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**FINAL EVALUATION
OF USAID/SWAZILAND'S
FAMILY HEALTH SERVICES (FHS) PROJECT**

645-0228

PP AMENDMENT II

**USAID COOPERATIVE AGREEMENT
645-0228-A-00-8021
THE FAMILY LIFE ASSOCIATION OF SWAZILAND
MANZINI, SWAZILAND**

**Submitted to: Ms. Anita Sampson
USAID/Swaziland**

**Submitted by: Devres, Inc.
Washington, D.C.**

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Eugene Weiss
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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Anti Immune-Deficiency Syndrome
AVSC	Association for Voluntary Surgical Contraception
BRM	Bromor Foods Industry
CAFS	Center for African Family Studies
CBD	Community-Based Distribution
CDC	Commonwealth Development Corporation
COPE	Client-Oriented Planning Efficiency
CTU	Contraceptive technology Up-date
CYP	Couple-Years of Protection
FHS	Family Health Services
FLAS	Family Life Association of Swaziland
FLE	Family Life Education
FP	Family Planning
FT	Full-time
GTZ	German Government Technical Assistance Agency
HIV	Human-Immunal-deficiency Virus
IBD	Industrial-based distributors
IEC	Information-Education-Communication
IPPF	International Planned Parenthood Federation
IUCD	Intra-Uterine Contraceptive Device (also IUD)
IYSIS	Inyoni Yami Swaziland Irrigation Scheme
LAM	Lactation Amenorrhoea Method
MCH	Maternal and Child Health
MIS	Management Information System
ML/LA	Mini-lap laparoscopy
MMC	Mananga Management Center
MMS	Mananga Medical Services
MOH	Ministry of Health
NGO	Non-governmental organization
NYU	New York University
ODA	Office of Development Administration
OHS	Occupational Health Services
O & M	Ogilvy & Mather (Marketing/publicity company)
PATH	Population and Technology in Health
PR	Public relations

PSU	Private Sector Unit
PVO	Private Voluntary Organization
QOC	Quality of Care
REU	Research and Evaluation Unit
RH	Reproductive Health
RHM	Reproductive Health Motivator
SBS	Swaziland Broadcasting System (also SBIS)
SIHS	Swaziland Institute for Health Sciences
SNAP	Swaziland National AIDS Program
STD	Sexually Transmitted Diseases
TA	Technical assistance
TOT	Training of trainers
UNICEF	United Nations International Child
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VSC	Voluntary Surgical contraception
VHS	Video Recording System
VHW	Village Health Worker
WHO	World Health Organization

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EXECUTIVE SUMMARY

Swaziland is a small country in Southern Africa, with--for sub-Saharan Africa--a relatively high income, literacy rate, and relatively high contraceptive use rate (25%). While the government integrates family planning services throughout the country, it does not have an official population policy. The Family Life Association of Swaziland (FLAS) is the premier NGO providing family planning services. Its three urban clinics, private sector industry program, and small CBD program contribute about 25% of the contraceptive use. FLAS also has had a nationwide campaign of information, education, and communications (IEC) activities. The problem of HIV/AIDS is growing rapidly with prevalence estimated at over 20%.

The first Family Health Services (FHS) grant to FLAS was awarded in 1988 to build up the capability of FLAS, especially its research and evaluation unit. Pathfinder International was awarded a companion grant to provide technical assistance. A much larger grant award was made in 1993 as an amendment with \$6,800,000 provided for all aspects of support. Important features were:

- o An expanded private sector program
- o The introduction of VSC/sterilization services
- o An extensive national IEC campaign
- o The creation of an endowment for FLAS
- o The purchase and construction of buildings

The evaluation focuses on how well FLAS has achieved the objectives of the FHS grant, especially with a view to future sustainability and cost-recovery. The evaluation team spent four weeks examining FLAS activities and making extensive field visits to FLAS program sites and relevant government, NGO, and donor offices.

Clinical Service Delivery and Quality of Care (QOC)

The service delivery component of the FHS grant amendment has strengthened FLAS' institutional capacity for high QOC in its services. FLAS has an excellent national reputation for high quality services attested to by representatives of the Ministry of Health and industry who laud without reservation its positive impact on FP activities in Swaziland. FLAS should also be commended for its role in the introduction of VSC services. Technical assistance and training provided by the Pathfinder Fund and AVSC has helped to accomplish this. FLAS could further strengthen its capability by building on its infrastructure in training, improving the promotion of condoms as a measure to prevent HIV/AIDS, streamlining infertility management, improving the package of reproductive health care along with increased fees for cost-recovery, and introducing Norplant services.

During the grant period, FLAS introduced and maintained VSC services (ML/LA and vasectomy) at two sites--the Ubombo Ranches industry clinic and the Mbabane FLAS clinic. Despite unforeseen launching difficulties, an infrastructure for services (suitable clinical sites, trained doctors and nurses, equipment) and a partial infrastructure for training have been developed. More minilap sets will be needed for training. The unforeseen attrition of doctors from the VSC pilot program has retarded but not stopped progress. There is enough of an infrastructure in place to build upon, though an increase in the number of sites where the services are available is essential. Further efforts at the promotion of VSC, both minilap and vasectomy, would likely be successful.

Private Sector Programs

The Private Sector Unit is now staffed with a competently trained team of professionals while a Resident Advisor and a number of consultants have provided technical assistance in many different areas. The private sector project has been implemented at 20 industries and plans are underway to introduce mobile clinic services to selected industries in the Matsapa Complex. Approximately 300 Industry-based Distributors (IBDs), 18 IBD supervisors and 26 nurses were trained to provide FP and HIV/ AIDS prevention services. Seminars were conducted for managers and supervisors at the industries and industry-specific pamphlets were produced for IBD distribution and condom dispensers were provided to industries in order to increase condom accessibility. Service statistics show an increase in condom distribution as well as increased usage of injectibles, pills and foam tablets. A pilot oral contraceptive re-supply scheme was successfully initiated at two industries; this should be expanded to all IBD sites. However, cash flow problems experienced during the last quarter of 1995 has had a negative impact on the program, especially the implementation of the mobile clinic.

Taking advantage of the current momentum, FLAS is embarking on an aggressive marketing strategy of selling its services to the industries; this should be implemented as soon as possible and is likely to be successful. In the future, more attention should be paid to the gender distribution of the IBDs so that it closely complements the work force. While management should be encouraged to adopt their own IBD incentive strategy, FLAS can facilitate the IBDs' work by conducting seminars for the supervisors on-site in order to increase their awareness of the need for the program along with supplying more condom dispensers to the industries.

Information, Education, Communications(IEC)

The FLAS IEC program has been very productive and effective in accomplishing one of its most urgent objectives: making FLAS and the importance of family planning well known throughout Swaziland. The IEC Unit, with the assistance of consultants and marketing organizations, has developed, tested, and disseminated a wide range of IEC messages, materials,

and media, implementing a large number of new activities in a short period of time. The IEC materials are, in general, of high quality. They have been well developed, produced, and distributed. However, FLAS should endeavor to have more of the IEC materials translated and printed in siSwati for wider circulation. FLAS's IEC unit has excellent skills, facilities, and equipment (e.g. marketing skills, IEC production capability, a radio studio) which could be used to generate income. These services could be made available to other NGOs in development, education, health, and family planning. However, FLAS's IEC media campaign was costly and, as the grant funds had to be spent in a relatively short period of less than two years, was at a level not sustainable in the future.

FLAS's male-focused IEC has helped to defuse male opposition to FP. FLAS IEC staff's enthusiastic, frank, and graphic teaching of condoms and how to use them is one of the most important components of the FLAS IEC strategy. Despite this, there is still a need for alternative FP services designed to reach men and more IEC male-focused IEC materials. Like FLAS' approaches to men, its IEC work with adolescents and young people is exemplary and deserves to be replicated. The three Reproductive Health Workbooks are excellent publications and are intended to eventually reach a substantial proportion of the Swazi population. However, young people who are informed and motivated to use contraceptives do not currently have easy access to them; programs to address this need have yet to be initiated.

Evaluation

The Research and Evaluation Unit (REU) of FLAS was created and developed under the initial FHS grant. It initiated an effective Management Information System (MIS) which has provided program managers with timely and comprehensive information on the FLAS services. While it currently needs a few minor adjustments in its computer software system and reporting methodology (For example, the reporting of condoms distributed through the industry dispensers needs to be included in the MIS), it is a strength of FLAS that it has such an effective system. FLAS has also undertaken a very wide range of program relevant research and evaluation, often with the assistance of international and local consultants. An impressive series of studies on youth and private sector target populations have been carried out. In addition, the last year saw two key studies examining the cost-effectiveness and cost-benefit of the clinic and private sector programs. These have been very helpful in preparing cost-recovery marketing plans.

Despite its accomplishments, because of delays and recent financial problems, FLAS was not able to undertake the key studies which would have allowed for an assessment of its major program activities under the FHS grant amendment--a post survey in the private sector program and a national study assessing the very large scale IEC campaign. It is suggested that these activities receive the highest priority for the future. Other suggestions for evaluation activities include more detailed studies of sexual practices and condom use patterns, small-scale field studies to determine catchment areas for CBD and IBD workers and the FLAS clinics, and more IEC studies focusing on how to better motivate and attract VSC clients. Given the small

number of staff of the REU, it is suggested that consideration be given to increasing its staff and obtaining assistance for the implementation and analysis of the FHS project impact studies described above.

Sustainability

The current and future financial and organizational sustainability of FLAS has been carefully examined. Except for the current short-term financial crisis, the continuation of FLAS programs in the future at about the same level of activity seems fairly likely. The endowment and infrastructure created by the FHS grant will greatly assist in ensuring FLAS' future stability. Though USAID funding will be ending this year, very substantial cost recovery programs appear about to be implemented. In particular, this should ensure the continuation of the private sector and clinic programs. In addition, there is a very receptive environment among other donors who will likely respond positively to FLAS requests for support.

While several proposals have recently been prepared and submitted, it is felt that the proposal development process could be improved, especially in regards to collaborating with the Ministry of Health and formulating requests based upon mutual needs. A number of very promising areas have been identified in terms of IEC, training, and service delivery. It is suggested that now that FLAS has matured as an organization and government has expanded its support for family planning, that FLAS consider changing its major focus from one of providing basic services to one of providing technical assistance, training, evaluation and research, and demonstrating important new program directions. The incorporation of an AIDS/STD prevention focus into its traditional emphasis on the promotion of family planning, as it has done in the private sector and IEC programs, is a major accomplishment and a very significant direction for the future of family planning programs in Africa.

I. OVERVIEW OF PROJECT AND EVALUATION OBJECTIVES

A. Health and Family Planning In Swaziland

1. Swaziland: General Features

Swaziland is a small land-locked kingdom in southern Africa between Mozambique and South Africa. It has a population of approximately 900,000 persons that is growing at about 3.2%. It is mainly rural (76%) with only two substantial urban centers: Mbabane and Manzini. It has a relatively high per capita income (\$1,090 in 1992) and literacy rate (80%) for Africa; even the rural population is mainly literate (76%). There is a large agribusiness rural industry sector with urban-like amenities for the workers in addition to the rural low-density homesteads with very low incidence of modern conveniences (electricity, water, etc.). Most of the rural population is dependent upon workers in industry, either in Swaziland or in South Africa. Sixty-eight percent of rural homesteads were found to have absentee workers with the typical rural household having an average of two migrants. The local work migrants return from once-a-month to once-a-year to their homesteads (Whiteside & Wood, 1994).

2. Health Status and Family Planning Practice

Given the relatively high (for Africa) income and literacy in Swaziland, there is a high level of mortality. The latest (1986) national demographic figures show an infant mortality rate of 98 and a child mortality rate of 141, along with a life expectancy of 56 years. Average completed family size 5.1, according to the 1988 FHS survey, while desired family size is between four and five children. Another national demographic and health survey is planned for 1996. Compared to most of Africa (with the exceptions of Zimbabwe, Botswana, Lesotho, and possibly Kenya), Swaziland has a high prevalence of modern contraceptive use that appears to be increasing rapidly. Services have been available in the private, NGO, and government sector for a number of years and a very high level of awareness and knowledge exists. In one industry worker study (Gulu, 1994), over 40% were using contraception and 36% of family planning users said they did not want any more children and "indicated an interest in VSC." The last (1991) national survey gave a prevalence rate of 21.7% for females, age 15-49. Urban use was higher (29%) than in rural communities (19%).

Substantial condom use is not for preventing pregnancy but for the prevention of STDs and AIDS. Swaziland's very high rate of HIV/AIDS is documented by Whiteside and Wood (1994) in which they report a national sentinel survey indicating 22% prevalence of HIV among a sample of antenatal clients. This was drastically higher than the previous year's studies and many in Swaziland, including the government, claim it is too high. However, no contrary evidence has been able to be obtained by the evaluation team. The pattern of work migration described above and the relative frequency of non-marital sexual activity significantly contribute to the very high rate of HIV/AIDS. Non-marital sex is common for both males and females;

this includes teenagers, beginning at age 16 or 17, young adults (FLAS clinic records show that over 50% of clients are single, yet average over two children), and workers in industries living away from their families.

3. Health/Family Planning Policy and Services

The Government of Swaziland has given strong support to population control and family planning, though it has not issued an official population policy; it has also given its backing to an extensive government AIDS control program. A recently completed overview of the economy produced by a blue-ribbon committee of the Kingdom (Economic Review Commission, 1995) warns against a "burgeoning population" and recommends a "holistic" strategy for tackling population growth. There is a large government system of health care that integrates family planning into its urban and rural services. Overall, there are 65 government hospitals, health centers, and clinics, 39 private facilities, 32 facilities operated by Mission organizations, 27 operated by industry, and four by NGOs. However, as in most of Africa, there is a concentration of the health facilities in the urban areas. In the scattered homesteads of the rural areas, over 50% of the families are more than two hours' walk from the nearest facility. The MOH provides family planning services through its urban and rural facilities as well as utilizing a large cadre of Rural Health Motivators (RHMs). The MOH reports that it served almost 30,000 new FP acceptors and had over 150,000 FP revisits at its facilities in 1994 (these numbers may be a significant undercount). The most popular contraceptive method in Swaziland is the injectable, followed by the oral contraceptive and then the condom. Injectable and condom use appear to be increasing significantly. The treatment of STDs comprises a significant component of government health services: 112,000 outpatient visits in MOH clinics were for "Genital Disorders" in 1994.

4. Role of the Family Life Association of Swaziland (FLAS)

The Family Life Association of Swaziland (FLAS) is a non-governmental, not-for-profit organization (NGO) founded in December, 1979, receiving the largest share of its support from IPPF. It is, by far, the leading and largest NGO providing family planning information, education, and services in Swaziland. FLAS served over 16,000 new users and had nearly 40,000 revisits in 1994. It has also played a very large role in providing treatment for STDs (10,000 visits in 1994) and HIV/AIDS education; its clinics also offer selected MCH and reproductive health services. In addition, it has played a very significant advocacy and policy role in Swaziland through both its organized education and media activities as well as its continuous interaction and collaboration with relevant government ministries and other NGOs. FLAS carries out the following activities:

- o Direct services: 3 clinics
 Private Sector Program in 20 industry settings
 CBD program in 5 locations

- o IEC: Extensive mass media production and dissemination
Family Life Education materials and programs
Rural women's empowerment program in 3 areas
Special seminars, workshops, meetings
Advocacy for women's and population issues
- o Training: Training of health professionals, paramedical staff, rural and industry volunteers and peer promoters (CBD, IBD)
- o Research/Evaluation: Management Information System for FLAS services and a large number of evaluative and research studies.
- o Contraceptive purchase and monitoring for the MOH

5. Role of International Donors

As a small country, Swaziland does not have the full complement of international and bilateral development organizations that exist elsewhere. However, it has had significant assistance from USAID, ODA (Britain), GTZ (Germany), a few PVOs such as Project Hope, and the group of United Nations organizations--UNDP, UNICEF, WHO, and UNFPA. For the last five years, IPPF has supplied the MOH with contraceptives in addition to its role of supplying FLAS with commodities. While UNFPA has had a large scale program of assistance to the government in a number of areas, its implementation has been slow. USAID's assistance to Swaziland will end in 1996 and the country office will be closed.

B. USAID Family Health Services (FHS) Grant (645-0228)

1. Initial Grant: 1988-1993

The FHS Project began in 1988 with the signing of two five-year Cooperative Agreements between USAID and FLAS (\$700,000) for local costs and between USAID and the Pathfinder Fund (\$1,700,000) for technical assistance, training, and the off-shore procurement of equipment. It was agreed that \$204,000 was also to be spent on the purchase of contraceptives. The effective start-up date was February, 1989, when the Pathfinder resident advisor arrived in Swaziland.

The goal of the project was to reduce Swaziland's high fertility rates and improve maternal and child health. Its purpose was to increase the prevalence of modern contraception, with emphasis on the expansion of services into new areas and increasing the accessibility of family planning services and information. The project also aimed to increase the demand for family planning services through nationwide IEC and to improve the MOH's family planning program. The project was designed to be implemented in two phases over five years. The focus of Phase I was the institutional development of FLAS with activities designed to strengthen planning and management, research and program monitoring, IEC and service delivery. The

plan for Phase II was to build on the accomplishments of Phase I, with a priority focus on the expansion of services in the private sector. Seven key intervention areas were outlined in the project design:

- o Management and Institutional Development
- o Service Delivery Expansion
- o IEC (FLAS was to become the main supplier of IEC materials for Swaziland)
- o Research and Evaluation (Development of a Research and Evaluation Unit and provision of a long-term advisor)
- o Leadership Awareness of the importance of population issues
- o Supplies and Equipment: Computers, IEC/clinical equipment, vehicles, contraceptives
- o Mission Management and Special Activities (evaluations, audits)

A mid-term evaluation of the FHS Project was carried out in September, 1990. Its positive assessment found that FLAS had progressed in virtually all areas of the project design. It was commended for its leadership awareness, IEC and family life education activities. Its clinic program had expanded its services and an effective CBD program was seen as a model by the MOH. Preliminary work had begun on a new industry-based program. The Research and Evaluation Unit had contributed to an improved national contraceptive procurement system, improved information systems for both MOH and FLAS programs, and had made its monitoring, evaluation, and research findings available for the improvement of FLAS services. Nevertheless, the assessment revealed that FLAS needed continued strengthening in terms of the number of staff and their capabilities. It recommended continued technical assistance and staff development. It also recommended further development and expansion of the IEC and private sector programs. In September, 1992, a \$300,000 increase in the project funds was authorized to meet the increasing needs of the expanding private sector and the IEC programs.

In early 1993, several assessments of the FHS grant were carried out. They found that improvements in the quality of services had taken place and that the private sector program had been expanded to seven industrial sites. This latter program emphasized STD/AIDS prevention in addition to family planning. In addition, an assessment of the IEC activities recommended that FLAS focus on a number of carefully defined activities and laid out a framework for a new IEC campaign that it was expected would have an impact on the national contraceptive prevalence rate. The USAID Mission used the recommendations of the assessments as a basis for the development of a Project Paper Supplement (Amendment).

However, a set of unique circumstances surrounded the development and awarding of the grant Amendment and the Mission decided that it would supplement the grant to FLAS to a much larger extent than it had originally planned. At this time only two and a third years remained for a proposed extended grant period due to a number of constraints, including the potential withdrawal of USAID from Swaziland. Thus, a relatively large amount of funds were made available to be utilized in a relatively short period of time. This fact was important in structuring the 1993 grant amendment.

2. FHS Grant Amendment: 1993-1995

On August 31, 1993, a Project Paper Amendment/Supplement to the FHS grant extended the project for two years to December 31, 1995. It increased the Life of Project Funding to \$6,814,558 (an additional \$4,114,000 was allocated) and modified the project activities and logical framework. The project would now concentrate its resources in four areas:

- o Expanded IEC activities
- o Expanded family planning and AIDS activities in industries and other private sector organizations
- o The introduction of voluntary surgical contraception (VSC) in at least four locations. VSC would be introduced at both FLAS' own clinics and at several private sector program clinics
- o The establishment of an endowment for FLAS and the purchase and renovation of a building for a clinic in Mbabane and the construction of its own headquarters building

It also increased the level of technical assistance (both long-term and short-term) to be provided by Pathfinder, PATH, AVSC, etc. The grant also provided funds for increased in-country and international training, vehicles, commodities, the printing and production of IEC materials, and for research, monitoring and evaluation.

The largest components of the increased funds were to go for the creation of an endowment (\$1.7 million), for the purchase and construction of buildings (\$1.1 million), a large-scale IEC campaign (\$1.4 million), and a variety of technical assistance (\$0.8 million).

Two aspects of the amended project are worth emphasizing. For the first time, the project paper included explicit recognition of the growing problem of HIV/AIDS and spoke of including the prevention of AIDS and STDs (through condom use) as an objective of the IEC activities. It also recognized the importance of AIDS prevention in the support given to the private sector project by industry management. At the time of the original program paper, AIDS was not seen as that important by the Government or by health professionals in Swaziland. Secondly, the provision of an endowment that would provide FLAS with an annual income for the foreseeable future and that would pay for the continuation of a significant portion of their basic program support, is a new, though not unique, form of program assistance.

The details of the objectives and planned activities of the grant amendment will be presented in the chapters dealing with each program component presented below.

C. Strategic Issues for the Future of FLAS

The purpose of strategic planning, as described in the 1992 report, FLAS Strategic Plan Through the 1990's, was "...to make informed judgements about what opportunities and risks the organization faces in its environment in the future and identifying alternate means of either

explicitly exploiting these opportunities or accommodating the risks." This is what the evaluation team attempted to do as it proceeded to make recommendations concerning the future of FLAS. The completion of the substantial USAID support of FLAS is a major change that FLAS needs to accommodate to in its future strategic planning. In reviewing FLAS programs and the current health and family planning situation in Swaziland, we have identified three key issues which we feel need to be addressed in order to make effective recommendations for the future. These are:

1. Sustainability and Cost Recovery

A very significant challenge for FLAS is to adjust to the increasingly important concept of cost-recovery or sustainability. Broader sources of funding are needed and a more aggressive/assertive search for project support funds is now required, with increased local fund raising as well. A number of questions arise concerning fees and services:

- o Should there be fees for contraceptives and condoms? If there are fees, will contraceptive use decline?
- o Should non-FP services be cut back, or are there advantages to providing a broad scope of reproductive or maternal and child health services? Or should FLAS simply raise service fees for non-FP services so that they are more self-sustaining?
- o To what extent can FLAS offer specialized family planning or reproductive health services and expect the community to rely upon government and private services for other MCH services?

A related issue concerns program efficiency: Are all clinic staff and physical facilities fully utilized? Are some of the staff spread too thin for the multiple roles some of them carry? Or does FLAS need to reorganize to become more effective and to meet the challenge of the move toward cost-recovery? Finally, the use of the funds made available by the endowment should be examined--how to balance potential future needs versus urgent current needs.

2. HIV/AIDS/STDs

HIV prevalence has likely reached 15% to 20% for the country as a whole and Swaziland joins a number of other African nations facing very high HIV prevalence that will greatly affect its future well-being. Further, the government of Swaziland, a number of NGOs, and, most importantly, FLAS itself, have initiated and implemented innovative, effective, and large-scale programs to combat the HIV/ AIDS/STD epidemic. However, the effort to combat AIDS and STDs has important implications on the design and implementation of family planning services. To begin with, the treatment and prevention of STDs significantly reduces the transmission of HIV. Further, most family planning methods do not protect against the transmission of HIV and other STDs. Thus, should FLAS actively promote Dual Method Use,

i.e., condom use in addition to the use of orals or the injection? Should all female clients be trained to negotiate condom use with their partners? The other side of the coin--men's issues and programs--also needs attention. The implementation of such a policy would have implications for FLAS objectives as well as the reporting and monitoring system used to assess the meeting of those objectives.

3. Expansion of FLAS services

Is further expansion of FLAS services an appropriate goal? An alternative view is that basic family planning services should be left to the government to provide, now that the government is actively involved and has a supportive policy. FLAS' role would then become one of providing technical assistance and support to the government program (and other NGOs that may provide services). FLAS service sites could also be used for training, research, and for experimenting with innovative services and demonstrating their value. FLAS could also provide services to the MOH and others--training, implementation technical assistance, IEC, contraceptive distribution/monitoring--in the same way it is providing them to the private sector, requesting financial support on a cost-recovery basis from international donors.

D. Evaluation Objectives and Methodology

1. Evaluation Scope of Work: Goal and Objectives

The goal of the evaluation was to assess the current status of the FHS Project that was initiated in 1988 and to make recommendations that addressed the future sustainability of FLAS. It was carried out in the context of USAID's plans to withdraw from Swaziland in the near future. Thus, the evaluation focused on two questions:

- o What has been accomplished by the FHS Project as a whole?
- o What activities will FLAS be able to continue after the completion of the AID grant in December, 1995?

Given that the project was comprehensively evaluated before the grant amendment was prepared and approved in 1993, this evaluation focused on the activities of FLAS carried out since the initiation of that amendment. It not only focused on the objectives of the FHS grant amendment and the achievement of those objectives, the evaluation also assessed the assumptions made in the Project Amendment design. Finally, the evaluation focused on the future of FLAS and made recommendations concerning FLAS' organizational and financial sustainability. The evaluation took place in November and December 1995.

2. Evaluation Team and Methodology

The evaluation team was comprised of four members: Dr. Eugene Weiss, who served as Team Leader and program development and evaluation specialist; Nicolas Danforth, Information, Education, and Communications specialist; Claudette Bailey, Family planning

service delivery and reproductive health care specialist; Joy Awori, Workplace and industry-based program development and management specialist. The evaluators were joined during most of the evaluation by key senior staff of FLAS and on occasion by PATHFINDER staff and a representative of USAID/Swaziland. These included:

FLAS:

Khetsiwe Dlamini, Executive Director
Musa Mgogo, Asst. Director, Programs
Khanya Mabuza, Head, Service Delivery and Private Sector Units
Mrs. Khombi Nkonde, Sr. Program Officer, PSU
Frieda Maseko, CBD Program Supervisor
Marjorie Mavuso, Head, Research and Evaluation Unit
Jerome Shongwe, Head, IEC Unit

PATHFINDER:

Millicent Obaso

USAID/Swaziland:

Anita Sampson

The team used a participatory approach to the evaluation process. FLAS senior staff and the Pathfinder representative were invited to participate in all aspects of the evaluation, including all field visits and discussions with representatives of other agencies and organizations. Numerous discussions were held both individually and in meetings of the senior staff organized to provide feedback to the FLAS staff of the evaluation team's progress and thinking, as well as to obtain detailed feedback from FLAS staff. This feedback has contributed to an understanding of the feasibility and practicality of the suggestions made by the evaluation team. The team held a number of meetings with the USAID representative who also participated in two of the meetings held to obtain feedback from FLAS staff.

Two of the evaluation team had previously worked in Swaziland while one had participated in the original setting up of FLAS. The other two members of the team had extensive African experience. A large number of program and background documents were provided to the team by both FLAS and USAID/Swaziland. Additional documents were obtained during the field visits and visits to other organizations. Appendix B provides a list of the documents and materials reviewed. In addition, members of the team reviewed IEC materials both at FLAS headquarters and at service delivery and media sites.

The team carried out first-hand observations at all three FLAS clinics (including the performance of a mini-laparotomy) as well as at eight private sector program sites. Both IBDs (Industry Based Distributors) and their program supervisors, as well as clinic staff were

interviewed and observed at the private sector program sites. Several government service delivery sites were also visited. Two communities where the FLAS CBD program is implemented were visited as were several schools where the FLAS Family Life Education and other educational programs are being carried out. Outdoor educational programs presented by FLAS and affiliated organizations were visited along with a number of mass media offices that have worked with FLAS. In addition, team members spent time with senior FLAS staff in their offices reviewing their reports, documents, and work plans. Finally, visits were held with many government staff in relevant MOH and other offices as well as with several NGO, PVO, and United Nations organizations. The evaluation team's first and last official visits in Swaziland were with the USAID mission for initial briefing and debriefing. Other meetings were held to share progress reports and to discuss preliminary findings. The team presented its complete findings and recommendations to FLAS before departing Swaziland. A complete list of institutions visited and persons contacted is included as Appendix A to this report. Documents reviewed by the team are included in Appendix B.

While the evaluation team was constituted to represent various specialties, it often worked together during the period of site visits to take advantage of its multi-disciplinary nature. On the other hand, in order to carry out the large number of site visits, it was necessary to have team members make individual site visits. At times, team members covered three different visiting areas in the same day. Although the different team members had different expertise and experiences, and thus, brought a different focus to each of the issues, the recommendations contained in the report are based upon a consensus of all of the team members. The complete report was prepared in draft and submitted for review to FLAS and USAID/Swaziland a few days before the team left Swaziland. Comments have been received and incorporated into the present report and a revised version was submitted to the USAID/Swaziland mission on January 9, 1996.

II. CLINICAL SERVICE DELIVERY AND QUALITY OF CARE

A. Introduction

The FHS Grant amendment embodied the overall objectives of the FHS grant, setting goals to intensify, enhance and ensure the ability of FLAS to achieve those objectives. The service delivery goals were to increase the availability of FP services by:

- o Improving and expanding the industry-based FP/AIDS pilot program, and,
- o Initiating a pilot program of voluntary surgical contraception in at least two industry medical facilities and one FLAS clinic.

FLAS clinics provide a large segment of the acceptors of modern methods of contraception in Swaziland. In addition, FLAS IEC activities and its training of outreach workers, including CBDs, IBDs and other family planning service providers, contribute significantly to the provision of family planning services. In particular, FLAS has assisted the development of clinical family planning service at 16 rural and urban industry sites.

The evaluation Scope of Work requested the Team to observe clinical family planning services at the three FLAS clinics and at five industry clinics. Clinics at Mananga Industries Mhlume, IYSIS, at Usuthu Pulp Health Services (Bhunya clinic) at Ubombo Ranches Health services, and at Simunye Health services, Ngomane, plus the three FLAS clinics in Mbabane, Manzini and Malkerns were observed.

Ubombo Ranches and the FLAS clinic in Mbabane are currently offering vasectomy and minilap services. All service delivery sites visited offer the full range of non-surgical contraceptive methods available in Swaziland. The industry clinics offer family planning in an integrated MCH/FP primary health care approach. The FLAS clinics offer a range of reproductive health care services.

The FHS Grant amendment provided for the improvement of the quality of care (QOC) and the expansion of family planning services through technical assistance from Pathfinder International through its regional office in Nairobi. Specific technical assistance in the establishment of VCS services and related issues was provided through the Association of Voluntary Surgical Contraception (AVSC) Regional Office in Nairobi.

B. Accomplishments: Clinical Service Delivery Inputs and Outputs

1. Inputs: Service Delivery Capacity Building

An objective of the initial FHS grant was to improve FLAS service delivery in its own clinics as well as in several industry settings. The amended grant, while not placing

emphasis on further improving FLAS' own services, expected that a high level of care would be continued. It did, however, expect that private sector services would be expanded and improved. The evaluation of the original FHS project noted that the industry project appeared to place more emphasis on STD/HIV/AIDS control and management than on FP. These activities have since then become an integral component of the training and practice of all service providers, e.g., IBDs, nurses, and nursing assistants, and have become institutionalized as elements of desired reproductive health care in Swaziland. Thus, the integration of AIDS and FP activities has now become the norm in Swaziland; it doesn't imply the neglect of FP services.

Technical assistance for service delivery capacity building and training and in the monitoring of quality of care was provided by AVSC and Pathfinder International during the FHS extension. The VSC Pilot project was monitored and supervised from Nairobi by AVSC whose commitment ends on December 31st, 1995. Table 1, "Service Delivery Capacity Building", documents the technical inputs, the providers of the technical assistance, the advice/recommendations, and the status of the recommendations in each area. Recommendations were welcomed and usually promptly executed by FLAS and the industry clinics. The recommendations addressed critical areas of quality of care such as infection control, management practices, training, counselling, and contraceptive technology. Details of the recommended practices are discussed in the relevant sections below. Appendix E provides a listing of all service delivery related courses sponsored by FLAS and their participants, including their duty stations.

2. Establishment of VSC Services

The second service delivery objective of the FHS grant extension was to initiate and pilot VSC services in one FLAS clinic and three industry sites. Project inputs were to include the training of service providers (nurse/doctor/teams), and the provision of equipment and physical facilities. Through an OYB transfer to RD/POP, USAID engaged AVSC to provide technical, financial and material support to FLAS to introduce ML/LA and vasectomy services during the period January 1st, 1994, to December 31st, 1995. Under this agreement, AVSC was responsible for training four doctor/nurse teams in ML/LA and two doctors in vasectomy in Kenya, twenty-four nurses in FP counselling in Swaziland, and the establishment of VSC services in four sites in Swaziland. Appendix E provides a listing of the sites for the pilot VSC services and the training and posting of relevant staff.

a. Ubombo Ranches

One ML/LA trained doctor and two nurses trained in VSC counselling serve the Ubombo Ranches. In addition, one staff M.D. who is qualified and experienced in ML/LA (but not trained in this project) also participates in ML/LA services which were established in 1994. Of these two, one can give only about half-time to VSC as he has currently taken on other commitments. To date, 52 MLs and 3 vasectomies have been done.

TABLE 1: SERVICE DELIVERY CAPACITY BUILDING

TECHNICAL INPUTS/ ADVISORY	TECHNICAL ASSISTANCE	ADVICE/ RECOMMENDATION	STATUS
1. FP Counselling course	Rose Kigegyera John Githiari	<ul style="list-style-type: none"> • 11 nurses trained; 6 from FLAS, 4 from industries and one from MOH. 	Done
2. Infection Prevention Workshop	Dr. Ezra Teri/Pathfinder	<ul style="list-style-type: none"> • 27 nurses trained; 6 from FLAS, 3 from industries, the rest from MOH and missionary clinics 	Done
3. Contraceptive Update course	Dr. Ezra Teri/Pathfinder - July 1994	<ul style="list-style-type: none"> • 11 nurses trained from FLAS and industries. 	Done
4. Human Sexuality course	Nanette Ecker/Pathfinder	<ul style="list-style-type: none"> • 53 FLAS, industry and MOH personnel trained 	Done
5. FP Counselling course	Dr. Margaret Mmeme	<ul style="list-style-type: none"> • 15 nurses trained from FLAS, MOH and industries. 	Done
6. TOT for FP Counselling	Dr. John Githiari Rose Kiregyera	<ul style="list-style-type: none"> • 11 nurses trained from FLAS, industries and MOH. 	Done
7. FP TOT	CAFS - Nairobi	<ul style="list-style-type: none"> * 1 nurse trainer trained. 	Done

Table 1 (cont.): SERVICE DELIVERY CAPACITY BUILDING

TECHNICAL INPUTS/ ADVISORY	TECHNICAL ASSISTANCE	ADVICE/ RECOMMENDATION	STATUS
8. Quality of care monitoring	Dr. Douglas Huber - Pathfinder International	<ul style="list-style-type: none"> • Suggested and provided list of questions for client satisfaction survey. • Shortened supervisory checklist from 24 pages. • Introduce CBD services • Develop female sterilization services • Modify clinical service manual (update) • In-service update on IUD loading 	<p>Used by REU; implemented.</p> <p>Reduced to 3 pages.</p> <p>Ongoing.</p> <p>Recommendation concurred with project ammendment; Introduced</p> <p>Ongoing</p> <p>Implemented non-touch technique</p>

Table 1 (cont.): SERVICE DELIVERY CAPACITY BUILDING

TECHNICAL INPUTS/ ADVISORY	TECHNICAL ASSISTANCE	ADVICE/ RECOMMENDATION	STATUS
9. Quality of Care Monitoring	Dr. Ezra Teri--Pathfinder International; July, 1994	<ul style="list-style-type: none"> • Conduct catchment area surveys to provide information for planning outreach and impact evaluation. • Establish outreach around clinics. • Diversify method mix and maintain constant supply of all methods. • Introduce Depoprovera, Norplant, VSC. • Conduct studies in client satisfaction. • Develop a training plan for all cadres of service providers. • Send senior service providers to Infection Prevention course. • Revise supervisors check list. * Reconsider infertility service 	<p>Not done</p> <p>Not done.</p> <p>Implemented</p> <p>VSC introduced, Depoprovera, Norplant not available</p> <p>Accomplished</p> <p>CTU accomplished</p> <p>Accomplished</p> <p>Accomplished</p> <p>No action</p>

CAPACITY BUILDINGTable 1 (cont.): SERVICE DELIVERY

TECHNICAL INPUTS	TECHNICAL ASSISTANCE	ADVICE RECOMMENDATION	STATUS
10. Site visits as medical follow up of VSC introduction at Mhlume clinic, Mananga Medical Services and FLAS Mbabane Clinic.	Dr. John Githiari, AVSC	<ul style="list-style-type: none">• Mhlume needs more ML/LA kits.• Decontamination of used instruments/ materials require improvement.• FLAS to provide 2 additional kits to Ubombo Ranches.• Surgeon from Mbabane to visit Ubombo Ranches to offer support in use of LA for ML.• Assisted surgeon to perform minilap/LA.• FLAS management to facilitate 3 ML/LA sessions per week at Mbabane clinic.• AVSC to provide financial/technical assistance to train 15 nurses in counselling in June 1995.	<p>Not yet provided. Service suspended when surgeon left.</p> <p>Done</p> <p>4 additional kits provided by FLAS.</p> <p>Still pending</p> <p>2 sessions are conducted Wednesday and Thursday.</p> <p>Done</p>

Table 1 (cont.): SERVICE DELIVERY CAPACITY BUILDING

TECHNICAL INPUTS	TECHNICAL ASSISTANCE	ADVICE RECOMMENDATION	STATUS
<p>11. Introduction of COPE quality of care approach</p>	<p>Dr. John Githiari, AVSC; June, 1995</p>	<ul style="list-style-type: none"> • AVSC to provide technical and financial support to introduce COPE for improvement of QOC. • AVSC to facilitate the training of one Doctor in no-scalpel vasectomy at Mbabane Clinic. • Introduced at Mbabane Clinic 	<p>Done</p> <p>2 Doctors now performing no-scalpel vasectomy</p> <p>3 Nurses, 2 Cleaners and 1 Groundsman trained in FLAS Mbabane Clinic.</p>

AVSC provided one and FLAS three minilap kits to this facility. The doctors frequently use a larger (4 cm.) incision instead of 2 cm. required for minilap instruments. MLs are performed under spinal instead of local anaesthesia. The doctors maintain that their clients are more comfortable and the facility has suitable available expertise for spinal anaesthesia in a staff doctor. Their accomplishment of 52 minilaps in one year is a success story. However, AVSC and FLAS are encouraging the MDs at Ubombo Ranches to work with the ML/LA trained MDs from Mbabane to develop their skills in ML/LA.

b. Mananga Medical Services

One doctor was trained in ML/LA and two nurses were trained in FP Counselling for VSC for Mananga Medical Services. The doctor has left the services but performed one ML/LA before terminating. The nurse/midwife FP coordinator and clinic sister report a substantial unmet demand for VSCs in this community resulting from an initial awareness campaign to start the service.

c. Simunye

Simunye Health services was the third industry ear-marked for establishment of VSC services. The doctor was unavailable for the first scheduled training and has not been able to reschedule it.

d. Mbabane

Two doctors and two nurses have been trained to work at the FLAS clinic in Mbabane. Both doctors also have No-scalpel vasectomy training. After a protracted start up period due to relocation of the clinic, the first minilap was performed on April 22, 1994. Since then, a total of twenty-four ML/LA and five No-scalpel vasectomies have been done. One vasectomy was carried out the last week of the Evaluation Team's visit.

Due to unforeseen circumstances, only one out of four established service delivery sites is actively offering both MA/LA and No-scalpel vasectomy services. The other active site does ML under GA and spinal anesthesia. This should not be seen as an accurate reflection on the potential for success. The following circumstances may have impacted negatively: the loss of the trained doctor at Mananga Industries and the unavailability of the coordinator-designate and session FP physician from Manzini, who has not participated in the VSC program since his training.

On the positive side are the following elements: motivated service providers report unmet expressed demand for services, four trained doctors who can increase their services at two sites; two physicians who can train others, 24 trained nurses and one trained nurse trainer. These technical resources plus a number of suitable service delivery sites provide an infrastructure for training and service delivery that can be developed, maintained and expanded with a lot of effort and a little added assistance.

FLAS headquarters staff and industry management and service providers expressed satisfaction with their VSC training. Observation of practice and interviews with service providers revealed the successful transfer of skills. Indeed, both FLAS and industry service providers consistently perform at a high standard of competence. The elements of service delivery/QOC that were the focus of the project inputs appear to have been institutionalized.

3. Outputs

During the grant period, the following outputs were achieved:

- o Mbabane clinic has been relocated into newly acquired spacious facilities, fully equipped for administering all presently offered reproductive health services, including operating room facilities for vasectomy and ML/LA.
- o VSC services were introduced at Mbabane FLAS clinic and Ubombo Ranches.
- o 8 vasectomies and 76 minilaps have been performed using the infrastructure set up through the FHS grant amendment.
- o 27 nurses were trained in infection control.
- o 40 nurses weretrained in human sexuality.
- o 27 nurses weretrained as service providers.
- o 12 nurses receiving CTU.
- o 1 nurse was trained as trainer of service providers
- o 1 nurse was trained as a FP counselling trainer
- o 24 nurses were trained in VSC counselling

Family planning acceptor rates have increased steadily in industry and FLAS clinics. Table 2 illustrates the increased level of services provided in the three FLAS clinics for a similar time period--January through September--from 1993 through 1995. Over the two-year period, new users increased over 50% while the number of revisits increased about 35%. Couple-Years of Protection (CYP) also increased almost 50%. The increased CYP has been greatest at Mbabane, and least at Manzini. Thus, Mbabane, with its new facility, has become the largest clinical provider of family planning services. If the seasonal pattern of services in 1995 follows that of 1994, the total number of New Users, Revisits, and CYP for the FLAS clinics in 1995 should reach 5,275, 25,847, and 9,791 respectively. This translates into about 440 new family planning accepters per month. Clinical services in the private sector program have similarly increased and are described in the section of the report devoted to the private sector program.

C. Quality of Care

The FLAS framework for accessing quality of care (a combination of the COPE approach and the Bruce framework) was used to assess quality of care (QOC) for this evaluation.

1. Access to Services

The three FLAS Clinics are located in the two main cities of Mbabane and

TABLE 2

FLAS CLINICS PERFORMANCE: 1993-1995

Measured by Usage

Indicator/Clinic	9 months, January to September		
	1993	1994	1995
<u>New Users</u>			
Mbabane	967	1482	1853
Manzini	1294	1738	1622
Malkerns	282	497	491
Total	2543	3717	3966
<u>Revisits</u>			
Mbabane	5083	8359	8899
Manzini	7002	6345	7937
Malkerns	2175	2392	2598
Total	14260	17096	19434
<u>Couple Years Protection</u>			
Mbabane	1603	2886	3553
Manzini	2774	2022	2809
Malkerns	686	769	1000
Total	5063	5677	7362

Figures extracted from September 1993, 1994 and 1995 FLAS Service Statistics Quarterly Reports.

Manzini and in the township of Malkerns in close proximity to the main roads. All are easily accessed by public transportation. The most strategically located clinic is the Manzini Clinic standing across the street from the main market which attracts many vendors and buyers from the area and other parts of Swaziland. All clinics are identified with the FP service site flag at full mast and small flags pointing the way.

These three clinics provide all methods of contraception available in Swaziland either directly or through a planned referral system. Only one FLAS clinic, Mbabane, provides VSC. Others refer their clients. FLAS clinics operate from 8:00 a.m. to 5:00 p.m. Monday to Friday and 8:00 a.m. to 1:00 p.m. on Saturdays. Saturday clinics allow accessibility to FP clinics by a clientele who would ordinarily only be able to avail themselves of the services on weekends, e.g., some working men and women and adolescents who have to attend school. Industry services are centrally located.

FLAS reproductive health care services are offered through an integrated modality which ensures the availability of services at all times during routine clinic hours except for services which require specialized expertise and appointments.

At some industry clinics, e.g., Usuthu Pulp and Ngomane where the level of FP service is low and expected to remain so due to the small number of females in the industry population, scheduled FP sessions are still conducted but clients who need to receive service are welcome at any time. The majority of industry services are fully integrated.

Most industry clinics use voluntary outreach (IBD/CBD) workers who provide motivational and contraceptive distribution services to employees on the job or in the residential villages. These services are offered in a variety of modalities. The three FLAS clinics have no outreach to their catchment area but do receive verbal referrals from MOH RHM and other health workers who serve suburban areas.

The mobile unit is a mobile consulting room in a minivan type vehicle. The front of the vehicle (driver and one passenger compartment) is completely partitioned off. It accommodates an examining table, a bench, and a supply cabinet with a table top working area securely installed against the partition. All equipment and supplies except drugs have been purchased. Staff have been assigned and oriented. However, launching of this service has been delayed, awaiting implementation of the new fee schedule which will be used instead of the previous schedule on which costing was predicated. Eight industries have engaged the services of the mobile van and are waiting for it to start.

2. Information and Informed Consent (counselling)

Many FLAS clients are informed and motivated through FLAS IEC activity. In industry, many clients are referred by IBDs. They arrive at the service delivery point with varying degrees of contraceptive knowledge and very often a choice of method. It was noted that all FLAS and industry clinic staff have a clear understanding of the responsibility to give

information with equal emphasis on each method of contraception to facilitate unbiased, informed choice by the client. This is done in group session when possible and appropriate and always during individual counselling.

The quality and quantity of counselling in most FLAS-supported clinics seems good. The nurses and other staff that we met appear competent, motivated, and enthusiastic about their work. The service providers showed great understanding, commitment, and concern for their moral and legal responsibility to their clients in eliciting informed consent. This is particularly necessary and true in the area of VSC services.

3. Safe Services

FLAS commitment to providing an infrastructure for safe, reliable, thorough, and accurate services is evidenced in the training of the appropriate and qualified service providers. They have also effective systems for infection control, adequate supplies of necessary equipments and commodities, and standard service delivery protocols to enable service providers to adequately follow guidelines for service through accessible desk reference material.

All the facilities visited seemed structurally safe, adequate or spacious in size, well maintained, appropriately and in some cases beautifully decorated. By any standard the new Mbabane clinic constitute a show piece among Family Planning clinic facilities.

All clinics visited had enough instruments for present client load including speculae. At one site the staff expressed the need for more uterine sounds and tenaculum forceps. Infection control is adequately practiced at all sites with equipment and commodities in place for universal precaution. Where incinerators and sharps disposals are not available staff improvise. All clinics had adequate sterilizing equipment (dry heat, autoclave and water), and the adequate provision for decontamination of used instruments was provided at all but one site where none was observed. This industry clinic (Ngomane) served most of its FP clients through two weekly sessions.

Industry clinics have access to laboratory services. FLAS clinics use government facilities. Mbabane clinic laboratory is not yet equipped but the physical structure is in place.

As mentioned in the input section of this component, during this extension period Infection Prevention Training was recommended and implemented by Pathfinder International and is satisfactorily practiced.

The FLAS manual of clinical service standards was developed in 1991 with TA from Pathfinder International and addresses history taking and physical assessment, FP methods, STDs, Laboratory tests, Counseling and Infection Control. This manual, although comprehensive and adequate at the time it was written in May, 1991, is now outdated. FLAS staff are in the process of revising and updating the manual to address current and expanded

reproductive health care needs. The FLAS staff are very familiar with the manual and use it conscientiously where applicable.

4. Privacy and Confidentiality

At all FLAS and industry clinics observed, there was adequate provision for privacy and staff awareness of the need for privacy and confidentiality; the physical layout allowed private space for individual counselling where interviews could not be overheard. Any procedure requiring the removal of clothing is done privately behind closed doors or screens. A client who arrives in the reception area at a FLAS clinic for service is only asked his/her name, pays a registration fee and joins the queue. Revisit clients are identified by the appointment cards they hold.

5. Continuous Supplies

FLAS plays a major role in the national FP logistics management system by preparing contraceptive procurement tables and acting as an agent for the government in the procurement of contraceptives. Through TA from Pathfinder, FLAS is now able to forecast national contraceptive needs. Government is highly appreciative of this role and compliments FLAS as an important stabilizing factor in contraceptive procurement, supply and distribution.

FLAS has a storeroom area for FP commodities at its headquarters. The room is spacious with adequate shelf space and low platforms to lift commodities containers off the floor. However the room needs to be better ventilated. At clinic level, all FLAS and industry clinics visited provide ample storage space where contraceptives can be locked away.

FLAS has established a client follow-up system which is based upon the needs of the specific method chosen. After a specified period, a client is informed of lateness by letter. After a subsequent specified interval, a client is deemed a defaulter and dropped from the register.

Clinic flow is closely monitored so that patients move through the clinic in a timely manner. Revisits are identified by their appointment cards and speeded through. A triage system is arranged among service providers and utilized at the point where the client presents for individual interview. Service providers decide among themselves how they will function and refer clients accordingly to each other.

6. Client Satisfaction

All clients interviewed expressed a high level of satisfaction with FLAS and industry staff. Staff-client rapport was observed to be high. Staff seem confident in their ability to establish good rapport and meet the emotional and medical/technical needs of their clients. A 1995 study of client assessment of FLAS services showed a very high level of satisfaction.

7. Staff Morale/Motivation

Generally, staff seem highly motivated and pleased with their work and operate as harmonious teams. The team spirit seemed to be nurtured partly by efforts to have all members of staff involved and participate to the extent of his or her ability. On-the-job orientation and training is given constantly to sharpen skills and increase one's ability to participate. A high degree of confidence was observed.

8. Management and Supervision

The FLAS clinics are supervised by the service delivery unit headed by a Program Manager who serves as program manager for both the service delivery and private sector units. Under the program manager is a Senior Program Officer for service delivery and training. This person supervises a number of program officers who monitor the activity of FLAS affiliated industry clinics.

Supervisory visits to monitor service delivery are made by the Senior Program Officer at regular monthly intervals to FLAS clinics. Other visits are done when issues require immediate action. A supervisory check list is used to monitor all aspects of service delivery. Then a conference is held with service delivery staff for immediate feedback and discussions.

FLAS compiles a monthly program/status report of clinic and industry activities which affords feedback on performance. Industry clinics communicate with their assigned monitor from the private sector unit. These monitors are program officers responsible to the Senior Program Officer of the private sector/service delivery unit. Each industry clinic has a staff member who supervises reproductive health care as part of his/her portfolio. In some cases, particularly where different cadres of providers are involved in service delivery, a number of industry health service staff monitor and supervise the progress.

Overall responsibility for FLAS collaboration with industry lies with the medical officer in charge of company health care and the FLAS private sector program manager. A supervisory checklist-- "Clinic Site Visit Checklist"--developed with TA from Pathfinder International is used for supervisory visits which are done on a monthly basis. The checklist is a two page document which summarizes and replaces a previous twenty four page document. It embodies the elements of cope and the FLAS QOC. Staff receive prior notice of planned visits. The supervisor does site monitoring using the checklist followed by a conference with staff giving immediate feedback and opportunities for discussions of findings.

During this grant period, Pathfinder International medical staff made two medical monitoring visits to FLAS and industry facilities providing on-the-job training and TA on QOC where necessary. In October of 1995, Dr. Guthieri of AVSC oriented the staff of Mbabane clinic to the COPE method of QOC--Client-Oriented-Provider-Efficiency.

For the next three months, clinic staff will observe issues related to service providers and will meet to discuss them and suggest changes as appropriate. During this three month period, staff will also monitor closely the elements of client rights as set forth in the Bruce framework of quality of care and report and discuss their findings.

All charge nurses in FLAS and industry clinics seemed functionally at the helm. They were well informed about the FLAS system and about FP in Swaziland. All seemed to have good rapport with their staff and demonstrated responsibility for all aspects of clinic management. Interest and initiative were expressed and demonstrated in on the job training of all members of staff. Client records were thoroughly and accurately documented and charge nurses seemed very familiar with the use and significance of data collection tools in QOC and monitoring the FP program. Clinic forms and IEC material were in adequate supply.

Staff seemed knowledgeable about the availability of health care resources in private and government facilities. Clients seemed to be well managed by nurses and referred appropriately either within the FLAS system or externally.

Nevertheless, based upon 5-6 visits by the Evaluation Team, staff do not seem to be fully occupied. Staff know the times of day and days of the week that are busy or slow and can plan their staffing schedule accordingly. Records show that the FLAS clinics usually serve less than 20 clients daily and could serve more. In addition, opportunities for client education are not always seized. For example, group IEC is often not given before clinic sessions because service providers believe that the inflow of clients is such that at any one time there is not a large enough group to warrant an IEC session.

9. Staff Development

Each industry and FLAS clinic has at least one member who is qualified in FP service delivery. In the majority of cases, service providers either joined already adequately qualified or received on the job training, including the Contraceptive Technology Update (CTU) as required (see Appendix E.1 for the list of staff development courses). The FLAS Private Sector Unit has trained a large number of number of nurses from industry in FP clinical skills. These courses and an annual CTU has been provided by Pathfinder International.

FLAS encourages the training and utilization of its staff to optimum capacity. Staff appear knowledgeable, confident and willing to offer verbal self-appraisal identifying their training needs.

10. Summary

FLAS clinics and the industry clinics affiliated with it provide generally high quality reproductive health care. FLAS employs appropriately qualified staff and provides them with adequate FP training and supervision. This equips them with the skills and attitudes required to provide information, assessment and treatment for a constellation of specified family

planning and reproductive health care issues. Industry clinics are manned by registered nurse midwives; family planning services are supervised by FP practitioners, all of whom have had a CTU in the past year.

D. Training Capacity

FLAS has one professionally-trained trainer who received her training skills preparation at the Center for African Family Studies (CAFS) in Nairobi and one Nurse trainer for FP VSC counselling trained by AVSC. Staff members assist with various components of the family planning curriculum relevant to their areas of expertise.

FLAS utilizes a five-week service delivery trainers manual for registered nurse midwives. While generally adequate, the manual needs to be updated to address the broader concepts of reproductive health care, including gender issues and human sexuality. AVSC's counselling curriculum is used for training VSC counsellors.

On the other hand, The Swaziland Institute for Health Sciences (S.I.H.S.) offers an eight-week course in family planning service delivery. FLAS staff often assist with training in the S.I.H.S. course. The three FLAS clinics and their staff provide an adequate clinical experience and preceptorship for students, both of its own course as well as for FP students from SIHS and elsewhere.

Although there is significant FP theory in the registered nurses curriculum of the Institute of Health Sciences, it is currently not intended that the graduates should attain competence as FP practitioners. They lack the requisite clinical skills. However, this could be rectified relatively easily.

FLAS has most of the infrastructure needed for training: its facilities can accommodate nursing students in terms of space, availability of equipment and all of the elements of QOC, including well-trained service providers who can assist with the preceptorship of students. However, relatively few teaching aids and materials are available for FLAS staff.

E. Family Planning Method Mix

While the most common contraceptive method used in Swaziland is the injection, other methods are also quite common; this is also true in FLAS and industry clinic facilities. Table 3 presents the number of new users and revisits by contraceptive method for the three FLAS clinics for the most recent period available, January to September, 1995. It also shows the number of commodities provided and the Couple-Years of Protection (CYP) that should result. While the largest number of New Users are registered to condom clients, by far the largest number of revisits is due to injectable users. Taking into account the period of contraceptive use expected for each contraceptive, the measure of CYP shows that the injectable contraceptive contributes the most, but that orals, IUCDs, and condoms also contribute from 74% to 90% of the CYP of the most common method, the injectable. Currently, nine cycles

of pills are given out at a revisit while 25 condoms are distributed at each visit. It should be noted that while each injection is automatically effective, not all of the pill cycles and condoms distributed may be used. Foam tablets contribute under 3% of total CYP while the number of diaphragms used is negligible.

1. Injectables

The injection used in Swaziland is Noristerat which has a two- month action. It is administered by a registered nurse at FLAS and industry clinics. It is not available through outreach activity. All service providers interviewed in FLAS and industry clinics expressed the view that male dominance and resistance to FP, coupled with women's low status and subsequent inability to negotiate sexual activity, nurture and promote the use of FP methods that are not easily detected; hence, the client preference for the injectable method.

2. Pills

The Pill is the second most commonly used contraceptive method in Swaziland. The variety of pills used are:

Standard dose - Ovrall

Mini Pill - Micronor

Low dose - Lofemenal, Eugynon 30

There seems to be effective transition from progesterone-only pills to other pills.

3. IUCDs

IUCDs are a less commonly used method of contraception in Swaziland but still contribute a significant portion to overall CYP. The high incidence of STDs in Swaziland dictates a careful screening and close monitoring of IUCD clients. The discontinuance rate is not high. The Copper T is the only brand of IUCD available in Swaziland from FLAS and the MOH; private doctors have other types.

4. Condoms

Condom use has increased in Swaziland as a protection against STD/HIV/AIDS. Clinic records and interviews with service providers indicate that a preponderance of condom clients are males who are using condoms mainly as protection against STD/HIV/AIDS. FP service providers are aware of and often promote the dual benefit of condom use as a barrier method of contraception and as a barrier against STD/HIV/AIDS. The routine promotion of condom use with other methods of contraceptives might be expected.

TABLE 3

THE NUMBER OF NEW USERS, REVISITS, COMMODITIES PROVIDED, AND CYP AT
FLAS CLINICS, JAN.-SEPT., 1995

CONTRACEPTIVE METHOD	NEW USERS	REVISITS	COMMODITIES	CYP
INJECTABLE	1,164	9,592	10,476	1,612
ORALS	515	3,316	18,863	1,451
IUCDS*	483	2,530	913	1,449
CONDOMS**	1,609	3,492	172,391	1,197
FOAM TABLETS	171	468	14,060	141
DIAPHRAGM/JELLY	24	36	112	36
TOTAL	3,966	19,434		7,362

* CYP for condoms has been calculated at the recently approved rate of 144 pieces per CYP. 27% of the condoms dispensed were recorded as being for STD treatment or FP backup.

** CYP for IUCDs was calculated at 3.0 years per new IUCD insertion.

However, the same providers contend that their experience is that a client who needs to secretly contracept cannot negotiate condom use. There may be a tendency among some FLAS providers who do individual counselling to assume that women who ask for injections cannot be empowered to negotiate condoms with their partners. This may too easily become a "self-fulfilling prophecy"; counsellors assume women cannot learn this skill, so they don't try to teach it.

These providers also agree that pregnant women seem better able to negotiate condom use in the interest of their baby. It was noted that no service provider observed during this evaluation had a condom on her desk or in easy access to the client being interviewed. Also, no client was observed accepting a condom with another method of contraception nor did the service records show dual method use.

The condoms used in Swaziland are sold in a dull, white packet as a "clinical" product in the context of disease prevention, not to promote pleasure. Thus, the promotion of condoms is mainly through negative images, building on fears, rarely utilizing the concepts of sexual pleasure or Swazi traditions. Unfortunately, the condoms distributed by FLAS and the MOH are from several sources and vary in types, sizes, and place of origin. Although there is no research on this issue, the inconsistency of condoms might add to level of mistrust--"they may break"--and indifference among potential clients; we were informed that some men believe that condoms, or their lubricants, may cause impotence. IEC staff work hard to counter these myths, but solid research has not been done to verify Swazi attitudes toward condoms, and to come up with alternatives. A standard high quality brand packaged locally and advertised in a careful marketing campaign could address and prevent such worries.

5. Foaming tablets

As a spermicidal method, the contraceptive vaginal foaming tablets are utilized and readily available in Swaziland at clinical service delivery sites and from outreach distributors. Their use, while limited, has been growing.

6. Diaphragms

The diaphragm is a readily available barrier method of contraception, minimally utilized in Swaziland. It requires the adjunct use of a spermicidal cream or jelly for the triple benefit of a fixative, a lubricant and a spermicide. The utilization of foaming tablets as a spermicide of choice for the Swaziland FP program precludes easy access to a spermicide for the sustained use of the diaphragm. Service providers report that, routinely, new diaphragm sets are opened to obtain the starter supply of spermicide cream or jelly to be used to replenish a client's supply. While most service providers state that foaming tablets are the only source of spermicide in Swaziland, a full expired carton of jelly spermicide was found in one FLAS clinic. That clinic had not had a diaphragm user in the past three years.

Even though contraceptive utilization data show that diaphragms are minimally used, most clinics visited were heavily stocked with them. Research findings that indicate that the pericervical area is the main portal of entry for sexually transmitted HIV may offer a reason for the use of the diaphragm other than its role as a contraceptive, for which it is not suited for most Swazi women.

F. Special Issues Affecting the Promotion of VSC

VSC services (ML/LA and vasectomy) have been introduced in Swaziland under the FHS grant extension. These services are now available at the FLAS Mbabane clinic and at the Ubombo Ranches medical facilities. The introduction of VSC services in Swaziland by FLAS was fraught with the following unanticipated problems:

- o Ill health and subsequent change of job of the first physician trainee and designate coordinator of the program, left the program with no leadership--only supervision and monitoring by AVSC staff from Nairobi. Although AVSC provided excellent technical support, it could not fill the gap for in country leadership. However a logical coordinator has emerged: One of the doctors at Mbabane FLAS clinic should assume coordination.
- o The movement of one other trained physicians ended the services at one site (Mlume clinic).
- o The industry site that has yielded the most minilaps (Ubombo Ranches) is not using the recommended procedure, citing the availability of a good anesthetist, a good hospital setting, and client satisfaction as justification for using spinal and general anesthesia. The majority of their clients fit the profile of overweight, post-partum grand multiparas.
- o Mbabane service providers have observed that the anatomical features and the epidemiological profile of the local population warrants careful screening and selection of clients for the procedure. Practitioners have observed that screening for obstetric history, history of STDs, present infection of STDs, old scars, body size and structure are very important. Marked differences between the ML/LA clientele of Kenya and Swaziland have been noted. These issues have been partially resolved by according the nurses greater responsibility for client screening.

Though vasectomy has only become available in Swaziland since July, 1995, eight vasectomies have been performed to date at the very limited number of facilities offering it. While a good start has been made, there is a need to make services available nationwide as soon as possible. In most countries where vasectomy was initially unpopular or unknown, the increase in popularity occurred because initial information was spread by word of mouth. Many men will not consider vasectomy until they have had a personal discussion with another man who

has experienced it. Thus, a special IEC effort is needed to exploit the word-of-mouth concept to promote vasectomy in Swaziland. No-Scalpel vasectomy, the technique now available, requires no incision or stitches in the scrotum, and is more appealing to both clients (less fear, fewer complications) and providers (less time and help required) than the earlier technique.

G. Reproductive Health Care Services

Although FLAS maintains a FP focus, it has gradually expanded its scope of services to include other reproductive health issues. Under the FHS extension it has further expanded its scope to address HIV/AIDS prevention and control through education, STD treatment and condom use.

The Government of Swaziland embraces the broader reproductive health care approach which is compatible with its integrated service modality. It is also the course indicated by Swaziland's demographic and epidemiologic profile of high infant and maternal morbidity and mortality rates, and the high incidence of STD/HIV/AIDS and childhood infections diseases.

Concern for women's health and gender issues also dictate this course. While FLAS seeks to address comprehensive reproductive health needs, the view that FP is perhaps the most important reproductive health care intervention is strongly held. Hence, every client of reproductive age is seen as a potential FP user and other clients entitled to appropriate advice and treatment to maintain sexual and reproductive health. Against this background, Table 4 presents the number of Non-FP services provided during the first nine months of 1995. The nearly 10,000 STD treatment visits and almost 3,000 STD counselling visits by themselves equal over half of the total number of 23,400 FP visits in the three clinics. When the number of infertility, MCH, Pap Smear, and pregnancy tests are added to the STD visits, one can see the scope and scale of FLAS Non-FP reproductive and MCH services.

1. Prevention and Control of STD/HIV/AIDS

FLAS and Industry clinics are experiencing a steadily growing number of STD/HIV/AIDS clients. A client who arrives at the clinic seeking STD services or whose health assessment presumes STDs, is given the following services:

- o STD/HIV/AIDS Counselling
- o History taking
- o Physical examination
- o Symptomatic treatment
- o Blood test for STDs (FLAS utilizes government facilities for blood tests. Industries provide their own facilities)
- o If blood test is positive for syphilis, patient is then given:
 - Specific antibiotic (if necessary).
 - Letter to partner (for contact tracing).
- o If a partner comes in for treatment, the following is done:

- STD/HIV/AIDS counselling
- Physical examination
- Symptomatic treatment
- Blood test for syphilis

If the partner's blood test is positive for syphilis, the partner is given further antibiotic treatment if indicated. Assuming that some clients may have multiple partners, or if medical history indicates, attempts are made to trace as many contacts as indicated by letters conveyed by the client. No tests are done to confirm a cure. Complete antibiotic course and the absence of symptoms is regarded as a cure.

FLAS assumes its social, public and moral responsibilities towards prevention and control of HIV/AIDS and thus has committed to a number of primary prevention interventions as listed below:

- o Education: Public and group education is offered through FLAS' IEC campaign. FLAS collaborates with the Swaziland National AIDS Prevention Program (SNAP). SNAP posters are displayed in FLAS clinics and public places in FLAS' catchment area. All clients who are interviewed individually are given some amount STD/HIV/AIDS education. Clients who are treated for STDs receive information on the complementary relationship between other STDs and HIV and the added importance of condom use at this time.
- o Condom use: Theoretically, universal condom use is advocated, though in practice, this appears not to be strongly promoted.
- o HIV Testing: Clients who request HIV tests or whose history indicate a need to rule out HIV/AIDS, are referred, with their cooperation, to appropriate government facilities to have blood work initiated. Industry clinics provide a HIV testing service.

Both industry and FLAS services provide pre and post HIV test counselling by referral to appropriate qualified staff, usually in government facilities through the national AIDS program. Some industries have trained AIDS counsellors.

2. Pregnancy Tests

Pregnancy tests are available at all FLAS facilities. Clients who seek this service only spend on an average about half-an-hour in the clinic.

3. Screening for Cancer

All new FP clients receive pap smears as part of initial and baseline data. The specimen is taken as soon as the client's physical condition permits. Thereafter, while she

TABLE 4

NON-FP SERVICES PROVIDED BY FLAS CLINICS, JAN.-SEPT., 1995

SERVICE	NO. CLIENTS
TOTAL STD CLIENTS	9,869
NEW VISITS	5,488
REVISITS	4,381
STD TESTS	5,800
STD COUNSELLING	2,934
PREGNANCY TEST	2,425
INFERTILITY	1,096
MCH (Prenatal, Child Growth, Child Treatment)	2,525
POSTNATAL	282
PAP SMEAR	1,148
YOUTH COUNSELLING	387

remains on a method of contraception, the tests are done annually. The specimen is sent to the government laboratory for testing. If the result is positive, the client is informed by a form letter requesting that she come to the clinic to receive the results. When she visits the clinic, the result is explained. She is counselled on significant health issues and referred to appropriate services.

All FP clients are taught self-forecast breast examination and encouraged to perform them regularly. In addition, breast examinations are done by service providers as part of a health assessment.

4. Infertility Management

Some FLAS staff are concerned about the steadily increasing number of infertility clients and the inordinate amount of time consumed for history taking and other investigations. The situation is further compounded by the fact that many clients do not present as infertility cases--and extra time is utilized in efforts to elucidate a clear and pertinent history.

Although supporting documentation does not exist, clinic staff's professional judgement is that close to 100% of infertility cases are secondary infertility due to STDs. This conclusion is supported by the high incidence of STDs in the country and the reinforcing evidence of high incidence from clinic data.

At one clinic, it is reported that much of the sessional physician's time is consumed in attending to infertility referrals. It is questionable whether this is suitable and/or productive use of expensive clinical expertise. It is well known that infertility management is frequently a long and tedious process best managed by infertility specialists or gynecologists with appropriate experience. Service providers seem greatly handicapped by the lack of protocols to enable them to expeditiously and adequately counsel and refer these clients out of the FLAS system before incurring tremendous unproductive use of staff time.

Current services offered to these clients are: history taking, physical examination, blood test for syphilis investigation, urine test, referral to M.D. for further investigations, including blood tests, for hormonal levels, before referral to external services.

5. Prenatal Services

FLAS clinics offer prenatal care to all clients upon request. There is no system in place to offer clients comprehensive maternity care either at the FLAS facility or by referral. All prenatal clients are investigated for STDs and treated if necessary. Blood work is done through government facilities.

6. Youth Counselling

FLAS clinics offer youth counselling on broad issues of human sexuality. Staff express appreciation for the knowledge acquired from the human sexuality course provided through the FHS grant extension. Counselling services to youth has been and will remain free. To date, there has been minimal utilization. Family Life Education services are offered by FLAS both in schools and in the community.

7. Cost-effectiveness of Reproductive Health Care

A cost-effectiveness study of FP and Non-FP services in FLAS clinics was carried out in early 1995. It showed that, in general, more than 50% of staff time is spent on Non-FP activities and that they account for a very large proportion of clinic costs. For example, Figure 1 shows that at the Manzini clinic, 41% of staff time is devoted to FP services, while 22% is spent on STD treatment and counselling and 33% is spent on other Non-FP services. Of the time spent on Non-FP services in the Mbabane and Manzini clinics combined, more than 60% is spent on STD services.

Figure 2 illustrates the commodity operating costs for Non-FP services at the three FLAS clinics. Eighty per cent of the total Non-FP operating costs in the Manzini and Mbabane clinics is due to STD services. In Malkerns, MCH services account for nearly half of the total Non-FP operating costs.

Clients pay a minimal fee for these services and infertility clients, who are often, in reality, STD clients, pay little or nothing. Increasing the charges for the Non-FP services, particularly STD treatment, is likely to substantially recover the costs involved, making it unnecessary to eliminate these services even in the face of the need for program sustainability. Indeed, all Non-FP services, except pap smears and youth counselling, show the potential to pay for themselves. Based on the clinic cost study, a proposal has been developed with an increased fee schedule for Non-FP activities. It is currently being reviewed and will likely be implemented in early 1996. This will probably result in a decreased demand for Non-FP services.

The very high prevalence of STDs in Swaziland, including their relationships to HIV/AIDS and infertility, renders their management a public health responsibility and a strong social obligation.

H. Conclusions and Recommendations

1. Overview

The service delivery component of the FHS extension grant has strengthened FLAS' institutional capacity for high QOC in its services. FLAS worked with industry staff with technical assistance from Pathfinder fund and AVSC to accomplish this.

FIGURE 1

MANZINI: TIME DEVOTED TO FP AND NON-FP SERVICES

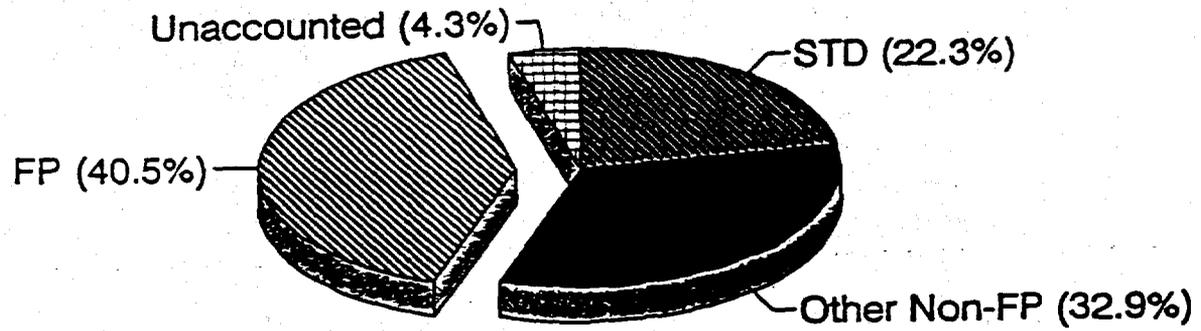
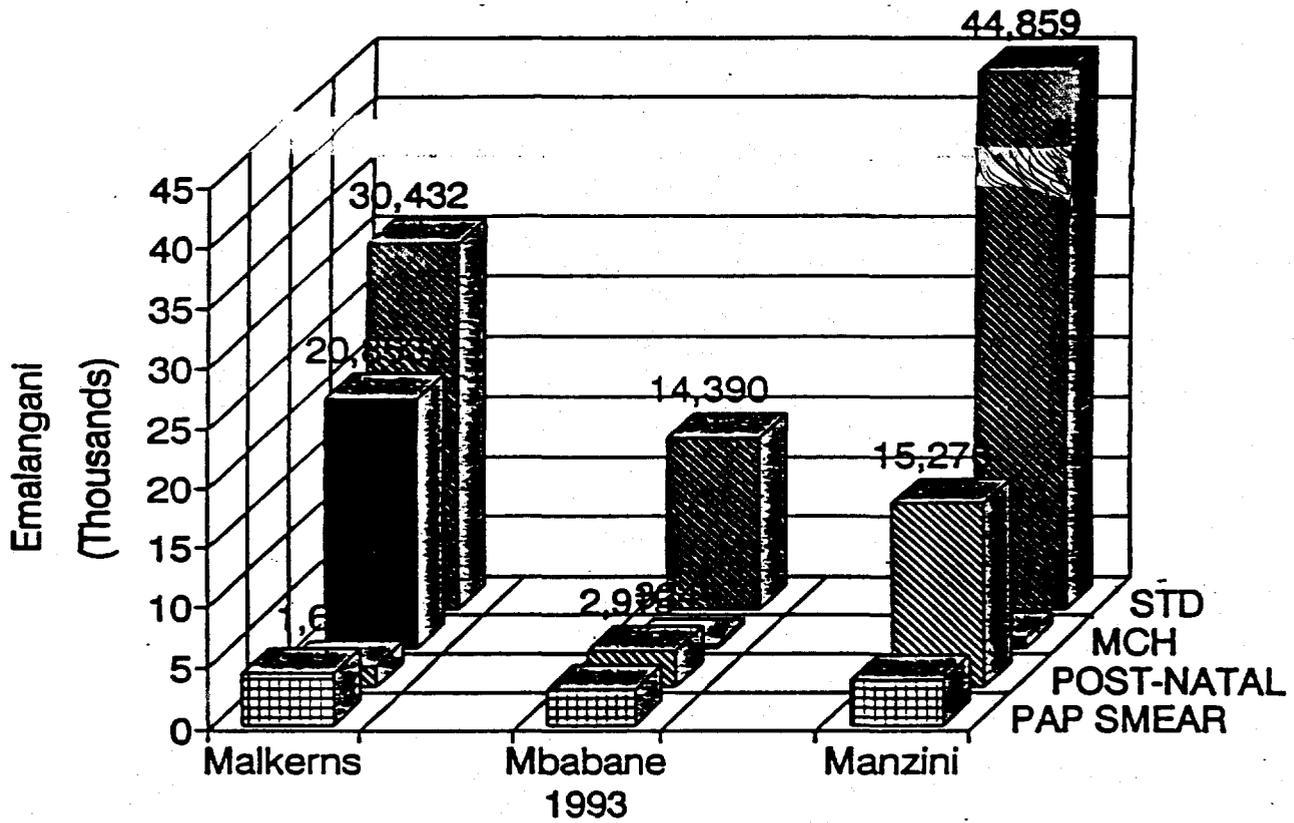


FIGURE 2

OPERATING COSTS FOR NON-FP SERVICES
(Commodities only)



FLAS has an excellent national reputation for high quality services attested to by representatives of the Ministry of Health and industry who laud without reservation its positive impact on FP activities in Swaziland. FLAS was also commended for its exemplary pioneering and leadership role in adolescent counselling, collaboration with industries (particularly in the areas of STD/HIV/AIDS management, training and outreach) and the introduction of VSC services.

During the grant period, FLAS has introduced and maintained VSC services (ML and vasectomy) at two sites--the Ubombo Ranches industry clinic and the Mbabane FLAS clinic. Despite unforeseen launching difficulties, an infrastructure for services (suitable clinical sites, trained doctors and nurses, equipment) and a partial infrastructure for training (trained nurse trainer, two doctors who assert confidence and availability to train, suitable training site) have been developed. More minilap sets will be needed for training.

The unforeseen attrition of doctors from the VSC pilot program has retarded but not stopped progress. There is enough of an infrastructure in place to build upon, though an increase in the number of sites where the services are available is essential. Further efforts at the promotion of VSC, both minilap and vasectomy, would likely be successful. However, the careful selection of suitable clients is an important issue as the VSC program gets underway; it is currently addressed adequately.

FLAS could further strengthen its capability as an FP institution of excellence by building on its infrastructure in training, improving the promotion of condoms and VSC, streamlining infertility management, improving the package of reproductive health care along with increased fees for cost-recovery, and addressing the phenomenon of male resistance to FP.

Specific conclusions and recommendations for various aspects of clinical service delivery and quality of care are presented in the paragraphs below.

2. Establishment of VSC Services

The following Conclusions were reached by the evaluation team:

- o The attrition rate among ML/LA physician practitioners has been high, resulting in limited VSC availability. Of four doctors trained, only two are currently practicing ML/LA and they are both at the same site. Thus, there is a strong need for more trained physicians.
- o Service providers express the view that there is a much greater unmet demand for minilaps than there are trained physicians to perform them. Although 76 minilaps have already been performed, it is felt that more trained physicians and more IEC will lead to a rapid expansion of services in the future.

- o The program currently has no defacto leadership, as the designated coordinator has not functioned in that capacity and is hard put to do so now, having not performed a VSC since training.
- o Because doctors at Ubombo Ranches are not using local anaesthesia when performing minilap, the purpose of the minilap--to avoid the risks and inconveniences of general and spinal anaesthesia--is being negated and its potential popularity diminished.
- o Careful selection of clients is crucial to the viability and growth of VSC services in Swaziland. Current VSC medical staff acquired their training on a different clientele than they now serve and must reorient themselves as their practice develops in Swaziland.

In response to the findings and conclusions noted above, the team has made the following Recommendations for FLAS:

- o Further develop FLAS' training infrastructure (for example, more minilap sets are needed) and begin VSC training in Mbabane as soon as possible. This will provide easier access to some providers who are unable to leave their duty stations for overseas travel and will provide medical staff an opportunity for learning to perform VSC with the type of clientele that will ultimately be served. Training could be conducted in several sessions over a period of time, enabling providers to travel from their duty stations to Mbabane and return after each session. AVSC should be consulted for advice and/or assistance with this.
- o Capture the present momentum in service delivery before it is lost by also facilitating a nationwide dissemination of VSC IEC.
- o Give serious consideration to appointing Dr. Ntiwane as Director/Physician, Coordinator/Supervisor for VSC activity. He is highly motivated, strategically located, and well-qualified having performed 14 ML/LAs and 4 vasectomies. He has the support of Dr. Shongwe, another highly motivated and trained physician practicing at the same site.
- o Persuade Ubombo Ranches staff to use the advocated procedure (local anaesthesia) to perform minilaps. Clients who don't meet the criteria for ML/LA may be offered tubal ligation under general or spinal anaesthesia. The same practice could be followed at other sites.
- o Consider engaging AVSC to continue to provide monitoring and supervision of the quality of care in VSC services.

3. Quality of Care

The following conclusions were reached regarding quality of care:

- o The overall quality of care at FLAS and industry clinics is very high. It is an example of excellence in reproductive health care.
- o The staff at all FLAS clinics seem to be not fully occupied with client care at all times.
- o Opportunities for more client education in the clinics appear to be available.

The evaluation team makes the following recommendations for quality of care based on its findings and conclusions:

- o Conduct a mini-study to track and quantify the utilization of time by all members of clinic staff. (REU)
- o Develop outreach activities by clinic staff in their clinic catchment and peri-urban areas when their clinic duties are very light. This would enhance the quality of care offered to the community and would better utilize the clinic staff. In addition to IEC activities, especially for VSC, such outreach work might distribute condoms, foaming tablets and pills (on a re-supply basis) and refer prospective clients to use the clinic services.
- o Encourage service providers at static clinics to make more of an effort to conduct group education when it is possible.

3. Training and Service Delivery Protocols

Conclusions reached regarding the training and service delivery protocols include:

- o There are at least two different FP service providers' curricula for registered nurses in Swaziland. This is unnecessarily confusing.
- o FLAS has most of the infrastructure needed for training, though there are a few minor deficiencies.
- o Although it was earlier recommended that FLAS FP service delivery protocols be updated annually, it has now been done for the first time. Recent and likely future changes in FLAS' service delivery scope, e.g., HIV/AIDS management, VSC services, cost-recovery measures, and reproductive health care services, make an annual updating in protocols more important.

The team made the following recommendations:

- o Continue working with other health training institutions, such as S.I.H.S., to produce a standard FP curriculum for Swaziland.
- o Encourage and offer assistance to S.I.H.S. to incorporate the FP service provider course into the basic nursing curriculum such that a level of competence as a FP Practitioner is acquired before graduation. FLAS could facilitate utilization of its clinics for clinical experience. Suitable qualified FLAS staff could seek appointment as ex-officio clinical instructors of SHIS for reproductive health and undertake the preceptorship of SIHS students as adjunct instructors.
- o Strengthen FLAS' infrastructure for training service providers by developing more teaching course materials, e.g., hand outs, lesson plans, student outlines, assignments, flip charts, tapes, etc. It could assign responsibility for teaching specific components of the curriculum to members of its staff by allocating teaching responsibilities appropriate to each staff's position and qualifications and have the assignments included in the job descriptions. Given its level of excellence in reproductive health care, it should consider marketing itself for the provision of training to other organizations in the region.

4. FP Method Mix

The following conclusions were reached regarding the mix of family planning methods currently used in Swaziland:

- o Although seven methods of contraception are now available in Swaziland, the dominance of the injectables, pills, and condoms, and the minimal use of some methods, e.g., foaming tablets and diaphragms, produce a limited method mix. This appears to reflect current client demand.
- o Service providers report an unmet demand for permanent and long-lasting methods, such as VSC and Norplant, as evidenced by requests from clients.

Recommendations pertaining to family planning methods include:

- o Consider diversifying the method mix by trying to further promote and make accessible permanent methods (vasectomy and minilap).
- o Introduce Norplant use in FLAS clinics. This may require an initial needs assessment, then a trial phase followed by a service delivery phase, and the training of providers to administer the method.

5. Acceptance of Male Resistance to FP and the Promotion of Condom Use

The following conclusions were reached regarding attitudes toward male resistance to family planning:

- o Clinic staff seemingly acquiesce to clients' injection preference. Staff express the view that the majority of clients cannot effectively negotiate contraceptive use with their spouses.
- o Universal condom use is not as aggressively promoted in FLAS clinics as it is in the Private Sector program.

To respond to these attitudes, the team recommends the following actions:

- o Offer gender sensitization and negotiation skills to service providers to enable them to better advise and teach their clients contraceptive negotiation skills.
- o Train counsellors to be more comfortable in dealing with partners, where both partners are willing to come to the clinic, in the context of "couple-friendly" counselling.
- o Offer all clients coming to FLAS services condoms if they are sexually active for protection from STDs/HIV/AIDS along with any other service applicable. This includes other methods of contraception.
- o Display condoms on all service providers' desks with a clear note inviting clients to help themselves.
- o Attempt to address client concerns about the types of condoms they distribute.
- o Work with the MOH and other NGOs to test-market a brand-name condom that is named, packaged, priced, and promoted specifically for Swaziland or for southern Africa. This brand of condom should be sold, not given away, both to inspire confidence and to generate income for FLAS and the IBD and CBD workers. To make money as well as to improve condom distribution, FLAS could play a major role in developing a condom retail sales campaign. This should be carried out in collaboration with condom marketing professionals and in harmony with the MOH and industry programs.

6. Comprehensive Reproductive Health Care and Infertility Services

The following conclusions were reached regarding comprehensive reproductive health care and infertility services:

- o FLAS clinics offer prenatal service but do not offer or encourage the full gamut of maternity comprehensive care throughout pregnancy and infant care thereafter.
- o Only one FLAS clinic, Malkerns, provides a broad spectrum of MCH/FP services on a regular basis.
- o Infertility management consumes an inordinate amount of staff time while yielding very little fees for service and utilizes a great deal of expensive physician referral time.
- o The great majority of infertility cases seen are probably secondary infertility caused by STDs.
- o Non-FP services take up over 50% of clinic staff time and require considerable operating costs to provide the services. The introduction of higher fees as now planned will likely reduce the demand for non-FP services.

As a result of the above findings and conclusions, the following recommendations are offered.

- o Consider a perinatal approach to maternity and reproductive health care. Such comprehensive care would include prenatal management, STD and other investigations, child birth education, preparation for breastfeeding, arranged referral for delivery, contraceptive counselling and the arrangement for contraception after delivery (including immediate postpartum minilap or IUCD, and lactational amenorrhea method (LAM) of contraception,), postpartum follow-up, immunization of new born, and growth monitoring (See appendix E.3 for further comments on perinatal care.). The cost-recovery aspects of the above services need to be carefully considered and planned for before any additional service is contemplated.
- o Develop protocols to enable the quick (timely) referral of infertility clients, e.g., through a detailed history, the simple existence of STDs could be ruled out. Once infertility is an issue, the client should be referred to other facilities that are better equipped to manage the treatment of infertility.
- o Implement an increased clinic fee schedule, as has been already developed, as soon as feasible so that the Non-FP services can become substantially self-supporting. Conduct an assessment of the impact of the increased fees on the demand for services, including client feedback, in the first few months of the increased fee schedule.
- o Sponsor and set up an expert advisory committee to monitor and influence the delivery of high quality reproductive health care in Swaziland to help bring about

higher quality reproductive health care on the national level. Involving both government and NGO service providers, the committee would afford FLAS an opportunity to develop a healthy collegial relationship with the other health care providers in Swaziland.

III. PRIVATE SECTOR PROGRAM

A. Background

1. Goals and Objectives of Private Sector Program

FLAS initiated the pilot industry-based private sector program during Phase I of the FHS grant. Earlier, a depot holder approach with minimal IEC activities had been tried at about 15 industries in the Matsapa Industrial Complex near their Manzini headquarters for the distribution of condoms. In 1988, under the 5-year FHS Cooperative Agreement with both FLAS and Pathfinder International, a number of additional activities were initiated, including a component for strengthening the capacity of industries to provide family planning services.

The mid-term evaluation conducted in September, 1990, observed the program and made the following recommendations regarding the industry-based activities:

- o FLAS should initiate a pilot industry-based family planning program in three rural-based companies.
- o FLAS should use the pilot phase to determine which services are more needed by companies, which are more marketable, and which are in FLAS' ability to provide on a large scale.

Following the evaluation, the project was amended and the expiration date extended to December 31, 1993. While the major goal and objectives remained unchanged, the modification called for Pathfinder to place a Resident Advisor to assist FLAS with the development and implementation of a pilot industry-based (Private Sector) component at three large companies.

In April, 1993, another assessment of the industry-based program was undertaken and some of the recommendations made were:

- o Project activities should be expanded to more large and medium-sized firms as well as the market-based private sector providers.
- o The project should aggressively increase access to oral contraceptives and voluntary surgical contraception.
- o The project should continue to try to emphasize family planning equally in conjunction with STD/AIDS prevention, rather than simply emphasize STD/AIDS prevention.
- o To improve implementation, FLAS management should move to more fully integrate the private sector family planning activities with FLAS' other technical activities.

In July, 1993, an amendment was made to extend the project until December 31, 1995. Although the original goals and objectives again remained unchanged, through the extended project, FLAS was expected to increase the availability of family planning (FP) services by:

- o Improving and expanding the industry-based FP/AIDS pilot program; and,
- o Initiating a pilot program of voluntary surgical contraception in at least three industry medical facilities.

In addition, the FHS amendment provided for a greatly expanded information, education and communications program and assistance for FLAS to move toward greater self-sufficiency.

The major goals of the program for the extension period, therefore, focused on extending technical assistance to additional private sector firms as well as improving the quality of family planning service provision at existing sites. Specific planned activities are outlined in Table 5.

2. Program Overview

The private sector program is based at industries located both in the urban and rural areas. A major component of the program are the mainly volunteer industrial-based distributors (IBDs) deployed to sensitize and educate their fellow employees about family planning, HIV/AIDS and STDs. While the IBDs are able to distribute condoms and foam tablets, and, in some industries, oral contraceptives, clients are referred to industrial clinics for other services. The program is implemented with the approval and commitment of top management who in all instances are willing to have employees assigned as IBDs or Supervisors. Management further provides approval for nurses, IBDs and Supervisors to attend relevant training as part of the program.

FLAS has subsidized the cost of technical assistance provided for the training of personnel, IEC development and materials, contraceptives and incentives for IBDs. Industries, on the other hand, have provided personnel costs, equipment, and training facilities for the IBDs.

To date, FLAS has assisted 20 industries (16 have active programs) with an estimated workforce of 25,200 people--approximately one third of all employees in the private sector in Swaziland.

3. Industry Profiles

The Federation of Swaziland Employers (FSE) categorizes industries into three categories:

- o Large industries: Ten industries with a work force of 2000 or more.

TABLE 5

PLANNED PRIVATE SECTOR ACTIVITIES AND STATUS

ACTIVITY	STATUS
1. Seminars with industry management, IBDs and their supervisors	Done
2. Promote longer acting FP methods	Ongoing
3. Pilot oral re-supply by IBDs	Implemented at 2 sites and is on-going
4. Establish IBD selection criteria	Established
5. Establish IBD incentive scheme	Established
6. Revise MIS reporting forms	Done
7. Expand IEC activities	Achieved the following:- ♦ Marketing for industry programs ♦ Developed & distributed industry- specific IEC materials
8. Expand IBD and clinic services to new industries	Program extended to 20 industries
9. Seminar for management of additional industries.	Conducted for 4 agro-businesses and 6 industries in Matsapha complex

- o Matsapha Industrial Area Companies: Medium to small firms.
- o Small Companies.

Table 6 illustrates FLAS' industrial coverage. During this evaluation, the team visited five large, one small, and two Matsapha industries. A brief profile of each follows. The attached map (Figure 3) and Table 7 provide an overview of all of the program sites.

a. Usuthu Pulp

A major producer of woodpulp in the region, Usuthu Pulp company employs approximately 240 workers. The company is located in the Western highveld region of Swaziland and comprise approximately 66,000 hectares of forest land. The welfare benefit package provided to workers includes housing, water, electricity, educational and health facilities.

The company operates four clinics and has a total of 36 Industrial-Based Distributors (IBDs) who refer fellow employees and/or dependents to these clinics for prescriptive contraception. The IBDs conduct peer education sessions on FP, STD, HIV/AIDS for groups of employees, and distribute condoms, foam tablets and available pamphlets.

b. Ubombo Ranches

A member of the Lonrho conglomerate of companies, Ubombo Ranches is a major producer of sugar in the country. Ubombo has a workforce of 3,000 employees and a total population of approximately 20,000 employees and dependents. The company provides housing, utilities, health care and subsidized educational facilities for its employees and dependents. Ubombo has a 50 - bed hospital and outpatient facilities and 20 village-based clinic posts each manned by a Village Health Worker\IBD. The VHW\IBDs distribute over-the-counter drugs such as painkillers, promote primary health care in the villages, conduct FP, HIV/AIDS awareness sessions including showing of relevant videos and distribute condoms as well as re-supplying orals. The VHW\IBDs refer prospective FP clients to the clinic for other services including initial supply of pills, injectables, IUCDs and permanent methods. Ubombo is located in the South East of Swaziland.

c. Mhlume Sugar

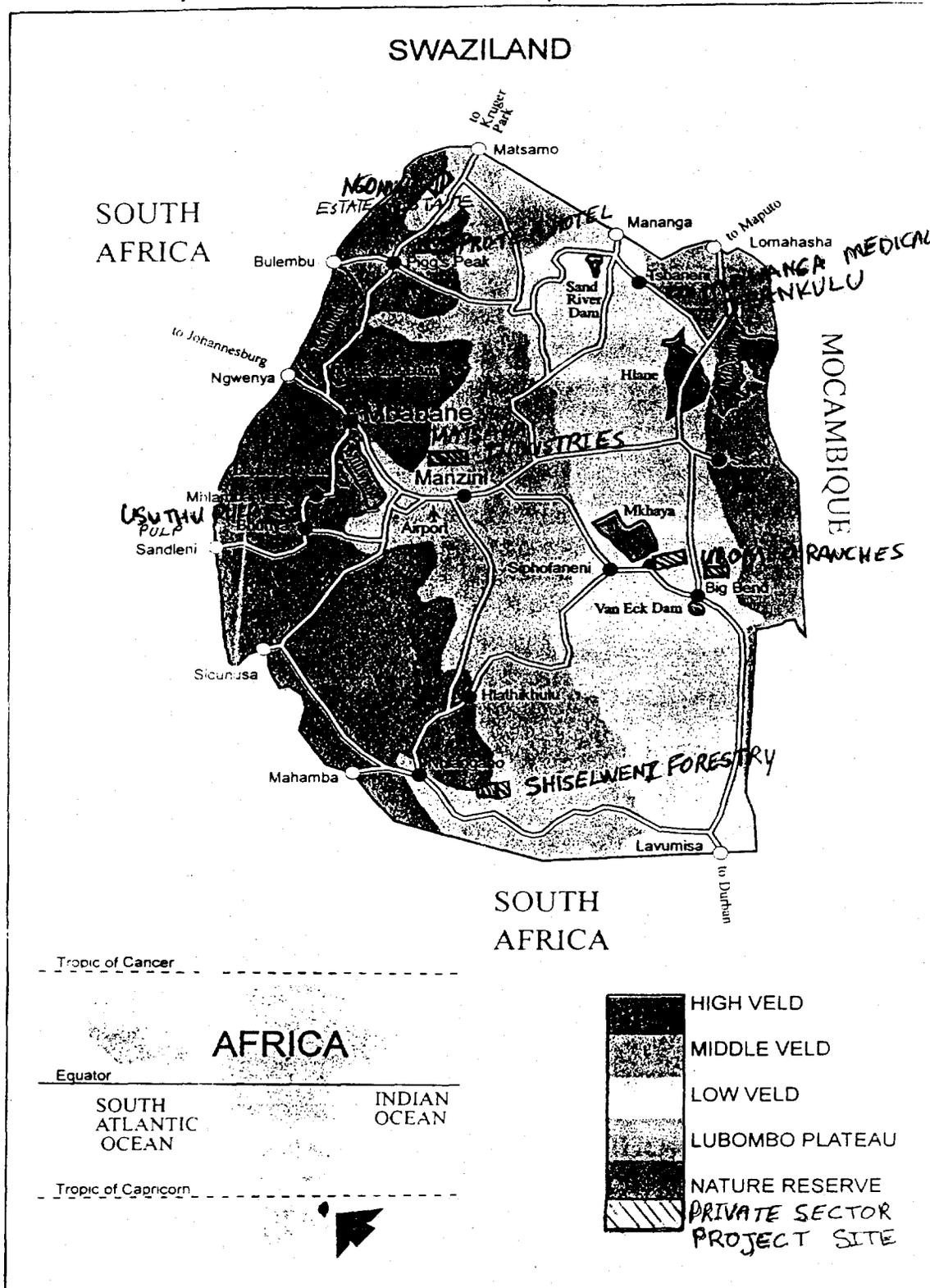
A sugar producing concern, Mhlume company is one of the four Commonwealth Development Corporation (CDC) entities that jointly own the Mananga Medical Services (MMS). MMS provides health care services for employees and dependents of five industries through a 22-bed hospital and an outpatient clinic both based at Mhlume Sugar and another clinic based at Inyoni Yami Swaziland Irrigation Scheme (IYSIS). The other three industries utilizing the MMS health services are Mananga Management Centre, Vuvulane

TABLE 6

FLAS INDUSTRIAL PRIVATE SECTOR PROGRAMS

<u>LARGE</u>	<u>MATSAPHA INDUSTRIES</u>	<u>SMALL</u>
Usuthu Pulp	Cadbury	Vuvulane Farms
Ubombo Ranches	Swaziland National Textiles	Mananga Management Centre
Mhlume Sugar	Bromor Foods	Ngonini Estates
Tambankulu	Swazi Paper mills	Shiselweni forest
Simunye	Sikanye Footware	Protea Hotel
Inyoni Yami S.I.S.	Super Frost	Cargo Carries
	Swaziland Breweries/ Coca Cola	Tambuti

FIGURE 3
PRIVATE SECTOR PROGRAM SITES



INDUSTRY	DATE PROGRAM BEGIN	NO. OF WORKERS			NO. OF SEASONAL WORKERS	SITE		HOUSING PROVIDED (Y N)	NO. IBDS			NO. CONDOM DISPENSERS	NO. OF CONDOMS 1994
		J	M	F		RURAL	URBAN		T	M	F		
LARGE													
1. UBOMBO RANCHES	1992	3000			800	RURAL		Y	21	1	20	-	24380
2. MMS	1992	4500			1500	RURAL		Y	58			10	49230
3. TAMBUTI	1992	400			250	RURAL		Y	20			-	3500
4. UPCO	1992	2360			NONE	RURAL		Y	36			-	20375
5. TAMBANKULU	1994	1381			500	RURAL		Y	10	1	9	5	23600
6. SIMUNYE	1994	3144			850	RURAL		Y	16	2	14	50	48173
SMALL													
1. SHISELWENI FORESTRY	1994	607			NONE	RURAL		N	11	4	7	4	6600
2. NGONINI	1994	375			250	RURAL		Y	10	1	9	5	24000
3. PIGGS PEAK PROTEA HOTEL	1994	173	120	53	NONE	SEMI-URBAN		N	9	5	4	5	20000
MATSAPHA INDUSTRIES													
1. NATEX		900	4000	500	NONE	URBAN		N	15	6	9	5	36000
2. CADBURY		336	184	188	67	URBAN		N	16	11	5	5	24000
3. BROMOR		89	84	5	70	URBAN		N	4	1	3	5	12000
4. SWAZI PAPER MILLS		750	740	10	NONE	URBAN		N		5	2	5	18000
5. SIKANYE		478	284	50	NONE	URBAN		N	4	0	4	5	12000
6. SWD BREWERIES		180	175	5	NONE	URBAN		N	1	1	0	5	6000
7. SUPER FROST		185	110	75	NONE	URBAN		N	2	1	1	2	

TABLE 7 PRIVATE SECTOR PROGRAM

Irrigated Farms and Cargo Carriers. All these companies are located in the North East of Swaziland not too far from the Mozambican border.

Mhlume Sugar has approximately 2000 employees residing in 30 villages and provides housing, utilities and health care for all employees and dependents. The 25 IBDs recruited at this industry participate in peer education activities as well as distributing of condoms, foam and relevant pamphlets. They organize videos shows for their respective villages.

d. Inyoni Yami Swaziland Irrigation Scheme (IYSIS)

IYSIS is predominately a citrus producing firm which is also involved in livestock management. It has approximately 900 employees, 15 residential villages and 25 IBDs who provide FP\HIV\AIDS educational talks and distribute condoms, foam tablets and resupply pills. They refer clients to the clinic for other methods.

e. Simunye Sugar Estate

Simunye employs approximately 1000 workers, has two villages and provides a comprehensive welfare benefit package for employees and their dependents. Health facilities comprise a clinic with three doctors, nurses and an IBD team of 16 peer educators. As in other industries the IBDs conduct FP\HIV\AIDS educational activities for fellow employees and dependents, distribute condoms and foam tablets and refer clients to the clinic for other methods. Simunye is located in North East Swaziland.

f. Cadbury Schweppes

Situated in the Matsapha Industrial Complex, Cadbury is one of the medium-sized industries assisted by FLAS. The company, involved in the production of bubble gum and chocolate candy, employs 400 workers and utilizes the Occupational Health Services (OHS) as a means for provision of health care services for the workers. There is no clinic facility at the company premises though a nurse from the OHS visits the factory on a daily basis to provide needed health services. The company has deployed fifteen IBDs selected from different sections in the industry and given that workers are not accommodated in designated company premises, IBD activities are limited to the employees and are conducted during normal working hours.

g. Shiselweni Forestry Company

Originally set up by the CDC, Shiselweni currently has a workforce of 550 employees. The company provides neither housing, educational nor health services for its employees. Workers are bused to and from work and procure health services from the government clinic. The industry has 11 IBDs trained to provide motivation and awareness about family planning, HIV/AIDS and STDs. This industry is unique in that it has only IBDs with no other medical backup on the premises. It is also the only industry visited which contributes

reduction in maternity leaves to this program. Shiselweni is located in southern Swaziland close to the border with South Africa.

h. BRM Swaziland

This is one of the industries expected to purchase FLAS services through the Mobile Clinic. Based in Matsapa Industrial Complex, the industry employs 230 workers, 90% of whom are women. Management allows each employee 1/2 a day off every month for securing FP services at FLAS' Manzini Clinic. They believe the Mobile Clinic to be beneficial as it will improve accessibility to FP services for the employees. BRM is devoted to production of garments for men.

B. Private Sector Unit and Staff

1. Organization and Staffing

As stipulated by the FHS Grant Amendment, a Private Sector Unit (PSU) was formed by FLAS and is staffed as follows (More detailed staff qualifications are presented in Appendix C):

o Program Manager - Mr. Khanya Mabuza

A nurse by profession, Mr. Mabuza holds a Masters Degree in Public Health and has 8 years' nursing experience in Swaziland. The Program Manager heads the Unit and co-ordinates all activities.

o Senior Program Officer - Ms. Khombi Nkonde

A nurse by profession, Ms. Nkonde is one of the core trainers in the Unit and coordinates the clinical services at industries and has attended a number of specialized courses in aspects of FP services.

o Program Officer - Mr. Makhosini Mamba

A nurse by profession, he holds a Diploma in General Nursing and Midwifery and has specialized training in several aspects of family planning. He is a resource person for clinical FP training and provides supervision to two industries.

o Program Officer - Ms. Thembe Mvubu

A teacher by profession, Ms. Mvubu is the Coordinator for IEC activities in the Unit. She also participates in the training of IBDs and supervises two industries. She holds certificates for training in several IEC areas.

o Program Officer - Ms. Busisiwe Mavimbela

She is a nurse and a core trainer for the FP course. She has diplomas in General Nursing and Midwifery and is the supervisor for Ubombo Ranches, Ngonini Estates and Protea Hotel. She is currently attending a CBD Management Course.

o Private Sector Nurse - Ms. Thobile Dlamini

A nurse by profession, Ms. Dlamini co-ordinates the activities for the Matsapa industries. She has certificates in VSC Counselling, Human Sexuality and Infection Prevention.

o Assistant Program Officer - Ms. Portia Khoza

A secretary by profession, Ms. Khoza assists with the co-ordination of training activities and the administration of the Unit. She also performs secretarial duties as necessary. She has diplomas in Office Administration, Desktop Publishing 5.0 and Corel Draw 5.0. She also has certification in many other secretarial, IEC, and public relations program areas.

o Driver - Bongani Ndzabandzaba

He is responsible for the Unit' vehicles, assists in IEC activities, and transports commodities to and collects service records from the industries.

In addition, the Unit has been provided with technical assistance from the Resident Advisor provided by Pathfinder. Major activities conducted by the Unit embrace the two identified goals aimed at program expansion and improving the quality of services. Staff responsibilities have, therefore, been so organized to respond to the above needs. The Program Manager, with assistance from the Resident Advisor, has decentralized functions for better management and to give special recognition to each individual's qualifications, skills and capabilities. The Unit is organized as per the organogram presented in Appendix D.2.

Given the key activity areas of nurses and IBD training, coordinating IEC activities, and monitoring and evaluation, the Private Sector Unit has an adequate complement of staff to execute its outlined duties. For administrative and supervisory purposes, the PS Unit has been combined with the Service Delivery Unit with the PS Program Manager as the head of the combined Department.

2. Institutional Capacity Building

Through the auspices of FHS, USAID has succeeded in investing and

establishing a highly skilled human resource base at FLAS. This has involved a two-pronged approach based on skills development and technical assistance.

a. Skills Development:

As illustrated above, all professional staff in the Unit have benefitted from additional training to strengthen their professional skills. Table 8 provides an overview of the courses provided for periods ranging from one week to one year.

The Masters Degree training provided to the Private Sector Program Manager has strengthened his management and communication skills. In his own assessment of the training, he indicated that the course was beneficial and appropriate for his needs. The TOT and CBD Management courses provided the needed skills for the training of nurses and IBDs. Given that none of the clinical trainers have Nursing Tutor qualifications, the TOTs can be considered a viable alternative in the interim. Training in Human Sexuality, Interpersonal Communication, and Infection Prevention were undertaken to acquaint staff with the relevant skills for improving the quality of services provided. FLAS staff plan to transfer those skills during the training of nurses and IBDs. To this end, the staff member who attended the Infection Prevention course collaborated with the MOH to organize and conduct a similar course for public and private sector nurses.

The marketing and financial management training is another example of the preparation underway for the marketing of FLAS' services to the private sector. Both courses were undertaken by the Senior Program Officer who is expected to participate fully, along with the Program Manager, in marketing FLAS services. Staff have also attended in-house training in "Speech Therapy" which was designed to prepare them for a business-like marketing of the private sector program.

Staff that were interviewed reported satisfaction with the different courses attended. The additional training has also equipped them with the skills necessary for managing their activities. Clearly this is an asset for FLAS.

b. Technical Assistance (TA):

In 1992, a Resident Advisor was deployed to assist with the implementation of the industry-based program. Her responsibilities included:

- o Provision of TA in the design of a comprehensive strategy and workplan for establishing and implementing an industry-based FP program.
- o On-the-job training of staff.

TABLE 8

SKILLS DEVELOPMENT TRAINING

<u>Course</u>	<u>No. Staff</u>	<u>Where</u>
Master Degree in Public Health	1	USA
Voluntary Surgical Contraception Counselling	3	Kenya
Training of Trainers (TOT) in FP	1	Kenya
CBD Management Course	3	Kenya
TOT AIDS	1	Kenya
Human Sexuality	3	Swaziland
Interpersonal Communication	3	Swaziland
Infection Prevention	3	Kenya, Swaziland
Integrated Marketing Communication	1	USA
Financial Management for Sustainability	1	Swaziland
FP Management Course	1	Kenya

- o Provision of on-the-job training and TA to FLAS and industries in conducting a cost-benefit assessment of program impact, cost-effectiveness analyses, setting up of a supervision and monitoring system, and in the collection of program performance indicators.
- o Provision of TA in the design of a marketing plan and development of marketing materials for a package of services and products.

These tasks were achieved and most of the planned targets were met.

Besides the Resident Advisor, a number of consultants have assisted the Unit in different areas of expertise. They include the following:

- o A Baseline Survey was conducted in early 1992 with the assistance of Drs. Mburugu & McCombe at five industries prior to the implementation of the program to:
 - Establish a benchmark against which to monitor and evaluate the project, and,
 - To generate specific data on knowledge, attitudes, and practices among workers and their dependents in order to prepare a well-informed IEC strategy and training curriculum.

Some of the findings of the survey indicated that there was considerable need for education on HIV/AIDS, for orienting services to men, as in some industries as they form the majority of employees, and for including the aspect of child spacing during counselling on FP.

- o Two consultants--P. Shumba & P. Savosnic--have assisted FLAS, firstly, to design, and subsequently, to modify the MIS forms used by IBDs and their Supervisors.
- o FLAS introduced an incentive scheme to motivate IBDs for their activities in the promotion of FP, STD and HIV/AIDS awareness. Given the ending of external funding through the FHS project, an alternative scheme was needed to continue the motivation of the workers. A survey conducted by consultants--C. Magagula & H. Kunene--outlined an elaborate strategy for continuing the program.
- o The contraceptive distribution activities by the IBDs had been limited to condoms and foam tablets. FLAS contracted a consultant--E. Anzeze--to design and initiate a pilot oral contraceptive resupply scheme by the IBDs at

two agro-business industries. The scheme was introduced at Ubombo Ranches and MMS. The evaluation done at MMS indicated that the IBD Supervisor had too large a number (57) of IBDs to closely monitor. They are spread out at the four industries that access health services from MMS. Given the long distances needed to reach each IBD as well as the large number of IBDs, it was recommended that Supervisors be identified in each industry, leaving the current IBD Supervisor as the person overall in-charge at MMS. Close monitoring and supervision were identified as crucial elements in the success of the program.

- o A Baseline Survey was conducted for the new industries that joined the program in 1994 with the assistance of the consultant, G. Gule. The purpose remained the same as in the previous survey conducted in 1992. The results were utilized in setting targets, especially for the extended IEC program.
- o A consultant, M. Manana, was contracted to introduce folk media IEC activities at industries by training IBDs in drama production, script writing and presentations. Four industries participated and produced plays as well as poems culminating in a national festival in December, 1993. In 1994, the consultant trained IBDs in four more industries. He also trained 17 FLAS staff.
- o The Industry Marketing Plan was developed with the assistance of the Futures Group as a strategy to market FLAS activities in order for the program to become more self-sustaining. The multifaceted approach included a Cost-Benefit Analysis carried out by D. J. Sine, a video tape to promote FLAS activities in the private sector developed by D. Brown, development of FLAS promotional pamphlets, and the costing of FLAS services. The cost-benefit analysis was undertaken at MMS to document for industries the financial benefit of investing in FP and AIDS prevention. The study specifically compared the costs of implementing the FP and HIV/AIDS program and the savings that would result from the program over a period of 10 years. The results indicated that investing in the program would result in savings for the companies in employee benefits due to averting unwanted births, preventing AIDS transmission and averting the high costs involved in AIDS patient care.

The technical assistance provided has enhanced FLAS' ability to respond to the needs of the industries by improving the services provided. Further, the consultancies have strengthened FLAS' capability to undertake activities, such as baseline surveys, on its own in the future. The marketing consultancy will assist to launch FLAS in the entrepreneur arena by aggressively marketing its services to the private sector. The TA received, therefore, has ably prepared FLAS staff to undertake such tasks in the future with minimal outside assistance.

C. Marketing Plan

Following the completion of the Cost-Benefit analysis, which was used as the basis, an assistance package in family planning and STD/AIDS prevention was designed to be made available to the industries. This Marketing Plan included the following components:

- o Training IBDs
- o Training nurses
- o Training doctors
- o Industry seminars and workshops
- o Contraceptives
- o Program monitoring and supervision
- o Mobile clinic
- o IEC materials and activities

Strategies for selling the package were also developed. Most important, existing businesses were approached to advise them about FLAS' need to embark on cost-recovery measures. During this meeting, the FLAS video was presented as well as the cost-benefit analysis findings. These two steps have largely been accomplished.

Following this initial marketing visit to the industries, FLAS was to tailor the industry program assistance package to each client's needs and to price it. Thereafter, FLAS would offer the packages to the different industries. FLAS is in the process of finalizing the tailored and priced packages. Table 9 presents an illustrative price list of services to be offered in the Marketing Plan for private sector services. FLAS expects to earn E 117,666 in 1996 from the private sector program.

D. Industry-based Distributors (IBDs)

1. Selection

All industries visited were able to articulate the criteria for selection of their IBDs. The industries are responsible for selecting their IBDs, and not FLAS. The selection criteria is characterized by the following features:

- o Utilizing of personnel in an already existing health care system (Ubombo Ranches, Cadbury)
- o Recruiting of volunteers from different villages on a plantation or from different sections in a manufacturing plant.

Differences still exist within each of the above categories. For example, Ubombo Ranches employs IBDs who are salaried Village Health Workers, while Cadbury and other industries in the Matsapha complex deploy "First Aiders" as IBDs. Based on

TABLE 9 FLAS MARKETING PLAN FOR PRIVATE SECTOR SERVICES

COMPONENTS	PRICE
IBDs (per IBD)	
-Training	E 350
-Refresher courses	E 70
-Support workshop (includes IBD "incentives")	E 00
-Quarterly monitoring fee (per industry IBD program)	E 750
Education:	
-Brochures (per 100)	E 175
-posters (per 10)	E 35
-Folk media workshop (per IBD)	E 70
-Mural painting (15 square meters)	E5,000
-Film showings	E 100
Nurses (per nurse):	
-Training (five-week course)	E3,900
-Training (five-day course)	E 800
-Refresher course (two days)	E 340
Doctors (per doctor):	
-Training in Minilap and Vasectomy--five day course	E1,925
Industry Management Seminar (per manager)	E 170
One-day seminar	
Contraceptives:	
-Condoms (unit price)	E .15
-Oral contraceptives (single cycle)	E 1.00
-Injectable	E 5.00
-IUCD	E 4.50
-Vaginal Foaming Tablets (per tablet)	E .12
Mobile Family Planning Clinic:	
Visit Fee	E 350
Counselling Fee (per client)	E 2
Contraceptives (see above prices)	-
Industry Clinic Monitoring (quarterly fee)	E 750

information from these IBDs, their position entails a teacher/advisory role which invariably places them in front of groups of workers for group talks, demonstrations, etc.

The First Aiders do not receive additional remuneration over and above their normal salaries as employees. The management of industries in this category logically introduced the IBD program within the existing health worker system to maximize their output without creating a parallel category of workers. The possibility of rejection of FP as a concept by some of these IBDs cannot be ruled out as, in fact, they are mandated to work as IBDs because of their already assigned role as a First Aider or a Village Health Worker. They are not provided with an opportunity to express their willingness or unwillingness to participate as IBDs.

Volunteer IBDs seem to be in the majority in the program as most industries follow this strategy. The volunteer IBDs do not receive monetary remuneration for working as IBDs and the industries concerned have no immediate plans for changing this. Management at one of the industries visited expressed his company's inability to consider the remuneration issue due to financial constraints. Management of another industry were contented with rewarding the IBDs with "special" recognition in the form of different uniforms (overalls) and FLAS' provided incentives.

The selection criteria of IBDs in different industries seems not always to be congruent with the gender distribution of the workforce; there is a definite bias in selecting women as IBDs. Reasons given by management of certain firms include women's dedication to duty, their positive approach to motivational activities, and their normally assigned duties which brings them in contact with the wives of employees.

2. Training

Training activities have included the training of industrial nurses in clinical FP, the training of IBDs, and the training of IBD Supervisors. To date 40 nurses, 300 IBDs and eight Supervisors have been trained.

a. Nurses

Nurses from those industries assisted by FLAS and from private physicians and government clinics were selected for a five-week training course. Topics covered in this course included contraceptive technology, population dynamics, communication and counselling skills, HIV/AIDS awareness and prevention, STD management, supervision and clinic management. The training incorporates a three week practicum period spent at FLAS' clinics. Two Program Officers (nurses) form the Unit's core team of trainers and are assisted by other FLAS staff and resource persons from government. A curriculum designed by FLAS and the MOH is utilized for the training. The centralized training takes place in Manzini and away from the nurses' worksites. However, five weeks is deemed too long a period for a nurse to be out of station by the management of

some of the industries, and they are, therefore, reluctant to release them for the course. Unmet targets in this sector have affected service provision at the clinic level.

b. IBDs

FLAS conducts on-site training for the selected IBDs for an initial period of two weeks. The training is designed to equip IBDs with communication skills and information on family planning and contraceptive technology, HIV/AIDS, STDs and record keeping. They are also taught to bring together workers for group talks, demonstrations, etc. IBDs have also received training in the development of folk theater productions, popularly known as folk media. Whereas the two week FP/HIV/AIDS course is conducted by FLAS staff, training in folk media productions was carried out by a consultant. IBDs receive a five-day refresher training to update their information.

c. Supervisors

Each industry has an IBD Supervisor who is empowered to carry out day-to-day coordination and supervision of the IBD program. To ensure adequate implementation of their duties, a training program was designed and each Supervisor was trained for one week. Topics for the course include contraceptive technology, HIV/AIDS awareness, and supervision. Additional training in human sexuality and interpersonal communication has been provided to these supervisors. On a quarterly basis, Supervisors attend a program review meeting with FLAS staff to discuss program implementation and strategies.

3. Activities

The three main components of IBD activities include motivational and educational talks, distribution of contraceptives and IEC materials, and referral to the clinic.

Talks which focus on FP and HIV/AIDS are provided either during working hours at the industries or during home visits. Plantations that provide housing for employees lend themselves easily to the concept of home visits where IBDs are able to reach not only employees but dependents as well. IBDs that are VHWs use this session for conduct of their primary health care routine which includes sanitation, hygiene, immunization monitoring and FP, HIV/AIDS awareness. Some of the male IBDs interviewed during this evaluation indicated that can communicate easily with women and vice versa. At one industry, however, female IBDs said that they can't communicate comfortably with men on issues related to sexuality. It is planned that additional IBDs who will be men will be deployed in this industry in order to correct this problem. The problem of effective cross-sex communication is likely to affect the IBDs in many settings.

Industries in the Matsapha complex do not provide housing for their employees. Motivational and educational activities take place on the industry premises. Most industries

have allocated specific time for these activities and incorporated them in the overall industry training program. During the allocated period (2-4 hrs per week), group talks as well as video shows are provided.

IBDs distribute condoms and foam tablets to those who request them and records are kept of the distributed commodities. Clients that request other methods are referred to the clinic and, in the case of Matsapha Complex industries, referrals are made to the Occupational Health Services nurse who visits the industries on a daily basis. At two of the agro-business industries, a pilot IBD pill re-supply scheme has been implemented for the last one year. This has improved accessibility for this method and had demonstrated that IBDs can successfully distribute pills if they have close supervision and a backup system at the industry clinic.

In order to increase condom access at the industries, a number of condom dispensers were developed and provided and have been strategically placed in order to allow for privacy. All industries visited expressed a high level of approval for this mode of distribution.

Along with contraceptives, IBDs distribute IEC materials, including pamphlets and booklets. Two pamphlets, one on AIDS and another on "How to Use a Condom", were specifically designed for the industries. Some of the copies were printed in siSwati while the majority were in English. The industries visited seemed to have sufficient stock of these and other pamphlets produced by FLAS. Materials in siSwati, however, are in short supply. Industry-specific IEC materials (pamphlets) were designed and produced for distribution. Other IEC activities undertaken include folk media performances at industries and a mural that was painted in a social hall at MMS.

Contraceptive distribution data is compiled by IBDs and, on a monthly basis, by IBD Supervisors who submit it to FLAS for tabulation and preparation of reports. The MIS format utilized by the IBDs is currently being revised to better track needed information on IBD activities in coordination with the industry clinics.

4. Incentive Scheme

IBDs want incentives as recognition of their services. The incentive scheme, recommended as a result of the assessment by the consultants Krystall and O'Brien, was implemented in 1994. The IBDs participated in a seminar to decide on the products and the logo for the program. A star (to represent their "illuminating" role) and a helmet (represent industry) were to form the logo with the wording "Kusho Simo", meaning, "This is it". This logo was placed on T-shirts and caps given out as incentives. Other items used as incentives were calculators, blankets, diaries and badges. All IBDs received these items as a recognition of services rendered in the program. Awarding of incentives to the IBDs in 1995 has yet to be carried out.

Given the conclusion of USAID funding, the program underwent a review to determine the appropriate "next steps". Consultants contracted to do the review recommended an elaborate scheme that appears inappropriate--too costly and unwieldy to be workable. However, the original FLAS incentive scheme is unsustainable given the need to move to a cost-recovery format. Thus, future implementation of the incentive scheme awaits decisions by individual industries who will now need to develop their own incentive strategies. IBDs will need to wait; it is hoped that they do not develop "waiting fatigue" that will affect their performance.

5. Implementation Constraints

FLAS had not entered into legal contracts with the industries for the provision of services rendered. This sometimes led to disruptions in the planned schedule of events as industries did not feel they were not bound by a agreement. Instances of discord include disrupted training schedules, poor selection of IBDs, and the lack of allocation of time for IBD activities.

Given that IBD educational activities are the key to the success of the industry program, sufficient time needs to be allocated for them. Most industries in the Matsapha Complex have overcome this problem by allocating time (2-4 hours per week) for this program. The activity has become institutionalized in the training department and included in the workplan. Other agro-industries rely on the IBDs' ability to allocate time prior to their field work (at 5 am), during lunch time, or in the evening after work. Some are able to succeed with this schedule. Many have resorted to conducting their IBD work during their time off. This arrangement does not ensure adequate execution of duties.

Several IBDs interviewed mentioned men's opposition to family planning as a significant barrier in their work. According to them, some women are forced to hide packets of pills to avoid marital disharmony. Many resort to the injectable contraceptive as this cannot be detected by their partners. More IEC support for these IBDs and to counter male opposition to FP is needed.

E. Clinic Services

All IBDs (except at Shiselweni Forestry and Protea Hotel) refer clients to the company clinics for prescriptive FP methods. Services provided at the industry clinics include MCH/FP, curative, laboratory services, dental, x-ray and, at the hospitals at Ubombo Ranches and Mananga Medical Services (MMS), surgery services.

Family planning services are provided by FLAS-trained or updated nurses. Most of the clients seen are referrals from the IBDs. Methods provided at the clinics include pills, injectables, condoms and IUCDs. Voluntary surgical contraception (VSC) is provided by the doctors at Ubombo Hospital (The trained doctor at MMS left.). Clients in the Matsapa Complex obtain services from the OHS Nurses who visit the industries on a daily basis.

Insertion of IUCDs, however, is done at the OHS clinic. Cash flow shortages and problems experienced by FLAS over the last quarter of 1995 have negatively impacted certain contract deliverables, especially the implementation of the mobile clinic in the Matsapa industries and some training activities.

Whereas industries are able to provide temporary FP methods easily, VSC services have been problematic. Out of the three sites planned to initiate VSC services, only two had a doctor/nurse team trained. The third site--Simunye Sugar--was unable to participate due to the doctor's inability to be out of station for the duration of the training. Of the two sites that started to provide VSC services, one--MMS--had to discontinue the services due to the doctor's departure from MMS. Services are currently being provided only at Ubombo Ranches.

Based on information received during visits to the industry sites, a demand for VSC had been created. Given the lack of service providers, however, requests for services have diminished. Clients who request VSC are, in one setting, referred to a nearby Mission Hospital.

F. Conclusions and Recommendations

1. Overview

The Private Sector Unit was set up and is headed by a competent Program Manager. Five other competently trained professional staff are deployed

in the Unit to conduct training activities and coordinate the industry program. A Resident Advisor and a number of consultants have provided required TA in many different areas while the training needs of staff have been met through attendance of selected courses both of long and short duration, in-country and overseas. Material inputs have included a mobile clinic van, vehicles, incentives for IBDs and office equipment.

FLAS did not enter into legal contracts with the industries. This sometimes led to disruptions in the planned schedule of events as industries were not bound by a agreement. Further, the time allowed for IBD activities was, in many instances, inadequate for their proper work. Many IBDs have to conduct educational activities during their free time; this is insufficient. Finally, cash flow problems experienced during the last quarter of 1995 has had a negative impact on contract deliverables, especially training, the implementation of the mobile van clinic, and the production of posters.

The private sector project has been implemented at a number of different agro-business industries in rural areas and plans are underway to introduce mobile clinic services to selected industries in the Matsapa Complex. This service has been deferred until 1996. To date FLAS has assisted 20 industries. Approximately 300 IBDs, 18 IBD supervisors and 26 industry nurses were trained to provide FP and HIV/AIDS prevention services. Seminars

were conducted for managers and supervisors at industries to create awareness about the program.

Seminars for managers and supervisors were conducted on-site for Ubombo Ranches, Usuthu Pulp, MMS, Ngonini Estates, Tambankulu Estates and Shiselweni Forestry industries. The five-day workshops aimed at introducing the IBD program and its benefits to the new industries and soliciting support for the program from middle managers and section supervisors. Topics covered included family planning, HIV/AIDS and its impact on the industry, sexual behavior of workers, and IBD activities. One-half day seminars were also held for managers of industries in the Matsapa Complex to sensitize them and create awareness about the IBD program. The presentations were the result of the marketing strategy developed for the program. As an outcome of this activity, the industries demonstrated more support to the program and to the IBD activities. Based on FLAS staff evaluation, the recruiting of IBDs became easier after the seminars.

Industry-specific pamphlets were produced for IBD distribution and condom dispensers were provided to industries in order to increase condom accessibility. Service statistics show an increase in condom distribution as well as increased usage of injectibles, pills and foam tablets. Over 12,500 Couple-Years of Protection have been the result of the program. The work force has also become increasingly aware of HIV/AIDS.

FLAS also launched a pilot oral contraceptive re-supply scheme at two industries-- Ubombo Ranches and MMS. IBDs have traditionally distributed only condoms and foam tablets, but through this scheme, they were able to improve their method mix. Recommendations from the evaluation of the program indicate that with adequate supervision, the scheme can be replicated to other industries.

Given the current momentum, FLAS should immediately embark on an aggressive marketing strategy of selling its services to the industries, forsaking its expansion program and concentrating on the industries already in the program and those waiting for the inauguration of the mobile clinic service, which should be initiated as soon as possible. Special attention should be paid to the gender distribution of the work force and, therefore, to the gender distribution in the selection of IBDs. FLAS should strongly encourage industries to select only those who are committed to the goals of the program while the management should be encouraged to adopt their own IBD incentive strategy. FLAS can facilitate the IBDs' work by conducting seminars for the supervisors on-site in order to increase their awareness of the need for the program.

FLAS can improve the industry program by extending the oral re-supply capability of the IBDs to all industries in the program along with supplying more condom dispensers to the industries (at a fee). However, the recording and reporting of condoms distributed through the dispensers needs to be made a part of the MIS reporting system. FLAS should endeavor to have more of the IEC materials translated and printed in siSwati for wider circulation, and should include more male-focused IEC. In order to assess the program, the

follow-up to the 1993 Industry Baseline Survey planned for the end of 1995 should be carried out as soon as feasible.

The paragraphs below summarize the specific conclusions and recommendations of the evaluation team.

1. Industries

The following conclusions were reached regarding FLAS services to industries:

- o FLAS has succeeded in expanding services to a majority of the large and medium-sized industries in Swaziland, comprising approximately 1\3 of the total employees in the private sector.
- o Based on information from the industries concerned, FLAS' services are considered to be of high quality and are greatly valued by the private sector. Furthermore, all industries visited during this evaluation indicated their willingness to continue collaboration with FLAS in the future.
- o Given that USAID is completing its assistance to FLAS, and the goodwill created between the industries and FLAS, FLAS is well positioned to continue providing technical assistance to the same industries but on a commercial basis. The willingness to diversify FLAS' financial base by providing consultative services will enhance FLAS' overall sustainability potential.
- o FLAS continues to collaborate with the Federation of Swaziland Employers (FSE) and the Swaziland Federation of Trade Unions (SFTU) during their interaction with industries. The union is aware of the realized benefits to the workforce as a direct result of the program. Features such as the radio information programs and condom dispensers were considered extremely beneficial for the workers.
- o FLAS has conducted several research studies to provide data for strengthening different aspects of the program. For example, a Cost-Benefit analysis was done to determine the level of savings that would be accrued as a result of introducing FP and AIDS program at industries. It ascertained the cost of the different components of the private sector program. Data derived from the study has been useful in developing a marketing strategy for FLAS' industry activities.
- o Assistance provided to industries has resulted in increased awareness about HIV/AIDS transmission and its prevention as well as the benefits of family planning. A Personnel Manager at one industry was willing to confirm that

every employee at his industry is aware of the AIDS problem. Furthermore, that industry has formulated a specific policy on AIDS. A manager at another industry attributes the reduction in maternity leaves to the FLAS program.

In light of these conclusions, the following recommendations are offered:

- o Initiate an aggressive marketing strategy of selling its services to the industries, especially those FLAS is current working with. All industries visited indicated a willingness to continue the collaboration but said they are waiting for FLAS' cost data before making definite decisions.
- o Consolidate FLAS' expansion program and concentrate on the industries already in the program. New industries should be brought in the scheme only after evaluating the success of the marketing strategy with the current industries. This evaluation can be based on actual implementation, financial costs and expenditures, and impact.
- o Institute the mobile clinic outreach program as soon as possible as an alternative to the provision of services to small industries with no health services. (NB: The mobile van has already been procured and equipped and at least four industries are ready to collaborate).

2. Private Sector Unit

The evaluation team arrived at the following conclusions regarding the performance of the private sector unit:

- o The Unit is manned with competently trained staff with the necessary skills for implementing the program. FLAS staff have been adequately prepared for implementing activities with the private sector. Inputs made by different consultants and the Resident Advisor have facilitated this process. Staff should, henceforth, become more assertive in their approach and should be able to perform with minimal assistance from the outside.
- o It is administratively combined with the Service Delivery Unit with the Private Sector Program Manager as the head of the combined Department. Having such a large department to coordinate and manage can lead to inefficiencies.
- o The Unit has relied upon and effectively utilized consultancies for a large range of services and for institutional capacity building as well. For example, staff have learned to cost and market TA provided to the private sector. Given the completion of the FHS grant, they will need to be more self-reliant in the future.

The recommendation for improving the services of the private sector unit is:

- o Assign separate coordinators to the Private Sector Unit and the Service Delivery Unit for better supervision and more effective management, with each coordinator reporting to the Program Manager. This, in effect, would leave the Program Manager as the head of the department but with two separate units. This arrangement would be congruent with the department's vision of decentralization.

3. IBDs

Conclusions regarding IBDs are as follows:

- o Industries have used both FLAS' and their own selection criteria for IBDs and some have selected those already in the health care area, i.e., Village Health Workers and First Aiders. Some VHW or First Aiders may, in fact, not be sympathetic to the concept of FP and HIV/AIDS prevention. Their selection, therefore, may be detrimental.
- o Gender has not been considered enough in the selection of IBDs. A distribution of IBDs congruent with the gender distribution of the served population would maximize their effectiveness. Also important is the ability to read and write and a commitment to the goals and objectives of the program, aspects not considered carefully enough in some of the industry programs.
- o While top management at the industries are committed to the success of the program and many are willing to allow time off for IBD educational activities, others have failed to allocate sufficient time for FP/HIV/AIDS educational activities during the work day. Expecting volunteers to go home-visiting for motivational activities after a long, gruelling day in the fields or in a factory is unrealistic.
- o Incentives continue to be needed and wanted by IBDs as a form of recognition for services rendered. A scheme to reward IBDs was implemented in 1994 by FLAS but, due to its cost, was unsustainable. A program that can be supported by the industries themselves is needed.
- o IBD MIS reporting forms were revised in order to allow for the collection of data on the amount of contraceptive pills re-supplied. IBDs were trained in their usage but the new forms are yet to be distributed.
- o Available data indicate that condom distribution has improved considerably as well as has the utilization of other contraceptives in the private sector program. Based on the FLAS MIS, performance figures indicate a steady

increase from 1992 to date for the different indicators. Table 10 illustrates the number of new acceptors, revisits, and Couple-Years of Protection (CYP) for 1992, 1993, 1994, and the first nine months (Jan.-Sept.) of 1995 for the IBDs and the clinic services combined. Over 16,600 contraceptive visits and distributions have been recorded for the first nine months of this year, and this is not counting the many condoms distributed through the condom dispensers. Extrapolated to a full year, this would equal over 5,000 Couple-Years of Protection for a population of approximately 20,000 workers.

Table 11 illustrates the relative contribution of the IBDs and the clinics in the private sector program. While most of the IBD clients are condom users, often on a one-time only basis, clinic clients are mainly injectable and pill users, and usually continuing clients. Thus, the clinics contribute more CYP. Given the conclusions reached by the evaluation team, the recommendations below are designed to improve the program:

- o Continue to encourage industries to utilize the developed criteria for the selection of IBDs. Special attention should be paid to the gender distribution of the work force and, therefore, to the gender distribution in the selection of IBDs.
- o Strongly encourage industries to select only those who are committed to the goals of the program particularly where a policy exists in the industry for selecting IBDs that are either Village Health Workers or First Aiders.
- o Encourage management to adopt an IBD incentive strategy. IBDs who volunteer their time and make such an investment should be recognized by the employer. The scheme need not be elaborate. A T-shirt and cap for each year of service are quite adequate as they clearly identify the IBD to the rest of the community.
- o Encourage section supervisors to follow through with management sentiments and plan for and allow IBD sensitization activities. FLAS can facilitate this process by conducting seminars for the supervisors on-site in order to increase their awareness of the value of the program.

5. Family Planning Services

The following conclusions were reached regarding family planning services:

- o The success of the industry program depends on increasing the accessibility of services. FLAS has introduced condom dispensers placed in private areas in the industries for easy access. FLAS has also piloted the re-supply of oral

TABLE 10

PRIVATE SECTOR PROJECT PERFORMANCE TREND (1992-1995)

<i>YEAR</i>	<i>NEW</i>	<i>REVISITS</i>	<i>CYP</i>
<i>1992</i>	<i>916</i>	<i>4475</i>	<i>1703</i>
<i>1993</i>	<i>4445</i>	<i>7195</i>	<i>2453</i>
<i>1994</i>	<i>7386</i>	<i>13093</i>	<i>4611</i>
<i>1995</i>	<i>5110</i>	<i>11557</i>	<i>3820</i>
<i>TOTAL</i>	<i>17857</i>	<i>36320</i>	<i>12587</i>

Note: 1995 Data is for January to August only.

TABLE 11: IBD AND PRIVATE SECTOR CLINIC PERFORMANCE, 1994

Performance Indicator	IBDs	Private Sector Clinics
New Users	6,111	1,275
Revisits	4,603	8,490
Condoms Distributed*	195,912	20,434
Foam Tablets Distributed	26,567	3,640
Oral Contraceptive Cycles	**	7,288
Contraceptive Injections		6,201
IUDs Inserted		110
Total CYP	2,012	2,599
FP Referrals	370	
STD Referrals	366	
IEC Talks	5,486	
No. People in Talks	41,195	

* Condoms distributed through condom dispensers are not included.

** Oral contraceptive cycles distributed by the IBDs at Ubombo Ranch and MMS are not included.

contraceptives by IBDs. Based on information provided by industries, both schemes are popular modes of contraceptive distribution.

- o A method mix that favors injectable is the outcome of a situation in which women are not able to effectively discuss family planning with their partners. On the other hand, many males choose condoms because of their interest in STD/AIDS prevention.
- o IEC materials distributed to clients play a major role in reinforcing the communicated message. Useful IEC materials were produced in both English and siSwati for the work force, though the majority appear to have been printed in English. Given that many and perhaps a majority of the workers lack effective English capability, there is a serious lack of materials printed in siSwati.
- o While all methods have increased, condom distribution (mainly by IBDs) has nearly tripled since 1993. Figure 4 shows the amount of each contraceptive method provided during the first nine months of 1992 through 1995. Further, condoms that are distributed by condom dispensers have not been included in the tabulated data. The high level of condom usage can be attributed to both the increased IEC activities as well as the work of the IBDs. Increased awareness about HIV/AIDS and STDs from the national campaign through the print media as well as the radio have also likely played a role. In fact, perhaps half of condom users use them primarily for STD and AIDS prevention, according to industry surveys. Given the escalating trend in HIV/AIDS cases worldwide and in Swaziland, condom distribution is increasingly becoming the main methodology used as a mode of prevention.
- o The most common contraceptive used is the injection. Figure 4 shows that while condom and pill use is given in approximately monthly units, contraceptive injections are good for three and (now) two months' use. Thus, the height of the bars for Injectables should be over twice as high. The popularity of the injectable can be seen in the data for the relative number of revisiting clients by method: Injectable clients made up 40% of all revisits, while condom clients were 36%, and oral contraceptive clients were 17% (1994 data).

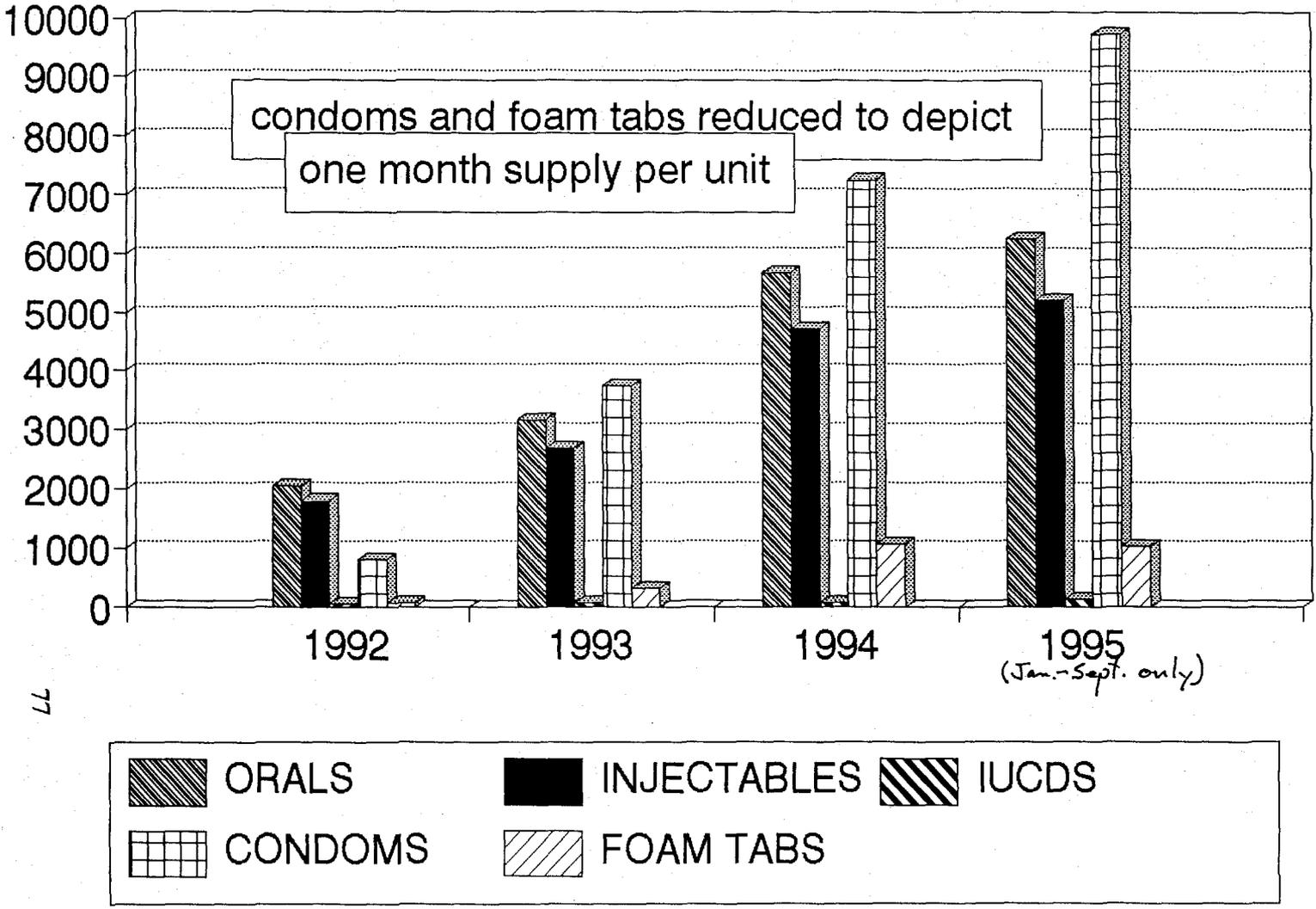
The following recommendations are offered to improve the family planning services component of the program.

- o Consider extending the successful pilot scheme on oral contraceptive re-supply by IBDs which has occurred at two facilities to all industries in the program. Special attention should be paid to supervising and providing backup to the IBDs in this area.

- o Continue to expand FLAS' supply of the condom dispensers to the industries at a fee to meet the increased demand for more dispensers. The recording and reporting of condoms distributed through the dispensers, however, needs to be made a part of the MIS reporting system.
- o Produce more of the IEC materials in siSwati for wider and more effective circulation.
- o Include more male-focused IEC in the industry program. Targeting men is an acceptable way of "demystifying" family planning and encouraging them to adopt it for themselves and their partners. The much-talked-about Swazi male opposition to FP can be overcome with effective IEC strategies; the industry sector is an important point of entry.
- o Carry out the follow-up to the 1993 Industry Baseline Survey that was planned for the end of 1995 as soon as possible to assess the likely impact of the program.

PRIVATE SECTOR PROJECT: COMMODITY DISTRIBUTION TREND 1992-1995
 (1995-January-September only)

FIGURE 4



IV. INFORMATION-EDUCATION-COMMUNICATION (IEC) PROGRAMS

A. FHS Project, 1988-1993

The purpose of the IEC component of the FHS was to strengthen FLAS' ability to produce effective family planning messages. FHS was to improve the quality of IEC messages and materials by assisting FLAS in improving IEC staff skills and equipment, and by strengthening IEC program management.

From 1988 to 1990 FLAS built and trained its IEC Unit, but IEC strategies remained basically unchanged from the previous pre-FHS period. In 1990, USAID provided a consultant to assist the IEC Unit to do a KAP study and a focus group study, drawing conclusions about IEC. The survey and focus groups suggested that FLAS's IEC should:

- o Link FP services to MCH programs;
- o Link FP IEC to Swazi love of children;
- o Stress problems caring for children;
- o Use interpersonal sources of IEC;
- o Provide intensive counseling and followup during first three months of [female] acceptance, when side-effects are the major cause of drop-outs;
- o Pay special attention to men.

The IEC Unit subsequently emphasized most of the strategies recommended in the report. The growing concern about STDs/AIDS in Swaziland seemed to indicate that more IEC emphasis was needed on preventing infection through condom promotion to men, with relatively less emphasis on spacing or limiting births.

B. Amended FHS Project: 1993-1995

The amended USAID Project Paper of August, 1993, is based in large part on the recommendations of Dr. Everold Hosain for a two-phase mass media campaign. The project recommendations were based on previous studies showing that the three main barriers to increased FP use which could be addressed by IEC were misconceptions about method risks and side effects, fear of male partners' reactions, and personal inertia from many factors. The project amendment spells out general goals, more specific purposes, detailed objectives, and activities supporting those objectives, for improving IEC skills in FLAS and an IEC campaign to increase the national level of contraceptive use.

The amendment's first (perhaps most important) goal is to "Expand Information, Education, and Communications services". The three other goals in the amended project depend on IEC: to increase industry-based family planning; include VSC; and ensure FLAS as a sustainable organization.

1. IEC Media Campaign

The purpose of IEC activities in the amended project was, "to increase the demand for FP and knowledge of how to prevent HIV infection through a major new Information, Education, and Communications (IE&C) campaign." (USAID, Amended Project Paper, 1993). The project was to foster "a major mass media marketing campaign, national in scope, to significantly increase interest in and demand for FP among the general public", a mass-media activity which USAID considered to be the best role for FLAS as "the only agency active in IEC" and "well-suited to USAID's projected phase down in Swaziland."

The "new" IEC strategy would get away from trying to increase family planning demand by emphasizing the general need for planning pregnancies and limiting family size -- issues already widely accepted. Instead, IEC would focus on access, the need to enable clients to get family planning services. The strategy emphasized FP supply over demand, proposing an "integrated marketing communication plan" addressing the major constraints to acceptance and continued practice of contraception.

The IEC Unit developed these concepts with the help of a Pathfinder consultant, Dr. Hosain, and recruited an advertising firm to work with them: Ogilvie & Mather Rightford Searle - Tripp & Makin from Johannesburg (O & M). The campaign, as finally implemented, had two phases:

- o Phase One (planned from July to September, 1994; implemented from October, 1994 to March, 1995):

This phase was intended to inform the public about FLAS's name, its purposes, and the services it offers, to give it credibility. It was assumed that if the organization became known, then its message (use family planning) and its services would be more popular and more acceptable. This phase was also intended to bring clients to FP service points: clinics, community-based distributors and industry-based distributors.

During this phase, the IEC Unit arranged for the design (using a nationwide search) of a new circular logo, replacing an older triangular one. Also during this phase the IEC Unit began vigorously promoting the location of FP service sites with a new logo, flags, and metal pennants which were to be used as signposts, plus an accompanying campaign with a series of radio, TV and poster ads.

- o Phase Two (planned from March to May, implemented June to October, 1995):

This phase was to address fears of the effects of modern FP methods, and provide IEC about the safety, benefits, risks, and side effects of each method.

The intention was to avoid misunderstandings about contraceptives and to ensure that every woman and man could, if they chose, make a free and informed choice of FP method. This campaign was also to address fears of the male partners' opposition, with special activities for men and women which would encourage male responsibility.

2. Project Inputs

The total amount budgeted for IEC activities, including research and evaluation, was over \$1.4 million, primarily for the mass media campaign. These expenditures paid for purchases of IEC equipment, management and training, technical assistance, and overhead expenses, as follows:

- o Technical Assistance (Pathfinder: \$284,768)
- o Training (\$47,387)
- o Commodities and Equipment (\$71,649)
- o Design, Production, Media Campaign: (\$1,380,426)
- o Research & Evaluation (\$28,565)

A summary of inputs to IEC is shown in Table 12. These inputs resulted in a wide range of outputs and activities in support of the five IEC objectives discussed below.

C. IEC Activities, 1994-1995

1. Objective: Public Relations to Position FLAS

a. Activities:

- o Radio Spots
- o TV Commercials
- o Newspaper Ads
- o Outdoor Advertising
- o Launching the FP Logo: Press Conference and Kit
- o "FLAS Page" in Newspapers

b. Details

Two bilingual 50-second radio spots on FLAS and its concern with family life and HIV/AIDS prevention were produced and broadcast on the SBIS English and SiSwati channels. The spots were scheduled in bursts to coincide with television and print campaigns. 48 spots per week were broadcast in SiSwati, resulting in 1056 spots for the

TABLE 12: SUMMARY OF FHS-FUNDED INPUTS TO IEC

A. TECHNICAL ASSISTANCE

The IEC Unit received technical assistance under the FHS amendment from Pathfinder and PATH, particularly to plan the mass media campaign and to assist the IEC Unit in developing method-specific and STD pamphlets. In each visit IEC staff studied the development process from conception to camera-ready copies including message content, strategy development, pretesting, layout and design, graphic artwork, color separation, and printing requirements.

B. TRAINING

- o Marketing & Advertising, Management practices (IEC Director), 10 months, NYU
- o Integrated Marketing (2 staff members), 3 weeks, NYU
- o Studio Management (3 staff), several weeks, Dr. Douglas
- o All IEC Unit - Mass Media production, 2 weeks, Dr. Douglas
- o All IEC Unit - Interpersonal Communications Training, 2 weeks, PATH
- o All IEC - Human Sexuality, Nannette Ecker
- o All IEC - AIDS Counselling - AIDSCOM

C. COMMODITIES AND EQUIPMENT

Equipment included: 1 x Hi8 video camera, 1 x VHS video camera, 2 x TV monitors 51mm, 1 x VHS video recorders, 1 x generator for field electrical supply, 1 x photo camera, 2 x video films

D. DESIGN, PRODUCTION AND MEDIA CAMPAIGN

Ogilvy & Mather was contracted to manage the campaign. During the development of all media, IEC staff attended Tissue and strategy presentations, video\radio productions, media\placement assessment, media budget reviews and pretesting of media work.

E. RESEARCH AND EVALUATION

FLAS contracted Research International to assess media campaign results. IEC staff participated in the presentation of the report, where the study sample, methodology, findings, and conclusions were discussed.

total campaign. Thirty-six spots were aired per week in English, with 792 spots for the total campaign.

One 45-second TV commercial in SiSwati and English was produced and aired in the STBC. A total of 42 spots were aired per week. The TV campaign had 504 spots in total.

Four print executions, showing the benefits of a small family on food and land (showing the pumpkin and the shield), and the importance to the nation of using condoms, were developed and rotated in the three newspapers: The Times of Swaziland, The Sunday Times, and Swazi Observer. These insertions were in press tabloid, full page, black and white. Totals: The Times of Swaziland, 60 insertions; Sunday Times, 35; Swazi Observer, 60.

For outdoor advertising, FLAS placed hard posters on security gates of shops and supermarkets in both urban and rural sites. A total of 100 posters (A1 size bilingual boards) were placed. These reflected the print ads of the pumpkin and the shield.

A press conference was held to inform the media of the FHS project (amended) and the new FLAS marketing/advertising strategy, and to solicit media support in this strategy. A press kit was prepared and distributed to participants. This activity had heavy media coverage in both television, radio and print. The Minister for Health was guest speaker. The FLAS President and the Executive Director spoke, along with the Federation of Swaziland Employers' Mr. Musa Hlophe and the Federation of Trade Unions' Mr. Jan Sithole. Chiefs from CBD areas were also invited to attend and gave remarks. Prizes were given to winners of the logo design competition.

A weekly article submitted by the FLAS Public Relations Officer, with assistance from the IEC Unit, has been published in two newspapers, The Times of Swaziland and the Swazi Observer. A total of 18 articles were placed in the Swazi Observer and 13 in the Times. These articles were targeted to men, women and youth. Seven freelance journalists were contracted to write them. Each article was reviewed by FLAS before placement.

2. Objective: Promoting Service Delivery Points

a. Activities:

- o FP Logo and Flag
- o 2 Radio spots
- o Referral cards
- o FLAS clinic cultural shows

b. Details

A meeting to discuss the idea of the FP logo and flag was held with representatives from FLAS, MOH, the private sector and other non-governmental organization representatives. FLAS placed an ad in the Times and Swazi Observer inviting people to design the logo. A total of 101 entries were received. A team of judges was set up to select the top ten designers. Prizes were given to the three top designers.

Another meeting was held with FLAS, MOH, private sector and NGO representatives to select the design and color of the flag. Three rounds of pretests of the color were made in the private sector, CBD areas, urban and rural sites. The logo and colors selected were given to a graphic designer for a complete design and layout of the flag, and 300 flags were printed.

Nine SiSwati 30-second radio spots urging people to follow the flag for FP services were produced and placed with SBIS. These were in dialogue and dramatized formats. All the spots were embargoed following a delay in MOH assurances of flag placement in their clinics. It was later resolved by FLAS to go ahead broadcasting the spots but to cut announcements of MOH clinics.

Although FLAS had also planned two 30-second TV spots urging people to follow the flag, this had to be canceled due to lack of funds. Other planned activities canceled included a special award to the most hard-working health worker, and four 1/4 page ads urging people to follow the FP flags.

Five thousand referral cards were to be distributed by CBD and IBD agents. In fact, 4000 referral cards were developed and printed in two spot color; 2000 were given to CBDs, and 2000 to IBDs to start distributing. The additional 1000 will be printed after evaluating the progress of this initiative.

Three clinic promotional shows were each staged by the Manzini Hub Youth, who performed poetry, a drama on FP and AIDS, and kwasa dances; by the Qothoma Cultural Group, who performed traditional dances; by the Sithole & Band, who performed country music; and by the S'dumo Shabangu's band, who performed mbacanga music.

3. Objective: Dealing with Fears

a. Activities

- o 4 Radio spots on FP safety
- o 5 Radio features on methods
- o Radio spot testimonial on method problems
- o 18 radio Call-in programs (women)
- o 6 Videos on methods

- o Providers' Seminars
- o Prescription Pads
- o 8 newspaper features

b. Details

Four bilingual radio spots, addressing misconceptions about the IUCD, condom, injectable and FP in general, were produced and placed in the English and SiSwati radio channels. These were played for two months. In total, 496 spots aired in SiSwati and 376 aired in English.

Five 15-minute radio feature programs on FP methods were aired. Dr. Douglas, a radio consultant, assisted in the scripting and recording of the radio SiSwati features. A total of eight programs were recorded with involvement of FLAS nurses and satisfied FP users. All the programs were mixed with music and sound effects and made ready for broadcast, but could not be broadcast due to failure in securing free time slots with SBS. They were then aired in the FLAS SiSwati "Temindeni" slot. They covered the pill, condom, diaphragm, loop, injectables, tablets, and the two permanent methods and were testimonial in nature.

One 50-second dramatized radio spot, testimonial in nature, urged people to go to the clinic every time they had an FP method user problem; 71 spots were broadcast in four weeks running 18 per week.

Eighteen radio call-in programs for women were produced and broadcast in the FLAS slot "sikhatsi sakho make" which ran weekly for 30 minutes per slot. The programs were pre-recorded and co-producers were gathered from the pool of FLAS clinicians. Four announcements were made in the SBS continuity and the news alerting people when to call and what topics to cover. More than 70 callers had fertility related problems.

FLAS also developed FP method videos. Eye to Eye Productions was contracted to produce eight videos on the condom, the IUCD, injectable, diaphragm, the oral pill, tablets, tubal ligation and vasectomy. Each of these videos are 15 minutes in length and combined video and computer material\animation. An additional video of family planning testimonials was produced. All these tapes were put in a U-matic master tape dubbed onto 10 copies of VHS format.

Four regional seminars for FP service providers were held in the Manzini, Lubombo, Hhohho, and Shiselweni regions. Regional Matrons in all the four regions were used as guest speakers. A total of 198 nurses in the MOH, company clinics and private clinics were involved.

"Prescription pads" on the pill, IUCD, injectable and condom and diaphragm, 300 pads on each method, were produced in full color. In total, there were 1,800 copies

produced, with 1,200 placed in the FLAS clinics. Some government clinics and company clinics also use them.

Eight newspaper articles on specific FP methods were run over eight weeks. Consultant Everold Hosein assisted in the development of the articles, covering the condom, loop, injectable, foaming tablet, diaphragm, oral pill, tubal ligation and vasectomy. Articles were placed in both The Times of Swaziland and Swazi Observer on the free FLAS page.

4. Objective: Overcoming Male-Related Constraints

a. Activities

- o Radio spots (males)
- o TV spots
- o News stories: chiefs; elders; men supporting women
- o Conference on Swazi culture, male responsibility
- o Chiefs' meetings
- o Symposium for men

b. Details

FLAS has been active in promoting male involvement in family planning and STD prevention. Innovative policies, IEC materials and media activities, and outstanding male providers (both doctors, nurses, IBDs and CBDs) make this a very promising effort at involving men in the family planning program. The evaluators were able to observe the program in action by seeing male condom and vasectomy clients at FLAS clinics; interviewing male IBDs, CBDs, and male nurses and doctors at FLAS and industry clinics; and participating in the one-day symposium. IEC staff's enthusiastic, frank, and graphic teaching of condoms and how to use them is one of the most important components of FLAS' male strategy.

A 50-second bilingual radio spot was produced, with male voice-over, addressing fears related to the condom and specific family planning methods. A total of 420 spots were aired on the English channel and 570 on the SiSwati channel. A 75-second TV spot addressing myths and misconceptions surrounding family planning and FP methods was developed and placed with STBC. A total of 47 ads were aired throughout the campaign.

A radio spot was broadcast featuring a female testimonial for joint decision-making on family planning, with a male voice-over encouraging men to support their wives to use family planning methods. 22 spots were aired in 3-1/2 weeks. A dramatized 60-second radio spot on AIDS\STDs was produced and placed at SBIS for broadcast. A total of four spots have been aired in one week and the expected exposure was 98 spots in four weeks. In addition, a newspaper article talking about men who support their partners' use of family planning was published in the FLAS pages.

A full day conference on the theme, "Swazi Culture and Male Responsibility", was held in Siteki in the FLAS Regional Office. An attendance of 47 men and 13 women participated with several regional administrators. The conference received full coverage on TV on the Asikhulumisane slot; three 45-minute slots were broadcast. A full recording for radio was made and broadcast in the Talena Nalena slot.

Four regional meetings for Chiefs and other authorities (Tindvuna tetinkhundla, bucopho and bandlancane) were held in Big Bend, Mayiwane, Ntfontjeni, Vuvulane, Siphofaneni and Manzini. A total of 580 men and 92 women were involved. In most of these meetings, the venues were at the Tinkhundla centres.

A one-day symposium for men from Manzini on family planning and reproductive health was held during the visit of the Evaluation Team. The symposium produced a dynamic discussion about male views on sexuality and reproductive health led by FLAS IEC staff assisted by male resource people, including a popular radio journalist and a folk media instructor.

5. Objective: Problems of Youth

a. Activities:

- o Reproductive Health Workbooks (3)
- o Family Life Education (FLE) in schools
- o Radio call-in (teens)
- o Mock Parliamentary Debates
- o T-shirts and stickers
- o Roadshows

b. Details

The IEC Unit is responsible for activities with youth. The most outstanding success in reaching teens nationwide was a series of "mock parliamentary debates" held among secondary school debating teams around the country. Debates were held district by district and were very popular, drawing large and enthusiastic crowds. Two of the latest rounds were broadcast on the radio and, despite the controversial subject, received general support. The evaluators listened to one broadcast and found it interesting and well managed. It is felt that the FLE program and the RH Workbooks have also been effective, though there no evaluative research has been carried out.

A consultant, Everold Hosein, developed draft copies of two Reproductive Health Workbooks for teenagers. Book One is for ages 10 - 14, Book Two for ages 15 - 19. A third booklet, "Talking Together: A Handbook for Parents and Their Teens", is distributed to parents by the schools to facilitate communication between the generations. The draft workbooks were reviewed in FLAS by the IEC staff, FLAS management and the Executive

Committee, who made comments and suggestions. A three day seminar was held, attended by FLAS IEC and service delivery staff, MOH nurses, teachers and local writers, to review and adapt the workbooks. Typesetting, layout and design, including graphic artwork, was done by J.V.P. Projects. Three rounds of pretesting were done in three primary schools and four secondary schools. 100,000 copies each of Book One and Book Two were printed in two-spot colors on 135-gram glossy paper. A distribution list was developed and over 30,000 copies have been distributed in schools and among career guidance teachers.

FLAS supports (with IPPF funds) an important program of Family Life Education (FLE) in secondary schools. The program is the responsibility of an IEC staff member who trains teachers at four secondary schools where FLE is taught as part of the regular curriculum, integrated into existing courses. The normal course takes about three weeks, usually integrated into Career Guidance, with elements included in Biology and Social Studies. The basic texts for FLE in schools are the three FLAS workbooks on Reproductive Health aimed at youth and their parents.

FLAS developed 13 episodes of a radio call-in show for teenagers. A co-producer for the radio call-ins for teenagers was contracted and announcements for the slot were made in the SBIS continuity and news. Six call-in programs were recorded and aired in the SBIS English channel in the FLAS slot, "Teen Talk". However, the slot was stopped following an SBIS decision to put the programme on hold until a more appropriate time slot could be found.

FLAS developed the concept of holding "Parliamentary Debates" about family planning issues; students debated whether family life education should be a required course (with parental consent) for all secondary school students. Schools in each region were invited to attend the debates. Two students from the debating team in each school participating in the debate were selected as parliamentarians, two teachers in each school accompanied them, and students from each participating school were invited to attend as observers.

Two mock parliamentary debates were held in the Manzini and Hhohho regions. 4,500 pupils in the two regions participated. One region (Manzini) had full coverage of TV, newspaper, and radio; in Mbabane, the debate was covered in full in the TV programme entitled, "From the Palace", thus receiving implied royal support. 19,000 Reproductive Health Workbooks, Book One and Book Two, were distributed during these debates, along with other promotional materials (T-shirts and stickers with FP messages, designs and layouts). FLAS has printed 10,000 T-shirts and stickers for teenagers as well as 2,000 A1 size posters based on the newspaper ads.

FLAS has sponsored, through Group Africa, over 30 "Roadshows" in rural and suburban areas. These outdoor entertainments combined music, dancing, and comedy with family planning and AIDS education. Over 13,000 people saw the roadshows so far.

6. Objective: IEC in Industry

Industry-based IEC is an important part of the Private Sector program (See the earlier Section on PS Programs) and is the responsibility of one person in the PSU. She ensures that IBDs are trained to provide FP education and motivational talks to employees in groups and counselling to individuals, and to distribute motivational materials. These talks are given at meetings in meeting halls or cafeterias during educational sessions and, especially on plantations, during breaks (e.g. for cane cutters, foresters, or fruit pickers.)

Typically, employers agree to give IBDs a certain amount of time away from their regular work to do FP education. They allow workers special half-hour breaks at least twice a month to discuss reproductive health matters, usually beginning with a video followed by a talk and discussion.

IBDs also visit employees after work hours in their homes, where they may be able to speak with both spouses and gain a sense of family needs. However, most workers are tired after the workday and IBDs typically do not see many people at that time. Like CBDs, they are neighbors who are often known, trusted, and accessible when clinics or professional providers are not available.

IBDs are trained by the PSU with help from the IEC Unit in different IEC strategies, including folk media with traditional Swazi songs and dances. At four industries, a professional trainer taught IBDs to produce plays which were subsequently held. IBDs also use audio-visual aids ranging from pamphlets and posters to videos (many industries have VCRs.) Each IBD is provided with female and male anatomical models, demonstration contraceptives, and pamphlets. Two pamphlets were developed expressly for the Private Sector program showing factory workers talking about STDs.

7. Objective: Community-Based IEC

The CBD program is funded by IPPF, not USAID, but the evaluators were interested in their effectiveness as an important component of outreach and IEC activities; CBDs have the potential to reach unserved rural populations, the great majority of the Swazi people, who live far from FLAS or industry clinics. Day-long visits to two rural sites (Hholohohlo and Malindza) provided colorful examples of the important role that CBDs play in promoting RH in hard-to-reach areas.

CBDs are adult men and women who receive about two weeks of training in FP/Reproductive Health services and promotion, and are paid a small stipend of E50 (\$15) per month "for soap to wash clothes and look neat" as they talk to their neighbors about FP/RH. The CBDs are supplied with condoms and foaming tablets, which they give away. In one area, CBDs also resupply the pill to women who have received a prescription from the clinic.

CBDs seem to be committed, concerned, and informed about their role. One neatly dressed man we met said he had walked for hours to meet the other CBDs and the supervisor from FLAS to discuss their work and receive their stipend, and replenish IEC materials. He said he would even be willing to work without a fee "because my people need my help." But, he added, the small fee he receives and the T-shirts and caps supplied by FLAS are important to him because they make it easier for him to take time away from his farming and chores at home. To receive nothing for his work, and to have no back-up support from FLAS, would make it more difficult for him to justify his efforts in the eyes of family and friends.

8. Media Campaign Results

The IEC activities appear to have been well organized and the IEC campaign seems to have been effective in raising the awareness of FP and FLAS, and in providing specific information regarding FP methods. A Research International study (called "Project Eraser"), a sample survey of 361 Swazis interviewed to assess nationwide awareness of FP, FLAS, and mass media information sources, showed that the ads and other IEC activities probably increased awareness of FP and FLAS, and that radio was likely to be the most cost-effective media.

The study found a high level of awareness of small family benefits, of the role of condoms in preventing AIDS, and the value of contraceptives to prevent unwanted pregnancy. While the problems of "too many" children (whose definition was unclear) were recognized, there was also significant concern expressed for the need to have children to provide for one in old age.

If the research results are representative, they show that the IEC campaign succeeded, at a minimal level, in reaching 3/4 of the population. The total reach of the media campaign ads was very high: 78% of the sample knew of at least one FLAS ad. Sixty per cent had heard of a family planning organization, of whom 80% had heard of FLAS (compared with 38% who knew of SNAP, the government AIDS organization). Half of all interviewed knew that FLAS teaches family planning, and 40% recognized the FLAS logo.

The study found that 50% of those sampled read newspapers, of whom 60% saw the FLAS ad. The total ad reach was an impressive 30% of the total population. Two newspaper ads had a 13% total reach: one comparing the Swazi traditional shield to the condom, the other showing more pumpkin for a smaller family.

Thirty-four per cent of Swazis watch TV, of whom 58% saw the one FLAS ad. Of that group, 43% understood that "fewer children are easier", while 24% understood the need to "limit your children". The TV ads had a total 20% reach, a very large number.

Newspapers and TV effects are impressive, but radio wins in popularity: over 87% of those interviewed listen to radio. Radio is even more popular among the poor (92%), males

(90%), and youth (15 to 29 years: 89%). Among stations preferred, SBS SiSwati was more than 12 times more popular than SBS English. 69% of radio listeners had heard some family planning ad, the equivalent of a formidable 60% nationwide reach, with youth and more affluent listeners seeming to remember the ads more than others.

Of the two radio ads tested, 37-42% remembered the family planning message in the ads, and 25-29% remembered the idea that a "small family is easier to maintain". Compared to two other FLAS ads in English, including "The Swazi Teenager", the FLAS ad "Temindeni" in SiSwati was over ten times more popular. Research International were not clear, however, whether FP or STDs was the main FLAS message communicated. Their main conclusions were:

- o "Radio would appear to be the ideal medium to reach the target market for family planning, namely the younger, poorer people in the population";
- o Fewer men are reached than women;
- o SiSwati is far more cost-effective than English, at least on the radio;
- o Outdoor posters are worthwhile at bus shelters, taxi ranks, and near shops.

While the mass media campaign did pretest materials during development to ensure that the materials made sense and were appealing, there has not been an evaluation of the role or cost-effectiveness of IEC in convincing people to use FP or to obtain specific FP services. Although the Research International study (described above) shows that people are aware of FLAS and family planning, it did not measure the use of family planning and attendance at FP clinics, though anecdotal evidence indicates there was clearly some impact. The tracking of public knowledge and attitudes begun in July, 1995, by Research International was to be repeated, and the next study was to have been in time for a final evaluation. But the opinion tracking could not be continued due to program delays and funding shortages. Nevertheless, FLAS staff gained valuable media programming experience from the wide range of IEC activities undertaken.

Even though the FLAS flags and logo signs were not used with MOH clinics as planned, they appeared to be useful in directing people to FLAS and industry clinics and, we were told, to CBD homes. Further, FLAS service statistics data show that new acceptors increased during the campaign period. While the number of new FLAS acceptors increased 56% in the first nine months of 1995 when compared to the first nine months of 1993, it is not clear whether or how much of that increase would have occurred anyway, without the IEC campaign. Thus, there is not, at this time, convincing data on whether the goal of promoting FLAS and MOH services and locations was achieved. The measurement of IEC impact on male attitudes and practices must also await further evaluative research.

The radio call-in shows, held Wednesdays from 1:30 to 2:00 pm, were apparently popular. Callers were plentiful and listeners seemed to be many--too many, perhaps, because the Swaziland Broadcasting System canceled the program, apparently because some people thought that a frank and open discussion about conception, contraception, and STDs/AIDS, no matter how popular, was inappropriate for a family audience during mealtime. SBS officially said that the cancellation was due to technical imperfections in the broadcast recording. Although SBS has said that the program may be reinstated when an appropriate time slot can be found for it, they have not yet been able to find a slot for several months; and they told the evaluators they are not likely to find one for a long time.

A good way for FLAS to measure the effectiveness of the promotion of service delivery points would be to ask FLAS and industry service providers to keep careful records on each client registration card where it asks, "Referred to FLAS by". This question may not seem important to busy providers, so it may not always be asked, and FLAS has not yet tabulated those few responses that have been given.

D. IEC MANAGEMENT

1. IEC Unit Staff

The April, 1993, IEC evaluation found the IEC Unit to be "a committed group of people with a strong interest in their work." The unit includes seven professionals: two focus on mass media, one works with radio, and another works with newspapers and TV. Several IEC staff have had specialized experience in other organizations, three have had training courses in other countries, and the Senior Program Officer has taken a one year course in managing social marketing at New York University.

From mid-1994 through August, 1995, the IEC Unit had a heavy schedule, planning and implementing the media campaign (for much of that time without the IEC Director) as well as continuing normal IEC activities in industries, communities, schools, and other groups.

2. IEC Planning

The 1993 FHS amendment suggested that the IEC Unit probably would not be able "without assistance" to "implement the kind of IEC campaign required to produce significant national impact." To meet the need for stronger management of the national campaign, FLAS hired the marketing company, O & M, to manage the campaign and the Unit Director went to New York for a marketing management course. The IEC Unit has tried hard to respond to the recommendations of consultants who have provided technical assistance to the unit during the FHS project and, in particular, during the media campaign of 1994 and 1995.

The IEC Unit has become specialized in several different functions and is thorough in planning and reporting on its activities. In terms of in-house management information, the unit reports regularly. IEC staff, like other FLAS professionals, use a Weekly Planner showing each staff member's daily plans, and monthly reports circulate throughout FLAS.

From 1994 to September, 1995, IEC staff were often very busy outside of FLAS headquarters at meetings or visits to other organizations and communities to organize and lead IEC activities. FLAS's IEC staff participate fully in traditional folk activities with CBDs and IBDs, bringing gifts to chiefs and elders. When necessary, some work in the community on Saturdays or Sundays and are allowed compensatory days off.

3. Cooperation within FLAS

There is an important overlap between the IEC Unit and the Private Sector Unit (PSU): While IEC is provided to many different target groups in Swaziland, the private sector is assumed to be the most important "customer" for IEC. The industries' needs are a top priority, and are taken more seriously than, for example, the communities served by CBDs, the schools providing FLE, or roadshow audiences.

FLAS management is aware that to avoid duplication and to ensure that the industries are well served, the two units need to closely coordinate IEC work in the PSU. There is one person assigned to manage IEC in the PSU; she was part of the IEC unit originally, but to ensure tighter management, she was moved.

IEC Unit communication with other parts of FLAS was also essential when a major public relations (PR) effort was made in recent years to build the image of FLAS as an organization and to promote its ideas. A full time PR Officer who works in the office of the Executive Director was hired; her job is to support the effort to position FLAS and to ensure that FLAS becomes better known throughout Swaziland. The PR campaign seems to have been quite successful because FLAS is widely known in Swaziland (see the Project Eraser report above).

The PR Officer contracts with several feature writers who draft articles for publication in various publications under FLAS's name. The drafts, aimed at male, female, and teen readers, are evaluated and edited by the PR Officer who circulates them to other managers for comment before they are sent to the media. Contracted writers, who are often given updates on reproductive health by FLAS, are "on background"; FLAS is the author of these articles.

4. Cooperation with Government

The IEC Unit continually collaborates with several government ministries, particularly the Ministry of Health's Swaziland National Aids Program (SNAP). SNAP is in charge of developing an action plan for AIDs control for all IEC in the country, a plan which

is still incomplete. The IEC Unit also collaborated with the Ministry of Education on a national curriculum for primary schools in reproductive health education, in implementing a "child-to-child initiative" in secondary schools, and in running an FLE seminar for career guidance counsellors in secondary schools. Under the Ministry of Information, FLAS is a member of the NGO broadcasting group.

5. Cooperation with Other NGOs

The IEC staff communicate and collaborate often with a number of other NGOs in the fields of STDs/AIDS (e.g., TASC), the arts (Siphila Nje Drama Society), and youth programs (Hub Youth). For a full list of collaborating NGOs and details on shared activities see Table 13.

E. Conclusions and Recommendations

1. Overview

The FLAS IEC Unit developed a large range of IEC materials and has been effective in making FLAS and family planning well known throughout Swaziland. The IEC materials are, in general, of high quality. They have been well developed, produced, and distributed. The three RH workbooks are excellent publications, and are intended to eventually reach a substantial proportion of the Swazi population of all ages and areas. At the same time, FLAS's sustainability in IEC has been greatly enhanced by the valuable learning experience of its management and staff, all of whom learned specialized IEC skills and benefitted from being exposed to many types of IEC activities and experiences. The IEC unit was very responsive to the many thorough reports prepared by IEC consultants. A summary of the recommendations by those consultants and the results of actions taken by the IEC unit as a result are included in Appendix F.

The IEC Unit was able to increase national awareness of reproductive health and family planning to a very high level--when compared to many African countries. A sample study in July, 1995, found a high awareness of small family benefits, condoms to prevent AIDS, and contraceptives to prevent unwanted pregnancy. The campaign clearly was able to take advantage of the advanced Swazi culture, with its high national literacy rate. 30% of Swazis saw the FLAS newspaper ads; 58% saw at least one FLAS TV ad, and more heard a radio ad.

The IEC Unit faced many obstacles in implementing its national media campaign. It faced a heavy schedule requiring rapid spending to meet the FHS grant deadline. Its manager and several key staff were often overseas on training programs. The FLAS campaign ran out of funds several months ahead of schedule. Finally, FLAS had limited

Table 13

IEC COLLABORATION WITH OTHER NGO'S

NON GOVERNMENTAL ORGANIZATIONS (COLLABORATORS)	ACTIVITIES WITH COLLABORATORS
1. SWANASO	- Attended monthly meetings where progress of AIDS counselling and information sharing was discussed.
2. TASK	- Shared IEC Materials and facilitation during seminars and meetings
3. SEBENTA	<ul style="list-style-type: none"> - participated in development of Sebenta pamphlets on Family Planning and AIDS issues. - Got the assistance of Sebenta in the translation of a number of FLAS pamphlets. - IEC invited by Sebenta to give FLE talks to a number of organized sebenta classes
4. SHAPE	- participated in a number of SHAPE teacher training programs for Secondary\High School teachers and headmasters.
5 RED CROSS	- Shared facilities on health education talks during workshops and seminars for both FLAS and Red Cross programs
6. HUB YOUTH	- Utilized Hub Youth during the FLAS clinic promotional shows. They performed dramatized shows including poetry on family planning and HIV/AIDS.
7. SIPHILA NJE DRAMA SOCIETY	- Utilized groups in performing on stage dramatized shows. They also assisted in developing scripts for radio spots.
8. COUNCIL OF SWAZILAND CHURCHES	- Collaborate with CSC in running seminars together and for FLAS to give talks to their member groups.
9. MAHLANYA YOUTH MAIZE GROUP	- FLAS invited each year to give FLE their groups.
10. BOYS SCOUTS AND BOYS BRIGADES	- Collaborate in FLAS giving FLE to their member and during their camps.
11. SWAZILAND YOUTH COUNCIL	- FLAS attends meeting

government support, both in terms of its small financial subsidy and in policy terms (as in the failed effort to identify all FP service delivery points). It should be commended for its achievements in the face of such barriers.

Because FLAS cannot say whether the increase in clients at FLAS clinics was a result of its IEC, FLAS should collect data from clinics and sample surveys measuring whether IEC has affected peoples' use of FP services. In the future, FLAS's IEC Unit will probably cut costs sharply and might be able to recover IEC costs from sponsorships and, hopefully, from subsidies from donors and the MOH.

FLAS' focus on men and youth are some of its strongest features. Men's programs could be expanded with the testing of male-only clinics, more male-friendly services, and condom dispensers or vending machines available everywhere, not only in industries. Similarly, FLAS's excellent school programs, teenage reproductive health workbooks, and radio programs which reach all ages, including teens, could be replicated nationwide, ideally with expanded MOH support. While FLAS's IEC staff have achieved a great deal, the unmet demand for reproductive health services--the gap between the people's knowledge and practice--remains.

2. IEC Program

The following conclusions were reached about the overall IEC Program.

- o The program has been very productive and effective in accomplishing one of its most urgent objectives: making FLAS and the importance of family planning well known throughout Swaziland. In this regard, the IEC Unit has developed, tested, and disseminated a wide range of IEC messages, materials, and media.
- o USAID funding has increased FLAS' sustainability in IEC by training staff to carry on IEC activities after USAID funding ends.
- o The project has provided valuable learning experiences for both IEC management and staff, all of whom have been able to learn specialized IEC skills. While IEC staff members have specialized in different types of IEC work, they have also benefitted from being exposed to many types of IEC activities and experiences in different media. IEC costs will be lower in the future because of less need for outside consultants.
- o IEC materials are, in general, of high quality. They have been well developed, produced, and distributed. The three RH workbooks are generally excellent publications, and are intended to eventually reach a substantial proportion of the Swazi population of all ages and areas.

- o A number of obstacles remain including a recent shortage of funds, problems with media "censorship", and a hectic schedule requiring hard work and many IEC activities implemented in a relatively short period of time. Additionally, some providers doing counselling may not use or have access to the full range of IEC materials during counselling. Despite these obstacles, the IEC Unit was able to increase national awareness of reproductive health and family planning to a very high level when compared to many African countries.

The following recommendation is offered to improve the IEC program:

- o Ensure that all counsellors have adequate supplies and make use of all IEC materials and equipment.

2. Male-Related Issues

The evaluation team concluded that FLAS's male-focused IEC may have gone far toward defusing male opposition to FP, though it has not yet been quantitatively measured. FLAS IEC staff's enthusiastic, frank, and graphic teaching of condoms and how to use them is one of the most unusual and important components of the FLAS strategy, is highly commended, and should be replicated throughout southern Africa.

Despite all this very real effort, there is still room for improvement because neither FLAS nor MOH clinics appear to be as popular with men as they could be. FLAS's efforts to involve men have not been sufficient, in part, because there is not enough effort made to have men feel comfortable in what is, traditionally, an all-female environment--the MCH/FP clinic service. FLAS clients, according to 1993 data, are 90% female; in Manzini, 99% female. This could be partly because services are associated with clinics and hospitals, but men interested in family planning do not feel "sick".

Men's interests are focused on their family's welfare and their personal sexuality. Like men everywhere, Swazi men are concerned about sexual performance and fear impotence and sexual diseases, particularly AIDS. Yet there is no place (other than an occasional article in the newspapers) where men feel they can easily get professional advice from a trained counsellor about sexual and reproductive concerns. While some Swazi men appear comfortable talking with female CBDs about FP and condoms, men usually feel more comfortable talking "man-to-man". Older men, particularly, may object if women appear to be dominating FP decisions, knowledge, and services.

Also, FLAS does not put much emphasis on national sports events or on reaching men through athletic teams, nor does FLAS feature Swazi political or business leaders, entertainers, or musicians in its IEC campaigns.

Given the findings and conclusions regarding specifically male-related issues in family planning programs, the following recommendations are made:

- o Test several different types of men's programs, including trying out providing services at community centers, mobile units, even in bars or sports events.
 - o Disassociate men's reproductive health programs from the clinical or medical model, and make it more appealing to men who feel healthy; sexual health should be tested as an important theme of IEC for men.
 - o Include men-only group discussions about male sexual and reproductive health including problems with condoms and fears about vasectomy and male roles and responsibilities in family life and child care.
 - o Encourage gender balance among IBDs, CBDs and clinic staff to ensure that men can talk to other men, "man-to-man".
 - o Test separate times for men to come for clinic services, particularly after work or at break-time in factories; and separate spaces, areas where men can have privacy and will not be embarrassed.
 - o Encourage national and community leaders (politicians, respected figures in music, the arts, entertainment, sports figures and other well-known men) to promote family planning.
 - o Generate income for FLAS by sponsoring sports events to both publicize Temindeni and RH and to reinforce its services to athletes.
3. Youth-specific issues

The team reviewed FLAS work with youth and concluded that like FLAS's approaches to men, its IEC work with young people is exemplary and deserves to be widely known and replicated throughout southern Africa. The mock parliamentary debates and the three reproductive health booklets were of high quality, understood (at least by English-speaking youth), and seemed to be popular.

Young people who are informed and motivated to use contraceptives, however, may not have easy access to them. For example, few teens appear to have access to condoms or foaming tablets. Even schools with FLE courses are not distributing condoms or FTs. There is a stigma attached to youth using a clinic which provides only reproductive and sexual health services. Teens feel awkward attending a FLAS clinic, which indicates to all that they are sexually active, infected, or pregnant.

Given these circumstances the following recommendations are put forth:

- o Expanding FLAS' FLE program nationwide with Ministry of Education support by developing proposals and seeking international assistance for the program.
- o Sponsor teen drop-in centers, after-school programs, cultural events, sports and games--providing a chance for teens to meet new friends in a safe and enjoyable environment where they are also provided RH education and services. This could help to minimize the stigma facing teens who go to FLAS clinics.
- o Train more teen peer counsellors to talk to teens.
- o Involve athletes as peer counselors and provide services to sports teams and at sports events by mobile units; it could test the use of the IBD model in sports or out-of-school youth groups.
- o Deal frankly with what interests young people about sex (pleasure) and not only its clinical aspects in youth-oriented IEC.
- o Promote the concept of Dual Protection: condoms plus another contraceptive method are especially important for young people.

4. Evaluative Research

The team concluded that it is difficult to know how effective FLAS's IEC has been in bringing clients to its services. Although the Research International study shows that people are aware of FLAS and family planning, FLAS has not done an evaluation of how effective its IEC messages and materials have been in encouraging people to adopt family planning, or visit clinics, and at what cost.

The team recommends the following actions:

- o Conduct research to prove that FLAS' IEC activities lead to increased use of its services. The national survey that was planned should be carried out as soon as possible.
- o Carefully measure the cost-effectiveness of the IEC Unit and the REU's IEC activities and do more research on IEC with small studies (e.g. operations research or the COPE methodology).

5. IEC Cost-Recovery

The evaluation team concluded that FLAS's IEC media campaign was comparatively costly because a relatively large amount of funds had to be spent in a very

short time (less than two years). The IEC campaign was designed on the assumption that family planning services would be provided free; it was not designed to generate income. Moreover, there is no explicit policy in FLAS that cost-effective IEC is an important goal. Thus, the IEC campaign, as currently designed, cannot easily be sustained without continued subsidies.

However, FLAS's IEC unit has developed excellent skills, facilities, and equipment (e.g. marketing skills, IEC production capability, a radio studio) which could be used to generate income. These services could be shared with FLAS's sister NGOs in development, education, health and family planning, and women's empowerment.

In response to the need to put the program in a position to generate some revenue, the team makes the following recommendations:

- o Reorient FLAS' IEC activities and materials toward achieving FLAS's new need for self-financing.
- o Develop an explicit goal of IEC related to cost-effectiveness. The IEC Unit could narrow its scope of work to high-priority, low-cost activities which are proven to be cost-effective. It appears that radio is the most cost-effective mass media.
- o Seek grants and donations for the IEC Unit to support its activities and establish with FLAS management what the unit's priority activities should be in the future.
- o Consider utilizing IEC for marketing or advertising services which clients pay for, thus assisting cost-recovery.
- o Seek sponsors for all IEC's advertising, including all roadshows; billboards in towns and along major roads; radio and TV spots; newspaper ads; and all other IEC. Reproductive health services could be sponsored by businesses like Coca-Cola, Barclay's Bank, or the industries where FLAS works, such as Cadbury's. The ads sponsored jointly with businesses could contain two compatible messages. A TV ad could show a mother, father and baby, saying, "To plan your family, see FLAS; to save for your child's future, visit Barclay's Bank".
- o Consider ways to generate income by selling IEC services to other agencies with health-related goals, by developing IEC materials, helping other health organizations manage IEC or marketing campaigns, and renting out their facilities, such as the radio studio.

V. EVALUATION

A. Research and Evaluation Unit (REU)

One of the objectives of the original FHS grant was to create and develop a Research and Evaluation Unit (REU) at FLAS that would undertake to develop a computer-based service statistics or Management Information System (MIS) that would be able to report on FLAS services and provide feedback to management on a timely basis. In addition, the REU would undertake evaluative research that could be used both for program design as well as for assessing the adequacy and addressing implementation problems of FLAS program services. Overall, the REU has met this objective.

The overall staffing and performance of the Research and Evaluation Unit (REU) has been quite good. While it is relatively small, it makes substantial use of outside consultants to carry out needed studies. At an earlier stage, a full-time Pathfinder Advisor was based at FLAS and worked to set up and establish the REU. Currently, however, the Unit may be too small to carry out the evaluative research that is likely to be asked of it. Appendix D presents the qualifications and specialized training undergone by the members of the REU.

B. Project Monitoring Activities

The service reporting system or Management Information System (MIS) is, overall, very well developed and highly effective. There are a few small problem areas, but the quality and timeliness of the frequent service statistics reports are excellent. The service data is both reported in a timely manner on a monthly, quarterly, half-yearly, and annual basis and is accompanied by analysis and interpretation. Excellent use of graphs and tables is made. The reports provide feedback to the Private Sector, CBD, and clinic service programs.

Table 14 presents a summary of the service statistics collected for the last full year of services, 1994. It shows that FLAS provided services to over 16,000 new family planning acceptors, had nearly 40,000 revisits, and was responsible for over 14,000 Couple-Years of Protection. FLAS' three clinics still provide over half of the CYP, mainly because of the largely continuing clientele using longer-lasting methods. However, the IBD program in the private sector served the most number of new users, showing the growing importance of this program outlet. It should be noted, however, that the IBDs mainly distribute condoms, and consequently, the distinction between new and continuing users is not always accurate. In addition, the IBDs, along with the CBD workers, provide referrals for family planning and STD treatment, and talk to large numbers of people. According to the reports, over 57,000 persons were exposed to the educational messages of the IBD and CBD agents. In terms of contraceptives, over 600,000 condoms (nearly equally distributed by the FLAS clinics, the IBDs and the CBDs) and 93,000 foam tablets were distributed (mainly by the CBD agents) along with nearly 27,000 cycles of pills. In addition, over 16,000 contraceptive injections

TABLE 14: 1994 CBDs, IBDS AND CLINICS COMPARATIVE PERFORMANCE
IN ALL PERFORMANCE INDICATORS

Performance indicator	CBDs performance	IBDs performance	FLAS Clinics	Private Sector Clinics	Total
New Users	3911	6111	4829	1275	16126
Revisits	4491	4603	22036	8490	39620
CYP	1998	2012	7472	2599	14081
FP Referrals	777	370	-	-	1147
STD Referrals	499	366	-	-	865
Total IEC talks	4224	5486	-	-	9710
Number of people in talks	15809	41195	-	-	57004
Condoms distributed	188858	195912	204050	20434	609254
Foam tabs distributed	54795	26567	8660	3640	93662
Orals	-	-	19513	7288	26801
IUDs	-	-	817	110	927
Inject	-	-	10000	6207	16207

*orals distributed by IBDs from UBO & MMS not entered

were given by the FLAS and private sector clinics while over 900 IUCDs were inserted. It should be noted that the service statistics are an undercount in that orals distributed by the IBDs at two of the industry sites have not been included in the totals. Further, as noted below, several outlets for the distribution of condoms are not included in the reporting system.

FLAS services have continued to grow during 1995. As presented in the earlier sections, both FLAS clinics and the Private Sector Program have served a larger clientele in the first nine months of 1995 than they did in the comparable period of 1994. In addition, the CBD program increased its contraceptive distribution significantly, distributing more condoms and foam tablets in the first nine months of 1995 (CYP = 2,824) than in the entire previous year (CYP = 1,998). Nevertheless, there are a number of small problems in the reporting system:

- o The definitions for the distinction of new acceptor from an old or repeat acceptor have been inadequate. There has tended to an overcounting of the number of new acceptors. This can be seen in its annual data for 1994 where the proportion of new acceptors to total visits is about 40%--a value that is not found in any established program. This is also misleading if one attempts to estimate the total number of acceptors from the data--an overcounting of the number of separate family planning users will result. The other problem has to do with clients that utilize more than one source of services. To date, a client new to FLAS, but a past user on contraception from another source, is reported as a new acceptor. It is understood that the REU has recognized this problem and is in the process of revising the definitions and implementing them.
- o It is likely that a proportion of the amounts given to FLAS clients are not being used because to date there has been no charge for condoms and foam tablets distributed. This is also likely when the amounts given out to each client are of the order of 20 to 30, as is the usual case. In calculating Couple Years of Protection (CYP), FLAS has used the figure of 100 condoms/foam tablets equal to one CYP. A figure that takes into account possible wastage or non-use is the 144 per CYP that FLAS intends to use in the near future when it revises its MIS computer software system. The use of condoms along with the use, at the same time, of another contraceptive by the female partner--an increasing practice--also reduces the contraceptive value of the condom.
- o The current system provides an undercount in the number of condoms (and foam tablets) distributed by FLAS. Several of the programs do not record or report their distribution. This includes:

- The Women's Empowerment program where the members of the groups--called Peer Educators--are given condoms and FTs to distribute.
- The IEC unit often distributes contraceptives at the presentations it gives.
- Contraceptives are made available both at the FLAS headquarters and at the national airport (in a dispenser). These are not reported.
- The condoms distributed through the dispensers used in a number of the industrial sites have not been reported.

The REU is aware of the problem and has intentions to remedy the situation. The incorporation of the record system for the supply and distribution of condoms and foam tablets to the different FLAS units and programs into the MIS would enable a more accurate reporting of FLAS contraceptive distribution.

- o There are some software problems in the current computer-based system. The REU is not able to combine the data from the Private Sector clinics with the IBDs. In addition, there are a few other limitations in the current system which FLAS has recognized and is in the process of recruiting a consultant to resolve them.

C. Evaluative Research

1. Overview: Amended FHS Grant Planned Evaluation

The FHS grant amendment paper described a number of specific program evaluation activities that were to be undertaken. These included, in general terms:

- o Documentation of project activities (Inputs, costs, outputs, constraints & opportunities). This has generally been done and is the focus of the current evaluation.
- o Special assessments by outside consultants.
- o Specialized studies that were to contribute to improving the effectiveness of project implementation.
- o An analysis of service statistics of the different programs.
- o Special large-scale surveys to measure the impact of the programs.

While the details of the evaluation of each program area is presented below, the evaluation team found, in general, that few of the specific evaluation activities described in the FHS amended project document planned to assess the impact of the private sector and IEC programs were carried out. This was due to both program implementation delays and the current lack of funds. Thus, the impact of the private sector and the IEC programs has not been able to be ascertained in an objective and comprehensive manner. We are left with examining FLAS family planning service statistics data and utilizing the impressions and anecdotal accounts provided by FLAS staff and the persons we met during the site visits. It was suggested that we might utilize the MOH national family planning service statistics as a measurement of program impact. This is not felt to be valid for two major reasons:

- o The MOH data is reported to be both inaccurate and incomplete, and any number of other factors may be responsible for changes in the family planning acceptance.
- o The MOH data is only available through the end of 1994, and much of the IEC campaign took place in late 1994 and most of 1995. Thus, the 1994 data will not reflect the impact, if any, of the IEC campaign.

It has also been suggested that FLAS service statistics be used as an assessment tool to evaluate the programs. While this makes some sense for the Private Sector program, it is not appropriate for the IEC campaign as one is not able to point to any specific aspects of the campaign as being responsible for any particular increase in contraceptive services, and there is no data available from FLAS clinics indicating clients' IEC exposure. However, a detailed examination, month by month, of the utilization of services over the three-year period of 1993-1995 that is correlated with the introduction and ending of specific IEC activities might show the impact of the IEC campaign, if monthly changes can be distinguished from the secular trend of overall increasing services. Finally, we are not able to measure contraceptive prevalence in the target population as a whole.

2. Service Delivery and Quality of Care

a. FHS Planned Evaluation

The FHS project document envisioned two evaluation activities for this sector:

- o Documentation of project activities (Inputs, costs, outputs, constraints & opportunities). This has generally been done and is the focus of the current evaluation presented in the earlier section on Clinical Service Delivery and Quality of Care.

- o Evaluation of clinical standards and quality of care. This has been the focus of two earlier site visits by Pathfinder consultants: The 1995 Trip Report by Dr. Teri and the earlier evaluation by Dr. Huber in 1993. It is also an objective of the final (present) evaluation report.

- b. Other evaluation activities

Other evaluative activities that were not specifically called for in the grant amendment have included:

- o Client Drop-out/Continuation studies. These studies have been based only upon how frequently clients return to the clinic. Adequate continuation is defined if a client is not over one year late in a scheduled return visit. This period varies for different types of clients. Rates up to 90% are found. Theoretically, a client could get pregnant, give birth, and return for more contraception and not be classified as a drop-out. Nevertheless, the studies show that FLAS is concerned with the FP continuation issue and that the continuation rate, as defined in the study, has increased in the last year.
- o Client Profile Study. This was a fairly limited study identifying some of the characteristics of clients as given in their records.
- o Client Satisfaction/Client Flow Study. In July, 1993, 525 repeat/revisit clients from all FLAS clinic services were interviewed. The study showed very positive attitudes toward FLAS (only 1.8% negative views) and short waiting times (10 minutes on average) except at Manzini (25% wait over 30 min.). However, 14% of those interviewed said they were given no counselling--a highly valued service. New clients might give a different picture.
- o Cost-Effectiveness Study of Clinics (Kinyondo, 1995). Carried out in early 1995, this study found a high proportion of staff time devoted to non-family planning services (56%), of which the largest was counselling and treatment of STDs. The study also found that most clients were willing to pay increased fees for services. This data was used as the basis for the clinic marketing proposal in which increased fees have been suggested for clinic services.

- 3. Private Sector Programs

- a. FHS Planned Evaluation Activities

The following evaluation activities were planned for the Private Sector Program:

- o Documentation (Inputs, costs, outputs, constraints, opportunities). This has been done.
- o A Baseline Survey of contraceptive prevalence, was to be carried out in late 1993. Instead, two separate surveys were carried out: in 1992 and again in 1994.
- o A Follow-up Survey was to take place in late 1995.

b. Completed Evaluative Studies

(1) Baseline Studies

Contraceptive use has been found to be very difficult to measure in the industry settings. Sexual relations with multiple partners is common, and contraception may be used with some partners, but not others. The industries employ many types of workers--those with families, those without, permanent, seasonal, male, female--this also makes measurement difficult. Interviewing in the previous studies has probably been inadequate: young college students/High School graduates, not always enough privacy, not always a same-sex interviewer, and not always including questions concerning the sexual partners' use of contraception (i.e., female respondents say they don't use condoms, while men say they do, but don't use the pill.) Three different studies have been undertaken in the industry setting; each used a different sample and somewhat different procedures.

(a) First Baseline study

In 1992 (Mburugu & McOmbe) four large industries with 16,550 employees were selected. N=1085. 82% permanent employees, 60% male, 40% female respondents. 75% of the interviewers were young female adults. 34% of the respondents indicated current FP use. But they were only asked about their own use, not that of a partner. For example: Males: 78% of FP use was condom, 1% was injection. Females: 3% of use was condom, 53% was injection. Ever condom use: 46% of men, 28% of women. No. of partners in last 2 months: None-21%, 1-61%, 2+-18%. 45% of respondents said they were "interested in considering VSC" after they had all the children they wanted.

(b) Second Baseline Study

From February to May, 1994 a study was conducted by Dr. Gulu of 21 industries (mainly smaller ones) with 7,300 workers, N=981; some were casual workers. However, 337 subjects were not asked the questions on sexual activity. Interviewers were under 21, and interviews were not necessarily private. 39% of subjects were female. Overall contraceptive use: 42%. This ranged from 24% to 48% in males and from 40%-46% in females in different industries. Very large educational differential: 26%

were using FP among those with no education compared to 48% for those with secondary education. 37% say they want no more children (desired family size = 5.3) and 52% say they are interested in learning more about VSC. The same problem arose as in the earlier study in that men and women indicated only their own contraceptive use, and only partially that of their partner. The primary reason FP users say that they use contraception was: AIDS: 20%, FP: 18% (27% of females say FP is the primary reason).

(2) Cost-Benefit Study

In July 1995, the Futures Group study attempted to compare the benefits that would derive from the program with the costs expended on it. It looked at the benefits of both reducing childbearing as well as preventing the transmission of HIV/AIDS. Study data were collected from 3 industries with approximately 3,000 employees. Respondents included 736 female employees and 1,454 wives of male employees of reproductive age. Only a limited analysis and report has been made available to the team. This is because the data is reportedly being analyzed in Washington and being written there (Futures Group). However, the summary report illustrated tremendous benefits for both FP and AIDS prevention activities. The study produced a contraceptive prevalence estimate of 42% ("a weighted average"). 48% of female employees were found to be FP users while 39% of the wives of male employees used contraception. Contraceptive use by males was apparently not ascertained.

c. Specific Assessment of the Private Sector Monitoring System

The Private Sector program utilizes the same monitoring system as the rest of FLAS, and, thus, has the same advantages in terms of frequent reporting and feedback of analysis of the service statistics. Monthly, quarterly, half-yearly, and annual reports of the service statistics are provided. However, it also suffers from the same drawbacks. In particular, as mentioned above, there is not a unitary system for reporting both the clinical and outreach (IBD) components of the private sector program; this hinders the effectiveness of the MIS in producing effective analyses. As mentioned earlier, plans to revise the software system were postponed. A serious lacunae is the fact that condoms supplied to the condom dispensers in the industries are not reported. This successful component of the program is likely to expand in the future and will require careful monitoring.

Another problem is the difficulty of ascertaining whether condom use is having any fertility impact. Given the patterns of sexual practices in the private sector communities, perhaps separate measures for female and male use of contraception is advisable, with the male measure being simply condom usage.

d. IBD Selection Criteria study

This was a study carried out by outside consultants (Magagula & Kunene, 1994) that did not really appear to be useful. Apparently, it didn't actually analyze IBD performance differentials in reviewing selection criteria. It looked at the problem of the IBD workers losing motivation after their initial enthusiasm. While it didn't add much new information, it reinforced the perceived need to provide incentives to the volunteer workers. On the other hand, the REU unit prepared its own memo on "Criteria for Recruiting new CBDs/IBSs" in January, 1995. It had compared the performance of different IBD/CBD workers with different background characteristics--sex, age, etc. The results appeared more useful and have been communicated to the programs.

e. Focus Groups

A report of a series of focus groups of IBDs and CBDs was prepared by the REU of FLAS in 1994, though a report of the study could not be provided to the team. (IBDs/CBDs Selection Criteria Study: Focus Group Discussion Findings.)

f. Anecdotal reports

There may be reductions in STD treatments in the industry clinics as a result of the IBD program--this has been reported anecdotally in one setting. The likely success of the IBD and clinic programs in the industry setting is probably already having a significant impact. It would be worthwhile to try to document this.

4. IEC Programs

a. FHS Planned Evaluations

There were a number of evaluation efforts planned for IEC programs.

They included:

- o Three Phases of the IEC campaign implementation were planned. Documentation (Inputs, outputs, constraints & opportunities) of each phase was to be carried out.
- o Three "Tracking" Surveys that would indicate public reactions to the campaign and desired attitudinal change were planned. Only the first one, termed, Project Eraser, was carried out. It served as a kind of Baseline Study.
- o Eight focus groups were to be held every six months. Instead, two rounds of four FGs were held before each of the first two campaigns/phases by O & M. Though these reports were felt by FLAS staff to be valuable, they could not be found by the REU or the evaluation team and could not be examined. Further FGs were abandoned due to lack of funds.

- o A FP Users Poll, a national survey of 1,500 respondents to be carried out in 1995, was abandoned due to lack of time.

- b. Evaluative studies Carried Out

- (1) Project Eraser: IEC Tracking Survey

This study provided valuable information concerning the communication patterns of the IEC target population. However, as it was not repeated, it met only limited objectives. It is discussed in the IEC program section above.

- (2) Roadshow Evaluation

The Roadshow was an outdoor entertainment that also provided education and motivation concerning family planning and AIDS prevention. Five very short interviews were held by Roadshow staff with members of the audience at each of the more than 20 performances. They showed a very positive reaction to the Roadshow and a universal understanding of the need for family planning and of the danger of AIDS.

- (3) Adolescent/youth studies

A great deal of program relevant information has been collected as part of a series of studies of adolescents and youth carried out over the last five years. Two specific studies of adolescents were carried out in preparation for the IEC campaign. One was a study of secondary students who had children and dropped out of school (Mkhwanazi), while the other focused on youth still in school (Maphalala). A similar earlier study had been carried out by Magagula & Nsibande (1993).

- (4) Other studies

The REU is currently undertaking a Health Needs Study (KAP) survey of prisoners (120) and handicapped persons (100). Given the pressing problems and the need for evaluative studies in existing FLAS programs, this is seen as a rather low priority area that appears to be diverting the REU from what should be more valuable research.

- D. Conclusions and Recommendations

- 1. Overview

The Research and Evaluation Unit (REU) of FLAS was created and developed under the initial FHS grant. With the assistance of a full-time Pathfinder advisor, it initiated an effective Management Information System (MIS) which has provided program managers with timely and comprehensive information on the FLAS services. While it currently needs

a few minor adjustments in its reporting definitions in the inclusion of all condoms distributed by all program activities, and in the computer software system, it is a strength of FLAS that it has such an effective system.

FLAS has also undertaken a very wide range of program relevant research and evaluation, often with the assistance of international and local consultants. An impressive series of studies on family planning issues, especially among the adolescent/youth and private sector target populations have been carried out. In addition, the last year saw two key studies carried out examining the cost-effectiveness and cost-benefit of the clinic and private sector programs. These have been very helpful in preparing cost recovery marketing plans.

Despite its accomplishments, FLAS and its REU were not able to undertake the key studies which would have allowed for an assessment of its major program activities under the FHS grant amendment. Because of delays and recent financial problems, it has not been possible to undertake a post survey in the private sector program or a national study assessing the very large scale IEC campaign. It is suggested that these activities receive the highest priority if additional funds can be obtained. Other suggestions for evaluation activities include:

- 1) More detailed studies of sexual practices and condom use patterns.
- 2) Small-scale field studies to determine catchment areas for CBD and IBD workers and the FLAS clinics.
- 3) More IEC studies focusing on how to better motivate and attract VSC clients.

Given the work load of the current Unit and its small number of staff, it is suggested that consideration be given to increasing its staff and obtaining assistance for the implementation and analysis of the FHS project impact studies described earlier. Conclusions and specific recommendations regarding this component of the program are described below.

2. Research and Evaluation Unit

The evaluation team concluded that the overall staffing and performance of the Research and Evaluation Unit (REU) has been quite good. While it is relatively small, it makes substantial use of outside consultants to carry out needed studies. The overall record of evaluation and research carried out by FLAS and its consultants is quite impressive. The single recommendation is:

- o Expand the REU now that a substantial amount of the previous technical assistance will not be available. In particular, the regular, perhaps part-time, employment of an experienced social scientist would be advisable.
- ## 2. Project Monitoring Activities

The following conclusions were reached by the team.

- o The service reporting system or Management Information System (MIS) is, overall, very well developed and highly effective. There are a few small problem areas, but the quality and timeliness of the frequent service statistics reports are excellent.
- o Services in the first nine months of 1995 increased over the same time period in 1994 in most categories.

The single recommendation related to project monitoring activities is as follows:

- o Allocate funds needed to carry out the plans and activities necessary to remedy the inadequacies in the REU reporting system as soon as possible.

3. Evaluative Research

The following conclusions were reached regarding evaluative research.

- o Not all of the specific evaluation activities planned for the private sector and IEC program in the FHS amended project document were carried out due to delays and the current lack of funds. Thus, the impact of the private sector and the IEC activities has not been able to be ascertained on a national scale as was planned.
- o While the planned Post-Survey in the Private Sector was not implemented, three studies of contraceptive use in the industries were carried out in 1992, 1994, and 1995. However, the studies used different samples and different forms of ascertaining contraceptive use. They were not planned to be comparable, and because of the differing methodologies, they cannot at this time be used, post facto, for direct comparisons.
- o All of the PS surveys show very substantial contraceptive use--within different sub-samples of the three studies, current contraceptive use varies from 24% to 48%. Condom use is fairly common: ever use of condoms was reported by 48% of the men in one study. However, much of the condom usage, perhaps half, is motivated by the wish to prevent AIDS and other STDs. This shows the benefit of integrating FP and AIDS programs, as has been done in the PS programs.
- o Excellent cost-effectiveness and cost-benefit studies were conducted in the clinic and the private sector program areas. The clinic study documented the large proportion of staff time spent on non-family planning activities (a fact not previously documented) and has provided an objective basis for the

determination of service fees in the marketing plan for cost-recovery in clinic services. The private sector cost-benefit study has also assisted in the development of the industry marketing plan as well as provided documentation of the benefits of contraceptive use for assistance in obtaining support of the industry management for the program.

- o Whether the condoms being distributed by the CBD and IBD workers are actually being used, and with what partners and with what frequency, has not been ascertained. Further, use of condoms at the same time as female contraceptive methods are used is practiced to some extent. Thus, the impact of these programs on CYP or other fertility measures cannot be accurately ascertained at this time.
- o A great deal of program relevant information has been collected as part of a series of studies of adolescents and youth.
- o A clinic client study showed very satisfied continuing FLAS clients; one of the factors was likely to be the relatively short waiting times.

In response to the above findings and conclusions the following recommendations are offered for the FLAS and the REU:

- o Undertake more evaluation activities that can be used for feedback and program development, i.e. relatively small-scale evaluative or operations research studies. Suggested examples:
 - Condom use/sexual practice studies: This type of study would help to assess the value of the current CYP measure for condoms and FTs. To what extent is dual method contraceptive use--condom plus another method--practiced?
 - Follow-up of clinic and CBD clients in their homes (actual measure of contraceptive use and continuation)
 - More IEC pre-test and media feed-back studies (especially for VSC IEC development)
 - Study of the geographic location (catchment areas) of FLAS clinic and CBD clients; assessment of the proportion of clients currently in school.
 - An evaluation of FLAS clinic counseling using interviews, observations, and checklists. This should examine the practices and attitudes of staff regarding contraceptive negotiation, condom use, and such issues as differential effectiveness in counseling women and men (how important is gender?), new or continuing clients, teens, etc.

- o Undertake the following priority evaluation activities:
 - An IEC national impact study is needed: What was the value of the "marketing approach" to IEC? Can a detailed analysis of service statistics for 1994 and 1995 help assess the impact of the IEC campaign? Can a cost-effectiveness assessment be made of the different media utilized?
 - An assessment of the effectiveness of VSC IEC.
 - A Private Sector Post Survey that is comparable in methodology and sampling frame to the 1992 and 1994 surveys is needed.
 - An assessment of the number of STD cases treated in Private Sector medical facilities over the last three years. Is there a reduction and is this related to increased IBD services?

- o Revise FLAS' target setting system so that it better reflects the catchment area population that a clinic, CBD worker, etc. is expected to serve. The automatic increase of 10% in target size each year is not likely to be appropriate in all settings. Relatively inexpensive field studies could indicate approximate target populations or catchment areas. In the industry or CBD settings, sample enumerations may be feasible.

- o Document the number of condoms being distributed by the women's empowerment program and the condom dispensers in the industries.

- o Make the structured feedback of the Roadshow audience interviews a more valuable small-scale evaluation activity by using a larger sample (20 respondents at each show), collecting data from a third of the Roadshows, and including a few of the more sensitive topics in the questions, such as, "Do you use contraception now?" or, "What will you do differently because of what you learned today?"

- o Seek additional funds to carry out the above recommendations including the addition of a social scientist, even if only on a part-time basis.

VI. ORGANIZATIONAL AND FINANCIAL SUSTAINABILITY

A major objective of the current evaluation is to determine what activities FLAS will be able to continue after the completion of the USAID grant in December, 1995. The answer to this question has been framed under two concepts both requiring assessment: organization sustainability and financial sustainability. Financial sustainability is obvious--will FLAS have the necessary funds needed to carry out its planned activities? However, organizational sustainability is also needed--will FLAS have the necessary staff competency, management and planning skills, and the infrastructure needed to carry out the planned program of activities? The evaluation team has examined both of these areas and presents below its findings and recommendations.

Many of the recommendations that are presented here have been made before, and many of them have been made by the FLAS staff with whom the team met during the evaluation. Further, some of them are being implemented at the present time or are planned for implementation next year. Nevertheless, we will mention them because we feel they indicate the direction FLAS should move in the future to increase its organizational sustainability.

A. Organizational Sustainability

1. FLAS Infrastructure

An important objective of the FHS Grant Amendment was to increase the sustainability of FLAS through the purchase and construction of buildings so that it would have more adequate facilities and would also be relieved of some of its annual payments for rent. This objective has been clearly met.

a. Buildings

The FHS grant has paid for the purchase and remodeling of a new clinic facility in Mbabane as well as the construction of a new headquarters office in Manzini. Both structures appear of very high quality and are well suited for their functions.

b. Equipment, etc.

The grant also funded the furnishing and equipping of both buildings as well as the purchase and equipping of a van to be used as a mobile clinic. All facilities appear well furnished and equipped. In fact, the level of furnishings is quite high, and provides the FLAS staff and its clients with very comfortable service and work spaces. Both office and clinical equipment are of high quality and function well. In addition, the computers and software in use at the headquarters office are up-to-date and competently

utilized. However, the mobile van that was to provide portable family planning services has not yet been put into use so it could not be fairly evaluated.

2. Organizational and Management Issues

a. Staff organization

The team has found that the form of FLAS staff organization is not always conducive to the most effective program management. The attached organogram (Appendix D.1) reflects the current form of FLAS organization as seen by FLAS. It is recognized that FLAS has undergone staff turnover, expansion, and the sending of a number of staff for international training. However, some staff appeared to the Evaluation Team to be over-extended, while some program areas seemed inadequately defined and coordinated. For example, the Private Sector Program does not have a senior manager that can focus all of his efforts in this program area. The same is true for the clinical services. The CBD and Women's Empowerment programs are placed under the direction of the IEC unit and are supervised by two different staff, though they are the only rural program services of FLAS and have a great deal of similar program aspects. Training is an area that does not have an identifiable focus at FLAS and is currently carried out by several of the units. The specific issues have been described in more detail in the preceding sections.

b. Coordination between service delivery and IEC activities

At times, the team observed a lack of optimal coordination between the service delivery activities and the IEC activities of FLAS. For example, the very well developed Family Life Education program in schools and the other IEC materials oriented and distributed to youth have not been accompanied by a corresponding effort to make family planning services available to the same adolescents and youth who are targeted by the IEC campaign. FLAS research recognizes that the youth are sexually active and susceptible to pregnancy, STDs, and HIV/AIDS, yet specific youth or teen services have not to date been designed. Is this a policy issue for FLAS? The same concern is relevant for men, who have been the special focus of a number of IEC activities and materials, but for whom special services have also not yet been designed. A related issue is the need to tie the local IEC promotion of VSC services more closely with the increased availability of VSC operations. A number of these topics have been described in more detail in the IEC section presented earlier.

3. Non-FHS Supported and Other Programs

For a number of years FLAS has implemented programs that have not received support from the FHS grant but that have been supported by their grant from IPPF. It was not within the Scope of Work to evaluate these programs. However, the team examined them in as much as they are relevant to the future of FLAS and its efforts at

sustainability and cost recovery. As such, the comments are included in the following section concerning FLAS' ability to obtain other sources of funding for these activities.

a. CBD Program

FLAS has supported 43 CBD workers in five localities for a number of years. They have provided 2462 CYP in the first eight months of this year--a very large increase (68%) over the comparable period last year. The average CBD agent during the year, 1994, according to the reports, recruited 61 new condom users and he or she resupplied clients with condoms 79 times, giving out an average of 31 condoms at each time. Each CBD agent also had 30 new foam tablet clients, made an average of 14 FP and 9 STD referrals, and gave 78 talks.

While the numbers are impressive, and site visits to two groups illustrated the enthusiasm of the CBD workers, the team is not aware of studies documenting the accuracy of their reports of distributed commodities. Condoms and foam tablets, the commodities distributed, are given out free and may or may not be utilized. The number of new users is almost as many as the number of continuing users resupplied--an indication of either a reporting problem or of a suspiciously large number of new users. Further, data are not available showing the population and families in the catchment areas reasonably served by each CBD worker. Finally, much anecdotal evidence exists as to the strong advantage of same-sex CBD workers. In other words, men are best served by male CBD agents, while women are best served by female CBD agents. In some areas, few male CBD agents have been recruited or are currently serving. Finally, the CBD agents have been hampered by not being integrated into the rural health care system and not being able to resupply oral contraceptives. The current proposal to IPPF for further assistance for the CBD program deals with most of these issues.

b. Women's Empowerment Program

FLAS works with three different groups in the Siteki area. While some national level awareness activities have taken place, most of the Women's Empowerment program involves working on a continuing basis with a large number of women (30-75) who form a local group and meet every week. They are given five and 10-day workshops on women's development issues with the collaboration of a range of government agencies. They are also taught the specifics of family planning and AIDS prevention and are given condoms to distribute, being referred to as Peer Educators. Perhaps 10 times as many women are brought together for the women's program than are worked with in the CBD program.

c. Contraceptive Storage and Monitoring

Since 1990, IPPF has been supplying contraceptives to both the Ministry of Health and to FLAS. In addition, FLAS has been handling the contraceptive ordering and monitoring system for the Ministry. This is greatly appreciated by the MOH

who do not have staff competent to carry out this function. Previously, FLAS did not have its own facility for storage and had to use the MOH facilities. It now has its own storage capability (since the new headquarters building was moved into) and is no longer using the MOH site. However, FLAS could seek donor or government funding support for the continuation of this service for the MOH.

d. Training of health professionals in the MOH and other NGO

FLAS has over the years trained a large number of health professionals in Swaziland outside of its own organization. This is described in the earlier section on Clinical Service Delivery and Quality of Care. It is an activity that might very likely be able to secure new funding from donor organizations.

4. Staff Competence and Technical Assistance

Staff competence has been assessed in each of the program areas discussed above. Over all, the evaluation team is impressed with the level and quality of FLAS staff. The series of long-term and short-term consultants who have worked over the years with FLAS under the general direction of Pathfinder International, AVSC, and others have been responsible for both greatly assisting FLAS to develop and implement its programs as well as for imparting their technical and managerial skills to FLAS staff. However, the evaluation team noted that, generally, there has been an over-reliance on external technical assistance and consultants, especially short-term consultants. The number of Trip Reports reviewed in the documentation of the FHS project is unusual. In some cases, the consultant was brought in to perform a specific task--such as a piece of research or a specific training--that could not be carried out by FLAS' own staff. In other cases, consultants were utilized to design and direct a program of activities over a considerable period of time. This role, because of the exigencies at the time which required rapid problem solving, may have weakened the opportunity for FLAS's own staff development. The specific contribution of consultants is discussed in each of the earlier sections.

It needs to be pointed out quite clearly, however, that this is not a criticism of FLAS. Virtually all of the technical assistance was part of the project design approved and funded by USAID. In particular, because of the relatively large amount of funds made available by the Grant Amendment in a relatively short period of time--compared to most projects--there was pressure to get everything done by the December, 1995 deadline. As USAID/Swaziland was withdrawing from Swaziland in 1996, it was not seen as feasible to provide for a no-cost extension. Another factor was the necessary international training of several key members of FLAS and the necessary postponement of their services. Thus, consultants were brought in with relative frequency, especially during the last 18 months.

From an institution-building perspective, an effective use of outside consultants and technical assistance would be to provide a great deal of assistance in the beginning, and to have it gradually decrease over the years as the host country staff take over more and more

of the important program responsibilities as their capabilities develop. In the last year of the current grant, rather than a gradual reduction in the amount of technical assistance, as the technical skills of FLAS staff develop, there appears to have been an intensification of assistance. We feel this has hindered the development of FLAS' ability to develop effective program problem solving skills.

It is noted that with the ending of the FHS program of assistance, there will be a greatly reduced availability of consultants for technical assistance. While FLAS will be forced to do without some of the specific technical skills the consultants have brought, they will, at the same time, be forced to solve more problems on their own and become more reliant on local resources. In the long run, this will increase their organizational sustainability.

5. Strategic Planning Process

A FLAS Strategic Plan was developed in 1992 over a period of several months with a great deal of staff time and the utilization of international consultants. In 1994, another Strategic Plan was developed from scratch with again much staff effort and other outside consultants. It appears to differ substantially from the earlier plan. In particular, the later plan appears to relatively ignore the sustainability issues and the need for FLAS to look to convert itself into a provider of technical assistance and services to other organizations rather than being a provider of basic services. It also appears to support the continued expansion of basic FLAS services. For reasons explained in the next section, we do not feel that this is a viable option for FLAS.

B. Financial Management

1. Sources of Funds and Financial Planning

While FLAS has traditionally been supported by IPPF, it has received a great amount of funds from USAID over the last seven years from the FHS grant, and especially during the last two years of the grant amendment. Through much of this period, the FHS grant provided support for about 30% to 40% of FLAS activities. In addition, the grant provided technical assistance, training, contraceptives, vehicles and equipment, and, as described above, new buildings. Thus, it is difficult to measure precisely the level of support provided by the grant as it is much greater than that indicated by its support of salaries and services. In addition, a very large scale IEC campaign funded by the FHS grant amendment was carried out in the last year or so; many of the activities were implemented by commercial organizations.

FLAS financial planning is carried out in a process designed by IPPF to be followed by all of its affiliates. A Work Program and budget is designed for each year and is submitted to IPPF for review and approval. The Work Program for 1995 indicates the following sources of funds: IPPF: 58%, USAID: 31%, Other: 11%.

2. The FLAS Endowment and its Utilization

In preparation for the awarding of the grant amendment, USAID authorized \$1,681,000 for the creation of an endowment for FLAS in September, 1992. It was contemplated that the income earned from the investment of the endowment funds would provide FLAS with an annual income of over E500,000 that could be used for salaries and other program expenditures, contributing about 25% of FLAS' recurrent expenses. The money was deposited into a FLAS bank account with Meridien Bank of Swaziland on June 3, 1993.

The endowment was subject to USAID oversight and a number of conditions for three years--until September 30, 1995. An important condition was that the funds had to be invested within Swaziland. In the future, funds may be invested elsewhere, such as in South Africa. On November 8, 1995, Coopers & Lybrand issued a report of an audit and evaluation of the performance of the endowment. It described the past performance of the endowment and foresaw a very likely increase in the rate of return from future investments. Thus, annual income may likely exceed the current plan for expenditure. FLAS may need to decide between utilizing all of its return on the endowment for its current programs, or to take some of the annual income and add it to the size of the endowment itself, thus ensuring a larger return from the endowment in the future, when needs might be greater. Current plans, as specified in the 1996 FLAS Work Plan, are to utilize a majority, but not all, of the available endowment income, while adding a portion of the 1995 and 1996 income to the endowment itself.

3. Status and Adequacy of Current Funding

Since September, 1995, FLAS has experienced a severe financial shortage requiring it to cancel or cut back significantly on FHS planned expenditures. The resolution of the problem has not been completed and it is not clear at this time what are the exact budgetary implications for the future.

Aside from the current financial problem, FLAS program plans for 1996 appear to provide for approximately the same level of services and activities as in 1995, except for the absence of some specific FHS-funded IEC activities. FLAS expects to receive approximately the same level of support from IPPF in 1996. Its Work Plan shows that it should be able to finance its current level of activity provided that its plans for cost-recovery through increased clinic fees and private sector program support fees are implemented and function as planned.

C. Financial Sustainability and Cost Recovery: Potential and Likely Sources of Additional Funding

FLAS has begun a significant effort at financial sustainability through both the increase of service fees and the development and submission of proposals for additional program funds. The following paragraphs detail these efforts.

1. Internal Sources of Additional Funds

FLAS has made specific and substantial plans for cost recovery in the form of Marketing Plans for both the Private Sector program as well as its own clinic services. These have recently been completed and are being reviewed for a final revision. They are discussed in the relevant sections presented earlier. If these plans are implemented, they will likely contribute to making the FLAS Private Sector program substantially more sustainable. At the present time, all specific expenditures for the Private Sector program are anticipated to be funded by the system of program fees to be paid for by the private sector industries. The proposed increase in clinic service and contraceptive fees will also assist clinic services, especially non-family planning services, to be more sustainable in the future. The 1996 Work Plan estimates that E403,000 will be obtained through local sources of income. This is over 20% of FLAS expected expenditures.

While FLAS has employed local fund-raising activities, such as FLAS membership fees, to raise funds, the amount brought in to FLAS by these means has not been substantial.

2. External Sources of Additional Funds

As described earlier, FLAS appears conflicted in its vision of its role in the future. On the one hand, it has begun the process of reaching out to other donors to "replace" the USAID funding that is ending, but on the other hand, it does not seem ready to accept a change in its role from one of mainly providing family planning services to one of mainly providing technical assistance and support to other (mainly government and private sector) programs and only demonstrating innovative service delivery programs and providing sites for research and training. In this sense, the private sector program is seen as a model of how FLAS might operate in the future. It is important to remember that Government free services are also easily available in the same locations as FLAS clinics. Especially if FLAS service fees are increased, as anticipated, the number of clients may not increase, and could, possibly, decrease. Thus, unless new services (such as VSC) or new program components are introduced, a significant increase in the level of services should not be expected.

On the other hand, the Evaluation Team has found near-universal appreciation and support for FLAS, and a receptiveness and enthusiasm for working with FLAS on new programs and project proposals. This includes staff interviewed in the MOH, at a number of NGOs, as well as at all of the international donors we have contacted. FLAS has already submitted several proposals to UNFPA and several other donors. The two one-year proposals to UNFPA are titled:

- o "Gender Capacity Building in Swaziland"
- o "FP, STD/HIV/AIDs Private Sector Program Implementation"

The first proposal suggests a range of advocacy and education programs focused on women's empowerment while the second appears to seek funding for the existing private sector

program. The Gender proposal could benefit from substantial further development. Other proposals include a Vision 2000 proposal to IPPF for support of CBD activities, a request for significant contraceptive supplies to KFW (a German organization), and a request to the British ODA. It is very likely that at least some of these proposals will be successful at bringing in funds.

D. Conclusions and Recommendations

1. Overview

The current and future financial and organizational sustainability of FLAS has been carefully examined. Except for the current short-term financial crisis, the continuation of FLAS programs in the future at about the same level of activity seems fairly well assured. The endowment and infrastructure created by the FHS grant will greatly assist in ensuring FLAS' future stability. Though USAID funding will be ending this year, very substantial cost recovery programs appear to be about to be implemented. In particular, this should ensure the continuation of the private sector and clinic programs. In addition, there is a very receptive environment among other donors who will likely respond positively to FLAS requests for support.

While several proposals have recently been prepared and submitted, it is felt that the proposal development process could be greatly improved, especially in regards to collaborating with the Ministry of Health and formulating requests based upon mutual needs. A number of very promising areas have been identified in earlier sections in terms of IEC, training, and service delivery. It is suggested that now that FLAS has matured as an organization, and that government has expanded its support for family planning, that FLAS consider changing its major focus from one of providing basic services to one of providing technical assistance, training, evaluation and research, and demonstrating innovative and important new program directions. The incorporation of an AIDS/STD prevention focus into its traditional emphasis on the promotion of family planning, as it has done in the private sector and IEC programs, is a major accomplishment and a very significant direction for the future of family planning programs in Africa.

The following conclusions and recommendations concern FLAS' organizational and financial sustainability and indicate the future directions the evaluation team believes FLAS should consider in light of the current situation.

2. Organizational Sustainability

a. FLAS Infrastructure

The team concluded that the FLAS infrastructure was greatly improved by the construction of a headquarters office and the purchase and renovation of a building in Mbabane for a clinic. Both buildings are well designed and suited for FLAS activities.

They significantly reduce the funds needed for annual rent and greatly improve FLAS' organizational sustainability.

No recommendations are made in this area.

b. Organizational and management issues

The following conclusions were drawn by the evaluation team.

- o The current FLAS organogram does not lead to optimal management and supervision of its programs.
- o The close integration of the IEC and service delivery components of FLAS programs has not always been operationalized.

In response to the evaluation team's findings and conclusions the following recommendations are put forth for possible changes in FLAS' staff organization in order to make it more effective in undertaking additional activities that might be financed by future grants.

- o Separate sections for the supervision of clinic services, for the management of the private sector program, and for outreach/CBD services.
- o Develop a more integrated and coordinated approach to CBD and Women's Empowerment programs. Many of the same activities are relevant to both programs. It would be more efficient in terms of both logistics and supervision to focus all such programs in one section of the country and assign a single supervisory staff to reside there. There is no clear advantage for a demonstration project to be located in widely scattered sites. However, it is recognized that there are specific reasons for the location of several of the CBD and Women's Empowerment programs. It is understood that FLAS has already made steps in this direction.
- o Strengthen FLAS' internal capacity for training with its own training specialists able to serve other units and possible additional programs.
- o Strengthen and improve the coordination of staff involved in the purchasing, distribution, marketing, and monitoring of contraceptives--including the purchasing and monitoring of contraceptives for the use of industry, NGO, and government outlets.
- o Strengthen coordination between service delivery and IEC activities.
- o Improve coordination of IEC and service delivery activities to make FLAS

programs more effective, especially in youth and male-oriented programs. This might be effected through regular senior staff meetings focusing on this issue.

c. Non-FHS Supported and Other programs

The team concluded that FLAS has developed several programs, such as CBD and Women's Empowerment, that have served as pilot projects for such activities in Swaziland. They have also developed capabilities in training and contraceptive management that are highly valued by the MOH and other NGOs.

One recommendation is offered as followed:

- o Develop proposals for additional support that will enable FLAS to work in a technical assistance role in Swaziland.

The recently revised Vision: 2000 proposal submitted to IPPF is an excellent example of this new perspective for FLAS in which the emphasis is on the development of sustainable programs rather than simply an expansion of FLAS services. Further examples of other areas where this concept could be developed are provided below. Key concepts included in the Vision: 2000 proposal are:

- Localized supervision, re-supply, and referral
- FP/medical training & support to local clinics
- IEC support
- Use of both male & female CBD agents
- Token charge for contraception
- Assistance to Government in developing a CBD program
- Capacity building at FLAS

d. Staff Competence and Technical Assistance

The conclusion was reached that FLAS appears to have greatly benefitted from the significant program of technical assistance provided by Pathfinder International, AVSC, and others. However, it may have become over-reliant on outside short-term consultants. This is not a criticism of FLAS' implementation of the FHS grant, however, as such assistance was built into the grant design. It is not anticipated that long term technical advisors will be needed in the future as, in general, FLAS staff have the skills and competencies needed to sustain and expand FLAS in the future.

Recommendations regarding staff competence are as follows:

- o Provide some limited short-term technical assistance on an as-needed basis in specific areas including training more physicians in VSC and planning specific research and evaluation activities, such as a national family planning users survey or a national IEC impact study.
- o Provide additional FLAS staff as needed in the clinical and evaluation areas. This is discussed in the relevant earlier sections.
- e. Strategic planning process

The team concluded that the current Strategic Plan does not appear to deal adequately with the organizational and financial sustainability issues facing FLAS.

In response to this conclusion, the following recommendation is suggested:

- o Review the current Strategic Plan in light of the current FLAS evaluation and revise and up-date the Plan through a discussion of the issues raised herein involving all of the senior staff.

2. Financial Management

The team arrived at the following conclusions regarding financial management:

- o Regarding sources of funds and financial planning, FLAS undergoes an exhaustive and valuable annual process of program planning and budgeting that is under the guidelines provided by IPPF to its affiliates. This review meets the needs of the organization at this time.
- o The FLAS endowment has substantially improved FLAS long-term sustainability and has ensured continued employment of most staff added during the period of the FHS grant.
- o In the last quarter of 1995, FLAS experienced a severe shortfall of funds due to an unforeseen over-expenditure of FHS grant funds. Once this current period is past, FLAS appears to be able to continue at about its current level of program activities through its continued IPPF funding and expected fees from its clinic and private sector programs.

In light of these financial issues the following recommendation is offered:

- o Consider the utilization of currently available endowment income funds that are in excess of those targeted for specified FLAS salaries for current priority activities rather than adding them to the base of the endowment.
- 3. Financial Sustainability and Cost Recovery: Potential and Likely Sources of Additional Funding

The following conclusions regarding FLAS's financial sustainability and potential for cost recovery were reached by the evaluation team:

- o While the internal cost recovery mechanisms have not contributed a substantial proportion of FLAS expenditures to date, there is a strong likelihood that internal sources of financial support will greatly increase in both the clinic and private sector programs.
- o FLAS expects IPPF to continue its support at the same level as previously, at least in the near future. This was confirmed by the IPPF Regional office in Nairobi.
- o FLAS has prepared and submitted several proposals to international donor organizations, including UNFPA, ODA, and KFW (Germany) to which the response is reported to be positive.
- o While FLAS has continuously over the years worked in collaboration with a number of persons in the MOH, these contacts have not been utilized sufficiently for the proposal development process. A number of useful areas for collaboration have been identified and discussed in recommendations below.

Recommendations to improve the prospects for FLAS' financial sustainability and cost recovery are as follows:

- o Strengthen approaches to local fund-raising, including the sponsorship of media activities by local businesses.
- o Implement immediately FLAS' new service fees (described in the recent marketing strategy documents for clinic and industry programs) on a pilot basis with a program of short-term, small-scale evaluation through focus groups and client interviews to provide feedback on their acceptance.
- o Improve FLAS' proposal development process by developing a FLAS capability statement indicating the areas in which FLAS is able to provide

assistance services, including training, IEC materials, technical assistance, and monitoring and evaluation.

- o Consider collaboration other international technical assistance agencies, such as Pathfinder or AVSC, in providing assistance to Swazi organizations.
- o Explore options for UN-based funding such as UNFPA. While such funding requires approval or collaboration with government, nevertheless, UN agencies now allow direct funding of NGOs, such as FLAS, for program activities that are consistent with government program objectives and plans. An effective proposal usually requires a substantial period of discussion and development of ideas that meets the needs of all involved. FLAS should submit additional proposals at this time. With the withdrawal of USAID, UNFPA may become the major funder in the family planning sector. Because of the very positive assessment of FLAS in the donor community, such efforts stand a good chance of success.
- o Engage in follow up discussions with other donors such as with GTZ, ODA, and other donors.
- o Intensify the process of negotiating with Government about providing assistance to them and requesting funding for specific activities mutually desired. Areas of possible collaboration on a direct sub-contracting arrangement could include:
 - Training of physicians, nurses and others. This could include training in VSC procedures and counselling as well as in clinical contraceptive services. FLAS could lead the development of a committee that would oversee the maintenance of quality of care standards for family planning services in Swaziland.
 - Development and implementation of IEC programs in both government and NGO facilities. This might include an expansion of the Family Life Education program in schools in collaboration with the government as well as with interested non-governmental schools. FLAS could also collaborate with the government on the implementation of a national IEC family planning campaign. It has a great deal of expertise in FP media production. Finally, FLAS could seek support for an expansion of its AIDS education activities. GTZ may be interested in supporting FLAS in this-area.
 - Continuing FLAS assistance to the MOH for contraceptive logistics monitoring and distribution. FLAS could also provide assistance to the MOH in improving its Management Information System (MIS).

- Considering options to expand FLAS' earlier efforts to develop and manage rural CBD programs. While the current CBD program does not seem sustainable, that envisioned in the Vison: 2000 proposal appears capable of initiating a large governmental involvement in this area. Similar proposals could be developed for working with NGO health care providers.
- o Involve all of the senior staff that have responsibilities for the program activities indicated in the proposal development process for external funding. Proposals should be passed around for feedback and input.
- o Develop a proposal in the future for an Africa Regional Center for Private Sector FP/AIDS Programs that would provide assistance with such programs on a regional basis.

APPENDICES

APPENDIX A

LIST OF PEOPLE CONTACTED

USAID/Swaziland

Anita Sampson, Program Officer
Jack Royer, Acting Director

Family Life Association of Swaziland

Khetsiwe Dlamini, Executive Director
Musa Mgogo, Asst. Director
Khanya Mabuza, Program Manager in charge of Private Sector Unit and Service Delivery Unit
Marjorie Mavuso, Manager, REU
Kombi Nkonde, Sr. Program Officer, PSU
Thombile Dlamini, Nursing Officer, PSU
Cedric Mgogo, Asst. Program Director
Millicent Obaso, Pathfinder Resident Advisor
Makhozini Mamba, Program Officer, PSU officer
Thembe Mvubu, Program Officer, PSU
Portia Khoza, Program Assistant, PSU
Bongani Ndzabandzaba, Driver, PSU

FLAS Board of Directors

Elizabeth Hlophe, President
Bhekithemba Hlatshwayo, Vice President

FLAS Clinic, Mbabane

Dr. Themba Ntiwane, ML/LA sessional surgeon
Dr. Kim Shongwe, ML/LA sessional surgeon
Janet Khumalo, Theatre nurse assistant and clinic i/c
Phindile Nkhambule, Theatre asst.
Henry Mabuza, Nursing asst.

FLAS Clinic, Manzini

Nomsa Fakudze, Sr. Nursing Officer
Joyce Mxumalo, general office attendant
Letitia Bennet, Nursing Officer FLAS Clinic, Malkearns
Janet Simelane, Sr. Nursing Officer

CBD areas:

Hhelehhele: 12 CBDs, Ms. Zodwa (supervisor)

Malindza: seven CBDs, many community leaders and participants

BRM Swaziland

Mr. McLean, Factory Manager

Mananga Medical Services

Dr. Ian Gilbertson, Medical Services Director

Sr. Dorothy Dlamini, IBD Supervisor and Nurse/Midwife

Sr. Cindy Mlambo, nurse

Joseph Mbonambi, Nursing Assistant

Inyoni Yami Swaziland Irrigation Scheme

Mr. Sibandze, Personnel Manager

Norma Mavimbela, IBD

Ubombo Ranches

Dr. Paul Canter, Medical Director

Dr. Ben Kavumbura, Medical Officer

Dr. Tim Nunn, Medical Officer

Mr. Clifford Mamba, Health Inspector and IBD Supervisor

Ms. Thuli Sibande, IBD/VHW

Ms. Mabuza, Nurse

Ms. Helen Shabangu, Nurse

Ms. Tuja Similani, Nurse Practitioner

Cadbury Industries

Mr. C.Mkhonza, Personnel Manager

Ms. Dlamini, IBD Supervisor

Shiselweni Forestry

Mr. Hall, Human Resources Manager

Mr. Roger Mdluli, IBD Supervisor

Ms. Filile Mdluli, IBD

Simenye Sugar

Dr. Coutinho, Medical Officer

Ms. Irene Nxumalo, IBD Supervisor/Nurse Family Planning Coordinator

Ms. Thoko Sinelane, Nurse practitioner/FP coordinator

Occupational Health Services

Ms. Sisimoiso Moyo, Nurse Practitioner

Usutho Pulp

Medical Director

Ms. Thandi Simelane, Nurse Practitioner/ FP Supervisor

Ms. Florence Ngozo, Matron

Ministry of Health

Dr. Rhodes Mwaikambo, UNFPA MCH/FP Advisor

Matron Matzebule, Chief Matron, Public Health

Dr. Shongwe, Dep. Director, Public Health Unit

Rudolph Mhaziya, Director, SNAP (Swaziland National AIDS Programme)

Sobhuza Health Centre, Manzini: Sr. Dorcas, other staff

Swaziland Federation of Trade Unions

Mr. Jan Sithole, General Secretary

United Nations Population Fund

Moses Mukasa, Country Director

Nosisa Mohammed, Program Officer, UNFPA

Njoki Wainaina, Gender Specialist Consultant

United Nations Development Programme

Tomoko Nishimoto, Deputy Resident Representative

Alfred Mndzebele, UNDP AIDS Program Officer

The Futures Group

Mr. Reed Ramlow, Regional Manager, Nairobi

Pathfinder International, Nairobi Office

Elisebeth Lule
Tom Fenn

Media houses

Swazi Times: Editor in Chief
Swazi Observer: Editor; three reporters
SBS: Principal Programs Director
STBC: Assistant Advertising Director

St. Michael's Secondary School

10 students and 5 teachers

VOCTIM

Barbara Fischer, GTZ Country Representative
Grace Mdluli, AIDS awareness irector

ODA

Judy Klepp, Program Officer

APPENDIX B

DOCUMENTS AND REPORTS REVIEWED

I. GRANT DOCUMENTS

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III. FLAS PROGRAMME DOCUMENTS

A. GENERAL PROGRAMME DESCRIPTION

1. FLAS Strategic Plan Through the 1990's. Martin & Virginia Gorosh (with FLAS staff). Aug., 1992.(2 copies)
2. 1992 Annual Report. FLAS. 1993.
3. 1994 Annual Report. The Family Life Association of Swaziland. Feb., 1995. (2 copies)
4. 14th Annual Report: 1994-1995. The Family Life Association of Swaziland. Undated.
5. Work Programme & Budget: 1995. The Family Life Association of Swaziland. 1994.
6. Work Programme and Budget, 1996. The Family Life Association of Swaziland.

7. Strategic Plan: 1996-2000. Family Life Association of Swaziland. 1995.

B. MANAGEMENT

1. Midterm Evaluation of USAID Family Health Services Project, Swaziland. Gorosh, Martin, et al, University Research Corporation, September, 1990. Also: Confidential Memo to Mission Director, USAID/Swaziland.
2. Review of Management Systems (consultancy study of FLAS). James Obaso, Inst. of Development Management, Mbabane. Sept. - Oct., 1993.
3. Final Evaluation: Endowment Fund Grant Agreement 645-0237-G-SS-0213-00. Family Life Association of Swaziland. 8 November, 1995. Coopers & Lybrand.

C. IEC PROGRAMME

1. Assessment of the IEC Program of FLAS and Development of a New IEC Program Strategy, Hosein, Dr. Everold N., Nisus Inc., New York, May, 1993.
2. Family Life Education (FLE) Programme for School Youth in Swazi Schools: An Evaluative Study. Cisco Magagula (Univ. of Swaziland) and Della Nsibande (Min. of Educ.). 1993.
3. FLAS, Brief To Advertising Agencies, 1993
4. Trip Report. Barbara Crook and Lorna Ng'ang'a, Sept. 29 - Nov. 5, 1993.
5. Trip Report. Edward Douglas, Undated. (probably 1994 sometime)
6. Trip Report. Hosein, ibid., Dec., 1994.

Visit to prepare a brief to advertising companies to implement FLAS 1994-95 advertising campaign.
7. Trip Report. Edward Douglas, March-April, 1995.
8. Trip Report. Edward Douglas, Sept. 26-Oct. 14, 1995.
9. Progress Report (Monthly). IEC Dept., FLAS. 1993-1995.
10. Temndeni. Newsletter. FLAS. Various issues: 1993, 1995.

11. Group Africa of the Amavulandlela: Summary of Services. Undated. Producer of Road Shows for FLAS. Likely 1995.
12. Research Report for Project Eraser [sic]. Research International South Africa (PTY) Ltd., Durban, July, 1995.
13. Progress Implementation Status Report (IEC Programmes). No author or date. Assumed to be handout in Nov., 1995.
14. CBD Service Statistics Annual Report (1994). Research & Evaluation Unit, FLAS. Jan., 1995.
15. Project Proposal on Community Based Distribution of Contraception. 1996-2000 (for IPPF). FLAS. Late 1995.
16. Family Life Association of Swaziland: Roadshow Interim Status Report. Group Africa. July, 1995.
17. FLAS Roadshow Interim Status Report. Group Africa. August, 1995.
18. FLAS Roadshow Interim Status Report. Group Africa. Undated (likely Nov., 1995)
19. Gender Capacity Building in Swaziland. (Proposal submitted to UNFPA) FLAS. Oct., 1995.

D. INDUSTRY PROGRAMME

1. FLAS Industry Based FP Program Assessment. Eric Krystall and David O'Brien. JSI. April, 1993.
2. Trip Report. Peter Savosnick, Pathfinder. July, 1994.
3. Private Sector Unit. Half Yearly Reports. 1993, 1994.
4. Private Sector Unit. Annual Reports. 1993, 1994.
5. Private Sector Unit. Monthly Reports. 1992-1995.
6. Baseline Survey Report on the (FLAS) Industry Based Family Planning/AIDS Project II. Dec., 1994. Gugulethu Gulu, Statistics and Demography Dept., University of Swaziland. (3 copies)
7. Industry-Based Distributors (IBDs) Incentive Scheme: A Report. Cisco

Magagula and Harriet Kunene. 1995.

8. A Cost-Benefit Analysis of Industry-Based Family Planning/AIDS Prevention Services. (Text of Presentation). No author or date. Assumed July, 1995.
9. Ubokhuluma (The house magazine of Ubombo Ranches, Big Bend, Swaziland.) "Ubombo hosts an AIDS awareness week." Pp. 2-3. Vol. 16, No. 10, Oct., 1995.
10. FLAS Industry Program: Year 1 Marketing Plan. Final SOMARC Draft. 1995
11. FP, STD/HIV/AIDS Private Sector Program Implementation (Proposal submitted to UNFPA). FLAS. Oct., 1995.

E. CLINIC PROGRAMME

1. Research Report on Individual In-Depth Interview with Service Providers.(FLAS) Polly McLean. 1991.
2. Manual of Clinical Service Standards (Service Delivery Protocols). FLAS, Sept., 1991.
3. Family Planning Trainer's Manual for Clinical Skills. Rhodes Mwaikambo, MD. FLAS, Feb., 1993
4. Trip Report. Douglas Huber, Medical Director, Pathfinder. March, 1993.
5. Trip Report: Needs and Quality of Care Assessment. Ezra Teri, Pathfinder. June-July, 1993.
6. A Family Planning Client Profile Report. Research and Evaluation Unit, FLAS. Nov., 1993.
7. A Family Planning Client Profile Report. Research and Evaluation Unit, FLAS. Nov., 1993.
8. Client Satisfaction/Client Flow Study Report. Research and Evaluation Unit. 1993. FLAS
9. Clinical Manual for Family Planning. FLAS. Undated.
10. Trip Report. John Kigotho and Margaret Meme, AVSC. July, 1994.

11. A Cost Study of Family Planning and Non-Family Planning Activities Provided by the Family Life Association of Swaziland. Godbertha Kinyondo., Feb., 1995.
12. Trip Report: Technical Assistance in Human Sexuality. Nanette Ecker, Global Inst. for Training, Mar.-May, 1995.
13. 1995 Half Year FP User Drop Out Rate Study Report. REU Manager. Sept., 1995. FLAS.
14. Clinical Site Visit Checklist. Claudette Bailey, Nov., 1995.
15. FLAS Clinics: Year 1 Marketing Plan. Final SOMARC Draft. 1995.

Clinic Staff

Name	Position/Title	Qualification	FP Education	Other Training/Skills
Veronica Nkambule	Nursing Assistant	<ul style="list-style-type: none"> ◆ Nursing Assistant Certificate 	<ul style="list-style-type: none"> ◆ Interpersonal Communication ◆ Human Sexuality ◆ Infection Prevention ◆ VSC Counselling 	<ul style="list-style-type: none"> ◆ Management of Child Morbidity
Janet Khumalo	Senior Nursing Officer	<ul style="list-style-type: none"> ◆ Diploma in General Nursing ◆ Diploma in Midwifery 	<ul style="list-style-type: none"> ◆ VSC Counselling Course ◆ Human Sexuality ◆ Interpersonal Communication ◆ Infection Prevention ◆ Contraceptive Technology Update ◆ Counselling HIV/AIDS ◆ Middle Level Management ◆ STD Management Course ◆ VSC Counselling ◆ Human Sexuality ◆ Interpersonal Communication ◆ Infection Prevention ◆ Contraceptive Technology ◆ Counselling HIV/AIDS 	<ul style="list-style-type: none"> ◆ Middle Level Management
Nomsa Fakudze	Senior Nursing Officer	<ul style="list-style-type: none"> ◆ Diploma in General Nursing ◆ Diploma in Midwifery 	<ul style="list-style-type: none"> ◆ Interpersonal Communication ◆ Infection Prevention ◆ Contraceptive Technology ◆ Counselling HIV/AIDS 	

APPENDIX C
 QUALIFICATIONS AND TRAINING OF FLAS STAFF

C.1. Clinic Program

Clinic Staff

<i>Name</i>	<i>Position/Title</i>	<i>Qualification</i>	<i>FP Education</i>	<i>Other Training/Skills</i>
<i>Sindi Mlambo</i>	<i>Nursing Assistant</i>	◆ <i>Nursing Assistant Certificate</i>	◆ <i>Human Sexuality</i> ◆ <i>Interpersonal Communication</i> ◆ <i>FP/MCH Course</i> ◆ <i>Breastfeeding</i>	
<i>S'thembile Ngwenya</i>	<i>Nursing Assistant</i>	◆ <i>Nursing Assistant Certificate</i>	◆ <i>Interpersonal Communication</i>	
<i>Henry Mabuza</i>	<i>Nursing Assistant</i>	◆ <i>Nursing Assitant Certificate</i>	◆ <i>Human Sexuality</i> ◆ <i>Interpersonal Communication</i> ◆ <i>Infection Prevention</i> ◆ <i>FP/MCH Course</i>	
<i>Happy Gama</i>	<i>General Office Attendant</i>	◆ <i>O'Level Certificate</i>	◆ <i>Interpersonal Communication</i> ◆ <i>Women Empowerment</i>	◆ <i>Elementary - Typing</i>
<i>Joyce Nxumalo</i>	<i>General Office Attendant</i>	◆ <i>O'Level Certificate</i>	◆ <i>Interpersonal Communication</i>	◆ <i>Elementary - Typing</i>
<i>Dudu Mkhathshwa</i>	<i>Nursing Assistant</i>	◆ <i>Nursing Assistant Certificate</i>	◆ <i>VSC Counselling</i>	

C.1. Clinic Program continued

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<i>Name</i>	<i>Position/Title</i>	<i>Qualification</i>	<i>FP Education</i>	<i>Other Training/Skills</i>
<i>Janet Simelane</i>	<i>Senior Nursing Officer</i>	<ul style="list-style-type: none"> ◆ <i>Diploma in General Nursing</i> ◆ <i>Diploma in Midwifery</i> ◆ <i>Family Nurse Practitioner</i> 	<ul style="list-style-type: none"> ◆ <i>VSC Counselling</i> ◆ <i>Contraceptive Technology Update</i> ◆ <i>Human Sexuality</i> ◆ <i>Interpersonal Communication</i> ◆ <i>Infection Prevention</i> 	
<i>Leticia Bennet</i>	<i>Nursing Officer.</i>	<ul style="list-style-type: none"> ◆ <i>Diploma in General Nursing</i> ◆ <i>Diploma in Midwifery</i> 	<ul style="list-style-type: none"> ◆ <i>FP Clinical Skills</i> ◆ <i>Human Sexuality</i> ◆ <i>Interpersonal Communication</i> ◆ <i>Infection Prevention</i> ◆ <i>Contraceptive Technology Update</i> 	
<i>Phindile Nkambule</i>	<i>Nursing Officer</i>	<i>Nursing Assistant Certificate</i>	<ul style="list-style-type: none"> ◆ <i>Human Sexuality</i> ◆ <i>Interpersonal Communication</i> ◆ <i>Infection Prevention</i> ◆ <i>FP/MCH Course</i> 	

C.1. Clinic Program continued

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PRIVATE SECTOR/SERVICE DELIVERY STAFF

NAME	QUALIFICATIONS	FP EDUCATION	OTHER
KHANYA MABUZA	<i>Masters in Public Health Honours Diploma in Human Resource Diploma in General Nursing Diploma in Midwifery</i>		<ul style="list-style-type: none"> - TOT fertility management - TOT AIDS course - Certificate project proposal - Certificate radio production
THOBILE DLAMINI	<i>Diploma in General nursing Diploma in Midwifery Diploma in Community Diploma in Health Nursing</i>	<i>Certificate in FP contraceptive technology</i>	<p><i>Certificates</i></p> <ul style="list-style-type: none"> - Interpersonal Communication - VSC Counselling - Human sexuality - infection prevention
THEMBI MVUBU	<i>Primary Teacher Certificate</i>		<ul style="list-style-type: none"> - Interpersonal communication & counselling - Human sexuality - CBD/IBD management - monitoring & evaluation - Family Life Education
BONGANI NDZABANDZABA	<i>O' Level certificate</i>		<i>Motor Mechanic</i>

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NAME	QUALIFICATION	FP TRAINING	OTHER TRAINING/SKILLS
KHOMBI T NKONDE	Diploma - General Nursing Diploma - Midwifery	<ul style="list-style-type: none"> - Family Planning practitioner - Training of trainer - Human sexuality - FP counselling (VSC) - Interpersonal communication - Integrated marketing and communication 	<ul style="list-style-type: none"> - Financial management - Communication skills - Word perfect - Quattro-Pro - Windows.
MAKHOSINI MAMBA	Diploma in General Nursing Diploma in Midwifery	Certificate in F.P.	Certificate in the ff.: <ul style="list-style-type: none"> - Interpersonal communication and counselling - CBD/IBD management - AVSC counselling - Humn Sexuality
PORTIA KHOZA	Secretarial certificate		Interpersonal communication Human sexuality Diploma in office administration Diploma in Desktop Publishing and CorelDraw 5.0 Certificate in Frontline & Public Relations Certificate in Desktop Publishing 4

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C.3. Research and Evaluation Unit

RESEARCH AND EVALUATION UNIT

OFFICER: MARJORIE MAVUSO
POSITION: RESEARCH AND EVALUATION MANAGER

QUALIFICATIONS:

1. BACHELORS DEGREE NURSING EDUCATION (1993)
2. DIPLOMA
 - a) General Nursing - 1981
 - b) Midwifery - 1981
 - c) Community Health- 1988
3. SHORT COURSES
 - a) Health Systems Research Course 5 weeks (1990)
 - b) Reproductive Health Research 5 weeks (1994)
 - c) Financial Management (1995)
 - d) Communication dynamics - Presentation & Image seminar (1995)
 - e) Human Sexuality Workshop 1 week (1994)
 - f) Computers:-WordPerfect
Quattropro
Introduction to dBASE
Introduction to Dos (1995)
Translating files from DBASE to SPSS (1995)

OFFICER: PHUMELELE DLAMINI
POSITION: RESEARCH AND EVALUATION OFFICER

QUALIFICATIONS:

BA SOCIAL SCIENCE (1990)

SHORT COURSES

Computers:- DBASE (1991)
Lotus 1-2-3 - (1992)
Introduction to Dos (1992)
Translating files from DBASE to SPSS -1995

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C.3. Research and Evaluation Unit

**OFFICER:
POSITION:**

**BETHUSILE KHUMALO
PROGRAMS OFFICER - REU**

QUALIFICATIONS:

**CERTIFICATE IN AUTOMATED OFFICE SYSTEMS - 1988
DIPLOMA IN COMPUTERIZED OFFICE SYSTEMS - 1990**

POST BASIC TRAINING

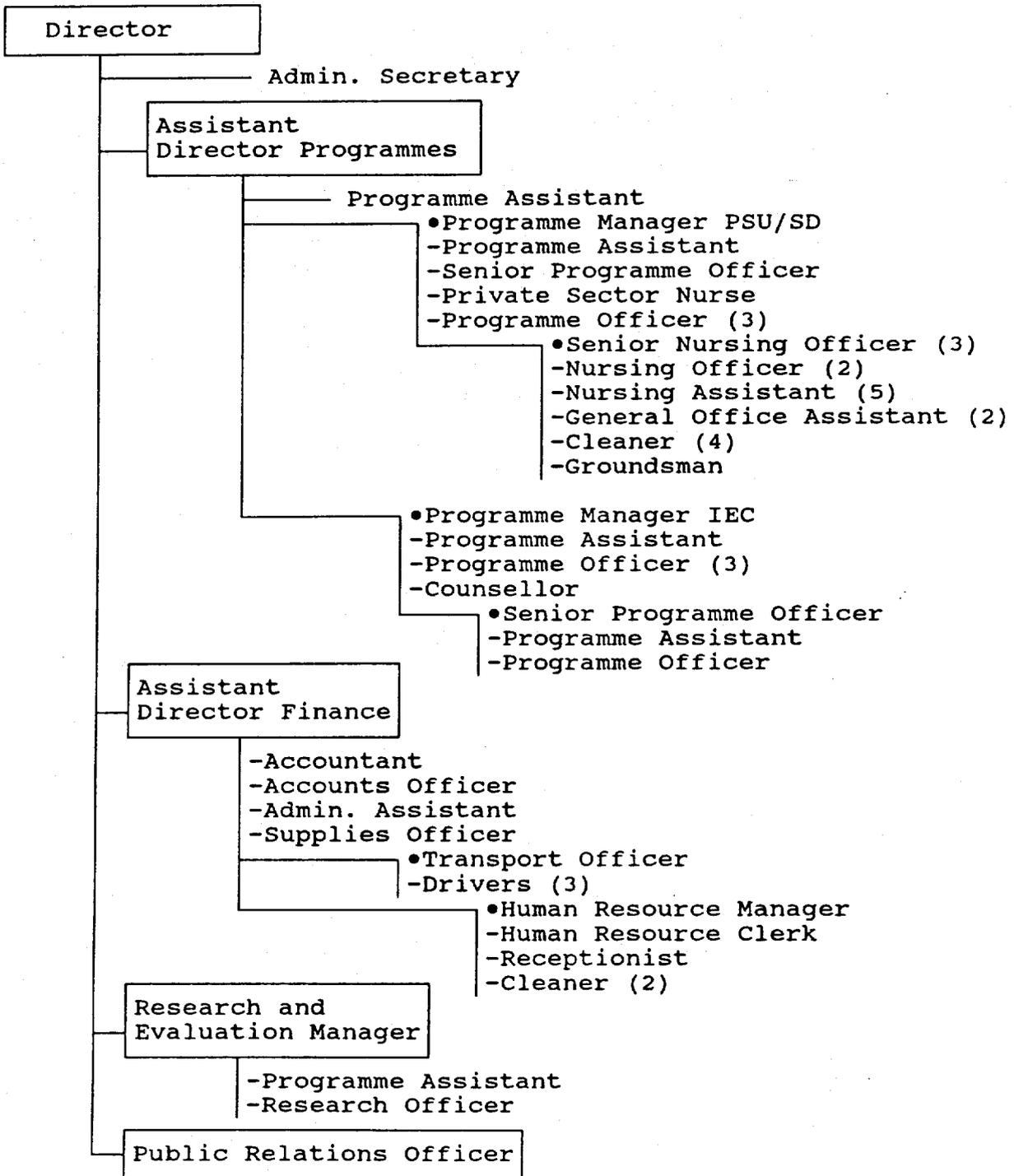
- a) Diploma in Desk Top Publishing - 1995
- b) Introduction to Dos - (1995)
- c) translating files from DBASE to SPSS - (1995)
- d) Currently pursuing Certificate in Adult Education

WORKSHOP

- a) Human Sexuality - 1994

APPENDIX D

D.1. ORGANOGRAM - THE FAMILY LIFE ASSOCIATION OF SWAZILAND



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Service Delivery Related Courses
Sponsored by FLAS

CTU

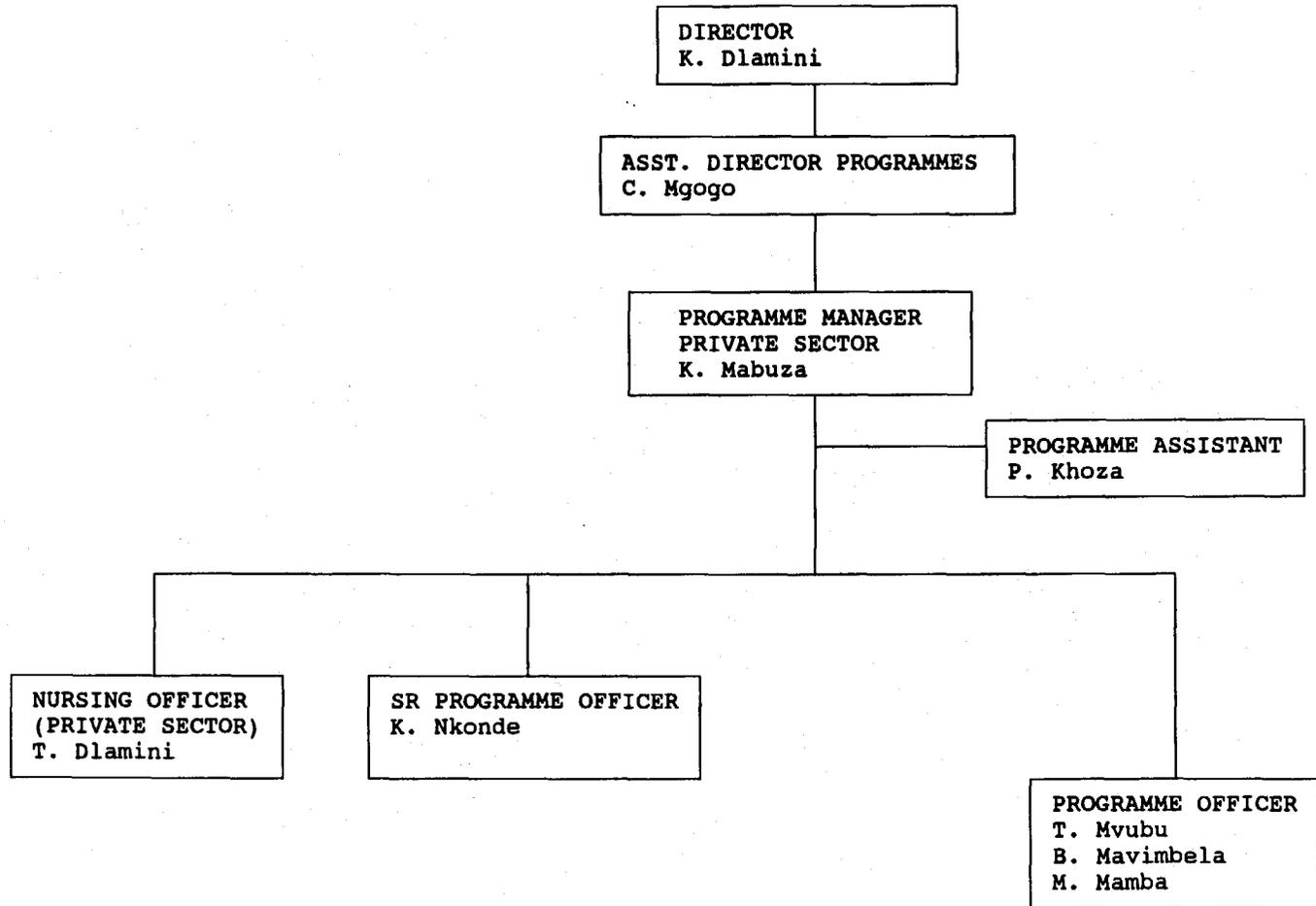
E.1. SERVICE DELIVERY RELATED COURSES

APPENDIX E

<i>Name of Participant</i>	<i>Duty Station at Time of Course</i>	<i>Time of Course</i>	<i>Present Duty Station & Title</i>	<i>Technical Assistance</i>	<i>Length of Consultancy</i>
<i>Nomsa Fakudze</i>	<i>Manzini FLAS</i>	<i>June, 1994</i>	<i>Manzini FLAS</i>	<i>Pathfinder</i>	<i>5 days</i>
<i>Busisiwe Mavimbela</i>	<i>FLAS PSU</i>		<i>FLAS PSU</i>	<i>Dr. Ezra Teri</i>	
<i>Khombi Nkonde</i>	<i>FLAS PSU</i>		<i>FLAS PSU</i>		
<i>Janet Khumalo</i>	<i>Mbabane FLAS</i>		<i>Mbabane FLAS</i>		
<i>Janet Simelane</i>	<i>Malkerns FLAS</i>		<i>Malkerns FLAS</i>		
<i>Irene Nxumalo</i>	<i>Simunye Clinic</i>		<i>Simunye Clinic</i>		
<i>Dorothy Dlamini</i>	<i>Mananga Medical Services</i>		<i>Mananga Medical Services</i>		
<i>Thandi Simelane</i>	<i>Usuthu Pulp Company</i>		<i>Usuthu Pulp Company</i>		
<i>Simiso Moyo</i>	<i>Occupational Health Services</i>		<i>Occupational Health Services</i>		
<i>Letticia Bennett</i>	<i>Manzini FLAS</i>		<i>Manzini FLAS</i>		
<i>Thuja Simelane</i>	<i>Ubombo Ranches</i>		<i>Ubombo Ranches</i>		
<i>Helen Shabangu</i>	<i>Ubombo Ranches</i>		<i>Ubombo Ranches</i>		

THE FAMILY LIFE ASSOCIATION OF SWAZILAND (Private Sector)

**D.2. ORGANOGRAM - THE FAMILY LIFE ASSOCIATION OF SWAZILAND
(Private Sector)**



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Service Delivery Related Courses
Sponsored by FLAS

VSC COUNSELLING COURSE

Name of Participant	Duty Station at Time of Course	Time of Course	Present Duty Station & Title	Technical Assistance	Length of Consultancy
<i>Zandile Dlamini</i>	<i>Mbabane PHU</i>	<i>December, 1995</i>	<i>Mbabane PHU</i>	<i>AVSC Counsellor Rosemary Kanya, Margaret Mmeme</i>	<i>7 days</i>
<i>Janet Khumalo</i>	<i>Mbabane FLAS</i>	<i>December, 1995</i>	<i>Mbabane FLAS</i>		
<i>Janet Simelane</i>	<i>Malkerns FLAS</i>	<i>December, 1995</i>	<i>Malkerns FLAS</i>		
<i>Nomsa Fakudze</i>	<i>Manzini FLAS</i>	<i>December, 1995</i>	<i>Manzini FLAS</i>		
<i>Dolly Lesabe</i>	<i>The Clinic</i>	<i>December, 1995</i>	<i>The Clinic</i>		
<i>Pauline Sebati</i>	<i>Tambankulu Clinic</i>	<i>December, 1995</i>	<i>Tambankulu</i>		
<i>Irene Nxumalo</i>	<i>Simunye Clinic</i>	<i>December, 1995</i>	<i>Simunye Clinic</i>		
<i>Gladys Gwebu</i>	<i>Ubombo Ranches</i>	<i>December, 1995</i>	<i>Ubombo Ranches</i>		
<i>Gugu Mabuza</i>	<i>Ubombo Ranches</i>	<i>December, 1995</i>	<i>Ubombo Ranches</i>		
<i>Dora Maduna</i>	<i>FLAS Headquarters</i>	<i>December, 1995</i>	<i>FLAS Headquarters</i>		
<i>Dorothy Dlamini</i>	<i>Mananga Medical Services</i>	<i>December, 1995</i>	<i>Mananga Medical Services</i>		
<i>Thandi Simelane</i>	<i>Usuthu Pulp Company</i>	<i>December, 1995</i>	<i>Usuthu Pulp Company</i>		
<i>Cynthia Nkambule</i>	<i>R.F.M. Hospital</i>	<i>December, 1995</i>	<i>R.F.M. Hospital</i>		

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Service Delivery Related Courses
Sponsored by FLAS

VSC COUNSELLING

<i>Name of Participant</i>	<i>Duty Station at Time of Course</i>	<i>Time of Course</i>	<i>Present Duty Station & Title</i>	<i>Technical Assistance</i>	<i>Length of Consultancy</i>
<i>Makhosini Mamba</i>	<i>FLAS Headquarters</i>	<i>October, 1995</i>	<i>FLAS</i>	<i>AVSC</i>	<i>5 days</i>
<i>Letticia Bennett</i>	<i>FLAS Manzini</i>	<i>October, 1995</i>	<i>FLAS</i>	<i>Dr. John Githiari</i>	
<i>Busisiwe Mavimbela</i>	<i>FLAS Headquarters</i>	<i>October, 1995</i>	<i>FLAS</i>	<i>Rose Kiregyera</i>	
<i>Veronica Nkambule</i>	<i>FLAS Malkerns</i>	<i>October, 1995</i>	<i>FLAS</i>		
<i>Prudence Mkhathshwa</i>	<i>FLAS Mbabane</i>	<i>October, 1995</i>	<i>FLAS</i>		
<i>Thelma Nkonde</i>	<i>Usuthu Pulp Company</i>	<i>October, 1995</i>	<i>Usuthu Pulp Company</i>		
<i>Violet Chunga</i>	<i>Tambankulu</i>	<i>October, 1995</i>	<i>Tambankulu</i>		
<i>Sellina Shongwe</i>	<i>Ubombo Ranches</i>	<i>October, 1995</i>	<i>Ubombo Ranches</i>		
<i>Asunta Simelane</i>	<i>Nhlangano Training Centre</i>	<i>October, 1995</i>	<i>Nhlangano Training Center</i>		
<i>Thabile Masuku</i>	<i>Mkhuzweni Health Center</i>	<i>October, 1995</i>	<i>Mkhuzweni Clinic</i>		
<i>Nonhlanhla Motsa</i>	<i>FLAS Headquarters</i>	<i>October, 1995</i>	<i>FLAS</i>		

Service Delivery Related Courses
Sponsored by FLAS

FP CLINICAL NURSES TRAINING

<i>Name of Participant</i>	<i>Duty Station at Time of Course</i>	<i>Time of Course</i>	<i>Present Duty Station & Title</i>	<i>Technical Assistance</i>	<i>Length of Consultancy</i>
<i>Makhosini Mamba</i>	<i>FLAS Headquarters</i>	<i>February - March 1995</i>	<i>FLAS Headquarters</i>	-	-
<i>Phindile Nkambule</i>	<i>FLAS Mbabane</i>	<i>February - March 1995</i>	<i>FLAS Mbabane</i>	-	-
<i>Nonhlanhla Motsa</i>	<i>FLAS Headquarters</i>	<i>February - March 1995</i>	<i>FLAS Headquarters</i>	-	-
<i>Gugu Mabuza</i>	<i>Ubombo Ranches Clinic</i>	<i>February - March 1995</i>	<i>Ubombo Ranches</i>	-	-
<i>Khanyisile Sibiya</i>	<i>Usuthu Pulp Company</i>	<i>February - March 1995</i>	<i>Usuthu Pulp</i>	-	-
<i>Dorothy Dlamini</i>	<i>Mananga Medical Services</i>	<i>February - March 1995</i>	<i>Mananga Medical Services</i>	-	-
<i>Nerissa Dlamini</i>	<i>Mananga Medical Services</i>	<i>February - March 1995</i>	<i>Mananga Medical Services</i>	-	-
<i>Lucia Fakudze</i>	<i>Simunye Clinic</i>	<i>February - March 1995</i>	<i>Simunye Clinic</i>	-	-
<i>Dora Mdziniso</i>	<i>Baphalali Red Cross</i>	<i>February - March 1995</i>	<i>Baphalali Red Cross</i>	-	-
<i>Mavis Mndzebele</i>	<i>R.F.M. Hospital</i>	<i>February - March 1995</i>	<i>R.F.M. Hospital</i>	-	-
<i>Agatha Mamba</i>	<i>Mshingishingini Clinic</i>	<i>February - March 1995</i>	<i>Mshingishingini Clinic</i>	-	-
<i>Khombisile Dlamini</i>	<i>Bhekinkosi Clinic</i>	<i>February - March 1995</i>	<i>Bhekinkosi Clinic</i>	-	-
<i>Fikile Motsa</i>	<i>King Sobhuza II Clinic</i>	<i>February - March 1995</i>	<i>King Sobhuza II Clinic</i>	-	-
<i>Jane Ntshalintshali</i>	<i>Mankayane Clinic</i>	<i>February - March 1995</i>	<i>Mankayane Clinic</i>	-	-

**Service Delivery Related Courses
Sponsored by FLAS**

FP CLINICAL NURSES TRAINING

Name of Participant	Duty Station at Time of Course	Time of Course	Present Duty Station & Title	Technical Assistance	Length of Consultancy
<i>Gcinaphi Dlamini</i>	<i>Hlane Clinic</i>	<i>March - April 1994</i>		-	-
<i>Zandile Dlamini</i>	<i>Lomahasha Clinic</i>	<i>March - April 1994</i>		-	-
<i>Nompumelelo Gama</i>	<i>Mbabane PHU</i>	<i>March - April 1994</i>		-	-
<i>Thoko Gule</i>	<i>Mliba Clinic</i>	<i>March - April 1994</i>		-	-
<i>Charity Hlongwane</i>	<i>Sithobela Clinic</i>	<i>March - April 1994</i>		-	-
<i>Matilda Jele</i>	<i>Mbabane PHU</i>	<i>March - April 1994</i>		-	-
<i>Thandi Khumalo</i>	<i>Lane Surgery</i>	<i>March - April 1994</i>		-	-
<i>Lucky Malindzisa</i>	<i>Piggs Peak (PHU)</i>	<i>March - April 1994</i>		-	-
<i>Irene Nxumalo</i>	<i>Simunye Clinic</i>	<i>March - April 1994</i>		-	-
<i>Thandi Sibandze</i>	<i>Piggs Peak Nazarene</i>	<i>March - April 1994</i>		-	-
<i>Goodness Thwala</i>	<i>Lobamba Clinic</i>	<i>March - April 1994</i>		-	-
<i>Liberty Thwala</i>	<i>Siphofaneni Clinic</i>	<i>March - April 1994</i>		-	-

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Service Delivery Related Courses
Sponsored by FLAS

HUMAN SEXUALITY

Name of Participant	Duty Station at Time of Course	Time of Course	Present Duty Station & Title	Technical Assistance	Length of Consultancy
Musa Mgogo	FLAS Programmes	8/8/94 - 12/8/94	FLAS Programmes	Pathfinder - Nanette Ecker	1 week
Leticia Bennett	FLAS Manzini Clinic	8/8/94 - 12/8/94	FLAS Manzini Clinic		
Sindi Mlambo	FLAS Manzini Clinic	8/8/94 - 12/8/94	FLAS Manzini Clinic		
Janet Simelane	FLAS Malkerns Clinic	8/8/94 - 12/8/94	FLAS Malkerns Clinic		
Bonisile Mkhwanazi	MOH Mankayane	8/8/94 - 12/8/94	Mkhulamini MOH		
Frieda Maseko	FLAS IEC	8/8/94 - 12/8/94	FLAS IEC		
Thuli Mthembu	Tambankulu	8/8/94 - 12/8/94	Tambankulu		
Sifiso Dlodlu	Simunye	8/8/94 - 12/8/94	Simunye		
Sifiso Zwane	FLAS IEC	8/8/94 - 12/8/94	FLAS IEC		
Busisiwe Mambimbela	FLAS PSU/SD	8/8/94 - 12/8/94	FLAS PSU/SD		
Dorothy Dlamini	Mananga Medical Services	8/8/94 - 12/8/94	Mananga Medical Services		
Lucky Khumalo	FLAS Finance	8/8/94 - 12/8/94	FLAS Finance		
Cookie Masuku	FLAS Administration	8/8/94 - 12/8/94	FLAS Administration		
Audrey Simelane	FLAS Human Resource	8/8/94 - 12/8/94	FLAS Human Resource		
Thandi Dlamini	FLAS IEC	8/8/94 - 12/8/94	FLAS IEC		
Janet Khumalo	FLAS Mbabane Clinic	8/8/94 - 12/8/94	FLAS Mbabane Clinic		
Musa Mdluli	FLAS REU	8/8/94 - 12/8/94	FLAS REU		
Khombi Nkonde	FLAS PSU/SD	8/8/94 - 12/8/94	FLAS PSU/SD		

Service Delivery Related Courses
Sponsored by FLAS

HUMAN SEXUALITY

<i>Name of Participant</i>	<i>Duty Station at Time of Course</i>	<i>Time of Course</i>	<i>Present Duty Station & Title</i>	<i>Technical Assistance</i>	<i>Length of Consultancy</i>
<i>Makhosini Mamba</i>	<i>FLAS PSU/SD</i>	<i>15/8/94 - 19/8/94</i>		<i>Pathfinder - Nanette Ecker</i>	<i>1 week</i>
<i>Portia Khoza</i>	<i>FLAS PSU/SD</i>	<i>15/8/94 - 19/8/94</i>			
<i>Lindiwe Nkosi</i>	<i>FLAS IEC</i>	<i>15/8/94 - 19/8/94</i>			
<i>Lindiwe Tsabedze</i>	<i>FLAS Human Resource</i>	<i>15/8/94 - 19/8/94</i>			
<i>Thembi Mvubu</i>	<i>FLAS PSU/SD</i>	<i>15/8/94 - 19/8/94</i>			
<i>Henry Mabuza</i>	<i>FLAS Mbabane Clinic</i>	<i>15/8/94 - 19/8/94</i>			
<i>Thoko Nhlabatsi</i>	<i>FLAS IEC</i>	<i>15/8/94 - 19/8/94</i>			
<i>Mcebo Mabuza</i>	<i>FLAS IEC</i>	<i>15/8/94 - 19/8/94</i>			
<i>Bethusile Khumalo</i>	<i>FLAS REU</i>	<i>15/8/94 - 19/8/94</i>			
<i>Nombuso Tfwala</i>	<i>FLAS IEC</i>	<i>15/8/94 - 19/8/94</i>			
<i>Dorah Maduna</i>	<i>FLAS IEC</i>	<i>15/8/94 - 19/8/94</i>			
<i>Nomsa Fakudze</i>	<i>FLAS Manzini Clinic</i>	<i>15/8/94 - 19/8/94</i>			
<i>Nicodemus Tumaletse</i>	<i>Protea</i>	<i>15/8/94 - 19/8/94</i>			
<i>Thobile Dlamini</i>	<i>FLAS PSU/SD</i>	<i>15/8/94 - 19/8/94</i>			
<i>Rodgers Mdluli</i>	<i>Shiselweni Forest</i>	<i>15/8/94 - 19/8/94</i>			
<i>Nompumelelo Gama</i>	<i>Mbabane PHU</i>	<i>15/8/94 - 19/8/94</i>			
<i>Veronica Nkambule</i>	<i>FLAS Malkerns Clinic</i>	<i>15/8/94 - 19/8/94</i>			
<i>Clifford Mamba</i>	<i>Ubombo Ranches</i>	<i>15/8/94 - 19/8/94</i>			
<i>Zilpa Gumedze</i>	<i>Mananga Medical Services</i>	<i>15/8/94 - 19/8/94</i>			
<i>Gillian Zwane</i>	<i>King Sobhuza II Clinic</i>	<i>15/8/94 - 19/8/94</i>			
<i>Njabulo Simelane</i>	<i>FLAS Finance</i>	<i>15/8/94 - 19/8/94</i>			
<i>Thobile Mkhonta</i>	<i>Ngonini</i>	<i>15/8/94 - 19/8/94</i>			

Service Delivery Related Courses
Sponsored by FLAS

INFECTION PREVENTION

<i>Name of Participant</i>	<i>Duty Station at Time of Course</i>	<i>Time of Course</i>	<i>Present Duty Station & Title</i>	<i>Technical Assistance</i>	<i>Length of Consultancy</i>
<i>Shirry Mwaikambo</i>	<i>Mbabane PHU</i>	<i>August 1995</i>	<i>Mbabane PHU</i>	<i>Pathfinder Dr. Ezra Teri</i>	<i>7 days</i>
<i>Phindile Nkambule</i>	<i>Mbabane FLAS Clinic</i>	<i>August 1995</i>	<i>Mbabane FLAS Clinic</i>		
<i>Thobile Dlamini</i>	<i>FLAS PSU/SD</i>	<i>August 1995</i>	<i>FLAS PSU/SD</i>		
<i>Veronica Nkambule</i>	<i>FLAS Malkerns Clinic</i>	<i>August 1995</i>	<i>FLAS Malkerns Clinic</i>		
<i>Leticia Bennett</i>	<i>FLAS Manzini Clinic</i>	<i>August 1995</i>	<i>FLAS Manzini Clinic</i>		
<i>Henry Mabuza</i>	<i>FLAS Mbabane Clinic</i>	<i>August 1995</i>	<i>FLAS Mbabane Clinic</i>		
<i>Sindi Mlambo</i>	<i>FLAS Manzini Clinic</i>	<i>August 1995</i>	<i>FLAS Manzini Clinic</i>		
<i>Elizabeth Shongwe</i>	<i>Mbabane Government</i>	<i>August 1995</i>	<i>Mbabane Government</i>		
<i>Zodwa Masuku</i>	<i>Mbabane Government</i>	<i>August 1995</i>	<i>Mbabane Government</i>		
<i>Sam Mkhawawiri</i>	<i>Mkhuzweni Clinic</i>	<i>August 1995</i>	<i>Mkhuzweni Clinic</i>		
<i>Yvonne Mhlanga</i>	<i>Piggs Peak PHU</i>	<i>August 1995</i>	<i>Piggs Peak PHU</i>		
<i>Eunice Zwane</i>	<i>Silele Red Cross Clinic</i>	<i>August 1995</i>	<i>Silele Red Cross</i>		
<i>Mavis Mndzebele</i>	<i>RFM Hospital</i>	<i>August 1995</i>	<i>RFM Hospital</i>		
<i>Thandi Gwebu</i>	<i>Ntfontjeni Clinic</i>	<i>August 1995</i>	<i>Ntfontjeni Clinic</i>		
<i>Thabsile Dlamini</i>	<i>Ubombo Ranches</i>	<i>August 1995</i>	<i>Ubombo Ranches</i>		
<i>Miriam Masuku</i>	<i>Ngonini Clinic</i>	<i>August 1995</i>	<i>Ngonini Clinic</i>		
<i>Futhi Mkhwanazi</i>	<i>Ndzevane Clinic</i>	<i>August 1995</i>	<i>Ndzevane Clinic</i>		

Service Delivery Related Courses
Sponsored by FLAS

INFECTION PREVENTION

Name of Participant	Duty Station at Time of Course	Time of Course	Present Duty Station & Title	Technical Assistance	Length of Consultancy
<i>Sebenzile Thwala</i>	<i>Hlathikhulu Government</i>	<i>August 1995</i>	<i>Hlathikhulu Government</i>	<i>Pathfinder - Ezra Teri</i>	<i>7 dyas</i>
<i>Thulisile Matsenjwa</i>	<i>RFM Hospital</i>	<i>August 1995</i>	<i>RFM Hospital</i>		
<i>Thembi Dlamini</i>	<i>Sithobela Health Clinic</i>	<i>August 1995</i>	<i>Sithoble Health Clinic</i>		
<i>Thoko Simelane</i>	<i>Simunye Clinic</i>	<i>August 1995</i>	<i>Simunye Clinic</i>		
<i>Sipho Dube</i>	<i>Siteki PHU</i>	<i>August 1995</i>	<i>Siteki PHU</i>		
<i>Nokuthula Mabuza</i>	<i>Mkhuzweni Health Clinic</i>	<i>August 1995</i>	<i>Mkhuzweni Health Clinic</i>		
<i>Winile</i>	<i>Mkhuzweni Health Clinic</i>	<i>August 1995</i>	<i>Mkhuzweni Health Clinic</i>		
<i>Sipho Gamedze</i>	<i>King Sobhuza II Clinic</i>	<i>August 1995</i>	<i>King Sobhuza II Clinic</i>		
<i>Bonakele Hlatshwayo</i>	<i>Nhlangano Health Clinic</i>	<i>August 1995</i>	<i>Nhlangano Health Clinic</i>		
<i>Kenneth Simelane</i>	<i>Piggs Peak Government</i>	<i>August 1995</i>	<i>Piggs Peak Government</i>		

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E.3. THE CONCEPT OF PERINATAL CARE

I. A. BACKGROUND

The working definition for the perinatal period is conception to six weeks after childbirth or miscarriage. The perinatal approach to maternity care utilizes this stress-free period during pregnancy, when conception will not occur and the six-week period of low fertility after childbirth when conception is unlikely to make a timely decision for contraception.

Prenatal care may be for many clients the first exposure to general and reproductive health care. Accordingly, it will be the first opportunity to consistently learn good general health and reproductive habits over an extended period of time. This period also affords opportunities for eliciting a comprehensive history and a thorough physical examination (a comprehensive health profile).

A first pregnancy is an opportunity to observe and use information gleaned to contribute to planning reproductive life. A woman's physiological response to pregnancy avails useful information for assessing her suitability for hormonal and other methods of contraception, reproductive capability, risk category, and general prognosis.

Maternal physiology provides for contraception during the postpartum period through lactation and breastfeeding. During this period, reproductive hormones interact to effect:

- ◆ *Anatomical and physiological return to the pregravid state.*
- ◆ *Contraception (low fertility).*
- ◆ *Lactation.*

As these elements of the maternity process are physiologically integrated, they are taught to service providers in that manner. The disparity in practice is usually attributable to the constraints and/or exigenceis of the health care system. The methodology used for integration will be mainly reorient service providers to a holistic approach, adn adapt their service delivery mechanisms to this approach. This entails:

- ◆ *Training (reorientation) of service providers to use the new approach.*
- ◆ *Orienting of outreach workers to make early referrals for antenatal care.*
- ◆ *Develop and utilize a client care plan synchronising education, health promotion activity, and decision making with the appropriate gestational or postpartum period.*

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B. THE INTEGRATION OF THE PERINATAL APPROACH INTO REPRODUCTIVE HEALTH CARE SERVICE DELIVERY IS APPROPRIATE FOR A NUMBER OF REASONS:

In Swaziland family planning services are offered in an integrated setting which includes antepartum and child welfare services. Fertility rates are still high and the majority of women in the childbearing period become pregnant even though most are aware of the availability of contraceptive methods, and many do not plan to become pregnant. Maternity services may therefore be the first opportunity for service providers to counsel and motivate clients towards contraception. The antepartum period may also be the time when the service provider is most likely to win the client's confidence and should therefore exploit this relationship to promote family planning and good reproductive health habits.

The age at which women experience their first pregnancies tend to lower while the number of early pregnancies increase dramatically adding a further dimension to the number of women in the childbearing period who become pregnant. Where family life education to adolescents is nonexistent the next opportunity for inculcating responsible health and reproductive habits is at first pregnancy.

Family planning targets people of reproductive age. Most women of reproductive age can be accessed through MCH services, since the majority get pregnant before using contraceptives.

Postpartum care was always intended to be an integral part of maternity care, but too often it does not include contraception. Contraception is important in ensuring adequate rest (recovery) from pregnancy for the mother, and adequate attention to the young child. The perinatal approach encourages acceptance of postpartum contraception as a routine and important reproductive health habit and demonstrates the wisdom in planning families.

APPENDIX F

Summary of Past IEC-Related Research Studies

<u>REPORT</u>	<u>IEC RECOMMENDATIONS</u>	<u>RESULTS</u>
<p>McLean, Polly, "Swaziland: Perceptions and Attitudes of Men and Women Towards Family Planning", consultant report to FLAS, Dec. 1990.</p>	<p>This survey concludes that family planning IEC and services should build on the traditional Swazi child-centered family and love of children by linking FP to MCH, urging "enormous amounts of counselling". Specifically FLAS should:</p> <ul style="list-style-type: none"> a. link FP and MCH programs; b. link IEC to Swazi love of children, emphasizing need to feed, clothe, educate children; c. use interpersonal IEC; d. provide intensive counseling and followup during first three months of [female?] acceptance, when side-effects are major cause of drop-outs; e. pay special attention to men. 	<ul style="list-style-type: none"> a. As recommended, FLAS integrated MCH into its FP services for about two years (prior to the FHS project) in hopes of providing a more appealing package of services to mothers and children, in keeping with its focus on "family life". This was done at Manzini and Malkerns, but was ended at Manzini after two years because it was found that quality FP services could not be provided by the overtaxed staff; in the crush of providing MCH, FLAS had begun to lose its focus on family planning, and the number of FP clients had begun to go down. At Malkerns the pressure on staff was not so great, so it continues to provide a more complete package of CH services for clients as it had done in the past. b. FLAS changed from its didactic, clinical approach to contraceptive counselling to a more child-focused approach emphasizing love for children and family welfare. c. Counselling staff trained in interpersonal communications and the GATHER method. d. Dropout rates were lowered to below 20% by hiring a field officer to followup dropouts in Manzini, and by improving client tracking. e. More emphasis was put on involving men.

<p>Gorosh, Dr. Martin, et al, "Midterm Evaluation of USAID Family Health Services Project", Swaziland, University Research Corporation, September 1990</p>	<p>Reports progress in first two years, recommends strengthening staff, increasing coordination, and continuing external advisor. Also suggested:</p> <ul style="list-style-type: none"> a. hand over CBD program to MOH, and increase MOH subsidy; b. increase official and traditional leadership awareness program targeting areas of resistance; c. improved management, research and evaluation. 	<p>FLAS management has increased its meetings and it circulation of activity reports among management staff. It also followed up most Gorosh recommendations:</p> <ul style="list-style-type: none"> a. FLAS has long sought to have the MOH take over the CBD program, and recommended that in its Vision 2000 plans. It would work closely with the MOH to support CBD activities if the MOH would take over. The chances of an increase in the MOH subsidy to FLAS may be limited, given the current talk of cuts in future MOH budgets. b. FLAS sponsors programs to increase FP awareness of chiefs, MPs, other leaders c. FLAS created the Research and Evaluation Unit in 1993, and sent FLAS managers on several international management training courses (e.g. IEC managers studied in Kenya, 1991 and 1993, and at Cornell in 1992).
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<p>Hosein, Everold "Assessment of the IEC Program of FLAS and Developmnt of a New IEC Program Strategy", Nisus Inc., New York, May 1993.</p> <p>AND -</p> <p>"Final Report: FLAS IEC Assessment" DATEX, Arlington, VA, May 1993. [same report as above]</p>	<p>Most important IEC study: Hosein proposes phasing out past IEC emphasis on promoting awareness of methods and need for FP, which are widely understood by 60,000 women who want to practice FP but don't. Proposes new "prescribed" phase: "integrated marketing communication" campaign, full scale advertising in print, radio, and TV to increase awareness of service sites and locations, address fears of family planning methods, and address male opposition and teen inertia. Includes detailed recommendations for national marketing and advertising.</p>	<p>The Hosein report becaame the basis for an intensive IEC campaign and the amended FHS contract.</p> <p>A wide variety of advertisements were sponsored to draw attention to FLAS services, from radio spots to flags and directional signs.</p>
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Pilot VSC Services

Service Delivery Site	MDs Trained/Date	Nurses Trained/Date	Vasectomy Kits	ML/LA Kits	Service Started	Vasectomy Done	ML/LA Done	Remarks
<i>Manzini Clinic</i>		<i>Leticia Bennett</i>						<i>VSC Counselling Course</i>
<i>Malkerns Clinic</i>		<i>Veronica Nkambule</i>						<i>VSC Counselling Course</i>
<i>Simunye Clinic</i>		<i>Irene Nxumalo Dec. 94</i>						<i>VSC Counselling Course</i>
<i>Ubombo Ranches</i>		<i>Gugu Mabuza Dec. 94</i>						<i>VSC Counselling Course</i>

E.2 PILOT VSC SERVICES

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<p>Krystall, Eric, "Eval. of Industry-Based FP Program", JSI/Kenya, April 1993.</p>	<p>Reviews IEC to date and recommends an industry-specific IEC focus segmenting special target populations and messages such as pill resupply and VC (where available). Different subjects would be the focus of targeted campaigns at different locations and different times, e.g. pill resupply, condoms, STD/AIDS, male involvement, or household economics. Industry-union-community staff should participate more in IEC development.</p>	<p>FLAS did not wish to emphasize certain methods to certain populations because it follows strictly the principle of free and informed choice among all methods for all clients.</p> <p>Employers and union and community leaders do meet together in planning FP programs at industries to avoid any suspicions and misunderstandings.</p>
<p>PATH (Barbara Crook, Consultant) et al, Trip Report of IEC Technical Assistance to FLAS, Nov. 1993.</p>	<p>Reports on a TOT workshop and curriculum development in counselling ("interpersonal communication and counseling" or IPC/C) to train 13 master trainers from FLAS, MOH, and industries in counseling skills and counselor training skills.</p>	<p>See above concerning new emphasis on interpersonal counselling. Training was for both the IEC and Private Sector staff; those who missed the initial training received "step down" training.</p>

<p>Douglas, Dr. Edward, Consultant in Radio advertising, Trip Report: April 1995.</p>	<p>Recommends detailed actions IEC unit can take to improve its management and effectiveness (prioritize, plan, communicate better), be more sensitive to target audiences' needs and reactions, and "cross-promote media activities" (each broadcast should announce the next one; print materials should promote radio programs; clinics should post and/or announce radio programs).</p>	<p>The IEC Unit has been conscious of the need to prioritize and should also be given credit for managing a large number of varied activities in a short time because of AID's spending deadlines.</p> <p>IEC staff pay careful attention to clients comments to providers, letters to FLAS, and phone-in calls.</p> <p>Newspaper ads did not announce radio programs because of the high costs of redesigning each ad, but each radio show announced schedules of subsequent shows.</p> <p>IEC activities were carefully phased: e.g. the books for teens were prepared, then students mock debates held, then teenager's conferences, then parent's conferences.</p>
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Pilot VSC Services

<i>Service Delivery Site</i>	<i>MDs Trained/Date</i>	<i>Nurses Trained/Date</i>	<i>Vasectomy Kits</i>	<i>ML/LA Kits</i>	<i>Service Started</i>	<i>Vasectomy Done</i>	<i>ML/LA Done</i>	<i>Remarks</i>
<i>Mbabane FLAS Clinic</i>	<i>Dr. Zama Gama July 94</i>			<i>0</i>		<i>-</i>	<i>0</i>	<i>Dr. Gama could not start due to ill-health then change of fulltime jobs.</i>
<i>Mbabane FLAS Clini</i>	<i>Dr. Kim Shongwe Jan. 95</i>			<i>1</i>	<i>April 95</i>		<i>8</i>	<i>The Mbabane Clinic Theatre was ready in April 1995</i>
<i>Mbabane FLAS Clinic</i>	<i>Dr. Themba Ntiwane Jan. 95</i>			<i>1</i>	<i>April 95</i>	<i>4</i>	<i>14</i>	<i>Mbabane FLAS Clinic was ready in April 1995.</i>
<i>Ubombo Ranches</i>	<i>Dr. P. Canter July 94</i>			<i>4</i>		<i>3</i>	<i>49</i>	<i>Procedures done under spinal anesthesia.</i>
<i>Mananga Medical Services</i>	<i>Dr. Stidnt July 94</i>			<i>1</i>			<i>1</i>	<i>The MD that was trained resigned. This service is no longer offered in MMS</i>
<i>Mbabane FLAS Clinic</i>	<i>Dr. Kim Shongwe June 95</i>					<i>0</i>	<i>8</i>	<i>Dr. Kim Shongwe has been on leave hence no clients for vasectomy were booked for him.</i>

Pilot VSC Services

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<i>Service Delivery Site</i>	<i>MDs Trained/Date</i>	<i>Nurses Trained/Date</i>	<i>Vasectomy Kits</i>	<i>ML/LA Kits</i>	<i>Service Started</i>	<i>Vasectomy Done</i>	<i>ML/LA Done</i>	<i>Remarks</i>
<i>Mbabane FLAS Clinic</i>	<i>Dr. Themba Ntiwane June 95</i>		<i>1</i>			<i>4</i>	<i>14</i>	<i>No Scapel Vasectomy done</i>
<i>Mbabane FLAS Clinic</i>		<i>Janet Khumalo Jan. 95</i>	<i>-</i>	<i>-</i>	<i>April 95</i>	<i>-</i>	<i>-</i>	<i>VSC Counselling Course</i>
<i>Mbabane FLAS Clinic</i>		<i>Thobile Dlamini July 94</i>	<i>-</i>	<i>-</i>	<i>April 95</i>	<i>-</i>	<i>-</i>	<i>VSC Counselling Course</i>
<i>Manzini FLAS Clinic</i>		<i>Nomsa Fakudze Dec. 94</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>VSC Counselling Course</i>
<i>Malkerns FLAS Clinic</i>		<i>Janet Simelane Dec. 94</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>VSC Counselling Course</i>