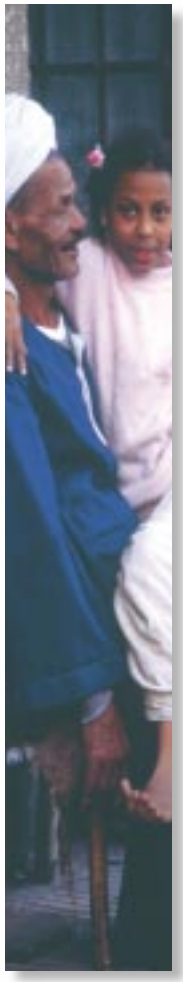
reports

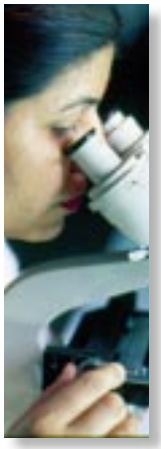
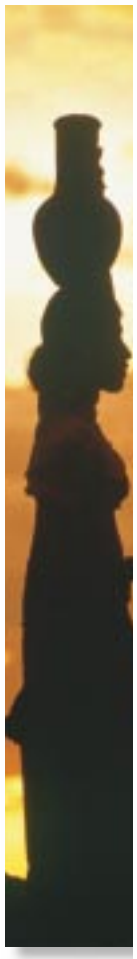
DFID Department for International Development

EV598
December 1998

A Synthesis of Population Project Evaluations





DFID EVALUATION DEPARTMENT

A SYNTHESIS OF POPULATION PROJECT EVALUATIONS

By

David Crapper

In May 1997 the Overseas Development Administration (ODA) was replaced by the Department For International Development (DFID). References in this report to the ODA apply to events, actions, etc prior to the changes of title and functions.

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PREFACE

Each year the Department for International Development (DFID) commissions a number of ex post evaluation studies. The purpose of the DFID's evaluation programme is to examine rigorously the implementation and impact of selected past projects and to generate the lessons learned from them so that these can be applied to current and future projects. It should be borne in mind that the projects concerned were designed a number of years ago, and policies and procedures will in many cases have been developed further in the light of changing DFID knowledge, including that emanating from evaluation studies such as this.

The DFID's Evaluation Department is independent of DFID's spending divisions and reports directly to the DFID's Director General (Resources).

Evaluation teams consist of an appropriate blend of specialist skills and are normally made up of a mixture of in-house staff, who are fully conversant with DFID's procedures, and independent external consultants, who bring a fresh perspective to the subject-matter.

This evaluation is a synthesis of the following four evaluation studies:

i) Employment-Based Family Planning Project (EBFP) (February 1997), EV 588 by David Crapper, Consultant Economist and Team Leader and Deborah Thomas, Population and Reproductive Health Consultant;

ii) Contraceptive Social Marketing Project (CSM) (February 1997) EV601 by D Crapper and D Thomas (as in (I) above); and Alan Handyside, Social Marketing Consultant;

(iii) Contraceptive Supply Projects in seven countries (CS) (May 1997) EV600 by Catherine Cameron, Consultant Economist and Robert Burn, Consultant Specialist in Contraceptive Logistics and Supply;

(iv) Kenya Population Project III (KPIII) (July 1997) EV595 by D Crapper (as in (i.) above), Malcolm Potts and Murray Culshaw, Consultant Specialists in Population and NGOs, respectively.

Other material drawn upon in the study comprised:

The on-going ODA project, Bangladesh Population and Health Consortium (BPHC);

A commissioned review of USAID evaluations of experience with Family Planning Programmes in 5 countries (USAID); a published World Bank review on Effective Family Planning programmes (WB); and a GTZ report on the Social Marketing of Contraceptives.

The evaluation process involves the following stages :-

(a) For each individual project evaluation:
- initial desk study of all relevant papers;
- consultations with individuals and organisations concerned with the project, including a field mission to collect data and interview those involved;
- preparation of a draft report which was circulated for comment to the individuals and organisations most closely concerned;
- submission of the draft report to the DFID's Director General (Resources) to note the main conclusions and lessons to be learned from the study on the basis of the draft report.

(b) For the synthesis study:
- preparation of the synthesis report which seeks to draw out the main points from the individual reports and identify the key lessons learned;

- meeting of DFID's Projects and Evaluation Committee with Evaluation Department and the author to discuss the main conclusions and lessons to be learned from the study on the basis of the draft report.

This process is designed to ensure the production of high quality reports and (EVSUM) Summary sheets which draw out all the lessons.

Christopher Raleigh
Head, Evaluation Department

ABBREVIATIONS LIST

CBD	Community-based distribution
CS	Contraceptive Supply
CSM	Contraceptive Social Marketing
CYP	Couple-Year Protection
DFID	Department For International Development (replaced ODA in May 1997)
EBFP	Employment-based Family Planning
FPAK	Family Planning Association, Kenya
GoB	Government of Bangladesh
GoI	Government of India
GoK	Government of Kenya
HAPAE	Health and Population Aid Effectiveness projects
HIV	Human immunodeficiency virus
H&P	Health and Population
HPD	Health and Population Division ODA/DFID
IEC	information, education, communication
IMR	infant mortality rate
IUT	intra-uterine device
JFS	ODA/DFID's joint funding scheme
KCS	Kenya Catholic Services (NGO)
KPIII	Kenya Population III Project
LF	logical framework
MI	management information
MIS	management information system
MCH	Maternity and child health
NAO	National Audit Office
NCPD	Kenya Government's National Council for Population Development
NGO	Non-Governmental organisation
OCP	Oral Contraceptive pill(s)
ODA	Overseas Development Administration (replaced by DFID in May 1997).
PSS	Parivar Seva Sanstha, Indian NGO
STD	Sexually transmitted disease
SDP	Service delivery point
UNFPA	UN Population Fund
USAID	US Government's Development Agency
VSC	Voluntary surgical contraceptive

SUMMARY, CONCLUSIONS AND LESSONS LEARNED

BACKGROUND

1. Although fertility levels have been declining steadily over the last 30 years, world population is still growing rapidly and could reach 12 billion before it stabilises. Surveys in most developing countries show that there is still a big gap between desired and actual family size but 50% of couples have no access to modern contraception. Child bearing is a major health problem for women and planned families improve the quality of life by allowing more parental time and resources to be devoted to each child.

2. The Overseas Development Administration (ODA, now Department for International Development, DFID) launched its "Children by Choice not Chance" initiative in 1991, with the aims of improving the coverage and quality of reproductive health services and the availability of contraceptives, giving women greater control over their lives, and helping countries to develop population policies. Since then, expenditure on Children by Choice projects has grown rapidly from £14 million to an average of £35 million per year in the last three years. DFID is now one of the leading donors in this field.

THE EVALUATION

3. The purpose of the synthesis is to bring together in one document an analysis of the findings and lessons learned from evaluations by ODA of a small sample of recently completed population projects, supplemented by evidence from the (rather limited) work done by other donors. It is not a comprehensive review of all recent ODA assistance for population related activities, nor is it a review of current DFID policy towards the sector, which has undergone considerable change since the ODA projects considered here were designed. Equally it does not reflect either ODA's influence in international conferences or ODA aid passed through multilateral donors. It should also be noted that most of the ODA projects examined were components of wider programmes of family planning assistance in the countries concerned, involving other donors who carried more responsibility than the ODA for overall project design.

4. The evidence for the conclusions of this synthesis was drawn from the following: four ODA evaluations, covering 10 projects implemented between 1988 and 1995; one on-going project; a review of the experience with family planning programmes of the US Government's Development Agency (USAID) in five countries over the last thirty years; a 1993 World Bank publication reviewing experience with aid for population activities;

and a 1997 report prepared for German Development Cooperation on experience with the Social Marketing of Contraceptives. For a detailed bibliography, see Annex B. The main chapters of the report are structured around a model logical framework developed by ODA's Health and Population Division in 1996 (Annex D).

5. Some of the lessons drawn in this synthesis (such as the need for more focused indicators, improved management information, and closer analysis of cost-effectiveness) are similar to the conclusions of a 1994 NAO report (see Annex B). As the NAO recommendations had in large measure been implemented by Health and Population Division (HPD) by the time this report was prepared, it also follows that the lessons highlighted in paragraphs 22-29, many of which are reflected to a greater or lesser extent in the findings of HPD's own report "Progress with UK Aid for Sexual and Reproductive Health" (1997), are mostly already being applied in current project planning.

OVERALL SUCCESS RATINGS

6. Over the past 30 years, family planning programmes, with considerable support from aid donors, have succeeded in bringing about major changes in fertility patterns, cutting in half the time required for the transition from high to low fertility. Contraceptive use has increased in countries of radically different cultures, with reduced costs and improved quality for consumers. Key elements in success have included securing political support, exploiting existing unmet demand, innovative delivery methods, multiple delivery channels, community based outreach, efficient management, quality services, information, education & communication (IEC) and training. However, the problem of how to sustain programmes without continuing and, in some cases, increasing external support has not been solved.

7. The ODA projects evaluated were all judged to have made a useful contribution to this process of declining fertility, to have achieved some of their objectives and to have generated some significant benefits in relation to costs. Notable successes included the establishment of a cost-effective Contraceptive Social marketing (CSM) programme, the emergency supply of bulk contraceptives to many countries at reasonable cost, and improvements in the quality of service delivery by some Non Governmental organisations (NGOs) in Kenya and Bangladesh. However, many of the projects had weaknesses in design and in implementation. For instance, none was able to meet its poverty objectives; some of the physical facilities provided were expensive; and, while some permanent benefits will have been generated by all the projects, only the Employment-based Family Planning Project (EBFP) was judged to be sustainable without further donor support. In

some cases, the apparent weaknesses were the result of unrealistic expectations at the design stage.

MAIN FINDINGS

8. Although ODA was not closely involved in the identification and design of any of the ten projects, project design was consistent with ODA population strategies, and all recipients except Mexico were priority ODA countries. However, the two Joint Funding Scheme (JFS) projects did not meet the JFS or India desk criteria that beneficiaries should be from the poorest communities. All the projects contained some design flaws which were not picked up at the appraisal stage: for instance, activities being concerned more with occupational health care services than family planning (EBFP); inadequate funds being included for marketing (CSM); an over-emphasis on IEC as against services, and in some cases an inappropriate choice of partner NGOs (KPIII); the prospects of reaching the target beneficiaries not being realistic (CS). Other criticisms were that appraisals did not always consider alternative and possibly more cost-effective interventions, or include the benefits to women and children's health of greater control over fertility (paras 2.6-11).

9. The logical frameworks used in all these projects were early models. Goal and purpose statements were at too high a level, and indicators too imprecise, making it difficult to attribute any changes to these projects alone as against the activities of others working in the sector. There were also too many objectives, and monitoring concentrated on activities rather than on impact (paras 2.12-18). In this respect, however, the projects were no different from those in other sectors at the time.

10. All except the Contraceptive Supply (CS) projects were implemented by NGOs. This worked well when the funding was direct, for instance through the JFS, but in Kenya the Government's intermediary agency was inefficient and inappropriate and in Bangladesh the Government intervened in the implementation of the project (paras 3.1-7). The CS projects followed a range of management models but this did not affect the results - the use of Field Managers and Development Divisions led to closer monitoring but did not guarantee progress would be as planned. The increasing use of consultants throughout the project cycle also makes it more important to institutionalise lessons across DFID (paras 2.11, 3.8). The DFID practice of managing projects in sterling rather than local currency can weaken its control over the volume and distribution of activities financed (para 3.10).

11. Family planning services provided by the public sector and by NGOs (including profit-taking organisations) have complementary advantages and drawbacks. NGOs can

concentrate better on family planning, engage more professional and committed staff, and provide a higher quality - and in most cases more cost-effective - service than the public sector is able to do. In principle they should be more participatory and flexible, and have an advocate's role; one of the NGOs' main roles in the past was to make family planning respectable in situations where the political or religious environment was hostile (paras 3.11-15, 3.22). However, NGOs cannot bridge all the gaps in public sector provision. Nor are all of their perceived advantages fully supported by the evidence; for instance, none of the four ODA projects implemented through NGOs managed to reach the poorest groups. Nor is working through NGOs a guarantee that programmes will be run independently of government. The public sector has broader geographical and social coverage and access to government and donor funding, but its need to cover the whole population may lead to a thin spread of resources and poor quality services (paras 3.16-18).

12. National surveys continue to find a significant unmet demand for family planning and improved access has been shown to increase use and encourage continuing use. All the ODA projects contributed to some extent towards improved access to a wider range of services, though in most cases they were unable to improve delivery and usage amongst the more difficult-to-reach communities. An additional way of increasing access would have been to encourage suppliers of natural family planning "services" to promote breast-feeding and wider knowledge of the infertile period (paras 4.2-4).

13. Population projects have made contraception available to large numbers of people, but it is still not reaching some poorer groups. Most of the projects evaluated had aspirations to do so and, for the JFS projects, this is a formal requirement. Some features of project design made it difficult to reach the very poor - for instance, the need to recover costs (CSM), the target group being in the formal industrial sector (EBFP), and concentration on urban areas (KPIII) (paras 4.7-13).

14. IEC is important to raise awareness and knowledge, especially among young people, to promote social acceptability, to reduce drop-out rates and to improve the effectiveness of use. To be successful, IEC programmes need to be well targeted, with the precise need for information established, and messages need to be repeated and the impact evaluated. On the other hand, it has to be recognised that low rates of contraceptive use can exist side by side with evidence of high awareness, for a number of reasons (eg high infant mortality rates, or lack of access for unmarried women). In designing programmes, there has been a tendency to underestimate awareness and to over-invest in IEC programmes rather than improving service delivery or attacking some of the other causes of low prevalence rates (paras 4.14-22).

15. The projects evaluated did not aim to address wider societal gender issues, but women are the primary beneficiaries of projects such as these which improve access to fertility regulation. All except the CS projects (which aimed to fill gaps in existing supplies) widened the choice of contraceptive method, an important factor in increasing prevalence. The EBFP project was unusual in that it set out to have a male focus, targeting male employees at the workplace (paras 4.25-31).

16. It is difficult to compare efficiencies across projects and across types of contraceptive methods, because of the shortage of cost data and the variation in methodology used. In broad terms, the cost per couple-year protection (CYP) for the CSM and CS projects was quite good in international terms, while EFBP and parts of KPIII were rather expensive. International experience suggests that clinic-based services (involving sterilisations) are the most cost-effective, followed by community-based distribution (CBD) and social marketing services. However, when other objectives are taken into account, the rankings are changed. For instance, CBD is more effective at reaching the poor, while CSM has the best cost-recovery record and more potential for sustainability. Thus, while cost per CYP is a simple and straightforward measure of cost-effectiveness, it is of most use in making comparisons over time within the same project, or between similar programmes. In all cases, it needs to be interpreted carefully and supplemented by measures of quality and access (paras 4.32-40).

17. One of the clearest findings from all the studies is the limited success towards achieving financial self-sufficiency - two common features of family planning programmes are the continuing high level of donor involvement and the limited degree of cost-recovery. This is true even of programmes operating in middle income countries (eg Tunisia), run by efficient NGOs (eg Honduras), and where the target groups were not necessarily poor (most CSM projects). For projects in poor countries and/or projects targeting mainly poor groups, it is unrealistic to expect to achieve financial self-sufficiency within the lifetime of a single project (paras 4.41-52).

18. The continuation of donor involvement and of subsidised family planning programmes has to be justified by the external costs of rapid population growth, both within countries (eg future government spending on education, slower economic growth) and in the outside world (eg environmental impact, emigration pressures). Subsidies to the final consumer should ensure continuing widespread access to family planning services, and maintain the momentum of the recent rapid growth in prevalence rates. Continuing donor support is necessary because most governments cannot afford to fund existing levels of investment in family planning, let alone cater for expected rapid increases in demand. There is no evidence from the reports considered here that projects involving subsidies and supported by external donors

weaken the effectiveness of the private sector, indeed these donor supported programmes have an excellent record of developing private sector capacity which would not have existed otherwise (paras 4.53-54).

19. Examples of community participation in family planning programmes are rare, and working through NGOs has not guaranteed that communities will be more closely involved. Community-based distribution strategies, however, have proved effective in situations where there are high levels of unmet demand (paras 4.55-58).

20. Effective project planning and management require the collection and analysis of reliable performance measures and research to test new approaches. All the USAID and ODA evaluations revealed weaknesses in this respect. Information systems failed to collect adequate data on costs, let alone impact, and provided few answers on the basic questions of cost-effectiveness and resource allocation. This was despite a purpose-built monitoring system having been set up in almost every project, in some cases at considerable expense. Problems included collecting too much unnecessary data, often for the wrong purposes, complicated collection systems and divorcing the responsibility for the collection of data from its analysis. These criticisms refer to relatively straightforward quantitative demographic data - almost none of the projects collected qualitative data, or data to measure the new and more sophisticated objectives such as institutional capacity or reproductive health (paras 4.59-69).

21. The purpose of most of the ODA projects was to increase contraceptive prevalence rates (paras 4.70-74) and their goal to reduce fertility and growth rates (paras 4.75-87). In most of the countries there were positive movements in national demographic trends, to which the projects undoubtedly contributed, but the data collected from the individual projects were not adequate to measure their contribution.

LESSONS LEARNED (Figures in brackets refer to previous paragraphs in this Summary)

22. In countries where awareness of and demand for contraceptives are high, donor assistance should concentrate on improving the delivery of services and access for under-served groups. Support for IEC should be limited to programmes which are well targeted (eg at young people) or which provide specific information to improve the effectiveness of contraceptive use. NGOs (including profit-making organisations) could be encouraged to concentrate on providing services, which they are able to do as cost-effectively as governments. NGOs also have the potential to act in areas a government may hesitate to enter, such as the provision of services for adolescents or HIV prevention among prostitutes. Not all NGOs, however, are good at all activities and their strengths and

weaknesses need to be assessed so that the most appropriate ones are chosen for each job (11, 12, 13 & 14).

23. In the period covered by this synthesis, population programmes were designed to contribute towards a rapid general increase in contraceptive usage. As the growth of prevalence rates levels out, the emphasis needs to shift to providing for poor and vulnerable groups more information on the benefits and possible side-effects of different contraceptive methods, improved access, and a better quality of service. The ODA projects covered by this synthesis demonstrate that clear poverty focus strategies need to be developed at the outset. Providing services to poor people may conflict with other targets such as efficiency and cost-recovery; hence project design, objectives and indicators need to be explicit about trade-offs between these targets. In projects such as CSM which operate through retail outlets, there is a need for careful choice of geographical area, distributors and stockists, and for advertising campaigns targeted at low-income groups. Working through NGOs is no automatic guarantee of reaching poor and vulnerable groups. Selection criteria for NGOs should include, for instance, those with substantial networks in rural areas and urban slums, or with access to adolescent groups. Because it is more expensive to target poor people, a longer term approach than funding single projects is even more important. In many countries it may be that in the long run the needs of the poorest can be met only through free public sector distribution outlets (8, 11, 13 and 19).

24. It is important that collaborating NGOs be consulted about project design and that their agreement and understanding be secured on the targets against which their performance will be judged. Financial targets are best established and monitored in the currency or currencies in which expenditure is incurred, especially in situations where devaluation of the local currency may permit a much greater volume of activities to be financed. (8 & 10).

25. Donors should not expect to achieve sustainable success from single projects. Aid for family planning requires a long term approach, within the context of an overall strategy for external interventions, and with clear indicators of achievements and of system development (see HPD study referred to in paragraph 5 above). This should not preclude designing projects in such a way as to promote greater self-sufficiency, for instance by choosing cost- effective methods of delivering family planning, working with the most efficient organisations, and promoting cost recovery when this is consistent with achieving other objectives. The level of subsidies should also be made explicit, by passing donor funds through national budgets, and targets set for increased local contributions. Nevertheless, strategic planning should recognise that most countries, and the majority of users of family planning services, will not be able to afford to pay the full cost of

contraceptives for the foreseeable future, and that continuing support from donors will be required to ensure widespread access to family planning services. (17, 18).

26. It is important that management information systems are kept simple, defined at an early stage, and agreed with the implementing agency. They should facilitate the use of data as a management tool, collecting data on the impact of IEC programmes and the number and unit cost of CYP achieved by service delivery programmes. Purpose level indicators should be more carefully specified so that they measure the impact of the project's activities and outputs, rather than the effect of other projects, or of other concurrent or historical trends (eg changes in the status of women, the effect of the cost of schooling on the demand for children, pressure on land etc). (20)

27. The potential macro-economic benefits of slower population growth are well understood but difficult to quantify, particularly for individual projects which only contribute to part of a country's programme. Economic appraisals should therefore focus on the micro-level benefits of population projects, such as improvements to women's and children's health resulting from greater control over fertility. (7).

28. NGOs whose religious beliefs preclude the use of physical methods of contraception should be encouraged to promote innovative and cheap methods such as breast-feeding, and to provide information more widely on the infertile interval, for the large number of couples using forms of periodic abstinence. (12)

29. Non-DFID staff are increasingly involved in preparing, appraising, managing and monitoring projects. Clear procedures need to be defined (as set out, for instance, in the HPD HAPAE document, ODA 1996) to ensure a consistent approach through all stages of the project cycle, and a structured approach to the drawing out and application of lessons needs to be in place. The appraisal stage of a project should always be led by a DFID staff member, in order to promote improved design as well as to ensure consistency with wider DFID policies (10).

1

INTRODUCTION AND BACKGROUND

Aims of the synthesis

1.1 The aim, as with all Evaluation Department syntheses, was to bring together in one document an analysis of the findings and lessons learned from evaluations by ODA, now (since May 1997) DFID, and by other donors, of investments in population projects, and thereby to improve the future effectiveness of similar projects. It is not a review of all ODA assistance for population-related activities, but of a small number of evaluations of completed ODA projects, supported by a review of the experience of other donors. Terms of Reference are at Annex A.

Coverage and approach adopted

1.2 The basic raw material for the synthesis comprised:

- four ODA evaluations, covering a total of ten completed projects implemented between 1988 and 1995:
  - Employment-Based Family Planning, India, 1990-93 (EBFP)
  - Contraceptive Social Marketing, India, 1989-95 (CSM)
  - Contraceptive Supply projects (7), 1992-95 (CS)
  - Kenya Population III, 1988-94 (KPIII)

- One on-going ODA project:
Bangladesh Population and Health Consortium, 1992 (BPHC)

- A commissioned summary review of USAID evaluations, covering their experience with family planning programmes in five countries. (USAID)

- A published World Bank review (1993) on Effective Family Planning Programmes (WB).

- A report prepared for German Development Cooperation on experience with the Social Marketing of Contraceptives.

1.3 The ODA evaluations and the USAID review cover experience from a total of 14 different countries, 4 in Asia, 3 in Latin America, and 7 in Africa. Further details of this and other documentation used are given in the bibliography (Annex B) and, of the countries covered, in Annex C. Summaries of the evaluation findings for each project, and of the USAID review, are in Annexes F to K.

1.4 The ODA projects evaluated were selected by Evaluation Department (EvD) in consultation with H & P Division (HPD). As is customary with evaluations, these cover only completed projects, in order to allow some assessment of long term project impact. Because of this limitation, the range of projects from which the selection was made was not large. The main surge of ODA investment in population projects began only in the early nineties (see below) following the publication of "Children by Choice", and these projects, many of which are recorded in HPD's own report "Progress with UK Aid for Sexual and Reproductive Health" (1997), are still being implemented. Hence, those chosen were only a small number of projects, mostly designed and, in some cases implemented, before current policy towards the sector was established.

1.5 This evidence was to the extent possible supported by the experience in the sector of other donors. An extensive search of evaluation databases, however, revealed that only USAID had carried out any formal ex-post evaluations in the sector. Five evaluations of US country programmes were therefore selected for further study and were the subject of a review report commissioned from an independent consultant (Thomas 1996).

1.6 After a brief review of design, appraisal and implementation issues, the synthesis adopts an issues-based approach and is structured around the model logical framework for Children by Choice set out in the HPD appraisal guide, HAPAE (ODA,1996). This is based on best practice for defining population project goal (improving health status), purpose (improving utilisation of services), and outputs. There is no suggestion that any of the projects evaluated here should achieve all or even most of the objectives defined in the model logical framework - indeed, since the projects were designed and implemented much earlier, they would not necessarily have failed if they had achieved none of these objectives. The model framework does however offer a useful check-list of current issues in population and reproductive health against which to measure past performance - access, affordability, equity, awareness, quality, choice, efficiency, sustainability, participation and monitoring.

Background: ODA aid for population

1.7 Fertility levels have been declining steadily over the last 30 years but the absolute number of people in the world is still growing rapidly, with 95% of the growth in developing countries. Total population is approaching 6 billion and, depending on future trends in fertility and birth rates, may not stabilise until it reaches double this figure in the first half of the next century.

1.8 This rapid growth imposes serious economic and financial burdens on developing countries, though in recent years the emphasis of aid for population has switched from macro-economic benefits to the issues of improving choice, reproductive health and quality of life. Over 200 million couples and an unknown number of single people have no access to modern contraception and those that do have access suffer from inadequate information and poor quality services. Child-bearing is a major health problem for women (especially young women) in developing countries, with over 500,000 pregnancy-related deaths each year. Planned families lead to improved quality of family life by allowing women to spend more time and resources on the health and education of each child and by providing more opportunities to earn incomes outside the home. Even as fertility levels fall, surveys still show a continuing gap between desired and actual family sizes.

1.9 ODA launched the "Children by Choice not Chance" initiative in August 1991. The main principle was that all men and women should be able to choose if and when to have children and a secondary assumption was that if this choice were widely available, fertility levels and birth rates would begin to fall. British aid was to be used to improve the coverage and quality of reproductive health services and the availability of contraceptives, to give women greater control over their lives, and to help countries develop population policies. The target was to start 15 new projects in two years.

1.10 The 1991 target of new projects was exceeded threefold and, in 1994, this was backed up by a promise to approve at least 50 new family planning and reproductive health projects, at a commitment cost of at least £100 million. As is shown in Annex E, ODA expenditure on Children by Choice projects grew rapidly in recent years, rising from £14 million in 1991-92 to an average of £35 million in the period 1993-96. The increase in expenditure in Africa has been even faster, growing by over six times between 1991 and 1996. DIFD is now one of the major donors in this field.

2

IDENTIFICATION, DESIGN AND APPRAISAL ISSUES

Identification and design

2.1 ODA was not itself closely involved in the identification and design of any of the ten projects evaluated. The two JFS projects (EBFP and CSM) were conceived and designed by the British and Indian NGOs involved. Six of the seven CS projects were a response to requests from the recipient government, or from the UN Population Fund (UNFPA). With KPIII, which was funded in parallel with the World Bank, ODA became involved after the project had been largely designed because the Kenya Government did not wish to use IDA loans to fund grants to NGOs.

2.2 The design of all of the projects was judged to be consistent with the recipient governments' family planning policies at the time, and for all but the two JFS projects, the recipient government was involved in project design. The projects were also generally consistent with ODA population strategies towards the country concerned, and all recipients except Mexico were priority countries for ODA's health and population aid. However, the two JFS projects did not meet ODA's health objective for India of targeting the urban and rural poor, nor the JFS criterion that intended beneficiaries should be the poorest communities in the country concerned.

2.3 The technical quality of project design was mixed and all projects contained some design flaws. For instance, the purpose and the activities in the EBFP project were inconsistent. The project purpose was to recruit family planning acceptors but the activities were largely concerned with occupational and preventive health, in which family planning played only a minor part. This was not picked up in the ODA appraisal. The main defects in the design of the CSM project were the inadequate resources devoted to the crucial area of marketing and to research into consumer needs.

2.4 The initial design of KPIII put as heavy an emphasis on IEC as it did on service delivery, even though awareness of contraception and the demand for smaller families were already quite high, while access to family planning was inadequate in many parts of the country. There was no consultation with the wider NGO

community about the design and the NGOs selected to implement the project were not necessarily the most suitable.

2.5 The CS projects were simpler concepts, intended to meet clearly identified, short term needs for types and brands of contraceptives already in use in Government programmes in the countries concerned. All the projects followed a policy of continuity in this respect. Even though the projects had the simple objective of maintaining supplies, nevertheless in most cases target beneficiary groups were named. The difficulty of reaching such target groups, given the weak distribution networks, was identified but not addressed in project design.

Appraisal

2.6 The NAO report (National Audit Office, 1994) criticised ODA appraisals for not always looking at alternative approaches to meeting objectives, and, thereby, not always choosing the most cost-effective interventions. Whilst this was true of some of the projects evaluated, it is unlikely that population projects were any worse in this respect than those in other sectors.

2.7 It was possibly true, however, of the appraisal of the KPIII, which did not try to justify the technical approach adopted (eg the emphasis on IEC and expensive fixed clinics); look at the cost-effectiveness of alternative ways of providing services (more voluntary surgical contraception (VSC) outreach, community-based delivery (CBD) programmes, rented clinics); assess the ability of the selected NGOs to meet project objectives (eg were they appropriate for delivering IEC programmes); or the possibilities for focusing on underserved groups (eg low income groups, poorer regions, adolescents).

2.8 JFS projects are subject to different procedures from directly funded projects, being appraised and monitored by advisers from external institutions. There is a danger that external advisers are not always fully aware of DFID policies and concerns but the system seems to work well if it results in continuity of advice (in the sense that it is better than ad hoc use of individual consultants). In the two cases evaluated, different advisers were involved at various stages and the value of continuity was lost.

2.9 In the EBFP project, the appraisal failed to pick up the fragility of the technical design (see para 2.3 above), while the CSM project was not appraised by a marketing specialist and, as a result, gave insufficient attention to the amount of consumer marketing needed to reach the sales targets. It was assumed that the cost of this could be met from the expected surplus on sales income, but this assumption was unrealistic.

2.10 Economic appraisals for KPIII and for most of the CS projects concentrated on describing the general macro-economic consequences of reducing fertility and population growth, in terms of the demands on public expenditure; the pressure on land and natural resources; the difficulties of training and employing a larger labour force; the impact of high dependency rates on poor and vulnerable groups; etc. These generalised benefits are valid, but appraisals should also focus on the more immediate benefits of investment in fertility control to women and their children.

2.11 In recent years (and, in this case, relevant to the CS projects only), ODA made more widespread use of consultants to prepare projects. Whilst this is essential to develop projects in a fast-growing sector, consultants may not be fully conversant with DFID procedures and there is a need for mechanisms to ensure lessons are transferred from one programme to another. DFID staff should appraise projects more carefully, in order to promote improved design as well as DFID ownership.

Use of logical frameworks (LFs) and indicators

2.12 Six of the seven CS projects, and BPHC and KPIII, had old-style logical frameworks. Frameworks are not a requirement in JFS projects, though their use is now encouraged.

2.13 The NAO report criticised the health and population projects it reviewed for having goal objectives which were too broad and difficult to relate to activities and an over-emphasis, both in setting indicators and in monitoring, on inputs (eg number of clinics built) rather than on impact (number of people using clinics). This is a fair comment on the projects under consideration here but health and population projects were no different from projects in other sectors of this period and these errors and omissions have been largely remedied in recent projects.

2.14 In the KPIII IEC programmes, indicators of activities were measured (the number of trainers recruited and trained, the number of people attending sessions), but not the impact of the teaching sessions on their understanding and use of family planning.

2.15 The EBFP project did not establish any indicators of achievement at all, even though this was common practice in the NGO's other projects, which were more service delivery-oriented. Setting targets, and reviewing them at mid-term, would have helped to prioritise activities in line with the project's goal and purpose. The CSM project relied only on sales figures to measure project performance and these are an inadequate proxy for the effective use of contraceptives.

2.16 CS project goals (and in some cases purpose) were defined too broadly - eg “help reduce fertility rates”. Such objectives may be suitable for longer-term projects, but for short-term gap-filling projects such as these, a lower level goal objective is required. Another problem with the CS indicators was that many were not precisely specified - eg “stock levels at service delivery points (SDPs)”. These two factors meant that LFs were of limited use in the monitoring and evaluation process.

2.17 Some of the CS projects identified target groups in their LFs but in all cases the intention was to fill gaps in the government programmes, so the real target was all clients of government facilities. Fundamental changes would have been necessary in the way projects were designed and implemented to meet these identified targets. The LF should have accepted this by specifying achievable objectives.

2.18 BPHC is an example of a project with too many objectives, which were neither fully clear nor agreed in advance with stakeholders. In fact, the project started before the project document was finalised. For simple projects, this may not matter but BPHC had multiple objectives, multiple donors and multiple implementing agencies.

3

MANAGEMENT AND IMPLEMENTATION ISSUES

Management arrangements

3.1 According to the World Bank 1993 report, the quality of management of family planning programmes was the greatest area of improvement in the 1980s.

3.2 With the exception of the CS projects, all the ODA projects were implemented through NGOs, with a variety of different intermediary mechanisms - in India, the NGOs were directly funded through the JFS, in Bangladesh the funds were passed through Government and intermediary NGOs, and in Kenya through a government agency.

3.3 The two Indian JFS projects were managed by an experienced and competent family planning NGO, PSS, although it had had no previous involvement in CSM and, in the event, its UK parent NGO provided inadequate in-house technical support to the project in the field. The German review of CSM projects concluded that, while in general the private sector was more efficient than the public, projects only succeeded if the implementing agency was highly professional.

3.4 The BPHC project experimented with using two intermediary NGOs to channel funds, provide advice, and supervise the operations of 10 field level NGOs, as well as funding some of the NGOs directly. The evaluation concluded that the NGOs funded through intermediaries performed as well as those funded directly. One constraint on the success of the intermediary model was that the intermediary NGOs were not trusted enough to be treated more independently than the field NGOs.

3.5 The BPHC project also used an External Support Group to provide professional guidance and to monitor project performance. This was remote (based in the UK) and expensive; its two roles of advice and monitoring conflicted, and whilst it was good on technical reproductive health issues, it was less able to cope with cross-cutting issues such as capacity building and financial sustainability.

3.6 The management arrangements for KPIII involved the use of a government agency (NCPD) to channel funding to the implementing NGOs. NCPD was a specialist

population agency with planning and co-ordination functions but no real power - this lay with the Health Department, which is responsible for all the SDPs (private and public). Considerable resources went into trying to strengthen NCPD's capacity but this was unproductive. It was not the most appropriate organisation to run a service delivery project as it lacked the autonomy to handle donor finances efficiently and it was unable to add value to the work of the NGOs. Much of the heavy investment in training was lost though staff leaving. The evidence of this project is that offering overseas training to almost the entire professional staff of an organisation is not an effective means of strengthening capacity.

3.7 No specific ODA project management arrangements were planned initially for KPIII, something which would not happen nowadays, but a field manager was eventually appointed in 1990. He was in the difficult position of being appointed by and paid by ODA, but based in the World Bank office, and responsible to each for separate components of the project. World Bank procurement problems were causing most difficulty at the time, and he spent most of his time on this, leaving little time to manage the ODA components. Management of these was left to the joint annual review missions. These took place regularly but hardly any site visits were made outside Nairobi, as a result of which the World Bank, for instance, was unaware that several civil works contracts had stopped, while for ODA, it meant a failure to pick up on the lavishness of some of the clinic construction.

3.8 The CS projects had a range of different ODA management arrangements - Development Divisions plus in-country staff, London advisers plus Field Managers, the British Council, a locally based adviser. The evaluation found no significant relationship between the type of management and the effectiveness of the project. The use of Field Managers and Development Divisions led to closer monitoring but did not guarantee progress as planned. ODA improved its management of projects in the last 6 years by recruiting around 20 Field Managers, and their increasing involvement makes it more important to institutionalise lessons learnt across DFID.

3.9 Only the CS projects involved competitive tendering. Such tendering was not necessarily any guarantee of quality and could be the reverse if it meant moving away from proprietary brands bought through normal channels.

3.10 In both of the JFS projects and, to some extent, in the NGO component of KPIII, financial management was in sterling rather than local currency. Depreciation of the local currency, which in India was not negated by inflation, permitted a much greater volume of activities to be financed than were originally approved - 32% more in the case of EBFP. The real level of activity in KPIII was probably not much greater than planned

but the rate of expenditure between the different NGOs varied between 68% more and 50% less than had been planned.

Role of NGOs

3.11 The private sector plays a significant role in running family planning programmes throughout the world. Its share varies, being highest in Latin America and Africa where on average more than half the family planning users rely on private sector supplies, but is lower in Asia where the average is only 20%. This depends on historical factors (NGOs and private firms in many countries were working in this field long before Governments) as well as on the predominant type of contraceptive in use (intra-uterine devices (IUDs) and sterilisations are more likely to be provided by the public sector).

3.12 A successful family planning programme which aims to maximise client access will generally involve using multiple service delivery channels - public, commercial and NGO. Of the ODA projects, all but the CS projects were implemented through NGOs and, in all cases, these complemented public sector programmes, some of which were also financed by donors.

3.13 Public and NGO family planning services have complementary advantages and drawbacks. NGOs have more freedom to focus their resources on family planning, to limit service coverage to maintain high quality, and to engage committed staff. Both in India and Honduras, the experience was that NGOs offered services of a consistently higher quality than the public sector; in particular, treating clients with greater respect and privacy. Management was more efficient, and staff more professional and committed.

3.14 NGOs have the potential to use participatory approaches and can thus provide useful feedback on what priorities and expectations people have from health services; they are flexible and more able to experiment than are government agencies and can provide lessons for scaling up; and have a wider advocacy role on behalf of beneficiaries.

3.15 On the other hand, NGOs can be criticised for their limited coverage; dependence on external funding; and the need to recover some costs may, in some cases, exclude the poor.

3.16 Some of the advantages which NGOs are perceived to have are not fully supported by the evidence, though in most cases they are probably better than government agencies. There is a belief, for instance, that NGOs have a comparative advantage, or potential, to focus on the poor and marginalised. The main problem is their lack of capacity to reach difficult populations. None of the four ODA projects implemented through NGOs managed to reach the poorest groups (see paras 4.7-13). There is also a potential conflict and trade off between poverty focus and the need to recover costs. NGOs have the

potential to deliver cost-effective services but they are not necessarily cheap if they are dealing with groups difficult to reach.

3.17 The advantages of the public sector include their broader geographical and social coverage and the availability of funds from the national treasury as well as from donors. On the other hand, public sector family planning activities have to compete with other health, social and political priorities for resources; and their need to cover the whole population may lead to a thin spread of resources and poor quality services.

3.18 Working through NGOs is, however, no guarantee that programmes will be run independently of government. The private sector still depends on a supportive government, and on subsidies to serve low-income users. In Bangladesh, for instance, the Government (GoB) reserved the right to, and in practice did, exclude particular NGOs from benefiting from BPHC, and to turn down particular projects submitted by participating NGOs if it disapproved. This may reduce the flexibility of the NGO model - in this case, the GoB's close involvement meant that reference had to be made to BPHC for every change of approach. In India, the CSM project was dependent on government for its supplies of subsidised contraceptives. In Kenya, the government would only allow NGOs to be funded through a government agency.

3.19 Donors need to be clear why they are supporting NGOs, whether as a sound long-term strategy or a short-term response to government incompetence, and of the need to co-ordinate with government programmes. Not all NGOs are good at all activities and the experience of KPIII is that care needs to be taken to analyse their strengths and weaknesses in order to choose those most appropriate for the jobs required of them. They should be consulted about project design and should agree and understand the targets against which their performance will be judged.

3.20 BPHC was judged to have been effective at supporting smaller NGOs. Those funded were relatively free from corruption and, as a result of project support, have grown in size and competence. However, this success involved close hands-on management and monitoring by the project management office and the ODA office in Dhaka, which might today be contracted out to others.

3.21 One of the main roles for NGOs in the past was to make family planning respectable. In Kenya, the first family planning programmes were begun 30 years ago by NGOs when the subject was very controversial. In Honduras where there was minimal or no political support for family planning, ASHONPLAFA became the country's leading family planning advocate and the main service provider. In the Philippines, NGOs played the leading role in promotion and delivery - the role of the commercial sector was insignificant.

3.22 NGOs could in future be encouraged to concentrate on the provision of services, which they are probably able to do as cost-effectively as government. NGOs also have the potential to act in areas a government may hesitate to enter, such as the provision of services for adolescents or HIV prevention among prostitutes.

3.23 The most successful form of public-private co-operation has been social marketing, where contraceptives (usually subsidised by the government) are marketed through commercial channels, thus taking advantage of existing distribution systems, as well as recovering a proportion of costs from the consumer. The experience of the CSM project in India, however, is that if this is to be financially self-sufficient in the longer term, the viable scale of operations may be much bigger than can be handled by a non-specialist marketing NGO.

3.24 Another means of using the private sector is through services provided at the workplace. Experience in the EBFP project in India and elsewhere is that such programmes are most attractive to employers in situations where large numbers of women are employed, or where employers pay statutory benefits and provide free health treatment for employees and their dependants, especially firms at isolated locations. In organisational settings where these conditions do not prevail, the marketing of employment-based family planning is more difficult, as proved to be the case in India.

4

IMPACT: ACHIEVEMENT OF GENERIC OUTPUTS, PURPOSE AND GOAL

4.1 As noted in paragraph 1.6, the headings in Chapter 4 are based on the model logical framework presented in the HPD appraisal guide (see Annex D). The model is used as a check-list of current issues in population and reproductive health against which to measure past performance.

OUTPUTS

Access to services

4.2 The USAID evaluators reported that in each of the countries studied, national fertility surveys had found a significant unmet demand for family planning. To enable individuals and couples to make effective reproductive choices, family planning programmes need to remove social, financial, information, psychological and administrative barriers to services and ensure that a reliable and appropriate range of services and contraceptives is available. Quicker access and availability of a broad range of contraceptive methods have been shown both to increase contraceptive use and to encourage continuing use. In Tunisia it was found that women who had heard family planning messages and had easier access to services were more likely to use contraception, and more generally, urban populations (which tend to be better covered) have higher contraceptive use than rural ones.

4.3 All the ODA projects contributed to some extent towards improved access. The CS projects had as their main aim continuing access to contraception, by avoiding a break in supplies. Although there were delays in most projects, the available management information (MI) does not permit a conclusion that these resulted in consumers being deprived of supplies. Both the BPHC and KPIII managed to strengthen the service delivery capacity of the main NGOs which they funded. The CSM project moved into smaller, rural settlements which were not supplied with other CSM brands, and succeeded in increasing the choice and availability of spacing methods for new consumers in those areas. EBFP probably achieved the least in that it concentrated on short-term awareness programmes not clearly linked with the sustained provision of services.

4.4 One of the main challenges of family planning programmes is to improve service delivery and use amongst more difficult to reach communities, often in the face of strong opposition from religious groups and the government. In general, the ODA projects were not very successful in this aim. The CSM project will have reached a small number of unmarried and teenage customers, and men who do not have access to supplies where these are routed through MCH clinics, but in each case only those who can afford to pay. The BPHC supported some NGOs working with remote fishing communities and others with adolescent slum dwellers. On the other hand, in KPIII, an opportunity was lost to encourage one of the programme partners, the Catholic Church, to increase the effectiveness of its natural family "services" by offering advice on breast-feeding, and by promoting wider knowledge of the infertile period, among the very large numbers of couples using unsophisticated forms of periodic abstinence.

Affordability of services

4.5 Without public provision of family planning services, the World Bank review estimated that the average user in developing countries would need to spend around 5-6% of income on contraceptives, though in some poorer countries, this figure would rise to 20% or more. (This compares with around 1% in developed countries, even though prices there are double).

4.6 The CSM project and the service NGOs in KPIII provided services at below cost, while there were no charges made in the CS projects, and to this extent, they will all have contributed towards this objective, though only in the short-term. The major success of CSM projects round the world has been in opening up hitherto untapped markets, reaching for instance people who fall beyond the reach of the free public sector but who cannot afford full cost private services. Nevertheless, projects which charge for their services are of no use for people who cannot afford to buy, hence however weak the public sector is, it will always have a role to play in serving the economically weakest groups.

Equity in provision of services

4.7 Each of the ODA projects had some aspiration to provide information or services to poorer groups, and for the JFS projects, this is written into the rules. None was particularly successful.

4.8 In BPHC, later versions of the logical framework dropped any reference to the

original target groups (the poor, the underserved and women). The participating NGOs had no policy of targeting the poor and may even have been precluded from doing so by government policy. The GoB decided in which areas the project should operate and these were selected (with some logic) to be areas which were underserved in the sense of having poor access and low prevalence rates. However, areas defined as such did not necessarily contain a high proportion of poor people but tended to be conservative and traditional areas which often contain better off communities. Three case studies undertaken as part of the evaluation showed that 25% of beneficiaries were moderately wealthy and 32% were rich. However, these definitions have to be interpreted in the context of income levels in Bangladesh, where the poorest are very difficult to reach. The bulk of the population is poor, and a valid target for projects of this kind.

4.9 The JFS scheme gives very high priority to population projects (it is the only sector which receives 100% funding), yet it appears to be very difficult to design population projects which meet the over-riding JFS objective of benefiting those from the poorest communities. For instance, the EBFP largely concentrated on low-middle income groups, in the organised industrial sector, who are relatively well off, especially in terms of job security. This reflected where the demand came from, as well as the need to charge for services, which meant concentrating on the better off and more enlightened firms.

4.10 The CSM project design was based on the use of commercial retail outlets, and it was not therefore possible for the project to restrict benefits to specific groups. There may be some scope for reaching poorer groups by using targeted advertising and marketing campaigns, and by careful choice of distributors and stockists, and the project did succeed (at some cost) in moving into otherwise unserved rural areas. CSM projects are generally more cost-effective in urban areas, where distribution and marketing costs are lower. More difficult and poorer target groups can be reached through CSM only if the conflicting aim of cost recovery is given a lower priority.

4.11 All the CS projects identified target groups in their objectives but the main objective in each case was the meeting of a temporary shortfall in contraceptive supply. A direct impact on poverty reduction was not an explicit objective and project design (not unreasonably) did not reflect these targets but simply used existing distribution systems. To have reached target groups would have required fundamental changes in the project design. Five of the seven were low income countries (the exceptions being those in Latin America). Although, in most cases, the project frameworks refer to poor or rural women as the target group, the beneficiaries were in fact, all users of the public health system, (except in Mexico where distribution was more focused on the poor). These projects therefore broadly benefited the poor rather than specifically targeting them.

4.12 The design of KPIII did not look at the needs of poorer groups, or try to select NGOs which specialised in reaching under-served parts of the country. The nature of the project means that it will have contributed to poverty reduction but there is no evidence that services were focused on the most needy. The large new fixed clinics constructed under the project are all located in urban areas and can therefore reach only the urban poor. Moreover, their high standard of design may also discourage the poor from attending. CBD programmes, that have the highest potential for reaching the poorest, were not a strong project feature. The IEC programmes were directed largely at schools, thus missing those children, often from the poorest homes, who do not attend schools.

4.13 If population projects are to have a poverty focus, time needs to be spent at the outset on developing strategies that will reach the poor. Working through NGOs is no automatic guarantee of reaching poor people, and care is needed to select the most appropriate NGOs with access to poor and vulnerable groups. If a project is allowed to operate only in areas selected by government, the aim should be to try to focus on poor groups in those areas. In many countries, it may be the case that the needs of the poorest can only be met through free public sector distribution outlets.

Increased awareness

4.14 IEC is important for the raising of awareness and knowledge, especially among younger groups, and the promotion of child spacing as socially acceptable and normal behaviour. IEC can also be critical in maintaining continuing and effective contraceptive use. The USAID evaluations concluded that, in a number of countries, poor IEC led to high drop-out rates and low use-effectiveness. Private groups can often be more flexible than the public sector in addressing sensitive issues, and are more effective at running modern consumer education campaigns giving specific information (what methods are available, where from, how much do they cost, how are they used) rather than the generalities common in traditional IEC programmes.

4.15 A 1990 review of IEC projects in sub-Saharan Africa, quoted by the WB review, identified many weaknesses. Successful programmes need to be long-term, responsive to the audience, of high quality, and co-ordinated with service provision. There is a tendency to approach IEC through one-off awareness programmes, sometimes without adequate research into what information the audience wanted or needed, without follow-up, and without impact evaluation.

4.16 In the EBFP programme, for instance, many employees received only one exposure to an awareness programme and this would have been more effective with back-up from worker-motivators as a continuing source of advice, as well as a sustainable source of

supply of contraceptives. No attempt was made to measure the impact of the IEC programmes in EBFP or KPIII.

4.17 Lack of proper information is a particularly important constraint on increasing usage of the oral contraceptive pill. In India, there are considerable fears and misconceptions which hinder its more widespread usage and studies elsewhere have shown that, even in countries where the prevalence rate for contraceptive pills is high, there are also high levels of incorrect usage. The CSM project in India did not have enough marketing funds to provide more consumer information - booklets were prepared for doctors only. Another issue is that doctors, who are a primary source of information, were often reluctant to promote a low margin CSM brand, rather than a commercial one.

4.18 On the other hand, there has been a tendency to underestimate the awareness of contraception and to put too many resources into IEC programmes rather than improving service delivery or attacking some of the other causes of low prevalence rates.

4.19 In Honduras, for instance, knowledge of family planning was found to be high and lack of knowledge was not an over-riding reason for non-use. KPIII's initial design put undue emphasis on IEC at the expense of service delivery, even though, on the one hand, awareness of contraception and the demand for smaller families was already quite high and, on the other, access to family planning was inadequate in many parts of the country.

4.20 There are a number of reasons why it is possible for low usage rates to exist alongside evidence of high awareness of contraception and strong desire to avoid pregnancy. These include: the lack of convenient access to services, for instance by unmarried women and teenage girls; the separation of family planning from regular health services; high infant mortality rates; and such cultural factors as women's low status and the long term insurance value of large families.

4.21 In support of this, the WB review claims that even if it were possible to fulfil only existing unmet need, in other words to concentrate on service delivery to those who are both aware of and want contraception, and with no more expenditure on promotion, it would be possible to bring fertility down, in all but sub-Saharan Africa, to close to replacement levels, ie around 2.0.

4.22 Additional evidence that services are of greater importance than information comes from comparison of the historic performance of family planning programmes in India and Sri Lanka. India had more public statements of support and better advertising but Sri Lanka delivered a wider range of contraceptives more effectively, especially through CBD, and its programme has been far more successful.

Quality and effectiveness of services

4.23 Research has shown that clients are more likely to use and to continue using services which ensure privacy and treat them with respect and this was demonstrated in several of the USAID case studies. According to the WB, improvements in quality may also lower unit cost if, for instance, these involve quicker throughput in an SDP, less form-filling, or the employment of more user-friendly paramedics. Compared to other areas, however, the development of tools for measuring quality has been relatively neglected (see paragraph 4.67).

4.24 Most of the ODA projects evaluated did not have specific components for improving quality, other than those mentioned in other sections of this chapter (improved access, more choice etc). The BPHC evaluation case studies, however, concluded that the quality of NGO-provided services is generally better than that in government programmes, and that beneficiaries are more likely to express satisfaction with them. To the extent that most ODA projects have operated through NGOs, they are likely to have contributed towards this objective.

Increased choice and women's empowerment

4.25 The projects evaluated did not aim to address wider societal gender issues, but women are the primary beneficiaries of projects such as these which improve access to fertility regulation. It gives them autonomy and control by allowing them to make choices about when and how many children to have. It helps young women complete their education. It reduces the risk of maternal mortality, especially for older women, by reducing the total number of children born and increasing their spacing and it reduces the dangers and costs associated with unsafe abortion. For every death avoided, a great deal of potential ill health is also averted. The wider use of condoms contributes to the control of STDs and HIV, to which women are more vulnerable than men.

4.26 Most of the projects contributed to increasing the available choice of contraceptive method. The CS projects were an exception in that they supplied types of contraceptive already in use in existing government programmes (except in Zambia, where Norplant was also supplied for the use in trials). As short-term stop-gap projects, it would have been unreasonable to use them to experiment with new brands or types of contraceptives. The CS projects also sought in their objectives to improve the quality of life of all contraceptive users, explicitly women in some cases, but as straightforward supply projects they did not address the social, economic and cultural barriers which prevent women from accessing contraceptives. Follow-on projects in the same countries did, however, adopt a wider approach which took these barriers into account.

4.27 The CSM project was fully in line with GoI policy to promote more widespread use

of temporary methods. It also aimed to increase women's access to and choice of temporary contraceptives, but gave insufficient attention to the differing strategies required in India for the sale of contraceptives to men and to women. In the Indian socio-cultural context, where discussion about family planning between couples is limited and men are the primary family decision-makers, the improved availability of contraceptives, without strong information and educational activities targeted at both men and women, is unlikely to have a significant impact upon women's decision-making power to buy contraceptives.

4.28 The potential of the CSM project to increase the awareness and use of oral contraceptive pills (OCPs) was not realised. Gender-specific data on purchasing patterns were not collected (anecdotal evidence suggests that men were the prime purchasers of both condoms and OCPs). Greater sensitivity to gender issues and their implications throughout the project cycle would have highlighted the need to develop different strategies for selling condoms and OCPs to men and women. One of the reasons was that women did not participate in the project's management and the level of gender-awareness amongst the project managers was poor.

4.29 By contrast, the headquarters unit of the BPHC project led by example in its staff recruitment and training policies but the approach to organisational gender issues was too narrow and target oriented, and it failed to influence change in the behaviour of the implementing NGOs. However, the evaluation case studies concluded that the project has led to gains in empowerment for women beneficiaries.

4.30 In KPIII, the two service NGOs made available a wider range of contraceptives - eg injectables, and Norplant and VSC outside formal clinics. Only the Catholic KCS offered the option of NFP services but it actively discouraged the use of alternatives. The evaluation identified some lost opportunities for NGOs whose religious beliefs prevent their recommending physical methods. These included the promotion of methods such as extended breast-feeding and the wider dissemination of information (including through the mass media) on the infertile interval, for the large number of couples using unsophisticated forms of periodic abstinence.

4.31 The EBFP project was unusual in that it set out to have a male focus, targeting male employees at the workplace. Women received some services through outreach activities in the community but this was not a major emphasis. However, the female partners of the workers targeted would also have benefited indirectly if the activities led to greater male responsibility for, and increased spousal discussion of, family planning. The extent to which project interventions were able to stimulate attitudinal and behavioural change in couples' family planning decision-making is not known but the project made a modest contribution to the difficult process of increasing male awareness and responsibility for family planning and for other reproductive health issues, such as sexually transmitted diseases and AIDS, which inevitably also affect women's health.

Efficiency of delivery

4.32 Experience from the USAID and ODA studies all illustrate the difficulty of measuring the effectiveness of family planning services due to the non-availability of cost data. Greater attention to the collection of cost data is required if governments, NGOs and donors are to use cost-effectiveness principles in designing and evaluating activities.

4.33 Generally, cost data, when available, were used to measure cost per couple year of protection. CYP measures the length of contraceptive protection provided by the use of different contraceptive methods, and is a straightforward and widely used indicator for measuring family planning programme effectiveness. However, CYP does not reflect quality of care issues, or the effort required to meet different target groups. If used as the sole decision-making guide, it would favour urban (high density populations) and clinic-based methods (these, and in particular sterilisation, have high CYP values). It would count against community-based distribution programmes which tend to focus on supply of contraceptives or on remote, dispersed communities. To gain a fairer assessment of effectiveness, CYP needs to be combined with measures of quality and access, such as user satisfaction, continuation rates, range of methods available, physical and financial access.

4.34 In Honduras, the NGO ASHONPLAFA had good cost data, which showed that, over time, cost-effectiveness had improved consistently. The order of cost-effectiveness was: first, clinic-based medical services; second, CBD: and third, social marketing, because clinic services are largely sterilisation and IUD, which have high CYPs. However, this conclusion must be counterbalanced by the fact that CBD is more effective at reaching the poor, so there is a trade off between equity and efficiency, while CSM, though the least cost-effective, has the best cost-recovery and therefore the greatest potential for sustainability. All methods are complementary, depending on the priority given to different objectives.

4.35 It is difficult to compare efficiencies across projects and across methods because of the variation in methodology used, and the ODA evaluations did not produce any useful comparative data on relative costs. In some countries, USAID have demonstrated good cost-benefit ratios for family planning programmes but none of the ODA evaluations had sufficient data to attempt a cost-benefit analysis. These are probably more appropriate for programmes as a whole rather than projects.

4.36 The CSM project in India was relatively cost-effective, even though revenues fell well short of costs. It supplied family planning services at a total cost of £2.05 per CYP (the cost of ODA support was 82 pence per CYP). These compare favourably with results from international studies.

4.37 International costs of contraceptives in the CS projects were, with one exception, within the range of then current international procurement prices. Even so, the evaluation concluded that reductions can be achieved by careful selection of supplier. UNFPA was the cheapest source because of its bulk-buying powers.

4.38 The costs of delivering CYPs in the EBFP project were very high because most of the activities and therefore expenditure were concerned with the provision of general health services.

4.39 Of the NGOs supported by KPIII, only the Family Planning Association (FPAK) kept cost data, and these were high. The ODA project would not have helped this if the full cost of the new clinics were factored into the calculation. The construction of new facilities can use up an excessive amount of resources without contributing much to the achievement of project objectives. Rehabilitating existing buildings, renting space, providing services in makeshift facilities nearer to the consumer, and/or promoting non-clinic-based CBD programmes may be more appropriate and cost-effective.

4.40 No costs were available from BPHC. The evaluation concluded it was unlikely that, even if collected, they would have been used to allocate resources. The BPHC allocated funds not according to need or per capita cost (this varied by a factor of 10), but on the ability of NGOs to absorb funds. There was no concern for cost-effectiveness of resource use, and Bangladeshi NGOs were not accustomed to an outcome or performance oriented approach, or trained to use one. The concentration was on managing resource disbursements, not on the efficiency of their use.

Sustainability

4.41 Operational sustainability, making sure programmes can operate without donor advice and management, is one thing that all these programmes might expect to achieve in the short-medium term. Financial sustainability, which depends on agencies achieving some degree of cost-effectiveness and cost recovery, has proved more difficult to achieve. ASHONPLAFA in Honduras, for instance, is one of the most successful NGO agencies and is institutionally sustainable, but it receives 62% of its funding from USAID.

4.42 There can be no universal criterion for deciding when a family planning programme can become financially self-sufficient. According to USAID evaluations, sustainability is not possible until a stable demand has been generated, with a CPR of around 30%. This seems highly optimistic, and unlikely to be sufficient in itself, as a number of countries (eg Kenya and Bangladesh) have already exceeded this level of CPR yet, without continuing donor support, their programmes could not be expected to maintain services to other than a small minority of people.

4.43 Tunisia was one of USAID's most successful programme and was judged to have the best potential for sustainability - positive factors included the strong political commitment which ensured continued budgetary support even in difficult economic conditions, perceived effectiveness and a strong training component. Even with these

advantages, however, and after 25 years of USAID involvement, the programme could not be fully sustained on withdrawal.

4.44 None of the ODA projects addressed sustainability from the beginning. The CS projects did not address the issue at all as they were a one-off supply to meet a shortfall. All recipients except Mexico are heavily dependent on donors and these projects will not have reduced dependency. However, subsequent projects in four of the countries contained CS components, in the context of health sector reform, to encourage sustainability.

4.45 In some cases, project design or project conditions could, for the best of motives, be in conflict with sustainability objectives. For instance, in Honduras, USAID saw the need to expand coverage to reach difficult groups (the poor, rural areas), but for the NGO implementing the programme, this had the double disadvantage of being a more expensive strategy, and one which offered less scope for cost-recovery. It is also important to set achievable targets. In the Philippines, unrealistic design targets were set, and were not met, resulting in the perception that the programme had failed, whereas viewed against realistic targets, it had been quite successful. When the USAID withdrew from the Philippines, the more expensive (but possibly some of the more effective) elements of the programme, such as outreach, could no longer be afforded and were dropped.

4.46 The relatively short period of ODA JFS funding may encourage agencies to go for short-term results so as to attract follow-on funding. In the case of the EBFP, this may have reduced selectivity in starting new activities, or taking on new firms, or in expanding geographical coverage. Similarly, in the CSM, there was a perceived pressure in the short term to push up sales which, as it involved expanding into new areas, increased the operation's cost and complexity.

4.47 CSM projects are a cost-effective solution to improved access to contraception, and are thus appropriate for the JFS, but may require a longer term approach than the maximum of five years funding which is generally permitted under JFS procedures. The CSM project in India could only become financially independent if it could raise the volume of sales three or fourfold, which would in turn require a major, and risky, investment in marketing and in project staffing, which needs to be externally funded.

4.48 More generally, the potential for CSM projects ever to cover full costs remains in doubt. The German review of CSM concluded that even those projects operating in the most favourable circumstances - serving middle income groups in better-off countries, with minimal expenditure on public information - have only been able to recover part of their costs. For projects operating in poorer countries, and targetting lower income groups, it is unrealistic to expect to achieve sustainability, without seriously compromising on poverty-focus objectives. Hence, a compromise has to be made explicitly between the conflicting aims of recovering costs and reaching target groups. In other words the poor

can only be reached if cost recovery can be made a lower priority.

4.49 To some extent the design and funding of the KPIII project has placed the family planning NGOs in a difficult situation. Funding was quite generous and some NGOs set up over-engineered, expensive programmes. As DFID's support is withdrawn, and the NGOs are thinking about self-sufficiency, the type of service they have to sell and its location makes it likely that they will focus on the middle strata of society. Originally, most NGOs had the service of the poor as a leading goal but that focus has now been lost. Of the ODA-funded NGOs in Kenya, only FPAK has made a start with charging for services but it is still able to recover only 9% of costs.

4.50 The only successful example of sustainability was the EBFP project. When funding ceased, the agency became more restrictive in selecting firms in which to operate, better at marketing its services, and insisted on charging employers the cost of services provided. Unfortunately, this will have further weakened the poverty focus, excluding those smaller companies both with less potential to pay for services and less able to provide health and family planning services to employees from their own resources.

4.51 With one exception, the CS projects made no provision for cost-recovery, as this would have been inappropriate for a short-term supply project - all that can be done is to follow standard practice. The exception was in Zimbabwe, where the introduction of a charge resulted in a significant drop in demand, and the consequent withdrawal of the charge.

4.52 Project design may need to accept that many countries, and many consumers of family planning services, will not be able to afford to pay for the full cost of contraceptives for the foreseeable future, and that continuing donor aid is therefore required. A strategy may need to be introduced from the beginning, focusing on how, when and over what time period support should be provided. This does not mean that funding should be withdrawn totally, if that is unrealistic, but that ways should be examined in which the financial dependence of countries or partner agencies is reduced. This may involve, for instance, forming consortia of NGOs and devising an exit strategy by which an increasing share of recurrent costs is funded by the NGO or the community, based on an early and realistic assessment of the level of services for which they can afford to pay.

4.53 Thus, two common features of family planning programmes are the continuing high level of donor involvement and the limited degree of cost-recovery. The continuation of donor involvement and of subsidies has to be justified by the external costs of rapid population growth, both within countries (eg future government spending on education, slower economic growth) and in the outside world (eg environmental impact, emigration pressures). Subsidies to the final consumer are necessary to ensure continuing widespread access to family planning services, and maintain the momentum of the recent rapid growth in prevalence rates. The evidence from the reports considered here is that projects

involving subsidies and supported by external donors, rather than weakening the private sector, have an excellent record in developing NGO and other private sector capacity to deliver services.

4.54 Most governments cannot afford to fund existing levels of investment in family planning, let alone cater for future increases. In Kenya, for instance, the government contributes less than 10% of the current cost of the family planning programme. If demand were to grow at current rates, and even allowing for some economies of scale in provision, the KPIII report estimated that by 2005 the total cost would be double that at present. For the government to take over full responsibility would mean increasing its financial contribution by 20 times, clearly not possible in a situation where per capita expenditure on health is actually falling. Thus, although individual projects will have generated some permanent benefits, the sustainability of programmes in their entirety will almost wholly depend on contributions from donors, who will accordingly need to develop long term strategies for aid for family planning, rather than expect sustained success from single projects.

Community participation

4.55 Community support is as important as national support to the success of family planning programmes but examples of community participation are rare. Of the USAID evaluation studies, only that for Honduras attempted to look at the programme from the users' perspective, using focus groups to assess the quality of services offered.

4.56 There is an implicit assumption that because NGOs are ground-roots organisations, using them is a guarantee that communities will be more involved. This does not seem to be the case. One reason is that participatory approaches may be more expensive for NGOs even though, on value for money grounds, they may still be justified.

4.57 In BPHC, none of the NGOs had involved communities in needs assessment, although this was encouraged at a later stage. The EBFP project was not able to consult workers, partly because of the industrial relations context in which it operated - the NGO which ran the project had to get management support before it could work within a firm. The CSM projects had no money for market research to try to assess who consumers were and what they wanted. As for KPIII, there is no evidence that the NGO community as a whole was consulted about the project design, and more specialist help could also have been given to the selected NGOs to help them plan their programmes. Community participation was not relevant for the CS projects.

4.58 Although not strictly participatory, community-based outreach strategies have in many countries proved to be the linchpin for the provision of information and supplies of

contraceptives. In Tunisia, for instance, USAID concluded that the home outreach programme was an important means of contacting and serving rural women, whose mobility outside the home is culturally restricted. There is consensus among family planning experts that CBD of non-clinical contraceptives in areas where there is a high unmet demand and poor services leads to increased contraceptive use, and plays a significant part in maintaining continuing use as a programme develops.

Monitoring and Evaluation

4.59 Effective planning and management requires a reliable and accurate information system, the collection and regular analysis of performance measures, and research to test new approaches. The USAID evaluations illustrate considerable weaknesses in both the collection and analysis of data, as did the ODA evaluations. Every report points to the lack of data by which to judge project impact. In many cases, the data do not even record with any accuracy essential management information such as the cost of the different project components. This is despite the fact that in almost every project, and in some cases at considerable expense, a purpose built monitoring system was set up. These were generally not focused on the key issues, were far too complicated, and were not designed by the people who would be generating, collecting or analysing the data.

4.60 The problem in many cases was not due to the lack of quantity of information. In BPHC, for instance, the quantity of information collected was huge and NGO staff spent 20% of their time on collecting and reporting data. The problem was to do with quality and relevance. The system was data-supply driven, the staff who collected the information were neither trained nor supervised, and were not its ultimate users. The main purpose of collecting the information was to measure the achievement of national immunisation and family planning targets. Since the demand for excessive data comes largely from the GoB, improvements cannot be made by one project on its own, though possibly if all donors operated jointly this might have some influence.

4.61 By contrast, some of the most successful programmes collect information on only a few key indicators. The World Bank quotes the example of a project in Indonesia, where just three pieces of information were collected - the number of new acceptors, the types of service provided, and stocks. The fewer the indicators, the simpler the paper work, the more accurate the data collected, and the more likely the data are to be analysed.

4.62 In other cases, the information collected was not relevant to the assessment of impact. For instance, the EBFP did not assess the level of family planning knowledge of target groups before and after IEC interventions. Another failing was not to measure additionality. EBFP kept information on the volume of commodities supplied and the number of referrals to clinics but this could not distinguish between additional users and those diverted from other sources of service.

4.63 In attempting to measure impact, CSM projects tend to focus on short-term quantitative data, especially sales figures, rather than on qualitative indicators which measure longer-term impact such as the level of understanding of contraception, improved continuation rates and the overall contribution to increasing prevalence. The Indian CSM project measured only sales results, and was unable, due to lack of funds for research, to build up information on the socio-economic characteristics of consumers and the background to their contraceptive purchasing. This information would have been useful both to measure long-term project impact, and to help the company in the short-term to refine its commercial and marketing strategies.

4.64 In other cases, no information was collected, it was irrelevant to the target being measured, or it was not used. In KPIII, detailed targets were set for IEC activities to be carried out by NGOs (numbers of teachers trained and numbers attending classes), but no data were collected by which to measure the qualitative impact of training programmes on either the trainee teachers or the trainees themselves. Progress reports on activities were submitted by NGOs to the managing agency, NCPD, but the latter made no attempt to consolidate and analyse reports.

4.65 Even in cases where targets were achieved, this did not necessarily accurately reflect success - for instance, in BPHC, one target was for 25% of NGOs to be operating independently. Project staff therefore concentrated their efforts only on the best 25%. In another case, the project used a check-list to measure "capacity strengthened" but altered the rankings if the results did not tally with their own instincts and knowledge of the NGOs.

4.66 The way the KPIII project budget was set up made it virtually impossible to monitor progress against the detailed targets in the project memorandum and, in the event, the distribution of actual expenditure bore little relation to that planned. Annual reviews by donors took place as planned but, because few visits were made outside Nairobi, these failed to detect implementation problems in the field.

4.67 Monitoring systems, evaluation methods and performance indicators should be defined at the design stage and discussed and agreed between DFID and the implementing agency. Either they should be capable of measuring the achievement of defined objectives or objectives should be limited to those for which achievement can be objectively measured in a cost-effective way. For IEC components, MI systems should facilitate the collection of data on impact, especially that of training programmes. For service delivery components, NGOs should be helped to collect and analyse data which will provide the number and unit cost of CYP achieved, and to use this information as a management tool.

4.68 National demographic and health surveys are central to family planning impact assessments but their quantitative nature has weaknesses. The survey methodology, by its very nature, discourages in-depth enquiries and is not a particularly good method for investigating respondents' depth of knowledge about contraceptives or perceived quality

of care. As demonstrated in the USAID Ghana and Honduras studies, qualitative data collection methods, (eg focus group discussions) are a useful tool for supplementing and investigating the meanings behind survey results. these were not used in the ODA projects.

4.69 In the old style population projects, goal and purpose indicators (growth rates, fertility levels, prevalence) were often easier to measure than some of the output indicators. The latter were concerned, inter alia, with target groups and quality of service, whereas the purpose and goal were simply numbers. As the thrust of support switches towards capacity building, financial sustainability and resource management, new indicators will need to be developed. Similarly, the shift in emphasis away from family planning and the measurement of demographic impact towards reproductive health will require the development of new measures of programme impact (such as maternal morbidity, abortion incidence, and measures of sexual health), and the development of appropriate methodological tools for collecting such data.

PURPOSE - Utilisation of services

4.70 In the HPD generic logical frameworks, the purpose statement generally refers to improved utilisation of services. In the case of Children by Choice, the indicators are readily quantifiable, the main one being the contraceptive prevalence rate. Related indicators are the number of contraceptives distributed, the number of new acceptors, and discontinuation rates. According to the WB review, the variation in prevalence rates explains two-thirds of the difference in fertility across developing countries.

4.71 The stated purpose of the CSM project was to increase prevalence rates through the increased use of temporary methods, the best way to measure this being the incremental CYPs produced by the project. In practice, the only way the project attempted to measure CYPs was through gross sales figures, making the (unwarranted) assumption that each sale resulted in an incremental and effective use of the contraceptive.

4.72 The purpose of the EBFP project was to offer clients the choice over the size of their families by recruiting and maintaining them as family planning acceptors, which (providing they were new acceptors) would be broadly equivalent to increasing prevalence rates. However, as the interventions were neither sustained nor linked to the provision of services, it is unlikely that the purpose was achieved to any significant degree.

4.73 The purpose of the KPIII was to improve the effectiveness of the Kenyan population programme, the indicators of which included increases in: contraceptive prevalence rate, in the volume of contraceptives distributed, awareness of family planning methods, and a decline in desired family size. During the project period , the targets for all these indicators were more than achieved, though they cannot all be credited to this

project. This suggests that purpose (as opposed to goal) level indicators should be more carefully and logically specified so that they measure the impact of the project's activities and outputs, rather than the influence of other concurrent projects or historical trends (eg other projects, previous projects, changes in the status of women, the effect of the cost of schooling on the demand for children, pressure on land etc).

4.74 In none of the 7 CS projects was data collected that would have measured the project's impact on prevalence rates. The purpose of the projects was to maintain supplies of contraceptives to family planning programmes during specified periods. The success indicator should have been related to the timeliness of delivery of the contraceptives. Although there were delays in most of the projects, the quality of the local MIS makes it difficult to assess whether the delays deprived clients of contraceptives. The evaluation concluded that stocks were very low, and rationing may have taken place in two cases, but that otherwise the purpose of filling in gaps in supply was achieved.

GOAL - Improved sexual and reproductive health

4.75 In the HPD generic logical frameworks, the goal statements refer to improved health status and, in the case of Children by Choice, to improved sexual health. This is to be measured by indicators such as maternal and child health (through declines in the maternal and infant mortality rates), reduction in the incidence of STDs and HIV, and increased and unforced choice for women (fewer unplanned pregnancies and abortions), as well as by the more traditional indicators of reduced fertility.

4.76 The projects and programmes which form the subject of this synthesis were based on older style family planning models of the 1970s and 1980s, which had demographic rather than broader reproductive health objectives. Demographic impact can be measured much more readily than health status, using as indicators (successively) increased contraceptive prevalence, reduced fertility levels and lower population growth rates. However, achievement even of some of the simpler quantified targets which affect reduced fertility will also benefit reproductive health (for instance, increased age at first birth, increased spacing of births) and will also have a positive effect on maternal health, by reducing the number of high risk births.

4.77 Over the past 30 years, family planning programmes, supported by socio-economic development, have fostered major changes in fertility patterns. There is now a large body of evidence of experiences with family planning programmes and the factors which contribute to their success. The USAID evaluations, for instance, endorse many of the accepted lessons, such as removing barriers to meeting unmet demand, multiple delivery channels, community based outreach, efficient management, quality services, IEC and training.

4.78 The WB 1993 review also believes that family planning programmes have been extremely successful in the past 30 years. They have cut in half the time required for the transition from high to low fertility and increased the use of contraceptives in countries of radically different cultures and in adverse circumstances, with reduced costs to consumers and improved quality. Key elements in success are political support, the exploiting of an existing demand, and the developing of innovative delivery methods. According to the World Bank, donor influence on family planning programmes has been more significant than on any other aspect of development, though it cannot succeed without national commitment and the influence of a blend of political, economic, social and cultural factors.

4.79 Four of the five countries evaluated by USAID confirm these positive conclusions about changes in fertility patterns. Over the last 30 years, Honduras achieved an increase in prevalence to 23%, a decline in fertility from 7 to 5.1 (less so in rural areas), and population growth has stabilised at 3%. However, fertility remains higher than in other countries with similar prevalence rates, probably due to such factors as lower age of first child, limited breast-feeding, and low effectiveness of contraceptive use. There was no political and public policy commitment to family planning, due largely to the opposition of the Catholic Church. This has prevented the serious provision of services through public sector facilities, and has caused an NGO to become the main provider. Nevertheless, even where political and cultural factors are hostile, progress can be made, but it is slower and more expensive.

4.80 During the 1970s and 1980s in the Philippines, contraceptive prevalence rose from 15 to 36%, fertility rates dropped by a quarter, and population growth rates fell from 3% to 2.3%. This was also achieved despite the opposition of the church.

4.81 In Tunisia, contraceptive prevalence rose rapidly and fertility also dropped. The USAID evaluation concluded that the earlier falls were due to other factors such as later age of marriage, declines in IMR and female emancipation. But, by reducing high risk births, the family planning programme had improved IMR rates and the number of high risk abortions. The programme had also created higher contraceptive prevalence rates than would be predicted from the level of female education and, from the mid-1970s, the bulk of the decline in fertility was attributable to contraceptive use. In Tunisia, family planning has had political support since the 1950s, and was the first Muslim country (in 1964) to establish a population policy. Political commitment and a supportive economy overcame such social factors as the low status of women.

4.82 In Kenya, fertility fell from 8 in 1977 to 5.4 in 1993, along with similar and significantly positive changes in awareness of contraception, family size, prevalence, distribution of contraceptives and population growth rate. Whilst many of these changes are a consequence of the family planning programmes, there were other factors at work too, such as the improvement of educational standards for women. One of the strongest

factors has been economic, ie the cost of children's education. As in the Philippines and Honduras, the decline in fertility has been achieved despite the influence of the churches on government policy. This was one of the risks identified in the ODA project framework and adversely affected the achievement of the ODA project objectives.

4.83 The exception to the success stories was Ghana, where the population programme in the '70s and '80s had almost no impact, as economic crises diminished the government's effectiveness in delivering services. The use of modern methods of contraception remained at only 5%, fertility declined only marginally, and population growth rates rose.

4.84 The ODA CS projects did not permit an analysis of their impact on fertility rates as they were not intended to meet the national demand for contraceptives but rather to meet short-term deficits.

4.85 The two JFS projects were too small to have a measurable effect on fertility, and their goals were set at more modest levels. The goal of the EBFP was to increase contraceptive prevalence but it is unlikely to have recruited enough new users to have had such an effect. The goal of the CSM was an institutional one, to strengthen the implementation of GoI population policy in northern India. Although its volume sales were quite impressive, these do not necessarily equate to incremental and effective use of contraceptives, and hence an unequivocal fall in fertility.

4.86 The goal of the BPHC was also institutional, to support NGOs in the delivery of family planning services - rather than the direct reduction of fertility. In the event, the evaluation was unable to judge whether the objectives have been achieved, because none of the indicators proved useful. The GoB's MIS overinflated the indicators; the research unit was not operational; there was no mid-term evaluation; and WB review missions were too superficial.

4.87 The goal of KPIII was fertility reduction, and the investments in NGO training, construction and service programmes will have made some contribution towards the further decline in fertility since 1993, but it is impossible to quantify how much of the trends in fertility can be ascribed to this project, as opposed to the family planning programme as a whole.

5

MAIN LESSONS LEARNED

5.1 In almost all countries, there is a significant unmet demand for family planning, and the design of programmes should concentrate on improving delivery and access to a broad range of contraceptive methods, especially for groups which are geographically or socially difficult to reach.

5.2 Improved availability needs to be supported by the provision of information and education, but this should be specific information on what methods are available, where to obtain them, how they are used and what they cost, rather than the general awareness-raising which has been common in traditional IEC programmes.

5.3 An effective family planning programme needs to cover a wide range of both contraceptive methods and means of delivery. There are trade-offs between efficiency, equity and sustainability, with different methods and means meeting different objectives; for instance, sterilisation is cost-effective, community-based distribution is good at reaching poor and dispersed communities, while social marketing has the best record on cost-recovery. There should also be promotion and advice on techniques such as the use of the infertile period and prolonged breast-feeding, for people whose religious beliefs preclude the use of physical methods.

5.4 Maximising client access will also generally involve using multiple delivery channels, including resort to the private sector for those who can afford to pay in full, services through NGOs with partial cost recovery, and free services through the public sector for the poorest groups.

5.5 Most donor assistance has been provided through NGOs, which have proved to be at least as cost-effective as governments in the provision of services. NGOs also have the potential to act in areas governments may be reluctant to enter, such as services for adolescents or for HIV prevention. Not all NGOs, however, are good at all activities, and their strengths and weaknesses need to be assessed so that the most appropriate ones are chosen for each job.

5.6 In particular, working through NGOs does not guarantee reaching the poorest groups. If population programmes are to have a poverty focus, this needs to be built into project design at the outset, with the potential conflicts with other objectives (such as

cost-effectiveness and cost recovery) acknowledged and provided for. This emphasises the fact that, in many countries, the needs of the poorest can be met only through free public sector distribution outlets.

5.7 Project partners need to be consulted about and involved in project design, and should agree and understand the targets against which their performance will be judged. Financial targets should be established and monitored in local currency, especially in situations where devaluation of the local currency may permit a much greater volume of activities to be financed.

5.8 A strategy for sustainability needs to be introduced from the beginning, focusing on how, when and over what time period support should be provided, and including realistic targets for reducing the financial dependence of partner agencies. However, such planning needs to acknowledge that there are almost no examples to date of family planning programmes in developing countries becoming self-sufficient, especially where poverty objectives are being pursued. Donor strategies should therefore accept that many countries, and many consumers of family planning services, will not be able to afford to pay the full cost of contraceptives for the forseeable future, and that financial sufficiency may not be achieved within the lifetime of a single project.

5.9 Most projects include some form of monitoring system, but these have generally proved to be too complicated, have not focussed on the key issues, and have not collected useful data on either impact or basic costs. Management information systems need to be simple, timely, defined at an early stage, and agreed with the implementing agency. They need to facilitate the use of data as a management tool, for collecting data on the impact of IEC programmes and the unit costs of service delivery. With the greater emphasis in projects now on capacity building, and on the broader aspects of reproductive health, new indicators will need to be developed.

5.10 Purpose level indicators generally need to be more carefully specified so that they measure the impact of the project's activities and outputs, rather than the effect of other projects, or of other concurrent or historical trends.

5.11 The potential macro-economic benefits of slower population growth are well understood but difficult to quantify, particularly for individual projects which only contribute to part of a country's programme. Economic appraisals should therefore focus on the micro level benefits of population projects, such as improvements to women's and children's health resulting from greater control over fertility. (7)

5.12 With the more widespread use of outside consultants, and of Field Managers new to DFID, for preparing, monitoring and managing projects, it becomes even more important for DFID staff to appraise projects more carefully, in order to promote improved design as well as DFID ownership. Consultants and Field Managers need to be made conversant with DFID policies and procedures, their roles clearly defined, and lesson learning across the Health and Population sector made more structured.

TERMS OF REFERENCE ANNEX A

AIMS

- to disseminate within the Department and elsewhere the findings and lessons learned from population evaluations and output-to-purpose reviews (OPRs) undertaken by the Department and by other donors;
- thereby to help enhance the effectiveness of the Department's support for the population sector.

SCOPE OF WORK

Donor experience with population projects as set out in evaluation and OPR reports will be reviewed and a synthesis report prepared summarising the main findings. To this end the following specific tasks will be undertaken:

a) review all of the Department's previous population evaluations;

b) review recent Departmental project documents, especially OPRs;

c) review evaluation material of key bilateral and multilateral agencies

The synthesis of the above materials should include inter alia specific consideration of the following:

a) the comparative merits of different ways of assisting the population sector;

b) the extent to which project activities can contribute to improvements in efficiency and effectiveness;

c) project monitoring and performance indicators;

d) the rÙle and policy implications of donor assistance to the population sector;

e) relevant cross-cutting issues including poverty, gender, environmental impact and any others identified from the documentation review.

The work should be informed by current Departmental, EU and World Bank donor policy relating to the sector. It should not attempt to summarise all possible issues but focus predominantly on the results of evaluation material only.

REPORTING

A draft report of around 40 pages length should be prepared, summarising the findings of the synthesis for subsequent submission to the PEC. The report will be revised as necessary, following receipt of comments, and a final document produced for circulation to interested ODA staff.

The above work shall be carried out in accordance with the booklet "ODA Evaluation Studies: Guidelines for Evaluators".

Evaluation Department, April 1997

BIBLIOGRAPHY ANNEX B

Cameron, C; Burn, R. 1997. Contraceptive Supply Projects. Evaluation Report EV 600 Overseas Development Administration, forthcoming.

Crapper, D; Culshaw M; Potts, M. 1997. Kenya Population III. Evaluation Report

EV 595 Overseas Development Administration, forthcoming.

Crapper, D; Thomas, D. 1997. Employment-Based Family Planning Project, India. Evaluation Report EV 588, Overseas Development Administration, February 1997.

Crapper, D; Thomas, D; Handyside, A. 1997. Contraceptive Social Marketing in Northern India. Evaluation Report EV 601, Overseas Development Administration, February 1997.

Lehmarin, L; Bartels, G; Biere, J. 1997 Social Marketing of Contraceptives in the Context of Family Planning Programmes. German Federal Ministry for Economic Cooperation and Development. 1997.

National Audit Office. 1994. Overseas Development Administration, Health and Population Overseas Aid. Report by the Comptroller and Auditor General. November 1994.

ODA, 1996. A guide to appraisal, design, monitoring and impact assessment of health and population projects (HAPAE). Health and Population Division, Overseas Development Administration. August 1996.

ODA, 1993 and 1996. Children by choice not chance. ODA Information Department. August 1991 and March 1996.

ODA, 1997. Progress with UK Aid for Sexual and Reproductive Health, HAPAE, Health and Population Division.

Riddell, R; et al. 1996. Evaluation of the Bangladesh Population and Health Consortium Project. Report by Options Consultancy Services for the Overseas Development Administration. July 1996.

Thomas, D. 1996. Mini-synthesis study of USAID assistance to family planning in Ghana, Honduras, Kenya, Philippines and Tunisia. Report for Evaluation Department, Overseas Development Administration, December 1996, unpublished.

World Bank. 1993. Effective Family Planning Programmes. World Bank, February 1993

COUNTRIES COVERED BY EVALUATIONS REVIEWED ANNEX C

Country	ODA single project evaluations	Contraceptive Supply evaluations	USAID programme evaluations
Bangladesh	X		
Ghana			X
Honduras			X
India	X X		
Kenya	X		X
Malawi		X	
Mexico		X	
Nigeria		X	
Pakistan		X	
Peru		X	
Philippines			X
Tunisia			X
Zambia		X	
Zimbabwe		X	

HPD GENERIC LOGICAL FRAMEWORK: CHILDREN BY CHOICE

ANNEX D

NARRATIVE SUMMARY	*VERIFIABLE INDICATORS*
Goal: • Improved sexual health in target group	Reduce difference between actual and desired number and spacing of children: • reduction in fertility rates • increase in average child spacing • increase in average age at first birth • reduced percent of births to under-19s Maternal and child health: • decline in maternal mortality rate • decline in infant mortality rate • reduction in number of high risk births Improved sexual health: • reduction of incidence of STDs and HIV Women able to make informed and uncoerced choice • reduction in number of unplanned pregnancies/abortions
Purpose: • Increased UTILISATION of cost-effective reproductive health services by target group	• number of contraceptives distributed (by method) • increase in contraceptive prevalence rate • number of new acceptors • reduced discontinuation rates
Outputs: 1. Improved ACCESS to appropriate reproductive health services	• proximity - percent of population living within x miles of facility • reduced waiting times at facility • reduced number of visits required
2. More AFFORDABLE services, especially for the poorest	• % of income spent on services and related costs eg travel • appropriate and well-understood exemption system in force
3. Improved EQUITY in provision of services	• increased expenditure on services used by poorest 20% • increase per capita expenditure in poorer regions
4. Increased AWARENESS of the benefits of, and the methods available for, improved reproductive health	• increased awareness revealed in surveys • increased female enrolment at schools • percentage intending to use contraception at next intercourse • fall in rate of teenage pregnancies

5. Improved QUALITY and EFFECTIVENESS of services	• Quality: convenience, attitudes of staff, provision of necessary information, technical competence, continuity of care, acceptability of services, greater privacy/respect • Effectiveness: availability of a range of methods, reduced stockouts,% of health personnel giving appropriate advice, reduction in unplanned pregnancies and abortions , integrated family planning/sexual health services.
6. Increased CHOICE of services, and women EMPOWERED to use them	• range of methods regularly available increases • absence of coercion • approval rating for reproductive health services (by gender) • % of women who have experienced coercive sex decreases • % of women undergoing female genital mutiliation decreases
7. Increased EFFICIENCY of service delivery	Cost per CYP declines , broken down by: • method - condoms, OCs, injectibles, sterilisation • means of delivery - clinic based, outreach, community based, social marketing • activity - production, marketing, distribution • source of finance - government, private, charitable - to give indication as to where inefficiency exists
8. Package of services SUSTAINABLE.	• net cost per CYP • per capita spending on reproductive health services (share of health budget) • economic growth projections • level of funding from alternative sources
9. COMMUNITY PARTICIPATION in design, monitoring, implementation	• examples of cases in which project management decisions were influenced by the community
10. Effective MONITORING and EVALUATION systems	Systems established including • baseline studies • clear definition of responsibilities for collecting and interpreting data and taking action

Activities:
- Construction of new facilities or rehabilitation of existing, including finance for private sector construction
- Strengthen management systems
- Provision of commodities
- Capacity building
- Information, Education, Communication
- Strategic policy work
- Advocacy
- Setting standards based on best practice
- Commissioning, execution and dissemination of research
- Setting up indicators, monitoring systems and operational research
- Community participation
- Identify alternative funding sources

ODA EXPENDITURE ON "CHILDREN BY CHOICE" PROJECTS SINCE 1991/2*

ANNEX E

£ million	1991/2	1992/3	1993/4	1994/5	1995/6
Africa	1.94	4.20	4.48	7.86	12.86
Asia	4.26	3.25	6.60	19.49	15.62
Latin America and other	.18	.23	.96	2.00	1.31
Multilateral and Research	7.51	8.01	22.59	9.18	2.51
TOTAL	13.89	15.70	34.63	38.53	32.30

* All projects with a PIMS marking of 4.

ANNEX F

EMPLOYMENT-BASED FAMILY PLANNING PROJECT, INDIA

F1. The project involved establishing an organisation to market occupational health care packages, with an integral family planning component, to large and medium sized employers in Delhi, Calcutta and Assam. It was implemented by Parivar Seva Sanstha (PSS), an Indian NGO associated with Marie Stopes International. ODA's Joint Funding Scheme (JFS) provided £216,570 between 1990 and 1993.

The Evaluation

F2. The evaluation was undertaken in April 1995 by two specialists in Economics and Social Development. The findings and lessons learned will be included in a forthcoming synthesis of population projects.

Overall Success Rating

F3. The project is judged to have been partially successful overall. The strategy of offering family planning indirectly along with occupational preventive health care was largely unsuccessful, as it was unable to secure sufficient commitment from employers and managers to family planning. In the longer run, however, the project has helped PSS to establish a capacity to supply family planning and reproductive health services more directly to employers on a paid consultancy basis.

Findings

F4. The key constraint was the lack of employer commitment. Generally, companies were only interested in short-term agreements and their contributions to activities were limited. Access to employees was constrained, giving them no chance to participate in defining their needs or in focusing project activities. Management resistance to worker-motivators - a key link to the establishment of effective EBFP - undermined efforts to create sustainable mechanisms. Under these conditions it was not possible for PSS to take a systematic and informed approach to the design of interventions

F5. This was a new activity for PSS which faced considerable problems in trying to sell its services to employers. Project design did not target specific industries or geographical areas, and implementation became spread over a wide geographical area. The initial approach of trying to contact managers independently was time-consuming and produced poor results. Networking through employer associations proved more effective.

F6. The objective of recovering costs steered the project away from smaller companies with less potential to pay for services, and, in effect, excluded those companies less able to provide health and family planning services to employees from their own resources. In the event, however, the amount recovered from employers was minimal.

F7. Health and family planning awareness programmes were the main activities implemented. In most cases, employees received only one exposure to an awareness programme and no follow-up. The programmes were not based on audience research and could have had only a limited impact in filling information gaps or motivating the audience for family planning. Information was generally not linked to service, and PSS was unable to ensure that any family planning demand generated could be met with appropriate supplies.

F8. The project benefited a range of socio-economic groups from low-income contract labourers to high-income professionals, with most falling in the low-to-middle income group. Direct beneficiaries were mainly men, though indirectly their female partners would have benefited if the activities led to greater male responsibility for, and increased spousal discussion of, family planning. However, the long-term impact on couples' family planning decision-making patterns was likely to have been small.

F9. Due to lack of data, it is not possible to measure the extent to which the project achieved its purpose of recruiting and maintaining new family planning acceptors. Given the unsystematic nature of most of the interventions - no reference to client need; short-term and often unsustainable activities; poor linkages between information and services - it is unlikely that significant numbers of new acceptors were recruited on a permanent basis.

F10. Even if all the contraceptives distributed through the project, and the referrals for sterilization, were incremental, the cost was very high at £22 per couple-year of protection.

F11. Despite the conclusion that the project had limited impact during the period of implementation, PSS have nevertheless gained considerable experience from the project. Since the end of ODA financial support, PSS has successfully started, on an albeit modest scale, to sell their family planning and reproductive health expertise to employers on a consultancy basis.

Lessons Learned

F12. Workplace-based family planning programmes are most likely to be financially attractive to employers in situations where large numbers of women are employed, or where employers pay statutory benefits and provide free health treatment for employees, or at isolated sites where firms provide comprehensive services for employees. In organisational settings where these conditions do not prevail, as was the case with most of the participants in this project, the marketing of EBFP will be more difficult.

F13. The design and negotiation of EBFP programmes should allow scope for systematic, need-based interventions with the potential for increasing family planning use, linking information, education and services, and involving worker-motivators.

F14. The difficulty of quantifying this project's impact illustrates the need (now more generally adopted in DFID practice) to define, at the appraisal stage, specific indicators of the achievement of objectives, to be reported on during implementation.

F15. JFS policy is to give high priority to population projects, and to concentrate benefits on the poorest groups. These aims may not always be compatible, especially where, as here, the target groups were (relatively well-off) employees in the organised industrial sector. An alternative criterion for JFS population projects would be to require them to be consistent with the DFID health and population strategy in the country concerned.

CONTRACEPTIVE SOCIAL MARKETING, INDIA ANNEX G

G1. The project involved marketing condoms and oral contraceptive pills at subsidised prices in 6 states in northern India, with the aim of increasing contraceptive prevalence through the use of temporary methods. It was undertaken by an Indian NGO, Parivar Seva Sanstha (PSS), an associate of Marie Stopes International (MSI), and was fundedthrough ODA's Joint Funding Scheme (JFS). ODA provided £500,000 between 1989 and 1995 for the purchase of contraceptive materials, while the cost of marketing and distribution was met by the Ford Foundation and from sales proceeds.

The Evaluation

G2. The evaluation was undertaken in April 1995 by a team comprising consultants in economics, social development and contraceptive social marketing. The findings and lessons learned will be included in a forthcoming synthesis of population projects.

Overall Success Rating

G3. The project is judged to have been partially successful, and to have achieved some significant benefits in relation to costs. It performed well in terms of cost-effectiveness and cost management, reasonably well in terms of institutional strengthening, but less well in developing marketing capability and in reaching the lowest income groups. Sustainability will depend on continuing external financial support.

Findings

G4. Implementation concentrated on achieving sales targets, and the project's main achievement was to sell over 44 million condoms and 776,000 cycles of oral pills, against targets of 45 million and 550,000, respectively. There was, however, less emphasis on achieving and measuring the objectives of raising contraceptive prevalence and awareness, or on consumer marketing, which should be a major component of a CSM programme.

G5. Insufficient funds were made available for marketing, which limited the development of consumer awareness and brand loyalty, and in particular failed to make a breakthrough in sales of the pill. The failure to create consistent consumer demand in the original areas of operation meant the project had to keep expanding into new geographical areas in order to meet sales targets, which stretched human and financial resources. During the later years of the project, PSS moved into smaller, rural settlements. This paid off in terms of regular sales, and has increased choice and availability for new consumers in areas not well served by other brands, though adding to the problem of stretched resources.

G6. The research programme intended to monitor progress and refine strategies was dropped due to lack of funds, and there were no other mechanisms for regular feedback from consumers. It is thus not possible to identify the characteristics of consumers or to measure the increase in prevalence, that is to assess the number of genuinely new acceptors reached by the project. What information is available suggests that condoms were bought by low-to-middle income groups, and the pill by reasonably well-educated, middle-income groups. The fact that sales are made through

retail outlets makes it impracticable to confine the benefits of CSM projects to the poorest. Particular social groups may be targeted through marketing campaigns (for which there were inadequate funds in this project), though financial viability will require this to be supplemented by mass sales in more populous areas.

G7. The project improved women's practical gender needs by increasing physical access and choice to temporary contraceptives, but the impact was limited by not taking into consideration the social, economic and cultural factors which ascribe family planning decisions to men and prevent women from purchasing contraceptives.

G8. The programme could only become financially self-sufficient if sales volumes were three or four times higher, which would require a major, and risky, investment in marketing and in additional project staff. Moreover, a rapid increase in turnover could realistically only be achieved by concentrating on the larger urban markets, and competing with other CSM organisations for market share. This would negate PSS' achievements to date in developing new markets and new consumers in smaller population centres. If this is to remain a CSM programme with developmental objectives, it will require ongoing financial support.

G9. Even though revenues fall well short of costs, the project has been relatively cost-effective, supplying family planning services at a cost of £2.05 per couple-year of protection (CYP). The cost of ODA support has been 82 pence per CYP.

Lessons Learned

G10. Social marketing projects need to include detailed distribution and marketing plans and adequate marketing funds to achieve target sales. Project preparation and appraisal should involve a social marketing specialist.

G11. Monitoring systems, evaluation methods and performance indicators should be defined at the design stage, and agreed with the implementing agency. They should be capable of measuring the achievement of defined objectives, not simply volume sales. Alternatively, objectives should be limited to those for which achievement can be measured in a cost-effective way. In situations where an intermediary organisation is involved in managing a project, its role and inputs should be clearly agreed at the outset.

G12. CSM projects need to take social, gender and quality of care issues into consideration in the design, implementation and management processes, as there is a risk that these concerns become marginalised in the drive to achieve sales.

G13. Where products are sold through retail outlets, benefits cannot be limited to specific groups (eg poor people). There may, however, be some scope for reaching such groups through targeting of advertising and marketing campaigns, and by careful choice of distributors and stockists.

G14. Even though it is not possible to target the poor, well designed CSM projects offer a cost-effective solution to improved access to contraception, and are appropriate for the JFS. Such projects, however, may require a longer term approach than the maximum of five years funding which is generally permitted.

CONTRACEPTIVE SUPPLY PROJECTS ANNEX H

H1. This report is a synthesis study of seven contraceptive supply projects undertaken by ODA between 1992 and 1994, in Malawi, Mexico, Nigeria, Pakistan, Peru, Zambia and Zimbabwe, at a total cost to ODA of £6.2 million. The projects were intended to maintain supplies in the short term to a country family planning programme.

The Evaluation

H2. The evaluation was undertaken in 1996, by consultants in Economics and Contraceptive Logistics. It involved a desk study of all seven projects, and field visits to Malawi and Zambia. The report provides material for a wider Evaluation Department synthesis study of population projects to be completed in July 1997.

Overall Success Rating

H3. These projects were judged to be only partially successful. They succeeded in the immediate objective of delivering supplies, but in five cases, three of which were regarded as emergency supply, the contraceptives were received after significant delays.

Main Findings & Lessons Learned

H4. With a number of donors operating in this field, there is a need for inter-donor and donor-MoH coordination at every step of the project cycle to avoid the risk of either duplication of supplies or of stock-outs.

H5. Project design needs to reflect more accurately the goal and purpose of projects, with appropriate and clearly specified indicators. Without these, project monitoring and evaluation of impact become difficult. Where consultants are used, either in the preparation of project submissions or thereafter, they should be closely managed by DFID staff.

H.6. Only one project involved a competitive tender, the rest using existing procurement arrangements. The quality of contraceptives supplied was assured by the purchase of proprietary brands. Only in the case of condoms provided for Zimbabwe was there room for error. Closer attention needs to be paid to the calculation of quantities to be provided. Estimates used should be checked wherever possible, since in-country reporting systems are often inadequate. The role of the private sector should not be overlooked.

H7. With one exception, the costs of contraceptives have been within the range of international public sector procurements. Even so, reductions in contraceptive costs may be achieved through careful selection of the procurement agent. The costs of contraceptives procured by UNFPA were invariably the lowest of the public sector range.

H8. Recent efforts to simplify contraceptive procurement arrangements should continue and results be disseminated to all appropriate DFID staff. DFID now has contracts with IPPF and Crown Agents, and a mechanism with UNFPA to effect contraceptive supply projects. The strengths and

weaknesses of each agent should be more fully considered in relation to the quantity, quality and time aspects, when determining which to use.

H9. Project design looked at only one aspect of transportation to country, the choice between air and sea freight. Other issues to consider in future should include single versus multiple shipments, and choice of port and inland route. All these decisions impact on project cost, the timing of delivery and effective product shelf life.

H10. More consideration needs to be given to weaknesses in the local contraceptive distribution system. Many projects identified this as a weakness but did include inputs to address it. As DFID's concern includes ensuring that supplies reach service delivery points (SDPs) and the eventual client, this should be reflected in project design, including, if necessary, the provision of a logistics strengthening element.

H11. DFID needs to clarify whether it requires target groups for contraceptive supply projects. Although all projects identified target groups in their project submissions, this was not reflected in project design, which simply used the existing distribution system. To reach target groups would have required fundamental changes to project design and delivery. The need for physical and social monitoring down to the end-user should also be clarified.

H12. Little use was made of conditionality, because of the short-term nature of the projects. In future, however, conditionality could be imposed on reporting requirements from recipient governments, parastatals and other agencies involved. Monitoring and reporting requirements were not always clearly specified to partner agencies.

H13. Economic appraisal should focus more on the micro level benefits accruing from these projects, about which there is no contention. The macro level benefits are less clear, particularly for short term projects which only contribute to a part of a country's supply, and do not therefore lend themselves well to this sort of analysis.

H14. Timeliness of delivery did not align with expectations at the time of project design. A better awareness is required within DFID of the lead times involved, including the number of steps between initial request and final delivery.

H15. There were no arrangements for cost recovery in these projects (with the exception of Zimbabwe). Although this is an issue of great interest to donors at present, for short term supply projects it would not have been useful to have tried to introduce this. The issue of user charges and cost recovery in the public sector can be more appropriately addressed through health sector reform programmes.

H16. These projects revealed a diversity of aid management arrangements, although there was no significant link between this and implementation or impact. Field Managers (FMs) were just being introduced across the H&P sector. The diversity of their skills and tasks points to the need for a more comprehensive induction to DFID policy and procedures before posting The role of such managers and H&P Advisers needs to be more clearly defined. Lesson learning across the H&P sector needs to be more structured.

KENYA POPULATION III **ANNEX I**

I1. The project was funded by ODA and the World Bank from 1988 to 1994. It aimed to make the Kenyan population programme more effective by increasing the demand for family planning services, and by strengthening the capacity of government and selected NGOs to deliver services. ODA contributed £4.6 million for clinic development, UK training, the running costs of 5 NGOs, and a new initiatives scheme for NGOs.

The Evaluation

I2. The evaluation was undertaken in August 1996 by a team of three consultants in Economics, Reproductive Health and NGOs. The team studied project documents, visited project sites and met and reviewed the work of the NGOs and other concerned agencies. The visit coincided with that of a World Bank review mission. The findings and lessons learned will be included in a forthcoming EvD synthesis of population projects.

Overall Success Rating

I3. The project is judged to have been partially successful. It made some contribution towards trends in declining fertility after 1993, it managed costs within budget, and it improved the quality of service delivery by some of the NGOs It performed less well in using IEC to promote demand, it failed to solve the technical and managerial weaknesses of the National Council for Population and Development (NCPD) and made only limited progress on the long-term sustainability of NGOs. Full achievement of objectives was constrained by the variability of political support, partly due to pressure from the churches.

Findings

I4. During the period 1989-93, there were significant positive changes in awareness and use of contraceptives, in desired and actual family size, in fertility and population growth rate. Most of these changes were under way before the project started, but the project will have made some contribution towards continuing fertility decline since 1993.

I5. The project design emphasised information provision as much as service delivery, even though awareness of contraception and the demand for smaller families were already high, while access to family planning was inadequate. The appraisal did not examine the cost-effectiveness of the proposed interventions, nor did it seek to focus on low income groups or regions. There were missed opportunities to set up outreach programmes, and to target adolescents (though in both cases this would have required dialogue with the GoK to bring about changes in policy). There could also have been wider consultation on project design within the NGO community.

I6. IEC activities were judged to have been unsuccessful. There was no attempt to measure their impact on the demand for services or on the decline in fertility. The limited quantitative evidence (available for just one NGO) was disappointing, while an independent review of a second concluded that its IEC programme was expensive and had made no impact. A third NGO limited itself to promoting one method, while the other two NGOs were

unsuitable partners, being unable to link IEC with service delivery.

I7 .The project's service delivery programmes were more successful. The number of delivery points was increased, a wider range of contraceptives was made available, and one NGO delivered a significant portion of the total national use. However, too many resources went into building a few large clinics, whose size was not justified by the throughput of customers, rather than on the rehabilitation of existing clinics.

I8. Project management depended to a considerable extent on the NCPD, but the investment in NCPD capacity building (primarily staff training) was mostly unproductive. With hindsight, it was not an appropriate organisation to run a service delivery project or to handle donor finances. Project monitoring was also hindered by the over-complicated management information system. Management by ODA and the World Bank comprised annual reviews, but because few visits were made outside Nairobi, there was a failure to detect implementation problems in the field.

I9. On cross-cutting issues, by offering increased choice and access, the project helped improve women's autonomy and status. It also assisted in the attack on poverty, though services were not focused on the most needy - the new clinics serve only the urban poor, outreach programmes were not a feature, and IEC was largely directed at teenagers in school. The contribution to fertility decline will help in the long run to relieve pressures on the environment, but population is still set to double, however successful the current family planning programme.

Lessons Learned

I10. Where awareness and demand for contraceptives services are high, project design should concentrate on delivery. NGOs can deliver services as cost-effectively as government, though not all NGOs are good at all activities, and their strengths and weaknesses should be assessed so as to choose the most appropriate ones for the job. Some NGOs also have the potential (not exploited in this project) to act in areas which governments may hesitate to enter, such as providing services for adolescents or prostitutes, and to offer access to poor and vulnerable groups.

I11. Rehabilitating existing buildings, renting space nearer to the consumer, and promoting outreach programmes may be more cost-effective than new buildings.

I12. NGOs whose religious beliefs preclude the use of physical methods of contraception should be encouraged to promote innovative and cheap methods such as breast-feeding, and to provide information more widely on the infertile interval, for the large number of couples using forms of periodic abstinence.

I13. NGOs should be consulted about project design and should agree and understand the targets against which their performance will be judged. Management information systems should be simple, facilitate the collection of data on impact, and help NGOs to collect and analyse cost data for use as a management too. The prospects for sustainability of NGO activities depend on their being cost-effective and on increasing the degree of cost recovery,

both of which should be promoted in the project design.

BANGLADESH POPULATION AND HEALTH CONSORTIUM **ANNEX J**

J1. This evaluation took place in 1996. Its purpose was to assess the extent to which BPHC is achieving its objectives of strengthening the capacity of indigenous NGOs to deliver quality MCH and FP services, and to advise on the merits of continuing the project.

Impact and Performance

J2. Despite the lack of data of consistent quality, the Evaluation Team (ET) view is that BPHC has succeeded in strengthening selected NGOs to encourage the take up and delivery of quality FP and MCH services. Three case-studies indicate that, among the gains, the CPR ratios have increased and trends in other indicators are positive. Additionally, BPHC activities do seem as cost-effective and productive as those provided by other agencies, and the quality of the services at least as good as that provided by the Government.

J3. Other achievements include: the BPHC office is well run and managed; it has developed considerable technical knowledge in the MCH and FP fields; it has achieved a number of important gender initiatives; and it has proved the possibility of funneling donor funds to small NGOs working at the village level.

Main Recommendations

J4. Donor support for BPHC should continue, with a number of changes.

J5. BPHC should, in consultation with the NGOs, introduce a more comprehensive and systematic approach to sustainability, focusing on how, when and over what time period it should support the NGOs, and the sustainability of their MCH/FP programmes. In the current programme, donor fund withdrawal has never been substantially addressed. While the intention is to examine ways in which financial dependence of NGOs is reduced, there is no presumption that all funds should be withdrawn.

J6. Priority should be given to a systematic appraisal of such re-orientation, and the report outlines the theoretical building-blocks for such an approach, as well as some more practical steps. One of the objectives would be to develop a new logframe, with a suggested revised purpose as follows: "To provide support to and develop the capacity of selected NGOs to expand poor people's access to, use of and quality of MCH and FP services in a manner which seeks to maximise the efficiency, effectiveness and sustainability of the programmes funded at both the NGO and village level."

More Specific Recommendations

J7. <u>Enhancing the effectiveness of MCH/FP approaches.</u> A series of changes should be made to BPHC's basic health service delivery package, covering reproductive health, the role and use of TBAs, STD prevention and management, and

incorporating a focus on men.

J8. Enhancing BPHC's capacity building initiatives. Though these have achieved notable successes, the approaches have been limited in scope. BPHC should adopt (with the NGOs) a new group of indicators focusing on financial sustainability, institutional development, innovation, and resource management. Relatedly, BPHC intermediaries should be directly involved in the development of any further phases of the BPHC project.

J9. While BPHC is unable to assist with NGO development to the extent that it would wish, the ET cautions against reducing the size of the programme. Other ways can be found to increase its efficiency in supporting NGOs,for instance by looking at geographical coverage, and the comparative costs and benefits of de-centralisation. However, an immediate policy of containment does not have to be permanent: in the longer term BPHC could administer and absorb a larger number of NGOs and NGO projects - provided that it addresses those factors limiting its ability to manage its portfolio efficiently and effectively.

J10. Improving and enhancing BPHC's cost-effectiveness. There are gaps in resource identification, resource allocation and priority setting, and the operational research and management support capacity are not oriented to cost containment. Many of these problems cannot be addressed quickly, and will need to be incorporated into the comprehensive sustainability programme. Overall, however, a fundamental shift should be made to focus attention more on programme outputs and less on resource inputs, including:

- BPHC should adopt cost centre accounting in order to introduce a standardised format for recording programme costs and related activities;
- Resource allocations should be based upon a more explicit set of criteria which reflect programme objectives and distributional objectives;
- Work should be undertaken to develop indicators which express activities and outputs in terms of resources required to achieve them.

J11. The weakness of the MIS is that it does not support management: it is data supply driven rather than user oriented, demand led and decision-oriented system. It is therefore recommended that BPHC adopt an integrated, targeted and customised MIS, including a set of customised Performance Indicators.

J12. BPHC's gender strategies. Though BPHC's gender strategy constitutes a serious effort to address the issue of gender equity, a number of weaknesses and limitations need to be addressed. Some of the current targets (eg that 50% of management positions be filled by appropriately qualified women) be reviewed and revised, and that BPHC focuses explicitly on the gender implications of its MCH/FP programmes at the community level.

J13. The target group for health service delivery. There is a lack of clarity over the project target group, the poor and the underserved. It is recommended that steps are taken to minimise inconsistent approaches amongst BPHC's different

stakeholders, and that an analysis is made of beneficiaries' socio-economic status.

J14. Priorities, strategic planning and management issues. The current PM has a number of weaknesses, not least the range of immediate objectives and the lack of prioritisation. Additionally, different stakeholders are not clear about the nature, direction, priorities and management of the project. This is exacerbated by the apparent absence of any meetings to prioritise and emphasise different project objectives. A related problem is the lack of clarity over the institutional boundaries between BPHC and AMOD concerning roles and responsibilities. Recommendations are made to address each of these.

J15. Some technical and procedural issues. Various Government departments drew the Team's notice to three procedural and technical issues - Government approval for BPHC projects, consistency in the forms NGOs have to complete, and the powers of the Project Finance Cell. The main report proposes how each of these issues might be resolved.

J16. External professional support to BPHC. The evaluation acknowledges the work and commitment of the External Support Group (ESG). Nevertheless, there are a number of concerns its dual and perhaps conflicting roles; a lack of continuity and its physical distance from the project; the changing nature of professional support required; the costs of providing such assistance. Priority should be given to assessing the strengths and comparative costs of using an alternative professional body or pool of expertise, likely to be located within South Asia. This is likely to prove much more cost-effective, though even if this is proved correct, a continuing future link with Nuffield should not be ruled out.

Wider Lessons of Donor-NGO Relations From BPHC and Beyond

J17. Donors need to be clear precisely why they are supporting NGOs. As funding to NGOs increases, donors need to analyse the extent to which their desire to meet immediate development needs will support the resolution of development solutions in the longer term.

J18. As NGO programmes expand it will be increasingly incumbent on donors to get together with the Government and the NGOs to ensure that losses and potential losses of development "parallelism" are minimised, for instance:

- Donors need to distinguish between supporting NGOs and managing that support themselves. An increasing trend has been for donors to contract others to manage projects and to channel funds to NGOs through other agencies.
- Donors need to be conscious of the impacts (intended and unintended) that such support has for other development "actors" not least the host Government, especially in terms of line ministry activity and policy formulation.
- While donors are (rightly) concerned that aid funds are spent effectively and efficiently, they need to ensure that funding is not so conditional upon results achieved that learning and experimentation is stifled.
- Recent World Bank documents argue that participatory approaches may well be more expensive (for NGOs and donors) than non-participatory methods. "Value for money" means linking the costs expended to the benefits achieved or expected; it does not mean that less money should always be allocated to NGO projects, nor that NGO interventions will always be "cheaper".

REVIEW SUMMARY: USAID EVALUATIONS OF FAMILY PLANNING PROGRAMMES

ANNEX K

K1. This report summarises the main findings of a series of evaluations of USAID support for family planning programmes in five countries, undertaken by USAID's Center for Development Information and Evaluation (CDIE) in the early 1990s.

Political, economic, social and cultural environment

K2. In each of the case studies, the blend of the political, economic, social and cultural environment had a strong effect on the performance of the family planning programme. Even where political and cultural barriers persist, family planning programmes can make progress but this tends to be slower. However, experience suggests that a population policy without continuing political support cannot make a significant contribution.

K3. The programmes evaluated belong to the family planning models of the 1970s and early 1980s, principally directed by demographic objectives and concentrated on family planning services, rather than broader reproductive health concerns.

K4. The relationship between female education, contraceptive use and fertility is strong, but varies with a country's stage in the demographic transition, the cultural context and national levels of development. In societies at the beginning of the transition, education tends to lead to increased fecundity and lower infant mortality due to improved nutrition and maternal health, and hence an increase in fertility. The impact of education on fertility was weak in poor, illiterate societies. It increases as societies move along the fertility transition and make broad improvements in education and then tails off again in societies with low fertility. Better educated women are more likely to use contraceptives and to choose more effective methods.

Programme factors

K5. Over the past 30 years, family planning programmes and socio-economic development have fostered major changes in fertility patterns. A large body of evidence now exists of national and local experiences and factors which contribute to programme success. The findings of the CDIE evaluations endorse many of the accepted lessons on what makes family planning programmes work.

K6. National fertility surveys in each of the countries found a significant unmet desire for family planning. To be effective, programmes need to remove social, financial,

information, psychological and administrative barriers to services and to ensure that a reliable and appropriate range of services and contraceptives is available. Quicker access and the availability of a broad range of methods have been shown to increase contraceptive use and encourage continuing use. Urban populations tend to be better covered and have higher contraceptive use and one of the main challenges is to improve service delivery amongst more difficult to reach communities.

K7. A key strategy is to use public, commercial and NGO channels. Public and NGO services are complementary. NGOs have freedom to concentrate resources on family planning, to engage committed staff, and to limit coverage to maintain high quality. On the other hand, NGOs can be criticised for limited coverage and dependence on external funding, and the need to recover costs may exclude the poor. In contrast, the public sector usually aims to have national coverage, receives its budget from the national treasury; and provides services to all. The disadvantages of the public sector are that family planning has to compete with other health, social and political priorities for resources; and the need to cover the whole population may lead to a thin spread of resources and poor quality services.

K8. Community based outreach strategies have proved crucial in providing IEC and contraceptives in some communities, particularly where women's mobility outside the home is culturally restricted, and in areas where there is a high unmet demand and poor services. CBD also plays a significant part in maintaining continuing use.

K9. Service delivery needs to be supported by an efficient organisational structure. The case studies provide examples of both vertical and horizontal organisation, the relative merits of which have been hotly debated in the literature. Evidence from these evaluations suggests that, while, in principle, integrated services may be more convenient and attractive to clients who can take advantage of health and family planning at the same location, it has not been proved that they produce better results. The most appropriate organisational structure will depend on political, technical and institutional issues and the stage of programme development.

K10. To be successful, programmes need to provide client-oriented, quality services. Research has shown that clients are more likely to use and continue using services which ensure privacy and treat them with respect. This was demonstrated in several CDIE case studies; however, tools for measuring quality have been relatively neglected.

K11. Strategic planning and management enables a programme to adapt to changing needs. The weakest programmes need to focus on promotion and advocacy, building up a constituency and delivering services to motivated couples. The priority concern of weak programmes is management, to extend coverage to meet existing unmet demand. Moderately strong programmes need to focus on increasing access and reaching beyond those already motivated. As a robust demand is established, efficiency concerns come to the fore, and the possibility of shifting costs to users.

K12. Effective management requires an accurate information system, the collection and analysis of performance measures, and research to test new approaches. The programmes evaluated by CDIE illustrate considerable weaknesses in these areas.

K13. Two other critical components are IEC and training. A strong IEC programme can raise knowledge about family planning, promote social acceptability, and is essential for continuing effective contraceptive use.Service providers need technical and communicative skills to provide quality care, which in turn attracts clients.

Measures of programme effectiveness, efficiency and sustainability

K14. Couple years of protection is a widely accepted measure of effectiveness. However, it does not measure quality of care, cannot distinguish between the various levels of effort required to gain CYPs in different settings, and cannot accommodate objectives such as improving access. It favours high density populations and clinic-based methods but is a poor measure of the performance of CBD programmes which focus on supply methods, or programmes for remote, dispersed communities. CYP needs to be backed up by measures of quality and access, such as user satisfaction and method continuation, client follow-up, method mix availability, referral effectiveness, technical competence of service providers, and access to services. Community based assessments which focus on users and non-users are particularly important to gauge the perceptions of target consumers. One of the weaknesses of the CDIE evaluations was the limited participation of primary stakeholders.

K15. The Lapham-Mauldin Program Effort Scale is used to highlight areas of a programme which require improvement and to document changes over time. Its judgmental nature has been questioned but a recent study has underlined its value compared with more direct approaches. Many aspects cannot be measured directly, eg the adequacy of training, and the cost of direct measurement is prohibitive on a large scale. The L-M scale is an affordable means of comparing results over time.

K16. Experience from the CDIE studies illustrates the difficulty of measuring cost-effectiveness due to lack of cost data. These calculations typically compare costs with CYPs. For reasons outlined above, these measures need to be interpreted with care to ensure that client choice, equitable access, and quality are not undermined by the pursuit of quantitative targets of CYP when informing resource allocation decisions.

K17. The long-term commitment required by donors in family planning calls for donors to have a long-term strategy from which projects can be developed. Sustainability is not feasible until a programme has generated a stable demand which, according to CDIE is a CPR of about 30%. The nature of family planning programmes means that they often require long-term donor commitment to have an impact - CDIE claims that the successful

withdrawal of a major donor requires 7-10 years of planning and preparation.

Impact assessment

K18. Demographic and health impact were assessed by calculating (respectively) the contribution of family planning to changes in fertility and reductions in infant mortality, drawing on data from national fertility surveys. Inadequate attention was paid to the impact on women's health, though this may partly be explained by the lack of information. Measurement of socio-economic impact is more difficult and was not fully attempted. The Famplan model, which estimates Government savings on health and education due to averted births provides a partial picture of socio-economic impact from a macro perspective but gives no indication of impact on users and communities.

K19. National demographic and health surveys are central to impact assessments but their quantitative nature has weaknesses. The methodology discourages in-depth enquiries and is not particularly good for investigating depth of knowledge about contraceptives or perceived quality of care. Qualitative methods, such as focus group discussions, are useful for supplementing survey results.

K20. To date, family planning programmes have placed greatest emphasis on measuring demographic impact. The shift in emphasis to reproductive health will require new measures of impact (maternal morbidity and mortality, abortion incidence, measures of sexual health) and the development of appropriate tools.

Project implementation

K21. It is difficult to assess the contribution of a specific donor, as programmes rely on inputs from several sources and these inputs are interdependent in their contribution to results. One of the lessons of the CDIE studies is that, at the outset, donors need to build into their strategic plans the means to measure performance and impact, otherwise they run the risk of failing to set initial benchmarks or establishing systems for data collection.

K22. Several of the CDIE evaluations highlighted the contribution that in-country technical USAID expertise made to facilitating projects and supporting policy and strategic dialogue with the various governments.

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