

FINAL REPORT

Prepared for:
USAID/Kinshasa .

MID-TERM EVALUATION
FAMILY PLANNING SERVICES DELIVERY PROJECT

object 660-0094

by

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ABBREVIATIONS

AMIZA	Agence Maritime Internationale du Zaïre
AZBEF	Association Zaïroise pour le Bien-Etre Familial Family Planning Association of Zaïre
BUPROF	Bureau de Problèmes Féminins; Women's Bureau
CASOP	Caisse de Solidarité Populaire
CCP	Conseil Consultatif du Projet; Project Advisory Council
CENACOF	Centre National de Coordination de la Formation au Développement; National Center for Training for Development
CND	Comité National des Naissances Désirables; National Committee for Desired Births
CRND	Comité Régional des Naissances Désirables
DEO	Design and Evaluation Office (USAID)
DSP	Département de la Santé Publique; Department of Public Health
ECZ	Eglise du Christ au Zaïre; Church of Christ in Zaïre
INTRAH	International Training in Health
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation; Fédération Internationale pour la Planification Familiale
JHPLEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH/FP	Maternal and Child Health/Family Planning
NGO	Non-Governmental Organization
OMS	Organization Mondiale de la Santé; World Health Organization
ONATRA	Office National du Transport
ONG	Organization Non-Governmental
PCS	Population Communication Services

PSND	Projet des Services des Naissances Désirables; Family Planning Services Project
REDSO	Regional Economic Development Services Office
KVM	Regie de Voie Maritime
SANRU	Soins de Santé Primaire en Milieu Rural; Basic Rural Health Project
TOT	Training of Trainers
UACP	Unité d'Administration et de Coordination du Projet; Project Management and Coordination Unit
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

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The team would like to acknowledge the frank, constructive and open atmosphere in which this evaluation took place. All parties were anxious to have our advice and open about the difficulties that the project faces. This work has profited greatly from that which has gone before, notably, the CDC evaluation of the CNND, the report of the PID design team, and the report of the study group to prepare the evaluation. The team profited enormously from the talented personnel who are involved in family planning in Zaire, expatriate and Zairian. They are too numerous to list; but we are particularly grateful for the backstop of Ken Heise at USAID and Eileen McGinn of the project; include equally Citoyenne CHIRWISA Chirhamolekwa, director of the project, and her deputies; the CNND and its staff. The outside evaluators profited from the sensitive insights, lively participation, and long hours of Citoyen KIKASA, CNND member of the team and Dr. PANGU, representing the DSP.

EXECUTIVE SUMMARY

1. A mid-term evaluation of Family Planning Services Project (660-0094) was carried out by a six-member team in Zaire June 10-28, 1985. The objective of the five year project is to increase the prevalence of contraceptive usage to 12% through 75 family planning units in 14 urban areas of Zaire. The team profited from a series of substantive reports on family planning activities in Zaire.
2. The team found that financial systems were in place and operational. Accomplishments in the training area had surpassed project targets and were providing a much needed service. Services are being provided in at least half of the targetted sites, but not all are fully operational. The team was surprised to find a very low number of acceptors of family planning services at project sites, with contraceptive prevalence estimated from project sources to be at less than one percent. The team feels that the basic premise of the project paper--that there is a large volume of unsatisfied demand for family planning services--was not justified. Further, project assumptions about availability of informational methods and adequacy of infrastructure seem poorly founded.
3. In many ways this evaluation is premature and this prematurity explains in part the lack of progress in various activities and the lack of conclusiveness in team findings. Delays were introduced at the very beginning of the project in getting project inputs from USAID. Further delays occurred as the project departed from its expected organizational pattern involving an informal arrangement integrating governmental activities into the existing structure of a non-governmental organization (the CNND). For various reasons, this implementation arrangement did not prove to be feasible; and a new project structure was created including the construction of project headquarters.
4. As a result of these changes, there are now two structures in the family planning field with an unfortunate duplication of effort. One section of the substantive recommendations of the report focuses on the various functions which are involved in the delivery of family planning services, and how they can be divided to reduce duplication of effort. Briefly these involve consolidating training and contraceptive supply in the PSND, the consolidation of the information and education function within the CNND, a closer collaboration in statistical reporting, and a fuller integration of supervision into the existing health zones.
5. The team commends the PSND for the steps it has taken to improve its internal efficiency and suggests further that equity be introduced into salaries and benefits which would be managed at the project level. The team concludes that project energy should shift away from internal

project organization and reorganization to service activities. In this regard, the team has offered recommendations for increasing community outreach, strengthening supervision, and increasing the emphasis on information and education about population issues of which family planning is but one aspect.

6. The problem of lack of collaboration between the project entities is a pervasive theme which has preoccupied project staff and recurs throughout the report. The team has offered several specific recommendations about formal arrangements which may clarify roles and responsibilities within the project, including the establishment of a protocol for activities to be carried out by the CNND under the project and the functioning of its consultative council. Further collaboration could be facilitated by participation of DSP personnel as volunteers with the CNND. The team has also offered more general recommendations by which communications can be improved. However, the team is not convinced that there exists good faith among the partners to resolve these differences and notes that no amount of specificity will resolve these problems in the absence of good will. The team also notes that the government of Zaire should clarify the principle of "naissances desirables"* enunciated in 1972 and should formally support the project by increasing its financial contribution and strengthening its instructions to health personnel. The team also encourages more coordination between USAID, IPPF, WHO and the UNFPA at the country level.

7. The team anticipates that the project agreement will need to be amended to extend the project completion date and make other changes as well. But amendments are not recommended at this time for several reasons: 1) The project is just emerging from the shakedown phase; 2) The staff need to have a chance to act on the recommendations of this report, as well as to adjust to a new team of technical assistants; 3) If the collaborative arrangements have not improved within a year, then major redesign of the project will be called for.

8. In the short term, project efforts should be concentrated on improving services in family planning units already under the project, and reaching the target number of units. The project should eventually be expanded to incorporate all family planning units in the 14 cities for training and resupply. Over the long term, the team sees the need for continued assistance by USAID in the field of family planning, including an extension of this project and possible follow-up. Future directions will greatly depend on the progress in resolving problems outlined above.

*The phrase which translates as "Desired Births" is used in Zaire to mean family planning.

SUMMARY OF MAJOR RECOMMENDATIONS

The recommendations are divided into three categories. The first is overall recommendations which require active intervention by USAID. These are followed in turn by specific recommendations for the improvement of each component of the PSND project. These will require follow-up by USAID. Several other recommendations not summarized here are useful for the internal working of the project and should be taken up in the course of routine project monitoring.

Overall:

- 1) A protocol should be negotiated between DSP and CNND clearly stating CNND role and responsibility in carrying out project activities and clearly specifying the budget and personnel contributions of CNND and PSND.
- 2) If in USAID's opinion, substantial progress has not been made after another year of experience in resolving problems identified in this evaluation, the project should be redesigned. Even if major redesign is not called for, the project will need to be amended and extended.
- 3) The government of Zaire should begin now to make an ordinary budgetary contribution to the project.
- 4) The streamlined Project Advisory Council and the Project Coordinating and Management Unit should function as planned in the project paper.

Administration:

- 5) The project should be audited.
- 6) Additional personnel needs should be met by seconding staff from the CNND and other government agencies, rather than by direct hire. The director's role in review, disciplinary action and reassignment of all staff regardless of source should be reinforced.

Contraceptive Supply:

- 7) Procedures for resupply, as yet untested, should be simplified and uniform for both PSND and CNND.
- 8) Expired contraceptives should be replaced by AID/W at no cost to the project.

Training:

- 9) The basic training program should be strengthened by adding a checklist of practical clinical requirements, by acquiring basic didactic materials, by emphasizing management training and by following up trainees.

IEC:

10) To avoid duplication, it is recommended that the project's IEC program be located at CNND. Materials developed there should be shared by all the family planning projects.

Family Planning Services:

11) To strengthen community outreach

- CNND needs to mobilize volunteers to support new clinics
- Health workers need to go outside the clinic
- Inauguration seminars should be put in place in communities prior to launching PSND activities.

12) The project strategy should be changed to increase the number of service points in cities already covered before expanding to additional cities.

Supervision:

13) Supervision should be improved by

- reinforcing the PSND supervisory unit with additional personnel
- using the existing supervisory protocol during clinic visits
- encouraging DSP supervisory medical personnel in health zones to play a more active role in family planning supervision.

Statistics:

14) The overall statistical system should be simplified and computerized for uniform and timely reporting of family planning activities.

15) A global statistical report for all family planning activities in Zaire should be compiled by the CNND and shared with appropriate medical authorities.

I. INTRODUCTION AND BACKGROUND

This report is a mid-term evaluation of the Family Planning Services Project (660-0094) obligated on September 30, 1982 and carried out with the Department of Public Health (DSP) of the Government of Zaire and the Comité National des Naissances Désirables (CNND). The evaluation was undertaken by AID with the participation of the same institutions. As a mid-term evaluation, emphasis is placed on process and structure rather than outputs. The detailed scope of work is shown in Appendix A. Briefings with USAID officials indicated internal organizational problems of the project and problems with collaborating agencies. The team's attention was drawn to questions of the long-term viability of the project.

The team was headed by Sarah C. CLARK, Regional Population Officer for West and Central Africa for AID based in Abidjan. Team members include Kathy JESENCKY, Program Coordinator for Africa at Family Health International who served as a consultant for the International Science and Technology Institute (ISTI); KIKASA Mwanalissa, editor of Afrique Zaire and Treasurer of the CNND; Jean LECOMTE, physician and independent consultant with ISTI; Gaël MURPHY, Health and Population Officer intern with AID; PANGU Kasa, physician and medical advisor to the Minister of Health.

The evaluation team carried out its work during a three week period in Zaire. It was divided into three groups for field visits to evaluate family planning units. One group visited family planning centers in Bas-Zaire; one group visited Kikwit in the Bandundu region; the other carried out field visits in Kinshasa and paid particular attention to problems at the central level. A common protocol was used during site visits. (The French version is attached as Appendix B).

In addition to the field visits, the evaluation included interviews with project staff, USAID and CNND personnel, review of project documents and progress reports.

Two major difficulties were encountered in the course of the evaluation. The first is the acknowledged departure of the project in execution from its original conception - the design team had specifically rejected creating an operationally independent structure in favor of a centralized planning and supervisory unit within the CNND (Project Paper, p 37). The team chose to accept the reality as it exists rather than dwell on the deviations. The second difficulty results from the delay in getting the project started, due at least in part to delays in getting family planning commodities and technical assistance through AID. As a result, some activities such as re-stocking of contraceptive supplies have not yet been needed. It is, therefore, impossible to provide relevant observations and recommendations on them.

The project was explicitly designed to meet unmet demand for contraceptives, and train health personnel in their use. According to the project agreement, the goal of the project is "to increase the use of voluntary family planning, assisting Zairian families to space their children and to have the number of children they desire". Quantitative targets are specified in terms of increasing contraceptive usage from three to twelve percent among couples living in the fourteen target cities. The seventy-five target centers in the fourteen cities have been divided into three pools as follows:

- 1st Pool Kinshasa, Bandundu, Bas-Zaïre
- 2nd Pool Shaba, Kasai-Occidental, Kasai-Oriental
- 3rd Pool Equateur, Haut-Zaïre, Kivu

There are nine activities which are to lead directly to attaining the goal:

- 1) actions to improve coordination of family planning service delivery.
- 2) development of technical skills
- 3) provision of training at several levels
- 4) production of didactic and informational materials
- 5) improvement of facilities through refurbishing and provision of basic equipment
- 6) provision of contraceptive commodities
- 7) development of an improved logistical support system
- 8) provision of actual service delivery
- 9) supervision, data collection and evaluation

These are more or less associated with nine outputs. (For more detail, see pages 11-12 of the project agreement).

- 1) an effective management system
- 2) three training centers
- 3) curricula for medical and nursing schools
- 4) 200 trained family planning service providers
- 5) an improved and simplified service statistics system

- 6) IEC Material in French and one local language
- 7) effective systems of logistics and commodity reporting
- 8) 75 urban service sites with 15 satellite community-based programs
- 9) 250,000 new and 125,000 continuing acceptors

The project is carried out as the *Projet Nationale des Naissances Désirables* (PSND) with staff from the DSP and CNND. It is located in a free standing building on the grounds of Kintambo Maternity Hospital. The building includes administrative offices, a teaching center, a model clinic, a warehouse and a garage for project vehicles.

There was no mention of the physical location of the project, but the project agreement implies that the DSP staff would be physically located within the then existing headquarters of CNND. However, the proffered space was found to be insufficient so that the project was eventually located in separate facilities. This physical change had several administrative consequences. Other deviations from the project agreement include the establishment of a physical training center in Kinshasa and the recruitment of staff directly to the project.

For the most part, these changes are understandable consequences of conditions which were not foreseen at the time of project design and have led to a more clearly articulated project structure. However, there are three negative tendencies which concern the evaluation team:

- the duplication of efforts and structures;
- the weakening of the CNND and its ability to carry out its independent functions; and
- the long-term viability of the project structure independent of US government funding.

The consequences of these major observations will be developed in the analysis given below, and further addressed in the recommendations which follow at the end of each chapter.

II. ADMINISTRATION/STRUCTURE OF THE PROJECT

Observations

Overall Administration: The organization of the project was described in the project agreement, with the day-to-day operations to be carried out by a Project Management and Coordination Unit (UAPC). Overall policy guidance would be carried out by an expanded version of the UAPC, the Project Advisory Council (CCP) with membership also including interested allied organizations. The project agreement implied that the project would be administered by CNND systems that were already in place with the attachment of a limited number of DSP personnel. The director was to be supplied by DSP while the CNND would provide other senior staff and also provide administrative, management, training and supervisory support to the project. (p 13 of the project agreement)

Administration is actually carried out by the director and deputy directors. (See Appendix C for the organizational structure.) Each head of service prepares an annual workplan. This workplan is then reviewed and accepted by the UACP and submitted to AID and DSP for review. When adopted it serves as a basis for the activities of the coming year. The evaluation team found the reports to be comprehensive and timely. However, the report on activities accomplished in the annual work plan is not reported in the same format as the activities which had been planned for that period. Effective administration has been hampered by what the project staff views as a lack of clarity in the roles of the implementing organizations in the project agreement, a cumbersome implementation arrangement, and a lack of job descriptions. The actions of the UACP are also hampered by the non-availability of key staff members on a full-time basis.

The Project Advisory Council has met formally only one time (although it met once informally to review the findings by the pre-evaluation study group). Confusion was expressed by various members as to why the council had not met more frequently, including lack of clarity as to who calls the meetings. The one time it did meet, discussions were protracted because of the involvement of a large number of agencies (as specified in the project agreement) which were not familiar with the project. The team found that a lack of effective communication between CNND and DSP people is at the base of many of the problems observed within the project. (This is treated more fully in Section IX on Collaboration). The proper functioning of the Project Advisory Council (CCP) in project guidance would go far in eliminating these and other problems.

Since the January examination by the pre-evaluation study group, a great deal of time has been dedicated to clarifying roles, relationships and responsibilities. The resulting structure (shown in Appendix C) seems to be feasible and workable but needs to be adhered to. It is felt that further efforts to reorganize, other than to accommodate anticipated changes in technical assistance and consolidation of program efforts with ONND, are not warranted.

As this project evolves, effective management systems are still being developed and with the addition of more distant training centers and clinics, administrative difficulties are foreseen. Much also remains to be done in the programming and training divisions. To help shore up management, changes are proposed in the technical assistance supplied by AID. An agreement has been reached that AID will provide two technical assistants: one fulfilling the role of technical advisor, the other continuing as the Assistant Director for Administration. The latter position will be filled by a locally recruited expatriate. The team is concerned however that in order to increase the long term viability of the project, an appropriate Zairian candidate should be identified and brought along to fill this position in future years. Since the present contractor will leave in July 1985, this changeover will take place in October 1985. To incorporate these changes, a new organizational chart has been developed (See Appendix D) on which a technical advisor has no line authority, but will act as an advisor to the Programming, Administrative and Training Departments. The team is concerned that technical advisors without "line" authority will not be able to function effectively in the absence of the Director. In any event, care should be taken to detail job responsibilities so that there is no confusion as to the advisor's role in the UACP. A good line of communication should be established so that the advisor is kept current of the activities in each division.

Financial Administration Because of delays in start-up of the project and a slower rate of expenditures than was expected, the project is adequately financed. The team found the project to be well managed; that financial responsibilities are taken seriously, and that accepted financial practices have been established by the project managers. These procedures were reviewed at an early stage of the project by the USAID controller and suggestions were made and incorporated to improve cash flow. However, project director and deputies reported that they were spending too much time on financial matters which were not being adequately addressed by the project accounting staff. The study group that prepared the mid-term evaluation noted that the project could benefit from an external audit and suggested implementing a regular audit program.

Project staff commented on the delays in getting financial reports out when the half-time controller was preoccupied with other activities. Delays in financial reports were also observed by USAID project management.

At present the system of bookkeeping and accounting is a manual one, but a computer system is to be installed which could be made available for accounting and generation of financial reports. The team observed that financial reports were not included in the Annual Report for 1984 and that the audit suggested by the pre-evaluation study group has not been carried out.

The budget as actually executed in counterpart funds bears no relationship to the budget as described in the project agreement because of changes in the dollar/zaire exchange rate, greater availability of zaires for project activities, and activities that were not foreseen.

The team noted that the project itself was generating revenues through renting space, provision of clinical services and sale of project produced IEC materials. The project plans to track and program these revenues for additional project activities.

Personnel The project agreement anticipated personnel to be supplied from the DSP and the CNND, with the DSP supplying the project director and some other personnel. CNND would supply deputy directors for Program and Training, and other support staff. A bilingual secretary was to be hired using counterpart funds; no other outside staff were anticipated. As noted above, the administration was to have been incorporated into the existing system of CNND. However, the project agreement did not establish an organizational or functional relationship between the various personnel.

Several problems became apparent in the early months of the project. Management has expended considerable effort to resolve them. These may be listed as problems of:

- loyalties of seconded staff to their host organization rather than the project
- inequality in salaries and benefits of personnel from different host organizations
- part-time versus full-time schedules
- lack of personnel from collaborating agencies to fill certain positions
- need for clear lines of authority over project activities
- greater personnel needs than anticipated in the project agreement.

These personnel issues were identified as critical and led in part to the study group preparatory to the mid-term evaluation. Both prior to that and subsequently, the UACP is commended for having taken many steps to address these problems. These include sessions of motivation for all employees; addition of salary supplements to DSP salaries to bring them more in line with CNND salaries; addition of personnel to the project. Several proposals have been made for the elimination of part-time employees. The UACP has made perhaps its most significant contribution in establishing lines of authority, areas of responsibility and position descriptions. Nonetheless, several problems prevail and in some cases (as previously noted in the pre-evaluation study group report), attempted solutions may have aggravated old problems or created new ones. For example, attaching supplements to the salaries of DSP workers but not to CNND salaries has left CNND personnel dissatisfied.

The team did not observe inherent organizational and structural difficulties between full and part-time workers that cannot be resolved through correct performance of duties, adherence to a work schedule by the employee, and sensitive scheduling by management. The team also observed that hiring direct staff has led to the creation of yet a third category of workers, adding more institutional unclarity and disparity between classes of workers. This distinction may however concern team members more than PSND staff. The team was not sure of the legal basis for hiring project staff outside the LSP and notes that this may lead to the creation of an independent institution at the expense of long term institutionalization. Discussion with various individuals and organizations led to the conclusion that it would be possible to establish a framework which could promote more equality. Such a system would have to include steps toward parity of compensation, centralized personnel administration and salaries. However, it was also reported that salaries for CNND staff are based on private pay scales and vary considerably from government salaries. So a perfect parity would not be possible even for comparable work if the employees keep their host affiliation.

Recommendations

Overall Administration

It is recommended:

1. That the existing project mechanism, the UACP, be used more fully to correct problems which result from non-performance of duties or accretion of duties.
2. That (as recommended by the pre-evaluation study group) the Project Advisory Council (OCP) be reduced in size to two representatives of the three principal organizations; that it be called to meet no less often than four times per year; that the direction of the project be charged with calling the meetings and preparing the agenda, but that the CCP may

be called to an ad hoc session through the office of the director at the request of any constituent member; that one time each year, an expanded version of the Council, including the members listed in the project agreement, be held to review the annual report of the current year and to adopt the workplan for the following year.

3. That the annual workplan be revised so that each service is assigned specific responsibilities, particularly those detailed in the protocol with CNND.

4. That the format of the annual report be revised so that planned activities are listed exactly as contained in the workplan for the relevant year. Unplanned activities may be shown separately and explanations given as to why they were undertaken.

5. That the TA provided to the project be increased as proposed by the project to one technical advisor and one administrator. But that steps should be taken so that in future years, this latter post will be filled by an appropriate Zairian candidate.

Financial

1. That the project should be subject to an external audit.

2. That financial reports be included in the annual report and other periodic reports.

3. That appropriate steps be taken (acquisition of software, training, computer time) so that financial accounts and reports can be computer-generated.

Personnel

1. That the director have responsibility for supervision of all staff working in the project regardless of host institution; the director's responsibilities include review, disciplinary action and reassignment.

2. That any further reorganization be deferred until integration of new personnel has taken place; the technical advisor should have line authority; further changes should be made only to accommodate modified program functions.

3. That management be sensitive to the problem of inequality of benefits between classes of workers and that when possible salary and benefits should be brought into line.

4. That additional personnel needs should be met by seconding additional staff from CNND, DSP or other government agencies as opposed to hiring directly by the project.

III. CONTRACEPTIVE SUPPLY

Observations

As stated in the project agreement, contraceptive supply was to be the responsibility of the CNND. More precisely, at the central level, the CNND would be assigned the responsibility to plan, order, receive and warehouse all contraceptives and medical equipment; to deliver them to the various family planning units (DSP, CASOP, ECZ, training centers etc); and to maintain and monitor the general supply system. At the same time, the project document sets up a supply unit within the PSND to handle the internal logistics of contraceptives within the DSP health system and to renovate and refurbish selected health facilities providing family planning services.

Thus, the seed was planted for duplication of efforts and confusion of responsibilities. In order to execute its mandate, the PSND set up a supply unit with four agents, namely:

- A Chief of Service, part time from CNND.
- A Deputy Chief of Services, part time from DSP
- An Assistant, full time from DSP.
- A Stockroom Manager full time from DSP

A consultant has just been hired on a short-term basis to review procedures.

Three major problems can be identified in the central supply service:

1. The lack of sufficient personnel to carry out the numerous tasks and functions of the supply service. Besides its two main responsibilities, i.e., supply of contraceptives and medical equipment and renovation of family planning units, it has assumed numerous other responsibilities such as the administration of project vehicles; contract negotiations between PSND and family planning units; printing of various forms and technical documents; and supervision of the material and equipment of the project. This has severely stretched staff resources.
2. The two principal authorities (Chief and Deputy Chief of Service) work on a part time basis.
3. Departure from the allocation of responsibilities spelled out in the project agreement, especially the ordering of contraceptives and equipment which was initially attributed to CNND. CNND continues to order and stock IPPF-supplied contraceptives. However, all USAID contraceptives are ordered and stocked through PSND and housed in the PSND warehouse. It was intended in the project agreement that project commodities, although from a different source, would flow through existing CNND channels.

Duplication is lessened somewhat since the same person heads the supply service of CNND and PSND and similar documents are being used for CNND and PSND stock management.

It is also important to consider how contraceptive supplies will reach the family planning units outside Kinshasa. The family planning units of Bas Zaire, Bandundu and Kinshasa have thus far received one standard supply of contraceptives and medical equipment which was delivered directly to individual units by the PSND Supply Service.

At the present rate of development of the delivery of family planning services, all the units visited by the evaluation team have, in general, sufficient stocks of pills, injectables and barriers methods for at least one year. Condoms are not very popular and the initial stock of six thousand pieces is often still largely untouched. All the family planning units have received IUDs and insertion kits; however many of them do not have personnel trained in IUD insertion, therefore they do not insert IUDs. Some units still need to be supplied with adequate medical material such as examination tables and lights.

Since all family planning units are still well supplied with contraceptives, mechanisms to resupply the family planning units have not yet been put into operation. It is therefore impossible to estimate effectiveness of resupply procedures (see Appendix E). Only general observations can be made. There are however two potential problems in this domain.

1. The project paper recommended that money be collected for the contraceptive services and the sale of contraceptive supplies, but that it be used at the local level to defray the costs of operation of the family planning units. However, ONND has adopted the policy that the money be remitted to help defer the costs of contraceptives, so that family planning units will become self-sufficient in contraceptive supply. Forty percent of the money generated is currently programmed for resupply. At the clinic level, personnel are not sure what is to be done with the money they have collected.

2. Another problem is the early expiration date of oral contraceptives provided by AID/W through the central procurement system. USAID/Kinshasa has signaled this problem to AID/W and has made several attempts to ship the contraceptives to more active programs in other countries. It is clear to the team that at the low usage rate, contraceptives will have passed their expiration date prior to being needed. The team concluded that even though the physical efficacy of the pills might be established through testing, their utilization in the program will hamper its credibility.

Recommendations

It is recommended:

1. That the PSND supply service concentrate its efforts on the priority actions a) to manage and distribute contraceptives and equipment to

family planning units b) to identify and carry out renovations and refurbishing the family planning units. Other functions such as the administration of the cars and the printing of documents should be assigned to administration services.

2. That PSND should store, distribute, and manage contraceptives and equipment for the project, and eventually for the country as a whole as more units are brought into the project. Project facilities can be used to store contraceptives for units served by CNND. For the time being, each organization can continue with its own policy.

3. That the standard supply of contraceptives given to the units of pools two and three be adjusted according to the experience of pool one, especially with regard to condoms and IUDs.

4. That PSND withdraw IUDs from family planning units which do not provide IUD services and distribute them to clinics that do.

5. That stocks of contraceptives be established at a regional level in order to avoid any risk of contraceptive stockout. Where health zones are operational, the PSND could deliver to the zonal medical chief a stock of contraceptives for the family planning units of that zone. Where the health zone system is not yet operational, these stocks could be handled by the Regional Coordinator of CNND who works with the project.

6. That a certain flexibility in the supply service should be maintained. The existence of a regional and/or urban depot of contraceptives does not mean that all the family planning units must necessarily get their supply from that depot.

7. That procedures presently planned for the resupply of family planning units be simplified (See Appendix E). Reports on stock management, provided quarterly by the family planning units, should fulfill the requirements for re-supply.

8. Since contraceptives will be donated to the program for some time to come, that fees collected from provision of family planning commodities and services be reserved for use at the local level.

9. That AID/W replace expired contraceptives with new stock at no cost to the project.

IV. TRAINING

Observations

A number of training activities are planned:

- Basic training of 200 medical and paramedical personnel in contraceptive technology;
- Training of trainers for each of the three regional centers;
- Development of didactic and informational materials for the training centers;
- Development of curricula for the medical and nursing faculties;
- Training update for personnel already delivering family planning services
- Training of regional coordinators in management and supervision;
- Short and long-term training in reproductive health and in management outside of Zaire for personnel involved in the project.

To accomplish these activities the project relies on personnel from the CNND and the DSP. At the national level an Assistant Director for Training has been named from the CNND and an assistant from the DSP. Training activities are to be carried out in three regional training centers: Kinshasa, Lubumbashi, and Kisangani, each to be headed by a part time regional training director appointed by the CNND with contractual training staff recruited from the CNND and DSP personnel. The first training center has been established in Kinshasa with its own physical structure and an attached clinic. The Assistant Director is also Training Director and Center Director, thus filling three positions each originally programmed as three half time positions.

The first training of trainers (TOT) took place in Tunis in November 1983, through the Office National de Planning Familial et Population with support from JHPIEGO. Medical and administrative personnel, many of whom had received prior training (from Pathfinder, IPPF, JHPIEGO) were trained to serve as in-country trainers and facilitators. This core group, supplemented by additional health personnel, has been responsible for most of the project's in-country training. Over the course of four one-month training sessions, the first beginning in February 1984, seventy-three medical and paramedical personnel have received basic training in family planning. Sixty-three of these personnel are from Kinshasa, Bas-Zaire, and Bandundu, the regions comprising the first pool. Initiation of the training program was delayed approximately one year due to the need to develop training objectives and curriculum, the lack of contraceptives and clinical training facilities, and delays in counterpart fund releases.

A second TOT took place in early 1985 under the direction of the local training institution, CENACOF. These trainers subsequently trained ten persons from Lubumbashi who will serve as the core group of trainers for the second pool of regions (Shaba, Kasai-Oriental, Kasai-Occidental).

The training program is composed of a theoretical and a practical component. The theoretical part is divided into four modules: Philosophy of Family Planning, Contraceptive Technology, Communications and Management. (See attached syllabus, Appendix F). Up until this time, ordered didactic materials have been slow to arrive. Copies of lectures are given as reference documents. The practical training component is on a rotation basis in five clinics. This practicum centers around clinic activities and the trainees do not have any community experience.

Although there was not enough time to evaluate in detail the technical competence of the trained personnel (there were few family planning acceptors present during site visits) the program has a built-in evaluation component which consists of a pretest, post-test and the trainers' evaluation of each trainee's skills. The trainees also provide input as to their satisfaction with the program.

During the site visits, contact with recently trained personnel indicated that they were satisfied with the program and felt that they were competent to deliver family planning services. However, there was a desire by some to have a longer practicum so that they could work for a longer period under supervision and gain confidence in handling a variety of cases. It is felt that the length of the practical experience would be sufficient if clinic utilization was increased. This would give each trainee a sufficient number of acceptors to consult in the planned period. If a problem exceeds the competence of the nurse, the client is referred to the attending physician. All personnel expressed interest in continuing education activities (some requests are however clearly inappropriate) and in having regular technical supervision.

Preparations have begun to establish a second training center in Lubumbashi. This center will train the medical and paramedical personnel who will staff the family planning clinics in the regions of Shaba, Kasai Occidental and Kasai Oriental. The PSND is in the process of negotiating a suitable location for the program. No permanent physical structure is planned. Space will most likely be available from the university or the regional medical offices. On-site training activities are programmed to begin in January, 1986. A concern should be noted about the effectiveness of the practical training component if the number of family planning acceptors in Lubumbashi is as low as in other cities. Currently there are only four clinics providing family planning services. It is doubtful that there will be enough clients for each trainee to fulfill the clinical practical requirements.

Up until this time, energies have been devoted to developing the basic contraceptive technology curriculum. Little has been done to develop curricula for the medical and nursing schools, although this is another of the major objectives of the project. Further delay will mean an increased number of personnel who must receive basic contraceptive technology training in special postgraduate courses which entails additional financial and personnel resources for future programs.

Likewise, no systematic program has been instituted to identify training needs and to update skills of those personnel trained by the CNND in the late '70's and already delivering services although one retraining workshop was held in January 1985. Several PSND staff members and selected medical personnel have received short term training in management, surgical contraceptive techniques and IEC from JHPIEGO, CEDPA, INTRAH and Columbia University. The PSND has supported overseas training for all three of the regional coordinators - two at Columbia University and one at JHPIEGO. As yet no one has been sent outside of Zaire for long-term training—one of the major reasons is language skills in English.

Discussions confirmed that the first phase of the programmed utilization of the Kinshasa training center for basic training of medical and paramedical personnel is almost complete. However, if the project and possible follow-on projects are going to increase coverage to include all urban health facilities providing family planning services, a long-term need for basic training of numerous medical and paramedical personnel will exist. Moreover the need for continuing education is ever present. Future use of the center and its clinic to train personnel in new contraceptive techniques and research is planned. Likewise, informational sessions for allied health personnel, community service organizations, and policy makers in the realm of family planning will be needed. Presently the center is used only 40% of the time for actual training so that space for other training activities exists if personnel and other resources are available. Besides providing space for its own training activities, it can generate income through renting space. This means of support has already been initiated with activities of SANRU.

The number of staff appointed to design and carry out all aspects of the training program is insufficient. For example, one individual is currently occupying three key roles. Elaboration and execution of each of the different training programs require additional personnel and material resources. Additional personnel could be requested from participating agencies; short term consultants can be drawn upon as needed.

Recommendations

It is recommended:

1. That a checklist of clinical practical requirements be given to each trainee to ensure that he or she is exposed to a variety of situations and has the necessary skills to complete their assigned tasks with competence.
2. That needed didactic and informational materials be acquired and adapted as soon as possible so that the training will be more effective.

3. That a system of continuing education for trained personnel be established through regular update newsletters, pamphlets, and seminars.

4. That a follow-up evaluation of each trainee's expertise take place six months after the training. This evaluation can pinpoint programmatic weaknesses and indicate continuing educational needs.

5. That a study be made of the utilization level of the existing family planning clinics in the Lubumbashi area to ensure an adequate number of acceptors available during the practicum. If there are not acceptable utilization levels, training should be scheduled in Kinshasa.

6. That at least two nurses from each health center and their immediate supervising physician be trained so that there is less risk of interruption of services in the absence of one nurse.

7. That the curriculum for medical and nursing students be developed and have the appropriate didactic materials and equipment available for the 1986-87 school year.

8. That ONND plan in its upcoming budget to hire a second staff member to be the director of the training center in Kinshasa, as planned in the project agreement.

9. That additional personnel needs be identified and that negotiations take place on how these needs will be met. Advantage should be taken of short-term and external consultants for tasks which need an expertise not easily available in-country.

V. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Observations

No specific IEC goals and strategies were included in the project document. The project was based on the assumption that sufficient demand for family planning services was present and thus the priority was to provide services to meet this demand. However, in the clinics visited, low utilization of family planning was observed. A definite need for an effective IEC program exists at all levels to explain to government officials, traditional leaders, business enterprises, community organizations and the people the benefits of family planning, respond to their questions, advise as to the accessibility of family planning services and motivate couples to become family planning acceptors. The usefulness of an aggressive IEC component is shown by the increase in the number of family planning acceptors in the Libota Lilamu training center clinic in Kinshasa after a community education campaign in March, 1985. The number of new acceptors increased from 53 in March to 107 in April.

Actual IEC is limited in scope. Site visits determined that IEC sessions for family planning are most often held in the clinic during prenatal, contraceptive and well-baby consultations. The frequency of these sessions is once or twice a week, however in some clinics they are as infrequent as monthly. Participation varies between 20 and 50 women with sessions lasting about 30 minutes. Lack of space contributes to the fact that there has been no effort to divide the participants into smaller groups for effective interpersonal contact and group discussion. The sessions are held either in a large multipurpose room, in the examination room or in the hallway. Individual motivational sessions are held when a woman comes for more detailed information or when she is ready to accept a method.

At the clinics, motivational sessions seem to emphasize the different methods available; personnel felt that women were already motivated to accept family planning since they appear at the clinic. Thus education sessions may put the accent on inappropriate themes. Research should be carried out to clearly determine the level of motivation of the population and barriers to contraceptive use.

In most clinics there were no IEC materials. Most often the walls were bare of any type of visual aid. Evidence that family planning services were offered was lacking or very inconspicuous. No red triangle logos which indicate the availability of family planning services were in evidence. The personnel are conscious of the usefulness of visual aids and are interested in receiving any that are available. Two clinics had copies of a simple flip chart produced by the ONND. The designs were stenciled on durable cardboard, but were not very large and may be difficult for women to understand because they were not colored. Easy to use visual aids which can be distributed to each family planning service are greatly needed. The PSND has just developed some such visual aid materials which it has pretested and is putting into production.

Little has been done to prepare the community to receive these family planning services and advise them that contraception is now available. In some cities, motivated clinic personnel are beginning this process. In four clinics, personnel are taking initiatives to reach potential acceptors. In Kinshasa, the nurses at the training center clinic go into the neighborhood to motivate the women. In another city a plan to educate men about family planning through companies which provide health services, including family planning for workers and their families is in place. One clinic is making arrangements to have community meetings and another is integrating a small community motivation program for family planning started by a protestant church. Thus the personnel are conscious of the need for IEC and are taking initiatives to go outside the clinic.

Research to determine motivation, appropriate messages, media and cultural sensitivities is essential. Preliminary work has been done by a joint commission of CNND/PSND/SANRU/PCS during a Family Planning Communication Study carried out in December, 1983. Also Tulane University will carry out a KAP study in the Kintambo section of Kinshasa, which is served by the training center clinic. Such studies will contribute to the general understanding of the community and the identification of barriers to family planning.

Recommendations

The evaluation team feels that having an IEC component at both the CNND and the PSND is a duplication of effort. Advantage should be taken of the CNND's long experience in IEC to have it develop a comprehensive IEC strategy, and to develop, produce and distribute materials. Therefore it is recommended:

1. That the IEC component of the PSND be incorporated into that of the CNND. Specific needs will be developed by PSND subject to the agreement or the arrival protocol.
2. That materials be designed and produced by CNND. These include logos and short technical documents which summarize contra-indications and side effects of family planning methods. PSND should make sure that each family planning unit is adequately stocked to carry out its own IEC program. In designing the materials, literary level, cultural sensitivity and ability of the audience to recognize symbols should be taken into account.
3. That the CNND organize its cadre of volunteers as a resource for community education in support of family planning as new communities are included in the project.
4. That community-based initiatives of health personnel be encouraged materially and technically.

5. That the IEC program be evaluated periodically to ascertain its appropriateness.

6. That short training sessions be held for clinic personnel to improve their communications skills and to demonstrate the use of the IEC materials developed for the clinics.

VI. FAMILY PLANNING SERVICES

Observations

The objective of the project is to provide by 1987 family planning services in 75 health facilities in 14 cities and to enroll 250,000 new family planning acceptors among which 125,000 who will be regular users of modern contraceptive methods, i.e., representing a contraceptive prevalence rate (CPR) of 12 percent among urban women 15-49.*

Facilities: So far, 33 governmental, military, industrial and church hospitals, clinics and dispensaries have been enrolled in the project to deliver family planning services in the urban setting of Kinshasa, Bas-Zaire and Bandundu. The selection of the health facilities offering family planning services is primarily the result of individual field visits by the project staff of the PSND to each individual clinic. The clinic then has to meet specific criteria to be enrolled in the project (See Appendix G).

Staff: A physician and usually one or two nurses (A1-A2-A3 levels) from the hospital or clinic are trained for one month by the PSND to form the team providing family planning services in their home facility. These individuals may have been trained previously by the ONND. The nurse, sometimes with the help of an assistant is responsible for providing the bulk of family planning information, counseling, and contraceptive services to clients as well as maintaining family planning patients and contraceptives supply records. Supervision, management and medical back-up fall under the responsibility of the physicians in charge of the unit.

Service Delivery: Family planning methods are either available on a daily basis, upon client demand, or by appointment as in the region of Bas-Zaire, or scheduled once a week as in the case of Bandundu. In Kinshasa, some clinics were open every day (two visited by the team); others from one to three days per week. New acceptors receive explanations of the type of methods available and related information such as appropriateness, use and side effects. A health history is taken; physical exams and laboratory tests are provided. The results are recorded on a well-designed individual medical form. Even though some clinics designate only one day per week for family planning, current users are resupplied throughout the week.

*The team noted an inconsistency in this objective. A recalculation of the CPR based on the figures given in the project agreement produces a CPR of 18%, with 250,000 users or 185,000 new acceptors to attain a CPR of 12 percent. It is the conclusion of the team that neither of these two figures will be approached.

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All facilities provide pills, injectables, condoms, vaginal foam and tablets. Some provide IUD insertion and even female sterilization.

Based on statistical data presented in a PSND 1984 report, the distribution of new acceptors by method is:

Pill	Injectable	Barrier	IUD	Sterilization
48.3	25.2	14.8	8.3	3.2

Payment for clinic services varies. For some clinics, such as those run by companies, consultations are free. With the government's emphasis on self-financing of public clinics, the acceptor is asked to pay 10 Z (\$.20) for the consultation and 5 Z (\$.10) for the medical form. Payment for contraceptives varies according to the method: 5Z (\$.10) for a cycle of pills, 15 Z (\$.30) for an injectable, 30 Z (\$.60) for an IUD and 5 Z for 20 condoms.

Quantitative Achievement: Statistical data for 1984 can give an idea of current demand for family planning services. Once again, one must note that some of these centers have been operational for only a few months.

Estimate of FP Users in PSND Units-1984

Region	Number of Units included in Project	Number of Units Reporting	Acceptors		
			New	Old	Total
Kinshasa	10	5	215	69	284
Bandandu	10	5	403	547	950
Bas Zaire	11	6	586	287	873
Kisangani	2	2	222	118	340
TOTAL	33	18	1426	1021	2447

Source: PSND Statistical Report 1984

Users for 18 of the reporting family planning units total 2447, for an average of 136 total acceptors per PSND clinic.

In the most generalizable hypothesis (i.e., if one considers that those units which have not reported statistical data have achieved the same level of performance as those units which did) the total number of family planning users would be:

$$\frac{2447 \times 33}{18} = 4486 \text{ users}$$

In 1984, the total population of the urban areas covered under the project was about 4,500,000, therefore, the target population of women aged 15 to 49 is about 810,000 (18% of the total population). Contraceptive prevalence achieved by project activities is therefore estimated at:

$$\frac{4,486 \times 100}{810,000} = 0.58$$

Contraceptive prevalence should be measured by all sources and not only by service statistics, so that the result shown above is surely an underestimate of prevalence from all sources.

The most striking observation in regard to family planning services is the low level of acceptance in PSND clinics. Although there is an indisputable need for contraceptive services as witnessed by the large number of illegal abortions and abandoned children, the awareness of the population concerning the availability, location, and safety of modern contraceptive methods seems to be negligible. The impact of IEC activities conducted by the CNND has not created a wide demand, and much more effort has to be made in order to identify and overcome the cultural, traditional, religious and legal barriers which limit access to contraception. Within the project itself, several constraints can be identified:

- the limited number of service delivery outlets;
- the selection of some units which do not provide statistical data, and may or may not provide family planning services;
- the restrictive eligibility criteria which in some cases limit access to married women, making it very difficult, if not impossible for a sizeable proportion of those in need (divorced and unmarried women, teenagers, and women without their husband's permission) to have access to contraceptive services (This may be offset somewhat by lax enforcement of the criteria.);
- the lack of community-based activities;
- the lack of follow-up of family planning acceptors resulting in poor continuation rates;
- and the relative "isolation" of family planning, not yet fully perceived by the medical community as being an integrated component of a comprehensive health service.

The team observed that IEC activities should be more closely linked to services. A program of seminars could be undertaken to prepare communities for expansion of family planning activities. Prior to beginning project activities, the PSND and the Regional Committee of the ONND could organize a one week seminar in the medical zone/region for the DSP regional authorities. Such seminars would explain the overall objectives of the project and seek practical support and identify ways to collaborate with the authorities. This collaboration would be especially important in the selection of future family planning units and in their medical supervision. It would also insure a stronger commitment from the medical community for the project. Further, interest in such activities has been expressed by the medical directors of the urban zone and General Hospital of Kikwit and Bas-Zaire. Such seminars could begin in these two regions within the next three months.

The team observed that even in units where persons had already been trained and contraceptives supplied, problems with facilities and supervision exist. It is not enough simply to declare the unit open, but project resources need to be directed toward establishing quality services and high continuation rates.

Recommendations

It is recommended:

1. That eligibility criteria for family planning services be reviewed so that these services are easily accessible to all women.
2. That health personnel be encouraged to conduct family planning information/motivation sessions via community, political or voluntary organization channels (e.g. youth groups, women's associations, Lions or Rotary Clubs). Family planning nurses should use the bicycles given by the project for community activities such as neighborhood meetings and home visits to family planning acceptors who do not come for followup visits.
3. That norms and standards for contraceptive use (being elaborated by the PSND) be published as soon as possible and distributed to the medical and paramedical community involved in family planning service delivery.
4. That project development take place by making services available in a larger number of health facilities in one city before moving to additional cities. (In one city only 4 out of 27 health facilities offered family planning services).
5. That the ONND cooperate with PSND to carry out seminars with the medical community in a region prior to inaugurating family planning programs.

VII. SUPERVISION

Observations

The Project Agreement clearly defines the responsibilities of each institution with regard to the supervision of project activities.

A supervisory unit at the national level was to be established within the PSND under the Program Division. Staff support was to be provided by the CNND and the DSP with technical support from the CNND medical advisory committee and a statistician. Major responsibilities of the supervision unit as outlined in the project agreement are to:

- establish standards for service delivery
- develop a supervision protocol
- assist regional coordinators through periodic visits
- develop a standard system of service statistics
- gather service statistics
- evaluate project activities
- inform and involve regional medical inspectors in the project
- promote internal DSP medical supervision
- facilitate CNND supervision
- supervise family planning units in Kinshasa.

Currently the PSND supervision unit is lacking adequate staff to undertake all of the responsibilities outlined in the project agreement. The two assistants have left without being replaced and the chief of supervision is on temporary leave. Meanwhile, other PSND divisions are attempting to take up the slack until the unit is operating. Candidates have been identified to fill the two assistant positions.

Unfortunately, supervision is not yet done routinely and is not as effective or as helpful as desired. Most PSND family planning units have been functioning for less than a year and the system for field supervision is still evolving. At the regional level, supervision should be assured by the CNND and CRND regional affiliates. Up until this time, most often multipurpose teams from PSND including the CRND have visited the units. Supervision was not emphasized because the agenda included a variety of activities. However, the project recently developed a protocol which should help in guiding the supervisors. (Attached at Appendix G)

To facilitate supervision PSND provided each CRND coordinator with a vehicle. (Fuel and operating costs are to be provided from the CNND budget). Unfortunately, the vehicle for Bas-Zaire was destroyed in an accident. The coordinator for the Bandundu region does not have funds available for fuel. Thus, neither of the coordinators is likely to meet the programmed number of supervisory visits (five per year).

Procedures for supervision have to be clearly spelled out and enforced. For example, if the vehicle in Bas-Zaire is replaced, all relevant persons should understand who is authorized to use the vehicle, for what reasons and where. Regional health authorities and the CNND can assist the coordinator in applying the regulations and lessen the risk of any misunderstandings or abuse. A percentage of the money collected from clients should be designated for fuel and per diem as needed by the regional coordinator to fulfill his responsibilities. Given the current low-rate of acceptors, further financial support from the PSND and the CNND may be necessary.

In addition to the logistical problem of having to cover large geographic areas with seriously underdeveloped road systems, regional coordinators have a variety of other responsibilities including training, administration, commodity and equipment supply. Also, technical supervision is impossible in regions where the coordinator does not have any type of health background.

At the unit level, all participating health facilities are responsible for their own supervision. The evaluation team observed that supervision within the family planning units varied considerably depending on the motivation of the physician in charge. Kinshasa nurses reported that they had adequate medical backup within their clinics, but would appreciate more help with record keeping and statistical data. In Kinshasa, the chief of supervision is directly responsible for the supervision of the family planning units, however the team found that of the four units visited, a total of one or two supervisory visits each since the beginning of the project were reported.

In regions where the supervision system is independent from the DSP, smooth and rapid integration of family planning activities into the existing DSP network is difficult. The degree to which existing DSP regional and local health authorities are underutilized as a resource for supervision was evident to the evaluation team.

The regional health office (headed by the regional medical inspector) expects to receive sufficient resources to be involved in supervision of family planning activities along with other health services. This involvement could be developed at several levels—training, joint planning and reporting, and supervision.

It was clear that regional teams varied in experience and willingness to carry out supervision. Particular needs exist at the regional and local level to improve administration and management, not only amongst coordinators but also amongst physicians who provide medical backup to family planning units.

Recommendations

In order to improve supervision, it is recommended:

1. That the two empty slots in the centralized supervision team be filled as soon as possible.
2. That scheduled supervisory activities be established to include an active use of the protocol for supervision of family planning units. Supervisory visits to the field by PSND staff should focus on strengthening existing supervisory mechanisms at the regional and local levels. Once the local supervision team is operational, one supervisory visit per year to the field by the PSND should suffice.
3. That supervisors be identified and trained for each family unit in the PSND project areas.
4. That the PSND accelerate its efforts to train doctors who have responsibility for medical supervision within the health zones; that the PSND attempt to better integrate supervision of family planning activities into the existing DSP structure; and that the PSND should attempt to incorporate statistical reporting on family planning into the existing reporting system.
5. Where the DSP has not established health zones, that the coordinator and PSND provide more intensive supervision and seek to identify ways in which the existing health structure and personnel may be utilized for closer supervision.
6. That PSND funded training of coordinators and physicians responsible for family planning include a more extensive curriculum in administration and management.

VIII. STATISTICS AND RESEARCH

Observations

Service Statistics

According to the project agreement, the CRND was to be in charge of developing a simple standardized system of service statistics and to gather and analyze statistical information. However, in 1984, the PSND recruited a statistician and set up its own service statistics. Various data collection forms were developed (clinical record form for acceptors, clinic registry, quarterly report forms and appointment cards) as well as instruction manuals. Although the data collection system is standardized for all family planning units (PSND and CRND), each organization processes only those data generated from its own facilities. There appears to be no consolidation and analysis of all family planning data at the national level, hence, no report exists that encompasses all family planning activities in Zaire. (If it does exist, no one has received a copy.)

In the field, personnel have different interpretations of new and old acceptors and visits. Thus, no guarantee exists of consistency between data gathered in different family planning units. What is recorded under "visit" is very confusing and of questionable interest. (Informational visit, programmed visit, never made visit, first visit of the year, other visits...). On the other hand, no data are collected which could be used to calculate discontinuation rates or rates of contraceptive failure.

Filling out reports is too often considered to be cumbersome, thus only about half of the family planning units of the project have sent statistical reports for 1984. Reports from family planning units are sometimes gathered by the CRND. The family planning unit provides three copies of its monthly report, two of which are sent to the CRND who report to the CRND and the PSND on a quarterly basis. However, some family planning units send their reports directly to the PSND. Sometimes the family planning unit does not retain a report for its own files. To date, there has been no consolidation and analysis of the data; thus no feedback to the field is possible. No copy of the family planning reports is sent to the regional medical inspector. To sum up, statistical data are incomplete, unreliable and of little use for planning, programming, evaluation and management purposes.

Research

The DSP has recently signed an agreement to undertake collaborative research with Tulane University. A Knowledge, Attitude and Practice type of survey of approximately 1500 women, age 15-49 is presently being carried out in the area of Kintambo of Kinshasa around the Libota Lilamu Center. The two major objectives of this study are (1) to give the PSND staff on the job training in methodology and in the practice of applied research techniques; and (2) to gather baseline data on attitude, knowledge,

practice and other contraceptive related issues. This study should aid the center in its community activities. Two other projects related to community based distribution are envisaged, one in the Kasai Oriental region and another in an area still to be decided upon.

Recommendations

It is recommended:

1. That the statistical system be reviewed, especially the definition of terms, upon the return of the PSND statistician now being trained at Columbia University. A clear, understandable and internationally acceptable definition should be given for acceptors, and simplification made to clarify the number and type of visits to be recorded.
2. That training of field personnel be reinforced in data recording and proper understanding of stated definitions, in order to insure coherence and consistency amongst data collected from different family planning units.
3. That a feedback information system be built into the service statistics.
4. That the medical authorities at all levels receive periodic family planning reports.
5. That the family planning units themselves be supplied with a sufficient number of blank report forms and retain one copy of the completed forms for their own files.
6. That resources of the PSND - especially the computer - be utilized to centralize and analyze all family planning data at the national level by CNND.
7. That future research focus on two salient areas:
 - Continuation rates, side effects, contraceptive failures, etc... of different methods.
 - Barriers to contraception. (Sociological, economic, medical, traditional, religious, political, logistical, etc.).

IX. COLLABORATION WITH OTHER INSTITUTIONS

Observations

Collaboration has not been a strong point of the project. DSP and CNND were meant to and are cooperating in the field of family planning through an AID-financed project. Administration and coordination of project activities were to have come from the CNND. However, in the evolution of the project, the PSND has come to resemble an "institution" that coordinates its own full program of activities more than a "project". Thus duplication of activities occur in the following areas:

- provision of contraceptive supplies
- IEC
- statistics
- training
- supervision of field workers

and in each case, duplicative structures have been developed to carry out these functions.

Both project staff and CNND have expressed their concern about the type of collaboration which exists. The PSND has evolved into a structure with considerable autonomy within the DSP, absorbing many of the functions and staff of CNND. CNND has meanwhile seen its independent role diminished.

The major complaints have been noted by many earlier reports and hinge on lack of coordination of efforts within the overall rubric of "naissances desirables". The PSND has the financing and government backing while the CNND has the mandate for coordination, the history and field experience, and the support of IPPF. The team feels that the unproductive climate between the two institutions which has led to reduced emphasis on services and too much emphasis on administrative and bureaucratic maneuvering negates the great potential of the project.

The team did not evaluate the program of CNND. Nonetheless, the team would like to express the conclusion that the interests of family planning in Zaire as well as the eventual success of the AID-financed project depend upon a resolution of these collaborative issues in such a way as to eliminate duplication of structures and to produce a strong and independent CNND with a narrower and more focused program. Decisive steps must be taken so that activities and energies can be directed toward improving access to and the quality of family planning services in the country. The CNND has a significant role to play, in the areas of population policy, public awareness (through its volunteer network), IEC

for all target groups, coordination of population activities, developing pilot programs, and program development in areas not served by the project. One of its unique features is its independence from government; it should remain free from government control. However, it should be remembered that it has institutional responsibilities to collaborate in national programs.

Collaboration between the two entities at the regional level also poses some problems. As the project document was written, the project was to take advantage of existing networks and fill the gaps. However, the regional health and population infrastructures are in transition and have changed considerably since the time of the project design. The project document did not anticipate the development of the urban health zone structure and assumed a more fully developed system of CRND regional networks than exists. However, experience leads the team to conclude that more cooperation is needed between the CRND staff coordinators and the existing health system. Further, the role of the regional president should be reduced vis-à-vis project activities. (More specificity is given in the above section on Supervision).

Outside the two principal organizations directly collaborating in the project, the project also coordinates with the AID-funded SANRU Rural Health Project and UNFPA. For SANRU, which is supporting the delivery of Primary Health Care supervision in 50 rural health zones, training and contraceptives are included. Contraceptives are supplied through SANRU project channels. Training for medical personnel has been provided by JHPIEGO in collaboration with the PSND and CNND to everyone's satisfaction. In the follow-up project to SANRU, the family planning element will continue to be reinforced through collaboration with the PSND project.

The UNFPA is anticipating funding a \$1,200,000 integrated MCH/FP project beginning perhaps as early as September 1985 in ten rural zones (two of which are also included within the SANRU project). There has not been much collaboration between USAID and UNFPA to date, although communications channels are open. Both organizations are represented on the expanded Project Advisory Council. Important elements for collaboration between the PSND and the UNFPA projects are evident, notably in training and supply of contraceptive commodities.

Recommendations

It is recommended:

1. That the PSND activities carried out by the CNND be subject to a protocol negotiated between DSP and CNND; and that sufficient project resources be allocated to CNND to carry out the workplan. The protocol should be submitted to the UACP by CNND; should have a well-documented budget, a calendar of activities and should indicate staffing needs to cover CNND activities as well as CNND staff contributions to PSND.

Project sponsored activities should be shown in the context of the overall CNND workplan. The protocol agreed to by CNND and PSND should form the basis for collaboration on all project activities. This protocol should be reviewed annually to reflect changes in project scope.

2. That adjustments within the project and CNND take place to consolidate functions:

--to locate all contraceptive commodities in the PSND with one warehouse manager, one system of supply and two sources of materials (IPPF and AID);

--that training activities continue as present, with CNND staff working through the project mechanism to carry out training programs.

--that technical training programs, baseline training, clinic management, contraceptive techniques, and re-training take place at PSND through the project. But that seminars, roundtables, and other awareness raising activities be included in the CNND mandate for non-project funding. Some training activities which border on training and awareness raising should take place in common. For example, the proposed inauguration seminars prior to initiating project activities in new places should be a joint activity of CNND and PSND with financing through the project under the rubric of "naissances désirables". (See section V)

--that the development of revised medical and health training curriculum be carried out by CNND. This activity may require outside technical resources; if so, they should be directed to CNND. This activity should be part of the protocol.

--that the supervisory function be decentralized. That supervision in the regions be taken over by the coordinator of naissances désirables (whose salary is paid by CNND) with the close collaboration of the regional health offices.

--that activities in the IEC section carried out by the project should be implemented by CNND with support of the project. There should be a unified IEC structure for the country with two sources of funding, PSND for project activities and IPPF (with perhaps outside agencies such as PCS contributing also) for activities in the field of development of materials for motivation at the clinic level, visual aids and mass media campaigns. The project-financed activities should complement IEC activities sponsored by IPPF and should be the subject of the protocol. The IEC section of CNND should be reinforced with adequate material and human resources to carry out the program and should be the entry point for technical assistance. The IEC unit within the headquarters of PSND should be eliminated and existing personnel should be reassigned to CNND, if possible.

--The statistical function continue as at present with CNND and PSND compiling service statistics on the units they serve. The data processing should be identical; resources, especially computers and software should be shared. An annual document should be prepared by the CNND reflecting data of the two services under the rubric "Naissances Désirables au Zaire". It should be transmitted to the Minister of Public Health and given widespread dissemination.

In addition to the program steps mentioned above, the evaluation team recommends the following:

3. That in order to avoid confusion among the public, wherever possible, reports and documents on population and family health issues be issued under the rubric of "Naissances Désirables" with both PSND and CNND logos in minor positions; that posters and fiches indicating services sites indicate only "Naissances Désirables".
4. That a representative of the DSP be invited as an observer to the Executive Committee of the CNND, that the director of PSND or designate be invited to all meetings and participate in other ways to help plan CNND activities. Further DSP staff members are urged to participate in the CNND as volunteers.
5. That all parties be invited to come together to work out these difficulties in a constructive atmosphere. If these actions are not successful in reducing tension, then USAID should work directly with CNND and PSND to separate project activities.
6. That there be closer donor coordination in the field of family planning; specifically that USAID and project staff work more closely with UNFPA as it begins project implementation to avoid duplication of efforts.

X. PERSPECTIVES FOR THE FUTURE

Financial and Institutional Viability of Project Activities

The PSND should not develop as an institution in and of itself although tendencies in that direction have been noted. The project was developed in order to reinforce family planning services in urban settings through channels which already existed. The project, because of its limited life span and of the definition of its role, is to be merged at some point into a national family planning program, institutionalized within the health structures of the country.

While the final evaluation of the project should decide the form and modalities of further AID support, it seems evident to the evaluation team that the need for further assistance beyond 1987 cannot be challenged. Because of the various technical and administrative difficulties encountered at the beginning of the project, important delays have occurred in implementation. Therefore the evaluation team recommends that USAID continue to assist family planning in Zaire for another five years after this project.

In the short-term the recommendations of this report should be adopted to avoid duplication that is wasteful of financial and human resources. If the two collaborating agencies cannot work in harmony along the lines indicated, then AID should work with each of them to redesign the program to separate the activities. It will probably be necessary to extend the life of the project for a period of two to three years to help make up for the delays already experienced in the project implementation. However, the team does not perceive that this is a priority until collaborative arrangements are smoothed out or other arrangements made.

In terms of project implementation, the team thinks that activities are expanding quickly in geographical areas, perhaps more quickly than is appropriate, given the need for adequate training and community outreach. The team would prefer to see more quality control in the services provided, more supervision and data collection than an expansion to meet the target goals. The team would also like to see the project incorporate training, contraceptive commodities, and supervision for all of the family planning units in the project cities as a step toward eliminating duplication and a move toward program consolidation.

It is clear that, over the longer term, the program must be incorporated into the existing health care systems, and should not continue as a project. In order to prepare for the organization of a national family planning program, the government should take the necessary legal, financial, administrative and technical steps to integrate family planning services within its primary health care policy including assigning clear administrative responsibilities for family planning.

A budgetary commitment should eventually be made by the DSP in order to cover family planning recurrent costs in areas such as training, supervision, administration, statistical analysis, supply services, etc. External donors could then supplement governmental funds in specific costs (equipment, logistics, contraceptive commodities, research, etc), as well as provide financial and technical assistance to the QND whose role will continue to be of paramount importance in population policy development and general information and motivation of various target groups. The ordinary budgetary commitment to project activities by the DSP should begin now.

Short-term assistance is still needed in specific areas: especially IEC, statistics and operations research. Initial efforts to get these activities underway have been attempted but these are less than vigorous because of the lack of technical expertise and materials. Short-term technical assistance has already been provided by JHPIEGO to supplement local facilitators during the training program. Needs assessments in the areas of training and IEC were completed by INTRAH and Population Communication Services respectively and Tulane University is working with the PSND to elaborate an operations research component.

COMPOSITION OF EVALUATION TEAM

THE EVALUATION TEAM WILL BE COMPOSED OF: THE REDSO/WCA POPULATION OFFICER (TEAM LEADER); TWO OUTSIDE CONSULTANTS WITH EXPERTISE IN FAMILY PLANNING PROGRAMMING AND SERVICE DELIVERY IN PROJECTS OF THIS NATURE; A REPRESENTATIVE OF THE GOVERNMENT OF ZAIRE'S MINISTRY OF PUBLIC HEALTH; AND A REPRESENTATIVE OF THE ASSOCIATION ZAIROISE POUR LE BIEN-ETRE FAMILIAL.

IV. SCOPE OF WORK

UNDER THE SUPERVISION OF THE TEAM LEADER THE EVALUATION TEAM WILL:

A. ASSESS THE EFFECTIVENESS OF THE PROJECT'S ORGANIZATIONAL STRUCTURE WITH RESPECT TO PROJECT MANAGEMENT AND COLLABORATION BETWEEN PARTICIPATING INSTITUTIONS;

B. EXAMINE THE APPROPRIATENESS OF THE ROLE PLAYED BY THE LONG-TERM TECHNICAL ASSISTANCE FURNISHED UNDER THE PROJECT AND DETERMINE WHETHER MORE OR LESS TA IS NEEDED;

C. EVALUATE PROJECT IMPLEMENTATION TO DATE WITH RESPECT TO:

-1. MANAGEMENT (PROGRAM PLANNING AND ADMINISTRATION, BUDGET, FINANCIAL RECORDS, LEGAL, PERSONNEL).

-2. COMMODITY PROCUREMENT AND DISTRIBUTION, AND PROCEDURES FOR REFURBISHING FAMILY PLANNING UNITS

-3. TRAINING, CURRICULUM DEVELOPMENT, IEC, AND THE CREATION OF TRAINING CENTERS

4. PROVISION OF FAMILY PLANNING SERVICES

-5. SUPERVISION AND OVERSIGHT OF PARTICIPATING INSTITUTIONS AND THE DEVELOPMENT OF MEDICAL STANDARDS

6. THE COMPILATION AND UTILIZATION OF STATISTICS

EVALUATION WITH RELATED PROJECTS AND PROGRAMS

. ASSESS THE PROSPECTS FOR THE FINANCIAL AND INSTITUTIONAL (TECHNICAL, MANAGERIAL) SUSTAINABILITY OF PROJECT ACTIVITIES UPON THE COMPLETION OF USAID ASSISTANCE; PROJECT ACTIVITIES UPON THE COMPLETION OF USAID ASSISTANCE;

F. MAKE SPECIFIC RECOMMENDATIONS FOR ANY REDESIGN OF THE PROJECT WHICH WOULD ENHANCE THE PROSPECTS FOR PROJECT SUCCESS. WHERE APPROPRIATE, THE EVALUATION REPORT SHOULD INCLUDE A DISCUSSION OF LESSONS LEARNED TO FACILITATE AND IMPROVE FUTURE USAID FAMILY PLANNING ACTIVITIES.

V. REPORTS

THREE DAYS BEFORE THE SCHEDULED END OF THE EVALUATION THE TEAM LEADER WILL SUBMIT FOR MISSION REVIEW A DRAFT EVALUATION REPORT DETAILING THE TEAM'S FINDINGS AND RECOMMENDATIONS. A FINAL DRAFT, INCLUDING AN EXECUTIVE SUMMARY THAT CONFORMS TO AID/W GUIDELINES, WILL BE SUBMITTED TO USAID PRIOR TO THE TEAM LEADER'S DEPARTURE FROM ZAIRE.-

SCOPE OF WORK FOR POPULATION SECTOR ASSESSMENT WILL BE PROVIDED SFPTEL. FERRITER

BT

#5317.

NNNN-

PROTOCOLE POUR LE TERRAIN.-

1 - ADMINISTRATION

- Qui dirige le projet ?
- Quelle est la structure administrative ?
- Quelles sont les relations entre les partenaires du projet (CRND, DSP Missionnaires, industrie etc) vis-à-vis des unités de prestation de service (PSND) ?
- Qui gère le projet PSND au niveau régional ?
- Zone de santé - quelle est son influence sur la coordination du PSND
- Quel est le degré d'intégration du PSND dans les services de santé ?
- Rapports d'activités : par unité et par région (CRND) (exemplaire)
- Quelle est la compilation et l'utilisation des statistiques ?
- Y-a-t-il un plan d'action d'activités, soit transmis par PSND central soit élaboré sur place. Y-a-t-il transmission d'objectifs nationaux aux régions ?
- Quelles sont les relations entre les responsables régionaux du PSND et le niveau central ? (réunions, instructions, transmission des rapports)
- Aspect financier, source de financement (ventes de contraceptifs, services, projet), ventilation par rubrique, dépense effectuée jusqu'ici. Rapport financier.

2 - APPROVISIONNEMENT

- Qui est responsable de l'approvisionnement (temps plein, partiel etc..)
 - Commande
 - Réception
 - Stockage
 - Distribution
- Méthode d'approvisionnement (contraceptifs et équipement médical)
 - modalité de la commande (trimestriel, semestriel etc)
 - satisfaction de demande (suffisance, délai de l'approvisionnement)
- Stock existant (état des produits, date expiration, quantité, nature, estimation de la durée des stocks disponibles)
- Tenue des fiches

.../...

- Etat du magasin, ventilation, FIFO
- Rupture du stock - pourquoi ? et durée de la rupture, sa conséquence.
- Y-a-t-il eu des changements dans le système d'approvisionnement. Si oui, est ce que c'est une amélioration ?
- Qui fait l'entretien de l'équipement médical ?

3. FORMATION

- Adéquation de la formation aux tâches et responsabilités de prestations des services de P.F.
- Avis des gens formés sur la forme du contenu de leur stage
- Qui, par qui, ou, combien de temps, comment?
- Y-a-t-il des documents de référence (guide, fiches techniques, manuels etc)
- Y-a-t-il un plan de formation au niveau régional ? Qui s'en occupe ?
- Y-a-t-il un budget pour la formation ?
- Evaluer les activités effectuées par les gens formés, notamment point de vue clinique ?
- Existence du personnel médical ou para-médical non encore formé par le projet qui fournissent des services de PF.
- Ceux qui ont été formés par le projet ont-ils formé d'autres personnes ?
- Y-a-t-il eu un suivi depuis la formation initiale ?

3 - IEC

- Y-a-t-il des séances et matériels d'IEC en quelle langue ?
- Quels sont les matériels et méthodes disponibles (brochure, radio etc) (fréquences, audiences, population cible)
- Quel est le rôle du CRND dans l'IEC ?
- Y-a-t-il d'autres organismes qui font l'IEC ?
- Est ce que le personnel a reçu une formation en méthode d'IEC ?
- Est ce qu'il y a une formation prévue pour le personnel ?
- Quel est le climat dans lequel le projet se déroule ? (social, politique)
- Qui fait l'IEC et comment ? (en ville, à domicile etc...) Animatrice?
- La motivation de l'acceptante ce fait comment et par qui ?

4 - PRESTATIONS DES SERVICES.

- Quels services ? déroulement des services (^à examiner horaires, nombre des visites etc)
- Quels sont les critères de l'éligibilités ? (cas spéciaux, pratique des critères)
- Qui fournis les services? Qui fait quoi? (médecin, infirmier, matrone formée)
- Nombres de nouvelles clientes par mois ? suivi des clientes? calendrier de activités de PF ?
- Intégration des services PF avec autres activités
- Caractéristique* - Catégories socio-démographiques des acceptantes
 - Notez les affiches, équipements, structure etc...
 - Quelle est la qualité des prestations des services, connaissance technique accueil, la durée d'attente, siège etc.

5 - SUPERVISION

- Qui supervise, fréquence, quand y a-t-il eu lieu la dernière visite à l'U
- ~~À~~ l'avis du personnel, est ce que la supervision est assez fréquente ?
- Responsable de supervision qu'est qu'il/elle fait, combien de temps a-t-il/elle resté ?
- Est ce que la supervision est formative ou aperçue comme purement un contrôle ?
- Est ce que les standards médicaux sont connus et appliqués (sans trop insister) ?

6 - STATISTIQUES

- Instruments des collectes : Est ce qu'ils sont compliqués, compris par le personnel ? comment sont-ils remplis (avec soins ou non)? d'où vient il ? Quel est la voie d'acheminement ?
- Est ce que des rapports sont élaborés et ensuite envoyés ? Si non, pourquoi ?
- Prenez des exemplaires de chaque instruments de collecte

7 - COORDINATION

- Y-a-t-il d'autres structures (unités) qui travaillent en dehors du PSND
- Est ce qu'il y a des liens entre les unités (référence, formation, standardisation etc)

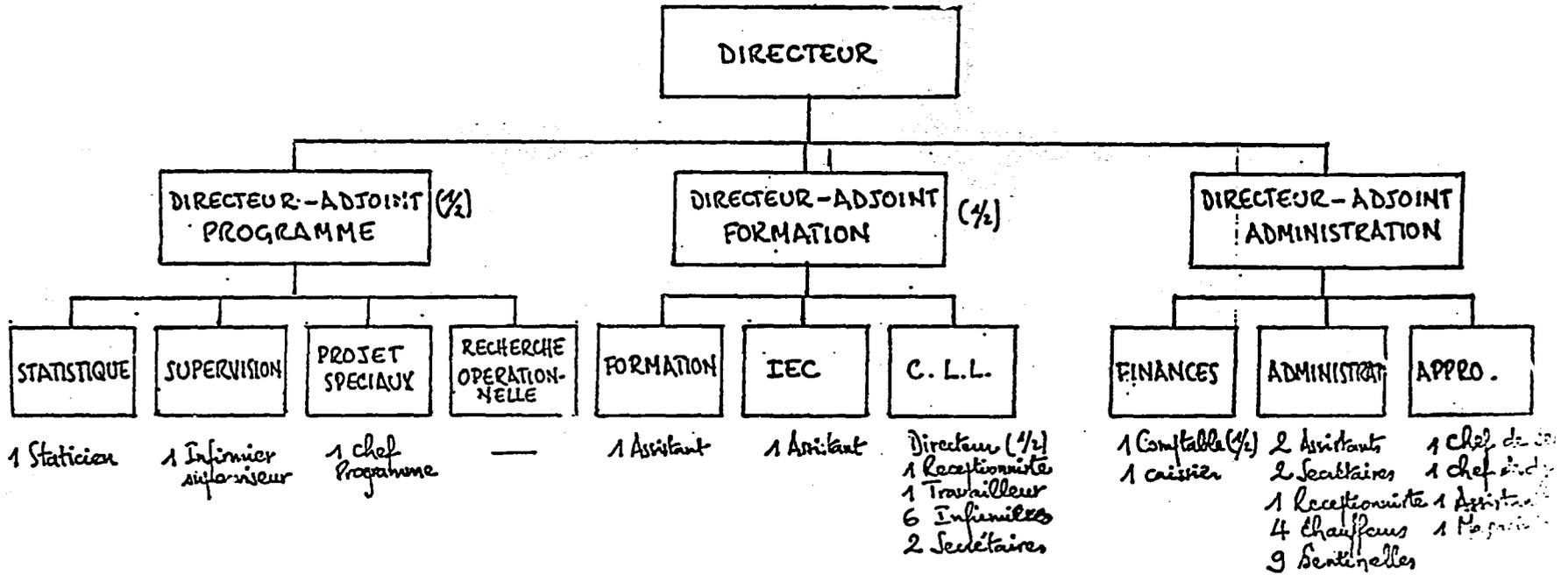
et celle du projet

8 - Quels sont les besoins de recherche opérationnelle ?

9 - Autres commentaires.

ORGANIGRAMME ACTUEL

APPENDIX C
CURRENT ORGANIZATION PLAN



SERVICE DES APPROVISIONNEMENTS & MATERIEL

REAPPROVISIONNEMENT DES UNITES DES NAISSANCES DESIRABLES

1/ CRITERES DE REAPPROVISIONNEMENT

Le réapprovisionnement de l'unité des naissances désirables passe par les critères suivants :

- a) - déposer à la Direction du Projet le rapport d'utilisation du matériel et contraceptifs.
- b) - avoir suivi les clauses du Protocole d'Accord signé entre l'unité et la Direction du Projet.
- c) - verser une somme d'argent équivalente à la demande se trouvant sur l'état de besoin.

2/ DEMARCHES A SUIVRE

1. - Déposer au Secrétariat de la Direction du Projet une lettre de transmission de l'état de besoin dûment signée par le Responsable autorisé.
Le Secrétariat, après avoir enregistré la lettre, annexe à celle-ci une fiche de réapprovisionnement et envoie au Service de Programme.
2. - Au Service de Programme, il s'agira de vérifier si l'unité est en ordre avec le Projet, surtout en ce qui concerne les clauses du Protocole d'Accord. Ensuite, l'état de besoin est envoyé au Service des Statistiques.
3. - Dans le Service des Statistiques, on s'occupera à justifier les raisons de la commande en comparant l'état de besoin au rapport d'utilisation. Si la commande est justifiée le document passe au Service d'Approvisionnement, dans le cas contraire, on signale à l'unité que la commande n'est pas justifiée pour telle ou telle raison.
4. - Au Service d'Approvisionnement, la vérification consistera à voir si les quantités disponibles permettant d'honorer la commande; si oui, la commande est envoyée aux Finances avec mention "OK", si non, on examine dans quelle proportion on servira.

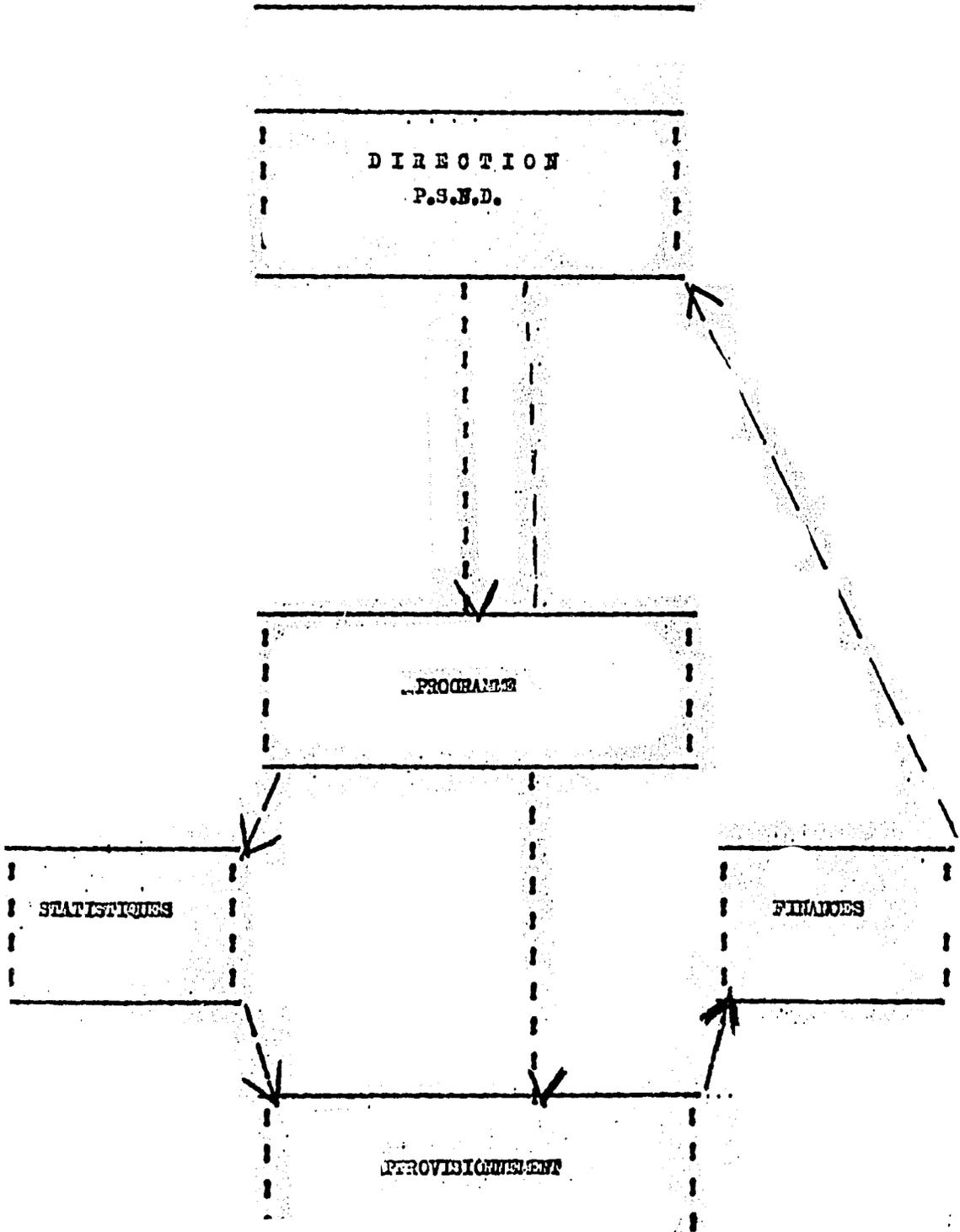
5. - Après paiement, le Service des Finances envoie le document à la Direction qui autorisera la sortie en posant la signature sur le bon de sortie/
magasin.
6. - Le document revêtu de la signature de la Direction rentre au Service des Approvisionnements pour livraison.

- UNITE DES HAISSANCES DESIRABLES DE :

- APPROBATION DES SERVICES DU P.S.N.D.

N°	SERVICES	APPROBATION	OBSERVAT.
1	DIRECTION	Réception suivant lettre de transmission du..... signée par	
2	PROGRAMME	Information Commentaires	
3	STATISTIQUES	Comparaison approvi- sionnement et utiliza- tion	
4	APPROVISIONNEMENT	Quantités demandées Quantités disponibles Quantités à fournir	
5	FINANCES	Paiement de Z.....	
6	APPROVISIONNEMENT	Livraison Moyen d'expédition....	

SCHEMA DE REAPPROVISIONNEMENT DES U.N.D.



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MOUVEMENT POPULAIRE DE LA REVOLUTION
 DEPARTEMENT DE LA SANTE PUBLIQUE
 PROJET DES SERVICES DES NAISSANCES REGULABLES
 B.P. 100 KINSHASA/VII

APPENDIX E - PROCEDURES FOR R...
 OF FAMILY PLANNING UNITS

CENTRE LIBOTA LILANGI

1ère SESSION DE FORMATION

1985

HORAIRE DES COURS POUR MEDICINS

1ère SEMAINE

PERIODES	LUNDI 08 AVRIL	MARDI 09 AVRIL	MERCREDI 10 AVRIL	JEUDI 11 AVRIL	VENREDI 12 AVRIL	SAMEDI 13 AVRIL
8H00-9H00	-	Aperçu sur les SSP	Philosophie des N.D.	Gynéco-Obstétrique	Méthodes et Techniques de la Contraception : Pilule	Stérilisation
		S/A Dr. LUVIVILA	S/A Dr. NIATUDILA	S/B Dr. NGUSA	S/A Cne SAHWA	S/B Dr. T...
9H00-10H00	OUVERTURE S/A Direction	- " -	- " -	- " -	- " -	- " -
10H30-11H30	- " -	Philosophie des N.D.	Historique de la Contraception	- " -	Méthodes et Techniques de la Contraception: Stérilet	- " -
		S/A Cne CHENTISA	S/A Cne KAZADI		S/A Cne SAHWA	
11H30-12H30	- " -	- " -	Anatomie et Physiologie des organes de Reproduction	Introduction au P.S.N.D.	- " -	Conférence M.S.T.
			S/B DR. NTABONA	S/B CNE CHENTISA		S/A Dr.

R E	P O S	DE	K I	D I	
14H30-15H30	Prise de contact et Informations Générales	Philosophie des N.D.	Anatomie et Physiologie des Organes de Reproduction	Examen Physique	Méthodes et Techniques de la Contraception : Stérilet
	S/A KAZADI	S/A Dr. NIATUDILA	S/B Dr. NIABONA	S/A one SAHA	S/A One SAHA
15H30-16H30	Exercices	- " -	- " -	- " -	Méthodes et Techniques de la Contraception : Spermicide
	S/A Gn OZALI				S/L One SAHA

Plan Semaine

PERIODES	LUNDI 15 AVRIL	MARDI 16 AVRIL	MERCREDI 17 AVRIL	JEUDI 18 AVRIL	VENDESDI 19 AVRIL	SAEDI 20 AVRIL
0800-0900	Méthodes et Techniques de la Contraception ; Conduite - Coût interrompu S/A Cne KAZALI	Méthodes Naturelles de Planning Familial S/A Dr BAVI	Stage	Stage	Stage	Communication en Matière des N.D. S/A Cn KAZALI
0900-1000	Scènes cinématographiques sur les Méthodes et Techn. S/Biblio Cne SALHA -Kanzala	- " -	- " -	- " -	- " -	- " -
1000-1100	Vasectomie et Ligature des trompes S/A Dr OSHUDI	- " -	- " -	- " -	- " -	Evaluation sur les Méthodes et Techniques de la Contraception S/A Cne SALHA
1100-1200	- " -	- " -	- " -	- " -	- " -	Impact de l'Allaitement maternel sur les N.D. S/A CEPLANT
R E P O S E S M I D I						
1400-1500	Méthodes et Techn. de la Contraception Depo-provera S/A Dr BAVI	Motivation aux N.D. S/A Cne MBIZI	Motivation aux N.D. et S/A Cne FUYILA	Motivation aux N.D. et Education Sanitaire par le Ministère S/A Dr IUDYA	et Communication en Matière des N.D. S/A Cn KAZALI	

TABLEAU

PERIODES	LUNDI 22 AVRIL	MARDI 23 AVRIL	MERCREDI 24 AVRIL	JEUDI 25 AVRIL	VEDREDI 26 AVRIL	SAMEDI 27 AVRIL
8H00-9H00	SALON	SALON	SALA 03	SALON	SALON	VISITE GUIDES Direction
9H00-10H00	- " -	- " -	- " -	- " -	- " -	- " -
10H00-11H30	- " -	- " -	- " -	- " -	- " -	- " -
11H30-12H30	- " -	- " -	- " -	- " -	- " -	- " -
	R E P O S		D E	M I	D I	
14H30-15H30	Organisation et Gestion d'une U.N.D. S/A G. MOLE					
15H30-16H30	- " -	- " -	- " -	- " -	- " -	

IVÈNE SEMAINE

PERIODES	LUNDI 29 AVRIL	MARDI 30 AVRIL	MERCREDI 1 MAI	JEUDI 2 MAI	VENREDI 3 MAI	SAMEDI 4 MAI
8H00-9H00	STAGE	STAGE		STAGE	Séance cinématographique sur le Planning Familial	
					IS/Biblio -OMARI	
					-MAUCHELO	
9H00-10H00	- " -	- " -		- " -	- " -	
10H00-11H30	- " -	- " -		- " -	Evaluation Générale sur la Hession	CLOTURE
					S/A Cns 6 KACADI - OMARI	Direction
11H30-12H30	- " -	- " -		- " -	- " -	
	RE	POS	DE	MI	DI	
14H30-15H30	Organisation et Gestion d'une U.N.D.	Système de collecte des données et d'élaboration des rapports			Système de collecte des données et d'élaboration des rapports	
	IS/A Cn NGOLE	IS/A Cn BONGHELE			IS/A Cn BONGHELE	
15H30-16H30	- " -	- " -		- " -	- " -	

CENTRES SELECTIONNES

- QUESTIONNAIRE PRELIMINAIRE -

1. Existe-t-il des activités des Naissances Désirables dans votre formation médicale ?
Lesquelles ?
2. Où, dans quelle partie ?
Pouvons-nous visiter ?
3. Qui en est le Responsable ?
4. Combien d'infirmières travaillent dans ce service ?
Y a-t-il un médecin ?
5. Quel est le niveau de chacun(e) d'entre elles ou eux ?
6. Si on installait un service des Naissances Désirables, dans cette formation médicale, cela gênerait-il la bonne marche des autres activités ?
7. Avez-vous des demandes de ce genre ?
Quelle est la moyenne des consultations gynécologiques par jour ?
Par mois ?
la moyenne des consultations prénatales ?
la moyenne des consultations de nourrissons ?

10. Quelles sont les infirmières qui pourraient être détachées pour une formation en Naissances Désirables ?

Et pour combien de temps ? Sans perturber la bonne marche du service.

11. Y-a-t-il des infirmières formées en "N.D." ?
des Médecins ?

12. Y-a-t-il des aménagements (bâtiments) à faire avant de débiter les activités des N.D. ?

Lesquelles ?

13. Est-il possible de garder les contraceptifs et autres matériels des N.D. ailleurs que dans le Dépôt commun ? Et en sécurité ?

B.P. 100 KINSHASA/IA

FICHE DE SUPERVISION

Région : Equipe de supervision :
 Sous-Région : N° de la visite :
 Unité des N.D. de : Date de la visite :
 Type de Centre :
 Composition de l'équipe:

INFRASTRUCTURE SANITAIRE

Eau Electricité Salle d'attente Salle de consult. Adequate
 Table d'examen Escabot Banos Fichier existant
 Contraceptifs disponibles Aération Gants
 Spéculums Matériel d'insertion DIU Poupinel Autoclave

INFRASTRUCTURE HUMAINE ET MATERIELLE

	BOH	MOYEN	MEDIOCRE
- Accueil			
- Propreté des l. Etat des locaux			
- Entretien du matériel			
- Technique médicale			
- Motivation du personnel			
- Circulation de l'information			
- Education et motivation des acceptants (es)			
- Suivi			
- Tenue des fichiers			
- Statistiques et rapports			

Nombre des acceptants à la dernière visite :

Nombre de nouveaux acceptants à la dernière visite :

Stock à la dernière visite :

Stock actuel :

Date probable de la prochaine visite :

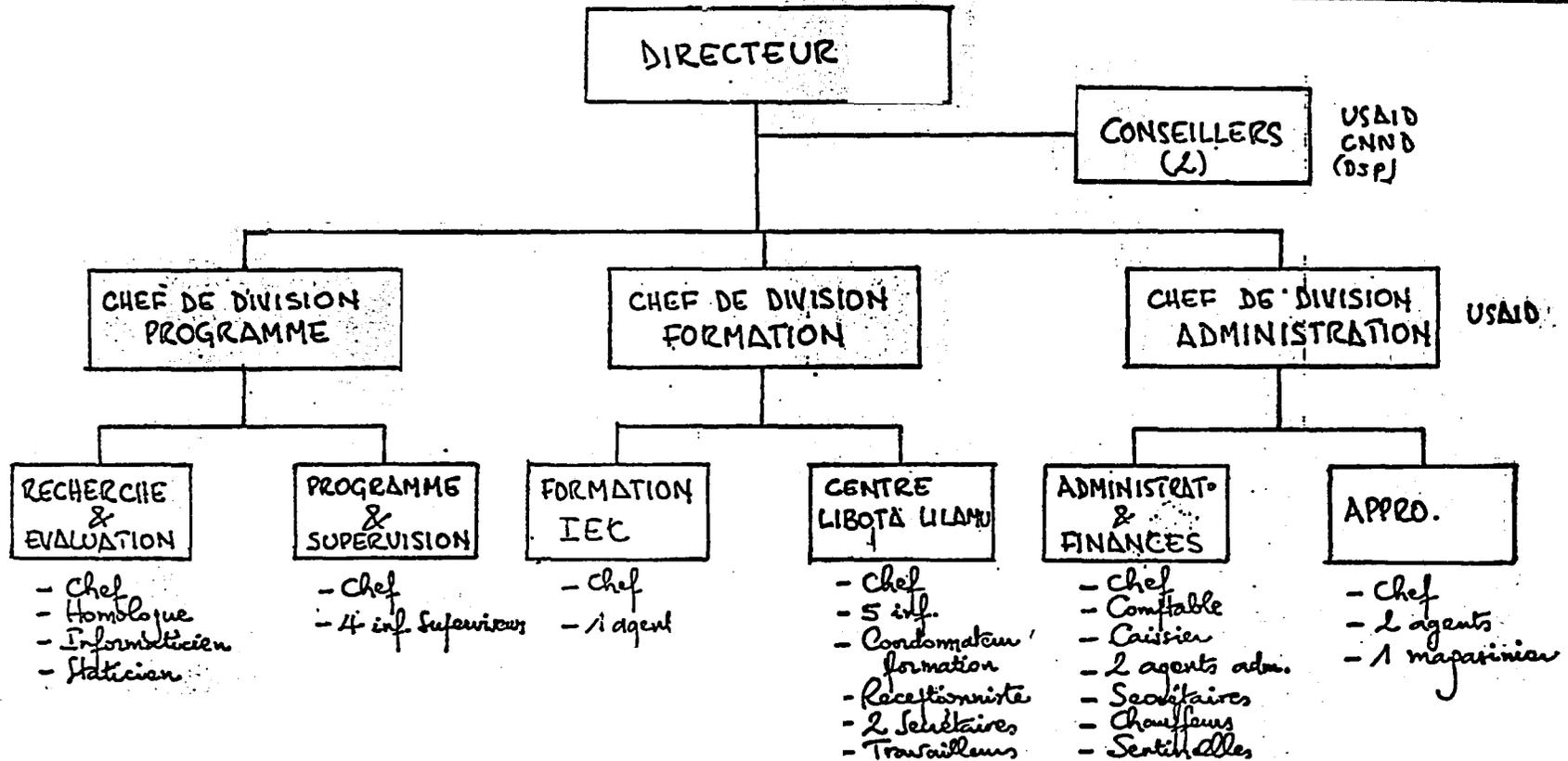
COMMENTAIRES/OBSERVATIONS :

- De l'équipe de supervision :

- De l'équipe de l'Unité des N.D. :

ORGANIGRAMME PROPOSE

APPENDIX H
SUPERVISORY PROTOCOL



LIST OF PERSONS CONTACTED

Département de la Santé Publique

Cn MUSHOBEKWA Kalimba

Wa Katana
Cn LUKASO Djate Lokogo
Dr PANGU Kasa

Commissaire d'Etat à la Santé Publique
Secrétaire Général à la Santé Publique
Conseiller au Département de la Santé Publique

PSND

Cne QHREWISA

Chirhamolekwa
Cn KAZADI Polondo

Cn MUTUMBI
Cn YUMA-BIN-YUMA
Cn KABANGU Meta
Cn KATSHINGU Tukole
Cn KKOSI Mbenga
Cn MUGARUKA
Cn MISAMU Kamitondo
Cn NSHANGALLIE
Cne MUSHIYA Lunganza
Cn MPIMBA Manata
Cn KASHANGA Buye Mahata

Cn MTUMBA Wa Ntumba
Cn MANGUELO
Cn OMARI
Cn KANZALA Ngenze

Directrice
Directeur du Projet Adjoint Chargé de Formation
Directeur Adjoint Chargé du Programme
Assisjant du Service l'Administration
Agent l'Administration
Secrétaire de Direction
Chef Service Finance et Comptabilité
Cassier
Chef de Service de l'Approvisionnement
Assistant aux Approvisement
Magasiniere
Employéé aux approvisement
Chef de Service de Recherches Operationelles
Chef de Service Projets Speciaux
Assistant Chargé d'IEC
Assistant Chargé de la Formation
Inc. Clinique Liboto Lilamu

CNND

Cn WAWA Sakrini
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Dr WILIPODINGA
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