growth in the urban areas as a result of natural increase and rural-urban migration.

A very real question exists as to the effect of the program on social organization, and more specifically on male-female roles. In traditional society, the practice of abstinence generally meant female abstinence while the male tended to be less restricted in his sexual behavior. This resulted in a certain level of control which males had over their wives. With the advent of modern contraceptives, the wife has a new type of freedom which some construe as threatening to the traditional male-female roles. Undoubtedly a program of this type will draw accusations that it is fostering a breakdown in the traditional structure of the family. A more realistic view is that this program is being introduced at a time when the change is already well in motion: traditional

methods are not entirely acceptable, polygamy is practiced on a much smaller scale, and women in many cases are discovering new roles as the direct result of increased urbanization and education. While family planning programs may tend to accelerate this change, it is important to recognize that change is already in motion long before the program will be introduced. And in fact, it may well help many couples to adjust to the pressures of the changing world around them.

ANNEX F

TECHNICAL FEASIBILITY

A. General Feasibility of this Approach to Fertility Regulation

Traditionally Zairian families have used methods of prolonged breastfeeding and sexual abstinence facilitated by polygamous unions to accomplish their birth spacing/fertility limitation objectives. As these traditional methods have become less functional with changing social customs, alternative approaches to fertility limitation are being considered.

One alternative chosen by some countries has been to let development take its course and expect that through the process of urbanization, improved education, improved economic levels, the problem of fertility regulation would take care of itself. The examples of western developed countries that passed through the demographic transition generally in this way are cited. Often, however, there is inadequate consideration given to the speed with which death rates have fallen or can fall and how fast social change is occurring in the developing world as compared to the length of time of the demographic transition of the developed world. Several countries (e.g., Mexico and Venezuela) have found that in the absence of readily available modern contraceptives this process of fertility regulation through modernization was not very effective. If effective at all, the process is found to be too slow to avoid a period of substantial increase in the incidence of short birth intervals, pregnancies to young adolescents and older women, very high parity and induced abortion -- all contributing to high levels of maternal and infant mortality and morbidity and conditions prejudicial to family and societal health and welfare.

Thus the GOZ has chosen a more direct approach to providing modern alternatives to the traditional means of child spacing, namely that of including contraceptive delivery in its health services.

A review of the literature on this subject finds ample discussion of the relative merits of providing contraceptive services in a relatively narrow focus vertical delivery system or in a more complex approach integrated with other health services, especially maternal and child health. Examples from Colombia, Brazil, Mexico, Indonesia, Thailand and Ghana suggest there are efficiencies and acceptability in the simple family planning emphasis focusing on community participation and even using retail sales channels. In parts of these same countries and in others such as Costa Rica, Panama, Kenya, the more integrated approach has been effective.

Whatever one concludes about the ultimately most effective and efficient approach to providing family planning services, it is clear that a Ministry of Health should assure that family planning services are made available through the existing DPH centers in the health system. Other approaches may be utilized parallel to this or as an extension to it. However, the most efficient use of present scarce human, physical and financial resources of the DPH is to first

build on the system presently in place. This has the additional advantage of being the most acceptable approach to medical and societal leadership, a fact that has much to do with the overall feasibility of the project.

Thus the decision was not made to begin with some of the simpler, less integrated approaches such as community-based distribution or commercial sales.

At the same time, the other extreme of a preponderant physician-oriented approach in costly health facilities was also rejected. Consistent with the DPH emphasis on primary health care and extension of effective services at minimum cost to the greatest number of the population, an approach maximizing the use of paramedical personnel was chosen. In so doing it is recognized that more attention must be paid to training and supervision of these personnel if the service is to meet health standards and be effective. These needs were taken into account in this project design. It is expected that this approach can lay the groundwork for utilizing some of the simpler (more cost effective and often more accepted by user) approaches of community-based distribution and commercial sales in the future.

The issues related to the feasibility and cost effectiveness of various kinds of contraceptives are discussed in Annex G. Suffice it to say here that for a variety of cost, delivery capability, logistic, health and user satisfaction reasons the contraceptive mix was chosen which is considered feasible on experience in Zaire.

Another consideration in project feasibility was the choice of relative emphasis on public or private sector institutions. There is good reason for greater confidence in the private sector as one sees its flexibility, the enthusiasm and dynamism of much of its leadership, and the vigor with which it approaches its work. Yet the private sector also has its limitations. Most of its support is from external sources. The private sector is not immune to the difficulties of internal politics, bureaucracy and management inadequacies.

The public sector has its well-known problems but the fact is that it has a widespread network of health service outlets that are presently in contact with a substantial number of the Zairian population. These can be utilized more effectively by adding a family planning component to complement existing service. Thus this project has been designed to support actions in the private sector through the CNND, CASOP, ECZ and various industries while at the same time also supporting the public sector Ministry of Health. The organizational arrangements of the project have been designed to develop close collaboration between the private and public sector, utilizing the comparative advantages of each as appropriate. These organizational arrangements have posed the most serious issue encountered in terms of the feasibility of this project. The organizational arrangements (especially those relating CNND to DPH) have been the subject of long study and discussion by the representatives of USAID, CNND and DPH. What appears a practical solution was found but this remains one of the key areas for constant attention and review. A model for greater project control and more centralized direction was rejected as it did not appear to adequately use and build the capabilities of the separate institutions. A

more regionalized structure was rejected for cost consideration as well as a concern that project standards would not be possible and the central planning decision-making unit would not have adequate first hand contact with the service delivery outlets. It is expected that this structure will be modified in practice, but it appears the most practical approach for project initiation.

B. Practical Feasibility of the Several Project Actions

The feasibility of various technical aspects of the project has been discussed throughout the paper. In general it can be stated that there is nothing contemplated within the project that has not been done already in Zaire with some success. There is no sophisticated technology with the exception of laparoscopy for tubal ligation and this will only be performed in a limited number of locations. There are already surgeons and nursing personnel trained to perform this function. There are requirements for a certain number of physicians trained in family planning to provide medical supervision; they are available. Some high levels of skill in project management and in the development of training programs is required. Intelligent and able persons are available to perform these functions; their skills can be augmented by training and technical assistance.

Looking more specifically at the various tasks required to achieve project objectives, the conclusion is the same as the general statement above; namely that with discrete inputs of training or technical assistance there are no areas where project objectives are not technically feasible.

1) The organization of a training program for paramedical personnel, including both didactic sessions and clinic and community practice: some training of this nature has already been accomplished by the CNND to establish clinic and community projects in various locations of Zaire. The Tulane Operations Research project has provided additional experience. The Basic Rural Health project has now completed two in-country training courses, one with JHPIEGO assistance and one developed largely by the medical faculty of the National University of Kinshasa, which is expected to provide direct assistance to this project. Organization, planning and management skills will be necessary to pull together the several components of didactic and practical training especially in Kisangani and Lubumbashi, but the technical feasibility is not in doubt. Skills available in Zaire will be augmented by training, long and short-term technical assistance and consultation from such centrally funded organizationas as JHPIEGO and INTRAH.

2) Development of curricula for pre-service training of medical and nursing personnel: Both the medical and nursing faculties of Zaire are recognized as functioning at an acceptable level. They have either adapted basic curricula from other countries or produced their own material appropriate to Zaire. Well-trained professionals are in place who can work with project personnel and consultants such as JHPIEGO and INTRAH to produce appropriate family planning curricula.

3) Development of didactic and informational material: The experience of CNND, the Bureau of Studies and Research for the Promotion of Health, the Tulane Operations Research project and the Basic Rural Health project all demonstrate the technical feasibility of designing and producing this type material in Zaire. Only for reasons of cost will consideration be given to printing outside Zaire.

4) Refurbishing of facilities: This is the simple kind of carpentry, plumbing, painting and wiring that only requires moderately skilled laborers, who are available throughout Zaire.

5) Delivery of family planning services: With the exception of sterilization and IUD insertion for which special training will be provided, the skills for distribution of other contraceptives under extended medical supervision can easily be acquired by the kinds of people contemplated in this project with the kind of training envisioned. This has already been demonstrated to some degree in Zaire by the CNN-ECZ, and Tulane Ops Research. It has been amply demonstrated as feasible throughout Asia and Latin America and in several locations of Africa.

6) Ordering, warehousing, and logistics of contraceptive delivery: As indicated by the CDC/APHA evaluation, the basic system is in place to handle this essential aspect of a family planning program. Within the project, CNND, the organization with the most experience, will be charged with this responsibility. They have a system that is improving in supply forecasting and ordering. Central warehousing is good. Logistics to up-country locations and commodity flow statistics must be improved. The evaluation indicates that this could be accomplished through judicial use of technical assistance (available from CDC) and by providing additional support for internal logistics. The project plans to utilize the recommended TA. It also has made provision for augmenting the present internal logistics system by utilizing channels of the DPH, CASOP and ECZ and providing financial assistance when absolutely essential. The services initiated by the project will depend to the fullest extent possible on end user financial support (fee for service).

In summary it can be concluded that this project takes an approach consistent with successful actions in Zaire and other countries to achieve fertility regulation. It builds on public and private sector institutions and programs already in place. It is consistent with the DPH and medical faculty's growing emphasis on primary health care. It will utilize the type of personnel most available to the system providing them skills that are within their demonstrated capacity. It is designed to minimize the burden on the government for the cost of extension, replicability and continuity. It does not introduce sophisticated technology or any approaches that have not already been demonstrated feasible in Zaire. The major issue of project feasibility, that of proper organizational arrangements to assure collaborative and effective implementation actions of participating institutions has been dealt with in consultation with all parties. The proposed system is determined feasible but must receive constant review.

ANNEX G

PID APPROVAL CABLE STATE 213510

STATE 213510

UNCLASSIFIED

AID-2 INFO AMB DCM ECON CHRON

ACTION TAKEN
NAME .... DATE ....

10327
RUEHKI
RUEHC #3510 2120304
ZNR UUUUU ZZH
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FM SECSTATE WASHDC
TO RUEH.I/AMEMBASSY KINSHASA IMMEDIATE 2121
INFO RUEFAB/AMEMBASSY ABIDJAN 8133

31 JUL 82
LOR: 0256
CN: 29225
CHRGE: DEAID/ZAIRE

ACTION	INFO
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ACTION DUE	
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UNCLAS STATE 213510

AIDAC, ABIDJAN FOR REDSO/WA

E.O. 12065: N/A
TAGS:
SUBJECT: ZAIRE FAMILY PLANNING SERVICES PID - 660-0094

1. ECPR CHAIRED BY FRANK CORREL, DAA/AFR, MET JULY 27 TO REVIEW SUBJECT PID. PP DEVELOPMENT FOR FIELD AUTHORIZATION APPROVED WITH FOLLOWING TO BE INCORPORATED INTO PP.

2. CLARIFY DURATION OF AMERICAN ASSISTANCE FOR COMMODITY INPUTS. PP SHOULD NOT CONVEY NOTION AMERICAN COMMITMENT IS INTENDED BEYOND PLANNED FINAL FY 86. A PLAN SHOULD BE REQUIRED TO SHOW INCREASING ZAIROIS RESPONSIBILITY IN FUTURE YEARS FOR FP COMMODITIES. THIS MIGHT BE HANDLED AS A COVENANT. IF GOZ FX CONSTRAINTS ARE RAISED, POSSIBILITY OF EXCHANGING CONTINUED AMERICAN COMMODITY PURCHASES AFTER CURRENT PROJECT IN RETURN FOR COUNTERPART EQUIVALENT IN TRUST FUND ACCOUNT MIGHT BE EXPLORED.

3. THE PID SUBSTANTIALLY ADDRESSES STANDARDS COVERING FAMILY PLANNING SERVICES IN ZAIRE. WHILE THESE ACCORD WITH AID POLICY, ECPR RECOMMENDS THAT THE PP FURTHER STRESS THAT ZAIROIS STANDARDS ARE BOTH VOLUNTARY AND GENUINE AND THE IS RESULT OF COLLABORATION IN DESIGN. IN ADDITION, IT MUST BE MADE ABSOLUTELY CLEAR THAT THIS PROJECT DOES NOT FINANCE OR PROPOGATE THE USE OF A DRUG THAT IS NOT APPROVED BY FDA FOR USE IN THE U.S., I.E., DEPO-PROVERA. REFERENCES TO DEPO-PROVERA SHOULD BE FOOTNOTED TO INDICATE THAT AID IS NOT FINANCING ITS USE.

4. ECPR RECOMMENDS THAT MAJOR PART OF THE ECONOMIC ANALYSIS FOCUS ON THE COST OF ALTERNATIVE APPROACHES AND THE ADOPTED APPROACH, I.E., COST EFFECTIVENESS OF THIS PARTICULAR PROJECT.

094

IRF COST SHOULD BE BUILT INTO THE BUDGET

3. THE GOAL AND PURPOSE STATEMENTS SHOULD BE CLARIFIED AND EXPRESSED IN QUANTIFIABLE TERMS, E.G., TO INCREASE THE NUMBER OF FAMILIES SPACING THEIR CHILDREN VS. MAKING FAMILY SPACING AVAILABLE.

4. COPIES OF ISSUES PAPERS PREPARED FOR THE ECPR ARE BEING FORWARDED FOR YOUR CONSIDERATION IN PREPARATION OF

SP. SEULIZ
ET
43510

ANNN

AID/W Issues Related to Family Planning Services Project

REF: State 213510

Para A : Clarify Duration of U.S. Commodity Supply

AID/W policy guidance was followed by insertion of two paragraphs in Section IV (F) Contradeptive Supplies (page 20) that indicate GOZ future requirements (similar language is in the Pro Ag).

Para B : Medical Standards and Clarify Depo-provera is not USAID-Provided

For futher clarification, a paragraph was added in Section IV (H) Service Delivery (page 22) emphasizing our responsibility, quality of service and voluntary requirements. Wherever Depo-provera is mentioned, it is stated that USAID does not provide (also done in Pro Ag). Also, see Section I (D) Family Planning Policy and Status (page 7).

Para C & Para D: The Social and Economic Analyses deal with these issues as requested, to the degree data is available (Annex E and page 34).

Para E Project Evaluation

Two are included (years two and four) and budgeted (see Monitoring and Evaluation Plan, Section VII (B) (page 39).

Para F Goal and Purpose have been changed as recommended to quantify in terms of family planning users. See Section II Goal and Purpose (page 10) and Log Frame- Goal and Purpose (Annex A).