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SWAZILAND

Family Health Services

(645-0228)

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1

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: A = Add, C = Change, D = Delete
 Amendment Number: _____
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2. COUNTRY/ENTITY: Swaziland
 3. PROJECT NUMBER: 645-0228

4. BUREAU/OFFICE: AFR [6] Family Health Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY 07 31 93
 7. ESTIMATED DATE OF OBLIGATION (Under 'B:' below, enter 1, 2, 3, or 4)
 A. Initial FY 88 B. Quarter 3 C. Final FY 91

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

A. FUNDING SOURCE	FIRST FY 88			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total (Grant)						
(Loan)	(875)	(525)	(1400)	(1700)	(700)	(2,400)
Other U.S. 1. AID/W				204	-	204
2.						
Host Country / PVO	-	400	400	-		
Other Donor(s)					800	800
TOTALS	875	925	1800	1904	1500	3,404

9. SCHEDULE OF AID FUNDING (\$000)

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

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 450 + 460
 11. SECONDARY PURPOSE CODE: 440

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BL	BV-BR	DEL	TRG	PVOW
B. Amount	500	500	200	200	1,000

13. PROJECT PURPOSE (maximum 480 characters):
 To increase prevalence of modern contraceptive and practice of child spacing in Swaziland.

14. SCHEDULED EVALUATIONS: Interim MM YY 07 93 Final MM YY 03 93
 15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000 935 Local Other (Specify) DFA

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

17. APPROVED BY: Signature R. D. CARLSON, Title Director, USAID/Swaziland, Date Signed MM DD YY 07 27 93
 18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AID/W	Agency for International Development/Washington
CA	Cooperative Agreement
CBD	Community-Based Distribution
CDSS	Country Development Strategy Statement
CFR	Code of Federal Regulations
CSM	Contraceptive Social Marketing
DFA	Development Fund for Africa
DHS	Demographic and Health Survey
EBD	Employer-Based Delivery
FHS	Family Health Services
FP	Family Planning
FPIA	Family Planning International Assistance
HPN	Health, Population and Nutrition
IPPF	International Planned Parenthood Foundation
LOP	Life-of-Project
IQC	Indefinite Quantity Contract
MOH	Ministry of Health
MOE	Ministry of Education
OPG	Operational Program Grant
P&E	Planning and Evaluation Unit (FLAS)
PCS	Population Communication Service
PVO	Private Voluntary Organization
PHC	Primary Health Care
PID	Project Implementation Document
PP	Project Paper
PPC	Bureau for Policy and Program Coordination
PSC	Personal Services Contract
R&E	Research and Evaluation
SOMARC	Contraceptive Social Marketing project
STD	Sexually-Transmitted Disease
TA	Technical Assistance
TIPPS	Technical Information for Population in Private Sector project
UNFPA	United Nations Fund for Population Activities
UNISWA	University of Swaziland
USDH	U.S. Direct Hire

EXECUTIVE SUMMARY

PROJECT PURPOSE AND DESCRIPTION:

The goal of the Family Health Services (FHS) Project (645-0228) is to reduce high fertility rates and to improve maternal and child health in Swaziland. The purpose of the project is to increase prevalence of modern contraception and practice of child-spacing, emphasizing expansion into new areas to extend family planning services and information to a wider number of Swazis.

The Project will consist of two phases each of 2 1/2 years duration. The first phase comprises activities designed to strengthen the Family Life Association of Swaziland (FLAS), an indigenous PVO, to undertake activities in research, management, planning and clinical services delivery. The second phase will emphasize expansion of family planning services, particularly in the private sector. The second phase will build on the activities undertaken in Phase 1, enabling FLAS to begin a "market-oriented" expansion of family planning services in private sector industries, and among private physicians and nurse practitioners. The FHS Project will address identified needs in seven key areas of family planning program implementation:

1. Management and Institutional Development

The FHS Project will provide short-term technical assistance and training in key management areas. These areas include, but are not limited to research and evaluation, program planning and management, clinical services, personnel development, financial accounting, commodity planning and logistics, and fund-raising.

2. Service Delivery Expansion

The FHS Project will assist in strengthening the capabilities of both FLAS and private sector clinics in providing family planning information and services. It will place particular emphasis on expanding employer-based service delivery systems through utilizing FLAS' expertise in providing technical assistance to the private sector. The Project will also explore how FLAS can recover the costs for such services it provides.

3. Information, Education, and Communication (IEC)

The FHS Project will support the expansion of FLAS' IEC unit. The unit will increase its capability to produce and disseminate high quality IEC materials through mass media and other channels. FHS will also support costs for the production of IEC materials until a multi-media center is operational. The IEC unit will continue to be responsible for all IEC activities within FLAS and will also become the principal supplier of IEC materials among the MOH, MOE, and all public- and private-sector clinics in Swaziland.

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4. Program Research and Evaluation

The FHS Project will support the creation of a Research and Evaluation (R&E) unit within FLAS. The project will provide a long-term specialist to assist with planning, evaluation and research work and to provide ongoing in-service training to R&E staff. The unit will have responsibility for collecting program service statistics, monitoring program implementation, testing new service delivery techniques, conducting periodic studies of client satisfaction and demand for services, projecting future program needs, and planning for service delivery implementation.

5. Leadership Awareness

Leadership awareness of the implications of population growth for national health and development prospects is already being supported through surveys and presentations under the Primary Health Care Project. The FHS Project will supplement this support through national and local seminars and workshops focusing on important population issues. The FHS Project will also support the participation of national leaders at international and regional conferences on population and development.

6. Commodities

The FHS Project will fund procurement of computers and software, limited clinical equipment, office equipment, IEC supplies and equipment, furniture and 2 vehicles. The AID/Washington centrally-funded Contraceptive Commodities Procurement Project will supplement the FHS Project with contraceptive commodities in the event of contraceptive commodity shortfalls.

These above six interrelated project components represent a coordinated approach to expanding the availability and use of family planning services in Swaziland. Throughout the Project, U.S.-based long and short-term technical assistance will seek to strengthen FLAS capabilities to address the growing demand for family planning services in Swaziland.

7. Mission Management and Special Activities

AID will retain a portion of the grant funds for evaluations/audits and to respond to additional opportunities in family planning/population.

EXPECTED ACHIEVEMENTS AND ACCOMPLISHMENTS

By the end of this five-year project, it is expected that there will be increased broad-based support for family planning programs among the private sector, the general public, and Swazi leadership. Information exchange and coordination among the various providers of family planning services will be established. The public will have increased knowledge of family planning benefits and services, and such services will be more accessible

through private sector facilities. An increased number of Swazi couples will be using modern contraceptive methods. FLAS will have improved management and technical skills, enabling it to respond to an increased demand for family planning services and to monitor the expansion of family planning use in the country. FLAS will also become more self-sufficient through cost recovery mechanisms. Under this project, FLAS' role will evolve into that of a coordinating body for all family planning activities, and a resource agency which provides training, technical assistance, and advisory services to others.

TERM OF THE PROJECT

The FHS Project covers a five-year period. The Project Activity Completion Date (PACD) is 5 years from the date of authorization, with initial AID funding beginning in FY 1988. The project will be divided into two phases each of 2.1/2 years duration. Only funding for Phase 1 is currently available. Phase 2 will be implemented contingent upon availability of additional funds and favourable outcome of the Phase 1 external evaluation.

INPUTS

Project inputs consist of long and short-term technical assistance, non-contraceptive commodities, training (both U.S. and in-country), support for local costs, and funding for special studies (research/evaluation/monitoring). The inputs will be provided through two Cooperative Agreements with FLAS and The Pathfinder Fund. The remaining project funds not included in either the direct support to FLAS or Pathfinder will fund USAID management oversight activities (audit and evaluations), establishment of an IEC multi-media production unit, and additional activities in family planning/population to be determined at a later date.

Additional AID inputs available to the Project include contraceptive supplies provided through an AID/W centrally-funded program; leadership training and IEC support through USAID's Manpower Development Project (SWAMDP 645-0218); and training and data collection from a Demographic and Health Survey to be carried out under USAID's Primary Health Care (PHC) Project (645-0220).

FINANCIAL PLAN

Level of assistance: The life-of-project bilateral funding over a five year period will be \$2.4 million, with funding for Phase 1 totalling \$1.4 million and phase 2 totalling \$1 million. This total excludes the cost of centrally-funded contraceptives estimated at \$204,000. The \$1.4 million in Phase 1 consists of the following components: Long-term technical assistance and support (\$359,920); short-term technical assistance (\$424,300); U.S.-based training (\$90,900); Swaziland-based training (\$40,900); equipment (\$81,500); Local support and supplies (\$220,900); USAID/Swaziland oversight and related costs (\$181,480).

FLAS' contribution to the project during Phase 1 is estimated to

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equal \$466,700 all in-kind. This amount is comprised of staff (clerical, administrative support personnel and supervisor staff), office space for the long-term technical assistance, training by FLAS staff, commodities/equipment and utilities. The above contribution under Phase 1 meets A.I.D. 25 percent requirement for contribution during Phase 1.

PROCUREMENT PLAN AND WAIVERS

The Procurement Plan in Section III.D. provides detailed information on all procurement to be undertaken under the FHS Project, including short- and long-term technical assistance, equipment, and commodities. The contraceptive supplies are not a part of Project procurement since they will be provided through an AID/W centrally-funded program.

MAJOR CONDITIONS PRECEDENT AND COVENANTS

The following conditions and covenants will be included, in substance, in the 2 Cooperative Agents. The requirements (see Section VI, pages 40-43), cover signature samples, and the need for an agreement on the relationships between the two Cooperating Agencies, (FLAS and The Pathfinder Fund). The Covenants for FLAS include requirements for technical assistance in financial management, the appointment of a counterpart for the Pathfinder long-term R&E Advisor and ensuring that all family planning services meet AID requirements in the areas of prohibited abortions and coercive family planning services. The covenants for the Pathfinder Fund include obtaining country clearance to operate in Swaziland.

MANAGEMENT AND IMPLEMENTATION RESPONSIBILITIES

The FHS Project will take advantage of the expertise and management experience of The Pathfinder Fund, a U.S.-PVO working in international family planning. Pathfinder assistance will be obtained through a Cooperative Agreement. FLAS, also through a Cooperative Agreement, will have responsibility for hiring local staffing, local procurement, training and other activities defined in the implementing section of the PP. The services described under Implementing Agency Responsibilities (Section III.A.2.) apply to the respective responsibilities of FLAS, Pathfinder, and USAID.

INITIAL ENVIRONMENTAL EXAMINATION (IEE)

A categorical exclusion under 22 CFR Section 216.2(c)(2)(vii) was approved on August 10, 1987. See Annex 7.

PROJECT DESIGN APPROACH

In order to assess the unmet demand for family planning/child-spacing services and to determine the most realistic ways to increase services through private sector channels, the Project Paper design team (see Annex 12) met with a cross-section of representative industries and firms in the private sector. This included discussions with both management and medical staff and visits to industry-based health facilities. Meetings were also held with individual providers of health and child-spacing services, private voluntary organizations (PVOs), other donors (IPPF, UNDP, UNFPA) and Government of Swaziland officials. The team assessed FLAS' management and planning capability as well as the delivery of FLAS clinical services. Field visits were made to selected rural public health clinics, both private and public, and a pilot community-based distribution program.

The information obtained in this process indicates a growing awareness to Swaziland's population growth problem, and a growing interest among private sector organizations in doing more in family planning. Preliminary data also support the assumption that there is a significant unmet demand for family planning information and services in Swaziland. These data form the basis of Project Paper assumptions, analyses, and the overall project design.

Family Health Services Project

I. PROJECT RATIONALE AND DESCRIPTION

A. BACKGROUND AND RATIONALE

Swaziland is primarily a rural society with strong traditional roots. According to preliminary UN estimates from the 1986 census, the population of Swaziland was approximately 706,000. An estimated 66 percent of this population reside in rural areas. The country is a monarchy, administered under a dual governing system reflecting both traditional and modern structures.

The distribution of health services, although much improved since the 1970s, is still skewed toward curative care, with most modern hospitals, and many doctors and nurses concentrated in the four major urban areas. A combination of two rural health centers, 115 government-run rural clinics and many private religious/ industrial health clinics form the base of the health care available to the rural population. Although family planning services are theoretically available within the context of integrated primary health care services at each of these facilities, in fact many nurses have had little or no training in clinical family planning skills and counselling. Additionally, in most clinics where family planning services are available they are offered only on demand and not actively promoted (see Technical Analysis, Annex 1).

Traditional methods of family planning have been practiced in Swaziland for many years. Breastfeeding and abstinence were commonly practiced for periods of up to two years following birth. With increasing urbanization and modernization, however, these practices are being abandoned, resulting in decreased intervals between births. Further, traditional methods of child-spacing are not being replaced by modern contraceptive methods, as evidenced by the prevalence rate for use of modern contraceptives estimated at only four percent (4%) (World Bank 1985).

Swaziland's population is currently growing at an estimated 3.4 percent per year (UN, 1987). This rate places Swaziland among the fastest-growing populations in the world. Swaziland's rate of population growth has been increasing at least since the early 1950s, when it was estimated to be 2.5 percent per year. With expected future reductions in mortality, abandonment of traditional fertility limitation practices (e.g., breastfeeding, abstinence, and polygamy), and the low level of modern contraceptive practice, Swaziland's population growth rate is expected to continue to increase, possibly exceeding 4.0 percent per year by the year 2000. This high and increasing rate of growth has produced a youthful age structure that guarantees continued population growth for decades.

The Government of Swaziland (GOS) outlines its development goals and strategies in its National Development Plans. The current

Plan (NDP4), drafted in 1983 and covering the period 1983/4 through 1987/8, acknowledges Swaziland's high and growing rate of population growth and the resulting youthful age structure. The Plan also notes the implications of rapid growth for development prospects in key sectors, including education, health, and employment. For the most part, the Plan offers solutions for accommodating rather than for influencing population growth.

Although the GOS has yet to formulate a formal population policy, family planning is but one of a number of elements of its national health policy. Family planning services and promotion of child-spacing is part of the Ministry of Health (MOH) maternal and child health (MCH) strategy. The National Plan also identifies as one of its two key health sector objectives: "to provide services which contribute towards an increase in child-spacing and a moderation in the rate of population growth" (NDP4, P. 473). Toward this end, the MOH in 1986 launched the AID-assisted Primary Health Care (PHC) Project, which includes a component for training MOH staff in family planning and child-spacing and the provision of family planning services at MOH health centers and clinics. To date, staff at all public health centers have been trained in family planning and in-service training programs are planned to reach hospital and health clinic staff, and rural health motivators. However, rather than actively promoted, family planning services are offered passively - available if sought out.

The GOS has begun to recognize the significance of its high population growth rate for the nation's ability to meet education, health, employment, and social services needs. Still, it has yet to introduce an active public sector family planning information and service delivery program. Much that has been accomplished in population awareness, family planning information and service delivery has been through non-government channels - primarily through the efforts of the Family Life Association of Swaziland (FLAS).

Relationship to AID Strategies

In the current Country Development Strategy Statement (CDSS), revised in 1984, USAID/Swaziland identifies as its principal objective: "building a firm basis for self-sustained and equitable growth." The CDSS ranks rapid population growth as one of four major problems facing Swaziland in reaching this development objective.

As noted in the CDSS, rapid population growth has important implications for future requirements in a number of key development sectors. Population factors underlie three other major problems identified by USAID/Swaziland:

- Poor health status: Population factors are linked to health status in two ways. First, infant and maternal mortality rates are sensitive to the timing of births. Unless child-spacing practices are adopted, mortality and morbidity rates

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among these two groups will likely remain high. Second, the MCH target population could double in the next 18 years, according to World Bank estimates. Such an expansion among this important health client group will place enormous strains on Swaziland's health delivery system and will likely compromise the quality of services available.

- High and growing unemployment: Swaziland's working-age population will double over the next 19 years. World Bank estimates indicate that the formal sector is unlikely to absorb more than one-fifth of new job seekers over this period. Unless traditional agriculture can absorb these additional workers, many will become unemployed or underemployed. With continued high fertility, large and increasing numbers of dependent children will be supported by less than fully-employed parents.
- Low productivity in traditional agriculture: With expected increases in laborers engaged in traditional agriculture, there will be pressure to bring new land under cultivation and to intensify land use. Land availability does not appear to be a major constraint in the short-term. But to increase labor productivity in this sector will require substantial investment in human and physical capital -- all the more so with expected increases in numbers of laborers. In addition, high rates of population growth will place increasing demands on traditional agriculture to produce subsistence levels of yields.

The CDSS stresses that effective solutions to all these problems require attention to human resource development. Even here, population growth has important impacts. World Bank estimates indicate that Swaziland's school-age population could double in just 17 years. This rate of growth has serious implications for the nation's ability to expand the percentage enrolled in school and at the same time improve the quality of education.

The FHS Project supports USAID/Swaziland's objectives by:

- Directly addressing the problem of rapid population growth;
- Directly improving health status of women and children through child-spacing;
- Indirectly easing solutions to other problems, i.e., reducing demand for health, education, food, employment, and other social services; and
- Directly supporting human resource development, in areas of program operations analysis and family planning service delivery.

B. PROJECT DESCRIPTION

1. Project Goal and Purpose

The goal of the FHS Project is to reduce high rates of fertility and to improve maternal and child health in Swaziland. The project will contribute toward reducing Swaziland's total fertility rate (currently estimated to be 7.0 children per woman) and infant mortality rate (currently estimated to be 124 infant deaths per thousand live births).

The purpose of the project is to increase prevalence of modern contraception and practice of child-spacing. The project will contribute toward increasing contraceptive prevalence from the current level of 4 percent to 15 percent by 1993. The project will contribute toward increasing the numbers of couples practicing child-spacing and increasing the length of birth intervals. The principal problem to be addressed by the Family Health Services Project is the high and growing rate of population growth in Swaziland, and the consequent health and social problems.

The FHS Project will be implemented over a period of five years with funding beginning in FY 1988. The Project will consist of two phases each 2 1/2 years long. The first phase comprises activities which strengthen FLAS' capability in research, management, planning and clinical skills. The second phase will emphasize expansion of private-sector family planning services.

The FHS Project represents the private-sector portion of the Mission's population sector strategy. As such, the project complements the public-sector orientation of the Primary Health Care (PHC) Project (645-0220), which includes a major emphasis on family planning as an MCH intervention. The FHS Project will closely coordinate with the PHC Project in areas of clinical services training and directing service delivery efforts to target client groups. The FHS Project will also coordinate with the Swaziland Manpower Development Project (SWAMPD 645-0218) in the areas of traditional leadership training and development communications for the IEC component.

The FHS Project is expected to achieve substantive outputs in a number of program areas as described in section 3 below. In addition, the Project will provide a foundation for continually expanding family planning programs and population policy activities as outlined in the Mission's population strategy.

By the end of the Project in 1993, it is expected that the following conditions will be achieved:

- The contraceptive prevalence rate for modern methods of child-spacing will increase to at least 15 percent;
- There will be increased knowledge of family planning benefits, use, and availability among Swazis and Swazi leaders;

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- There will be an expanded family planning data base which could be used for national planning on population;
- The capacity of the private sector to respond to an increased demand for family planning will be expanded.
- A Swazi private voluntary agency will be institutionally strengthened to respond to an increased demand for family planning services.

2. Description of Project Components

The project will be implemented in two major phases. Phase 1, approximately 2 1/2 years in duration, will focus primarily on strengthening FLAS itself. Most of the activities during this period will be directed toward institution building in preparation for outreach activities scheduled in phase 2. The second phase will build on the activities undertaken in phase 1 enabling FLAS to expand services in the private sector. Most of the outreach activities will be directed toward private (for profit) industries where health services are already being provided, and toward private medical and nursing practitioners. In addition to support provided directly to FLAS through the Cooperative Agreements, a small portion of Project funds will be retained to support opportunities in family planning which are outside the scope of the FLAS effort. These activities, however, will be determined at a later date with mutual agreement between FLAS and USAID.

The FHS Project will address identified needs in seven key areas of family planning program implementation:

- a. Management and Institutional Development
- b. Service Delivery Expansion
- c. Information, Education and Communication (IEC)
- d. Program Research and Evaluation
- e. Leadership Awareness
- f. Contraceptive Commodity Support
- g. Mission Management

A summarized description of each of the seven components is described below.

(a) Management and Institutional Development

The project seeks to strengthen FLAS' capabilities to better manage, plan, and evaluate all its present activities and those additional activities which will be introduced during the project (e.g. research and evaluation, private-sector marketing). Towards this end, the project will fund training and technical assistance directed to FLAS in specified areas where strengthening management and program operations will result in improved quality of service and an expansion of family planning wage. The Project will also fund the salaries of new FLAS staff and purchase selected commodities which will assist in strengthening the organization.

Under management and institutional support, the specific areas identified for assistance are:

- research and evaluation, program planning, management and monitoring;
- financial accounting and budgeting;
- management information systems;
- family planning information education and communications (IEC) program management; and
- local fund-raising capabilities.

Project resources directed toward strengthening research and evaluation, program planning, management, and monitoring will consist of long-term and short-term technical assistance, training and funding for new FLAS staff. The Pathfinder Fund will provide a long term technical advisor (up to 48 months) to support the creation of a new Research and Evaluation (R&E) Unit within FLAS. Local personnel will also be recruited with Project funds to staff the R&E Unit and other units of FLAS. The R&E Unit will have responsibility for collecting and maintaining FLAS program data as well as undertaking special studies for program management, monitoring, and evaluation. (Section (d) below describes the role of the R&E unit in more detail.)

Short-term TA in family planning program management for FLAS senior management will also be provided as will be funding for short-term training in management/program planning for FLAS senior staff and in-country management workshops. The long-term R&E Advisor will also possess management skills for use as appropriate in project implementation.

In the area of financial accounting and budgeting, the Pathfinder Fund will provide technical assistance on a quarterly basis to assist FLAS in upgrading its internal financial accounting and tracking system. This will be augmented by a contract with a local accounting firm who will assess FLAS' financial and administrative reporting system and provide needed restructuring. A project-funded administrative assistant will also possess basic financial skills for use as appropriate by FLAS financial staff. The Project will fund a computer system to enable improved financial record keeping and budgetary controls. Training courses will be provided for relevant FLAS staff on financial tracking and record keeping using the computer and software.

Project support for strengthening management information systems will consist primarily of long-term TA and computer equipment. The R&E advisor will assist FLAS in establishing computerized monitoring functions for tracking client load, commodity usage, and inventories, and other data necessary for program monitoring, planning, and management. Short-term TA during the first year of project implementation will supplement the efforts of the R&E Advisor.

Strengthening IEC program management will be accomplished through training and short term technical assistance. The project will fund short-term U.S. training in IEC program management for the

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Senior Family Life Educator. Regular consultancies in IEC will also assist in upgrading the quality of IEC materials/products and management of the IEC Unit.

Finally, the project will support cost recovery schemes (described also under service delivery) and short-term TA and training in fund raising techniques for FLAS executive staff engaged in such activities. Short-term TA from a fund-raising specialist will evaluate FLAS potential for fund-raising in Swaziland, assist the Executive Director to develop a fund-raising strategy, orient FLAS staff in fund-raising techniques, and provide follow-up assistance as requested. Short-term training in the U.S. will also be provided for the Executive Director at a fund-raising institute.

In summary, the FHS Project will provide FLAS with a mix of resources (short and long-term TA, short- and long-term training, funds for local staff, commodities) to effect improved management and monitoring; strengthened financial accounting and budgeting; initiating a computerized management information system; and increased capacity for raising funds. The expected result of these efforts is to maximize FLAS' capacity to manage not only a larger organization, but an organization with added functions.

(b) Service Delivery Expansion

Many of the activities described above will occur during the Project's first phase aimed at strengthening FLAS management. During this same period, however, the Project will also focus on strengthening and streamlining FLAS' own clinical family planning services, and establishing alternative family planning service delivery mechanisms. These institution-building efforts then become the basis for the outreach activities of the second phase where the Project, possibly through FLAS as an intermediary, will expand family planning service delivery in private sector/employment-based industry services. This outreach involves integrating those elements which comprise service delivery, i.e., management, personnel, training, logistics, facilities, commodities and client needs.

During the first phase, the FHS project will initially assist FLAS in improving its own clinical effectiveness and efficiency; maximizing human resources through training and re-aligning functions; expanding its services and upgrading its client monitoring systems; and establishing alternative service delivery mechanisms. The scope of this assistance is detailed in the following paragraphs.

Clinical Service Delivery: During the first year of the Project, short-term TA will assess FLAS' clinical needs; analyze clinical protocols, client load, and client flow; and determine a more streamlined service delivery system which maximizes staff skills. The functions of clinical and general office staff may be reviewed and, where possible, skills upgraded through on-the-job or in-service training. Such training would enable the general office

staff to assume the more routine clinical functions now handled by professional staff, thereby allowing professional staff to focus on clinical and technical care of clients. A more efficient data collection/record keeping system will be introduced at the 3 FLAS clinics and evaluation tools will be developed for the clinical staff.

The Project will also equip an additional examining room at each of the Mbabane and Manzini FLAS clinic facilities to handle increasing client load.

Improved Counseling Techniques: Short-term TA and workshops will be funded to improve counselling techniques for all FLAS clinic staff, to effect a reversal of the current 50 percent discontinuance rate in contraceptive users. Office staff members may be encouraged to undertake client counseling as part of their normal duties to relieve the Nurse Practitioners and Nurse Assistants of time-consuming routine educational tasks.

Employment-Based Family Planning Programs: With Project funds, FLAS will employ an additional nurse practitioner in Phase 1 to develop and implement clinical outreach activities in the private sector. This nurse and other FLAS clinical staff will receive training in technical assistance techniques, enabling them to provide clinical TA to industry-based clinic staff. In the capacity as a clinical services advisor to the private sector, the nurse practitioner and FLAS nursing staff will assist private sector health staff to a) upgrade clinical family planning services, b) provide better IEC services, and c) identify resources for expanding FP services. The FLAS nurse practitioner will also identify technical training needs of private sector clinic staff; however, clinical training for private sector nurse practitioners will be provided under the Primary Health Care Project (645-0220).

In Phase 2, FHS will fund the recruitment of a qualified Marketing Officer based at FLAS, to assist in expanding child-spacing services within large industries or private sector firms where some health care is already being provided. This Marketing Officer will be given short-term technical assistance on how to conduct formative research to assess company needs and to formulate cost/benefit information on expanded industry-based planning services. This cost/benefit information will be presented to industry management so as to obtain commitment of company resources toward expanded FP within the company. The Marketing Officer will work closely with the IEC Unit in developing special messages for employees in these firms and in costing any EBD services which may be introduced into a company.

The proposed approach for marketing family planning services to the private sector is based on an industry by industry "roll-out" strategy, beginning with the largest company in an individual industry until that industry has been saturated. Priority will initially be given to those companies which have existing health

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care services. The marketing approach also includes strategies for (a) introducing company-subsidized EDB programs where appropriate, and (b) cost recovery through "selling" FLAS services to the targeted companies in the areas of information/education materials, and technical assistance, in clinical FP services and services management.

(c) Information, Education and Communications (IEC)

FHS will strengthen FLAS' ability to provide family planning messages through assisting the IEC unit with staff, material and equipment to affect an improvement of the quality of all IEC materials and messages. FHS will fund the salary of a qualified graphic artist experienced in creating health education messages and materials. The Project will also support the production costs for IEC materials until a multi-media production unit is established at an agreed upon site during the LOP. The graphic artist, in conjunction with the R&E unit; will be responsible for pre-testing all materials and messages. Visual materials produced within the IEC unit will be contracted with outside services as required.

The project will also provide basic IEC equipment and supplies to the FLAS IEC unit. This may include a film projector and screen, cassette player, art supplies, audio equipment and supplies, video tapes, editing equipment overhead projector, camera, and film. A project budget for annual replenishment of supplies will be created in addition to a project budget for production of materials (i.e. printing posters, reproducing film, etc).

FHS will also facilitate the formation of an IEC coordinating committee comprised of external organizations and service providers, established at FLAS' initiative. This committee will have as its mandate reaching consensus on the need for and content of all messages and materials produced by FLAS under this project. The committee will not have "approval" authority, but rather will be a consensus-building mechanism to recommend technical approaches for consideration in FLAS IEC planning and implementation schemes. FLAS will be given project funds to support the costs of these committee meetings which in most cases will not exceed two to three meetings per annum.

The project will also fund equipment for a new multi-media IEC production unit which will be located outside FLAS. This unit will be accessible to FLAS as well as other PVOs and GOS officials. The establishment of this unit will occur late in Phase 1 of the Project.

The project will support training for all current members of FLAS' IEC and training unit. This on-the-job training will include instructions in video production, photography, formative research, pretesting, monitoring, public speaking, advanced script writing for radio and video, and advanced radio production. The

Senior Family Life Educator will receive overseas training in IEC program management and administration. Some additional assistance may also be provided by the Field Director of the Development Communications Project/SWAMDP (645-0218). Other training may can be provided through FHS short-term technical assistance.

Short term TA will be provided to FLAS' IEC unit in areas of formative research and analysis; materials design, production, pretesting, and dissemination; and program planning, monitoring and evaluation.

Finally, the IEC unit will work closely with the marketing officer in developing messages targeted to industries and other private sector services. IEC will also coordinate with R&E in obtaining research data for IEC activities.

(d) Research and Evaluation

The FHS project will support the creation of a Research and Evaluation Unit (R&E) within FLAS. The project will provide funding for a long-term advisor, salaries for 2 locally-hired staff, equipment and furnishings. The Unit will have responsibility for collecting program service statistics, monitoring program implementation, testing new service delivery techniques, and conducting periodic studies of client satisfaction and demand for services. It will direct all R&E activities within FLAS and coordinate with that of the Health Planning Unit of the MOH and the Central Statistics Office of the Department of Economic Planning and Statistics in determining demographic trends in Swaziland. As appropriate, the unit will draw upon the resources of SSRU (Social Science Research Unit) of the University of Swaziland (UNISWA).

Long Term Technical Advisor: The FHS project will provide a long-term technical advisor to FLAS in the areas of operations research and program evaluation. The technician will be funded for up to four years to work with the R&E Unit in carrying out program monitoring, evaluation and research responsibilities. The advisor will provide in-service training in evaluation and research to his/her counterparts. The advisor will have technical skills in demography, statistics, research methods, microcomputer operations, and management skills. The advisor will be recruited and supported through Pathfinder and as such will provide overall direction and management of the Pathfinder portion of the project. The advisor's job description is detailed in Annex 10.

Program Monitoring, Evaluation and Planning: The FHS project will systematize data collection activities within FLAS and set up regular program implementation reporting cycles. The R&E Unit is expected to produce periodic reports to FLAS management on which program planning and implementation decisions can be based. The unit will also develop (in collaboration with FLAS management) goals and benchmarks for evaluating program performance and identifying areas where implementation can be improved.

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Specialized Studies: The Project will support a number of specialized studies for improving program implementation. Most of these studies are expected to be coordinated through the R&E unit, although other in-country resources may be used to carry out or assist with the research. The R&E unit will also periodically conduct other surveys which will aid FLAS in planning and focusing its activities (knowledge, attitudes, and practices among specific target groups; client satisfaction with services). The unit will also assist the IEC unit to design and pre-test new IEC materials.

(e) Leadership Awareness

The FHS project in concert with the Traditional Leadership and Development Communications components of SWAMP (645-0218) will use media, workshops, formal and informal meetings and other opportunities to build a consensus of support for child-spacing and related family planning activities among Swazi leaders. These leaders will represent all sectors of the economy and social structure in Swaziland. The FHS project will fund IEC Committee meeting aimed at building consensus on family planning issues and in the review of child-spacing messages produced by FLAS.

(f) Contraceptive Commodities Support

FLAS manages, monitors, and assists in distributing contraceptive supplies for the Ministry of Health as well as its own operations. All MOH contraceptive orders are processed thru FLAS. The FHS project will assist FLAS in improving its capacity to monitor contraceptives distribution, and to plan and forecast national requirements. Particularly, FHS will assure a reliable and continuous supply of a wide range of effective and safe contraceptive commodities throughout the life-of-project. The national requirement for contraceptive supplies is expected to accelerate in later years of the project when demand for commodities is expected to increase. Thus, the project will supplement, if needed, the contraceptive supplies provided to FLAS by other donors (Ministry of Health and FPIA). This component of the FHS project will be supported through the S&T/Pop Commodity Procurement program (936-3018) and is expected to total approximately \$204,000 during LOP. That project will be responsible for procuring and shipping the requested contraceptive commodities to FLAS upon Pathfinder notification of required quantities and mix.

The FHS project will support short-term TA and training for FLAS staff on assessing contraceptive supply needs. FLAS will conduct such assessments semi-annually to determine the adequacy of the supply mix in view of shifting demands for specific methods. In the event of an unexpected commodity shortfall, the R&E Advisor will be responsible for notifying Pathfinder of the required quantities and mix of contraceptives based on the findings of the assessment.

(g) Other Activities

A portion of the Project funds will be retained under the Grant to be used for other family planning/population opportunities outside the scope of the FLAS grant. These activities, to be determined at a later date with mutual agreement by FLAS and USAID, may include those components listed above or new activities not described within this project paper. These additional activities may possibly be implemented by other organizations in Swaziland.

(h) Summary of Project Components

Linkages Between the Project Components: Initially, the Project will focus on upgrading FLAS' research, management, planning, and clinical capability during the first two and 1/2 years. Project activities anticipated for phase 2 build on the FLAS institution building planned during phase 1. Well-focused long- and short-term TA and training are necessary to effectively integrate all seven project components. Research and evaluation activities relate to and support IEC, clinical, and private sector activities. The private sector activities in phase two (including employment-based service delivery and private-sector targeted IEC activities) will be undertaken once the management, research and institution-building foundations are established.

Linkages with other Bilateral Projects: The project will coordinate with other USAID-funded projects. The Swaziland Manpower Development Project (645-0218) will provide assistance in leadership training. The Development Communications component of SWAMDP will support IEC expansion. The Primary Health Care Project (645-0220) will collect family planning data in the Demographic and Health Survey planned in 1988, and provide training to clinic staff in clinical family planning.

Linkages with External AID Projects: The FHS project is dependent on S&T/Pop to provide various short-term technical assistance through buy-ins from other centrally-funded projects. Also, contraceptive commodities will be provided from the centrally-funded S&T/POP Commodities Support Project (936-3018).

3. Project Outputs

Because specific outputs for individual activity areas are too numerous to list here, they are fully detailed in Annex 8. Therefore, the following outputs briefly list the key changes that need to be brought about through project inputs to accomplish the project objectives. These are more highly aggregated outputs than those listed in Annex 8 and should be read together with the above project activity description to gain a complete understanding of the logical progression from project purpose to project inputs:

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C. PROJECT COLLABORATION WITH GOS AND OTHER DONOR ACTIVITIES

In Swaziland, donor assistance in family planning is provided by the United Nations Fund for Population Activities (UNFPA), the International Planned Parenthood Federation (IPPF), and Family Planning International Assistance (FPIA). All three donors provide assistance directly to FLAS. IPPF and UNFPA also fund family planning activities with the GOS. FLAS also receives external assistance from the Unitarian Service Committee of Canada (USCC), and the Lutheran World Federation (LWF).

As the primary funding agency for FLAS, IPPF provides an annual cash grant for specific project activities, project support expenses, and administrative/general costs. FLAS and IPPF recently completed a three-year plan of support to commit IPPF funding through 1990, although IPPF fully expects to continue supporting the organization beyond 1990. The 1988 IPPF cash grant is estimated to cover 95 percent of FLAS' operational costs, with the remaining costs to be borne by FLAS and other donors. IPPF cash grants are expected to increase annually by an estimated 5 percent to cover operating inflation costs. IPPF and FPIA together supply all the contraceptive requirements of both the Ministry of Health and FLAS. Both IPPF and FPIA provide FLAS with occasional internal technical assistance mainly in the areas of program monitoring and reporting to the respective donor organization.

UNFPA recently designed a four-year (1988-1991) family planning project which contains IEC budgetary support to FLAS, and direct assistance to the MOH maternal care and family planning programs. In addition, UNFPA plans to place a U.N. Volunteer in FLAS to assist the IEC Unit in its activities. The UNFPA proposal describes various technical assistance and training activities provided to the GOS in the following areas: (a) upgrading clinical family planning and program management skills, (b) population awareness for specified target groups, (c) strengthening of MOH statistical analysis and reporting for program management.

USCC and LWF donate funds which are administered by FLAS for emergency assistance to needy families and financial scholarships for secondary school education. As outlined in the FLAS/IPPF three-year plan, these additional activities are expected to continue through 1990 and possibly beyond.

FLAS coordinates its activities with the Ministry of Health through a MOH representative on its Executive Committee. In addition, the Ministry recently invited FLAS to become a member of the National Maternal and Child Health (MCH) Committee.

USAID support in family planning, through the Family Health Services Project, is designed to avoid duplication of other donor activities and enhancing donor collaboration. All FHS activities were formulated with IPPF and FPIA support to FLAS in mind. In implementing FHS, the project will strive toward maximizing donor collaboration for all family planning and population activities.

II. COST ESTIMATES AND FINANCIAL PLAN

A. PROJECT BUDGET

The total estimated cost of implementing the FHS project over a five year period is \$2,400,000 with possibly \$204,000 supplemental funding from AID/Washington for back-up contraceptive supplies if required. During FY88 \$1.4 million in Mission funds will be obligated; the remaining \$1.0 million will be obligated in 1990 based on availability of funds and a favorable outcome of the Phase 1 evaluation.

The first phase of the project will be implemented through Cooperative Agreements, to the Family Life Association of Swaziland (FLAS), and to the Pathfinder Fund. Assuming funds are available for Phase 2 activities, an appropriate contracting mechanism will be identified during the mid-project evaluation for implementation of Phase 2 activities.

Table 1 presents a summary project budget. The assumptions used in preparing the budget are summarized below. A more detailed breakdown of the budget and budget assumptions is contained in Annex 5.

Direct Assistance to FLAS is provided for all in-country and correspondence training, for commodities, and for covering the incremental local costs FLAS will incur as it implements the project. These costs include extra staff, supplies, and office space costs as well as costs related to project research and materials production. Funding in the Pathfinder category is allocated for expenses related to fielding three long-term staff (the long-term advisor, administrative assistant, and secretary), for expenses related to short-term technical assistance, and for expenses incurred in U.S.-based training. Funding for Mission Management is allocated for the cost of one financial management consultancy to meet the requirements of a project covenant, for two project evaluations and one audit, for the cost of purchasing a multi-media system during Phase 1, and to meet the funding needs of other family planning and population opportunities which may arise outside the scope of the activities detailed under this project.

The project budget outlined in Table 1 and Annex 5 do not include the proposed supplemental funding (\$204,000) for purchasing and transporting contraceptives to fill any contraceptive shortfalls which may occur. These commodities will be supplied by the AID/Washington Contraceptive Commodities Procurement Project.

The FLAS Cooperative Agreement includes all identified project costs which will be implemented jointly by FLAS and USAID.

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TABLE 1
FAMILY HEALTH SERVICES PROJECT
Summary Budget by Phase and Organization

	Phase 1		Phase 2		TOTAL	
	AID	PVO	AID	PVO	AID	PVO
FLAS	\$343,412	\$466,670	\$209,770	\$495,418	\$553,182	\$962,088
Training	\$40,891	\$7,439	\$21,349	\$0	\$62,240	\$7,439
Correspondence	10,914	0	13,207	0	24,121	0
In-Country	13,400	7,439	0	0	13,400	7,439
Workshops	16,577	0	8,142	0	24,719	0
Commodities	\$81,597	\$85,125	\$0	\$0	\$81,597	\$85,125
Vehicles	32,000	0	0	0	32,000	0
Other	49,597	85,125	0	0	49,597	85,125
Local Costs	\$220,924	\$374,106	\$188,421	\$495,418	\$409,345	\$869,524
Staff	39,551	189,350	72,242	260,628	111,793	449,978
Supplies	24,950	107,541	24,950	141,588	49,900	249,129
IEC Materials	121,724	0	60,767	0	182,491	0
Research	14,411	0	4,961	0	19,372	0
Rent/Utilities	20,288	62,215	25,501	78,202	45,789	140,417
Contingency	0	15,000	0	15,000	0	30,000
PATHFINDER	\$875,103	-	\$731,145	-	\$1,606,248	-
Long Term TA	\$359,917	-	\$259,325	-	\$619,242	-
Advisor	246,882	-	179,432	-	426,314	-
Support Staff	17,185	-	23,801	-	40,986	-
Advisor Interviews	18,000	-	0	-	18,000	-
OM/MGT Fee	77,850	-	56,092	-	133,942	-
Short-Term TA/OH	\$424,286	-	\$422,354	-	\$846,640	-
US Training/OH	\$90,900	-	\$49,466	-	\$140,366	-
MISSION MANAGEMENT	\$181,485	-	\$59,085	-	\$240,570	-
Evaluation/Audit	71,663	-	36,465	-	108,128	-
Financial TA	6,000	-	0	-	6,000	-
Multi-Media Equipment	80,380	-	22,620	-	103,000	-
Other Activities	23,442	-	0	-	23,442	-
TOTAL	\$1,400,000	\$466,670	\$1,000,000	\$495,418	\$2,400,000	\$962,088

** Does not include \$204,000 for back-up contraceptive supplies if needed.

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TABLE 2
 FAMILY HEALTH SERVICES PROJECT
 FLAS Contribution by Year of Expenditure

	Phase 1			TOTAL
	YEAR 1	YEAR 2	YEAR 3	
In-Country Training	\$2,750	\$3,025	\$1,664	\$7,439
Furniture & Equipment	85,125			85,125
Local Costs -				
FLAS Staff	70,000	77,000	42,350	189,350
Supplies	39,000	43,898	24,643	107,541
Office Space/Utilities	23,000	25,300	13,915	62,215
Contingency	6,000	6,000	3,000	15,000
TOTAL FLAS CONTRIBUTION	\$225,875	\$155,223	\$85,572	\$466,670

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B. LOCAL CONTRIBUTION TO THE PROJECT

Because Phase 1 of the project is the institution-building phase during which FLAS will be strengthened and its capabilities enhanced, FLAS's normal recurring operating costs form the major part of FLAS's contribution to the project.

FLAS's contribution to the project during Phase 1 is presented in Table 2. FLAS's Phase 2 contribution will be analyzed at the time Phase 2 is approved. All amounts contained in Table 2 incorporate a 10 percent annual inflation rate.

FLAS currently spends about \$2,750 each year for staff training and development, \$70,000 per year for salaries, \$10,000 per year for office supplies, \$29,000 per year for vehicle maintenance, and \$23,000 each year for office rental and utilities. All of these recurring resources are contributed to the project during Phase 1.

FLAS currently owns \$85,125 of furniture and equipment that will be available for FHS project use. The entire amount represents a FLAS contribution at the beginning of the project. Also included as a FLAS contribution is the inflation portion of additional supplies costs which FLAS will incur as a result of the FHS project. USAID will agree to fund \$9,980 of supplies costs each year. This amount should be sufficient to pay for the incremental supplies costs during year 1 but will not be sufficient to pay these costs as they rise each year as a result of inflation.

Finally, FLAS's operating costs will rise approximately \$6,000 each year during Phase 1 while implementing FHS. These resources will benefit FHS and, therefore, form part of FLAS's contribution to the project.

During Phase 1 FLAS's contribution will be \$466,670 which represents 25 percent of total project costs.

C. RECURRENT COSTS

A major issue in the design of the Project was the ability of the FLAS to meet the recurrent cost implications of an expanded staff and new activities. Achievement of project outputs depends on FLAS ability to expand activities in several areas and yet to minimize dependence on external donor financing for recurrent expenditures.

Recurrent personnel costs for additional FLAS staff will be financed completely by AID during the initial years of project implementation. FLAS will assume the costs of these personnel and various supply costs beginning in Phase 2 with support from IPPF. The project assumes that IPPF support to FLAS will be sustained at current levels and possibly increased beginning in 1990. In addition, the Project will support FLAS efforts to strengthen its fundraising efforts so as to enable the organization to assume a greater share of its recurrent costs.

These issues are more fully explored in the financial analysis in Annex 5.

III. IMPLEMENTATION PLAN

A. IMPLEMENTATION RESPONSIBILITIES

The FHS Project will be implemented through the Family Life Association of Swaziland (FLAS) with support from a Cooperating Agency (CA). During Phase 1, the Pathfinder Fund will be the CA assisting FLAS. As mentioned several times above, the scope of Phase 2 will be determined at a later date dependent upon the outcome of the Phase 1 evaluation and availability of funds. For the purposes of this section, the responsibilities of FLAS, Pathfinder, and USAID are detailed for Phase 1 activities only.

1. FLAS

FLAS will be the primary agency responsible for implementing FHS resources in Swaziland. FLAS, responsible for implementing the project activities listed in section I.B.2. above, will:

- Assume day-to-day implementation of the project;
- Utilize the expertise of the Pathfinder Fund in strengthening and expanding FLAS' capability as described in this document;
- Prepare an annual project workplan in conjunction with the Pathfinder Fund, including allocation of FLAS and Pathfinder budgets;
- Identify and schedule short-term technical assistance in conjunction with Pathfinder and obtain USAID approval for all consultancies;
- Oversee local procurement of equipment and commodities in concert with Pathfinder;
- Upgrade FLAS' financial capability to meet donor standards;
- Work closely with all consultants to accomplish work tasks as described in the consultants' scope of work;
- Provide USAID with quarterly reports on progress of the project and quarterly financial reports;
- Recruit six staff for the positions identified in the project;
- Identify and coordinate training of local staff as per the annual workplan; and
- Obtain all USAID approvals for Project activities as required.

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2. Cooperating Agency

The Cooperating Agency will be generally responsible for assisting FLAS in the implementation of this project, and for providing long- and short-term TA, and all U.S.-based training.

Specifically during Phase 1, Pathfinder as the Cooperating Agency will be responsible for the following:

- Recruit candidates for the long-term advisor position;
- Provide long-term TA for up to 2 1/2 years (long-term advisor, secretary, and administrative assistant);
- Prepare, in conjunction with FLAS, a project workplan complete with all project inputs and the corresponding FLAS and Pathfinder budgets;
- Provide timely and appropriate short-term TA as described in the Project workplan and as approved by USAID;
- Schedule in-country and U.S. training based on the work plan developed with FLAS;
- Provide backstopping and monitoring from headquarters and the regional office as needed;
- Administer and track all out-of-country training;
- Assist FLAS in preparing an Annual Report;
- Submit monthly reports on the project status and monthly financial reports to USAID/Swaziland.

Both FLAS and Pathfinder are responsible for ensuring that all procurement of goods and services and all project-funded training activities are in accordance with U.S. government regulations. In particular, commodity procurement will be based on at least two bids/programs for equipment/commodities in excess of \$500 and suppliers will be selected based on criteria of quality, service, price and availability.

3. USAID

The USAID Health, Population, and Nutrition Office will have responsibility for overall project management and monitoring. The Assistant Regional HPN Officer will be the Project Officer for this Project. Examples of USAID/Swaziland implementation responsibilities are as follows:

- Assist Pathfinder in selecting the long-term technical advisor and administrative assistant to be funded under the Pathfinder Cooperative Agreement.

- Review and approve the annual project workplan prepared by FLAS and Pathfinder for project implementation.
- Serve as the primary contact point for FLAS and Pathfinder for obtaining decisions on grant and project matters. Provide direction to the long-term advisor in accordance with the terms of the contract and AID policies and regulations.
- Review progress reports submitted by FLAS and Pathfinder and identify issues affecting implementation and achievement of project goals/objectives.
- Arrange financial management consultancy as required in a Project covenant.
- Arrange all evaluations and audits;
- Determine location of the multi-media center and arrange procurement of all equipment;
- Determine appropriate use of funds for additional opportunities in collaboration with FLAS.
- Participate in project meetings involving Project representatives.
- Monitor compliance with conditions of the Project grant and buy-in.
- Participate in other monitoring activities of the project as necessary to achieve project objectives.

B. IMPLEMENTATION SCHEDULE

Figure 1 depicts the phasing of activities during each phase of the Project. The details of this implementation schedule are contained below:

PHASE ONE (0 - 30 months)

Month 1-3 Cooperative Agreements with FLAS and Pathfinder awarded;

Recruit, advertise for long-term advisor and Administrative assistant. Pathfinder monitoring visit for orientation and thereafter every four months to review progress. Long-term Advisor selected and arrives at post;

AID/FM will examine FLAS programme for grading and upgrading;

Begin Computer procurement and vehicle procurement; X

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- Month 4-5 Staff training in Computers for FLAS. Financial Management consultancy (covenant requirement);
- Secretary and Administrative Assistant recruited; FLAS Nurse Practitioner recruited;
- Project Work Plan prepared and reviewed by Pathfinder monitoring visit; workplan approved by USAID;
- Secretarial training conducted;
- Deputy Executive Director attends U.S. course on Program Management;
- U.S.-based training programs (9-12 months) identified for FLAS staff; one staff member departs for U.S.;
- Consultancy to plan and conduct FP workshop for insurance industry;
- Consultancy for clinic staff on clinical effectiveness/efficiency.
- Month 7-9 Implement recommendations from above consultancies;
- Senior Family Life Educator attend U.S. course in IEC program management;
- MIS consultancy to conduct needs assessment related to clinical service delivery data collection and R&E needs;
- Technical assistance to FLAS Clinic staff on improved family planning counselling techniques;
- Two FLAS staff begin correspondence degree programs at UNISA;
- Pathfinder monitoring visit.
- Months 10-12 R&E staff recruited and begin work;
- Second training sessions in micro-computer applications;
- Design annual service statistics data collection tool for use by the R&E Unit to collect data for each of various end users of such data;
- Implement technical assistance recommendations on counselling techniques and continue to improve clinic efficiency and effectiveness;
- Management workshop conducted;

- Develop year 2 workplan and Pathfinder monitoring visit to review workplan;
- Complete annual client service statistics evaluation for FLAS Clinics and distributors;
- Follow-up consultancy on progress in implementing recommendations regarding increased clinic efficiency and effectiveness.
- Months 13-15 FLAS conducts 1-week workshop in IEC Techniques and Update on Contraceptive Technology in conjunction with Institute of Health Sciences. Thereafter, organizes one per year;
- Consultancy on commodity supply forecasting; contraceptive supply evaluated and forecast completed;
- MIS Consultancy to organize and conduct workshop on improved service delivery and R&E data collection system. Recommendations from workshop implemented;
- Follow-up consultancy on family planning counselling techniques;
- Conduct a client satisfaction survey in FLAS clinics;
- FLAS staff member returns from year-long U.S.-based training;
- Pathfinder monitoring visit.
- Months 16-18 Recruit Graphic Artist and Marketing Officer;
- Complete client satisfaction survey in FLAS clinics;
- Consultancy in IEC to develop IEC Plans for next 2 years; training for IEC staff in video production;
- Pathfinder monitoring visit;
- Second FLAS staff member departs for U.S.-based 9-12 month training;
- Establish IEC Coordinating Group.
- Month 19-21 FLAS Director to U.S. for fundraising course;
- Third training sessions on micro-computer applications;
- IEC consultancy to begin training in formative research methods and IEC materials pre-testing;

- Consultancy in private sector marketing approaches (to be coordinated with above IEC consultancy) to determine needs in private (for-profit) sector;
- Third staff member begins correspondence training;
- Pathfinder monitoring visit;
- Determination of location of multi-media Unit.
- Month 22-24 Pathfinder audit for Year 2;
- Consultancy on private-sector outreach and TA skills for FLAS nursing staff;
- IEC Coordinating Group meets;
- Pathfinder monitoring visit.
- Month 25-27 Second annual Update on Contraceptive Technology;
- Follow-up consultancy on counseling skills;
- Follow-up consultancy on IEC techniques and marketing approaches for the private sector; begin formative research on 3 pilot companies; begin developing IEC materials for private sector outreach;
- Multi-media Unit established and equipped;
- External Evaluation of Phase 1;
- Pathfinder monitoring visit.
- Month 28-30 Project audit needs assessment;
- Follow-up consultancy in fundraising techniques;
- Follow-up consultancies in IEC/marketing for private sector;
- Follow-up consultancies for private sector nursing outreach and TA;
- FLAS management workshop;
- Pathfinder monitoring visit;
- Determination of Phase 2 status;
- Second FLAS member returns from year-long U.S.-based training.

PHASE TWO

- YEAR 1 Hire marketing assistant;
- Begin implementing private sector approach based on research and pilot activities conducted in previous phase;
- Consultancies in IEC, marketing, and private sector nursing TA as needed for private sector outreach.
- Begin phasing-out USAID support for select Project-funded FLAS staff;
- Third annual Update on Contraceptive Technology;
- Second Leadership Awareness seminar;
- Research activities continue, including relevant KAP studies, male motivation studies, client satisfaction, etc.
- Third FLAS staff member departs for 9-12 month U.S.-based training;
- IEC Coordinating group meets.
- YEAR 2 Continue support for expansion of FP services in the private sector;
- Continue phase-out of USAID salary support for FLAS staff;
- Long-term advisor departs;
- Fourth annual Update on Contraceptive Technology;
- IEC coordinating group meets.
- YEAR 3 (6 mo. only) Phase-out of all USAID support;
- Final Project evaluation.

C. PROCUREMENT PLAN AND RESPONSIBILITIES

Technical assistance inputs for Phase 1 will be procured via two separate Cooperative Agreements to be initiated between AID and FLAS, and AID and the Pathfinder Fund, respectively.

FLAS, with the assistance of advisory services from Pathfinder, will undertake all supply procurement, local training, and research activities. In addition, the FLAS Cooperative Agreement will contain funding for other potentially viable Swazi organizations' initiatives. Procurement procedures for such initiatives will be decided jointly by USAID and FLAS. The FLAS Cooperative Agreement will contain funding, accessible by USAID only, to provide for evaluations and an audit to be contracted from outside sources.

All procurement under the subject project shall be in accordance with Delegation of Authority 551, Section 5.K., and the AA/AFR approved DFA Procurement Policy Recommendations and Africa Bureau Instructions dated April 4, 1988. Accordingly, AID Geographic Code 935 is the authorized code for source and origin of goods, including motor vehicles, and nationality of all services procured under the project. No procurement waivers are required. Notwithstanding, all procurement under the project shall adhere to the following order of preference: (1) Code 000; (2) Host Country; and (3) Code 935. The source/origin for procurement of pharmaceuticals and for ocean shipment of supplies shall remain as delineated in AID Handbook 1B.

Most supplies to be purchased with AID funds will be procured by FLAS and will be titled to the FLAS with USAID acknowledgement. Some supplies may be purchased by USAID directly, as FLAS' authorized agent.

Pathfinder will provide long- and short-term technical assistance and supporting overseas training for FLAS staff. The Pathfinder Cooperative Agreement will contain language permitting the expansion of Pathfinder's assistance/advisory services to other Swazi organizations whose initiatives are supported in conjunction with the terms of the FLAS Cooperative Agreement as cited above.

Depending upon the outcome of the post-Phase 1 evaluation, and the availability of sufficient funding at the time, Phase 2 activities will be provided via appropriate contracting mechanisms. Both of the above Cooperative Agreements will contain language permitting their extension to cover the Phase 2 program, if such action is acceptable to USAID and FLAS or Pathfinder, respectively.

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It is expected that the Pathfinder Fund will negotiate a bilateral agreement with the Government of Swaziland, permitting its presence in Swaziland, and a Memorandum of Understanding with FLAS, describing their roles and mutual working relationship, during July 1988. It is planned that the two Cooperative Agreements with AID will be negotiated and signed in July 1988, and the long-term TA arrive on-site in October 1988.

IV. MONITORING AND EVALUATION

A. USAID MONITORING RESPONSIBILITIES

The USAID Health, Population, and Nutrition (HPN) Office is responsible for project management and monitoring. The Assistant Regional HPN Officer will be the Project Officer for this Project and will be responsible for monitoring compliance with the two Cooperative Agreements and Project Description. The Project Officer will also monitor the development of project workplans and implementation of workplans as described in the Implementation Responsibilities above. USAID will track expenditures of Project funds as required for all USAID projects.

B. EVALUATION AND AUDIT PLAN

The evaluation plan makes provisions for one external mid-project evaluation and an external end-of-project evaluation which incorporates an impact assessment. In addition, provisions are made for an audit following the completion of Phase 1.

The mid-project evaluation, arranged by USAID in consultation with FLAS, will be a review at the end of Phase 1 (month 30 of implementation) to determine the success of Phase 1 activities and to identify the direction necessary during Phase 2. The effort will evaluate progress made toward attaining project objectives with a particular emphasis on identifying problem areas or constraints which may inhibit project implementation. This Phase 1 evaluation will also focus on the performance of FLAS and Pathfinder in terms of coordinating inputs (TA, training, logistics, commodities) with project activities to produce real outputs.

The end-of-project impact evaluation is scheduled prior to the PACD (March 1993). USAID will collaborate with FLAS in organizing the evaluation to assess whether the project achieved its purpose and reached the goal that is set forth in this document. A component of this evaluation includes an impact assessment to determine contraceptive knowledge and prevalence and to determine fertility rates.

Finally, the Project has funding for an audit needs assessment to be conducted at the end of Phase 1. If determined that an audit is necessary, USAID will arrange for an independent audit firm to evaluate project costs, including an examination of the Grantees (FLAS and Pathfinder) financial procedures and internal controls relating to project expenditures. In addition, it is understood that Pathfinder will conduct annual internal audits during Phase 1.

V. SUMMARY OF ANALYSES

A. TECHNICAL ANALYSIS - SUMMARY

Although demographic data for Swaziland is scanty and generally out-of-date, preliminary results from a recent census (1986) indicates that the current population is approximately 706,000 with an estimated 3.4 percent annual growth rate (U.N., 1987). Contraceptive prevalence is unknown, but believed to average about 4 percent, which is low for Africa in general and particularly for countries in the Southern Africa region. Family planning acceptance, however, is higher among younger, more educated, and formally-employed segments of the population.

The GOS, through its National Development Plan, has acknowledged Swaziland's high and growing rate of population growth. The GOS promotes child-spacing through the Ministry of Health maternal and child health (MCH) program. In addition, leaders and government officials have attended various seminars and conferences on family planning, and population growth and development through AID-supported RAPID presentations and training of chiefs. Although Swaziland has not yet embarked on a wide-ranging population policy, a recent seminar for parliamentarians (June 1988) demonstrated that negative leadership attitudes are slowly neutralizing and acceptance of family planning is growing among the nations policy makers. As a result of this seminar, a Parliamentarians committee has now been established to begin developing a strategy for a national population policy.

Family planning and child-spacing (FP/CS) services are provided through clinics and other health facilities. Although services are available within most government and mission clinics, they are not promoted and are offered only on demand. FLAS, on the other hand, actively promotes FP/CS. Their success is demonstrated by the share of FP clients they serve in Swaziland - 30% of all clients utilizing family planning services are FLAS clients.

Demand for FP/CS services appears to be high and growing, particularly among urban, younger, and formally-employed segments of the population. Although data is limited, demand among rural women would probably increase if resistant male attitudes were neutralized and misconceptions about FP/CS were reversed. Many women in Swaziland who accept family planning for the first time never return for follow-up services. In fact, among FLAS clients, the discontinuation rate is approximately 50% - that is, 50% of FLAS clients who attend for the first FP/CS visit never return for the second visit. Many reasons for not utilizing FP/CS services include fear of side effects and adverse health effects, distance to services, and social stigma. Improvements in client counseling, follow-up, and promotion of FP services will increase demand for services and reverse the discontinuation rates so common in Swaziland.

Discontinuation rates are especially high for men who accept condoms for the first time. Most men who receive condoms never return for resupply. Despite the likely cultural reasons for such high discontinuation rates, the most probable explanation is that condoms are provided as a preventive measure against sexually transmitted diseases (STDs) and not for contraception. With the rise in STDs and AIDS in Swaziland, condom use is expected to increase substantially - but for health, not family planning, reasons. Increasing the demand for condoms and minimizing men's negative attitudes toward family planning may make condoms (and other methods of contraception) more acceptable for family planning purposes.

The project will address these constraints to family planning by focusing on demand-generating activities, particularly in IEC materials developed and distributed by FLAS. The Project will strive to increase the demand for service through more effective public education, more effective counseling, and more effective promotion of FP/CS at the health care site.

Supply of FP services is also a major factor contributing to Swaziland's low contraceptive prevalence rate. Although most clinics in Swaziland are theoretically able to provide family planning, in reality many nurses are inadequately trained to deliver services and provide the counseling and follow-up necessary for a successful family planning program. In addition, many of the clinics lack adequate privacy, water and electricity, and basic equipment to provide good quality services. The Project will assist in upgrading FLAS' three clinics to assure that adequate space and equipment is available for all FLAS clients. The Project will also facilitate technical training of nurses in rural areas through the Ministry's Primary Health Care Project.

In order to obtain the greatest impact on family planning practices in Swaziland, the Project is designed to focus on the most receptive target group - namely agricultural/forestry workers and employees in the larger manufacturing industries. In Swaziland, more than 50% of those formally employed can be reached through the largest five firms, most of which have on-site health facilities and provide care to both employees and their families. Larger companies within Swaziland, particularly those with high female employment, have expressed a willingness to purchase services to expand family planning among their workforce. Smaller companies, however, have little or no infrastructure for healthcare services, and do not appear willing to invest financial resources in child-spacing.

Because full support of company management is critical for the success of an employment-based family planning program, the Project will demonstrate through business analyses that companies can benefit from establishing a birth spacing program in financial terms as well as improving the overall health and living standards of employees and dependents. Expanding family planning through the private sector is a natural market for FLAS, and can assist in helping FLAS to evolve into a technical and administrative resource for all family planning activities within Swaziland. A more detailed technical analysis is found in Annex 1.

B. ADMINISTRATIVE/INSTITUTIONAL ANALYSIS - SUMMARY

The Family Life Association of Swaziland (FLAS) is a pioneer in family planning activities in Swaziland. Founded in December 1979, FLAS assists and supplements the Ministry of Health in the promotion of healthy family life and child-spacing. Since 1985, FLAS has been an associate member of the International Planned Parenthood Association (IPPF) when the MOH ceded its IPPF membership to the Association. The Ministry, however, retains a position on the FLAS board (Executive Committee).

FLAS is managed by the Executive Committee which meets quarterly at a minimum. The powers of the Executive Committee are broad and far-reaching, including the direct implementation of FLAS policies, the creation and abolishment of posts, employee supervision and dismissal rights, and supervising financial records. The Association is headed by an Executive Director and a Deputy Program Director under whom are four departments: family life education, family life practices, training, and finance. Currently, there are 28 employees working within three clinics and one head office.

FLAS currently serves an estimated 30 percent of all family planning clients in the country, and it has repeatedly in the past initiated innovative family life education and family planning activities.

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FLAS is one of the few non-governmental organizations in Swaziland to have received substantial assistance from many international donors. FLAS has traditionally introduced family planning programs to meet the needs of the population and to support specific activities in order to meet the demands of donors and according to the availability of funds. While this approach has the advantage of targetting opportunities, it has led to a lack of focus on the association's aims, goals, and objectives.

Furthermore, FLAS lacks a global evaluation of overall activities. Most of the organization's planning is done according to each individual donor organization schedule without regard to other inputs FLAS receives. This has resulted in over-extension and a heavy workload which are particularly evident within the IEC and service delivery components of the organization.

Financial support for FLAS has come mostly from donors - cost recovery and fundraising cover little of the organization's operating costs. While many of its fundraising activities have not proven to be successful in the past, FLAS has indicated a growing awareness that it can and must reduce its reliance on international donors and generate more of the funding to run the organization.

In order to undertake more sophisticated and complex activities in the areas described within this project paper, FLAS requires upgrading and support in certain areas of the organization. In particular, the institution of FLAS needs strengthening especially in the areas of management/planning, fund-raising, IEC, research/evaluation, and service delivery. The interventions proposed in the project are intended to maximize FLAS's capabilities to plan and implement extended family planning service programs. But these increased capabilities depend on improved administrative and institutional capacity of the association.

A further examination of the association and its capabilities is contained in Annex 2.

C. ECONOMIC ANALYSIS - SUMMARY

The FHS Project has been determined to be economically viable because it will (1) save the GOS and Swazi citizens scarce resources, (2) help reduce the rate of maternal and child mortality and morbidity, and (3) provide family planning services at a rate consistent with other African FP programs. In addition, population projects in general are generally economically efficient when judged by AID standards.

Benefits associated with a declining rate of population growth are estimated for the education and health sectors in Swaziland. Based on the analysis described in Annex 3, school enrollments may decline by more than 200,000 in the year 2015 with a concomitant savings in education expenditures (more than \$13 million in public expenditures and \$4 million in private expenditures by 2015). In the health sector, an estimated 600,000 reduction in health client population translates into a savings in government outlays of more than \$4 million by 2015.

Cost-benefit comparisons (of the savings described above and the costs of providing family planning programs) demonstrate that savings begin to exceed costs in approximately 1996. Expected savings in the education and health sectors alone justify the investment in family planning.

In addition, improved maternal and child health will reduce levels of morbidity and mortality which also contribute to reduced health care costs associated with high risk births.

Finally, the recurrent costs for Swaziland family planning programs is estimated to be \$20 per couple which is the average cost for all Sub-Saharan African programs (World Bank).

A more detailed analysis of the economic effects of the FHS Project is contained in Annex 3.

D. SOCIAL SOUNDNESS ANALYSIS - SUMMARY

While traditional methods of birth spacing have been widely practiced in Swaziland, use of modern methods is estimated to be quite low in the nation at-large. Yet, there is evidence that services are being utilized more heavily in urban areas and within public and private sector clinics. In particular, the urban, formally-employed, and younger segments of the population are more receptive to family planning. However, males appear to be less likely to accept family planning interventions and the use of modern methods. The FHS project addresses these issues by emphasizing the development of IEC materials aimed at male audiences and the promotion of family planning services for employees within the industrial areas and clients of the private (for-profit) sector.

The direct beneficiaries of the FHS project will be the couples of Swaziland who will have access to safe, effective, and affordable methods of family planning enabling them to voluntarily choose the number and spacing of their children. Enhanced health and well-being of their families is an additional benefit to these couples.

Secondary beneficiaries of the Project include the national and traditional leaders of Swaziland who will have improved information on population development and health relationships

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which can serve as a basis for improved population policies and family planning programs.

A more detailed social soundness analysis is found in Annex 4.

E. FINANCIAL ANALYSIS - SUMMARY

A summary of the Project's financial analysis is provided in section II, entitled "Cost Estimates and Financial Plan". The full analysis, including levels of local contribution and recurrent cost consideration is contained in Annex 5.

VI. CONDITIONS AND COVENANTS

A. FLAS

CONDITIONS PRECEDENT TO INITIAL DISBURSEMENT

1. Prior to the first disbursement under the Cooperative Agreement, the Recipient will, except as the parties may otherwise agree in writing, furnish to AID in form and substance satisfactory to AID:

- (1) A statement of the name(s) of the person(s) acting as the authorized Representative of the Recipient for purposes of the Project, and of any additional representatives, together with a specimen signature of each person specified in such statement; and
- (2) Evidence that FLAS and The Pathfinder Fund have negotiated and signed a Memorandum of Understanding (MOU) or other written Agreement, acknowledged and concurred in by USAID, which sets forth their roles, responsibilities and relationship with respect to each other under the Project.

COVENANTS

Covenants imply a more continuous action by the Recipient in project implementation and constitutes mutual agreement on specific issues affecting the Project. The following covenants will be included, in substance, in the subject Cooperative Agreement:

- (1) FLAS shall permit an independent local accounting firm to periodically audit its financial accounting procedures and shall upgrade such procedures in accordance with recommendations made by the accounting firm.

- (2) FLAS agrees that all project funded family planning services will be voluntary and no coercion will be used, and that all services will be provided without discrimination as to class, sex, race or national origin. Likewise, FLAS covenants that no project funds will be used to finance any costs related to (a) performance of an abortion or involuntary sterilization; (b) motivation or coercion of any person to undergo an abortion or involuntary sterilization; (c) provision of any financial incentive to any person to practice or undergo an abortion or sterilization; or (d) research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a method of family planning.
- (3) FLAS shall advertise and use competitive procedures for all USAID funded positions within its organization.
- (4) FLAS shall pre-test all IEC materials and messages before finalizing and disseminating them.
- (5) FLAS shall ensure that the long-term technical advisor financed under the project will have an appropriate Swazi Research/Evaluation counterpart throughout the term of his or her appointment.

B. PATHFINDER

CONDITIONS PRECEDENT TO INITIAL DISBURSEMENT

1. Prior to the first disbursement under the Cooperative Agreement, the Recipient will, except as the parties may otherwise agree in writing, furnish to AID in form and substance satisfactory to AID:

- (1) A statement of the name(s) of the person(s) acting as the authorized Representative of the Recipient for purposes of the Project, and of any additional representatives, together with a specimen signature of each person specified in such statement;
- (2) Evidence that Recipient has entered into a written Agreement with or has otherwise received written clearance from the Government of Swaziland authorizing the Recipient's presence in Swaziland in connection with the subject Project; and
- (3) Evidence that FLAS and The Pathfinder Fund have negotiated and signed a Memorandum of Understanding (MOU) or other written Agreement, acknowledged and concurred in by USAID, which sets forth their roles, responsibilities and relationship with respect to each other under the Project.

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COVENANTS

Covenants imply a more continuous action by the Recipient in project implementation and constitutes mutual agreement on specific issues affecting the Project. The following covenants will be included, in substance, in the subject Cooperative Agreement:

- (1) The Recipient agrees that all project funded family planning services will be voluntary and no coercion will be used, and that all services will be provided without discrimination as to class, sex, race or national origin. Likewise, Recipient covenants that no project funds will be used to finance any costs related to (a) performance of an abortion or involuntary sterilization; (b) motivation or coercion of any person to undergo an abortion or involuntary sterilization; (c) provision of any financial incentive to any person to practice or undergo an abortion or sterilization; or (d) research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a method of family planning.
- (2) The Recipient agrees to perform periodic evaluations and audits of its Swaziland operations and activities in connection with the subject Project.

TECHNICAL ANALYSIS

OUTLINE

- I. Introduction
- II. Socio-Demographic Background
 - A. Demographic Characteristics
 - B. Social Considerations
- III. Family Planning Policy in Swaziland
- IV. Description of Family Planning Services in Swaziland
 - A. Background
 - B. Coverage of FP Services
 - (1) Clinical
 - (2) STDs
 - (3) IEC
 - (4) Manpower
 - C. Contraceptive Preferences
 - (1) Socio-Cultural Factors
 - (2) Clinic Data on Method Acceptance and Use
- V. Constraints related to Demand for FP Services
 - A. Traditional Beliefs
 - B. Knowledge, Attitudes and Practices
 - C. Attitudes toward Public Education Efforts
 - D. Economic Factors
- VI. Constraints Related to Supply of Family Planning Services
- VII. Viability of Private Sector Involvement
 - A. Private Industry
 - B. Private doctors/nurses
 - C. NGOs

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I. INTRODUCTION

This document provides an overview of Swaziland's current situation regarding child spacing practices, family planning services delivery, and population growth/demography. The purpose of this analysis is to define the technical parameters surrounding the proposed Family Health Services (FHS) Project with respect to the project's goal to increase contraceptive prevalence and expand the availability of family planning services.

As detailed elsewhere in the body of the FHS Project Paper, the two major thrusts of the FHS Project are (1) to promote family planning services in the private (for-profit) sector through enabling industries to expand their already established health services, and (2) to strengthen family planning information, education, and communications (IEC) activities in Swaziland. The proposed organization to implement these activities is the Family Life Association of Swaziland (FLAS), the only private family planning agency in Swaziland. Thus, this analysis focuses primarily on FLAS' activities although those activities undertaken by the Ministry of Health (MOH) and other organizations are briefly reviewed.

This document contains six major sections: (1) socio-demographic background; (2) the status of family planning policy; (3) a description of family planning services currently offered in Swaziland, including a discussion of sexually transmitted diseases (STDs); (4) a description of constraints related to the demand for or practice of child spacing; (5) a description of the constraints related to the supply of family planning services; and (6) a discussion of the viability of involving private for-profit organizations in the expansion of family planning services.

II. SOCIO-DEMOGRAPHIC BACKGROUND

A. Demographic Characteristics

Demographic data for Swaziland are scanty and generally out-of-date. Censuses have been historically held at regular intervals throughout the country, but only the last three (in 1966, 1976, and 1986) were full dwelling-to-dwelling enumerations conducted by personal interview. Vital registration of births and deaths is also incomplete and estimates of fertility and mortality can only be derived from census inquiries regarding past and recent child-bearing, child survival, and parental survival. However, the Government of Swaziland (GOS) recently embarked on a national campaign for universal birth registration and universal death registration is expected to be enforced in the next two years. Although results of the 1986 census have not been yet released, provisional results show that the population size is approximately 706,000 with an annual growth rate of 3.4% (U.N., 1987). Until the 1986 census figures are fully analyzed, the best estimates of socio-demographic indicators are extrapolations of 1976 census data and estimates from social service data such as health statistics (see Table 1).

Prior to 1973, when modern family planning services were first introduced through Ministry of Health facilities, traditional child spacing was commonly practiced through abstinence and prolonged breastfeeding. These traditional practices, however, have declined significantly in the recent past and adoption of modern contraceptive methods have not kept pace with the disappearing traditional child spacing methods. Consequently, Swaziland's population has rapidly grown during the last three decades.

Swaziland's rate of population growth has been increasing since at least the early 1960's when it was estimated to be 2.5% per year. Currently, the estimated population growth rate of 3.4% places Swaziland among the fastest growing countries in the world. With the Total Fertility Rate (TFR) averaging seven children/women and given expected reductions in mortality over the coming years and possible increasing rates of fertility (in the absence of family planning interventions), the population growth rate could exceed 4.0% per year by the year 2000.

This recent history of population growth rates has created an in-built momentum through its effect on the age structure. With nearly half its population under the age of 15 years, Swaziland is guaranteed continued population growth for decades to come, even with an accelerated decline in fertility.

Contraceptive prevalence in Swaziland in 1985 was believed to average about four percent, which is low for Africa in general and particularly for countries in the Southern Africa Region (World Bank, 1985). By comparison, the prevalence of modern methods was estimated in 1984 to be 28% in Zimbabwe and 19% in Botswana - two

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TABLE 1
SUMMARY OF SOCIO-DEMOGRAPHIC DATA

Total Population (1986).....	706,000 (estimated)
Crude Birth Rate (1982).....	50.8/1,000 population
Crude Death Rate (1982).....	17.0/1,000 population
Rate of natural increase (1986).....	3.4% (estimated)
Population Doubling Time.....	20 years
Average number of children per woman.....	7.0
Life expectancy at birth.....	53 years
Infant mortality rate.....	110-130
Neonatal Mortality as compared to overall IMR births	24%
Maternal mortality rate.....	128.5
Patients per midwife/nurse.....	55
Female population.....	52%
Male population.....	48%
Population under 15 years of age.....	48%
Female population 15-44 years.....	22%
Population 15-64 years.....	49.2%
Population over 65 years.....	2.2%
Dependency Ratio.....	108%
Urban population (1986).....	36%
Rural Population (1986).....	66%
Rate of rural-urban migration (1984).....	10%
Growth of urban areas.....	4.4%
Growth of rural population.....	2.4%
Literacy level (female) (1980).....	58%
(male).....	64%
Primary School (net enrollment ratio)	80%
Secondary School (net enrollment ratio)	40%
Land under cultivation	93,354 ha
Grazing land.....	865,303 ha
Per capita GNP (1983).....	\$870
Inflation rate (1983).....	14%

Source: World Bank, 1985; Ministry of Health; Family Life Association 1988-90 Plan; UNDP/Swaziland; UNICEF/Swaziland.

countries which are similar to Swaziland in levels of socioeconomic development. Several limited studies have shown generally favorable attitudes toward family planning and relatively high rates of acceptance of family planning, especially among younger, more educated and formally employed population groups. High discontinuation rates and very resistant male attitudes, however, appear to contribute significantly to the low national prevalence rate in the Kingdom.

Labor emigration from Swaziland to the mines and farms of South Africa was substantial for many decades, although in recent years the movements have been temporary and cyclical rather than permanent. Approximately 5% of the total population, and about 20% of the male working age population, worked outside the country in 1976 (World Bank, 1985). Internal migration from the rural areas into the towns has been increasing but current data on urbanization rates is limited.

Although Swaziland could support a population several times its size both in food and reasonable levels of income and standards of living from the agricultural sector, the central issue is not the absolute size of the population, but rather the speed at which the population is growing and the ability of the country to develop resources to support such an increase. Rapid population growth will produce a substantial increase in consumption needs and pressures on government supply for services - particularly in agricultural, health, education, water and sanitation, energy, and housing sectors. The World Bank noted that despite Swaziland's experience with high economic growth during the 1960's and 1970's, the net effects of rapid population growth and continued high levels of fertility over the next 30 years will result in severely curtailed prospects of economic and social development.

B. Social Considerations

Only in recent history has Swaziland experienced a growing incidence of social problems such as unemployment and related crime; school dropouts due to teen pregnancies; infant and child abandonment; deaths or severe health problems related to illegal, "back-street" abortions; shortages of school spaces for qualified students; and urban housing shortages are relatively recent in the country's history. Older Swazis claim that as recently as a generation ago, such problems did not exist. Today, however, accounts of these and other social ills are commonly reported in the local press.

The appearance of such problems are related to overly rapid rural-urban migration without a concomitant growth in social and employment opportunities; growing economic pressures; reduced or more competitive employment and educational opportunities; changing familial traditions including more women working outside the home and a trend away from extended families toward a more nuclear

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family structure; and rising fertility due to altered traditional marriage and child-spacing practices. Rapid population growth will only exacerbate the current situation. If growth were to continue at the present rate, it is unlikely that Swaziland will be able to adequately create the necessary employment opportunities or provide sufficient coverage of support services required to address and prevent these growing social problems.

Without an expansion of family planning utilization and a reduction in overall fertility to prevent unwanted births and to curb the country's population growth rate, Swaziland will experience growing severity of these problems.

II. FAMILY PLANNING POLICY IN SWAZILAND

The GOS outlines its development goals and strategies through its National Development Plan. The current Plan (NDP4), drafted in 1983 and covering the period 1983/4 through 1987/8, acknowledges Swaziland's high and growing rate of population growth and the resulting youthful age structure. The Plan also notes the implications of rapid growth for development prospects in key sectors, including education, health, and employment. For the most part, the Plan offers solutions for accommodating rather than for influencing population growth.

The GOS currently supports the provision of family planning services and promotion of child spacing as part of its maternal and child health (MCH) strategy. NDP4 identifies as one of its two key health sector objectives: "to provide services which contribute towards an increase in child-spacing and a moderation in the rate of population growth" (NDP4, p. 473).

The GOS has yet to formulate a formal population policy. Family planning is but one of a number of elements of its national health strategy, but without strengthened GOS commitment to formulating and implementing a population policy, successful expansion of family planning services in Swaziland and resulting reductions in the national population growth rate will be less than optimal. In NDP4, the GOS recognizes that "until a wide-ranging population policy - including appropriate changes to the social, economic, and institutional arrangements - is formulated and implemented, the influence of family planning services will be limited" (NDP4, p. 225).

Two separate RAPID presentations and two national conferences on population and development have been held since 1979. While leaders have yet to develop a formal consensus on population policy issues, the most recent seminar (June 1988) resulted in greater support for curbing the population growth rate to sustain Swaziland's progress in economic development. As a result of this seminar, a parliamentarians committee has been established to begin developing a strategy for a population policy.

A formal population policy is not necessary for initiating family planning activities, but progress in reducing high rates of growth will be greatly enhanced if the GOS actively promoted increased awareness and ready access to FP services.

Approximately 50% of chiefs in Swaziland have participated in leadership seminars which included sessions presented by the Family Life Association (FLAS) on family planning. Traditional chiefs and tinkhundla governors comprise an important leadership constituency in Swaziland. There is some resistance within these traditional groups to introducing modern contraceptive methods - in part because modern contraception is associated with increased promiscuity among youth and women. Still, these leaders are open to discussion and are interested in learning more about family planning - as evidenced when population and family planning issues have been raised in workshops for traditional leaders. Most chiefs have returned to their communities and have initiated discussions with their constituents on seminar topics. Unfortunately, however, no written family planning materials have been developed to assist these leaders in disseminating family planning information. Furthermore, many of the chiefs are illiterate and require specialized materials to assure that accurate and complete information is passed on to their communities.

While Swaziland may not be prepared to embark on a wide-ranging population policy in the near future, negative leadership attitudes toward family planning are slowly changing. Continued efforts in leadership awareness will assist in neutralizing opposition to the individual practice of family planning and will facilitate more constructive development activities in relation to population growth.

III. DESCRIPTION OF FAMILY PLANNING SERVICES IN SWAZILAND

A. Background

Health services in Swaziland are delivered through various government/mission clinics and hospitals, private industry-based clinics, and private practitioners (who are mostly located in the urban areas). The MOH estimates that 69% of the rural population live within 8 kilometers of any clinic or hospital, government or otherwise. The distribution of fixed GOS/mission medical facilities is shown in Table 2.

Most clinics are staffed by at least one nurse-midwife and a nursing assistant who operate the clinic from 8 a.m. to 5 p.m. Monday through Friday with staff on call for emergencies at night and on weekends. There is a strong curative bias in Swazi medical services, although attention to preventive care is growing. Outpatient services in most of the fixed facilities listed above offer MCH services, including varying levels of family planning services upon demand.

While private-sector services are operationally and financially autonomous, all clinics, with the exception of private physician

services, are supposed to be supervised by a MOH regional nurse supervisor or public health matron responsible for assuring MOH protocols, policies, and reporting are implemented. Unfortunately, transportation constraints have precluded complete supervisory coverage and non-government services are generally under-supervised. Despite poor supervision, health services in all GOS/mission/industry facilities are relatively consistent in terms of technical protocols (both curative and preventive) and service delivery policies through the efforts of the MOH to involve these personnel in most training activities. However, because private physicians and nurses have generally not participated in these training efforts, their involvement in adopting MOH protocols and policies has been limited. Most MOH in-service training efforts to introduce new health care approaches are aimed at government, mission, or industry-based health personnel, and generally do not reach private nurses or physicians.

TABLE 2

Fixed Medical Facilities in Swaziland

<u>Region</u>	<u>General Hospitals</u>	<u>Rural Health Centers</u>	<u>Public Health Units</u>	<u>Clinics</u>	<u>Outreach Sites</u>
Manzini	2	0	2	53	50
Hhohho	3	1	2	30	27
Shiselweni	1	0	1	19	12
Lubombo	1	1	1	30	24
TOTAL	7	2	6	132	113
GOS portion	3	1	6	115 (est)	125 (est)

Source: Ministry of Health, EPI Plan, 1987

Note: Figures do not include private physicians or private nurses operating their own private practices.

While costs of mission and GOS outpatient and inpatient services were equalized in 1984, neither for profit industry services nor private nurse/physicians services were party to the equalization scheme. In the MOH mission, facilities, and industry health family planning services are generally provided free-of-charge following payment of an initial registration fee (E1.00). FLAS and private physicians and nurses typically charge higher fees for all visits, including family planning.

The major providers of family planning services in Swaziland are FLAS, the Ministry of Health, mission clinics, industry-based clinics, private practitioners, and a few NGOs such as the Baphalali Red Cross. Their various services are described in the following section.

B. Coverage of Family Planning Services

(1) Clinical Services

In a 1987 nation-wide review of Primary Health Care service delivery, most clinics surveyed provide family planning services, although the mix of contraceptive methods offered varies and may be quite limited.

The data in Table 3 represents FP services offered only in rural or peri-urban areas, and does not reflect the more accessible, wider range of services offered by FLAS and private physicians in urban settings. While most MOH/mission/industry-based clinics do provide limited family planning services, many do not have staff fully trained in family planning technology. The quality of services varies in relation to the amount of training that the health care provider has received (McDermott, personal communication). In 1986, the MOH, with support from UNFPA prepared family planning protocols and began introducing them to clinic staff through a training sessions in contraceptive technology and counseling. Since then, follow-up on-the-job training and introduction of protocols to additional clinic staff has been carried out with assistance from the Primary Health Care Project. To date, nearly half the clinics have been reached and, despite the absence of data to measure the impact of these efforts, many believe that the clinics are beginning to provide better quality services as a result of the guidance provided by the new protocols and on-the-job training support.

FLAS, the most active provider and promoter of family planning in the country, operates three clinics in the Mbabane - Manzini corridor and serves approximately 30% of all family planning clients in the country. FLAS has initiated many informational and educational activities targeted at both clinic attendees and the general public (see following IEC section). FLAS' clientele consists mainly of younger, more educated, or urbanized women, although recent efforts to combat sexually

TABLE 3Family Planning Services Offered in Selected Swaziland Clinics

	<u>Number</u>	<u>Percentage</u>
Total Clinics Surveyed	30	100
Clinics Providing FP	28	93
Methods: OCs	28	100
Injectables	25	89
Condoms	25	89
Foaming Tablets/Jelly	17	64
IUDs	10	36
Diaphragms	6	21

Source: 1987 Primary Health Care Review, Ministry of Health [draft report].

Note: Clinics surveyed are a combination of government, mission, and private nurse services located in rural or peri-urban Swaziland.

transmitted diseases (STDs) have generated a growing male clientele. Yinger (1985), in evaluating a sampling of FLAS' client records, found that nearly 60% of the clientele were younger than 25 years, only 15% were older than 35 years of age, and approximately 70% had two or fewer children. 72% of clients in FLAS clinics are single, and 41% have completed Form 4 or 5 (equivalent to U.S. grade 11-12 in high school). Only 10% of FLAS clients were found to be unemployed or not attending school. There are notable differences between the clientele in three clinics in terms of education, occupation, and marital status which relates to the location of the clinic. The Malkerns FLAS clinic is not as accessible to teenagers and consequently the Malkerns client generally is older, married, less well-educated, and likely to hold a lower skill job than the Mbabane or Manzini FLAS client who is younger and better educated.

Yinger also analyzed continuation patterns and found that overall, 50% of FLAS clients had never returned for a second visit to the FLAS clinic. While the data indicates high discontinuation rates, it is unknown whether clients have sought family planning in other clinics than FLAS. Nevertheless, high discontinuation rates appear to be a widespread problem throughout Swaziland, and may be due to inadequate counseling, follow-up, or other cultural factors.

Private practitioners also provide family planning services to a more elite and educated population who are more likely to accept family planning than the more traditional rural communities served by the MOH or mission clinics. Most private practitioners offer the full range of contraceptive methods.

In addition to services provided through fixed health facilities, the Red Cross provides outreach family planning services through its five divisional offices located in each region and through its one clinic and eight mobile clinics. Contraceptives are provided free-of-charge to any person desiring supplies, although a physician's examination is required for those individuals requesting oral contraceptives or the IUCD. FLAS also has initiated a pilot community-based distribution (CBD) program in two rural communities and in the Mozambican refugee camps. The FLAS-recruited and trained CBD workers provide family planning information and commodities (condoms and foaming tablets) to community members. The refugee camp CBD workers also provide health education on other MCH services such as ORT, immunizations, and ante-natal care.

Ministry policy (1979) states that family planning services are to be provided on demand to adult women following a complete medical examination. Generally, however, this is not enforced and some non-prescriptive methods are provided without a full medical examination. The only exception to the MOH policy is FLAS' pilot CBD program which offers non-prescriptive methods (condoms, foam, jelly) without an exam. Such policies should be reviewed with respect to the need to conduct a medical exam, and the possibility of supplying and re-supplying oral contraceptives through CBD programs without an examination.

While the husband's consent is not legally required for a woman to receive family planning, health workers are encouraged to exercise their judgment in requiring consent based on their knowledge of the cultural characteristics of the community served. With the exception of tubal ligation, where stated consent between partners would be preferable, enforcement of consent is not desirable.

(2) Sexually Transmitted Diseases

FLAS reported to the Swazi press on November 24, 1987, that more than 44,000 cases of sexually transmitted diseases (STDs) were treated between 1983 and 1986 in government hospitals and clinics, excluding private practitioners and traditional healers. The principal STD problems in Swaziland include syphilis, gonorrhoea, candidiasis, chancroids, herpes, and other minor venereal diseases. Most clinics presumptively treat STDs in the absence of laboratory confirmation.

The incidence of STDs has been growing at an alarming rate. MOH statistics for 1984 show that sexually transmitted diseases (specifically syphilis) accounted for more than 5% of total

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outpatient visits to hospitals and clinics. Adding genito-urinary complaints (contributing to an additional 6 percent) or and estimated total STD incidence rises to 11%. A 1985 WHO consultant (Nsanze) investigated the incidence of STDs through clinic interviews and examinations of STD patients, and corroborated these estimates by calculating that the STD contribution of outpatient visits to total approximately 10.8%. An analysis of 1984 delivery data at Mbabane Government Hospital shows that 50% of the stillbirths were serologically positive for syphilis (80 stillbirths among 3,000 deliveries) (McGrath, personal communication).

While these figures are extremely high for any African country, they are most likely underestimates of the actual magnitude of the STD problem, since not all fixed facilities or private physicians report statistics on STD visits. Furthermore, the rate of syphilis has possibly increased since 1984 as evidenced by positive rapid plasma reagin (RPR) tests, a serological test for syphilis, conducted in 1986 on 22,820 women attending antenatal clinics. Positive RPR rates averaged 11.7% of the test population and were higher for women from industry areas (14%) than for women from urban (12%), towns (11.9%) or rural areas (10.7%).

Gonorrhoea and other STDs may account for a further 10-15% incidence above the 11% calculated above, bringing the estimated annual STD incidence to levels approaching 25% of the population. While clinical diagnosis has improved since 1984 due to MOH technical training efforts, and thus may account for the statistical rise in STDs, health professionals believe that many cases go still untreated (and unreported) due to the stigma associated with STDs and possible use of traditional remedies. In addition, patients who cannot afford the fees for STD treatment at FLAS or other more expensive private services and who are referred to less expensive government services may be "lost" in the referral process. [FLAS has reported that nearly half of the clients who receive counselling about STDs do not receive treatment at their clinics (FLAS, 1987).]

STD education is limited. The Ministry of Health has few educational materials for STD patients. FLAS, however is involved in STD education and information efforts to promote STD treatment and prevention (see IEC section following).

Acquired Immune Deficiency Syndrome (AIDS) has also recently appeared in Swaziland. In early 1988, the MOH officially reported fifty-five (55) AIDS patients, although it is unclear whether these are actually HIV carriers or actual AIDS cases. Earlier, the MOH admitted unofficially to having many more "cases", although the Ministry would not release the exact number of cases. Anecdotal information suggests that AIDS is affecting a cross section of racial and economic segments of the Swazi population.

Although AIDS is a notifiable disease in Swaziland, it is certainly under-reported due to lack of diagnostic skills among health workers and the refusal of private physicians to report HIV-positives to the MOH because of patient confidentiality

problems. In a July 1987 non-random survey of 60 clinic personnel, Wallace found that 28% could not define AIDS, and 33% could not define how AIDS affects the body. Only 30% of those surveyed could define 3 practical ways of preventing AIDS transmission. To date, the MOH has not permitted any AIDS education efforts to be conducted until inter-sectoral agreement on the content of the message can be obtained. In the meantime, the general public and health personnel receive most their AIDS information through word-of-mouth and press reports. Clearly, there is a need for consistent and accurate dissemination of AIDS information on diagnosis, transmission, pathology, and prevention for both the general public and health personnel.

The World Health Organization plans to assist the MOH in conducting a serosurvey to measure the national prevalence of AIDS, providing the MOH with laboratory testing equipment and training, and assisting in AIDS education and training.

(3) Information, Education, and Communication (IEC)

Most clinical family planning services are offered on demand, and are not actively promoted because of perceived political or cultural sensitivities. Family planning is also not promoted due to the lack of adequate family planning information materials which can be distributed to active or potential users. Notably, FLAS is the only institution in Swaziland which is involved in active promotion of family planning. In the last several years, FLAS has embarked on numerous IEC activities directed to specific target groups - men, younger women, school children, chiefs, women's groups, and parliamentarians.

FLAS' efforts in IEC first began in 1979 with the hiring of a Family Life Educator. The unit expanded to two people by 1983 and to five full time employees by 1987. Most of the staff were originally trained as teachers, and have gained limited IEC experience through short workshops and on-the-job training. FLAS prepares in-house most of the family planning materials (e.g. booklets, posters, radio messages) available in the country with some assistance from the MOH Health Education Unit. Materials are developed in response to expressed needs of a community or as determined by FLAS senior level staff. In general, materials are not pretested with the target audience prior to final production; consequently, the quality of FLAS' materials has been less than ideal due to limited funds and lack of experience in materials production. FLAS also produces regular radio messages, generally 15 minutes in length, for broadcast several times per week.

Other agencies capable of producing family planning education materials include the MOH Health Education Unit, which has facilities for graphic art production, and the Development Communications Center at Swaziland Broadcasting System (SBS), which has limited capacity for radio/audio production. Neither SBS or HEU independently develop FP materials or messages without

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FLAS involvement. Aside from FLAS, no other agency or organization in Swaziland is involved in public education and motivation of family planning.

FLAS has undertaken IEC several projects aimed at male motivation. Lectures and information are provided to male employees of selected companies, and employer-based distribution (EBD) programs have been established at 3 firms. FLAS provides full support for training and supplying EBD workers with commodities and materials for family planning promotion.

FLAS has also undertaken several leadership awareness activities with community leaders and parliamentarians to reduce negative attitudes toward family planning. FLAS has collaborated with the Office of Tinkhundla, through the AID-funded Swaziland Manpower Development Project, in providing FP information to chiefs and women's organizations. FLAS also conducted a seminar on Population and Development for parliamentarians in 1985, where parliamentarians made several recommendations regarding promotion of family planning and the need for population and development planning.

While initially very sensitive, family planning awareness activities directed to leaders have been well-received. FLAS staff, select GOS officials, and USAID advisors believe that in Swaziland the demand for family planning information is very high, and once such information is successfully disseminated, resistant attitudes may diminish. FLAS intends to continue its leadership awareness activities to promote greater acceptance of family planning at a political and leadership level.

FLAS has also been involved in educating the public on prevention and treatment of STDs. More than 8% of FLAS visits are STD-related. During late November 1987, FLAS conducted a national education campaign to promote treatment of STDs, to increase awareness of the problems, and to reduce the stigma attached to the diseases. However, in order to effect a reversal in the increase of STD cases, quality materials and messages information on the causes of STDs (including AIDS) need to be developed for the general public.

(4) Manpower in Family Planning

As stated above, most health providers offer family planning services on demand. However, what is exactly provided depends on the training and experience of the provider and the availability of needed equipment and support systems for that provider.

Between 1973 and 1976, fourteen Swazi nurse-midwives completed courses in clinical family planning skills. Most attended Meharry Medical College in the U.S., and several were sent to a family planning training of trainers (ToT) course in Tanzania. These fourteen nurse-midwives formed the first core of trained family planning personnel in Swaziland.

In the early 1980's, the two nursing colleges, the Swaziland Institute of Health Sciences (SIHS) and the Nazarene Nursing College (NNC), respectively introduced theoretical family planning content into their basic nursing curricula. Unfortunately, to date, pre-service family planning training at the basic nursing level is still limited to classroom theory, and neither SIHS nor NNC offer supervised family planning clinical training and counseling to basic nursing students. At the post-basic level, however, SIHS teaches family planning in its one-year midwifery program (which is completed by 85% of all nursing students following basic nursing training) and in its new post-graduate public health nursing program. The midwifery curriculum is currently being modified to include more theoretical and practical family planning content with consideration toward a competency based approach to pre-service training.

The Good Shepherd Nursing Assistant School in Siteki began including family planning in its nursing assistant curriculum in 1976, although in the limited two-year training program, the family planning curriculum is primarily theoretical. Since the school is funded by the Roman Catholic Church, modern methods of contraception, while taught, are not advocated.

Until 1986, most training in family planning was mostly theoretical with little or no supervised clinical experience offered, nor any strong emphasis on client counseling. In 1986, however, the MOH and UNFPA sponsored clinical family planning in-service training, including supervised practical sessions, to 33 nurse-midwives. Thirteen of these nurse-midwives were then selected to attend a training of trainers workshop, to gain the necessary skills for follow-up training of other clinic staff. Subsequently, two one-week in-service training sessions were held in late 1986 for a total 25 participants, each to update the family planning skills and knowledge of the student. These trainers have also been assisting in on-site training of clinic staff in the use of the new family planning protocols and on the use of a new service statistic form.

Despite the progress achieved through these in-service training efforts, major gaps remain with respect to coverage of personnel and the course content. To date, all follow-up training has been directed to nurse-midwives and nursing assistants have been excluded, even though they regularly relieve nurse-midwives in all clinic services, including family planning. Because nursing assistants are so vital to the clinics and health service delivery, in-service family planning training must be provided to these personnel. In addition, family planning counseling has been weakly addressed in all training efforts as a major and important component of service delivery. With Swaziland's very high drop-out rate (see next section on contraceptive preferences), improvement of counseling skills is critical to provision of good quality family planning services.

For the most part, those nurses who have received training are

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providing FP services, but lack support for improving, expanding, or promoting those services. Poor supervision, lack of technical updates, lack of adequate equipment (e.g. speculum, spatulas for pap smears, light sources, sterilization equipment, etc), insufficient supplies of contraceptives, absence of educational materials, and vehicles for outreach or follow-up affect the quality and availability of family planning services. The MOH is trying, through its new regional supervisory system, to address some of these constraints. Many of those nurses who have not received technical in-service training still provide limited services, but lack the confidence to undertake more without guidance.

In-service training and family planning program strengthening will continue in the future. The MOH, through the Primary Health Care Project, plans to develop a five-year plan for the Ministry's FP program, develop updated training modules for pre-service training, conduct in-service training for clinic staff, and introduce revised FP protocols by the end of 1988. It is envisaged that the vast majority of the nurses in the government/industry/mission health services will have received training and/or guidance in expanding family planning in the next several years.

C. Contraceptive Preference

(1) Socio-cultural Factors

There are a number of issues related to contraceptive preferences which are discussed under other sections of this analysis - specifically "Constraints to Demand for FP Services", and "Constraints to Supply of FP Services".

While many socio-cultural factors affect contraceptive method preferences, traditional methods may not be practical for all segments of the population; for example, working women who formula feed their infants cannot rely on breastfeeding as a means of child spacing and may develop more preference for modern methods over traditional methods. Methods which can be "hidden" often are used by women when gaining their husband's or partners's support is not possible. Economic pressures also encourage parents to use modern methods. Thus, in the absence of detailed, nationwide KAP-type data, contraceptive preferences can only be inferred from other socio-cultural information or clinic reports on family planning visits as discussed below.

(2) Clinic Data on Method Acceptance and Use

Data collection concerning actual use of the various methods has been less than complete and systematic to date. However, the MOH is attempting to improve the completeness and reliability of FP data through introduction of a new service statistics form and in-service training. The following information on contraceptive use in Swaziland was provided by the MOH (see Table 4).

TABLE 4

New Acceptors of Contraceptives in Swaziland: 1982-84

		<u>1982</u>	<u>1983</u>	<u>1984</u>
Oral Contraceptives	N=	5078 (73%)	4680 (79%)	4379 (74%)
IUCDs	N=	854 (12%)	658 (11%)	797 (13%)
Injectables	N=	990 (14%)	593 (10%)	771 (13%)
TOTAL	N=	6922 (100%)	6931 (100%)	5947 (100%)

Source: Ministry of Health, Public Health Unit.

Note: The total number of new acceptors, including those using other methods than those listed in the table is unknown. Also, data does not represent FP services provided by private practitioners.

As illustrated in Table 4, in 1982-84 new acceptors selecting modern methods of contraception in Swaziland, excluding barrier methods, more commonly accepted the pill (three-quarters of new acceptors) and the remainder chose equally between the IUCD and injectable. This may be due in part to the greater availability of the pill in clinics as compared to other methods. The fact that IUCD insertion requires special equipment, supplies, and trained staff which are not available at all clinics and that the injectable is periodically out-of-stock may skew data interpretation towards concluding that the pill is the most favored method.

In 1983, 596 family planning users changed methods and 406 changed in 1984. Those changing from the injectable to the pill accounted for 25% of all change in 1983 and 13% in 1984. Those changing from the pill to another unspecified method totalled 29% of all changes in 1983 and 14% in 1984. Reasons for these method changes was not collected.

MOH data for new versus continuing user visits in 1983-85 is presented in Table 5 below. In comparing the use of all methods provided in Swaziland clinics during this period, approximately half of total users selected oral contraceptives, one-tenth injectables or IUDs, and less than one-third a barrier method.

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TABLE 5
NEW VERSUS CONTINUING USERS OF CONTRACEPTIVES
SWAZILAND: 1983-85

<u>METHOD</u>	<u>NEW USERS</u>			<u>CONTINUING USERS</u>		
	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Barrier	2565 (30%)	2159 (27%)	2478 (28%)	874 (5%)	792 (4%)	912 (4%)
IUCD	658 (8%)	797 (10%)	714 (8%)	1644 (9%)	2010 (11%)	2129 (10%)
Injectable	593 (7%)	771 (9%)	1404 (16%)	987 (6%)	1699 (10%)	3719 (17%)
Orals	4680 (55%)	4379 (54%)	4226 (48%)	13792 (80%)	13328 (75%)	15253 (69%)
TOTAL	8496 (100%)	8106 (100%)	8820 (100%)	17297 (100%)	17829 (100%)	22013 (100%)

Source: Ministry of Health, Public Health Unit.

An interesting feature of the data presented in Table 5 is the far greater new acceptance rate of barrier methods as compared to continuing use of barrier methods. These figures most likely represent condoms given for STD treatment/prevention. Possibly other factors such as the length of visit required to obtain condoms discouraged the client's return for re-supply. Also, clients may not have liked or understood the method. Further research, however, will be necessary to determine the causes of such high discontinuation rates.

Injectables had stable use among roughly 10% of the users whose numbers increased from 1983 to 1985. New acceptance of oral contraceptives declined slightly from 55% to 48% for those using a modern method (excluding sterilization); however, numbers of continuing pill users remained high.

Because of the high prevalence of STDs in Swaziland, the continued prescription of the IUD as a method must be questioned. In cases where a client has multiple partners or is at presumed high risk of STD, the likelihood of pelvic inflammatory disease and possible subsequent infertility (or

worse) associated with IUD insertion should be considered. As STD screening is not available at the clinic level, prophylactic antibiotic treatment could be provided at the time of IUD insertion. However, prior to implementing such a recommendation, a study should be conducted on IUD users and their experience with complications and the manner in which such complications were handled.

In summary, the pill is the most commonly delivered contraceptive in Swaziland for both new and continuing users. Barrier methods are the second most "popular" contraceptives for new users, but continuation rates are extremely low, possibly due to the fact that barriers are being distributed for STD prevention/treatment and not necessarily for family planning purposes. Assumed "preference" for oral contraceptives, as interpreted by the service delivery data presented in Tables 4 and 5, may be due to the wider availability of the pill compared to other methods, and the shortage of equipment and trained staff to provide alternative methods of contraception - particularly the IUD.

V. CONSTRAINTS RELATED TO DEMAND FOR FAMILY PLANNING SERVICES

A. Traditional Attitudes and Beliefs

Traditional Swazi culture is strongly intertwined with child bearing and the identified need to have children to maintain ancestral beliefs through time. It is stated that the more descendants one has, the bigger one's ancestral shrine will be and if no children are borne, then no one will remember that individual. It is also important in Swazi tradition to have female children for both economic and religious reasons. Lobola, or the traditional cattle payment made to the women's family at marriage, can be viewed as the "child price" or that which fills the gap created when parent's lose their daughter. Thus, the traditional religious system strongly affects the concept of child bearing and the cultural pressures favoring large families.

In modern-day Swaziland, traditional, pronatalist cultural values are quickly disappearing especially among the younger, formally employed, and more educated segments of the society. Growing economic pressures to feed, educate, and clothe one's children are particularly powerful forces contributing to the desire to limit family size.

B. Knowledge, Attitudes and Practices

Most of the population have some, albeit limited, knowledge of family planning and those who are knowledgeable may not practice family planning because of resistant cultural attitudes. Men in particular are resistant to family planning because of the prestige associated with large family sizes and fears of female

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promiscuity associated with reproductive freedom. Despite misunderstandings and resistance, the general public's demand for family planning information appears to be already quite high and increasing. Anecdotal information (UNICEF, FLAS, SWAMP) indicate that both the general public and Swazi leadership are interested in "knowing what family planning is really about", although willingness to practice or promote family planning is not strongly linked to FP knowledge at the present time.

Many Swazi women already know about family planning. In two separate KAP surveys (Shongwe, 1986; Ndlangamandla and McDermott, 1987) conducted in one peri-urban area and in two rural communities, 97-58% of female respondents could recall at least one contraceptive method; women in the peri-urban area were more likely to mention modern contraceptive methods, and the pill in particular while rural women more commonly reported withdrawal as a FP method. Only 2% of peri-urban women nearly 42% of rural women could not recall a method of family planning. Most respondents in both surveys also knew where FP services could be provided - 81% of rural women and 97% of peri-urban women knew that the clinic or other health facility provides family planning services.

As Shongwe notes, however, knowledge of family planning does not necessarily translate into practice. Only 23% and 30% of rural and peri-urban women respectively reported that they practice family planning. Many reasons cited for not utilizing FP services include fear of health risks; loss of weight, spotting, and other side effects; loss of libido (in the case of condoms); distance to clinic or other source of services; and social stigma.

Changing child-rearing practices, particularly breastfeeding practices, also affect demand for family planning. Many Swazi women believe that breastfeeding is effective in preventing pregnancy. However, the wide-spread use of formulas in conjunction with breastfeeding, especially among formally employed or urbanized women, undermines the already minimal contraceptive effects of lactation.

C. Attitudes toward Public Education Efforts

Demand for STD information is quite high as would be expected by the widespread prevalence of STDs in Swaziland. Although distribution of condoms in treatment of STDs can not be considered as family planning practice, FP methods and information provided in conjunction with STD treatment may promote child spacing indirectly.

Attitudes toward FP public education efforts vary widely. Anecdotal information suggests that certain segments of the population find family life education in the schools or on the radio offensive, while others indicate that they enjoy the radio shows and appreciate the information disseminated. Both negative

and positive reactions have been reported with respect to FLAS' family planning posters and awareness/motivational efforts. Although no data exists at the current time, the variation in reactions to FP and public education activities is believed to follow socio-demographic lines, with the more educated, younger, and formally employed segments of the population exhibiting greater receptivity to FP services and information.

D. Economic Factors

The cost of family planning services, both monetary and non-monetary (time, travel, etc) may also contribute to the low prevalence of contraceptive use in the country. Clinics in Swaziland are generally only open during working hours. To obtain family planning services, the costs of losing productive working hours, time and money for transportation to the clinic, and costs for the clinic visit can provide significant constraints to demand. In addition, poor quality services may further discourage adoption of family planning services.

VI. CONSTRAINTS RELATED TO SUPPLY OF FAMILY PLANNING SERVICES

Numerous constraints related to the delivery of family planning services also influence the low contraceptive prevalence rate. While clinics are distributed throughout the country, and most the population lives within 8 km of a fixed facility, transportation to these facilities is often difficult. Bus services are limited, and walking times are too great to motivate people to seek family planning.

Many clinics lack trained staff, adequate equipment, or the full range of contraceptives to provide good quality services. Basic needs such as running water and electricity are absent from many clinics. Rural health services, in particular, lack adequate privacy for delivery of family planning services. Once patients do arrive at a health facility, waiting times are usually so long as to discourage all but the most motivated users. Clinics are understaffed. In addition, many of the nurses are perceived to treat their clients poorly.

Family planning is not completely integrated as part of primary health care, and consequently family planning is not promoted to many potential users attending clinics for other curative or preventive reasons. Little time is devoted to counseling, advising or educating clients on the benefits of family planning. Many patients receive FP services without adequate explanation or side-effects. Little or no follow-up occurs with discontinued users.

Training and support to clinics in providing family planning will improve the delivery of services at fixed facilities and remove

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many of these constraints. However, significant increases in family planning use will not occur without more active promotion at the community level through either CBD programs, radio messages, or other outreach efforts.

VI. VIABILITY OF PRIVATE SECTOR INVOLVEMENT IN FAMILY PLANNING

Despite limited data, demand for family planning appears to be highest accepted among formally-employed and more urban populations than other groups. Traditional channels for delivering family planning services have not always reached these more receptive segments of the population and alternative channels, such as employment-based services, hold good promise for expanding family planning practice in Swaziland.

In 1985, over fifty percent of those formally employed could be reached through the five largest firms (see Table 6). Since then, many more companies have come to Swaziland, and the overall labor force has grown significantly. (Unfortunately, more current employment information will not be available until the completion of another survey in 1988.) These companies, particularly the larger firms, represent an ideal target group for directing family planning expansion efforts.

Many large firms have on-site health facilities and provide care to both employees and their families. In some cases, family planning services are already available to employees and their families, but not actively promoted. As demonstrated in other countries in Africa (Population Reports, 1987), employers believe the benefits to their worker's welfare and to the business make the promotion of family planning a worthwhile investment. Benefits accrued to the worker through making services available in the workplace include:

- protection of women's health through avoiding high risk pregnancies;
- avoiding unwanted pregnancies;
- having healthier children;
- maintaining employment as desired;
- more accessible services to both men and women;
- possibly a safer workplace by reducing personal stress and related industrial accidents.

Benefits which accrue to the business include:

- healthier workers who stay on the job longer, take less sick leave, and perform better;
- less need for maternity benefits;
- reduced need for other social service and health care costs;
- possible improvement in labor-management relations;.

In Swaziland, many employers appear to be receptive to expanding family planning services within their organization. In discussions with management representatives of several larger

TABLE 6
EMPLOYMENT BY SIZE OF FIRM

Swaziland, 1984-85

<u>Number of Employees</u>	<u>Number of Firms</u>	<u>Number Employed</u>	<u>Percent of Total Employed</u>	<u>Cumulative Percent</u>
over 3,000	1	4,000	11.6	11.6
2,000-3,000	4	10,000	29.0	40.6
1,000-2,000	4	6,000	17.4	58.0
500-1,000	2	1,500	4.3	62.3
400-500	3	1,350	3.9	66.2
300-400	3	1,050	3.0	69.3
200-300	12	3,000	8.7	78.0
100-200	21	3,150	9.1	87.1
50-100	23	1,725	5.0	92.1
25-50	40	1,520	4.4	96.5
under 25	93	1,209	3.5	100.0
TOTAL	206	34,504	100.0	100.0

Source: Based on a Survey of Firms conducted by the Swaziland Federation of Employers.

firms in Swaziland, interest was expressed in obtaining assistance to expand family planning services for their employees, and managers also appeared receptive to funding the cost of expanding services. Because many of these large firms currently offer health care through their company clinics or hospitals, they are more likely to offer employee/dependent benefits and to promote child spacing than smaller companies.

Smaller firms in Swaziland have little or no infrastructure for providing health care services and consequently, they did not express willingness to invest financial resources to promote child spacing services. One alternative for promoting employment-based family planning programs in small companies is employer-based distribution (EBD) activities sponsored by FLAS for contraceptive distribution and IEC activities.

Among all the companies examined in this design, IEC activities were by far the weakest component of all company-sponsored family planning programs. Many company clinic and management staff expressed a need for more IEC materials and assistance in undertaking IEC activities. FLAS was mentioned repeatedly as an organization that the companies wished to work more closely with

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to strengthen their IEC efforts.

Insurance schemes in Swaziland and Southern Africa presently do not reimburse for contraceptives, or any other preventive healthcare. Because many companies offer medical insurance schemes to their employees in lieu of on-site medical facilities, changes must be made in the coverage of family planning services by insurance programs. A workshop proposed under this Project aims to present the need for preventive (and child-spacing) coverage in insurance programs.

In addition to the employment-based facilities and insurance schemes provided to employees, many private practitioners offer child spacing to individuals on a fee-for-service basis. At least one private health care firm (Occupational Health Services in Matsapha) offers child spacing and other preventive health care services for a fee to employees of over 40 commercial operations. Private physicians and nurses are another target group for expanding and promoting family planning services to the general public.

In summary, industry management in Swaziland is generally interested in becoming more active in promoting family health and child spacing; however, they need assistance in assessing demand, designing and implementing an IEC program, training nurses or EBD workers, and arranging contraceptive supply. Expanding child spacing service delivery through the private sector is a natural market for FLAS. FLAS' skills in clinical services delivery, IEC, and the research/evaluation functions to be established under this project can benefit those industries desiring to promote employment-based family planning programs. However, because of the diversity of companies in the private-sector, FLAS needs to first consolidate its own outreach efforts and then expand into the private sector using a market segmentation approach. The proposed activities in Phase 2 of this project will provide the means for implementing such an approach.

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ANNEX 2

Administrative/Institutional Analysis

FLAS was founded in December 1979 and is registered under the Protection of Badges and Names Act. As with all PVOs in Swaziland, it is also registered with the Ministry of Interior as a voluntary not-for-profit organization. Although FLAS is a non-governmental organization, it maintains a close working relationship with the Ministry of Health because of its activities in reproductive health and family planning. The objectives of the association are:

1. To assist and supplement the activities of the Ministry of Health and other government agencies in the promotion of healthy family life and the creation of a sense of awareness of the importance of family health in all respects so that it becomes a way of life.
2. To assist and supplement the activities of the Ministry of Health and other government agencies in the education for acceptance of child-spacing as a basic human right available to all.
3. To work with other organizations and government agencies in the implementation of community schemes in family health, so that the quality of life for the individual person, the family and the community may be improved.
4. To help and assist in the education for the understanding of the nature, cause and effects of growth in population on people in their own communities, countries and the world.
5. To assist in the distribution of information concerning all aspects of family health education and welfare.

Since 1985, FLAS has had associate status with the International Planned Parenthood Federation. It is comprised of volunteer members who have a strong voice in the running of the association through a National Assembly and committees and through a constitution voted by volunteer members. Prior to 1983, GOS had membership of IPPF and subsequently ceded it to FLAS. However, the GOS retains a position on the board of the Association through a representative of the MOH who sits on the Executive Committee.

The governmental interest in FLAS is also evident in the MOH willingness to include the Association in its MCH/FP program with possible financial assistance to FLAS. FLAS enjoys a good reputation with the general public maintained through its numerous radio programs, seminars, workshops and campaigns. Its activities are regularly featured on the national radio and television and in the local press. It also participates as founding member and accommodates the Assembly of Non-Governmental Organizations and is a full member of the Non-governmental Interagency Radio Group.

The affairs of the association are managed by an Executive Committee. The Executive Committee which meets at least once every three months is composed of the association's office bearers, four volunteer members, a representative of the Ministry of Health and the Executive Director who is the Secretary of the Executive Committee. Two committees, the Finance and Administration Committee and the Program Committee whose duties are not described in the association constitution have oversight over their specific area of assignment and make recommendations to the Executive Committee. The powers and duties of the Executive Committee are broad and far reaching. These include directing the implementation of FLAS policies, creating and abolishing of posts within FLAS, responsibility for employment, supervision and dismissal of staff and for keeping proper and accurate records of financial and other transactions, drawing up by-laws necessary for the execution of FLAS policies and reporting matters pertinent to FLAS administration to the Annual General Meeting of the National Assembly. The Executive Committee is elected for a period of two years. The National Assembly which constitutes the policy-making body of the association, meets at least once a year.

Currently, FLAS personnel is composed of 28 full time employees who are distributed into specialized units. Senior Management include the Executive Director and the Deputy Executive Director who is also the Director of Programs. Under her there are four department heads, namely the Senior Family Life Educator, the Senior Family Life Practitioner, the Training Officer and the Finance Administrator. A current organizational chart is attached in the Appendix.

The Senior Family Life Educator has the responsibility to develop and oversee FLAS programs in information education and communication (IEC) and the community-based distribution (CBD) program. This department is staffed by two full time Family Life Educators, one full-time CBD Coordinator, one full time Field Educator and 47 part time CBD workers. The Senior Family Life Practitioner supervises the service delivery unit staffed by twelve full time staff distributed among the Mbabane, the Malkerns and the Manzini Clinics.

The staff include one Family Life Practitioner, one Nurse Assistant, one General Clinic Assistant and one Orderly each at the Mbabane and Malkerns Clinics and two Family Life Practitioners, one Nurse Assistant, one General Clinic Assistant and one Orderly at the Manzini Clinic. The Finance Administrator heads the Finance Department which is composed of an Accounts Assistant, one Driver, a Cleaner and a Store-keeper seconded to the MOH contraceptives store in Mbabane. A Training Officer holds a departmental head level position although this officer does not have supervisory responsibilities. The organization employs two secretaries who are under the direct supervision of the Deputy

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Executive Director. FLAS uses consultants to provide counselling and medical back-up services on a part-time basis. All FLAS staff except clinical personnel, CBD workers and the Store-keeper are based at the association headquarters in Manzini. Volunteer contributions in terms of time to supplement staff by providing administrative assistance to the organization which was one of the factors that accelerated FLAS growth has not increased significantly with the association's expansion. However, volunteer members continue to contribute their time in providing counselling and specialized services.

The Executive Director, her deputy, unit heads and the Training Officer form FLAS Management Team. The Executive Director or the Deputy Executive Director often delegate, after consultation, decision-making and implementing authority for routine operative activities to department heads while policy, personnel and financial issues are referred to the Program Committee, the Finance Committee or the Executive Committee.

From 1980 to 1985, FLAS operated a total of 6 projects. From 1985 to 1987 this number increased to 15 and the number of full-time staff grew from 13 to 28. Out of these 15 projects, three have little relation to child-spacing and two are marginally connected with family planning, two are management oriented volunteer and staff training and resource development, four deal with information, education and communication to various segment of the population, one with reproductive health and two with direct service delivery. This does not compare favorably with a staff of 13 operatives in the organization. In the service delivery area, FLAS is operating 3 clinics in Manzini, Malkerns and Mbabane and has 28 CBD outlets distributed throughout the four districts of Swaziland and Industry Based Distributors in 20 industries in Matsapha near Manzini.

In IEC, FLAS undertakes extensive activities in family life education. These activities include lectures in 6 pilot schools, seminars for youth leaders in the four districts, lectures and group talks to church groups and university students. IEC staff also organize and conduct seminars to raise the awareness of Members of Parliament about population issues, design and implement radio programs, publish a quarterly newsletter, organize youth forums and debates. In the training area, IEC staff trains Social Workers and Home Economists in counselling and motivation. In 1987, FLAS initiated a new program to educate the public on STDs through printed material and using the radio. Through income generation and status of women projects, FLAS trains women leaders from the four districts of the country in family planning, women legal status and how to start and maintain an income generating project.

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Service delivery is provided mainly through FLAS network of three clinics located in the two main towns of Mbabane and Manzini and in the density populated area of Malkerns. The clinics appear to be well staffed and well equipped to provide services and in fact have been chosen as practicum sites by the Institute of Health Studies. It seems, however, that job assignments within the clinic do not fully utilize the skills and capacities of staff as most of the service delivery and administrative activities are to be performed by the Nurse Practitioner who also supervises clinic activities. Family Planning service delivery is also provided through CBD and company-based distributors under supervision from the IEC Unit. While this can be explained by the fact that the IEC Unit has traditionally been the promoter and outreach arm of FLAS, it would appear that CBD and company-based activities should fall under the service delivery unit which has the expertise to guide, supervise and improve these service delivery modes.

The three projects which are marginally-related to family planning but earn good-will to the association are scholarships for secondary school students and Creche in the Women's Prison and Emergency Assistance towards such expense as funeral expenses, school fees and purchase of seed for needy individuals. The association also conducts human resources development through in-country training for staff and volunteers and fund-raising activities through sport tournaments, fashion shows, dinner dances and donations.

FLAS under its 3-year plan, 1988-1990, plans to concentrate in three main areas; male motivation, service delivery and CBD activities and at the same accommodate a total of 1,250 nurse trainees in their three clinics.

FLAS since its inception has endeavored to recruit talented and well-educated staff for their professional positions, although many of them do not have family planning or related experience in their former occupation. FLE Educators and the Training Officer are all former secondary school teachers. Family Life Practitioners are Registered Nurses with extensive experience in government service, Nurse Assistants are well trained and administrative personnel appear to have the right qualifications and background. Most of the professionals at FLAS seem to be well-motivated and knowledgeable about their work despite the low average number of years of employment of staff (2 years, 8 months). This is reflection a of the relatively young age of the organization and not of staff turnover which appears to be low.

Precise personnel procedures, grade and salary scales and supervisory tools provide the framework of personnel management. Guidelines on store-keeping, record-keeping and simple straight forward financial accounting and equipment utilization are in use. The association is presently developing a policy of upgrading its

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staff resources, but many of the association employees have in the past benefited from overseas and in-country training programs in family health program management, training of trainers and counselling techniques. However, it is apparent that some of the training activities were not planned to respond to the needs of the position or to reinforce the institutional needs of a rapidly growing organization with an expanding scope of activities.

Management and Administrative Constraints with FLAS

FLAS is and perceives itself as a pioneer in family planning activities in Swaziland. In this regard, it has boldly moved to expand its activities to serve approximately 30 percent of family planning clients in the country. Its efforts to initiate and pilot family life education and child-spacing services are not only recognized by the public and donors but also by the MOH which assigned it a significant role to play in the private-sector. FLAS is fortunate not only to have received the support of a volunteer membership with high standing in the Swazi society but also to have attracted the attention and confidence of international donors. This support has accelerated the growth of the organization and this in turn has enabled the association to meet some of the numerous needs of the population not only in family planning but in other related areas like youth counselling, marital counselling, and assistance to the needy. During its life of sustained expansion and growth, FLAS has demonstrated high absorptive capacity. While FLAS has strived to introduce management tools to administer its expanding resources and portfolio of programs, it appears that certain areas of the organization's operations need support and upgrading if FLAS is to successfully overhaul the quality of its products (i.e. services and informational materials) and undertake more sophisticated and complex activities in the area of research and promotion of family planning use within private-sector industries.

Program Planning, Monitoring and Implementation

FLAS as one of the few non-governmental organizations working in the area of family planning in Swaziland has received substantial assistance from many international donors. Its work in promoting child-spacing and reproductive health through the media has publicized the name of the organization throughout the country. This situation has led to pressures to meet the demands of FLAS donors and recipients. FLAS has traditionally introduced programs to meet the needs of the population and according to availability of funding to support specific activities. This approach while it has the advantage of targeting opportunities has led to a lack of focus on the association's aims, goals and objectives. The

resulting effect of this lack of focus has been the development and execution of programs which are not related to child-spacing or reproductive health.

Another problem which compounds the lack of focus has been the lack of a global evaluation of FLAS overall activities. Consequently, most of FLAS planning was done according to each individual donor organization schedule and focus without due regard to other inputs FLAS was receiving. This resulted in over-extension and a heavy workload which are evident especially within the IEC and service delivery units. One of FLAS main orientation is in family life education and informational campaigns. The IEC Unit which has responsibility for conducting IEC activities has also to supervise CBD activities and fund-raising efforts. In the Service Delivery Unit, it appears that division of labor and job assignment are not equitably shared among staff. This is further exacerbated by an aging Nurse Practitioner workforce.

While staff seem to be enthusiastic and well-motivated the heavy workload imposed by the numerous tasks to be performed to achieve the objectives of some 15 projects can have a negative effect on morale and talent retention. However, it is to be said that FLAS did not have technical resources and was not in position to acquire such resources to provide management with adequate information to plan and monitor the organization expansion.

Technical and Managerial skills of FLAS staff

As said earlier, FLAS strives to attract talented and educated staff. However, the scarcity of technical and managerial skills within Swaziland, especially in the population sector and FLAS limited resources have had adverse impact on the organization's operations. The quality of products in the area of IEC materials production and financial accounting, budgeting and reporting, and research activities have stagnated. Most of the materials the IEC Unit creates are produced in-house and the quality of these materials could be greatly improved. The information content of messages has not been consistent. Some of the materials produced have marginal relevancy as they relate to child-spacing and others are questioned as to their cultural appropriateness. The accounting system FLAS currently uses meets minimum requirements set forth by its parent body IPPF. IPPF has however, expressed dissatisfaction with FLAS reporting and budgeting. There is a need to enhance FLAS ability to produce meaningful reports which can serve as management tools.

With regard to research and evaluation, the association has undertaken very little in this area, and where such activities

were conducted the scope and quality of the research were less than ideal. FLAS efforts to perform routine evaluation of its own activities to date have been limited.

Cost Recovery and Fund-Raising

FLAS has provided most of its services free of charge except for family planning services for fees are generally lower than those charged by Government facilities. FLAS seminars workshops and training sessions are provided free to the general public, private and public companies and institutions. Its information materials are available to everyone at no cost.

Up to a recent date, FLAS has considered fund-raising and cost recovery as a means to publicize and further the organization and its aims. Generated income from fund-raising activities has not attained a level which can support the association activities on a meaningful level. Fees generated from services have yielded insignificant amounts. The long term strategy for generating increased donations relies heavily on methods which have not proven to be successful in the past. However, there is an emerging awareness that FLAS can and must raise some of the share of the cost of running the association locally and reduce its reliance on international donors.

FLAS Institutional Development Needs

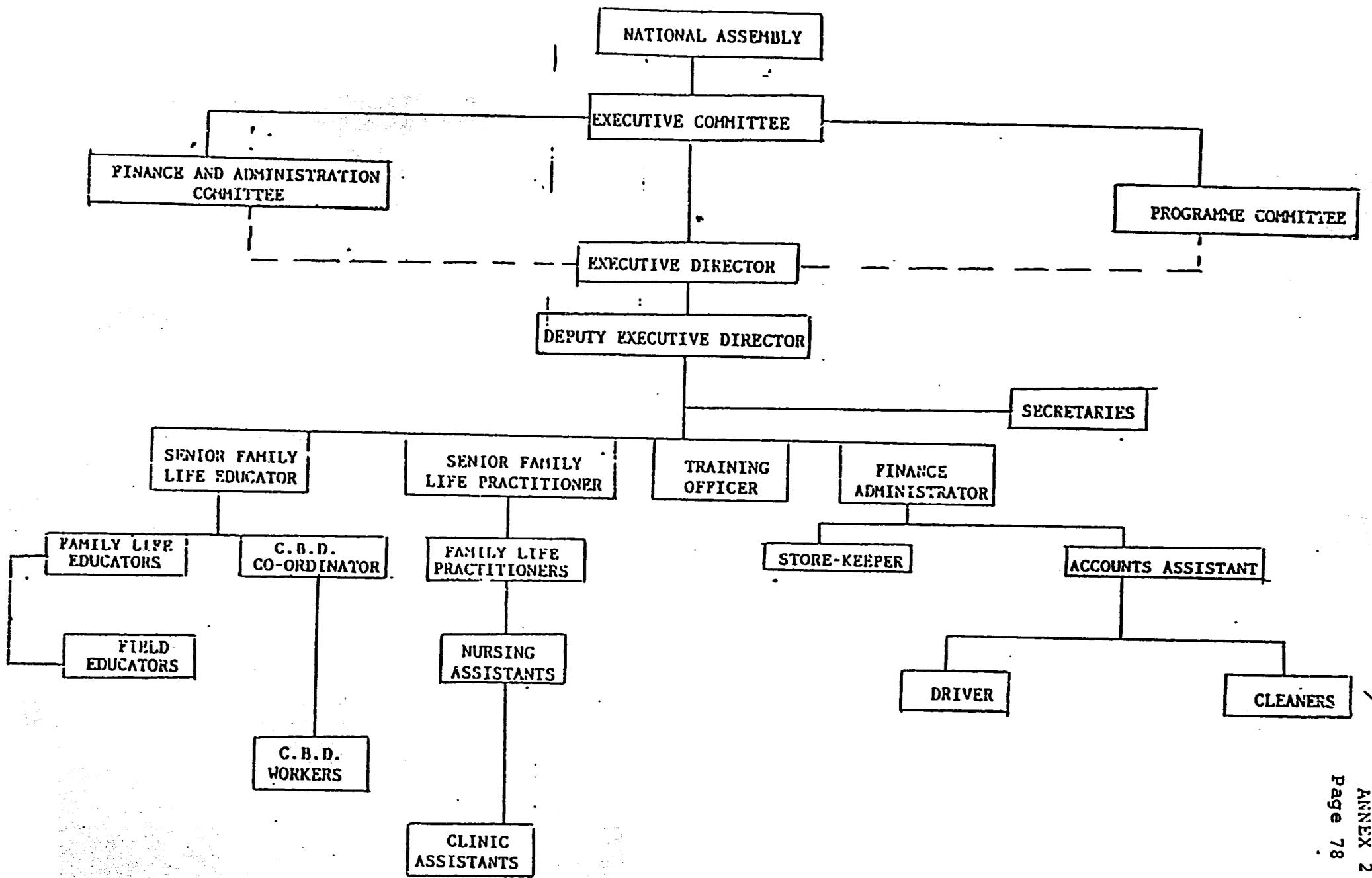
The immediate needs of FLAS to strengthen the association and to consolidate its present programs so that it can undertake any additional activities are as follows:

- A long-term advisor for a minimum of 3 years in research and evaluation to assist the association in program planning, management and evaluation and to transfer his/her management and evaluation and research skills to the Senior Managers of FLAS and to assist FLAS to conduct regular evaluations and research activities.
- Creation and institutionalization of a research and evaluation unit which will design and direct research and evaluation activities to guide the association in program planning and monitoring.
- Upgrading of the IEC Unit through additional staff, short-term training and technical assistance in materials production.
- Short-term TA in management of service delivery and additional staff training in financial accounting and budgeting.

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- Provision of equipment to enable staff to produce quality IEC materials, and to provide support for research activities and financial accounting, budgeting and reporting.
- Short-term TA in marketing to upgrade FLAS approach to service delivery in the private-sector.
- Short-term T.A. and training in fund-raising.

The FHS project purpose is to increase the prevalence of modern contraception in Swaziland. FLAS, as the main provider of family planning services in the private-sector is well positioned to accelerate awareness and usage of modern methods of contraception. Interventions proposed in the project document are intended to maximize FLAS capabilities to plan and implement extended family planning service programs to accommodate increased numbers of couples. But increased capabilities of FLAS to render such services depend on the improved administrative and institutional capacity of the association.



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ANNEX 3ECONOMIC ANALYSIS

The purpose of this section is to determine if the FHS Project is cost-beneficial to the U.S. and Swaziland Governments. Projects addressing social welfare problems (e.g., health, education, and family planning) are particularly difficult to assess in cost-benefit terms because of problems in quantifying real costs and long-term consequences in monetary terms. This analysis undertakes this task with a number of requisite qualifications. The analysis demonstrates that the FHS Project is economically viable because (1) it will save the GOS and Swazi citizens scarce development resources, (2) it will help reduce the rate of maternal and child mortality and morbidity, (3) the cost per user is consistent with other African family planning programs, and (4) population projects have been judged to be generally efficient by AID standards.

I. Cost-Benefit Analysis. AID Handbook 3, Appendix 3E acknowledges the pitfalls of estimating the economic benefits of human resources projects. In recent years, however, cost-benefit methodologies have been developed which have found acceptance among many economists.

These methodologies rely on calculations of the numbers of births averted and the present discounted value of averted births in terms of public sector savings, primarily in education and health care costs -- two sectors where shifts in population growth have the most immediate impacts. The principal problem with these methodologies is that they must make many assumptions, some of them tenuous. In addition, they do not take into account such possibilities as technological breakthroughs that might bear on the nation's capacity to accommodate large additions to the population.

Nevertheless, some of these analysis have been quite accurate in specific, short-term measurements. The validity of these short-term approaches have been confirmed by retrospective studies. In Mexico, the Social Security Institute estimated that family planning investments have saved the system 9 pesos in reduced health care costs for each peso invested over a 15-year period. An analysis of the investments made in Indonesia's National Family Planning Program concluded that reductions in fertility over the period 1971-1984 produced substantial savings in public expenditures in education and health, returning \$2 for every \$1 invested in family planning. Projecting these savings over a thirty-year period results in a \$9 return for every \$1 invested.

For the purposes of this paper, a cost-benefit analysis has been conducted based on demographic and program data compiled for Swaziland. This analysis relies on projections of recurrent

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program costs and of public (and private) savings in the education and health sectors. The analysis is discussed in the following subsections.

Estimating Program Costs: Recurrent family planning program costs are estimated through a projection routine based on Bongaarts' proximate determinants of fertility methodology. This results of this projection routine is presented in Table D-1. It begins by estimating changes in Swaziland's population growth rate and age structure over a thirty-year period (1985-2015). A projection based on a moderate fertility decline scenario has been adapted from a World Bank demographic analysis for this purpose. This scenario assumes a decline in total fertility rate from 7.0 to 3.8 children per woman and an associated increase in women of reproductive age from 165 to 479 thousand over the projection period.

The second step requires estimating changes in the various proximate determinants of fertility. For this, two changes are introduced. First, it is assumed that the mean age at first marriage will increase over the projection period, resulting in a decrease in the percent of women (of reproductive age) in union from 80 to 75 percent. Second, there is an assumed decline in the average length of post-partum infecundability (PPI) related to reduced length and intensity of breastfeeding known to accompany urbanization and modernization processes. This decline is estimated with international data by regressing levels of PPI on total fertility rates. This results in an estimated decline in PPI from 11.6 to 6.5 months over the projection period.

A third step in this routine involves estimating levels of contraceptive prevalence required to attain declines in fertility based on the underlying proximate determinant assumptions. These estimates are generated from calculations using Bongaarts methodology. These indicate a rise in the contraceptive prevalence rate from 4.0 to 54.3 percent over the projection period. This routine also produces estimates of the number of family planning users over the thirty-year period. The number of users rises from 5,300 to 195,000 over this period.

The final step involves assigning recurrent costs to the family planning program. For this, it is assumed that the Swaziland program will provide services meeting needs for 80 percent of family planning users. It further assumes that the annual recurrent costs for providing services to a single user averages E40, which translates to \$20. Recurrent programs costs, then, are estimated to rise from \$85,000 to \$3,120,000 in constant 1985 dollars over the projection period.

This analysis makes a conservative assumption concerning changes in recurrent per-user costs for providing family planning services. While constant per-user costs are assumed throughout the projection period, per-user costs may be expected to decline as the program expands due to increased program efficiencies and economies of scale. In addition, the FHS project has a strong cost-recovery element aimed at expanding family planning through employer-based and employer-financed services. This element should result in reducing the burden on the public sector for funding family planning service expansion.

Estimating Program Benefits for Education Sector: Benefits associated with a declining rate of population growth are estimated for the education sector in Swaziland. The results of this analysis is presented in Table A-2. At the basis of this analysis are two population growth scenarios projected by the World Bank. The first (projection A) assumes no decline and the second (projection B) assumes a moderate decline in fertility. From these projections, the population of school age is isolated. Both projections begin with a 1985 population in ages 6-17 of 234,000. This age group grows to 825,000 under projection A conditions and to 565,000 under projection B conditions over the course of the projection period.

Based on a comparison of the two projection scenarios, a reduction in school enrollments associated with fertility decline is estimated. This reduction estimate assumes constant enrollment rates of 94 percent among primary and 36 percent among secondary school-age children, as reported for 1983 by the World Bank. The reduction is not realized until year 6 of the projection period when the 1985 birth cohort reaches school-age. The reduction reaches 3,760 by the year 1995 and grows to 204,960 by the year 2015.

Finally, public and private savings in education expenditures associated with enrollment reductions are calculated. The public savings calculation assumes constant annual recurrent costs per additional student of E102 for primary and E318 for secondary school. The private savings calculation assumes constant annual recurrent costs per additional student of E24 for primary and E112 for secondary school. These estimates are drawn from the Government of Swaziland's Fourth National Development Plan. Public savings amount to \$192,000 in 1995 and increase to \$13,097,000 by 2015 (in constant 1985 dollars). Private savings amount to \$45,000 in 1995 and increase to \$4,097,000 by 2015 (in constant 1985 dollars).

This analysis assumes no increase in the proportion of all children enrolled in primary and secondary school in Swaziland -- nor an increase in recurrent expenditures per students

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accommodated or the quality of schooling provided, education sector savings associated with a fertility decline will be even more dramatic.

Estimating Program Benefits for Health Sector: Benefits associated with a declining rate of population growth are estimated for the health sector in Swaziland. The results of this analysis is presented in Table A-3. Again, this analysis relies on a comparison of two population growth scenarios projected by the World Bank. In this analysis, however, the total population rather than a subset is treated as a single client group. Both projections begin with a 1985 population of 757,000. The total population grows to 2,506,000 under projection A conditions and to 1,895,000 under projection B conditions over the course of the projection period.

Based on a comparison of the two projection scenarios, a reduction in the health client population is estimated. Client reduction reaches 31,000 by the year 1995 and grows to 611,000 by the year 2010.

Finally, public health care savings in expenditures associated with client reductions are calculated. The calculation assumes constant annual recurrent costs per additional client of E15 as estimated in the Government of Swaziland's Fourth National Development Plan. Public savings amount to \$233,000 in 1995 and increase to \$4,583,000 by the year 2015 (in constant 1985 dollars).

This analysis assumes no variation in individual health care costs across age and sex groups. Yet, in most instances, health care costs are higher for maternal and child population groups than for the population at large. Further, by improving child-spacing practices, family planning can reduce complications surrounding the birth even itself and can, thereby, reduce costs associated with those complications. Additionally, this analysis assumes no improvements in quality of health care provided over the projection period. Had these assumptions been adopted, health care savings associated with a fertility decline would have been even more marked.

Benefit-to-Cost Comparisons: Based on the foregoing analyses, benefits of reduced expenditures in education and health can be compared with costs associated with Swaziland's family planning program. This comparison is presented in Table A-4. The first two columns of the table list annual and cumulative program costs for each year in the projection period. The second two columns list annual and cumulative savings totaled over public and private education and health sectors for each year. The final two columns present benefit-to-cost ratios calculated for each year and cumulatively over all preceding years.

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This table reveals that costs outweigh savings over the first ten years of the projection period -- though the annual ratio draws closer to unity with each year. By year eleven, however, savings exceed costs. The year 1996, then, is the "break-even" point for this analysis. By year fifteen, cumulative savings exceeds cumulative costs. The year 2000, then, is the "pay-back" point for this analysis. By the year 2000, the annual benefit-to-cost ratio is nearly 2-to-1 and by the year 2015 it is nearly 7-to-2. In terms of cumulative totals, the benefit-to-cost ratio in 2005 is nearly 2-to-1 and by the year 2015 reaches a 4-to-1 total.

On the basis of this analysis, expected savings in the education and health sectors alone justify the investment in family planning. As noted in the previous subsections regarding changes in the quantity and quality of education and health services over the projection period. Had less conservative assumptions been adopted, the break-even and pay-back points would have been achieved earlier in the period. Additionally, this analysis isolated the savings realized in two development sectors: education and health. Similar savings will likely be experienced in other development sectors (e.g., agriculture, energy, housing, water and sanitation). Had the analysis been extended to these sectors, the break-even and pay-back points would have been achieved even earlier.

II. Improved Maternal and Child Health. By promoting healthful spacing of children, the FHS Project will contribute to reduced levels of maternal and child mortality and morbidity. In addition to the human resource benefits of improved health and productivity of the population, this intervention will contribute to reduced health care costs associated with high-risk births.

III. Program Efficiency. The total recurrent costs for the Swaziland family planning program currently do not exceed \$150,000. This is translated to less than \$20 per couple. The World Bank estimates that the average recurrent cost for all Sub-Saharan African family planning programs is \$20 per couple. Thus, the costs of family planning in Swaziland are reasonable by present African standards.

IV. Efficiency of AID Family Planning Program. The Program and Policy Coordination Bureau of AID conducts periodic assessments of the efficiency of its development programs. A recent report from PPC/CDIE indicates that population projects have been among the most efficient and effective of all AID programs. This project should not deviate from that pattern, and thus represents an efficient use of AID funds.

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ANNEX 4SOCIAL SOUNDNESS ANALYSIS

A. Socio-cultural Context: Swaziland's population was estimated to be over 750,000 in 1985. Preliminary results from the 1986 census, however, place the population size at just over 700,000. Population density is about 28 per square kilometer which is not high by either world or African standards. While the population size is not large -- most experts agree that in terms of physical resources only, Swaziland could support a population several times its current size -- it is growing at 3.6 percent per year, placing it among the fastest growing populations in the world. This high rate of population growth has significant negative consequences for Swaziland in a number of important areas.

A major challenge to Swaziland in the coming years is the improvement of health status. Population factors are linked to health status in two ways. First, infant and maternal mortality rates are sensitive to the timing of births. Unless child-spacing practices are adopted, mortality and morbidity rates among these two groups will remain high. Second, the MCH target population could double over the next 18 years, according to World Bank estimates. Such an expansion among this important health client group will place enormous strains on Swaziland's health delivery system and will likely compromise the quality of services available.

High rates of unemployment is another critical problem. Swaziland's working-age population will double over the next 19 years. World Bank estimates indicate the formal sector is unlikely to absorb more than one-fifth of new job seekers over this period. Unless traditional agriculture or other informal sectors can absorb these additional workers, many will become unemployed or underemployed. With continued high fertility, large and increasing numbers of dependent children will be supported by less than fully-employed parents.

Finally, Swaziland's non-commercial agricultural is characterized by low levels of productivity. With expected increases in laborers engaged in traditional agriculture, there will be pressure to bring new land under cultivation and to intensify land use. Land availability does not appear to be a major constraint in the short-term. But to increase labor productivity in this sector will require substantial investment in human and physical capital -- all the more so with expected increases in numbers of laborers. In addition, high rates of population growth will place increasing demands on traditional agriculture to produce subsistence levels of yields.

B. Beneficiaries: The direct beneficiaries of the FHS Project will be the couples of Swaziland who will have access to safe, effective, and affordable methods of family planning. This will enable them to choose voluntarily the number and spacing of their

children, and to enhance the health and well-being of their families. Improved information on treatment and prevention of STDs and increased access to condoms will further improve the health of Swazi families.

Secondary beneficiaries of the FHS Project will be the national and traditional leaders of Swaziland and government officials generally, who will have improved information on population, development, and health relationships. This will provide them with a basis for formulating improved population policies and for implementing effective family planning programs. Additional beneficiaries of the FHS Project will be the staffs of the principal Swazi implementing institutions (including FLAS, private physician and nursing providers, and Swazi industries) who will have improved capabilities for planning, implementing, and evaluating their programs.

To date, there have been no national demographic surveys upon which to estimate demand for family planning services. There have been a few small-area studies which indicate demand for family planning among young, urban, and formally-employed couples. During the first year of project implementation, a DHS (Demographic and Health Survey) is expected to be carried out under the Primary Health Care Project. The DHS will provide a wealth of information regarding fertility behavior, unmet demand for limiting and spacing births, knowledge of family planning, source of supply, and constraints to modern method use. Because it is national in scope, the DHS will uncover variations in demand across subgroups and subregions of Swaziland. The DHS will provide needed information for guiding program implementation so that appropriate information and services are provided to project beneficiaries.

Apart from the DHS, the FHS project has a strong research component focused on making better use of service delivery data and conducting small, focussed studies on the information and service needs of specific subgroups of the population (e.g., industry employees and populations within clinic catchment areas). Research efforts supported under the FHS project will enable ongoing assessments of beneficiary needs in relation to service delivery interventions. Because heavy emphasis is placed on institution building, the FHS project will facilitate continuing assessments of needs beyond the term of the project.

C. Participation: The design team for the FHS project included the Deputy Director of FLAS. In preparation of the design, the team met with representatives of various Swazi organizations, active in providing health care, family planning, and communication services in Swaziland. These representatives provided information essential for determining the feasibility of various approaches to project implementation, supplied useful reactions to planned project activities, and offered important

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insights into relevant aspects of Swazi society and institutions. The team had extensive meetings with representatives of various units of FLAS, including Board members, executive officers, technical units, and staff from its three clinics. In addition, the team met with representatives of nine private sector industries, three private health care services, three private voluntary organizations, three research and training institutions, and various departments within five Government of Swaziland Ministries.

The design team also met with individuals having important expertise relating to key aspects of the project. Two anthropologists familiar with Swazi culture and institutions were interviewed with regard to traditional family, community and societal values, beliefs, and customs. They provided important insights into the diversity to Swazi culture, particularly in light of increasing urbanization and modernization. The team met with a group of broadcasters to gain impressions of listenership attitudes -- generally with regard to traditional roles of women and specifically with regard to family planning messages. Meetings were also held with private physicians and nurses to gain insight into their perceptions of patient needs and service provider capabilities in the area of family planning.

Participation of Swazi individuals and organizations will continue as the FHS project is implemented. The majority of project activities are expected to be implemented directly through FLAS. FLAS-based activities include a component for strengthening their own service-delivery, management and evaluation capacity, but for the most part emphasis is placed on improving FLAS capabilities for supporting other family planning service provider organizations. This includes providing training to private sector clinic staffs for counseling clients on method choice, providing support to these clinics in assessing client needs in family planning, as well as developing relevant IEC (information, education, and communication) materials for use in both private and public sector clinics. Because FLAS will expand its work in directing and coordinating service provision in Swaziland, it is important that FLAS take an active role in developing a consensus among public and private sector providers in areas of service provision protocol and IEC message content. The FHS project includes a component for assembling and sustaining an inter-agency committee which will provide such a forum.

The FHS project also will support the production (and dissemination) of improved IEC materials for leadership groups. In developing these materials, small formative research studies (employing focus group research methodologies) will be undertaken to ascertain leadership attitudes and informational needs in areas relating to population and family planning. In this way, leadership groups will contribute to the development of appropriate and useful IEC materials.

D. Socio-cultural Feasibility: While traditional methods of birthspacing and fertility limitation have been widely practiced in Swaziland, use of modern methods is estimated to be quite low for the nation as a whole. Yet, there is evidence that services are being utilized more heavily in urban areas and within industry-based clinics. Through interviews with staffs of public and private sector clinics, estimates of current levels of family planning use can be estimated. Among five firms having appropriate data, three showed monthly use rates higher than four percent (see Table F). One firm, Swaziland Fruit Cannery, reported family planning use to be more than thirty percent. These statistics indicate a significant level of demand -- especially since virtually no IEC activities accompany service provision, and that in most cases services are available upon request only at a single clinic site. Current levels of use, then, are likely to represent only a fraction of potential demand for spacing or limiting births.

Interview with clinic staff reveal that women using these services often prefer non-detectable methods (e.g., injections and pills) because they can use them without the knowledge of their husbands. Among large portions of the population, males appear to be less likely to accept family planning interventions and the use of modern methods. Differences in the acceptance of modern family planning among males and females have roots in attitudes of the role of women and in access to information on family planning and child-spacing.

Men in Swazi culture have traditionally been responsible for making financial and family decisions. The capacity for men to maintain this responsibility has been weakened where males have taken employment that requires their absence from the homestead for periods ranging from single workdays to months (in the case of temporary emigrants). In these instances, women by necessity have had to take on more of the responsibility for these decisions. It has been further weakened where women have taken wage employment and have the opportunity to manage a share of family income. In many instances, changes in attitudes on the role of women have lagged behind this transition in family responsibilities.

Differences in attitudes on family planning can also be attributed to the focus of information and services on female client groups. Information on family planning methods and on the health benefits of birthspacing are not widely available -- often it is available only on request at private and public clinics. Because of their more frequent contact with nursing staff during prenatal and antenatal periods, women are more likely to receive this information. Men are less likely to be informed about use of family planning or about the health advantages of birthspacing. Often, modern methods are associated with promiscuity and consequently men become suspicious of the intentions of wives who desire to use modern contraceptives.

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The FHS project addresses this issue by emphasizing the development of IEC materials aimed at male audiences. As part of this effort, research studies will be undertaken using questionnaire and focus group formats to determine the attitudes of men on family planning and maternal and child health issues. One of the expected outcomes of the FHS project is improved knowledge of these issues -- particularly among males.

Public sector clinics, while providing family planning services, do not actively provide information or promote these services. This is in part due to insufficient training in method use and counselling. But it is also due to a reticence within the GOS to promote services too quickly -- especially in communities where leadership groups have not shown support for expanding services. The FHS project will facilitate an improved administrative environment within public and private service delivery systems. This can be expected at several levels. First, a number of high-level leadership seminars are planned under the FHS project to raise awareness of population and family planning issues. Second, the FHS project will contribute to improving the IEC materials and capabilities of service providers in providing family planning information to clients. Third, through improved IEC information for traditional leaders, the FHS project will contribute to increased awareness and greater acceptance of family planning in communities.

E. Impact: In the early years of the FHS project, it is expected that services will be expanded significantly among industry employees. While such an expansion does not benefit the most disadvantaged segment of Swazi society, a certain majority of those employed in these industries are manual laborers who receive relatively low incomes. An emphasis on this employed sector is justified for a number of reasons. First, it is believed that demand for family planning among the poorer rural segments of the population is quite low and that active promotion of services in these areas may be resisted by traditional leadership groups. By improving services among a population segment that is inclined to make use of them, this expansion may serve as a useful demonstration of family planning benefits for traditional leadership groups.

Second, the formally-employed segment represents a large and growing subgroup of the Swazi population. A 1984-5 survey conducted by the Federation of Swaziland Employers showed about 35,000 employees among 206 responding firms. Extrapolating from this total to the 314 current members of the Federation results in an estimate of more than 50,000 employees. Assuming that most of these employees are in reproductive ages, this group represents nearly thirty percent of the estimated 176,000 reproductive-age couples in Swaziland. And this number is growing in Swaziland

due to a heavy influx of new businesses in recent years. Rough evidence of this increase is that the membership in the Federation of Swaziland Employers has nearly doubled over the last six years.

Third, many of those employed in industries have families and friends in their homestead areas and maintain close ties to their communities. Those who are formally employed are often important change agents in rural areas as they bring new ideas and introduce new technologies to their families and friends. By expanding services to this segment, ideas about child-spacing and family planning may be quickly diffused to rural areas -- and thereby facilitate acceptance in rural areas.

Finally, the private sector approach adopted in the FHS project emphasizes self-sufficiency in service delivery. In many instances, industry managers can be shown that family planning can help reduce their own operating costs, both through reducing absenteeism, reducing health-care costs associated with childbearing and antenatal care, and reducing the number of dependents requiring benefits. By making service delivery self-supporting in this sector, public service delivery systems will be relieved of the burden of serving this population segment. One outcome of the FHS project, then, will be increased sustainability of family planning efforts.

F. Issues: Four characteristics of Swazi society have important implications for the design and implementation of the FHS Project: traditionalism, family planning norms, family life education, and urbanization.

Traditionalism: Swaziland is a monarchy with strong traditional roots. The country is divided into about 200 chiefdoms. Each chief relies on a system of deputies and councils to assist him in running sociopolitical affairs for the local community, composed on average of 260 homesteads. Chiefdoms are organized into 40 regional administrative units known as tinkhundla. Tinkhundla governors have traditionally been responsible for resolving disputes, planning regional services, disseminating information, and communicating local problems to the King on behalf of the constituent chiefdoms.

In its transition to a modern political system, Swaziland has chosen to build upon this traditional system rather than overlay a parallel system. Members of the national Parliament are selected through a multi-stage nomination and election process which operates through chiefdom and tinkhundla structures. Tinkhundla governors serve as liaison between chiefdoms and national ministries, and are represented at the national level by the Office of the Indvuna Tinkhundla, which has Ministry status and oversees local affairs.

urban growth is proceeding at about ten percent per year. This high rate of urbanization reflects both growth in the supply of urban jobs and growth in demand for non-agricultural employment from a rapidly growing rural population.

While studies on family planning attitudes and practice are quite limited in Swaziland, existing evidence suggests that attitudes toward modern methods of family planning are changing, particularly among urban, formally-employed, and younger segments of the population. Desired number of children is lower in urban than rural areas. A majority of urban couples feel children are an economic burden. Younger urban couples are more likely to approve of family planning. Younger urban women are more aware of modern methods. The FHS Project can enhance its effectiveness by improving access to services for these particular population segments.

ANNEX 5
FINANCIAL ANALYSIS

I. USAID BUDGET ASSUMPTIONS

While FLAS is responsible for project implementation, it will receive much assistance from both a Cooperating Agency and USAID in implementing various aspects of the Family Health Services Project. The FHS budget (see Table A) illustrates USAID funding for the different activities which will be carried out by the three main players implementing FHS activities.

The budget incorporates a 5 percent annual rate of inflation for all commodities and services purchased in the United States and a 10 percent rate of inflation for commodities and services procured within Africa. As illustrated in Table A (Project Budget by Year of Expenditure), total project costs are \$2,600,000. \$1.4 million will be obligated and expended during Phase 1 (years 1 - 2 1/2) and \$1.2 million will be obligated and expended during Phase 2 (years 2 1/2 - 5) pending a favorable outcome of the Phase 1 evaluation and availability of funds.

1. Cooperating Agency

A portion of the Project (\$1,606,248 over the life-of-project) will be used to purchase the services of a Cooperating Agency to provide long-term and short-term technical assistance and to assist in arranging U.S.-based training. During Phase 1, \$875,103 will be used for a Cooperative Agreement between USAID/Swaziland and The Pathfinder Fund. Phase 2 Cooperative Agreement activities may be performed by Pathfinder or another Cooperating Agency, depending on the outcome of Phase 1 activities and availability of funds. An appropriate contracting mechanism for the CA in Phase 2 will be determined at a later date. The estimated project cost for these Phase 2 activities totals \$731,145.

- a) Long-Term Technical Assistance is provided for the duration of the project.
- Long-Term Advisor: \$105,000 per year to cover costs of travel, salary, benefits, shipment of personal effects, education allowances, etc. The Advisor will be recruited directly by the Pathfinder Fund from either the U.S. or any African country. Funding is provided through year 4.

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- Support Staff: One Administrative Assistant at a cost of \$4,100 per year and one Secretary at a cost of \$2,900 per year to be recruited within Swaziland. Funding is provided through year 5.
 - Recruitment of Long-Term Advisor: \$18,000 is provided during the first few months of project implementation to cover travel costs to Swaziland for 3 advisor candidates. These individuals will be interviewed by FLAS, Pathfinder, and USAID for the Long-Term Advisor position.
 - Management and Overhead: During Phase 1, the Pathfinder Fund will provide ongoing management of their portion of the project and periodic monitoring visits to Swaziland. Their current fee for providing these services is 27.6 percent of total direct costs. While it is not known at this time whether Pathfinder will be the Cooperating Agency chosen to implement Phase 2 activities, their overhead rate of 27.6 percent has been applied to Phase 2 costs on the basis that it is reasonable and that the Agency chosen will impose a similar charge.
- b) Short-Term Technical Assistance is also provided for the duration of the project.
- Pathfinder will recruit and schedule all project-related short-term consultancies at an estimated cost of \$15,000 per person-month. Table B summarizes these consultancies by type and year during which each occurs. A total of 40 person-months is funded, 21 during Phase 1 and 19 during Phase 2.
 - Management and Overhead: 27.6 percent of all Pathfinder total direct costs is charged by Pathfinder as a management and overhead fee.
- c) U.S. Based Training will be arranged by Pathfinder.
- Funding is provided for 9-12 month training courses in the U.S. for 3 FLAS staff members. It is anticipated that one will complete training during year 1, one will begin in year 1 and finish in year 2, and that training for the final member will be conducted during years 3 or 4. The estimated cost per training course of \$22,000 includes travel, tuition and per diem.
 - Three short-term training courses will also occur in the U.S. at an estimated cost per course of \$12,800 including travel, tuition and per diem costs. Two of these courses are expected to occur in year 2 and one in year 3 of Phase 2.

- Management and Overhead: 27.6 percent of the total direct cost of all U.S.-based training procured by Pathfinder will be charged as a management and overhead fee.

2. Direct Assistance to FLAS

The Cooperative Agreement between USAID and FLAS consists of \$553,182 direct assistance to FLAS and \$240,570 which will be retained by USAID for activities described in section 3 below. During Phase one, \$343,412 and \$181,485 (for FLAS and USAID activities respectively) will be:

- a) Training in Africa will be procured and arranged by FLAS staff. Funding of \$62,240 over the life-of-project is intended to cover the costs of obtaining correspondence degrees, performing in-country training, and sponsoring workshops.
 - Correspondence Degrees: 3 FLAS employees will obtain 4-year correspondence degrees at an estimated cost per year for tuition, books, fees, and travel (3 trips/year) of \$1,650. For budgeting purposes we have assumed that all three will commence their studies half-way through year 1 and finish in the middle of year 5.
 - In-Country Training: 3 two-week courses introducing micro-computer operations and applications will be provided by a local computer consulting firm (\$1,000 per course) during the Phase 1. One two-week course on advanced secretarial skills will be provided through a local training program during year 1 at a cost of \$1,000. Additionally, \$6,000 is provided for additional in-country training courses to be identified during Phase 1.
 - Various Workshops, Seminars, and Conferences will be funded from FHS project funds. An illustrative list of workshops to be funded under the Project is provided in Table C.
- b) All project-related commodities will be procured directly by FLAS. The list contained in Annex 9 (Commodities To Be Purchased Under FHS) is reproduced here as Table D to illustrate the types of commodities purchased and the years during which they will be bought.
- c) Local Costs which will be borne by FLAS but funded by the project include the costs of permanent additions to FLAS staff, supplies, materials production, research, and office space and utilities.

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- **FLAS Staff:** Six full-time staff members will be hired by FLAS over the five-year period of the project. Three (the Research Officer, Graphic Artist, and Marketing Officer) have estimated annual salaries of \$5,200 each and three (the Nurse Practitioner, Research Assistant, and Marketing Assistant) have estimated annual salaries of \$4,100 each. Staff are expected to be hired at various times over the first three years of the project. Table E illustrates the timing of these staff additions. Five of the six new positions will be phased into FLAS's permanent staffing structure and phased out of project support during year 5.
- **Supplies:** Supplies will be funded by the project at a rate of \$9,980 per year. This is intended to cover all incremental supplies costs during year 1 incurred by FLAS as a result of FHS activities. The additional cost of supplies due to inflation is not funded by the project and will be paid by FLAS from other donor contributions (see Table Y. Recurring Incremental Costs to FLAS for FHS Activities). The \$9,980 is meant to cover \$2,000 for additional costs of vehicle maintenance, \$1,800 for computer supplies, \$1,000 for photocopy supplies, \$5,000 for IEC supplies, and \$180 for subscriptions to various journals.
- **Materials Production costs** are estimated to be \$45,000 per year to cover the costs of producing IEC materials in the private sector until the purchase of a multi-media system during year 4. Beginning in year 4, materials production costs should decrease to \$12,000 per year. Funds allocated are intended to cover the costs of printing materials, costs for radio time, and related services.
- **Research:** Funds will be provided for hiring 36 person-months of interviewer time at an estimated cost of \$500 per person-month.
- **Office Space and Utilities:** \$7,500 per year is provided to cover the costs of office space (\$4,500) and utilities (\$3,000) for the Pathfinder staff and the new FLAS staff.

3. USAID Activities

\$240,570 of project funds will be earmarked and committed directly by USAID for implementing various project activities. While the money will be obligated under the FLAS Cooperative Agreement, it will be managed and by USAID. Of this amount, \$181,485 and \$159,086 are allocated for Phase 1 and Phase 2 activities respectively.

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- Evaluations/Audit: Two external evaluations (\$30,000 each) are funded at the completion of each phase. In addition, an assessment of the need for an external audit (\$10,000) is planned at the end of Phase 1. If an audit is deemed necessary it is budgeted to occur at the end of Phase 1 (\$25,000).
- Financial Technical Assistance: \$6,000 is allocated at the beginning of the project in support of a project covenant to fund a 2-month consultancy from a local accounting firm to strengthen FLAS's accounting capabilities
- Multi-Media Equipment: The cost of equipping a multi-media unit for production of IEC Materials is estimated to be \$103,000, split funded between Phase 1 and Phase 2.
- Other Activities: \$123,442 has been budgeted in Phase 1 for meeting additional opportunities in population and family planning in Swaziland. Prior to committing these funds FLAS and USAID will mutually agree on how the funds will be expended.

II. RECURRING COSTS

All of the FLAS direct support during the life-of-project will be recurring to FLAS upon completion of the Project, except project-related research costs. These costs, as shown in Table F (column entitled Year 6 and after), include additions to FLAS staff, extra purchases of supplies, office rent and utilities, and materials production costs of maintaining an IEC unit.

During the life-of-Project, however, FLAS will begin assuming additional recurring costs which have been introduced by the Project. These are funding for staff, supplies, materials production, and rent/utilities. All project costs, except a portion of incremental supplies costs, will be financed 100 percent by USAID through year 4.

Table E, summary of FLAS staff additions, shows that by year 5, Project support for the six new staff positions is completely phased-out. Only the salary of the research officer is fully funded by USAID in year 5. Salaries of the other five staff additions are paid in part or whole by FLAS during year 5. All six positions are permanent additions to FLAS staff, therefore, 100 percent of their salaries in year 6 and thereafter will be borne by FLAS.

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The incremental cost of purchasing FHS-related supplies is estimated to be \$9,980 in year 1 and each year thereafter. However, the actual cost of these supplies is likely to increase each year because of Swaziland's high rate of inflation. USAID will fund only \$9,980 of supplies costs per year. The additional inflation-induced cost of these supplies will be borne by FLAS and is estimated to be \$11,030 over the life of the project.

The ability of FLAS to bear the recurring costs of the project depends on the success of the project itself. It is expected that funding for the additional recurring costs will come from the IPPF annual grant, which are generally unrestricted as to use. The IPPF cash grant is determined annually based on the availability of funds and IPPF's perception of how successfully FLAS is achieving family planning objectives.

FLAS's objectives and the methods by which they will be achieved are presented to IPPF in the form of a three-year plan and a work program. Subject to the availability of funds, IPPF's contribution is based on acceptance of the final approved work programme and the excess of FLAS's projected expenditures over its projected income from other sources.

During project design the FHS project design team aimed to keep IPPF staff apprised of USAID's plans for FLAS. IPPF's suggestions were integrated into the project design to the maximum extent possible. The FHS Project as described herein has IPPF support and is consistent with and enhances IPPF's objectives for FLAS for the future. IPPF has expressed its willingness to pick up the cost of certain additional staff members based on its assessment of FLAS's current needs irrespective of the FHS project.

The Project design has aimed to alleviate the burden to IPPF of financing additional staff and recurring costs by slowly transferring the cost of staff members beginning in year 5. It is assumed at this time that IPPF and FLAS will be able to absorb the additional salary costs (in year 5) and supplies costs (over years 2-5). The incremental costs to be absorbed in year 6 as a result of FHS activities will be \$53,479. The equivalent cost in an inflation-free world or in 1988 dollars is \$33,206. IPPF's 1988 cash grant to FLAS is \$240,000. Transferring the cost of FHS activities will, therefore, require an increase in IPPF budgetary support of approximately 14 percent - a significant increase but one which IPPF and FLAS have indicated that they will be able to absorb because of the value IPPF places on this project.

The costs for year 6 detailed in Table F will, of course, continue well beyond year 6. The intent of the fund-raising FHS activities and the technical assistance training for FLAS

clinical staff (using FLAS nurses as consultants to the private sector clinics) is to gradually increase FLAS income-generating capacity and foster less dependence on donor assistance. While these activities undoubtedly will produce some income during the life-of-project, the amounts are likely to be small because of the enormous front-end costs in terms of time and resources associated with project start-up. However, it is expected that FLAS's income generating base will expand each year as more private enterprises are added, and benefits will accrue long after USAID's involvement has terminated. For this reason, project-generated income has been excluded from the above analysis but it will be a significant factor in FLAS's ability to carry out FHS activities in the long run.

TABLE A
FAMILY HEALTH SERVICES PROJECT
Budget by Year of Expenditure

	Phase 1			Phase 2			Total	Phase 1 Total	Phase 2 Total
	Year 1	Year 2	Year 3	Year 3	Year 4	Year 5			
COOPERATING AGENCY:									
Long Term Technical Assistance -	\$130,152	\$150,504	\$79,260	\$79,260	\$166,987	\$13,077	\$619,241	\$359,917	\$259,325
Long Term Advisor	78,750	110,250	57,881	57,881	121,551	0	426,313	246,881	179,432
Support Staff	5,250	7,700	4,235	4,235	9,317	10,249	40,986	17,185	23,801
Recruitment of Long Term TA	18,000	0	0	0	0	0	18,000	18,000	0
Overhead/Management Fee	28,152	32,554	17,144	17,144	36,119	2,829	133,942	77,850	56,092
Short Term Technical Assistance -	\$95,700	\$180,873	\$147,713	\$105,509	\$177,256	\$139,589	\$846,640	\$424,286	\$422,355
Consultancies	75,000	141,750	115,763	82,688	138,915	109,396	663,511	332,513	330,998
Overhead	20,700	39,123	31,950	22,822	38,341	30,193	183,129	91,773	91,355
Training -	\$46,778	\$44,122	\$0	\$38,636	\$10,930	\$0	\$140,367	\$90,900	\$49,466
U.S. Training	36,660	34,579	0	30,279	8,488	0	110,005	71,239	38,767
Overhead	10,118	9,544	0	8,357	2,343	0	30,361	19,662	10,700
TOTAL COOPERATING AGENCY	\$272,630	\$375,499	\$226,973	\$223,406	\$355,073	\$152,666	\$1,606,249	\$875,103	\$731,146
DIRECT ASSISTANCE TO FLAS:									
Training -	\$21,875	\$15,235	\$3,781	\$3,297	\$13,110	\$4,941	\$62,240	\$40,891	\$21,349
Correspondence Degrees	2,475	5,445	2,995	2,995	6,588	3,624	24,122	10,915	13,207
In-Country Training	9,000	4,400	0	0	0	0	13,400	13,400	0
Workshops	10,400	5,390	787	303	6,522	1,318	24,719	16,577	8,142
Commodities -	\$67,060	\$14,537	\$0	\$0	\$0	\$0	\$81,597	\$81,597	\$0
Vehicles	32,000	0	0	0	0	0	32,000	32,000	0
Other	35,060	14,537	0	0	0	0	49,597	49,597	0
Local Costs -	\$65,227	\$99,585	\$56,113	\$58,593	\$73,069	\$56,758	\$409,345	\$220,925	\$188,421
FLAS Staff	2,747	22,405	14,399	16,880	37,135	18,228	111,793	39,551	72,242
Supplies	9,980	9,980	4,990	4,990	9,980	9,980	49,900	24,950	24,950
Materials Production	45,000	49,500	27,225	27,225	15,972	17,569	182,491	121,725	60,766
Research	0	9,450	4,961	4,961	0	0	19,373	14,411	4,951
Office Space/Utilities	7,500	8,250	4,538	4,538	9,983	10,981	45,788	20,288	25,501
TOTAL DIRECT ASSISTANCE TO FLAS	\$154,162	\$129,356	\$59,894	\$61,891	\$86,180	\$61,699	\$553,182	\$343,412	\$209,770
USAID ACTIVITIES:									
Evaluations/Audit	0	0	71,663	0	0	36,465	108,128	71,663	36,465
Financial Technical Assistance	6,000	0	0	0	0	0	6,000	6,000	0
Multimedia Equipment	0	0	80,380	0	22,620	0	103,000	80,380	22,620
Other Activities	23,442	0	0	0	0	0	23,442	23,442	0
TOTAL USAID ACTIVITIES*	\$29,442	\$0	\$152,043	\$0	\$22,620	\$36,465	\$240,570	\$181,485	\$59,085
TOTAL PROJECT COSTS	\$456,234	\$504,856	\$438,910	\$285,296	\$463,873	\$250,931	\$2,400,000	\$1,400,000	\$1,000,000

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TABLE B
 SUMMARY OF SHORT TERM TECHNICAL ASSISTANCE
 Number of Short-Term TA Person-Months

	Phase 1			Phase 2			Total	Phase 1 Total	Phase 2 Total
	Year 1	Year 2	Year 3	Year 3	Year 4	Year 5			
Service Delivery Expansion	4	3	4	2	3	2	18	11	7
Information, Education, Communications		2	2	1	2	2	9	4	5
Management Support & fundraising		2	1	2	3	2	10	3	7
Management Information Systems	1	1					2	2	0
Commodity Planning		1					1	1	0
Total	5	9	7	5	8	6	40	21	19

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TABLE C

SUMMARY OF IN-COUNTRY WORKSHOPS
Number of Workshops

	Phase 1			Phase 2			Total	Phase 1 Total	Phase 2 Total
	Year 1	Year 2	Year 3	Year 3	Year 4	Year 5			
Private Sector Insurance Seminar	1						1	1	0
Management Workshop	1						1	1	0
Contraceptive Technology Update		1	1		1	1	4	2	2
Leadership Awareness Conferences		1			1		2	1	1
Information, Education, Communications Workshops		2	1	1	2	2	8	3	5
Total	2	4	2	1	4	3	16	8	8

SUMMARY OF IN-COUNTRY WORKSHOPS
Cost in U.S. Dollars

	Phase 1			Phase 2			Total	Phase 1 Total	Phase 2 Total
	Year 1	Year 2	Year 3	Year 3	Year 4	Year 5			
Private Sector Insurance Seminar	\$10,000	\$	\$	\$	\$	\$	\$10,000	\$10,000	\$0
Management Workshop	400						400	400	0
Contraceptive Technology Update		440	484		532	586	2,042	924	1,118
Leadership Awareness Conferences		4,400			5,324		9,724	4,400	5,324
Information, Education, Communications Workshops		550	303	303	666	732	2,553	853	1,700
Total	\$10,400	\$5,390	\$787	\$303	\$6,522	\$1,318	\$24,719	\$16,577	\$8,142

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TABLE D
PROJECT INPUTS

	Year 1	Year 2	Years 3-5	Total
COMMODITIES TO BE PURCHASED UNDER FHS				
COMPUTER EQUIPMENT:				
1 IBM AT	\$7,000		\$0	\$7,000
1 IBM PC	5,000		0	5,000
Software (SPSS, DOS, Lotus 1-2- WordPerfect, PC Paint, D-BaseIII, Desktop Publishing) at \$500/each	3,500		0	3,500
2 Six-Plug Power Strips	60		0	60
2 Printers	5,000		0	5,000
PHOTOCOPIER	10,500		0	10,500
CLINICAL EQUIPMENT:				
Exam Tables, 2 Tray Tables, 2 M Light Service Tables, 2 Blood Pressure Sets, 2 Stethoscopes, 24 Speculum, 2 Supply Cupboards	1,500	1,650	0	3,150
VEHICLES:				
1 Four Wheel Drive Van	16,000		0	16,000
1 Sedan	16,000		0	16,000
ELECTRIC TYPEWRITER	1,000		0	1,000
DESKS/CHAIRS (Supplemental to the in-kind grant)	1,500	550	0	2,050
AV EQUIPMENT:				
Video Camera, Recorder and Monitor		8,800	0	8,800
P.A. System		1,023	0	1,023
Slide Projector		303	0	303
Screen		341	0	341
Camera (35mm with wide angle & zoom lenses		660	0	660
Cassette Deck (with slide/tape synchronizing capability)		440	0	440
Overhead Projector		770	0	770
TOTAL COMMODITIES	\$67,060	\$14,537	\$0	\$81,597

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TABLE E
SUMMARY OF FLAS STAFF ADDITIONS
Number of Months Supported by Project

	Salary Per Year	Phase 1			Phase 2			Total	Phase 1 Total	Phase 2 Total
		Year 1	Year 2	Year 3	Year 3	Year 4	Year 5			
Search Officer	\$5,200		12	6	6	12	12	48	18	30
Graphic Artist	\$5,200		8	6	6	12	6	38	14	24
Marketing Officer	\$5,200		8	6	6	12	6	38	14	24
Physician Practitioner	\$4,100	8	12	6	6	12		44	26	18
Search Assistant	\$4,100		12	6	6	12	3	39	18	21
Marketing Assistant	\$4,100				6	12	3	21	0	21
Total		8	52	30	36	72	30	228	90	138

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TABLE F
FAMILY HEALTH SERVICES PROJECT
Recurring Incremental Costs to FLAS for FHS Activities

	Phase 1			Phase 2			Project Total	Year 6 & After
	Year 1	Year 2	Year 3	Year 3	Year 4	Year 5		
COOPERATIVE AGREEMENT:								
Long Term Technical Assistance -								
Long Term Advisor								
Support Staff								
Recruitment of Long Term Advisor								
Overhead/Management Fee								
Short Term Technical Assistance -								
Consultancies								
Overhead								
Training -								
U.S. Training								
Overhead								
TOTAL COOPERATIVE AGREEMENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
FLAS DIRECT COSTS:								
Training -								
Correspondence Degrees								
In-Country Training								
Workshops								
Commodities -								
Vehicles								
Other								
Local Costs -								
FLAS Staff	\$0	\$998	\$1,048	\$1,048	\$3,304	\$27,253	\$33,651	\$80,732
Supplies		998	1,048	1,048	3,304	22,621	22,621	33,256
Materials Production						4,632	11,030	16,071
Research								19,326
Office Space/Utilities								12,079
TOTAL FLAS DIRECT COSTS	\$0	\$998	\$1,048	\$1,048	\$3,304	\$27,253	\$33,651	\$80,732
USAID ACTIVITIES:								
Evaluations/Audit								
Financial Technical Assistance								
Multimedia Equipment								
Other Activities								
TOTAL USAID ACTIVITIES	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL FLAS RECURRING INCREMENTAL COSTS	\$0	\$998	\$1,048	\$1,048	\$3,304	\$27,253	\$33,651	\$80,732

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FHS BUDGET
AID PAYMENT PROCESS

Methods of Implementation and Financing

The following table exhibits the payment processes which will be followed under this project. In no instance do they depart from the Agency's policies. The Mission will be entering into two separate Cooperating Grant Agreements - with a US-based PVO and the other with an indigenous PVO. The US-based PVO is an Agency approved PVO and the indigenous PVO has had a financial management review where their procedures were found to be satisfactory. Furthermore, the indigenous PVO has been certified by USAID/Swaziland as eligible to receive US funds.

<u>TYPE OF ASSISTANCE</u>	<u>METHOD OF IMPLEMENTATION</u>	<u>METHOD OF PAYMENT</u>	<u>PRE-PAYMENT REVIEW</u>	<u>POST-PAYMENT REVIEW</u>	<u>AUDIT</u>	<u>AID INTERNAL CONTROL</u>	<u>COMMENT</u>
PROJECT ASSISTANCE SERVICES:							
Cooperating Agreement	PVO-U.S.	Direct Pay	PO-ACO	N/A	IG	Good to Excellent	1
Cooperating Agreement	PVO-Indigenous	Direct Pay	PO-ACO	N/A	IG	Good to Excellent	2
Direct Contract	non-profit or profit contractor	Direct Pay	PO-ACO	N/A	IG	Good to Excellent	3
PROJECT ASSISTANCE COMMODITIES:							
AID Procurement	Purchase Order	Direct Pay	PO-ACO	N/A	IG	Good to Excellent	4
AID Procurement	Contract	Direct Pay	PO-ACO	N/A	IG	Good to Excellent	4

1. For services performed in the field, the Project Officer should have a good basis for voucher approval; whereas, home office services will be more difficult to monitor. PVO has an approved OM rate.
2. All goods and services will be procured in the field, so the Project Officer should have a good basis for voucher approval. No OM rate will be paid.
3. Services will be performed in the field and the Project Officer should have a good basis for voucher approval.
4. USAID fully involved in procurement and payment but problems of compliance with procurement regulations, e.g. limit of shelf items, vehicle procurement, waivers and price.

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ANNEX 7
 INITIAL ENVIRONMENTAL EXAMINATION
 OF
 CATEGORICAL EXCLUSION

COUNTRY: Swaziland

PROJECT TITLE: Family Health Services

PROJECT NUMBER: 645-0228

FUNDING: FY 1988 \$775,000
 LOP \$1,600,000

CATEGORICAL EXCLUSION PREPARED BY: J.C. Johnson, Program Officer,
 USAID/Swaziland

ENVIRONMENTAL ACTION RECOMMENDED:

POSITIVE DETERMINATION	___
NEGATIVE DETERMINATION	___
CATEGORICAL EXCLUSION	<u>X</u>

CATEGORICAL EXCLUSION:

This activity meets the criteria for a Categorical Exclusion in accordance with 22 CFR Section 216.2(c) and is excluded from further review because under Section 216.2(c)(2)(vii) programs involving nutrition, health care or population and family planning services except to the extent such programs include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.) are not subject to the provisions of Section 216.3. Since this project only provides basic population/family planning related technical assistance and training, with a small component for commodities, USAID/Swaziland has determined that the proposed project meets the criteria as specified in Section 216.2(c)(2)(viii) for a categorical exclusion and has received the concurrence of the Africa Bureau Environmental Officer with this determination. As per 86 STATE 228562, AID/Washington has delegated authority to you as Director to approve the IEE. This is consistent with Africa Delegation of Authority 551 dated December 1986.

APPROVED: R. Hiesmann

DISAPPROVED: _____

DATE: 8/10/87

CLEARANCE: RLA/SA:EJSpriggs: [Signature] date: 7/31/87

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ANNEX 8

SPECIFIC PROJECT OUTPUTSA. Service Delivery Expansion

- A Marketing/Private Sector function created within FLAS to market and sell FLAS' services in the private sector and to collaborate with the IEC and Research and Evaluation Units in conducting market research and measuring program effectiveness.
- Strengthened and expanded child spacing service delivery capability within large companies where the infrastructure for direct healthcare provision already exists.
- Expanded employment-based motivational activities and contraceptive distribution, particularly in small companies where clinical infrastructure is nonexistent.
- Development of income generating programs designed in collaboration with other FLAS units; pricing mechanisms developed for selling FLAS' services and IEC materials to private sector services with the intention of recovering costs and facilitating financial self-sufficiency within FLAS.
- Initiation of an employment-based distribution system in those companies where increased demand for clinical services will overburden existing clinic staff.
- Increased service delivery capability at FLAS through the funding of equipment for two rooms currently not used for clinical services delivery.
- An increase in knowledge and positive attitude toward child-spacing among employees and dependents in selected private-sector firms.
- An increase in the prevalence of modern contraceptive use by new and continuing users, as indicated in clinical service data in the private sector clinics, FLAS clinics, and from EBD records.
- Improved efficiency and effectiveness of clinical service delivery in family planning in both industry and FLAS clinics, resulting in increased numbers of family planning clients counselled or served and a decreased drop-out rate.

B. Information, Education, and Communications (IEC)

- FLAS' IEC and Research and Evaluation Units will develop the capacity to conduct formative research (KAP study, focus groups and in-depth interviews) by the end of the project.

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- FLAS' IEC Unit, in conjunction with Research and Evaluation Unit, will conduct formative research in 75 percent of the private companies currently providing family planning services by the end of the project.
 - FLAS' IEC Unit will develop the capacity to produce high quality print, broadcast, photographic, and video materials by the end of the project.
 - FLAS' IEC Unit will produce, pretest, and disseminate materials among at least three target groups: employees of private industry; clients of private, MOH and NGO clinics; and leadership audiences (reached through Office of Tinkhundla Community Services workshops or parliamentary session).
 - FLAS' IEC Unit will produce and disseminate a high quality brochure, describing FLAS services and products, for private sector use and distribution.
 - Target audiences will have increased access to information on family planning by the end of the project.
 - Improved production and dissemination of family planning materials will improve the knowledge of targetted audiences on the need for family planning by the end of the project.
 - Increased access to information on family planning will contribute to an increased demand for family planning services and an increased use of family planning methods by the end of the project.
 - A multi-media center will be established for production of IEC messages and materials.
- C. Research and Evaluation
- FLAS will have the capability to conduct both internal and external research and evaluation projects related to its organizational goals.
 - The R&E Unit will develop commodity supply monitoring and forecast systems contraceptive procurement planning.
 - The R&E Unit will develop service delivery monitoring systems to track client visits and to assist FLAS in planning of clinical services activities.

- The R&E Unit will complete (in conjunction with IEC, Marketing and Clinical Services staff as appropriate) discrete formative research studies on the following:
 - KAP surveys among industry management, employees, and dependents in 3 pilot companies to design new IEC materials;
 - service delivery needs assessments for specific companies;
 - impact assessments of IEC activities in communities, schools, and male motivation in selected industries;
 - impact assessment of CBD and EBD programs with respect to contraceptive prevalence and drop-out rates;
 - a client satisfaction survey to evaluate client satisfaction with services at FLAS and in the private sector; and
 - others as appropriate.

D. Management Support

- Improved overall program planning and monitoring skills among senior FLAS staff and selected members of the association's executive committee;
- Improved financial accounting, budgeting, reporting and planning within FLAS;
- Improved communication skills among FLAS staff and within FLAS;
- Enhanced uniformity in messages and contraceptive information disseminated on contraceptive methods and issues;
- Improved data collection, analysis, and utilization of service statistics for program and organizational monitoring and planning; and
- Decreased dependency on donors for financial support and improved capacity to mobilize local support for the association.

E. Contraceptive Supply

- Improved capacity within FLAS to monitor distribution of contraceptives and to plan/forecast for national contraceptive requirements in Swaziland.
- Adequate contraceptive supplies maintained at all times in all private sector services and at the central family planning stores.
- Statistical capability established for determining coverage levels (e.g. couple-year protection) through improved data management and monitoring of commodity distribution and use.

F. Leadership Awareness

- Increased understanding among parliamentarians and chiefs of population and development issues and family planning issues.
- Reduced negative attitudes toward family planning.
- Increased support among leaders for expanding voluntary family planning services in Swazi communities.

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ANNEX 9
PROJECT INPUTS

SHORT TERM TECHNICAL ASSISTANCE

ILLUSTRATIVE LIST

- A. Service Delivery Expansion (Private sector expansion and clinical upgrading).....(18 person-months)
- Increasing FLAS clinical efficiency and effectiveness.
 - Training FLAS staff in counseling techniques.
 - Developing clinical technical assistance approaches for FLAS clinical staff; training in provision of technical assistance to industry-based family planning services.
 - Follow-up and evaluation consultancies in implementation of clinical TA.
 - Planning and conducting workshop for leaders in insurance industry.
 - Developing annual and long-term marketing plans; training marketing staff in Cooperating Agency and FLAS; designing industrial assessment studies and selecting pilot companies to initiate private sector activities.
 - Analysis of marketing research; development of product and service lines, including pricing procedures; designing agreement form for use in selling FLAS programs to private companies.
 - Assessing company needs based on marketing research results; identifying appropriate company-specific programs, including appropriate IEC materials.
- B. Information, Education, Communications.....(9 Person Months)
- Training in formative research; training of interviewers for KAP study; development of IEC workplans for years 1 and 2.
 - Analysis of formative research in industries; designing IEC package of materials for industry use; establishing representative review mechanism for materials/messages developed; training in video production.
 - Analysis of formative research in clinics; development of FLAS brochure; introduction of materials in industry, including development monitoring mechanisms; pretesting and initial production of leadership awareness materials.

ANNEX 9
Short-Term TA List

- C. Management Support and Fundraising.....(10 person-months)
 - Management audit and workshop, plus three follow-up visits.
 - Financial accounting and internal auditing; assistance in bringing financial management in compliance with AID requirements.
 - Fund Raising strategy formulation; assistance in fund raising techniques.

- D. Management Information Systems.....(2 person months)
 - Management information systems needs assessment, review, revise, and strengthen FLAS record keeping, program monitoring, and programmatic reporting.

- E. Commodity Planning.....(1 person month)
 - Assistance in tracking contraceptive commodity distribution, and in forecasting need for future supplies.

Annex 9
PROJECT INPUTS

COMMODITIES AND SUPPLIES TO BE PURCHASED UNDER FHS

<u>ITEM</u>	<u>COST (US \$)*</u>
COMPUTERS:	
- one IBM AT.....	7,000
- one IBM PC.....	5,000
- Software (SPSS, DOS, Lotus 1-2-3, WordPerfect, PC Paint, D-Base III Desktop Publishing) at \$500/ea.....	3,500
- two Six-Plug power strips (\$30/ea).....	60
- two computer printers.....	5,000
PHOTOCOPIER:	
- one photocopier.....	10,500
CLINICAL EQUIPMENT:	
- exam tables, two tray tables, two mobile light service, two blood pressure sets, two stethoscopes, twenty-four speculum, 2 supply cupboards,	3,100
VEHICLES	
- one 4 wheel drive van.....	16,000
- one sedan.....	16,000
TYPEWRITERS	
- one electric typewriter.....	1,000
DESKS/CHAIRS	
- supplemental to the in-kind grant.....	2,050
IEC EQUIPMENT:	
- Video Camera, Recorder and Monitor.....	8,800
- P.A. System.....	1,023
- Slide Projector.....	303
- Screen.....	341
- Camera (35 mm with wide angle and zoom lenses).....	660
- Cassette Deck (with slide/tape synchronizing capability).....	440
- Overhead Projector.....	770
SUB-TOTAL (FLAS commodities).....	81,547
MULTI-MEDIA UNIT (to be purchased in year 4 if funding available): audio/video equipment, darkroom equipment, printing equipment, enlargers, reducers, etc.....	103,000
SUB-TOTAL.....	\$184,547
SUPPLIES OVER THE LIFE OF THE PROJECT:	
IEC SUPPLIES (Art supplies, blank cassettes, video and reel-to-reel tapes, slicing tape, editing tape, transparencies, stencils, black/white and color slide and print film)	
COMPUTER SUPPLIES (Disks and computer paper)	
PHOTOCOPY SUPPLIES, JOURNAL SUBSCRIPTIONS.....	\$49,900
GRAND TOTAL.....	\$234,447

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ANNEX 9
PROJECT INPUTSILLUSTRATIVE TRAINING AND WORKSHOP ACTIVITIESOut of Country

- Management of Family Planning Programs, U. California, Santa Cruz (UCSC) - 6 weeks - (for FLAS Program Director)
- IEC techniques at UCSC - 6 weeks - (for Senior FLE Educator)
- Fundraising - one month - at unspecified U.S. location (for Executive Director)
- Family Planning Program Management - nine months - at unspecified U.S. institution (for 1-2 FLAS employees)
- B.S. Degree at University of South Africa - correspondence education for 2-3 FLAS employees

In-Country

- Private sector policy seminar for health insurance representatives (with short term TA).
- Management Workshop - 2 weeks - (with short term TA) for FLAS senior staff and members of the executive committee.
- Accounting - 2 months - (with Price Waterhouse/Swaziland) for FLAS Finance Administrator and Program Director.
- Contraceptive Technology and IEC Techniques Update - 1 week each year - for all non-clinical FLAS staff to be conducted annually in conjunction with SIHS and FLAS clinical staff.
- Two Leadership Awareness conferences for Parliamentarians and other leaders - 3 days each.

ANNEX 9
PROJECT INPUTS

RESEARCH, EVALUATION, AND MONITORING ACTIVITIES
ILLUSTRATIVE LIST

- A. Research Studies..... \$18,820 for funding 24 months of interviewers for all studies; included in FLAS subgrant
- Formative research (KAP and focus group) for industry management and employees.
 - Service delivery needs assessments on company by company basis beginning with 3 pilot companies, then approximately 4 new companies/year.
 - Formative (KAP and focus group) research on a company by company basis one industrial sector at a time.
 - Formative research (KAP and focus group) for clinics within industry, the MOH, mission clinics, and FLAS.
 - Formative research for leadership awareness.
 - Client satisfaction survey to evaluate services at FLAS and in the private sector.
 - Evaluation of clinic and EBD service statistics
- B. Evaluation/Audit:..... \$108,128.
- External Evaluation to be conducted in 1990
 - External Evaluation to be conducted in 1992 (if funding permits)
 - Audit Assessment to be conducted in 1990
 - Audit to be conducted in 1990
- C. Monitoring visits..... by Cooperating Agency: included in budget for long term TA as part of overhead
- Quarterly Project monitoring visits to examine project progress, and technical assistance
 - Annual internal management audit of Cooperating Agency implementation of project.

ANNEX 10

RESEARCH AND EVALUATION ADVISOR

TERMS OF REFERENCE

A. Duties and Responsibilities

The Research and Evaluation (R&E) Advisor is the principal long-term technician for the Family Health Services Project. In his/her capacity as advisor to FLAS, the Advisor will:

1. Provide technical assistance and consultation to FLAS and the Research and Evaluation Unit in designing of its annual workplan.
2. Provide on-the-job training to staff in the R&E Unit, assist as necessary, in designing research studies identified in the workplan.
3. Provide on-the-job training in implementing various research studies undertaken by the Unit, in particular provide technical assistance in field study management methods.
4. Provide on-the-job training and technical assistance in evaluating research findings and applying the results to program planning, implementation, and evaluation.
5. Assist FLAS management staff in utilizing research information towards improving organizational management, and in identifying areas of unmet needs in staffing, training, service delivery, outreach, educational materials, commodity supply and logistics.
6. Assist FLAS management in developing tools and frameworks for setting organizational goals, objectives and priorities.
7. Assist FLAS management in planning scopes-of-work for short-term consultants, monitoring their performance, following-up on their recommendations, and assessing additional assistance requirements.
8. Provide general support to FLAS management, as requested in systematizing planning, decision making, and evaluation processes. However, the Advisor will have no decision making authority.

ANNEX 10

B. Experience

Minimum ten years progressively responsible experience with emphasis in the following areas:

1. Strong research background which includes experience in research methodology, survey instrument design, study design, sampling, execution of field studies (including staffing, training, budgeting, and supervision), data analysis, and reporting.
2. Expertise in microcomputer operations and research-related software, including data entry, editing, and statistical analysis packages.
3. Experience in applying research findings for identifying service needs, planning program inputs, implementing program activities, and evaluating program performance.
4. Background in organizational management with demonstrated experience in program management in progressively responsible positions within an organization(s).
5. Preferred experience in managing non-profit organizations including experience with volunteer workers and fund-raising.
6. Experience in personnel management, fiscal planning, budget control, designing workplans, and tracking progress in program implementation.
7. Expertise in planning and developing infrastructures within an organizational structure, such as administrative policy and procedures, personnel management systems, and fiscal oversight and management systems.
8. Facility with time management tools, such as pert charting, preferably including experience with microcomputer program planning software.

C. Qualifications

Masters degree required, PhD desirable, in one or more of the following areas: program planning/evaluation, research statistics, computer applications, demography. Strong academic background and experience in management required.

ADMINISTRATIVE ASSISTANT
TERMS OF REFERENCE

The Administrative Assistant (AA) will be responsible for providing administrative and logistical support to the Research and Evaluation Advisor and FLAS in carrying out all project activities.

Generally, the AA will prepare all AID required documents for consultancies, training, procurement of equipment and commodities; draft communications to AID and Pathfinder offices; draft project progress reports; arrange logistics for consultants, overseas and in-country training, commodity shipments.

Specifically, the AA will report to the Management and Research Specialist and be responsible for:

- o Arranging all short term consultancies, including obtaining necessary AID approvals; identifying buy-ins to other AID/Washington projects; arranging in-country travel, making hotel reservations, making necessary appointments for the consultant, prepare orientation materials and provide orientation to all consultants and external Pathfinder or AID staff, and provide other logistical support as required.
- o Preparing PIO/Ps for all overseas or regional short- and long-term training, including obtaining the necessary AID approvals; arranging travel, visas, advances, and medical clearances for travel/living costs, transportation within Swaziland; obtaining receipts and documentation for preparing travel vouchers; obtaining training and travel expense reports from each overseas participant.
- o Arranging procurement of all equipment, vehicles, and commodities, including identifying necessary specifications, and obtaining several quotations for each purchase; obtaining necessary AID approvals for all commodity purchases; arrange customs clearances, transportation, storage, or transfer to the Ministry of Health (in the case of contraceptives) as required; obtain all necessary receipts and documentation required for payment; arrange payment for all purchases.
- o Arranging in-country training logistics for project activities; make necessary facility reservations, including meals, and any hotel reservations; arranging travel reimbursements for relevant participants; assisting in preparing materials for training; obtaining or drafting training reports; obtaining receipts and documentation for all relevant training expenses; arrange payment for all in-country training activities.

ANNEX 10

- o Assist FLAS as required in maintaining all project financial records.
- o Assist FLAS and the R&E Advisor in preparing project implementation reports, including monthly quarterly, and yearly activity reports to be submitted to FLAS, USAID/Swaziland, and all Pathfinder offices; assist FLAS and the R&E Advisor in preparing monthly, quarterly, and yearly project financial reports to be submitted to FLAS, Pathfinder Officers, USAID/Swaziland; open and maintain filing system for all project records; prepare letters, telexes, and other communications necessary for project implementation and reporting; maintaining all communications channels with FLAS, CA offices, and USAID/Swaziland.
- o Assisting in project implementation as required.

QUALIFICATIONS

- Experience:-- Minimum three-four years progressively responsible work experience in project administration and financial accounting;
- Demonstrated experience in book-keeping, drafting of reports;
 - Excellent organizational skills;
 - Knowledge of Swazi institutions;
 - Knowledge of AID administrative procedures and regulations highly desired.
- Education: -- Secondary school graduate with accountancy training at the diploma or certificate level required at minimum; University degree in commerce or administration with accounting training highly desired.
- Other: -- Excellent interpersonal skills, self-motivated, able to work independently, organized and able to meet deadlines.

Table I.
Projected Contraceptive Procurement Costs
Swaziland: 1985-1995 *

YEAR	FAMILY PLANNING USERS	ORAL CONTRACEPTIVES		IUD		INJECTABLES		CONDOMS		TOTAL COMMODITY COSTS
		USERS	CYCLES	USERS	UNITS	USERS	UNITS	USERS	UNITS	
1985	6,600	2,356	30,631	475	127	1,234	4,937	1,518	151,800	\$39,734
1986	7,660	2,735	35,550	552	143	1,432	5,733	1,762	176,179	\$47,498
1987	8,890	3,174	41,259	640	171	1,662	6,653	2,045	204,473	\$56,780
1988	10,318	3,693	47,905	743	199	1,929	7,718	2,373	237,312	\$67,976
1989	11,975	4,275	55,576	862	231	2,239	8,957	2,754	275,424	\$91,141
1990	13,896	4,951	64,491	1,001	268	2,599	10,394	3,196	319,609	\$96,992
1991	16,257	5,807	75,494	1,171	321	3,042	12,167	3,741	374,133	\$115,943
1992	19,042	6,793	88,373	1,371	375	3,561	14,243	4,390	437,963	\$141,000
1993	22,290	7,958	103,449	1,605	440	4,158	16,673	5,127	512,676	\$170,006
1994	26,093	9,315	121,098	1,879	515	4,879	19,518	6,031	600,139	\$204,979
1995	30,550	10,906	141,793	2,200	603	5,713	22,851	7,027	702,650	\$247,193
COST/UNIT		\$0.27		\$1.13		\$4.53		\$0.36		

-Based on World Bank estimates, assuming moderate fertility decline and moderate growth in contraceptive prevalence.

-Contraceptive method mix based on 1993 survey of users in Manzini;

-Calculation of annual unit requirements taken from Population Council Working Paper, 1986;

-Total costs include assumption of 3 percent annual rate of inflation;

-Calculations exclude shipping costs and costs attributable to commodity wastage.

Table G.
Contraceptive Supply and Associated Couple Years Protection:
Swaziland, 1985-93 *
(,000)

Contraceptive	SOURCE	CYP FACTOR	1987		1988		1989		1990		98-93 SUPPLY MIX	95-95 DEMAND MIX
			QTY	CYP	QTY	CYP	QTY	CYP	QTY	CYP		
ORALS (cycle)		13.3	111.0	9.5	169.0	13.0	195.0	15.1	208.0	16.3	32	37
Eugynon 30	IPPF		27.0		32.0		35.0		37.0			
Nor-20	IPPF		0.0		33.0		32.0		35.0			
Ovral	IPPF		0.0		15.0		33.0		30.0			
Moriday +50	FPIA		30.0		35.0		39.0		43.0			
Ls Feminal	FPIA		30.0		33.0		30.0		30.0			
Norminest	FPIA		24.0		27.0		30.0		33.0			
CONDOMS (hundred)		1.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	13	25
Condoms	FPIA		6.0		6.0		6.0		6.0			
IUDS (unit)		3.5	3.5	7.0	3.5	7.0	4.0	9.0	4.5	9.0	19	7
Copper T	FPIA		3.5		3.5		4.0		4.5			
INJECTABLES (dose)		4.0	15.0	3.3	30.0	7.5	40.0	10.0	50.0	12.5	22	27
Nur Isterate	IPPF		15.0		30.0		40.0		50.0			
FOAM PABS (strip)		16.7	25.0	1.5	25.4	1.5	27.5	1.6	29.5	1.8	4	3
Neo Saramon	IPPF		0.0		0.4		0.5		0.5			
Conceptrol	FPIA		25.0		25.0		27.0		29.0			
DIAPHRAGMS (unit)		3.5	0.9	1.9	1.1	2.1	1.2	2.4	1.4	2.7	5	2
Diaphragm	FPIA		0.9		1.1		1.2		1.4			
JEL/FOAM (can/tb)		6.0	1.0	0.2	12.0	2.0	17.0	2.8	20.0	3.3	6	2
Delphen Foam	FPIA		1.0		12.0		15.0		18.0			
Jelly	FPIA		0.0		0.0		2.0		2.0			
TOTAL CYP				28.8		39.1		46.0		51.3	100	100
TOTAL CYP IPPF				5.8		13.4		17.5		20.4		
TOTAL CYP FPIA				22.9		25.7		28.5		30.9	36	
WOMEN AGE 15-49				176.2		181.0		187.4		193.0	64	
CYP PREVALENCE				16.3		21.5		24.5		26.6		

* Supply data are adapted from FLAS, "Three Year Plan 1988-1990", 1987.
Demand data are adapted from Jack Graves, "Foreign Trip Report: Swaziland", August 1986.

ANNEX 12Members of the Project Design Team

FLAS: Nomcebo Manzini, Deputy Director, FLAS

USAID: Joan C. Johnson, Program Officer, Team Leader
 Mary Pat Selvaggio, Deputy Regional Health,
 Population and Nutrition Officer,
 Technical Coordinator

AID/WASH: Scott Radloff, Economist, S&T/Population

TECHNICAL ADVISORS:

Jean Karambizi, The Pathfinder Fund, Nairobi
 Regional Office, Management Specialist

Deborah Helitzer-Allen, Academy for Educational
 Development, Malawi,
 Information, Education and Communications
 Specialist

Maureen Clyde, John Short Assoc., Baltimore Md
 TIPPS Project Private Sector Specialist

Anita Bennetts, (Pop Tech Project)
 Bennetts & Associates, Co. Clinical Services and
 Evaluation Specialist

OTHERS

Alan Foose, Health Population and Nutrition
 Officer, USAID/Swaziland

E. Spriggs, Regional Legal Advisor, USAID/Swaziland

D. Lake, Regional Contracts Officer, USAID/Swaziland

J. Gonson, International Development Intern,
 Financial Management Office, USAID/Swaziland

R. Solloway, Financial Management Officer,
 USAID/Swaziland

Annex 13.
Organizational Contacts for Project Design

- A. Family Life Association of Swaziland
 - 1. Borad of the Executive Committee
 - 2. Office of the Executive Director
 - 3. Family Life Education Unit
 - 4. Clinical Services Unit
 - 5. Finance Unit
 - 6. Mbabane Clinic
 - 7. Manzini Clinic
 - 8. Malkerns Clinic
 - 9. CBD Workers Hhohho Region

- B. Private Sector Industries
 - 1. Swaziland Fruit Cannery
 - 2. Conco
 - 3. Usutu Pulp Company
 - 4. Havelock Mines
 - 5. United Plantations, Ngonini Estates
 - 6. Ubombo Ranches
 - 7. Swaziland Brewers
 - 8. Vuvulane Irrigated Farms
 - 9. Simunye Sugar Estates

- C. Private Health Services
 - 1. Medscheme Administrators
 - 2. Occupational Health Services

- D. Professional Associations
 - 1. Medical Association of Swaziland
 - 2. Federation of Swaziland Employers

- E. Private Voluntary Organizations
 - 1. Red Cross of Swaziland
 - 2. Salvation Army
 - 3. Raleigh Fitkin Memorial Hospital

- F. Education and Training Institutions
 - 1. Social Research Unit, University of Swaziland
 - 2. Nazarine Nursing College
 - 3. Swziland Institute for Health Sciences
 - 4. Good Shephard Nursing School

- G. Ministry of Health
 - 1. Office of the Permanent Secretary
 - 2. Department of Health Statistics
 - 3. Department of Health Planning
 - 4. Department of Health Education
 - 5. Family Planning Stores
 - 6. Primary Health Care Unit

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- H. Ministry of Finance and Economic Planning
 - 1. Central Statistics Office
- I. Ministry of Interior
 - 1. Swaziland Broadcasting Service
- J. Office of Tinkundla
 - 1. Department of Community Development
- K. Individual Contacts
 - 1. Private Physicians (three)
 - 2. Nursing Student (one)
 - 3. Anthropologists (two)
 - 4. Radio Broadcasters (four)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

From 04/01/88 to 03/31/93
Total U.S. Funding: \$2,600,000

PROJECT TITLE AND NUMBER: Family Health Services (FHS) Project (645-0228)

Narrative Summary Verifiable Indicators Means of Verification Important Assumptions

Project Goal

-Reduce high rates of fertility.

Prevalence rate surveys.

-More Swazi couples are willing to use modern contraception.

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

The contraceptive prevalence data and vital statistics. rate for modern methods of child-spacing will increase to at least 15 percent; There will be increased knowledge of family planning benefits, use, and availability among Swazis and Swazi leaders; There will be an expanded family planning data base which could be used for national planning on population; The capacity of the private sector to respond to an increased demand for family planning will be expanded. A Swazi private voluntary agency will be institutionally strengthened to respond to an demand for family planning services.

-Health and demographic survey increase contraceptive

-Leaders in Swaziland seek to prevalence and to increase child-spacing practices. -Current unmet demand for family planning -- demand will continue to increase over term of project. -Other donors provide necessary complementary inputs.

Project Outputs:

Magnitude of Outputs:

1. Increase access to family planning services and provide information on health benefits of child-spacing.

-Extend access through existing service delivery channels. -Expand delivery through new channels (Employer Base Dist). -Information on health benefits of child-spacing incorporated into all family health promotion programs.

-Health and demographic survey data and service statistics.

-GOS will continue to support expanded availability of family planning services. -Major industries will provide resources to initiate and expand employer-based delivery (EBD).

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PROJECT TITLE AND NUMBER: Family Health Services (FHS) Project (645-0228)

Narrative Summary	Verifiable Indicators	Means of Verification	Important Assumptions
<u>Project Outputs:</u>	<u>Magnitude of Outputs:</u>		
2. Improve knowledge about availability, benefits, and use of family planning and child-spacing.	-Increase in numbers of couples who are aware of available FP services, health benefits of child-spacing, alternative methods of family planning.	-Health and demographic surveys.	-Swazi couples desire information on family planning methods and their availability.
3. Research local capabilities for research monitoring and evaluating program implementation.	-2 staff members trained in program research evaluation and analysis techniques and regularly applying skills.	-Participant training reports. -Program monitoring reports and reports on research and evaluation findings.	-Qualified staff recruited and made available by FLAS will be in position to use learned skills.
4. Improve technical and management skills of program staff.	-Selected FLAS staff trained in IEC, service delivery techniques, program management, fundraising, and technical assistance skills. -3 staff members trained at degree level -3 staff members trained in 9-12 month technical and management programs in U.S. -Increased client load.	-Participant training reports. -Program monitoring reports. -Fund raising records. -FLAS annual reports. -Client statistics.	-Qualified staff recruited and made available by FLAS will be in position to use learned skills.
5. Assure continued supply of contraceptives.	-2 staff members trained and regularly monitoring commodity supply and planning for future requirements.	-Participant training reports. -Commodity logistics reports.	-Qualified staff recruited and made available by FLAS will be in position to use learned skills.
6. Increase leadership awareness of implications of family health and development.	-National seminars and workshops on family health and development conducted. -Results of demographic and health surveys disseminated	-Seminar/workshop reports. -Copies of demographic survey analyses and policy briefs.	-GOS completes process of consensus-building on family health policy issues.

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PROJECT TITLE AND NUMBER: Family Health Services (FHS) Project (645-0228)

Narrative Summary	Verifiable Indicators	Means of Verification	Important Assumptions
Project Inputs:	Implementation Target:		
1. Long-term technical assistance.	-1 research and management specialist for up to 4 years; -1 Admin. Asst. and 1 secretary for up to 5 years; \$619,241.	-AID records and contractor reports.	-Availability of AID funding.
3. Short-term technical assistance.	-40 person-months technical assistance; \$846,639.	-AID records and contractor reports.	-Availability of support through AID central projects.
4. Training, workshop seminars.	-3 participants in correspondence degrees \$24,122. -in-country seminars, workshops and conferences; \$13,400. -3 staff members trained in U.S. for 9-12 months and 3 staff attending 1-month courses; \$140,367.	-AID and FLAS records. -AID records and contractor reports	-Appropriate staff available for training. -Appropriate staff available for training.
5. Local program support.	-Salaries, Supplies, costs of materials production, office rent and utilities, commodities \$409,345	-AID and FLAS records. -FLAS procurement records.	-FLAS can recruit appropriate staff. -FLAS can sustain increased staff size. -FLAS can manage procurement of supplies and commodities for project.
6. USAID Activities	-evaluations/audits, multi-media unit equipment, other opportunities: \$240,570.		-Other opportunities arise for USAID support in FP field.
7. Contraceptives	-Back-up supplies if required supplied by AID/W project \$204,000	-AID procurement records	-Other donor institutions meet contraceptive supply commitments -AID/W project continues to obtain low-cost contraceptives to meet short term request.

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5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1988 Continuing Resolution Sec. 526. No.
 Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?

2. FAA Sec. 481(h). (This provision applies N/A
 to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without

Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

N/A

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4. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? No.
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No.
6. FAA Secs. 620(a), 620(f), 620D; FY 1988 Continuing Resolution Sec. 512. Is recipient country a Communist country? If so, has the President determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism? Will assistance be provided directly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification? No.
7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.
8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? At least one OPIC-backed project has been developed. However, there is no overall bilateral agreement between Swaziland and OPIC.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the Taking into Consideration memo.) Funds have been appropriated and are in National Budget for payment of U.N. obligations.
14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? No.
15. FY 1988 Continuing Resolution Sec. 576. Has the country been placed on the list provided for in Section 6(j) of the Export Administration Act of 1979 (currently Libya, Iran, South Yemen, Syria, Cuba, or North Korea)? No.
16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No.
17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No.
18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) No.

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19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? No.
20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.) N/A
21. FY 1988 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No.
22. FY 1988 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? N/A
23. FY 1988 Continuing Resolution Sec. 543. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? Yes.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? No.

FY 1988 Continuing Resolution Sec. 538. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

2. Economic Support Fund Country Criteria

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? N/A

FY 1988 Continuing Resolution Sec. 549. Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

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5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? Yes.
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? Yes.
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? N/A

4. FAA Sec. 611(b); FY 1988 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
(a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. This is essentially a private sector family planning institutional development project, with no likely direct impact on these matters.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). The project will utilize the services of a U.S. PVO and will finance procurement of goods and services from U.S. suppliers.
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. The project does not involve assistance to the Government of Swaziland, hence no local currency contribution is expected. No local currencies are owned by the U.S.

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10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.
11. FY 1988 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
12. FY 1988 Continuing Resolution Sec. 553. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 007," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? N/A
13. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? No. However, by contributing to reduction of population growth rate, project will help reduce pressures on delicate ecosystems.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A
15. FY 1988 Continuing Resolution. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? Yes.
16. FY Continuing Resolution Sec. 541. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? Yes.
17. FY 1988 Continuing Resolution Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N/A
18. FY Continuing Resolution Sec. 515. If deob/reob authority is sought to be exercised in the provision of assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified? N/A
19. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). Standard obligation procedures will be followed.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FY 1988 Continuing Resolution Sec. 552 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? N/A
- b. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and a) See answer to question A7 above.

insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

b) See answer to A7 above.
c) By contributing to the reduction of population pressures on scarce resources, project will support self-help development fund.
d) Project supports an indigenous, women led PVO to improve and expand it's services and influence.
e) See answer to A7 above.

c. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used? Yes.

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

e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? N/A

f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes, the ultimate beneficiaries are the poor majority.

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- j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.
- k. FY 1988 Continuing Resolution. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 20 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? It is expected that project grantees will sub-contract with such entities to the extent possible for short-term technical assistance.
- l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared Yes. This is primarily a technical assistance and institutional-oriented project, and a categorical exclusion from AID environmental procedures was approved.

or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

- n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? N/A
- o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A
- p. FY 1988 Continuing Resolution If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in (a) Yes.
(b) Yes.

accordance with the policies contained in section 102 of the FAA; (c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

(c) Yes.

(d) Yes.

(e) Yes.

2. Development Assistance Project Criteria
(Loans Only).

N/A

- a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.
- b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?
- c. FY 1988 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds?
- d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

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

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No.
7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes. However, it is anticipated that technical assistance will be provided by a U.S. PVO under a cooperative agreement.
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes.
9. FY 1988 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? N/A
10. FY 1988 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes.

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B. CONSTRUCTION

N/A

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress?

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? N/A

4. Will arrangements preclude use of financing:

- a. FAA Sec. 104(f); FY 1987 Continuing Resolution Secs. 525, 538. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion? (1) Yes.
(2) Yes.
(3) Yes.
(4) Yes.
- b. FAA Sec. 483. To make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes.
- c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.
- d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.
- e. FAA Sec. 662. For CIA activities? Yes.
- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? N/A; superceded by DFA procedures.

- g. FY 1988 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.
- h. FY 1988 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues? Yes.
- i. FY 1988 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.
- j. FY 1988 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology? Yes.
- k. FY 1988 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.
- l. FY 1988 Continuing Resolution Sec. 516; State Authorization Sec. 109. To be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? Yes.