

*FAMILY LIFE ASSOCIATION  
OF SWAZILAND*

*TRIP REPORT*

*JULY 11 - 26, 1994*

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# Family Life Association of Swaziland

Trip Report 11th - 26th July 1994

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## EXECUTIVE SUMMARY

This report outlines the work accomplished during a visit to the Family Life Association of Swaziland (FLAS) from 11th - 26th July 1994.

This first visit to the FLAS focused primarily on a review of the Industry Based Distributor (IBD) component of the Industry Based Project. In particular, a review was made of the family planning service statistics reporting systems, to identify the key issues or constraints in these systems and to recommend strategies to address these key constraints. The outputs were accomplished during this visit:

- ✍ modified the record keeping and reporting formats for the IBD component and for the clinics to reflect the programmatic changes taking place [oral contraceptive resupply by IBDs and the provision of Voluntary Surgical Contraceptive services by the clinic program].
- ✍ assisted in the development of IBD selection criteria and recruitment procedures (guidelines)
- ✍ developed guidelines for IBD performance evaluation.
- ✍ proposed a series of recommendations to improve the supervisory systems (and utilization of information)
- ✍ assisted in the development of the contraceptive procurement tables for FLAS.

In general, the utilization of management information needs to improve to fully utilize the potential of the MIS. One of the weak links in this utilization of information within FLAS lies in the supervisory systems. Without effective supervisory systems, any improvements to the information systems will not translate into improved performance.

There are several activities that need to be carried out to improve the current supervisory systems. One of the activities will be the development of a more systematic approach to supervision where supervisory observations and interventions are recorded. This will enable supervisors to more easily review supervisory interventions and relate them to performance. One of the recommendations of this report is to conduct a supervisory workshop for both managers from headquarters and project supervisors.

## 1. INTRODUCTION

This report outlines the work accomplished during a visit to the Family Life Association of Swaziland (FLAS) from 11th - 26th July 1994.

This first visit to the FLAS focused primarily on a review of the Industry Based Distributor (IBD) component of the Industry Based Project. In particular, a review was made of the family planning service statistics reporting systems, to identify the key issues or constraints in these systems and to recommend strategies to address these key constraints. The specific objectives are outlined below:

### Specific Objectives:

1. Revise the MIS format and simplify it as recommended in the Industry Program Assessment report of 1993.
2. Introduce revised MIS to industries
3. Develop recommendation/guidelines for Industry Based Distributor (IBD) selection criteria.
4. Develop guidelines for IBD performance evaluation.
5. Prepare contraceptive procurement tables for FLAS requirements in 1994.

### Methodology

A series of field visits were carried out to all three FLAS clinics, two new industry projects and two ongoing industry projects. Information was collected through interviews with project supervisors and clinic staff as well as IBDs during the site visits. Additional insights into the functioning of the various systems was provided by FLAS headquarter staff, in particular from the industry and programs departments and from the research and evaluation department. Supplementary background information was also provided by a number of technical reports and reviews carried out over the last couple of years. A one day workshop was conducted with the industry project supervisors<sup>1</sup> to review some of the recommendations for changes to the system and the new reporting formats.

### MIS Review and Recommendations

This section summarizes the observations and recommendations made during the MIS review. A more detailed and specific set of recommendations for both the clinic and IBD reporting systems is presented in the second section of this report.

**Key Issue:** The data collection and record keeping tools (pre-printed registers, cards and reporting forms) of FLAS are of high quality. Each clinic is supplied with a "Daily

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<sup>1</sup>. See Appendix for list of participants

Register and Report" and a number of additional registers are kept to record and report all FP related activities. This proliferation of registers especially in the FLAS clinics<sup>2</sup> results in a significant replication in data recording. In particular a lot of data is recorded in the register that is also recorded on the client card. Each additional transfer of data is likely to increase the number of errors in the information. Furthermore, it is noticeable that the Daily Register/Report is in fact not being used as a register but primarily as a report to FLAS.

There seems to be a number of different reasons for some of this duplication:

- There is a tradition of keeping registers and a general feeling that it is important to record everything even if it means recording things several times.
- Some information is recorded because the clinic may be asked by the Ministry of Health to provide some information.
- One of the uses of an additional register is so that the return date can be recorded. This is useful when a client returns to the clinic and has either forgotten her/his client number and/or the date (month) she/he was supposed to return to the clinic<sup>3</sup>. As long as the client can remember approximately on what day (he/she) last visited the clinic, the register can be used to find the return visit date, and (if recorded) the client number.
- Some of the clinics have several stations at which services are provided. Information is therefore recorded in a separate register or on a piece of paper and later transferred to the main register.

When reviewing the information systems, several issues were identified that relate to the use of the information systems and the supervisory systems that they support. Furthermore, several issues related to overall IBD performance (e.g. selection criteria and performance evaluation) were also identified.

**Recommendation:** To reduce the volume of recording and duplication, a new Daily Register and Report (draft) has been developed which adds a few new fields to the register. This will enable the clinics to reduce the number of other registers and to maintain a single "Register" of FP activities in the clinics. The new register will also record/report a number of VSC indicators. This new format was presented to the Industry Project supervisors and staff at a one day workshop held on the 20th July<sup>4</sup>; their comments and feedback have been taken into consideration in modifying the format. The

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<sup>2</sup>. The one industry-based clinic reviewed at Ubombo Ranches used far fewer additional registers than the FLAS clinics.

<sup>3</sup>. It is not uncommon that the client loses the return card and has never memorized the client number.

<sup>4</sup>. See Appendix for list of participants.

next step in this process will be for the Research and Evaluation Unit (R&E) to review the format with other senior FLAS managers and to field test the format in a number of clinics, (probably in the FLAS clinics first).

**Key Issue:** The current MIS system does not keep track of the number of new clients to modern methods of family planning (only the number of new clients to the program). This will become increasingly important as the program will want to measure the impact of the new IEC strategy on the ability of the program to recruit new acceptors to modern methods of family planning.

**Recommendation:** The clinics and the IBD program should continue to record the new clients to the program but should also add the new acceptor to modern method of FP to the records. This has been done in both the prototype clinic register/report and the new IBD register/report.

**Key Issue:** The industry project will soon start pilot testing the resupply of oral contraceptive clients by the IBDs. This will require the IBDs to keep much better client records.

**Recommendation:** A new client recording system has been designed for the IBDs and is described in detail in the next section of this report.

**Key Issue:** Any improvements in the information systems will not realize improvements in the performance of the project unless the other tangential factors that impact upon performance are also addressed. For example, IBD selection and supervision are two significant factors seen as having a direct impact upon the performance of the Industry based project. There are also other determinants of overall performance such as how accessible the services are to the clients and potential clients (e.g. how easy is it for an employee to go to the clinic to receive services and contraceptive supplies?).

**Recommendations:** During this review attention was focused on the supervision of the IBDs as a specific area that requires improvement. Currently the industry project supervisors do not have enough time to provide adequate supervisory support to the relatively large number of IBDs. FLAS may want to test and implement an additional supervisory level where senior IBDs are selected and trained as the immediate supervisors. They in-turn will need to be selected with care and in a manner which motivates rather than de-motivates other IBDs. In addition to increasing the number of immediate supervisors, there is a need to improve the supervisory skills of the project supervisors. A draft concept has been developed for a 3-4 day workshop on supervision for FLAS managers and project supervisors<sup>5</sup>. The purpose of the workshop is to improve supervision by enabling the supervisor to change roles from one of checking and simply making sure that the supervisee does what he/she is supposed to do, to a role where the supervisor is primarily concerned with helping the supervisee do her/his job more efficiently and effectively. (Supervisor taking on a greater share of the responsibility for the performance of the supervisee).

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<sup>5</sup>. See Appendix for supervision workshop outline - concept

**Key Issue:** There is no formal system in place to record project supervisory observations and interventions. This also contributes to difficulties in assessing IBD performance on factors other than absolute output. [It also makes it difficult to supervise the supervisors] It is often not entirely fair to reward IBDs solely on the basis of their absolute output (number of clients served, referrals, IEC talks, CYP etc) because the geographic areas that the IBD cover are different. IBDs working in particularly difficult areas and/or making significant personal improvements but not being best (or second best) may be demotivated by knowing that they are not rewarded on the basis of effort or improvements.

**Recommendation:** A system is needed that will contribute towards improved supervision and at the same time provide documentary support for assessing IBD (and supervisors) performance. A Personnel Notebook system (draft prototype) has been developed<sup>6</sup> and discussed with the project supervisors. The key components of the system require the supervisor together with the supervisee (in this case the IBD) to sit down and develop personal performance targets. The supervisor will then routinely monitor performance using the MIS and interactions with the IBD and record the observations, problems, recommended solutions and results in the notebook. The next step in the process of introducing this system will be for the industry project (FLAS) managers to meet, review and discuss the system and develop a workplan for field testing and introducing the system to the supervisors.

**Key Issue:** One of the key issues identified in the 1993 assessment of the industry project was the feedback report that were being provided to the project supervisors from the R&E unit. Since then a number of improvements have been made in the content of the feedback reports which has improved their usefulness for the management of the project. Additional improvements that were outlined in the assessment report are planned by the R&E unit. However, one observation during this visit is that although some improvements in feedback can be made, in particular as they relate to the presentation of information, the supervisors skills in using this information to improve the efficiency and effectiveness of the project needs to be enhanced.

**Recommendation:** The R&E unit will continue to develop better and more concise feedback reports to the project. These will include the new definition of "new acceptor" (to modern methods of FP). An MIS workshop for FLAS managers and project supervisors should be developed and conducted in the near future. This would focus on developing the skills of the supervisors to translate project objectives into specific site targets (setting normative targets<sup>7</sup> for the IBDs) and in the use of information to make decisions that impact positively upon the performance of the project.

**Key Issue:** Although the IBD selection criteria is important it is also important to provide guidelines for the process of recruiting, selecting, rejecting after training, resigning after a specific period of time and de-selecting or rejecting after a specific period of time.

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<sup>6</sup>. See Appendix for instructions and guidelines on how to use the Personnel Notebook system.

<sup>7</sup>. See Appendix for the article on monitoring and evaluation which was distributed to all project supervisors after the one day workshop (20th July).

section 3 of this report. Included in the selection criteria is a series of recommendations for the "ideal" process to be used in selecting IBDs. Furthermore, a number of recommendations have been made as to how to de-select and purge the system of non-performing IBDs. These recommendations need to be reviewed and discussed by the industry project staff who will be able to provide additional insight into the most appropriate strategy of implementation.

**Key Issue:** Currently all data processing is carried out at FLAS headquarters. There are two separate database programs for FP service statistics, a dbase application for the FLAS clinic data and a Paradox application for the industry based data.

**Recommendation:** That the service statistics application be developed to such a stage where an executable copy can be given to the industries to enter the data directly, produce their own trend and comparative analysis reports and provide FLAS HQ with data on disk.

**Key Issue:** In the future, VSC services will be provided by FLAS and industry clinics. This will necessitate further development on the service statistics application to incorporate the new indicators, new acceptors and IBDs distributing pills.

**Recommendation:** The first step will be for the R&E unit to include the new fields in the database to reflect the changes in indicators. A second step will be to integrate the FLAS and industry databases into one computer program.

**Key Issue:** Some of the Project Supervisors are unsure of how they should report their own IBD activities.

**Recommendation:** Project Supervisors often spend some time providing IBD services and should therefore use the standard IBD Register/Report to record all IBD related activities that they carry out. These should be added on the monthly supervisors report together with the data from the other IBDs.

**Key Issue:** The FLAS CBDs are currently using the same type of register as the IBDs.

**Recommendation:** FLAS CBDs should continue to use the same registers as the IBDs. Therefore, any changes to the IBD register will also be incorporated in the CBD registers.

**Key Issue:** Some additional observations were made during the field visits on factors which may impact on the performance of the program. For example, it may be a medical barrier when the policy of the industry does not allow the workers (in particular the female workers) to visit the clinic during working hours.

**Recommendation:** To include a review of medical barriers when conducting studies of ("mini-studies"<sup>8</sup>) of FP coverage in industry projects

**Key Issue:** The IBDs interviewed during the field visits felt that a lot of the IEC

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<sup>8</sup>. A recommendation was made by Dr. Ezra Teri (SRTA/Medical Services, Pathfinder Int. July 1994) that the R&E unit assist the industry clinics to design mini-studies to collect more detailed catchment area data. The analysis of the industry baseline data questionnaires which will be carried out in September 1994 (Dr. Mburugu) may reveal some additional barriers to access.

**Recommendation:** One interesting suggestion by the IBDs was that HIV/AIDS victims be recruited to help the IBDs get the message across to the potential clients. Making the point that just because you cannot see it does not mean that it does not exist.

**Key Issue:** During the development of the contraceptive procurement tables<sup>9</sup> a comparison between commodities distributed from the FLAS store (bin cards) and the commodities issued to the clients (routine reporting - MIS) shows that there are significant variations. Due to time constraints it was not possible to conduct any form of detailed analysis of the commodity logistics system.

**Recommendation:** Currently all commodity data is derived from the FLAS central store. Each clinic should in the future submit a quarterly stock report to the R&E unit who will ensure that the clinics are maintaining a minimum three month buffer stock. The stock information from the clinics should be reconciled with the central store data and compared to the service statistics data at the end of the year. During the first year it may be appropriate to conduct a semi-annual review so that adjustments can be carried out during the year.

Prior to the introduction of any new commodity reporting system, the R&E unit should conduct a more detailed study of the commodity logistics system. The following are some of the areas that need to be reviewed:

- determine the level of buffer stock in the FLAS clinics and a sample of the industry clinics, to determine understocking or overstocking;
- explain the discrepancies in the 1993 data (bin cards vs. service statistics);
- check for possible expired (will expire) commodities;
- ability of clinic personnel to keep accurate records, and;
- possible training necessary to improve contraceptive management.

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<sup>9</sup>. See Appendix for contraceptive procurement tables.

## 2. Specific Recommendations

To reduce the amount of time spent recording data, only one register would be used to record all fp clients and services. In addition, some information that is not being recorded should be added to the register. This would require that a number of changes be made to the FLAS "Daily Register/Report". A copy of the draft FLAS Daily Register/Report and a detailed description of the fields is shown on the following pages.

**Key Issues:** Currently the term new acceptor refers to a client who is new to the clinic (or new to the CBD agent as the case may be). A number of weaknesses were identified with using this definition:

- It is difficult to know how many clients are actually new to modern methods of family planning. An important measure of project performance and an important management indicator is the measurement of size of target population and the current contraceptive prevalence rate (CPR). It is also important to know how many in the target population have ever used a modern method of contraception (Contraceptive Aceptance Rate) and therefore how many in the target population have never used a modern method of FP. This has relevance for the IEC approach as experience has shown that to be effective messages have to be developed and used for different types of clients. For example, you do not need to create awareness amongst former clients but you may need to counteract rumors and misconceptions. However, it is common for many FP programs to use the same messages for potential clients, current clients and former clients. One measure of the impact of the new IEC strategy will be how many new acceptors to modern method of FP is the program able to generate?
- The review of the record keeping system indicates that there is some double counting of clients, particularly amongst IBDs. i.e. new clients for one IBD who have been clients of another IBD or of a clinic are recorded as new clients of the current IBD or clinic. This double counting, particularly in the environments with highly mobile populations, gives a somewhat distorted picture of the impact of the program. This may explain the high number of new acceptor (clients) in relation to the number of revisits.

**Recommendation:** FLAS should use a new acceptor definition which would record the number of new acceptors to modern methods of family planning. This much stricter definition requires that both IBDs and clinic staff are trained in asking the correct questions to determine if the user is new to modern methods of FP.

The clinics should continue to record new clients which are easily identifiable through the

issue of a client number<sup>10</sup>. New clients are issued a client number and preferably recorded in red ink. The column "New FP Acceptor" (currently column 4) is used to record (with a tick) if the client is new to modern methods of FP. A client who returns to the clinic or the IBD after a long absence is not considered a new client or a new acceptor but a revisit client.

A client who is switching from one clinic to another and maintains her original client card should also keep her old client number and add the prefix "T" to the end of the client number, e.g. 123/94T. This will enable the program to monitor the total number of clients switching source. If a client is switching but has lost her original card, a new card and number should be issued and the letter "T" added to the end of the number. **Clients switching from one FLAS clinic to another FLAS clinic or Industry Project clinic, or from an industry project clinic to a FLAS clinic should not be counted as a new client or new acceptor.** A visitor to the clinic, (temporary) should not receive a new card and should be recorded as a revisit. If the records show that the number of clients switching clinic is significant, it would be useful to conduct a small survey to determine the reasons for clients switching. A survey should categorize the reasons into a) reasons related to the quality of care that the FLAS can do something about, b) other reasons that FLAS cannot impact upon directly.

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<sup>10</sup>. All FLAS clinic and most industry clinics use a simple consecutive numbering system which also indicates the year (e.g. 123/94). Some industry clinics use the employee number as the client "card" number. FLAS should recommend that some client numbering system be used by all clinics. Irrespective of the numbering system used, the clinic should record each client as either new client or revisit client in the FLAS Daily Register/Report.

## **FLAS Daily Register/Report (Fields)**

Outlined below are the fields and field descriptions for the new FLAS Daily Register/Report shown on the next page.

**Date:** The clinic should record the date of each client served.

**Client Number:** Columns 2 & 3 are deleted and replaced by a single column which is used to record the client number. New clients are recorded in red ink. It is not absolutely necessary to record the consecutive number when the client is seen as it is easy and fast to simply count the number of clients seen from the beginning of the month or day should that information be needed. Furthermore, the cumulative totals clearly show how many clients have received services from the clinic.

**Name:** The first and last name of the client.

**New Acceptor:** Record with a tick if the client is a new acceptors to modern methods of family planning.

**Orals:** If the client receives pills record the number of cycles distributed in this column. Add an "N" and a "\ " in front of the number of cycles distributed if the client is a New Client (New to the clinic). If the client is a revisit client write an "R" in front of the number of cycles distributed. e.g. N\3 shows that the client was a new client and that she received 3 cycles of pills. R\2 shows that the client was a revisit client and that she received 2 cycles of pills. Note: that a new acceptor is also a new client but that a new client is not necessarily a new acceptor.

**Other Contraceptives:** Repeat the same steps for the other contraceptives, i.e. for new clients place an "N\" and for revisit clients place an "R\" in front of the number of contraceptives distributed.

**Surgical Methods:** Clinics carrying out voluntary surgical contraception (VSC) should record in one of the three columns, BTL, Interval or Postpartum. The same columns are used by the clinics who are referring clients to other sites for (VSC).

**FP Counselling:** Clients receiving FP counselling should be indicated with a tick in this column.

**MCH and Medical:** Clients receiving any MCH and/or medical service should be marked with a tick in this column.

**Pregnancy Test:** All clients receiving a Pregnancy Test should be marked with a tick in this column.

**Infertility/Sterility:** Clients receiving Infertility/Sterility services should be marked with a tick in this column.

**STDs:** Clients treated for STDs should be indicated with a tick in this column.



**Post-Natal:** Clients receiving post-natal services should be indicated with a tick in this column.

**Pap-Smear:** Clients receiving pap-smear services should be indicated with a tick in this column.

**STD counselling:** Clients receiving STD counselling should be indicated with a tick in this column.

**Youth counselling:** Youth receiving counselling services should be indicated with a tick in this column.

**Return Date:** A column is added to record the date of return of the client. This column would become the last column of the page.

**Note:** condom clients are recorded without a client number and the cell is left blank (alternatively, a simple consecutive number can be used to record the number of condom clients seen during the month).

**Note:** clients who receive more than one service should be marked in the appropriate columns.

**Layout:** The register is rotated to landscape so that each cell (column/row) is slightly larger. If the size of the register is maintained, fewer clients are recorded on each page. However, the ease of recording is improved and the risk of recording in the wrong column/row is reduced. However, the number of clients per page can be maintained by slightly increasing the size of the register.

**Total Fields:** The total fields at the bottom of the page are slightly modified to record the clients which are new to modern methods of family planning. The first row of the summary table will record the number of new clients (to the clinic) by method. The second row will record the number of revisit clients to the clinic and the third row will record the quantity of contraceptives distributed according to type of contraceptive. An additional row will be added just below the commodity line to record the number of new acceptors to modern methods of family planning according to method.

**Note:** when a clinic has more than one nurse working at the same time they should each maintain their own register. The data from the different registers need not be compiled at the clinic. However, the data should be summarized and provided as feedback by the FLAS R&E unit.

**Key Issue:** Following successful field trials IBDs will in the near future be allowed to distribute oral contraceptives to revisit clients. Following the trend in other countries it is also likely that well trained IBDs will be allowed to distribute pills to new acceptors. It will therefore become very important to be able to track these clients to assure that quality services are provided. IBD should therefore maintain a register for all oral pill clients and record the dates on which they need to be resupplied.

**Recommendation:** A client register for the IBDs needs to be developed and the IBDs trained in its use. A draft outline for an IBD register is shown below:

Name	Client Number	Sex	Age	Parity	Address	Start Date	Pills	End Date	Pills						
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Note: A number of pre-printed pages with the above format for the IBDs Pill Client Register could be included as part of the IBD's Register/Report. An estimate can be made of the expected total number of clients that an IBD would serve and the appropriate number of pages printed.

**Date;** to record the date on which the client becomes a new client of the IBD.

**Client Number;** each new pill client receives her client number from the clinic<sup>11</sup>. When recording the client number in the register the IBD should add the prefix "D" to the number. Clients who transfer from one IBD to another should have the suffix "T" added to the end of the number e.g. D123/94T.

For example, an oral pill client who starts in the clinic and has the client number = 129/94 and moves to the IBD as her supplier of oral contraceptives has her client number transferred to the IBD's register and maintains her original clinic client number with the addition of the prefix "D". If at a later date she transfers to a different IBD she should keep her old client number but add the suffix "T" i.e. D129/94T.

**Note:** Condom or foaming tablet clients need not be recorded in the IBDs client register. They are predominantly highly mobile and prone to receive their contraceptive supplies from multiple sources.

**Name:** First and last name of the client.

**Age:** Age of the client.

**Parity:** Parity of the client.

**Address:** Address of the client.

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<sup>11</sup>. All new pill clients will receive their client numbers from the clinic. In addition, they will also receive their first 3 months (or more) supply of pills from the clinic. When they start receiving pills from the IBD, their client number will be transferred to the IBD's register.

Date: The first date should correspond to the date of the first visit, subsequently, the IBD should record the date on which the client is expected to be resupplied. Note that although the IBD records the date of the next resupply, he/she should not record the quantity until after the actual resupply visit (at the time of the visit). Note: as the IBD will only be recording oral pill clients in this register it is not necessary to specify the method, only the quantity being distributed.

Quantity: The IBD should record the quantity of oral pills (cycles) distributed to each client at the time of distribution.

Note: Using the same size register as the current Daily Register or FLAS Distributors Report would allow for approximately 10 resupply visits to be recorded on a single page. When a row has been completed a new row should be started. A red star can be used next to the name to show that the client has a previous record in the register. It would not be necessary to repeat all the information previously recorded (age, parity etc.) to the new row in the register.

## **Simplifying the IBDs "FLAS Distributors Daily Report"**

If the IBD agent uses the new pill client register, some modifications can be made to the IBDs register which will simplify recording and reporting. A simplified register/report is shown on the next page. The field definitions are show below:

Date: The IBD should record the date of each client served.

New Acc: = New Acceptor: The IBD should record all new acceptors to modern FP with a "1"

New Clients Pills: In this column the IBD should record the number of pill cycles distributed to the client if the client is given pills and is a new client.

New Clients Cond: In this column the IBD should record the number of condoms distributed to the client if the client is given condoms and is a new client.

New Clients F-T: In this column the IBD should record the number of foaming tabs distributed to the client if the client is given foaming tabs and is a new client.

Revisit Pills: In this column the IBD should record the number of cycles of pills distributed to the clients if the client is given pills and is not a new client.

Revisit Cond: In this column the IBD should record the number of condoms distributed to the clients if the client is given condoms and is not a new client.

Revisit F-T: In this column the IBD should record the number of foaming tabs distributed to the clients if the client is given foaming tabs and is not a new client.

Ref. FP: In this column the IBD should record when a referral is made to a clinic for a family planning method, i.e. the client is expected to become an acceptor of some method after the visit to the clinic. Each referral is marked with a "1". This column is also used to record all clients referred for counselling on methods.

Ref. Side: This column is used to record any client referred to the clinic who are complaining of side effects. (using a "1")

Ref. Exam: This column is used to record all referrals for examination. For example, when IBDs are distributing oral contraceptives the clients should still be required to visit the clinic for a proper check-up and examination once a year. (Assuming that there are no complications or side-effects).

Ref. STD: This column is used to record all referrals for reasons of STD.

Ref. Other: This column should be used to record all other referrals to the clinic. e.g. for other reasons can be for MCH, or any of the curative services.



## **FLAS Supervisors Monthly Report**

The supervisors monthly report will require modification to take into consideration the changes to the IBD's Daily Report. Outlined on the next page is a sample Supervisors monthly reporting form.

**Name IBD:** This column is used to record the name of the IBD.

**New Acc:** Columns 2,3 and 4 are used to record the number of new acceptors to modern methods of family planning. There are three columns to record new acceptors by method (pills, condoms, and foaming tablets). To complete this column the supervisor must count the number of new acceptors for each method. Essentially, the IBD record both new acceptors to condoms and new acceptors to foaming tablets. They are not expected to supply oral contraceptives to new acceptors of FP.

**New Clients:** Columns 5, 6 and 7 are used to record the number of new clients to the IBD by method.

**Revisit Clients:** Columns 8, 9 and 10 are used to record the number of revisits carried out by method. A revisit constitutes a resupply of contraceptives.

**Referrals by Method:** Columns 11 - 15 are used to record the referral that are made by the IBD by type of referral. For example, all clients referred to the clinic so that they can receive a contraceptive method are recorded in the first column "FP". The second column is used to record all clients referred because of complaints of side-effects. The third column is used to record all clients referred for examination, e.g. pill clients who are receiving their supplies from the IBD may need to go for an annual check-up (examination) at the clinic. The fourth column is used to record the referrals for STD and the fifth and final column is used to record all other referrals such as MCH etc.

**IEC Talks:** This column is used to record the number of IEC talks conducted by the IBD. It is not necessary to include the topics of the IEC talks only the actual number of talks given.

**Number of Participants:** The last column on the form is used to record the number of participants at each of the IEC talks.

**Other Key Issues:** One of the observations made during the assessment is that although there is a lot of quantitative information recorded and reported on the IBD project, there is very little qualitative and programmatic information.

**Recommendation:** Each month the project supervisor should attach a single page comments section to the monthly report. This comments section should identify any constraints encountered during the month as well as highlight any specific initiatives (consistent with workplans) and any successes. This can then be used to identify critical issues (that may require additional supervision) that need to be addressed by FLAS and provide information on lessons learned that need to be shared with other sites and FLAS in general.



## **IBD Selection Criteria**

The selection of IBDs has been identified as a possible area of weakness in the project. Although some selection criteria has existed it has not been formalized to the extent that the industries have applied it to their process of selection. A study carried out in September 1993 by the R&E unit of FLAS "Industry Based Distributors (IBDs) Profile and FP Commodity Distribution Report" looked at several of the factors which influence the performance of the IBDs. This report has been supplemented by a recent data gathering exercise carried out by the R&E unit which conducted over 40 interviews with IBDs and four focus group discussions with IBDs and supervisors. The September 1993 report has also been updated with complete 1993 data. These studies and discussions with the Industry Project staff are summarized below as recommendations [selection criteria] to the sub-projects:

### **Education:**

The IBDs need to be able to read and write so that they can make full use of the IEC materials in the project and report accurately on the activities that they carry out.

There is no clear evidence that higher education means overall better performance. However, IBDs need to be selected from different cadre within the companies so that they are primarily addressing the range of health and reproductive needs of their peers.

### **Sex:**

1993 data shows that female IBDs have a slightly higher average performance in both the distribution of condoms and foaming tablets than their male counterparts. It is possible that this will become more evident in the distribution of oral contraceptives as well.

**Recommendation:** Maintain a balance between the male and female IBDs which reflects the composition of the target population (i.e. the number and sex distribution of the potential clients in the catchment area).

### **Age:**

The 1993 data shows that IBDs between the ages of 40 and 44 years are the most productive distributors of foaming tabs and condoms. However, it may not be productive to exclude younger or older IBDs who may be able to reach peer groups (albeit smaller groups to start with) more easily. What can be said about 1993 data is that;

- There is no clear correlation between age of IBD and mean condom distribution.
- There is some correlation between age of IBD and mean foaming tablet distribution.

### **Family Planning Practice (IBDs as users of modern FP):**

This indicator has not been reviewed in the studies carried out by FLAS. However, experience from other countries show clearly that community distributors who are also users of modern methods of FP outperform non-users by a significant margin. The project feels confident enough to make the recommendation that IBDs be users of modern FP. [For male IBDs this can be translated to mean either condom user or for married males, that their wives use a modern method].

### **Communication Skills:**

The service provider must be able to communicate with his/her target population. However, this skill (or lack there of) may be difficult to identify without observing the IBD in practice. It is also a skill that can be developed through training where the service providers ability improves as his/her knowledge of the topics increases and more experience in communicating with the target population is gained.

### **Qualitative Indicators:**

A number of qualitative indicators are considered important in influencing the performance of the IBDs. These indicators are primarily based on the perceptions of the service providers. For example, a number of indicators were identified during focus group discussions with the IBDs and are summarized below:

#### **Respect and Standing in the Community**

Interviews and discussions with IBDs indicate that the behavior of the IBDs such as setting good examples for the clients to follow, plays an important part in how effective an IBD can be in recruiting and maintaining clients. It is also important not to confuse popularity with respect and standing in the community.

#### **Commitment:**

IBDs should be selected on the basis of their commitment to the goals and objectives of the program. When an IBD is new, commitment is really willingness to work as an IBD. Later, commitment is really measured by quantitative indicators; is the IBD performing? In other words, commitment translates into action which leads to programmatic results. The Industry Based Program needs (already identified as a need by the program managers) to focus attention on IBDs who are committed and able to perform. An IBD may be very willing but not able to take the time off to perform the duties required by the program, in which case another IBD with time - and/or stronger commitment should be selected.

#### **IBD Selection and Discharge Process**

The process of selecting an IBD is as important as the actual criteria that is used in the selection process. Two key issues have also emerged in discussions with the project

supervisors and the industry project staff: a) how to "get rid of" non-performing IBDs and b) how to allow those IBD who have volunteered their services for a number of years to freely leave the IBD activities. The following recommendations are made on the selection and de-selection process:

- an initial recruitment drive should be made after which a panel made up of the project supervisor, senior medical officer, union representative (if there is one) and a representative from FLAS industry project will form a panel for the selection of the IBDs to be trained. Under certain circumstances it may be useful to include a village representative (elder). A greater number of IBDs should be selected for training than the industry actually needs. This will allow the de-selection of non-performers after the training.
- the training - probation period should extend through the first three months after the first training session.
- the performance of the IBD should be closely monitored during the first three months with the supervisor carrying out at least one on-site supervisory visit to observe the communication and counselling skills.
- a three month performance evaluation should be carried out and non-performing IBDs should be thanked for their interest and not confirmed as IBDs. Any equipment handed out to the IBDs should be returned.
- the remaining IBDs should be told that they are volunteering for a period of two years after which they will be asked if they would like to continue to function as IBDs. They will receive a certificate of appreciation and possibly some other token of appreciation after successful completion of two years of service.
- there will be an annual performance evaluation where the main indicator will be the quantitative output of the IBDs. Non-performing IBDs will be thanked for their contribution and asked to leave the project so that a performing IBD can be selected. This weeding out process should be carried out at the end of every year.
- new IBDs need to be selected to replace the non-performing IBDs and the IBDs who are retiring from the voluntary work of the IBD.
- IBD training should be institutionalized so that the industry can recruit and train IBDs as the need arises. The project supervisor is the logical trainer for the IBDs. Whenever possible, staff from the FLAS training unit should assist the project supervisors to gain the skills necessary to conduct the in-house training of IBDs.

## **IBD Performance Criteria**

Currently the only method to evaluate IBD performance is by the absolute figures presented in the service statistics. As mentioned on page 5, the lack of a formal system to record project supervisory observations and interventions exacerbates the difficulties in assessing the IBDs performance.

Outlined below is a concept for a system for the supervisors to maintain written records of all supervisory observations and interactions during the year.

The purpose of the personnel notebook system is for the supervisor to keep a written record of all staff members he/she supervises and to record all significant observations and interactions with them. In addition, the personnel notebook should record the observations made of their performance and include such dimensions as the quality and accuracy of their record-keeping and reporting etc. Furthermore, include any additional information that will enable better supervision of staff. The personnel notebook is also intended to facilitate the evaluation of staff performance, both personal and the supervised staff. Supervisors should be able to review the records kept to determine not only the frequency of interactions with the staff, but also the type of feedback and support provided to staff.

### **Content:**

The personnel notebook system uses a small hardcovered notebook to record personal particulars and observations. Outlined below is the standard format that we would like followed when using the notebook.

- a). Write your name and title on the inside cover sheet of the notebook.
- b). List all the staff members that you supervise (in alphabetical order).
- c). Allocate an equal number of pages for each employee using nearly the whole notebook but leaving enough space to add additional staff members who may join during the year. Remember that you will be using a new notebook every year (storing the old notebook at the end of the year).
- d). Record the following personal data of each employee you supervise: Name: Personnel Number: Age: Start Date: (approximate if necessary). For IBDs, include Parity, and Current Method of FP:
- e). The first step in using the personnel notebook is to write down the individual performance objectives for each person you supervise. This should be done at the beginning of each year. For example if you are supervising an IBD you would set targets for New Acceptors to FP, New Clients, Revisits, CYP, Referrals and IEC activities. In a sense, these are personalized targets set by the supervisor and IBD together. Every IBD will not necessarily have the same target. For example, one IBD may be working in a area where there are few female employees and/or where

there are very few female dependents living in the village. It would be unrealistic to expect the IBD to easily recruit female clients for foaming tablets, or refer many female clients to the clinic. Another factor that must be taken into consideration when setting targets is the past performance of the employee. It is not productive to set a target which is so unrealistic that the employee (IBD) will be de-motivated by the fact he/she cannot reach the target. Neither do you want to set average targets for high performing employees. It is important to remember that the role of the supervisor is to help the employee perform his/her job more effectively and efficiently. This is accomplished by continuously providing on-site support, training, and motivation.

- f). Every time a significant observation is made about an employee it should be recorded in the notebook. It is difficult to predetermine what is significant or insignificant. However, below are some examples of events that should be recorded and some events that should not be recorded in the notebook; for example, if you are supervising a IBD you should record:
- late reporting, errors (e.g. incorrect tabulation) in the data recorded,
  - anomalies in the data (e.g. a large number of IEC talk and a high number of participants at these talks but very few clients; or if too few or too many contraceptive commodities are on average being distributed to the clients),
  - low performance (e.g. few clients, few IEC talks etc.),
  - observations that you make about the quality of the IBDs work (e.g. as seen during a supervisory visit such as how well or poorly the IBD communicates with the clients, etc),
  - positive and negative feedback from clients,
  - high or significantly improved performance;

If you have noted on one monthly report that the performance of the IBD is low, it should be recorded in the notebook and most importantly, communicated to the IBD. The reason for the low performance should be determined during the supervisory contact with the IBD and recorded, and the supervisor's advice/recommendations (to the IBD) on how to improve performance should also be recorded in the notebook.

The following month the supervisor should make a point of monitoring the performance to determine if it has improved. If additional recommendations or admonitions need to be given they should also be recorded.

It is very important to record the date of each observation/ recommendation and each interaction between the supervisor and the supervisee.

Every supervisory visit to an IBD must be recorded and include the date and purpose of the visit.

You should NOT record gossip or non-work related matters and it is NOT necessary to record long narrative descriptions about each supervisory contact. Routine matters should not be recorded (e.g. the fact that the IBD attended a staff/IBD meeting or that the IBD is performing what she/he is supposed to do as part of the job).

**Note:** If there is an immediate supervisor the senior PO PSU who is supervising the IBD supervisors will use a similar criteria when recording the performance of the IBD supervisors. For example, by periodically reviewing the supervisors' notebook (i.e. the notebooks kept by the supervisors to record the performance of the IBDs), observations should be made and recorded about the quantitative (e.g. number of supervisory visits) and qualitative (e.g. type of recommendations made to the IBDs) aspects of the supervisors work. For example:

- is the supervisor identifying issues and problems with the IBDs?
- is she/he making good, useful recommendations to the IBDs?
- is the average performance of the IBDs she/he is supervising increasing?

### **Supervisory Structure:**

With a need to intensify supervision it will not be possible for the project supervisor to spend sufficient time with each IBD if she/he is supervising too many IBDs. The recommendation is therefore that each project supervisor select a number of immediate supervisors and train them to provide more intensive interaction with the IBDs. It is difficult to know exactly how many IBDs a supervisor should have but the project may want to try a 10 to 1 ratio (ten IBDs to every immediate supervisor) and then assess the impact and performance after a year to see if the number is too small or too large.

**Selecting Immediate Supervisors:** The selection of an immediate supervisor should follow similar criteria as that for the selection of the IBDs. In on-going industry project sites, senior IBDs should be selected using similar IBD selection criteria. Furthermore, the performance of the IBD can be used as an indicator of selection. The following issues need to be considered in deciding the selection of immediate IBD supervisors:

- There is a need to select good performers who are liked and respected by the other IBDs.
- IBD supervisors should continue to work as IBDs.
- The need to develop job descriptions for the IBD supervisors.
- Promotion to an IBD supervisor may be used as a system of motivation, higher status etc.
- IBD supervisors need to be trained in supervision - they will become the front line who in-turn will provide on-site training of the IBDs. For

example, during an update training workshop you would train the project supervisors and the IBD (immediate) supervisors. They will return to their sites and conduct training sessions for the IBDs.

- The primary function of the immediate supervisor is to help the IBD perform his/her job more effectively and efficiently.
- New industries may want to wait 6 months to determine the performance of the IBDs before selecting any immediate supervisors.

**Assessing the performance of the immediate supervisor:** The project supervisors will use a similar criteria when recording the performance of the IBD supervisors. For example, by periodically reviewing the supervisors notebook (i.e. the notebooks kept by the supervisors to record the performance of the IBDs), observations should be made and recorded about the quantitative (e.g. number of supervisory visits) and qualitative (e.g. type of recommendations made to the IBDs) aspect of the supervisors work. For example:

- is the supervisor identifying issues and problems with the IBDs?
- is she/he making good, useful recommendations to the IBDs
- is the average performance of the IBDs she/he is supervising increasing?

## **Supervisory Systems**

During the field visits carried out in early July 1994 to review the MIS one of the strategic issues identified was the weakness of the current supervisory system(s). To address this issue, this questionnaire was administered to the project supervisors (incl. four members of staff from FLAS<sup>12</sup>) during a one day workshop to try to collect some background information on what parts of the system function well and which parts of the system may need to be changed or eliminated. This information will be used to help design a training course on supervision for project supervisors and senior managers at FLAS.

A series of specific and open-ended questions were asked to seek the opinion and perception of the supervisory systems from the point of view of how the project supervisor is supervised, and from the point of view of how the project supervisor supervises other members of staff.

The questionnaire (package) is made up of four sections:

- Section 1. A single open-ended question that solicits the opinion of the interviewee on his/her perception of the current supervisory system.
- Section 2. A series of questions aimed at determining some of the dimensions of the current supervisory system.
- Section 3. A separate questionnaire that solicits the perception of the interviewees on how they are supervised.
- Section 4. A separate questionnaire that asks the interviewee how they supervise other members of staff.

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<sup>12</sup>. See Appendix for workshop agenda and list of participants

## Section 1.

**Question: How well do you feel that the supervisory system is working? In particular, is there anything that you feel is wrong with the system and anything that you feel is good about the system?**

**Responses:** Out of 13 respondents the following was noted:

- 5 respondents stated that the supervisory system is not working well;
- 4 respondents stated that the supervisory system is working well;
- 3 respondents stated that the supervisory system is working fairly well but could do with some improvements.

### **Responses Related to the System Not Working**

**The following reasons were listed to describe why the system was not working well:**

- a). There is no formal training before one assumes supervisory responsibilities.
- b). No real introduction of supervisor to subordinate before taking up responsibilities.
- c). Supervision is not a fixed, planned or continuous activity.
- d). There is not enough time for supervision.
- e). There is too much writing reports.
- f). No clear guidelines on how supervision should be carried out.
- g). The role of FLAS in supervision is not always clear.
- h). Supervision is carried out on a very adhoc basis - lack of continuity.
- i). Poor record keeping - reporting.
- j). Information is not reaching the right people (in time or at all).
- k). The scope of work (roles and responsibilities) is not always well defined.

## Section 2. Supervisory System Checklist

Seven questions were asked to ascertain the extent to which the supervisory system benefits from institutional support. Although the process of completing the questionnaire with a score that corresponds to the respondents opinion on the accuracy and/or completeness of the statement(s) does not lend itself easily to any form of statistical analysis, it does allow us to make some inferences and draw some conclusions about how the system works. No attempt has been made to calculate an average score for each question.

Questions:	Response:
Q1. Does your system have clearly delineated lines of authority and well-defined supervisory levels?	The majority (7 out of 13) of respondents stated that this is only partly true. 5 respondents stated that it is completely true, while 1 respondent did not know.
Q2. Does your system clearly describe appropriate supervisory procedures and provide tools for effective supervision such as guidelines, job descriptions, and supervisory protocols?	6 out of 13 respondents stated that this is only partly true. 4 respondents stated that it is not true while 3 respondent stated that it is completely true.
Q3. Do managers at all levels receive and use data generated by the supervisory system?	5 respondents stated that this is completely true. 3 respondents felt that it is not true while 2 respondents stated that it is only partly true. 3 respondents did not know.
Q4. Do senior managers within the organization understand how the supervisory system functions and how it <i>should</i> function, in order to improve quality and bring about desired outcomes?	6 respondents stated that this is true. 3 respondents stated that it is not true while 1 stated that it is partly true. 3 respondents did not know.
Q5. Do staff members at all levels of the organization understand the importance of supervision in achieving organizational goals?	A majority of the respondents 8 out of 13 stated that this is only partly true while 3 stated that it is not true. 2 respondents stated that it is true.
Q6. Is there an operational unit within your organization that has the responsibility for planning, implementing, and monitoring supervisory activities?	5 respondents stated that they do not know. 5 respondents stated that this is true.
Q7. Are adequate resources allocated in your annual budget to carry out supervisory activities and to maintain the supervisory system?	5 respondent answered "don't know" while 4 stated that this is only partly true. 2 respondents stated that this is true while 2 stated that it is not true.

## **Section 2: Key Issues**

The responses to the questions in section 2 raises the following issues:

- Q1. Do job descriptions and organizational chart need to be reviewed and/or clarified in relation to supervisory responsibility?**
- Q2. Do additional supervisory tools need to be developed?**
- Q3. Do managers at different levels need to improve the use of information generated by the MIS?**
- Q4. Would managers benefit from additional training in using information for decision making?**

### Section 3: Assessing How You are Supervised.

Eleven questions were asked to determine the respondents' perceptions on how they are supervised. Each question represents a desired mode of behavior for a good supervisor. For example, (question 1) supervisors should always try to give sufficiently complete and specific instructions about what they expect from the people they are supervising.

In this section an average score for each question has been calculated. To interpret the score for each question, the closer the score is to 1 the more likely it is that the respondent agrees with the question or statement. For example if the average score is 1, then each respondent has answered "Always" to the question. Shown below is the scale used to rate each question.

- 1 = Always
- 2 = Sometimes
- 3 = Very Seldom
- 4 = Never

#### WHEN YOU ARE SUPERVISED:

Questions:	Average Score:
Q1. Do you feel that you are given sufficiently complete and specific instructions about what you are expected to do in your work?	[1.69]
Q2. Does your supervisor explain targets, deadlines, and dates for activities in advance?	[2.15]
Q3. Does your supervisor admit his/her own mistakes?	[2.38]
Q4. Do you get all the support you need from your supervisor?	[1.92]
Q5. Does your supervisor delegate responsibility appropriately?	[1.92]
Q6. Do you trust your supervisor to always treat you fairly?	[2.33]
Q7. Does your supervisor recognize merit when it is warranted?	[2.46]
Q8. Do you feel that your supervisor deals with problems in an honest and straightforward manner?	[1.69]
Q9. Do you feel that your supervisor gives you opportunities to participate and use your own initiative?	[1.85]
Q10. Do you feel that your supervisor gives the real reasons for problems or decisions?	[2.23]
Q11. Do you feel that your supervisor helps you do your work more effectively and efficiently?	[2.15]

#### Section 4: Assessing how you supervise.

Twelve questions are asked to determine the respondents perception on how they supervise. Analogous to the previous section, each question represents a desired mode of behavior for a good supervisor. For example, (question 1) supervisors should never scold a member of staff in the presence of another. In this section no attempt has been made to calculate an average score for each question. Instead, the answers to each question has been reviewed and commented on in the right-hand column of the table below:

#### WHEN YOU SUPERVISE HAVE YOU EVER:

Questions:	Response:
Q1. Have you scolded a staff member in the presence of others?	5 out of 13 respondents felt that they might have done this without thinking of the consequences. 5 stated that they never do this. One respondent said that he/she has done it but very seldom. Two respondents feel that they do not do this enough.
Q2. Do you ever show favoritism toward certain employees?	6 respondents stated that they never do this. 3 felt that they might have done it without thinking of the consequences. 2 stated that they had done it but very seldom while one person stated that he/she did it too often. 1 respondent felt that she/he did not do it often enough.
Q3. Have you ever blamed a staff member for your own mistake?	A majority of the respondents (8 out of 13) stated that they never do this. 2 respondents felt that they might have done this without thinking of the consequences. 3 respondent stated that they do this but very seldom.
Q4. Do you ever discuss personal matters of a staff member?	5 respondents felt that did not do this enough. 4 respondents stated that they never do this while 2 respondents stated that they might have done this without thinking of the consequences while 2 stated that they did this but very seldom.
Q5. Do you provide excessive supervision by being too vigilant, checking even unimportant details?	5 respondents stated that they never do this. 2 respondents stated that they do this but very seldom. 3 respondents stated that they without thinking of the consequences while 3 respondents felt that they did not do this enough.

Q6. Do you gossip with one employee about another?	5 participants stated that they never do this. 4 respondent stated that they might have done this without thinking of the consequences while 2 respondents felt that they did this but very seldom.
Q7. Do you react negatively to a staff members' ideas?	A majority of the respondents (8 out of 13) stated that they never do this while 1 felt that they might have done this without thinking of the consequences. 3 respondents stated that they don't do this often enough!! while 1 respondent stated that they do this but very seldom.
Q8. Do you give your staff an opportunity to participate and use their own initiative?	A majority of the participants stated that they did this too often!. 2 respondent stated that they did this but not often enough while 3 respondents stated that they do this but very seldom.
Q9. Do you give your staff the real reasons for problems or decisions?	5 participants stated that they did this too often! 4 very seldom and 4 not enough.
Q10. Do you attempt to see the supervisee's point of view?	A majority of the participants stated that they did this too often! 2 very seldom. 2 not enough and 1 respondent stated that they never do this.
Q11. Do you trust your staff members?	4 participants stated that they did this too often! 4 very seldom. 4 not enough and 1 never.
Q12. Do you delegate responsibility appropriately?	A majority of the participants (9 out of 13) stated that they did this too often. 2 very seldom. 1 never and 1 not enough.

## Final Word

There are several activities that need to be carried out to improve the current supervisory systems. One of the activities will be the development of a more systematic approach to supervision where supervisory observations and interventions are recorded. This will enable supervisors to more easily review supervisory interventions and relate them to performance. The two questions that need to be answered by the supervisor are; am I observing the factors which have an impact upon performance? and secondly, am I helping the supervisee improve-perform his or her job more effectively and more efficiently? The participants of the one day workshop agreed that many of the changes that need to take place relate to a change in attitude toward supervision as well as the development of some tools to facilitate the process of supervision.

## Next Steps

Several recommendations have been made in this report to modify the formats for data collection and reporting. In addition, some changes to the supervisory system have been proposed. Outlined below are a series of activities that need to be carried out to implement the recommendations in this report:

1. FLAS should review the draft report and provide comments and feedback that can be incorporated before the report is finalized. This should be accomplished by mid-August.
2. Any changes, modifications and/or recommendations will be incorporated into the final report. [1 week after draft review is completed]
3. New FLAS Clinic Register/Report finalized and printed (limited number for field testing).
4. A separate set (document) of detailed instructions for the clinics and IBD formats will be compiled.
5. R&E unit will provide on-site training of Register/Report to FLAS clinic staff.
6. Field testing should be carried out for at least two months before a complete review is carried out by the R&E unit. New clinic Register/Report is introduced to all industry (project) clinics. This can be accomplished by training the project supervisors who in-turn will be responsible for introducing the new formats to the clinics.
7. New IBD Register/Report is finalized and printed (limited number for field testing).
8. New IBD Register/Report is introduced to the IBDs who will distribute oral contraceptives. They will field test the register for a period of at least two months before a review is carried out by the R&E unit. New IBD Register/Report is introduced to all IBDs and to the CBDs. This can be accomplished by training the project supervisors who in-turn will be responsible for training the IBDs.
9. The implementation process should be closely monitored by R&E (requesting the project supervisors to highlight all implementation issues for the first couple of months). Follow-up visits should also be carried out to selected sites (both clinics and IBDs).
10. A 3 - 4 day workshop on supervision should be carried out for FLAS managers and project supervisors. During this workshop participants will review and discuss the "Personnel Notebook" system.
11. A 3 day workshop on MIS-Monitoring and Evaluation should be carried out for FLAS managers and project supervisors. The objective will be to improve the

utilization of information to improve the effectiveness and efficiency of the program and will also build upon the workshop on supervision.

12. The R&E unit will design new streamlined management and feedback reports on the basis of new indicators. The majority of feedback reports to the industry project should be graphical representation of comparative and trend analysis. (Pathfinder will assist in the design of new feedback reports).
13. Project Supervisors should be asked to attach a one page comment section to the monthly report from the industry project. The comment section should highlight specific events that have taken place during the month, what has worked particularly well and what has not worked, and what action has been taken to resolve these problems. Proposed start date: **immediately** so that the reports can be reviewed during the MIS workshop.
14. Adjustments should be made to the existing database(s) so that the new indicators can be incorporated. After completion of the field testing phase of the new clinic and IBD formats, the two existing computer applications should be merged to form one application. This application should also include the new VSC indicators. The new application should form the basis for an executable program that can be distributed to the industries to enter their own data and generate their own management reports<sup>13</sup>. FLAS HQ will receive the monthly data in the form of diskettes and thereby substantially reduce the volume of data entry.
15. Any new computer application should include a data base file of the baseline data for each industry. This should also include fields for the annual targets. This will enable the R&E unit to use the baseline data and target data on a regular basis (e.g. quarterly) to see if both individual sub-projects and the whole project is meeting its objectives. [Prior to the development of a new database, the R&E unit should develop a spreadsheet application to generate comparative reports on a quarterly basis].
16. The R&E unit should conduct a review of the commodity logistics system (outlined above) and introduce a simple, quarterly commodity report for the clinics.
17. A review of the implementation activities should be carried out at the end of six and twelve months. (Follow-up Report).

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<sup>13</sup>. Two of the industries visited during the field work expressed a willingness and ability (computers and capacity) to enter the data.

## Appendix I

- List of Participants
- Workshop Topics
- Work Schedule

# ***FAMILY LIFE ASSOCIATION OF SWAZILAND***

***IBDs MIS ISSUES SEMINAR - GEORGE HOTEL - MANZINI***

***20/07/94***

## ***LIST OF PARTICIPANTS***

	<b><i><u>NAME</u></i></b>	<b><i><u>ORGANISATION</u></i></b>
1.	<b><i>DOROTHY DLAMINI (MRS)</i></b>	<b><i>MMS</i></b>
2.	<b><i>BOYBOY MNDZEBELE (MR)</i></b>	<b><i>UPCO</i></b>
3.	<b><i>THOBILE DLAMINI (MRS)</i></b>	<b><i>FLAS</i></b>
4.	<b><i>THEMBI MVUBU (MS)</i></b>	<b><i>FLAS</i></b>
5.	<b><i>RODGERS MDLULI (MR)</i></b>	<b><i>SHISELWENI FOREST</i></b>
6.	<b><i>THULI MTHEMBU (MISS)</i></b>	<b><i>TAMBANKULU</i></b>
7.	<b><i>JOSEPHINE MATSEBULA (MRS)</i></b>	<b><i>UBO</i></b>
8.	<b><i>BUSISIWE MAVIMBELA (MRS)</i></b>	<b><i>FLAS</i></b>
9.	<b><i>SIMISO MOYO (MRS)</i></b>	<b><i>OHS</i></b>
10.	<b><i>NOMSA FAKUDZE (MRS)</i></b>	<b><i>FLAS</i></b>
11.	<b><i>NICODEMUS TUMALAETSE (MR)</i></b>	<b><i>PROTEA</i></b>
12.	<b><i>IRENE NXUMALO (MRS)</i></b>	<b><i>SIMUNYE</i></b>
13.	<b><i>THOKO DLAMINI (MRS)</i></b>	<b><i>NATEX</i></b>
14.	<b><i>HELEN SHABANGU (MRS)</i></b>	<b><i>UBO</i></b>
15.	<b><i>KHOMBI NKONDE (MRS)</i></b>	<b><i>FLAS</i></b>
16.	<b><i>THOBILE MKHONTA (MISS)</i></b>	<b><i>NGONINI ESTATE</i></b>
17.	<b><i>MUSA MDLULI (MR)</i></b>	<b><i>FLAS</i></b>
18.	<b><i>PETER SAVOSNICK (MR)</i></b>	<b><i>P/FINDER - AFRICA REGION</i></b>

## FAMILY LIFE ASSOCIATION OF SWAZILAND

**IBD SELECTION CRITERIA STUDY CONSULTANT'S (MR. PETER SAVOSNICK)**

**WORK SCHEDULE (JULY 11 - 26, 1994)**

<b>DAY OF WEEK</b>	<b>ACTIVITY</b>	<b>TIME</b>
<b>MONDAY 11/07/94</b>	- Briefing meeting with FLAS - Review of available literature	<b>8AM - 1PM 2PM - 6PM</b>
<b>TUESDAY 12/07/94</b>	- Briefing meeting with USAID - Visit all FLAS clinics	<b>9AM - 10AM 11AM - 4.30PM</b>
<b>WEDNESDAY 13/07/94</b>	- Visit Shiselweni HL&H and Shiselweni Forest Project Sites	<b>9AM - 5PM</b>
<b>THURSDAY 14/07/94</b>	- Visit MMS - Meet Dorothy at IYSIS - Meet Dr. Gilbertson at Mhlume - Meet IBDs at IYSIS	<b>11AM 11.30AM 12 NOON</b>
<b>FRIDAY 15/07/94</b>	- Visit Ubombo Ranches	<b>10AM</b>
<b>MONDAY 18/07/94</b>	- Data analysis and Report write-up	<b>8AM - 5PM</b>
<b>TUESDAY 19/07/94</b>	- Data analysis and Report write-up	<b>8AM - 5PM</b>
<b>WEDNESDAY 20/07/94</b>	- Review of Reports & Registers	<b>9AM</b>
<b>THURSDAY 21/07/94</b>	- R & E Discussions	<b>8AM - 5PM</b>
<b>FRIDAY 22/07/94</b>	- Public Holiday	
<b>MONDAY 25/07/94</b>	- Review of contraceptive procurement	<b>8AM - 5PM</b>
<b>TUESDAY 26/07/94</b>	- Debrief with USAID - Debrief with FLAS	<b>8AM - 5PM</b>

**FAMILY LIFE ASSOCIATION OF SWAZILAND**  
**PRIVATE SECTOR PROJECT**

**IBDs AND CLINICS SUPERVISORS ONE DAY SEMINAR ON MIS ISSUES**

**29/07/94**

**LIST OF ACTIVITIES TO BE DISCUSSED**

- 1. IBDs Selection Criteria**
- 2. Evaluating IBDs performance**
- 3. Programmatic changes that will impact upon MIS**
- 4. Improvement of programme service data use (feed back mechanism)**
- 5. Strengthening of IBDs supervision**

**NOTE:** *Seminar proceedings will commence at 10.00 am until 4.00 pm at the New George Hotel - Manzini. Lunch will be served.*

# Appendix II

## Family Planning Registers and Reports

## Observations on FLAS Clinics Registers and Reports

Outlined below are the FP registers and reports currently in use at the FLAS clinics. Attached at the end of this appendix are copies of the existing Daily FP Register/Report, IBD Monthly Register/Report and the Project Supervisors Monthly Register/Report.

### Clinic 1

**Register 1. Daily Register.** This register is kept at the reception and entries are made as the client is served by the receptionist. The last column of the register "Method" is completed after the service has been provided. This information is provided by the FP Nurse. Both FP and non-FP services are recorded in the last column.

Date	Consecutive numbering	Name	Age	Sex	Address	Method (service provided)
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**Register 2. New Acceptor Client Register.** This register is used to record new clients to the clinic. Entries are made by the receptionist when she talks to the client.

Date	Client Number	Name	Address
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Notes: All new clients are recorded in this register, however condom clients are given a client number without recording either their name or address. They are not recorded on a client card.

### Other Registers

The FLAS clinics also maintain a number of registers to record other the other activities of the clinic. These are listed in the table below and although there are some variations in the format they are similar for all the three FLAS clinics.

Additional Registers kept in the FLAS clinics	
•	Daily Register/Report
•	Receipt Book. (The receipt book is used to record all monies collected)
•	Pap Smear Register
•	Pregnancy Test
•	STD Client Register
•	STD Treatment Book
•	Referral Book
•	Doctors Book

## Reports

The two main reports from the FLAS clinic to headquarter is the "Daily Register/Report" which reports the family planning information, and the MOH Outpatient Report. They are used in all the three FLAS clinics.

### CLINIC 2

#### Register 1. Client Register

Date	Consecutive Number	Name	Age	Sex	Address	Return Date	Treatment	Service Given
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Register 2. Family Planning Register: Note that this register runs across two pages:

#### Page 1

Date	Consecutive Number	Name	Age	Sex	Client # <sup>14</sup>	Address
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#### Page 2

Marital Status	Parity	Children Alive	Children Dead	Method	Quantity	Return Date	Remarks
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### CLINIC 3

#### Register 1. Client Register

Date	Consecutive number for Month	Consecutive number for Day	Name	Age	Sex	Address	Reason for Visit
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#### Register 2. New Acceptor Register

Date	Client number	Consecutive number for Day	Name	Age	Sex	Address
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<sup>14</sup>. New Client numbers are marked in red ink.

## Ubombo Ranches Hospital

The Industry Project clinics also use the FLAS Report/Register to record all FP clients served. A review of the clinic registers showed that the clinic used one register in addition to the FLAS register to record clients. This register is shown below:

### Client Register:

Date	Serial #	Name	Age	Address	Visits	Method	Date of Return
------	----------	------	-----	---------	--------	--------	----------------

Serial #: the serial number is a consecutive number from the beginning of the month.

Visits: in the visits column the FP-Nurse records "R" if the client is a revisit and the client # (e.g. 112/93). "1st" if the client is new and the client # that is issued, (this is recorded in red ink). The FP-Nurse will also record "Visitor" for those clients coming from another clinic who are not expected to return as regular clients.

Method: in the method column the FP-Nurse will record the method given and the amount distributed.







# Appendix III

Background on Industry Based Distributors

Profile Study

## Background to the Industry Based Distributors (IBDs) Profile Study

### Introduction

The IBDs are a component of FLAS' Industry Based Family Planning and AIDS project. The IBDs are industry personnel who volunteer to be trained by FLAS so that they can help during their spare time in the distribution of non-prescriptive contraceptives and the resupply of oral contraceptives in their respective companies of employment.

The Industry-based FP/AIDS project is still at pilot stage and operates in eight large industries, viz; Mhlume sugar company, IYSIS, Cargo Carriers, Mananga, Vuvulane, Ubombo Ranches, Tambuti and Usutu Pulp Company. IBDs of each company are chosen by the individual company's management then submitted to FLAS for training.

No documented IBD selection criteria for IBDs is in place to this day; people just volunteer. It is generally preferred that they can read and write and have a reputable social standing in their respective communities.

### Mananga Medical Services (MMS)

This is a medical centre for five other companies which belongs to the project. These companies are Mhlume company, IYSIS company, Vuvulane Irrigated Farms, Mananga Agricultural Management Centre and Cargo Carriers.

MMS has fifty-eight registered IBDs (as of 3rd May 1993) and one IBD supervisor and operates three clinics with two doctors. This staff is responsible for the health of about 45,000<sup>15</sup> people, of which 22% is eligible to receive contraceptives.

### Tambuti (TAM)

This company has twenty registered IBDs (as of 3rd May, 1993) and one supervisor. The company has one clinic which is maintained by two nurses. One of the two nurses also serves as a supervisor for the IBDs. This clinic caters for about eight hundred (800) permanent employees which increases to over 1,500 during peak seasons.

### Ubombo Ranches (UBO)

This company has twenty IBDs (Village Health Workers) who are employed to do full time community health work. This is the only company that has employed the IBDs full time. These twenty IBDs are supervised by one nurse supervisor. This company has about 20 000<sup>16</sup> inhabitants of which 22% are eligible to use contraceptives. The company has one hospital and one clinic (at the Mill) served by two doctors.

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<sup>15</sup>estimated figure received from company's management

<sup>16</sup> estimated figure received from company's management

Usutu Pulp Company (UPC)

This company has forty-two registered IBDs (as of 3rd May, 1993) who are supervised by two nursing sisters. This company operates three static clinics and has five sites covered by a mobile clinic. The company has two medical doctors.

The company has a total population of about eleven thousand (11 000) of which 22% are eligible for contraceptives.

Following is a table showing individual company data.

Industries' Data Base

Company	Population	No. of IBDs	No. of supervisors	No. of clinics	No. of doctors	No. of IP nurses
MMS	45 000*	58	1	3	2	3
TAM	800*	20	1	1	0	1
UBO	20 000*	20	1	1	2	2
UPC	11 000*	42	2	3	2	2
TOTAL	76 800	140	5	8	6	8

\* estimated figures.

# Appendix IV

## Personnel Notebook System

**Family Life Association of Swaziland**

**Personnel Notebook System**

**July 1994.**

### **Personnel Notebook**

Outlined below is a draft concept for the development and implementation of a system for supervisors to maintain written records of all supervisory interactions that they have during the year.

#### **Objective:**

The purpose of the personnel notebook system is to keep a written record of all staff members that you supervise and to record all your interactions with them as their supervisor. In addition, the personnel notebook should record the observations that you make of their performance and include such dimensions as the quality and accuracy of their record-keeping and reporting etc. Furthermore, you should include any additional information that will enable you to better supervise your staff. The personnel notebook is also intended to facilitate the evaluation of staff performance, both your own and that of the staff you supervise. Your supervisor should be able to review the records you keep to determine not only the frequency of your interactions with the staff, but also the type of feedback and support that you are providing to your staff.

#### **Content:**

The personnel notebook system uses a small hardcovered notebook to record personal particulars and observations. Outlined below is the standard format that we would like you to follow when using the notebook.

- a). Write your name and title on the inside cover sheet of the notebook.
- b). List all the staff members that you supervise (in alphabetical order).
- c). Allocate an equal number of pages for each employee using nearly the whole notebook but leaving enough space to add a couple of new staff members who may join during the year. Remember that you will be using a new notebook every year (storing the old notebook at the end of the year).
- d). Record the following personal data of each employee you supervise: Name: Personnel Number: Age: Start Date: (approximate if necessary). For IBDs include Parity, and Current Method of FP.

e). The first step in using the personnel notebook is to write down the individual performance objectives for each person you supervise. This should be done at the beginning of each year. For example, if you are supervising an IBD you would set targets for New Acceptors to FP, New Clients, Revisits, CYP, Referrals and IEC activities. In a sense, these are personalized targets set by the supervisor and IBD together. Every IBD will not necessarily have the same target. For example, one IBD may be working in a area where there are few female employees and/or where there are very few female dependents living in the village. It would be unrealistic to expect the IBD to easily recruit female clients for foaming tablets, or refer many female clients to the clinic. Another factor that must be taken into consideration when setting targets is the past performance of the employee. It is not productive to set a target which is so unrealistic that the employee (IBD) will be de-motivated by the fact he/she cannot reach the target. Neither do you want to set average targets for high performing employees. It is important to remember that the role of the supervisor is to help the employee perform his/her job more effectively and efficiently. This is accomplished by continuously providing on-site support, training, and motivation.

f). Every time a significant observation is made about an employee it should be recorded in the notebook (including the date). It is difficult to predetermine what is significant or insignificant. However, below are some examples of events that should be recorded and some events that should not be recorded in the notebook. For example, if you are supervising a IBD you should record:

- late reporting, errors (e.g. tabulation) in the data recorded,
- anomalies in the data (e.g. a large number of IEC talks and a high number of participants at these talks but very few clients; or if too few or too many contraceptive commodities are on average being distributed to the clients),
- low performance (e.g. few clients, few IEC talks etc.),
- observations that you make about the quality of the IBD's work (e.g. as seen during a supervisory visit such as how well or poorly the IBD communicates with the clients, etc),
- positive and negative feedback from clients,
- high or significantly improved performance;

If you have noted on one monthly report that the performance of the IBD is low, it should be recorded in the notebook and most importantly, communicated to the IBD. The reason for the low performance should be determined during the supervisory contact with the IBD and recorded, and the supervisors advise/recommendations to the IBD on how to improve performance should also be recorded in the notebook.

**Routine matters should not be recorded (e.g. the fact that the IBD attended a staff/IBD meeting or that the IBD is performing what she/he is supposed to do as part of the job).**

**Every supervisory visit to a IBD must be recorded and include the date of the visit.**

**You should NOT record gossip or non-work related matters and it is NOT necessary to record long narrative descriptions about each supervisory contact.**

**The following month the supervisor should make a point of monitoring the performance to determine if it has improved, if additional recommendations or admonitions need to be given they should be recorded.**

**The senior PO PSU who is supervising the IBD supervisors will use a similar criteria when recording the performance of the IBD supervisors. For example, by periodically reviewing the supervisors notebook (i.e. the notebooks kept by the supervisors to record the performance of the IBDs), observations should be made and recorded about the quantitative (e.g. number of supervisory visits) and qualitative (e.g. type of recommendations made to the IBDs) aspect of the supervisors work. For example:**

- is the supervisor identifying issues and problems with the IBDs?**
- is she/he making good, useful recommendations to the IBDs**
- is the average performance of the IBDs she/he is supervising increasing?**

# Appendix V

Notes: Developing a System to Monitor and Evaluate

**Family Life Association of Swaziland**

**Developing Systems to Monitor and Evaluate**

**[IN COLLABORATION WITH PATHFINDER INTERNATIONAL]**

A monitoring and evaluation system is the link between planning and reality; It is the way that managers know whether programs which were designed to meet specified targets are likely to accomplish their objectives, or whether some type of mid-course correction is needed to accommodate unforeseen problems or changes in the operating environment. Because of this central role in family planning programs, considerable time and effort must be given to the design and use of a monitoring and evaluation system so that accurate, relevant, and timely information will be produced. This paper presents a step by step process for the development of a monitoring and evaluation system for family planning programs.

A set of standard indicators is recommended for monitoring the various programs within family planning. These indicators, should be chosen based on their simplicity, ease of collection, ability to predict effectiveness and impact, and usefulness to program managers. Managers should choose a number of indicators appropriate to their own needs based on the types of interventions they have chosen and the size and complexity of their programs. Many managers will wish to augment these standard indicators with additional indicators specific to their organizational needs. We believe, however, that despite the heterogeneity of the programs, there is a need to form a uniform data base of family planning programs. It is only through the use of standard definitions and indicators that meaningful comparisons across programs and countries can be made which will allow country managers, and donors to make sound decisions regarding the progress and impact of family planning programs. In addition, the use of standard indicators which have been thoroughly tested and documented will help program planners and managers to develop a workable monitoring system without duplicating the efforts and mistakes of those that have gone before them.

## **II. DESIGN OF A MONITORING AND EVALUATION SYSTEM**

The design of a monitoring and evaluation system is an dynamic process which starts in the project design phase with (SET OBJECTIVES) and goes through a cycle one step at a time until the monitoring and evaluation system is complete, and plans for its use (MAKE DECISIONS & TAKE ACTION) are in place. It is important at each step to remember where you are headed since the outputs of each step become the inputs of the following step. The first four steps in this process are outlined in this paper, (Set Objectives, List Activities, Select Indicators, Set Targets).

While it may seem tedious to go through the steps presented in this section it should be remembered that monitoring and evaluation are fundamental management tools, and often mean the difference between a program which is well planned and accomplishes its objectives and one which is never quite able to impact on the health of its target population. A doctor relies on information about a patient to make decisions about treatment plans and then carefully monitors the patient's status to see if the treatment is successful or if changes are needed. The manager who is responsible for a family planning program should be equally careful to monitor initial program plans and ensure that any unforeseen changes in the operating environment that impact on a family planning program will not go unnoticed and that appropriate changes to the program can be made.

This system provides a model to be used by managers to begin the development of a monitoring and evaluation systems. However, because every country and program are different, and will have different resources available to them, the system will necessarily need to be customized for each program. Therefore, an important part of the development process will be a periodic review of the monitoring system itself for necessary revisions and "debugging." Indeed, the most successful monitoring systems are those that are developed interactively with the system users so that a practical, easy to use system is finally developed.

# Set Objectives

The first step in the process is to set objectives. You must first know where you are going before you decide how to measure your progress along the way. An objective should be measurable and sufficiently limited in scope so that one could logically expect it to be reached within the stated time period. A program will typically have many objectives, and it is these objectives against which the success of the program should be ultimately judged.

An example of an objective for a MCH/FP program might be: "Within our region, to increase the contraceptive prevalence rate from 8% to 15% by the end of the third year of the program." Note that this objective is both measurable and time limited; at the end of three years one could test whether the objective has actually been met.

It is important to remember that each program will have multiple objectives. The objective of an increase in contraceptive prevalence might for example be combined with another for CYP etc. Each program manager will need to decide for him or herself how many and which objectives are appropriate for a particular program.

The mechanics of choosing appropriate objectives are:

First, decide what it is that one hopes to accomplish in a specific program. In the example above, we are trying to increase the use of contraceptives in an industry, or district or province, etc.

Second, ask how much can realistically be done in a given time period. Constraints such as available personnel, cost ceilings, and infrastructure requirements will all limit the possible impact of a program. Again using the above example, a 7% increase was chosen as a target based on some form of knowledge such as current levels of use, past experience in other areas, budget, staff available, and other relevant information.

Finally, choose how you will measure the outcome. Again, using the above example, we might be able to measure current contraceptive use by conducting a survey and then monitor the contraceptive use over time. Obviously, it is a lot harder in reality to set objectives since often accurate data on past experience, or the target population is impossible to obtain. This is precisely the reason that a monitoring and evaluation system is important; to enable managers to know when original estimates are inaccurate and must be corrected.

# List Activities

The second step in the process of developing a monitoring and evaluation system is listing activities. This step represents the programming of activities and is often referred to as an implementation plan. While the selection and listing of activities will obviously vary considerably depending on the type of program which is being implemented, there are a few guidelines which may be helpful in stating those activities for the monitoring and evaluation system.

Each objective will normally have many activities associated with it which need to be successfully completed before the objective will be reached.

An activities list should include all the activities necessary to accomplish a given objective. If important activities are left out, and not monitored, we might think we are progressing satisfactorily towards achieving an objective when, in fact, we are not. For example, if we do not include an activity such as "Provide adequate supplies of contraceptives" we may find that after many months of work to develop a family planning program, we do not have sufficient supplies to stock the clinics and health centers.

Activities, like objectives, should be measurable so that one is able to know, at any point in time whether a stated activity has been successfully completed. Since activities represent the operationalizing of the objective which are measuring in our monitoring and evaluation system, it is critical that we understand how we will actually measure our activities. While the next step SELECT INDICATORS will define the milestones we will use along the way, it is also necessary to have a clear statement of when we have finished an activity. This means that each activity must be measurable.

Each objective should have a separate activities list.

While some activities may overlap among several objectives (such as recruit IBDs for FP and ORT objectives) all activities should be included for each objective to avoid confusion.

An example of one activity for the objective which was stated on the previous page might be: "Train IBD health workers to teach mothers the appropriate and correct use of oral rehydration solution. Another activity should be to train them in basic physiology, how the specific methods they will be distributing work, and effective ways to approach and communicate with people in the community. The training workplan itself will contain a series of objectives that will in turn result in a series of activities; for example: they should also be given information about how the whole IBD program will work, including the resupply and record-keeping systems. Furthermore, a very important part of training is the correct use of checklists to assess the safety of a method for each individual client, and to know when to refer a client to a professional health provider in case of complications or for clinical methods. Both the FP and ORT training can be quantitatively (how many are being trained) and qualitatively measured (such that 90% of IBD workers are able to pass a competency based performance test 6 months after they have completed their training course)."

# Select Indicators

The third step in this process, the selection of indicators, is seen by many as the core of designing a monitoring and evaluation system, since it is the process of defining what it is that will actually be measured during the course of a program. Indicators will have certain characteristics which include:

It must be representative; it must tell us something about the status of a program which will allow better decision making or suggest corrective actions. For example, the indicator: "Number of IBD health workers trained" tells us something about the direct outputs of our training program. If we find we are training inadequate numbers of health workers for our program needs, an expansion of the training program may be required. It must be measurable; since we will use an indicator to measure our status with regard to achieving an objective, it must be possible to know whether we have made any progress since the last time we collected the information.

In many cases this may mean that an indicator should be quantifiable, but some indicators may need to be qualitative rather than quantitative. "Number of health workers trained" is easily quantified, while a measure of the effectiveness of the training may be more appropriately qualitative.

It must be economical; every indicator takes resources of time and money to collect. It is important that we balance the cost of collecting an indicator with the value that we will get out of the information. "Number of health workers trained" should be easy and cheap to collect and give us important information; "Number of children never weighed" will be very difficult and expensive to collect and will probably not provide any useful information.

It has a time dimension; indicators typically fall into one of 4 types related to the sequencing of activities in a program's life:

- **BASELINE INDICATORS** define the status at the baseline period, i.e. at the beginning of programs before which changes due to the current plans take place.
- **LEADING INDICATORS** measure changes that occur early in the program when internal systems are changing but when services to people have not yet changed significantly. These indicators describe the resources allocated or scheduled for allocation which are necessary before changes in outputs or behavior can occur. It is important for managers to pay careful attention to these leading indicator:, as they will be the earliest indication of the likely success of the program.
- **COINCIDENT INDICATORS** measure changes that occur in services to people and take place in the middle years of a program when it is increasing its size and effectiveness. For example, number of client contacts and active users, monitoring occurs after the workers are trained (**LEADING INDICATOR**) and working in the field.
- **LAGGING INDICATORS** measure changes in the impact period which occurs late in a program after the services have been in place for some reasonable time. These indicators measure the long-term results which the program has had on the target population. For example, birth rates.

Most effectiveness and impact indicators are in this category as are most indicators used for final evaluations of program performance. Note however, that because these indicators often do not change until late in a program, they are less useful for guiding "short term" decision making during program implementation than for long term planning and for planning subsequent programs which are being considered.

The process for selecting indicators is difficult since there are many considerations which must be kept in mind for each indicator. The first step in the process is to answer the following question for each activity:

1. What are the questions we need to answer to know whether we will accomplish our activity?
2. What information do we need to answer these questions? (indicators)

Answering these questions is not a simple task since it requires an understanding of the relationships between the activity we hope to accomplish, the information collection system, and the feasibility of collecting certain kinds of information. There is unfortunately no international standard set of FP indicators; terms like couple year protection CYP, acceptor and dropout, seem on the surface to be relatively simple indicators, however, there are several different ways to define all of these indicators. It is recommended that great care be taken when attempting to redefine FP indicators that are already in use in the country and whatever definitions are used they must be communicated to and understood by the data collectors and recorders. Many program managers will find that they require additional indicators to monitor activities unique to their program.

# Set Targets

The process of setting targets is one of the most important and yet least often performed steps in program planning. This is often because many managers have difficulty setting realistic targets. Without good baseline data on which to set appropriate targets, managers often prefer to use vague descriptive targets rather than quantitative ones so they can not be held accountable for interim results. While this may make sense from the managers point of view, it will make it difficult to identify early on when a program is getting off track. It is in other words important to not wait until it is too late to correct it. This lack of explicit targets also makes it difficult to set priorities and coordinate the efforts of different groups working on the same program since mixed and sometimes contradictory messages may be given about where to focus resources.

**Three methods are commonly used for setting targets.**

The first is to divide the expected program outputs by the number of years in the program to come up with an estimate of annual outputs. Thus if a family planning program has an objective of 100,000 new acceptors in 4 years a target of 25,000 new acceptors per year is set. This method, while mathematically correct is not usually accurate since a new program should expect fewer acceptors in the first year when training and logistics have to be arranged than the subsequent years when the program is running smoothly. Since the targets are unrealistic, we do not know after one year whether we are in fact on schedule for meeting our final objective or not.

The second method is to take the previous years result and add 10% for this year's estimate. If a program has been performing well, this method may give us a sensible target, but how do we know whether or not a program is performing well? What we accomplish with this form of target setting is measuring whether or not it is performing as well as last year. If there are correctable problems which occur year after year, we will not know about them since our targets are based on comparative performance, rather than absolute standards.

The third method, which is the most difficult, but also the most useful, is to set targets according to a normative standard based on past experience or from a review of program capabilities. If for example a target population of 100,000 new acceptors is to be reached within 4 years there are several factors we have to take into consideration. Below are some examples of the types of factors that will influence the target setting:

- How many new acceptors can a IBD worker be expected to recruit per month?
- How long does it take to recruit a IBD worker?
- How long does it take to train a IBD worker?
- How many IBD workers do we intend to train?
- How many of those we train will actually start working in the field?
- When can we expect the first IBD workers to start?
- How many and how often do we expect to replace IBD workers during the project period?

As can be seen from the above, if you have no experience of a IBD program, it will be necessary to make some sort of estimate of the factors above, possibly through discussions with other supervisors at ongoing project sites. While this may seem an arduous and time consuming activity, it allows us to make more qualified estimations than would otherwise be possible. We should also be expected to monitor the first months activities very closely and be prepared to make adjustments based on the data collected through the monitoring and evaluation system.

If a system is used to set personal performance objectives for each IBD (or any employee) then you are in reality using a normative target setting approach. Although this entails more work at the beginning of the year (or performance period), the end result is a more effective system that can be used to monitor and manage the program and result in improved performance of the program as a whole.