THE ROYAL NORWEGIAN MINISTRY OF DEVELOPMENT COOPERATION

Evaluation Report 2.88

Evaluation of the Norwegian Multi-Bilateral Programme under UNFPA

An independent report
by
DECO a.s.

Evaluation of the Norwegian Multi-Bilateral Programme under UNFPA

S. Møgedal
E.. Sandved
C. Widstrand
A. Wirak

DECO a.s
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PREFACE

In the early part of 1987 the Norwegian Ministry of Development Cooperation (MDC) decided to carry out a study of the UNFPA administrative operations, with the intention of specially looking at the project administration, reporting and evaluating systems as well as at the efficacy of using UNFPA as an agency for implementing Norwegian development policy in the health and population field.

Problems that MDC was interested in included such major problems as the involvement and minimum acceptable interference of the donor in multi-bi projects and if UNFPA project reporting gives an accurate description of reality. Other problems include the MDC handling of the professional aspects multi-bi projects with regard to the division of labour in the ministry, as well as the major problem of heavy donor influence in the population and family planning sector.

The task was given to Development Consulting AS (DECO) Oslo (A. Wirak) and DIGAMMA International Development Consultants Ltd Ottawa (C. Widstrand). The work has consisted of desk studies in Oslo (A. Wirak) and at UNFPA Headquarters in New York (C. Widstrand) as well as visits to UNFPA financed programmes in Nicaragua and Nepal to make three case studies of the projects NIC/85/PO3 in the Socialist Republic of Nicaragua and NEP/80/P12 and P/13 in the Hindu Kingdom of Nepal. The case studies were carried out by E. Sandved (Nicaragua) and S. Møgedal (Nepal). Widstrand participated in both studies. This report is a joint production effort by the four participants in the evaluation.

The consultants wish to thank the many colleagues and officials who have spent innumerable hours trying to educate us. Our special thanks go to Dr Nafis Sadik, Executive Director of UNFPA, to Ms C. Pierce and Mr Tevia Abrams, Chief and Deputy Chief respectively of the Interregional and Multi-Bilateral Projects Branch, to Ms Kerstin Trone, Chief of the Evaluation Branch as well as to their many colleagues for their helpfulness in providing information at the UNFPA Headquarters in New York. The friendly support and helpfulness of Ms Cecilie Landsverk and Aase Danielsen at the Norwegian Mission to the UN is also gratefully acknowledged as well as the help and assistance of many officials of MDC in Oslo.

An ambition of the consultants has been to try to keep this document as short as possible. However, there is a lower threshold under which any narrative or analysis becomes incomprehensible because the background is not described in sufficient detail. The present report certainly has sufficient detail but we hope, however, that the reader will bear with us and maybe even enjoy the narrative parts. We also presume a general knowledge of MDC/NORAD programmes, objectives and procedures.

Oslo, March 1988

PREFACE

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LIST OF ABBREVIATIONS

AED	Assistant Deputy Director
CBS	Central Bureau of Statistics (Nepal)
CRS	Nepal Contraceptive Retail Sales Company
CTA	Chief Technical Adviser
DAIM	Direccion de Atencion Integral Materno (Nicaragua)
DAIN	Direccion de Atencion Integral al Infante (Nicaragua)
DCE	Direccion Cooperacion Externa (Nicaragua)
DGAM	Direccion General de ATM
DMI	Direccion Materno-Infantil (Nicaragua)
DRSAP	Deputy Representative and Senior Adviser on Population, UNFPA
DTCD	United Nations Department for Technical Cooperation
EPI	Expanded Programme on Immunization (Nepal)
ECOSOC	Economic and Social Council of the United Nations
FAO	Food and Agriculture Organization of United Nations
FP	Family Planning
FPAN	Family Planning Association of Nepal
FPR	Final Project Report
GNP	Gross National Product
HEFA	Previous name of Health and Family Planning Division, Ministry of Development Cooperation, Norway
HELSE	Health and Family Planning Division, Ministry of Development Cooperation, Norway
HMG	His Majesty's Government, Nepal
ICHSDP	Integrated Community Health Services Development Project (Nepal)
IEC	Information, Education and Communication
IER	Internal Evaluation Report
ILO	International Labour Organization
IMO	International Maritime Organization
INEC	National Institute of Statistics and Census (Nicaragua)
IPPF	International Planned Parenthood Federation
IUD	Intrauterine devices
M&E	Monitoring and Evaluation
MCE	Ministry of External Coordination, Nicaragua, *(Ministerio de Cooperacion Externa)*
MCH	Mother and Child Health Care
MDC	Ministry of Development Cooperation, Norway
MED	Ministry of Education (Nicaragua)
MINSA	Ministry of Health, Nicaragua, *(Ministerio de Salud)*
MOH	Ministry of Health
MTR	Midterm Review
NCP	National Commission on Population (Nepal)
NGO	Non government organization
NORAD	Norwegian Agency for International Development
NPC	National Planning Commission (Nepal)
PAHO	Pan American Health Organization
PBHW	Panchayat Based Health Workers (Nepal)
PHC	Primary Health Care

PPR	Project Progress Report
PRAC	Programme Review and Allocation Committee, UNFPA
RFA	Risk Factor Approach
SEARO	South East Asian Regional Organization
TFR	Total Fertility Rate
TPR	Tripartite Project Review
UMN	United Mission to Nepal
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNIPAC	UNICEF's storage depot in Copenhagen
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

The main issues addressed in this report are: What does the present collaboration between the Ministry of Development Cooperation, (MDC) and UNFPA in the multi-bi field look like, should it be continued and, in that case, how can it be improved? What are the main characteristics, problems and challenges of the UNFPA assistance in Nepal and Nicaragua? Is this assistance relevant to country needs, is it in accordance with the two governments' health and population policies as well as the MDC development assistance policy? What is the role of UNFPA in the two countries examined, is UNFPA a relevant agency for norwegian funding of health, family planning and population projects in Nicaragua and Nepal?

1. Although there are quite a few problems, technical and intellectual, the general conclusion is that the collaboration between UNFPA and MDC is functioning fairly well and that the projects supported by MDC and run by UNFPA are performing as well as could be expected.

2. In the cases of Nepal and Nicaragua project performance and achievements are well above average in the context of development projects in those countries. The UNFPA projects are relevant to both the country needs and the government policies.

3. Project selection and the Norwegian input. One of the main ideas with using multi-bi channels for development cooperation is that the donor does not have to be concerned with day to day running of projects. Procedures for selection of projects for Norwegian consideration have improved and rather than be presented with a long shopping list of a variety of projects UNFPA now selects a few for serious consideration. One problem here is that Norway may be slotted for special types of projects, such as delivery of paper, equipment, etc. On the other hand such projects do not seem to cause any major technical problems.

   The Norwegian input into the project cycle - considering the present staff capacity - should be at the selection stage and at the mid-term review as well as ad hoc evaluations. This means that the presence of a professional department in NORAD, the HELSE, should be ascertained. If HELSE cannot cope with this extra work-load MDC should seriously consider hiring consultants on a long term basis to follow UNFPA projects over time.

   The absence of an expressed policy or consistent strategy in the health and family planning field on the part of MDC hampers the development of a coherent UNFPA/MDC programme.

4. Project reporting. The problems here concern the evaluation of projects and the long winded reporting process from project via various institutions to MDC.

   There are new evaluation procedures in place in UNFPA. The organization has over the last years put much effort into formulating assessment procedures which could be translated into action oriented advice for on-going projects.

   It remains to be seen how these new procedures will work in the future.

   The information flow from project to MDC could be much improved if the UNFPA and MDC could devise an informal way of for example letting the project managers send their reports for information directly to MDC to be followed later by the same report through the official channels. The internal circulation of such documents within the MDC also seems to need improvement.

5. The team endorses the recent moves in MDC to include UNFPA multi-bi projects also among the main countries of cooperation. This will, however, need a careful assessment of the position of the MDC Resident Representatives in this connection.

6. Norway at one point supported a major activity in UNFPA: the production of the Needs Assessment Reports for a wide variety of countries. That contribution has now ceased but there is certainly a need for another type of Norwegian input of a similar kind.

   The intellectual and professional importance that UNFPA should have in the fields of Family Planning and related areas could be supported by Norway. There is at present a need for extra funds for UNFPA to be able to organize workshops or other scientific gatherings where the state-ofthe-art and recent advances in various disciplines and problem areas essential to UNFPA work could be discussed (not only by the medical profession but by other disciplines as well).

7. The team has very carefully studied a variety of UNFPA policies and procedures. They are described and discussed in detail in the report. During the field trips special attention was paid to the functioning of UNFPA at the country level. The following comments may be of use to UNFPA and to MDC:

   (a). The continuity in the field is often through the local officers as the Deputive Representative and Senior Adviser on Population, (DRSAP), changes rapidly and stations are left without DRSAP for extended periods. In other cases there are no DRSAPs but only local officers either in the UNDP office or at the project or ministry level. The education and further training of that type and level of personnel is of vital importance especially where the UNFPA is a major contributor.

   In the case of Nicaragua, UNFPA is not present but represented through UNDP. Here, the PAHO is the executing UN agency and UNDP plays, logically, a relatively passive role. However, the way PAHO performs its role as the international executing agency is critically reviewed in this report. In Nicaragua the UNFPA programme is important both in size and quality, but suffers from lack of coherence and coordination. We recommend a direct UNFPA presence in Nicaragua, not at least because there is a need for support to a coherent and coordinated population planning and we believe that the conditions exist for a valuable UNFPA contribution.

   In Nepal, UNFPA is faced with a weak national coordination capacity and the practical UNFPA commitment in this field could be strengthened, in order to take advantage of the potential inherent in the existing integrated programme strategy. The Nepal case also presents the difficulties that might arise from the fact that UNFPA is a fund rather than an executing agency. The implementing problems related to executive agencies as intermediaries are assessed.

   (b). Absorptive capacity. Many of the problems we found in Nicaragua and in Nepal with projects and programmes are not caused by deficiencies in the UN or UNFPA system, but are rather reflections of underdevelopment in general and of the situation in the country. Management and operation procedures, experience and styles differ widely. In many cases the training in management and administration, like for example in Nicaragua has been neglected for years. In Nepal the government administrative systems are complex and national coordinating capacity low in the field of health and population.

In the Nicaraguan case, the report stresses that most project problems must be related to the general problem of public development administration. The way international agencies perceive and relate to such problems is of importance. We have critically studied the role of PAHO in Nicaragua and have concluded that the PAHO execution model is not the best one in a long run development perspective. PAHO works within the Nicaraguan Ministry of Health (MINSA) and has gone too far in taking over the administration of the project. In fact, the MINSA is hardly involved at all in the administration of the project funds. We have suggested that the project should be supplemented with institutional-administrative support to MINSA and that this is a better response in the long run to the related public administration problems.

Other aspects of the role and performance of PAHO have also been singled out in the report. The direct PAHO involvement within the MINSA produces some disruptions of the formal external cooperation procedures the government wants to impose. The project assistance provided through the Chief Technical Adviser (CTA) does not seem to fit very well into the problems the CTA according to the TRP should help solving.

We feel that the role of PAHO in Nicaragua is not an exception, but is related to the overall PAHO strategy and policies for health care assistance. We do, however, recommend a closer look at the PAHO role in the project since some aspects of PAHO performance might contradict Norwegian development cooperation policies in terms of recipient government administrative capacitybuilding.

Such general problems may be aggravated by the way external agencies like UNFPA create additional demand on the national system for coordinating and implementing capacity. In pursuing own planning and monitoring models tailored to the agency's own needs, and selecting scattered single project components for support which does not become integrated parts of a comprehensive national strategy, UNFPA along with other agencies has contributed to fragmentation and imbalances.

(c). Realistic planning. The magnitude of the population problem and the low absorptive capacity for external assistance makes it extremely important to set priorities and plan realistically. Up to present UNFPA programming seems to have been too ambitious, and the eagerness to be involved in all sectors pertaining to population has not been matched by sufficient attention to structural constraints and carrying capacity of national structures. In the country cases studied, this problem is more relevant to Nepal than Nicaragua.

(d). Technical and professional backup. In many cases the service provided by the executing agencies is not up to standard. The staff of the technical back up division at UNFPA HQ is small and mainly used for assessment of projects. In the case of Nicaragua, the UNFPA technical back-up is minimal, but this might be explained by the PAHO role and the fact that it is a predominantly medical health care project. The team would therefore recommend to MDC to discuss ways of increasing the UNFPA back-up system regionally.

8. The implications of HIV infections for service delivery, changes in emphasis of multi-bi projects and eventually on demographic structures should be carefully followed by UNFPA. This is an area where the above mentioned scientific information support could be of use.

1. UNFPA IN GENERAL

1.1. INTRODUCTORY COMMENTS ON THE UNFPA

More than thirty years ago the United Nations established a Population Division in the Secretariat for a very special purpose: to establish the size of the populations of the member states. Payments to the organization depended on capacity to pay, expressed in national income and per capita income, hence the necessity to find population figures. The Division is now a major contributor of statistical analysis and base data.

A voluntary Trust Fund for population activities was established in 1967 (renamed in 1969 the **United Nations Fund for Population Activities (UNFPA)** to serve as the main agency to coordinate UN activities in the population field and for channeling population assistance to national programmes. During the last 20 years World Bank lending has also become available to help financing of national population programmes and the Bank has been very active in large scale projects and at the policy level. Bilateral funding for population programmes has increased during the last 20 years, and there has been a marked increase also in NGO activities in the field (IPPF, Population Council etc).

1.1.1. *UNFPA objectives*

The UNFPA is subordinate to ECOSOC on policy questions and to the Governing Council of UNDP. (UNDP provides services to UNFPA in some administrative, financial and personnel matters, for which UNDP is paid a fee, for 1988 estmated at US$ 1.4 million). Over the years there have been a variety of minutes, guidelines and interpretations added to the original ECOSOC document (Res. 1763 (LVI). 18 May 1973) and this makes the objectives somewhat difficult to express precisely. For the purpose of this document we shall offer some generally accepted interpretations.

In the early years UNFPA tried to accommodate a great variety of approaches in respect both to the countries and the activities it was prepared to support within the general idea of assisting countries to solve their population problems. It was at this stage, as Margaret Wolfson has pointed out important for the UNFPA to win

> *"a firm political constituency... as an institution dedicated to the cause of population assistance, and hence, to widen countries' awareness of the importance of the 'population issue' in general".*

This state of affairs culminated in the Mexico Conference 1984.

UNFPA has attempted over the years to introduce greater coherence in its criteria for support by defining four rather wide priority programme areas in which the Fund assists governments:

(1) <u>Family planning</u>

In 1986 UNFPA assistance in this area totalled $ 54.9 million or 51.2 per cent of total programme allocations. Total allocations for 1969-1986 reaches US$ 615.4 million or 46.6 per cent of total assistance).

(2) <u>Communication and education</u>

(US$ 18 million or 15.5 per cent of total programme allocations in 1986, US$ 165 million or 12.5 per cent of total assistance over the time-span 1969-1986).

(3) **Basic data collection**

(In 1986 US$ 10.9 million, or 9.4 per cent of total assistance. US$ 192.4 or 14.6 per cent of total assistance has been spent in this area 1969-1986).

(4) **Utilization of population data and research for policy formulation and development planning**

(This sector includes population dynamics research, formulation and implementation of population policies. Totally in 1986 the fund spent US$ 21.4 million in these areas. Over the period 1969-1986 the allocation has been US$ 224 million or 17 per cent of total assistance).

There are in addition to the four priority areas also some other areas where the Fund works with *multisector activities* (training, workshops, seminars, dissemination of information etc) and a variety of *special programme interests* (women, population and development, youth, the question of aging). In these areas the Fund spent US$ 6.3 million or 5.4 per cent of total programme allocations in 1986. During 1969-1986 the allocations have totalled US$ 124.5 millon or 9.4 per cent).

The work is to be done while recognizing some general principles such as **sovereignty** of governments. It supports all countries irrespective of their attitude to family planning. **Neutrality** is important. UNFPA does not prescribe any specific approach or solution. **Flexibility** is another principle meaning that UNFPA is prepared to assist with all kinds of programmes within its mandate.

As of May 1987 UNFPA supported 2 300 projects in 53 priority countries and in a substantial number of non-priority countries. UNFPA's 1987 income was approximately $ 155 million from 94 donors. UNFPA's largest donor, the US which contributed US$ 36 million in 1985 decided for a variety of reasons to make no pledge for 1986. However, many other countries increased their pledges and the US withdrawal probably only left the organization short of 2.5 million as compared with 1985. The total pledges since 1969 through 1986 total $ l.5 billion.

There is an ongoing effort to supplement funds through multi-bilateral arrangements. Such efforts generated US$ 3.5. million in 1986. From the inception of the multi-bilateral programmes in 1976 contributions received from multi-bilateral donors for 46 projects amounted to US$ 34.3 million. *The contribution of Norway to the multi-bilateral fund since 1977 has amounted to approximately US*$ 15 million or 43 per cent of the total.

1.1.2. Population issues and the UNFPA contributions

The increased awareness of population issues among LDC governments and the apparent slowing down in parts of the world of the rate of population growth combined with very high or increasing rates of population growth in other parts are perhaps the most interesting aspects of the population development today.

The size of populations

There are hopeful signs that global population may stabilize in the future, the question is when and at what level. The UN medium projection gives a stable population of l0.2 billion at the end of the next century.

This is an extrapolation of current trends. The Asian rate of growth has come down from 2.5 to 1.7 over the last two decades. This is, however, mainly because of the rapid fall of China's birth rate. Growth rates in Africa have increased but the global rate has come down from 2.2 in 1974 to 1.76 in 1985.

This reduction in the global rate may not seem much against the fantastic rise of population figures over the last 25 years when we have added another billion, the forth, to the world' s population in the 15 years between 1960 and 1974. The fifth billion which the world's population is predicted to reach this year only took only 13 years whereas the earlier increases where over much longer time spans: the third billion took 32 years and the second 120).

It is however important to remember that in the Third World the fertility rate has declined by 15% over the same 15 years. The growth rate,however remained the same because of the compensatory effects of the decline of the mortality rate of "which we should be proud" (Leon Tabah).

But the situation is far from salutary and insufficient progress has been made both in reducing fertility and in redressing another major problem: the imbalance of population distribution.

Rapid population growth

which means annual increases of 2% or more and a population doubling time of approximately a generation is troublesome. Some African countries, such as Kenya have a rate of natural increase of more than 4% per year. This implies doubling of the population every 17.5 year. The Net Reproduction Rate is 3.5 implying that the next generation will be more than three times the size of the present one.

The major **UNFPA contribution** during the last ten years has been mainly in two areas:

(a) excellent work in the **collection of basic data**, for example in the work with censuses and analysis of census material in Africa and in the assistance to national administrations to collect vital statistics.

(b) a successful **creation of awareness**. The message that population and population growth is not a fantasy problem has now sunk in. The change of attitudes in governments between the two international conferences in 1974 and 1984 on population has been dramatic.

The impact of the organization on other population issues is more difficult to assess. Among such issues are:

Family planning, an area where UNFPA has been active for a long time. We now know that family planning is one of the great unmet needs of LDCs and the lack of access to family planning information and services is a major weakness at present. What we know less about still is the various barriers to acceptance such as traditional attitudes and motivation at the local level as well as the problems of capacity in national systems to deliver. The gap between demand and supply will widen with increasing awareness and education.

The relation between population and development is another old issue which UNFPA is interested in giving more and renewed attention. Every Population Needs Assessment undertaken by UNFPA so far has stressed the need for demographers or population experts in ministries of planning and finance to help relate population size and growth to development goals. Although some progress has been made in this regard, particularly in Asia, there is much more to be done in this area. It is, however, a very difficult area:

*Predictions of the **population dynamics and responses to economic challenges** and opportunities is a very difficult field, highly political, and fraught with intense disagreements between economists and others. Attempts to isolate a simple analytical*

> *economics of population growth for example are a valid way of seeking insights on specific economic-demographic relationships, but are likely to be seriously misleading if aspiring to comprehensiveness.*
>
> *There is an ample supply of hypothetical mechanisms that link demographics to economic variables and selection among them can yield widely varying net effects (Widstrand 1985, McNicoll 1984).*
>
> *The design and performance of development institutions and in the kind of social arrangements they support and create are grey areas, largely inaccessible to formal economic analysis To such areas belong problems of shifts in kinship frequencies, land ownership and land tenure, and of social stability. It would seem that the implications for social organization* ***are not effects of population size but rather effects of the rate of growth.*** *There will be significant effects on local government, national policies and the international system of the continued rapid expansion of the labour force.*
>
> *This situation also reflects the general narrowness of the research base from small scale anthropological studies "mired in societal minutiae" (McCullock 1984) to tunnel vision demographic calculations and obsession with figures rather than what produces the figures.*

The role and the status of women is an issue that has developed with an increased force during the last ten years. It was the theme for the 1985 State of World Population Report. UNFPA developed its first guidelines on women, population and development already in 1976 (UNFPA/PA/80/16, 1987).

The guidelines stressed the need for projects designed specifically for women but integrated in other programmes - in particular projects on additional education, training and skill development and for community development programmes.

The activities fall into two major categories (a) support to projects specifically designed to improve the status of women and (b) special initiatives to ensure that

> *«all projects developed for submission to the Fund for technical and financial assistance are formulated, appraised and implemented taking fully into account the role of women and their participation in population and development related activities*
>
> *(Report Exec. Dir., Gov. Council 1987/32 part II).*

Each Needs Assessment Report contains a section on women and all country programmes supported by UNFPA include some projects aimed at improving the condition of women. The improvement of the role and status of women and her participation in income generating activities is a very important goal in itself. Because a woman's status and opportunities are also clearly related to demographic variables (e.g. fertility and maternal mortality) improving the situation of women should also be a component of any population policy.

It is therefore fair to assume that UNFPA centrally has laid the policy groundwork for an increased attention to women in their projects.

The consultants, however, have a feeling that the new and advanced Scandinavian debate on women-centered development has not effectively reached UNFPA (nor the UN system which has an interagency group organizing meetings on Women and Youth), at least not in a way that has had an impact on programme planning up to now.

UNFPA is also involved in research and projects concerning the **movement of populations in time and space;** two very important aspects of any national development effort. Changes in the **age structure** such as increased percentages of children, adolescents or aged people in a population have immediate effects on planning and long term effect on development in general.

Two aspects of population movement in space are important: (a) movement into cities and towns and (b) movement over national borders. The creation of megacities in Asia and Latin America is now the single most urgent problem for some national governments. The refugee problem is probably the most important migration problem in Africa today. UNFPA has an important role to play in all these areas.

1.2. UNFPA PROCEDURES: PROGRAMMES, PROJECTS

(Ad: Terms of Reference sections 3.2.1. (a), (b), 3.2.2. (b), (c) and (e) ii, iii and v)

This section, 1.2.1. and the next deal with the various criteria and practices of selecting a priority country or recipient country, the project cycle and the selection of and ensuing problems with executing agencies.

In the section 1.2.2. we then deal with the problems of running and monitoring/evaluating projects. Both these sections are part of the same cycle but we have tried to dissect some of the problems, and their suggested solutions.

1.2.1. *Selection of recipient countries.*

Recipient countries can be selected in many ways, the most usual is the demand forthcoming from a country itself. However, there is a set of established rules which define the UNFPA priority countries to which two thirds of the available resources should go.

Short background.

Early in the history of the UNFPA many different ways of distributing the resources of the organization between developing countries were discussed such as allocation by Indicative Planning Figure (IPF, the UNDP system for resource planning), either for country or for region, or allocation of the resources exclusively to the Least Developed Countries or those most seriously affected.

In 1976 the Governing Council (and subsequently also the Economic and Social Council as well as the UN General Assembly) adopted a system of priority countries for population assistance (PCPA), recommending the Executive Director to establish priority status by looking at four demographic indicators: (a) population growth rate, (b) gross reproduction rate, (c) infant mortality rate and (d) density of agricultural population on arable land.

These gave an indication of the major population problems and as well as an approximation of the general status of welfare and development.

By applying certain threshold levels for these indicators and using an upper limit for the GNP/capita a group of 40 countries were selected as priority countries, and some 14 as "borderline countries". The Council in 1977 also recommended that two-thirds of the total programme resources available to the UNFPA for population activities at the country level should be established as a ceiling (or goal?) for assistance to this group of priority countries.

The Governing Council in 1982 revised the system to include further criteria for selection.

The selection of specific factors were conditioned by four considerations:

(1) the criteria should be objectively measured,
(2) selected criteria should have uniform meaning and definition,
(3) data should generally be available for all developing countries from sources recognized internationally and
(4) all data should be recent and from the same period.

These considerations show some of the problems and some of the criticisms the 1976 selection had run up against. However, no major changes were made in 1982: two thirds of the available country programme resources should still be made available to priority countries, some criteria were modified and the threshold levels changed. [1]

This led to a (the current) list of 53 priority countries. Over time (1977-85) of the original 40 plus 14, 19 have been demoted to non-priority status whereas 18 new countries have come into that category.

Once the country is on the list it cannot be taken out until the system is updated or revised whatever happens in the meantime to the indicators in that country. The current system will probably come up for revision in 1988 after five years of experience.

However, in 1986 one felt a need to further refine the categorization of countries. Thus a distinction should be made within the priority countries of those that are very poor and the others. Among the non-priority countries a useful distinction should be made between those with a population problem and those without.

Obviously, in view of the financial constraints this would enable the Executive Director to modify and adapt country level support in a much better way. It also means that the support for the priority countries will be slightly higher than the two thirds. [2]

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1. So for example instead of using annual population growth rate, the annual increments to total population was to be used, the GNP/capita threshold was raised from $ 400 to $ 500 (same as UNDP), gross reproduction rate was lowered from 2.75 to 2.5, infant mortality rate from 176 to 160 and agricultural population density on arable land from 2.2 to 2.0 per hectare.
   It is interesting to note the semantics concerning the 2/3rds of "available" resources. In 1976 on said quite clearly that 2/3/s of total available UNFPA resources available for country programming should be used, in 1982 this has changed to a "goal or ceiling of 2/3 ..") and in 1986 the turn of the phrase is "... all efforts should be made to attain the targets of devoting up to two thirds.." (DP 1986/38). It must of course be mentioned that there has never been any problem to reach the two thirds level.

2. There are different interpretations of what really happened at the 1986 Governing Council and what the GC really decided. Some of the officers we talked were quite emphatic that that the Governing Council had decided to endorse the Executive Directors suggestions for the revised guidelines for the next two years or with the beginning of new country programmes,where appropriate. Others were of the meaning that nothing had happened and that the situations would now await the five year revision in 1988.

1.2.2. *Selection of programmes and projects, the Project Cycle.*
(ToR 3.2.2. (b), 3.2.1. (a), (b))

The World Bank, the USAID and most of the UN system use a project cycle approach (cf Warren Baum, "The Project Cycle," *Finance and Development,* December 1978) which outlines the logical steps of a procedure from identification, preparation and appraisal of projects to their implementation, supervision and evaluation.

Each of the UN organizations however have made alterations and amendments to this process to adapt them to their own needs.

UNFPA has often used the UNDP formula, the logical framework, but has also developed their own refinements in manuals for Needs Assessment and Programme Development, as well as instructions for the Preparation of a Project Document (UNFPA/19/Rev. no 3. 22 January 1986; UNFPA Manual for Needs Assessment... 22 November 1985).

One important step in the process for UNFPA is the development of a **country programme.**

Such an exercise begins with a **Population Needs Assessment Mission and Report.** This is a departure from the other agencies use of the project cycle approach, but important for UNFPA. UNFPA has since 1977 sent out 113 missions to make a complete needs assessment of a country with emphasis on the population problems and with the aim to assist the recipient government to identify its needs in the broad area of population and the need for development assistance.

To date, population needs assessment have been made in 69 priority countries and 44 non priority countries.

Such needs assessments are undertaken in close collaboration with the government and the donors and are later published (often in several languages). They are very ambitious undertakings and give, if they are printed soon enough, a wide view of a country and its problems.

To date some 90 such needs assessment reports have been published. Much of the work has been done under a multi-bi project financed by Norway (GLO 1977/P 24). Some of the early reports are now being updated or changed to include new data.

The needs assessment mission reports are reported to have been valuable to UNFPA and to other donors in the field, as they have provided a succinct analysis of the population situation against a background of the general development and the general development problems of the country.

The Needs Assessment Mission produces in its report most information needed for **Country Programme** development. A country programme is a long term framework for population/development activities directed towards the achievement of national long term objectives. The output of the programme development phase should permit the formulation of technically sound programmes and projects within the programme.

The most important part of the programme concerns the nature of the projects to be supported in each sector, resource allocations for each sector and the proposed executing agency and/or cooperation organization in the country, and finally the role of the UNFPA and degree of UNFPA involvement and support. The programme is often changed to reflect developments and changing government priorities.

A common format (or lay-out, the format changes quite often) is used for the country programme document submitted to PRAC and the Governing Council Over time the document gets increasingly detailed and specific as it progresses from its initial outline presented to the PRAC to the time it reaches the Governing Council.

The country programme draft is produced in the field by the Deputy Representative and Senior Adviser on Population (DRSAP) (in discussions with the government) immediately following the needs assessment mission. The draft country programme is then sent to HQ in New York for technical appraisal, and general review. The country programme must then be approved by the Programme Review and Allocations Committee (PRAC) and finally by the Governing Council.

In reality it is the PRAC which decides what background is needed and what policies should be in place before **project formulation** can take place. Changes at the Governing Council level take place but not very often.

Project formulation is usually done by project formulating missions. Timetable, content and personnel is planned by the Geographical desks in the Programme Division. Project formulation can take many forms but one essential policy must theoretically be adhered to: *all projects should be drafted by Government.*

This happens from time to time but is not the rule. Too often projects are drafted by the project missions, consultants from executing agencies or the DRSAP which can cause problems with the responsibility for the implementation of projects. It may also make the Government look as if they had no commitment.

Project proposals are then appraised by the UNFPA DRSAP to ensure that the project (a) falls within UNFPAs mandate, (b) that the nature of the project and the support requested are in accordance with UNFPA policies, (c) that the project falls within the recommendations of the NAM/Country Programme framework approved by PRAC and the Governing Council, and (d) that implementation and executing capacity of the government or the executing agency is adequate to the task. The DRSAP is also supposed to provide what is called "substantive comments", (which usually means reasons why a project should **not** be mounted).

Thereafter the project document is sent to UNFPA Headquarters for technical appraisal by a technical officer and also to the UN agency concerned. The appraisal should include:

a. ***How** the project was formulated, **who** prepared the project document and who was involved in the project formulation;*

b. *Objectives and justification of the project;*

c. *Relevance to UNFPA mandate, policies and procedures, and how issues of concern to women are included;*

d. *The project design*

e. *The method of project execution (with or without executing agency)*

f. *The institutional framework;*

g. *Advance preparations and obligations;*

h. *Capability of the Government in execution its responsibilities;*

i. *Relationship to other external assistance;*

j. *Utilization of project results;*

k. *Adequacy of monitoring and evaluation plan;*

l. *Any other pertinent information not listed under a-k.*

Before forwarding the project document to headquarters, the UNFPA Deputy Representative appraises the project request to ensure that:

a. *The substance of the project falls within UNFPA's mandate;*

b. *The nature of support requested are in accordance with UNFPA policies;*

c. *The project falls within the recommendations of the country programme framework approved by PRAC/the Governing Council-approved country programme;*

d. *Implementation and execution capacity is adequate to the task.*

He/she should ensure that the requested document follows the format outlined in UNFPA/19.

He/she should provide additional comments on managerial/operational aspects of the request on the basis of his/her knowledge of the situation in the country, with particular reference to the proposed government inputs; and the capacity of the government implementing/co-ordinating machinery.

He/she should provide such substantive comments, as appropriate.

The project request should be forwarded simultaneously to the appropriate Technical Officers for appraisal. The Programme Officer prepares a memorandum for transmittal which should include the following information:

a. *The relationship of the proposed project to the national population programme or to other existing/forthcoming projects;*

b. *The relevance of the project to NAM recommendations/Governing Council-approved programmes;*

c. *Any political/operational problem in implementing other UNFPA-supported activities in the country;*

d. *Any problem area in proposed project and/or areas which should receive special attention in technical appraisal;*

e. *Financial implications of the requested budget and the need, in any, to reduce it by some amount;*

f. *The capacity of the proposed executing agency, government, United Nations or other, to carry out the work; and*

g. *Any additional information the Programme Officer feels would be useful in making a technical appraisal of the request.*

The Programme Officer should also indicate the urgency of the need for comments. Under normal circumstances, a time limit of about four weeks should be set for comments from the Technical Branch.

In appraising a project request, the Technical Officer ascertains, ***inter alia***, that:

a. *The objectives of the projects are clearly stated, as specific and quantified as possible, and relevant to the population objectives of the government;*

b. The proposed approach is technically sound, internally consistent and conductive towards attaining stated objectives;

c. The timing of the project is appropriate to related activities in the country programme (included those supported by government and other donors and UNFPA;

d. The work plan for implementation is feasible given normal time lags in recruitment, procurement, etc.;

e. The planned activities include numerical output targets (e.g., how many courses will be held for how many trainees), where possible;

f. The total budget as well as its individual components (from both UNFPA and the Government) are justified and sufficient for the achievement of stated objectives;

g. The requested budget is realistic and detailed information on all budget line components is included;

h. The nature an extent of government contribution (personnel, premises, other) its timeliness and quality are described in sufficient detail;

i. The institutional framework for implementation and execution are appropriate to the nature of the project whether it is:

(i) Government
(ii) United Nations organization
(iii) NGO
(iv) other

j. There are sufficient government commitment to attaining the objectives of the project in terms of organizational/legislative measures;

k. There are arrangements for government takeover of costs of relevant components;

l. There are replication possibilities, given local conditions, if it is a pilot project;

The UNFPA HQ programme officer should examine project for plans for i.a. monitoring/evaluation and prepare a board sheet (a project summary) for PRAC.

Approval mechanisms.

There are different levels at which projects submitted to UNFPA for funding are approved:

A. The Governing Council

- country programmes and comprehensive agreements,
- projects and programmes costing more than US$ 1 million,
- innovative projects which deserve the councils consideration and discussion
- any project that governments of the Governing Council wish to have submitted or projects the Executive Director decides to submit.

B. UNFPA headquarters

PRAC is the principal body responsible for recommending decisions to the Executive Director on programmes and projects and for deciding on allocations.

The Assistant Executive Director is the ex officio chairperson of PRAC since 1982. The Executive Director has delegated the following "approval and associated authority" to the AED:

(i) administration of trust funds (rule 105.2);

(ii) authority to initiate the submission of a particular project, or type of project, to the Governing Council (rule 108.2);

(iii) all project approvals given to the UNFPA by the Governing Council under Regulation 8.2 (rule 108.3);

(iv) agreement on the adequacy of any individual project document and, by signing approved documents, making commitments on the parts of the UNFPA to the recipient government (rule 108.4);

(v) the designation of executing and associate agencies to implement or to assist with the implementation of UNFPA assistance to the project (rule 108.5);

(vi) suspension or termination of project assistance or existing executing agency arrangements (rule 108.6);

(vii) final revisions of project budgets and allocations needed to wind-up a completed project (rule 110.2).

C. Other headquarters staff

The Chief, Programme division has approval authority of up to US$ 50 000 or 20% of project costs for supplementary project budgets, whichever is less.

Geographical branch chiefs have approval authority for supplementary budgets of US$ 20 000 or 20% of project costs whichever is less

DRSAPs and Programme division branch chiefs can make a variety of budget line changes, movement of funds between years etc.

Field approval. DRSAPs have $ 10,000 per calendar year for smaller projects such as local seminars and workshops, ad hoc arrangements, and rental or purchase of small items of equipment.

Reprogramming. The third phase of the project cycle concerns **project implementation and revisions** or reprogramming as suggested by monitoring or evaluations.

Project changes or revisions are quite common, and issue from evaluation or monitoring recommendations. If the orientations of the project is completely changed it should, however be treated as a new project.

1.2.3. *Multi-bilateral projects.*

As this report is especially interested in the multi-bi arrangement we first deal with such project criteria.

The objectives of the UNFPA multi-bilateral programme are mainly to augment the resources of UNFPA for population projects and to provide a channel through which additional co-ordinated external assistance can flow. The UNFPA negotiating and administrative capacity is helpful to overburdened recipient and donor governments in coordinating population assistance with other developmental activities.

There is a considerable flexibility in the methods which can be employed or adapted to meet the requirements of participant governments and agencies.

However, **the projects under the multi-bilateral programme are processed as any other UNFPA project.** Thus, to be selected and included in the UNFPA multi-bilateral listing a project has to fulfil the following criteria:

(a) The project should be fully documented by a project request correctly drafted in the recognized format,

(b) The objectives of the project should be within UNFPA's mandate and respect its approved workplan categories and

(c) The potential recipent country for a country project should agree to the presentation of the project for multi-bilateral support.

The following guidelines apply:

(a) Preference will be given to country projects,

(b) Regional, interregional and global projects may be included if their funding is urgently required and if they concern high priority activities as designated by the UNFPA Governing Council and

(c) In the case of a country project the government should approve the inclusion of the project in the multi-bilateral list.

1.2.4. *Selection of executing agency.*

The relationships between UNFPA and the specialized agencies of the U.N. family makes a complicated story.

UNFPA is a fund. This means that the Fund most often uses other agencies to execute their projects.

Projects in the field are implemented either by an "executing agency", or by the Government, so called direct execution or execution by "implementing agency". Both methods have their problems and drawbacks. UNFPA itself sometimes executes its own projects.

The **executing agencies** are most often agencies of the UN system such as the WHO and its regional organizations PAHO, SEARO etc., FAO, ILO, UNESCO, UN departement for Technical Cooperation (TCD) etc. Sometimes, although seldom and mainly in connection with joint ventures for instance, the World Bank or one of the regional development banks. At other times the executing agency could be a fiscally responsible NGO such as the IPPF, the Population Council or a university.

The most common UNFPA partners in the U.N. system are the Population Division of the U.N. Secretariat and WHO.

The choice of agency depends on various factors. One and maybe the most essential should be the competence. Some agencies have carved out a niche for themselves such as UNESCO in population education, the TCD in census arrangements and analysis, the FAO in rural development and the WHO in MCH and primary health care.

The population sector is multidisciplinary and often there is no single source of technical expertise for a population project. For instance in Nepal different sources of technical backstopping were needed for a project which required expertise on women's concerns, production aspects for cottage industries and population issues.

Thus, since none of the UN agencies has an overall competence in population questions the choice in certain population sectors involving the mandates of the various agencies eg. population and development planning, IEC etc., is often made on other premises. There is in times of shrinking UN economic support an interest among the agencies to cash in on the 13% administrative overhead that UNFPA (and UNDP) pays for the execution of a project. As one sometimes moves in grey areas of competence the struggle can be fierce.

Most agencies have so-called population advisors either regional or interregional who are financed by the UNFPA but selected by the agency in question. UNFPA may have an unofficial say in the selection but is not systematically consulted on the selection. This has led to some interesting appointments over time of advisors who are not able to respond adequately to needs in the population sector. The question is raised here as some of the Norwegian multi-bi projects have been interregional, and as the backstopping support these representatives are supposed to give is essential to the well-being of many projects.

The relation between UNFPA and the **Population Division of the U.N. Secretariat** is an important one. UNFPA was created from a fund administered by the Population Division.The Division and its work is now financed to a great extent by UNFPA and also collaborates with UNFPA in regional and global population studies. The U.N. ECOSOC and the General Assembly need the Population Division (with its mandate to produce population statistics) for their own policy making purposes in population issues. They need an institution which is outside the UNFPA, and which can provide data useful to both organizations (as well as serving as a watchdog on UNFPA's activities related to the World Population Plan of Action as agreed to by the two International Conferences on Population).

WHO is often essential in countries where there is no UNFPA Deputy Representative (such as Nicaragua) and UNFPA finances a unit in WHO to provide technical and management advice.

UNDTCD is involved mainly in census and vital statistics projects.

UNESCO has over the years developed a competence in population education (cf center in Bangkok etc). The backstopping is however at the regional level with regional advisors, who of course have too large areas to oversee and assist.

Other executing agencies are **ILO**, and the **Regional Economic Commissions.**

FAO is the least used of the agencies but with FAO UNFPA runs country level projects for more than US$ 7 million. There is also an UNFPA coordinator at FAO HQ in Rome.

The collaboration between the **World Bank and UNFPA** is less than ideal. In many countries the Bank is the leader in the field, e.g. (with rather mixed success) in Kenya and with donor orientation problems in Bangladesh. The Bank has in-house capacity in the field and an enormous weight and importance as the major financier of development in the Third World. However, the Bank is not involved in population issues in Nepal nor in Nicaragua.

The use of **NGOs** in the execution of projects is probably the most cost-efficient use of funds for small and medium scale projects, especially in the family planning field. UNFPA works with the large international specialized NGOs (The Pathfinder Fund, The International Planned Parenthood Federation, the Population Council The Population Institute etc) but also with smaller local groups, who tend to perform better than the UN agencies as their organization is less complex and they are more flexible in their management style. There seems to be an optimal size for such groups for them to be able to work in competitive and specialized settings.

Such groups are important even if they cannot be used to execute large scale projects. It is through small local groups that the family planning programme in Thailand has worked towards success. For the delivery of family planning services in Africa small local groups, indigenous social organizations (women's groups,market women's associations, *Maendeleo wa Wanwakwe, Umoja wa Wanawake* etc) could probably be of utmost importance. But to identify such groups and develop programmes with them put an additional strain on the UNFPA field staff and raises the importance of strong field presence and the quality of staff.

Direct execution. For political reasons the UN system has over the last years given more and more projects over to be executed by government departments or institutions. In many cases backstopping services are provided from regional or interregional advisors attached to a UN agency such as the DTCD or a NGO or an academic institution. UNFPA charges 5 % for its own support sevices to such government-executed projects, and this is paid for by the donor country in multi-bi arrangements.

Some projects in Nepal are executed by a government "implementing agency" in a mix with executing agencies such as UNICEF and WHO. For discussion on the relative merits of execution by an UN agency, or by some other arrangement as well as the problems of backstopping, see below 1.2.6.

1.2.5. *UNFPA at the national level*

a. **The Resident Representative** of the United Nations Development Programme (UNDP), is ex officio also the Representative of UNFPA. The UNFPA Representative is Duty Resident Representative and Special Adviser of Population (DSRAP). There are just over 30 such posts. This means that the Res Rep of UNDP fulfills the role alone in more than 80 countries. He is, however, probably the busiest and most overburdened person in the UN system and has most often little time for UNFPA activities.

   In Nicaragua, as in many other places where there is no DRSAP the UNFPA business is handled by a local programme officer, who deals with the practical aspects of redirecting reports, financial statements, the setting up of Tripartite meetings and similar jobs.

   Worse is the situation where the Res Rep has a UNFPA representative, but is himself not particularly interested, or interested only in family planning or some part of the UNFPA programme. The relationship is so loosely defined that this may cause problems and be to the detriment of the programme. In most cases, however, it is the UNFPA representative who takes the substantial decisions, in collaboration with New York.

   There is a rationale and a real need for UNFPA to stay within the administrative framework of UNDP. For example the centralized funding and integration into UNDP programming and mutual reinforcement through projects is important. In the field it is important to have access to banking, administrative facilities etc through UNDP without setting up a separate UNFPA administrative field system.

b. The **DRSAP** when he exists certainly has his work cut out for him. It is quite clear that most UNFPA offices in the field are insufficiently equipped to carry out the manifold functions of the programme, such as monitoring, evaluation, checking project design and formulation, relations to national authorities etc.

One problem which needs addressing is the **turnover of DSRAPs**. In Kenya where population growth rate is higher than almost anywhere else the programme had no DRSAP for almost two years. Nigeria the largest country in Africa with a population of some 100 million there was no DRSAP for almost a year. In Nepal it would seem that the DRSAP is called to New York or moved somewhere else precisely at the time of important happenings in the programme.

The importance of the presence in the field of the DRSAP is shown in the implementation rate. The implementation rate for 1982 - 1985 of UNFPA projects is 86.98 with the DRSAP present and 81.42 with no DRSAP present (Governing Council UNDP DP/1987/36, table 3).

In the Nicaraguan project, where there is no DRSAP, it took some years before an acceptable project document was produced.

This means that in many UNFPA offices the continuity of the programme and of the relations with government depend on local UNFPA staff, not on the international staff. In Nepal this will not cause any problems because of the excellence of the local staff. In other countries, however, the consultants are not so sure that officers have the training and background to run the programme by themselves during long periods of no DRSAP.

c. Relations to other agencies and to government.

The quality of the relation of the local UNFPA representative to government depends to a great extent on if there is an appropriate government institution to relate to. Usually this means a ministry of health, a ministry of rural development and of course the ministry of finance. In many countries there is some kind of population commission usually in the vice presidents office or in the realm of a national planning or development commission, with policy advisory functions.

In Nepal, such an institution was set up with bilateral donor money, but has suffered from indecisive leadership and lack of "clout". In Nicaragua the UNFPA relations are with the respective ministries, and in the MoH via the local PAHO representative. This seems to be a usual arrangement in countries with no UNFPA representation and large MCH type programmes.

In the relations with other agencies at the local level the relationships with the World Bank are interesting. In Nepal the WB is not interested in population programmes at present. In Nicaragua the WB presence is minimal. In 17 other countries the World Bank leads the coordination of the large population sector programmes. UNFPA could well leave the leadership to the Bank in the large programmes in these 17 countries. Alternatively, UNFPA could find a niche beside the Bank (whose forte really is the brick-and-mortar type of investment activities) in dealing with and assisting in improving government self-reliance in action research and surveys related to population programmes.

In relation to other agencies it is important the UNFPA "has its eyes on the ball" and does not get left out. In the large UNICEF Urban Services Programme in India, a large scale MCH programme for 140 million urban dwellers in that country family planning services are not even mentioned and UNFPA has never been asked to take part or to get involved in any way in that programme. In Nepal a project/policy proposal by UNFPA/The Ministry of Health on a mother and child health care programme has been pre-empted by a similar UNICEF programme.

d. Operational and coordination roles

Questions of implementation will always be on UNFPA's desk. Especially in government programmes where capacity is low, most financial and administrative tasks end up in the UNFPA office. However, this seems to be a part of putting population assistance to effective use, and UNFPA must take on an executive role when this is necessary and as far as this is humanly and economically possible. (Therefore, in our opinion the discussion whether UNFPA should be a Fund or an executing agency is somewhat irrelevant).

This is not as easy as it may seem on paper. The obvious priority of **putting assistance to effective** use seems sometimes to be forgotten both in New York and in field offices. The immense amount of paper work, the innumerable minor catastrophes that need to be dealt with daily would seem to make actors in this office game forget or at least temporarily forget that the important part of the work they are doing is to reduce population growth, reduce fertility or redress the balance of population distribution.

1.2.6. *Discussion*

a) Needs Assessments.

In many cases the Needs Assessment Reports have been the base for the development of a coherent programme. This depends finally not so much on the reports itself but on the capacity of the country to use such documents for a development purpose and also on the capacity of UNFPA and its local representatives to coordinate the programme work with government. In other cases the costs have certainly been higher than the benefits.

The Needs Assessments were probably a good thing to have done. There is a question whether they are worthwhile updating: they take a lot of money, the procedure of getting them passed by governments and agencies and whatever is time-consuming and, before they are printed, they are out of date again. They consume a lot of working hours at the local level: the revised Needs Assessment for Nepal was based on a mighty tome of all the relevant material for the Assessment brought together by the local staff.

This process could perhaps be shortened. Maybe there would be a case for a different approach and a less ambitious and less time consuming updating, such as country programme reviews and short missions to deal with only one or two important sectors.

One thing which is very important is that the needs assessment as far as we can see seldom looks really hard at management issues, and institutional management capacity. (An exception is the recent Nepal update, probably because of the immense and obvious management problems within the H.M. Government)

The reason for this may be that none of the participants in the missions have been interested in or instructed to look into such matters, which however are essential to development, to running, track-keeping and coordination of projects as well as the development of self reliance.

The Needs Assessment are not baseline studies (nor were they meant to be). However, for impact evaluation and quantitative monitoring one probably needs such studies, maybe with less ambitious geographic coverage.

There is a general shortage of analysis of the need for further studies in the socio-cultural field in the Needs Assesment document and indeed of such studies in project preparation. There are many general references to the importance of such studies in family planning situations or in MCH projects, but no detail. This is for example the case with the Nepal document and again makes projects difficult to plan and evaluate.

b) Collaboration in the UN system

There is little material or few studies on the effectiveness of this collaboration aside from a few programme evaluations carried out by UNFPA. At the top management level there is, however, some indication of concern about effective collaboration, at least in words.

No agency is really better or worse than any other. Many have their own problems, though. The WHO is for example split in several regional organizations, each with their own policies and priorities. And problems. PAHO has always had problems with their institutional memory as they have been rotating central and field staff at a fast rate, and it is sometimes impossible to find someone at PAHO in Washington who has a long experience of the projects they are executing. WHO/Africa has always been run like a kingdom of its own and has not always produced the best quality experts.

Some agencies are not equipped to handle projects in the field and their services are only to provide experts and help in procurement. The administration charge of 13% that agencies charge seems to be very high in certain cases for the shoddy services provided. This is one of the reasons why UNFPA is moving towards more project execution by government or implementing agency or to execution by NGOs.

One aspect of work with the agencies is the long time it takes to clear even minor issues. Thus the combination of the four to five months turnaround time of the agencies and the extremely complicated and time consuming procedures of the H.M.Government in Nepal develops into enormous disbursement problems and constant lack of funds at the district level where the action takes place.

c) The World Bank and UNFPA

Unfortunately we found that UNFPA was not really connected in any meaningful way to the Bank programmes. We feel that there could be great advantages to both parties if a modicum of collaboration could be established and formalized. The Bank disperses and coordinates enormous amounts of money in the population field. UNFPA has probably (or has a chance to have) a much better relationship with governments in some of the very special and touchy fields of population programmes. However, as has been said many times, UNFPA may well be wary of the Bank's methods of operation and of its policies, which could disturb a good UNFPA relation to government.

UNFPA could well leave the leadership to the Bank in the large programmes in these 17 countries. Alternatively, UNFPA could find a niche beside the Bank (whose forte really is the brick-and-mortar type of investment activities) in dealing with and assisting in improving government self-reliance in action research and surveys related to population programmes.

d) Coordination of programming cycles

It also seems impossible to get the programming cycles of UNDP/UNICEF/WFP/UNFPA synchronized. (Again, an exception seems to be Nepal where by pure coincidence the cycles of UNFPA, WHO and UNICEF almost coincide.)

e) Implementation

Implementation is defined by UNFPA as "the process of carrying out the activities required to achieve a project's goal and objectives from the time of approval to its completion and final evaluation." Many consider that the primary measure of success in the implementation of a project is the expenditure of funds allocated by the project by the agencies responsible for it. This is not the case (Governing Council UNDP DP/1987/36).

If an agency is chosen, they either execute a direct control by appointing a project manager or by their representative on site. The selection process is one over which UNFPA has little control and the fund is, as has been said above, regarded as a fund of money rather as a source of competence and information.

Sometimes there is a Chief Technical Adviser (CTA) but in many cases neither expert nor field representative is available. Thus in Nicaragua the project went on for years and a proper project document was not prepared until the appoinment of a CTA in late 1985.

Again, past UNFPA experience shows that problems occurring are often related to the qualifications of internationally project staff recruited by the agencies and of the quality of the procurement system and of the technical backstopping.

Such technical backstopping is one of the significant determinants of successful implementation. In UNFPA terms backstopping includes the substantive and managerial inputs a project receives from the executing and funding agencies that are not part of the project itself but come to it through regional advisers and from the local regional and headquarters office of the agencies and the UNFPA. (Governing Council UNDP, DP/1987/36).

However, many agencies and indeed UNFPA do not have the technical staff necessary to backstop projects adequately. This situation gets more serious when there are no funds for the provision of a full time technical adviser to projects as field presence is a key determinant in backstopping and monitoring.

This is a very important point as the credibility of the UNFPA hinges on the excellence of its delivery and programme implementation.

f) Direct execution

As has been said above there has been an increase in the Directly Executed Projects that UNFPA is funding. The problem here is basically that there is still a lack of commitment on the part of certain countries which tends to slow down government execution. But the main problem is that many governments lack the capacity to implement programmes, even if the finance is at hand. This is of course more a reflection of the general state of affairs in some developing countries than of population programmes.

However, this is a real problem. It puts demands and strains on local representatives who in many instances have to take over the running of projects both from non-functioning governments and inadequate executing agencies. (The staffing and the capacity of the UNFPA office is often not structured to handle this situation.)

1.3. UNFPA PROCEDURES: EVALUATION

Linkages between policy, project planning, design, implementation and evaluation procedures and feedback into projects.

(Ad ToR 3.2.1. (d), (e) and 3.2.2. (e) v. and (f)

1.3.1 *Procedures for UNFPA monitoring and evaluation.*

There are several levels of monitoring and evaluation of projects within the system.

The ambitious monitoring and evaluation system of a project usually consists of the following series of activities:

(UNFPA Guidelines, UNFPA/PA/86/7)

ILLUSTRATION 1.3.2.

MONITORING AND EVALUATION REQUIREMENTS FOR PROJECTS

TYPE OF M & E	*TYPE OF PROJECTS*	*TIMING*	*PARTICIPANTS*
Project Progress Reports (PPR)	*All projects over 1 year duration*	*Every six month*	*Project Management **
Field Monitoring visits	*Those requiring particular attention for technical or administrative reasons*	*As often as required*	Proj. Mngt.*, *Gov't UNFPA, exec. agency*
Internal Evaluation Reports (IER)	*All projects over one year duration*	*Annually*	*Project Management★*
Internal Evaluation Exercises	*Those requiring particular attention for technical or admin. reasons*	*Periodically, depending on need*	*Proj.Mngt.*, Govt. UNFPA & exec. agency*
Tripartite Project Review (TPR)	*Projects over $ 100.000 or those requiring special attention, e.g. innovative or complex projects*	*Annually*	*Gov't. including project management★ UNFPA & executing agency*
Independent In-depth Evaluation	*Special criteria ** ring life*	*Once dur- of UNFPA of proj. chosen*	*Evaluation Branch*
Final Project Report (FPR)	*All projects*	*2 months before end of project*	*Project Management*2*
Final TPR	*Same as TPR*	*Termination of project*	*Gov't. including project mngt.* UNFPA & exec. agency*

* The leaders of the national staff and international staff of project together constitute the project's management.

** See "UNFPA Guidelines and Procedures for Independent, In-depth Evaluations," p.8, 1984

To this may be added the management mechanisms of centrally (and physically) **keeping track of a project** and its various contortions and finally a system for financial management and control.

In UNFPA usage **monitoring** means the continuous assessment of the progress of a project compared to project plans. The main information sought concerns timeliness and adequacy of actual activities, the products of such activities and the delivery and use of inputs.

Evaluation tries to ascertain the relevance, effectiveness and impact of a project in view of its objectives. Evaluation also seeks to determine why things worked as they did or did not work as planned, all to provide lessons for the future. Evaluations therefore also include an analysis of the relevance of the project design. (UNFPA/19/Rev. No.3, 22 January 1986).

An important part is the new ideas about **feedback into project management of evaluation results.** See below.

Other types of evaluation include the evaluation of large scale regional projects, and **independent in depth evaluations** of sector projects such as women's projects etc.

1.3.2. *Description of the system.*

a) Project Progress Report.

This has been the basis for UNFPA project activities control. It is produced by the project manager every six months and should give information on activities and outputs compared to plans etc., and difficulties and recommendations for their solution. It is sent to the UNFPA representative (Res.Rep. UNDP) to the executing agency , the government and to the UNFPA headquarters. Usually the reporting times are January to June and July to December, or whatever dates that are outlined in the work plan. For projects receiving multi-bilateral funds, two extra copies should be made available and sent by the UNFPA representative to the HQ for distribution to the donor.

b) Internal Evaluation.

Once a year the project undergoes **internal evaluation.** The initiation of internal evaluation is the responsibility of the project management and the Government and the local UNFPA representative. It should ideally occur once a year in connection with the second PPR and the new form provides for a format for the PPR and the Internal Evaluation. The Internal Evaluation includes as a minimum comments using the standard form on how the project has achieved its immediate objectives, if it is on track towards the solution of the long-term objectives, as well as comments on project design and suggestions for revisions and project design if necessary. It is done in a variety of ways. In addition to the self-evaluation using the form it can be done by sub-contracting to national or international organizations, to individuals or executing agency staff. If external consultants are used, the report must be finalized on site and discussed with the Government.

c) Independent, in-depth Evaluation.

This procedure is distinguished from the above by its greater intensity and by the participation of the Evaluation Branch of the UNFPA. There are Guidelines for such evaluations, "UNFPA Guidelines and Procedures for Independent, In-Depth Evaluations".

The usefulness of an in depth evaluation lies in having someone from the outside looking at the project and assess the impact of UNFPA financial assistance and to ensure high standards of technical cooperation. Many of such recent reports, which also have to be finished in the field

and discussed and hopefully agreed upon with the Government are summarized in "Comparative Results of UNFPA Evaluations, New York 1986". UNFPA's position on the recommendations of the evaluation is transmitted to the parties concerned. The Evaluation branch has established a system for follow up actions to be taken by UNFPA (see below).

Not all project get this type of evaluation, especially since the introduction of the system with internal yearly evaluations. Today most independent evaluations focus on programme or comparative evaluations.

The PPRs, the Internal Evaluations (the monitoring and evaluation report) and if available and necessary the report of any in depth evaluation are the basis for the discussions at the tripartite reviews.

d) Tripartite reviews.

The Tripartite Project Review (TPR) is a formal, planned and periodic mechanism for joint discussion at a meeting between the parties directly involved in the implementation of a project. Such parties include

(a) representatives from the government (coordinating agency, ministry or project management
(b) the international executing agency if any
(c) the designate of the UNFPA representative, usually the Deputy Representative,
(d) UNFPA HQ staff if appropriate
(e) any outside agency with technical competence but not directly involved in the implementation of a directly executed project.

The TPR considers the above mentioned reports, discusses the progress of the project and shall record if the performance is as planned (or not).

TPR also decides on changes in objectives, work-plan and budget to be recommended to the project authorities, as well as on management actions which are deemed necessary to achieve the projects objectives. The reasons for any problems and non-achievement should be recorded.

TPRs are always set up for projects with budgets over US$ 100,000 or such projects which are innovative or very complex.

The timing of TPRs should be included in the Evaluation and Monitoring Schedule submitted with the project documents to the UNFPA HQ.

In the case of projects with **multi-bilateral funding,** particular attention should be given to project components receiving inputs from multi-bi donors who also should have copies of the report of the TPR. Such donors could also be invited to take part in the meeting.

e) Termination of projects.

The reporting at the termination of projects is also well regulated and consists of a Final Project Report which records the results of projects.

1.3.3. *Feedback mechanisms*

There is a danger that evaluation and monitoring is done more because they are looked upon as some unnecessary but compulsory evil rather than as a means of improving project performance.

The feedback of evaluation and monitoring results is an absolutely crucial part of the project cycle. Procedures for such a feedback will have to be in place to provide a framework for administrative and management action.

UNFPA has for the 1987 session of the Governing Council produced an interesting paper suggesting a structure for such procedures, (DP/1987/39, 12 February 1987) which we follow for the description of the new structures.

There are two types of feedback mechanisms or rather two types of situations demanding different approaches. The first type is the feedback of experience from evaluations of a particular project. The other concerns the feedback of lessons learned in evaluations to the UNFPA itself and to the executing agency staff involved in programming and policy development.

a) Structures for feedback from individual projects

Such feedback systems are well established in UNFPA through the series of meetings outlined above where the results of internal and independent evaluations can be channeled back to the implementing level. Individual project evaluations both independent and internal are immediately fed back to the parties concerned (governments executing agencies and UNFPA) in the form of a report. Discussion on such reports is required during the Tripartite project review meetings.

Reports of independent in depth evaluations are presented to the parties but also to the UNFPA Policy Committee, which takes a stand on the recommendations. Implementation of decisions is followed up by the Evaluation Branch through inquiries to the UNFPA Programme Division and the DRSAP. A large number of such recommendations seem to have been used either to revise ongoing projects or in the preparation of project extension.

A new type of **project record** has been devised and suggested by the Program Division Chief (see appendix) which either in computerized or print-out form would give the details of a project at a glance, from history, budget and objectives to evaluations, problems, changes in personnel records of meetings held etc. If such a type of file had existed the work if the present consultants would have been much easier.

b) Structures for feedback into policy and planning divisions of the UNFPA

Feedback systems would ideally include collection of reports, analysis of such reports, computer storage of project and evaluation information and the lessons learned, analysis and synthesis of lessons learned feedback to decision-makers in an easily digested format and finally on-going follow -up to ensure that data are used.

Collection of reports.

This would seem to be a fairly obvious procedure but routines should be developed to make all evaluation reports available to the Evaluation Branch. Analysis of such reports is the main activity and will produce for each report a short summary of results and assessment of the quality of the evaluation and identification of the recommendations. Formats should be devised to ensure uniformity in presentation.

Classification of the lessons.

Such a classification has already been attempted, and will later include both managerial and technical issues. **Computerization** of all the results would be an immense help to most of the staff involved in policy, planning and implementation.

Presentation of results for feedback.

The most important issue here is the translation of experience from one or several projects. This is a very difficult process, not without its pitfalls. It is not enough to produce a narrative. A long and well argued discussion may not be read. On the other hand the recipe book type of prescriptions can be

misunderstood. The recipients may not be aware of the existence of a document or information on a variety of problems. The amount of reading matter produced and delivered within the UN organizations makes for an enormous information problem. Probably the easiest way of getting the prescriptions across is to impose some of them at the time of the revision of a project. If the Evaluation Branch is given the opportunity to assess a project before it goes to the PRAC, we think much could be done.

1.3.4. *Discussion*

a) Project Progress Reports.

Although an important part of the monitoring process, there are still some problems with the PPRs. Often they come very low on the list of project management priorities. This is now being changed by exhortation and by a new format. One would maybe like to see a discussion on the minimum acceptable format.
Secondly, it would seem that the PPRs are very much concerned with figures and with trivia. Sometimes one feels that the substance of the project development is left out.

Thirdly, the agency and the NY HQ who are supposed to answer to the PPR and make suggestions or suggest solutions very often do not do this, as the desk officer gets a pile of such PPRs from various countries every day, and physically does not have the time to follow up. Often therefore PPRs have to be followed by cables and other communications, especially if there are major problems. In the Nepal project one can follow the complaints about medicines ordered in 1983 until they finally arrive in 1986. Nothing seems to has happened in the meantime.

The scanty PPRs are one reason for the introduction of the **Internal evaluation.** The new internal yearly evaluation is a departure from earlier tradition and a very good initiative. It means that all projects get looked at several times during the project period. The new Monitoring and Evaluation document format will certainly help.

Earlier, an in-depth evaluation often was necessary or called for by the parties when a project started to misfire, and some of the evaluation reports from the early 80's are a somewhat depressing reading. Now in-depth evaluation can be channelled towards projects which are interesting from other points of view than mismanagement, i.e. experimental projects, projects with a direct impact on policy, or projects which may generate methods and general experience worth trying elsewhere.

b) Tripartite Project Review meetings.

Earlier when the PPRs were very scanty and evaluations were rare, TPR meetings were often concerned with the moving of items between budget lines and not much with the content and substance of the project. We feel that this may now hopefully change and that the whole rather elaborate and ambitious reporting, monitoring and evaluation system which is now in place should pay dividends in the future. One prerequisite for this is of course that there is a feedback mechanism into the project management from the decisions and recommendations of the above activities.

This is a major problem, and for multi-bi donors with projects far away from their own HQs and in countries where they are not represented this may be a problem of communications and of not knowing what is happening.

Copies of reports from Tripartite Meetings may be on the road for a long time. For example the procedure in the Nicaraguan project is that the project reports to the immediate section in the MINSAS dealing with MCH, which reports to the PAHO representative and to the external

affairs department of the MINSAS. PAHO reports to the central PAHO office in Washington, from where in due time the report goes to UNFPA HQ in New York. From there, and maybe with comments the report goes to the Norwegian Mission to the UN and from there to the Ministry of Foreign Affairs in Oslo for delivery to the Ministry of Development Cooperation. In the MDC the report ends up in the Multilateral division and it is not clear whether it is read or just filed away. It is not routine to send the reports to the "professional" desks in the NORAD department dealing with health and population.

We strongly feel that MDC/NORAD should be represented at Tri-partite meetings as often as possible. *More important, though, is to be present at the formulation stage of the projects and at the mid-term review.*

Let us also make the comment that many problems could be avoided if more time and effort were put into the careful planning and preparation of projects. This is easy to say but what does it mean? Planning includes of course a definition of objectives and goals. But we also feel that maybe the major problem in project preparation is not only the definition of goals but the **lack of depth and relevance in problem analysis** which is **the** base for project conceptualization. Such preparation would not only make evaluation easier, but would also do away with problems which have their origin in fuzzy objectives and fuzzy thinking with ensuing vague project documents.

Having outlined the procedures and strategies as they appear in various texts we are of course concerned about the difference that there must be between the procedures on paper and what happens in the real world. One must tolerate some slippage and some bad (late, uneven) performance in reporting. But the problem is then for UNFPA where to draw the line.

A minimum would be to have the red lamp blinking somewhere if a project is on its way towards some kind of catastrophe. We think that such warnings were possible even with the old system, maybe the new system will give earlier warning lights. But early warning, although necessary, is not enough. One must also know what the project does substantially towards fulfilling its goals and objectives.

Internal evaluation and Tripartite meetings which are built on reports that deal with the subject matter and not only with personnel changes, new tires, and shifts between budget lines will probably serve as well as one can expect or accept. But this is a question of in service training and education of programme officers, national programme officers and project managers. Maybe also of agencies. These groups will not only have to know about, but also understand the absolute necessity for the UNFPA Monitoring and Evaluation Report. And understand that it is important to spend some time on them, even if this seems unnecessary when you are under heavy pressure in the field. Such training is now provided or at least one has started with courses for a variety of different personnel groups at Headquarters.

Generally the new ideas and procedures for evaluation and monitoring are well conceived and should function very well. In our opinion the new procedure with internal evaluation, i.e. a yearly obligatory look at the project and the way it is going will be the important part of the steering mechanism of UNFPA. But the system is new and has not yet been tested or rather has not yet had time to develop. We feel however, that much has been achieved by putting the procedures on paper.

We are also impressed by the seriousness and dedication of the staff that is dealing with these matters in the various divisions and branches. They will need their dedication as full implementation of the new system will most probably take much staff time.

The structures for **feedback into the projects,** - another part of the steering mechanism - are also excellent on paper.

However, the consultants have a feeling that feedback from projects are delivered to executing agencies and to UNFPA HQ but is not necessarily used as a management tool to guide project officers and implementors. A lot will probably depend on how much time and energy the center will be able to put into the analysis and systematization of the incoming reports and chewing them for consumption elsewhere in the system. Computerization will probably help considerably as will the suggested new project register format.

The new systems will also produce a more open organization, which certainly from the point of view of the donors will be a good thing.

The Evaluation Branch have written two very interesting and ambitious documents: Comparative Results of UNFPA Evaluations (May 1986) and Summaries of Independent In-Depth Evaluations undertaken by UNFPA 1979-1985 (April 1986).

These documents show the approach the Evaluation Branch and the UNFPA will have towards systematizing and analyzing results of the evaluation and monitoring procedures.

Comparative Results of UNFPA Evaluations (by far the most interesting book, the other one is a list with short summaries of the evaluations) drawing on some 50 evaluations since 1972 shows the distinction between common issues and specific lessons. Under common issues one treats the project cycle items and also the question of TCDC. Under specific lessons on finds the role and status of women, population education, MCH/FP, population and development and basic data collection. This is a collection especially useful to MDC.

One points out the necessity for more **thorough analysis of the local country situation.** Other interesting observations concern:

- The limited availability and high mobility of local staff, is a major constraint in project implementation.
- The need for early assessment of training needs and involvement of local personnel in projects.
- Evaluations and the monitoring machinery should be used as a management tool.
- The importance of detailed planning for census taking, in cartographic work for censuses and the importance of gradually expanding areas of vital registration (rather than to try to introduce a nation-wide system at once)
- The enormous difficulties in placing the responsibility for providing MCH/FP services and formulating population policy in a single institution dominated by doctors.
- The need to clarify what "integration of population into development planning" really means, at the national and local level.
- The importance of having women involved in the design of projects, not only as ad hoc participants but in a structured way, like in Nicaragua.

One is well aware of the problems of generalization, what goes in Costa Rica does not necessarily pass in Zaire or Fiji. Also that evaluations which are five years old or more often concern projects which were started at a time with much less background of basic data, or in environments without any understanding of population issues. But the analysis focuses on the problems and the obstacles to successful project performance. There are few ideas about what makes projects tick.

1.4. IMPRESSIONS OF THE PRESENT STATE OF THE ORGANIZATION AND ITS PROBLEMS

The consultants can see some **problems other than those mentioned above** affecting UNFPA. Such problems are outlined below.

But first it needs to be said that the organization now seems to be on its way into a new era under the leadership of dr Nafis Sadik. She comes from the programme side of the UNFPA and is well aware that the content and quality of projects and project performance is essential to the future work and indeed survival of the UNFPA. Although UNFPA is a fund, it also has an **operational competence** in the manifacetted field of population and should not only be looked upon as a source of funds for agencies of various sorts.

UNFPA is the organization within the international development assistance system that should be at the **frontier of knowledge** within the population sector and also in the process of generating new knowledge. Its projects should be assessed against what one knows about linkages and determinants and against what has worked in the recent past in various types of projects. Here UNFPA has a role to **take an intellectual lead,** keep itself informed of the state-of-the-art, if any, and initiate research of its own on topics which reflect UNFPAs short term and long term needs.

Spread of the HIV infection

A recent problem is the spread of HIV infection and the impact on programmes and projects. The AIDS pandemic is an international health problem of extraordinary scope and unprecedented urgency. Scientific research has so far had two major breakthroughs: the identification of the virus itself, and the recent discovery that the genetic background of the victims (the so-called Gc gene and its combinations) influences the infection rate and the severity of the disease. Africans seem to have a higher proportion of a deadly Gc-combination than Europeans or Asians.

It is a major health problem in Africa today. The HIV infection seems to have a hot spot in the Burundi-Rwanda-Uganda region and is spread over large parts of East and Central Africa. The usual trade routes as well as the route down the river Zaire would seem to have produced the present pattern.

The spread of the disease in Africa is through heterosexual intercourse and probably also through a combination of the well known indiscriminate use of injections for any small ailment and the use of needles which have not been disinfected. The injection theory would explain the incidence of disease among children 5 to 13 for example in Uganda. If they survive at 5 they probably have not got the disease in utero, and at 13 most are not yet sexually active.

No full treatment or vaccine is at present available, and the future containment of the disease will depend on education and propaganda and the use of condoms unless the virulence of the pathogen declines rapidly.

The implications for UNFPA are clear: one will have to prepare oneself for an almost new situation in "family education" and in the provision of condoms and foams with antiviral properties. Most MCH and FP projects financed by the Fund will have to have an AIDS education component and provide the condoms, which may provide some minimal protection against infection. UNFPA is at present "in the process of developing guidelines for staff and Governments".

The Fund works in close collaboration with the ad hoc group set up in the WHO, which is the UN centre for coordination and information on research efforts, incidence and prevalence of the disease etc. The Fund has also recently commissioned a study by an independent consultant on the future requirements of condoms in Africa to be presented in June 1987, as well as a study on the demographic implications of AIDS if any.

The Fund is also open to requests from Governments in this area, and has recently received requests from Nigeria and other African countries to supplement family education projects.

Centralized decision making, pros and cons of.

Another problem of the past which needs looking into very carefully is the centralized decision-making. Field representatives of the UNFPA have very little leeway and almost all decisions are taken in New York. A measure of centralization is the discretionary financial power of various levels in the organization. This practice may reflect on the perceived quality of the UNFPA field staff, which as in all UN organizations is very varying. It may be a reflection of the personal preferences and management style of earlier management.

We do not know what would be a reasonable center-periphery balance but a very centralized system causes an inflexibility in the organization, which then cannot respond quickly to new initiatives or instant opportunities. It also causes an enormous flow of paper back and forth to New York and an almost inhuman workload on the country desks and in the procurement section. Half the UNFPA professional staff is therefore also needed in the New York headquarters. The centralized system is beneficial in that it looks after the flow of resources in a responsible way and in the absence of a DRSAP. It could give the center a fairly good day-to-day picture of the global situation and makes fast personal decisions on major issues possible

Field staff and HQ staff

The **staff situation** has been stabilized over the last three years by changes in the direction of personnel management, in the allocation of staff between the field and the HQ and between desks and offices to meet increasing and changing demand on staff time. Furthermore, most staff formerly employed on project contracts and under other unorthodox arrangements have now either been laid off (discontinued) or had their situation regularized.

The ambitious new Africa programme, launched at the 1987 Governing Council will in our opinion stand and fall with the number of dedicated and knowledgeable officers that can be allotted to that programme both in the field and in New York. In the 45 Sub-Saharan countries which the programme touches there are at present only 24 internationally recruited officers (DRSAPS and programme managers).

If the situation in Africa requires a special commitment of the international community also in the population field and if donors agree that the strategy and the action plan are worth supporting, the Fund should be given the means to carry out its work.

Again we would like to stress the importance of the very good national officers we have met over the years and who provide continuity in the programme. Sometimes one feels that DRSAP are not really necessary.

In-house coordination within UNFPA

A major difficulty is that the Evaluation Branch and the Programme Branch are organizationally far apart.

At the project **appraisal level,** the evaluation branch in the UNFPA should get to see the documents during the technical review in order to suggest revisions to make the project easier to assess later on, and to help establish of separate goals and objectives at different and measurable levels. The branch could also check the monitoring and evaluation schedules and make suggestions. We feel this would be a very important tool for further assessments and for the feedback system as a whole.

The **relation with the executing agencies** is a world wide problem for the UN funding organizations. Projects are either executed by other UN agencies, by NGOs or by governments. In all cases high quality backstopping is of utmost importance. In Nicaragua PAHO provides good backstopping, in Nepal backstopping has been scanty and irregular

UN agencies and/or their regional or interregional representatives (often changing) are in many cases not providing the technical and managerial backstopping which is needed, for a variety of reasons.

We believe however that such problems will again be vigorously attacked by the new administration.

Procurement

UNFPA has now a small procurement unit of its own. To the consultants this unit seems to be understaffed - if one has the ambition to look after ones own procurement, one should give the unit a chance to perform satisfactorily. The unit has the responsibility not only for the procurement of a variety of supplies, but must also channel the vehicle procurement and has to ensure that UNIPAC works according to UNFPA's interests.

2. NORWAY AND UNFPA

2.1. NORWEGIAN POLICIES

2.1.1. *Objectives of Norwegian development assistance.*

The *overall aim* of Norwegian development assistance is repeatedly stated in White Papers from the latest years as:

> *"To contribute to lasting improvements in economical, social and political conditions of the population in developing countries"*

The assistance is to be utilized in order to give the greatest possible development effect for the poorer sectors of the population, preferably in the least developed countries and should not create dependency on continued assistance. The resources allocated to development assistance must be used as efficiently as possible in order to achieve this goal. The overall aims of Norwegian development assistance relate to all forms of assistance, whether it is channeled through UN, NGOs or in the form of bilateral projects and programmes.

The majority of the Norwegian people (according to recent polls) and the political parties in the Norwegian Storting, are in favour of increasing the development assistance further from the present level of just over 1 per cent of GNP. There seems also to be a general consent to the main principles of the assistance.

A recent White Paper on development assistance, (Stortingsmelding no. 34 (1986-87), February 1987) indicates the present Social Democratic government's policy. It gives 5 "priority sectors":

1. Management of natural resources and environment,
2. Economic growth,
3. Improvement of living conditions for the poorest segments of the population,
4. Human rights and
5. Peace.

The third "sector" seems to be the one with closest relevance to family planning, and it is stated:

> *"It is a particularly important objective to ensure women's participation in the development process, and to strengthen their economic, social and political conditions"*

An earlier White Paper issued under the then existing coalition states:

> *"rapid population increase can reduce the effects of development activities and increase the need for physical and social infrastructure at the cost of more productive oriented investments. Therefore activities securing increased income and employment possibilities in particular for women, family planning programmes, increased education for women and better access to intermediate technology and services are important inputs to a more balanced population growth."*

The main *principles* for Norwegian development assistance are stated to be: priority to the poorest countries, recipient orientation, provision as grants, that the point of departure should be the recipient countries' needs, plans and priorities, aid to be unconditional and untied, aid to be divided equally

between bilateral and multilateral channels, bilateral aid to be concentrated to a few main cooperating countries and *at least 10% of ODA to finance programmes covering family planning, including mother/child health.*

One selection criterion for new main countries of cooperation is a development oriented and socially just policy respecting human rights as they are stated in the UN Declarations and Conventions.

2.1.2. *Norwegian Multi-bilateral Assistance*

At present (November 1987) Norway has multi-bilateral agreements with the following 7 UN Organizations: UNICEF, UNFPA, FAO, ILO, UNCTAD/GATT (ITC), UNESCO and IMO.

Agreements on the so-called "co-financing" basis are also made with the World Bank/IDA, the Asian and the African Development Banks. Multi-bi was introduced as a new form of organizing development assistance more than 10 years ago. The multi-bilateral assistance to the 7 UN organizations totaled NOK 159.7 mill. in 1985. In addition NOK 189.7 mill was co-financed through the banks in 1985. In 1984 a new form of co-financing UNDP-projects emerged, under which utilization of Norwegian products and services became possible.

During the investigation of background material in MCD for the present study the evaluation has not been able to find any comprehensive discussion of the multi-bi as a form of development assistance, including strategies to be applied, objectives etc. However, several assumptions, means and objectives are briefly mentioned in various documents, the most important being the White Papers.

White Paper no 36 states that the organizations receiving Norwegian multi-bilateral aid by and large are well administered. Multi-bilateral assistance as a form of aid makes it possible to relieve the Norwegian administration by utilizing the international organizations' planning and implementation capacity. Norway can through multi-bilateral assistance *strengthen the role of the UN-organizations* in the developing countries and *show solidarity with a number of developing countries* - in particular the poorest and least developed - which are not among the group of main cooperating countries within the priority sectors of Norwegian development assistance, for instance rural development, food production, health and family planning, strengthening of the position of women etc.

The Storting's Committee on Foreign Affairs has added to this that the principle of *untied aid* also relates to multi-bilateral assistance.

COVERAGE

There has been a shift in the geographical coverage of multi-bilateral assistance. It was previously held that the main rule was *not to finance multibilateral assistance in main cooperating countries.* Later reports, however, state that multi-bilateral assistance to the main cooperating countries *can be* a valuable supplement to the bilateral assistance, enabling dialogue and reciprocal exchange of experiences.

Two preconditions for multi-bilateral assistance are mentioned: namely that the *recipient governments have requested the assistance* and that *UNDP has assessed the project proposal in question.*

2.1.3. *Mother and Child Health Care/Family Planning in Norwegian Aid*

a) *Brief history*

Norwegian financing for family planning activities was given considerable attention as early as 1951 when the question on "Norwegian assistance to underdeveloped countries" was on the agenda for the first time. Miranda describes some aspects of the evolution of the discussions concerning family planning and mother and child health care since then. One of the observations made was that the family planning and population activity sector had been a controversial and conflict generating aspect in an otherwise seemingly conflict-free debate on Norwegian development assistance. (A. Miranda 1983).

While the discussion today (although limited) is not only concerned with the earlier disagreements between malthusian and ethical/moral judgments, the topic is still a sensitive one. The official debate in Sweden in 1979, which led to a drastic shift in emphasis within the Swedish assistance to India, from family planning to "social forestry", has not had its parallel in Norway.

About 10 years after the first Storting-debate on development assistance, family planning was again raised as an issue in the Storting as a consequence of a report which interestingly enough concluded that family planning activities best could be assisted through bilateral aid due to the then limited involvement in this sector of the UN-organizations. In 1965 an expert commission ("Evang-utvalget"), was given a mandate to assess whether Norway should contribute to family planning activities within development aid. The commission concluded positively and emphasised that family planning should be integrated with public health care in order to strengthen the latter and minimize costs.

The evolution of Norwegian assistance to family planning during the seventies was characterized by the contrast between on the one hand the relatively large financial contributions and on the other the limited intellectual involvement in Norway. Some explanations for this have been proposed:

- *family planning has traditionally been recognized as a sector primarily concerning the medical profession,*
- *family planning has never been properly assimilated as a topic for the debate on Women in Development (WID), but rather considered to be part of the "health sector",*
- *the official view seems to have been that the necessary quantity and quality of knowhow and personnel were not available in Norway; hence the priority to financial assistance. This again could have prevented the development of such expertise in Norway. (Miranda p. 20-21)*

b) Norwegian Objectives and Strategies for Family Planning and Mother and Child Health Care.

Ideally for evaluation exercises one should assess attainments according to the aims, objectives and strategies for the sector, programme or project in question. A comprehensive policy/strategy document for Norwegian development assistance to family planning and mother and child health care has never been written. One recent White Paper, however, gives some priorities and perspectives worth mentioning. (Stortingsmelding 36, Chapter 10.3).

Norwegian aid to the health sector is primarily aimed at *strengthening the primary health care in rural areas.* In addition to the medical services stronger emphasis is laid on improved water supplies, sanitation, hygiene, nutrition and health education. One other important element is *local participation* in planning and collaboration of health activities.

Family planning activities should be *integrated* with mother/child health care and should constitute a natural part of primary health care. It is indicated that the *right to self-determination* on the number and spacing of children is closely related to fundamental human rights. Norwegian assistance in this field therefore is on the basis that these rights are not violated. Activities geared towards strengthening the *role of women* in education, employment, legal rights and participation in decision making is given considerable weight.

c) Economy

The proportion of Norwegian aid devoted to family planning/mother and child health care has been, and is, relatively large compared to other industrial countries. Norway is the only DAC-country with an ear-marked fixed proportion (10 per cent) of ODA for this sector. Assistance is provided through bilateral, multilateral and multi-bilateral aid.

Multilateral assistance.

In the period 1970-74 mother and child care and family planning received 15 per cent of total Norwegian multilateral aid, for 1975-79 and 1980-82 the figures were 16 per cent and 15 per cent respectively. Norwegian multilateral assistance was during this period divided between UNFPA and UNICEF (40 per cent each), WHO (10 per cent) and IPPF (10 per cent). In 1983, however, there were a reduction of NOK 10 mill. in the regular contributions to UNFPA while UNICEF contribution was increased by NOK 20 million. (Miranda, 1983, Tab. 1-6).

In 1985 the distribution of Norwegian assistance was as follows:

UNICEF	*141*	*million NOK*
UNFPA	*95*	*- "-*
IPPF	*35*	*- "-*
WHO Research Programme	*15*	*- "-*
WHO Immunization Prog.	*7*	*- "-*
WHO Diarrhoea programme	*0,5*	*- "-*

Bilateral assistance

The percentage of bilateral assistance to family planning and mother and child care varies considerably from year to year (1970-71 6 per cent, 1975-79 9 per cent and 1980-82 8 per cent). Without the relatively large amounts absorbed by the multi-bilateral side, the quantitative target of 10 % of ODA to the sector would not have been attained.

Overall Budget Procedure

The total annual frame for multi-bilateral assistance is determined by MDC according to general budget procedures. Proposals are made by the Multilateral Department in cooperation with the Planning Department. The same Departments propose distribution of funds for the various UN-organizations and banks, taking into account the general Norwegian guidelines for development assistance and also the efficiency of organizations in utilizing the funds.

2.1.4. *Discussion*

Most statements given in White Papers or other authoritative documents are kept on a rather general level and thus of limited direct relevance for evaluation purposes. Given the commitment of allocating 10 per cent of Norwegian ODA to the sector, some major questions could be asked: What

are the criteria for allocation of funds between multilateral, multi-bilateral and bilateral aid? What are the criteria to be applied for selection of different organizations? These and many similar questions have to be better clarified from a policy point of view, before any proper assessment can be undertaken.

In the absence of a policy paper, one could try to describe the strategies and objectives according to the priorities actually made from Norwegian side within this sector during recent years, i.e. some kind of "post-programme definition of objectives". Needless to say, such an approach has clear limitations. Instead we summarize the relevant objectives and aims for the multibilateral assistance and family planning/MCH health care in the following illustration:

ILLUSTRATION 2.1.4.

EXISTING POLICIES AND NORMS FOR THE FP/MCH WITHIN MDC PRESENTED AS A "HIERARCHY OF GOALS"

OVERALL AIM OF NORWEGIAN DEVELOPMENT ASSISTANCE	*TO CONTRIBUTE TO LASTING IMPROVEMENTS IN ECONOMIC, SOCIAL AND POLITICAL CONDITIONS OF THE POPULATIONS IN DEVELOPING COUNTRIES*				
PRIORITY SECTORS	*Management of natural resources and environment*	Economic Growth	Improvement of living conditions for the poorest segments of the population	Human Rights	Peace
FORMS OF AID	*MULTILATERAL*	MULTI-BILATERAL	BILATERAL		
PRINCIPLES OF ASSISTANCE	• *priority to poorest countries* • *recipient orientation* • *provision as grants* • *based on recipient countries needs, plans and priorities* • *aid to be unconditioned and untied* • *10 per cent to family planning/MC health care*				
OBJECTIVES OF FP/MCH	*Increase women's participation in the development process*	*Strengthening the primary health care in rural areas*			
PROCESSES	*Strengthening women's economic social and political condition of health activities*	*Local participation in planning and coordination health care*	*Integration of FP services in primary norms*	*No violation of Human Rights*	
ACTIVITIES	*PROJECT AND PROGRAMME LEVEL*				
INPUTS	*PROJECT AND PROGRAMME LEVEL*				

The above illustration tries to *describe* the state of the art of the Norwegian hierarchy of goals related to this field. In the opinion of the evaluation team the components of the "hierarchy of goals" are, as they stand, relatively fragmented, not linked to each other in a logical manner. It would be better if a logical approach were used, with each level of the hierarchy connected to the next, so as to indicate the logical steps from inputs and activities to the ultimate aims of development assistance. In short, the whole set-up is ***weak on strategy***. Bearing in mind the large range of different conditions prevalent in the developing countries this is perhaps not so strange. Still it should be possible to formulate some generally applicable links in the hierarchy.

Also the illustration shows that although there are general highlevel objectives and some indications on objectives and processes, there are no statements on the objectives relating directly to family planning/mother and child health care.

Finally, more emphasis should have been on Norwegian activities and inputs. What *kind of projects and programmes* should be given priority, and *what kind of inputs to these activities* should be sought?

The main conclusion at this point is the *urgency to develop a Norwegian policy and strategy for family planning and mother and child health care* - based on the aggregated experiences so far in this field. When overall objectives and aims - including geographical priority areas - are better identified, it will become easier to spell out sub-objectives and activities and define the assumptions for each "link" in the hierarchy.

A clear statement of Norwegian policy would allow better evaluations of the multilateral organizations at present implementing Norwegian financed assistance within this field. Also for assessing programmes/project requests such policy would be of immediate use.

In connection to this, it is proposed to investigate and compare the policies of two of the largest organizations at present involved in family planning and mother and child health care on the international scene, namely UNFPA and the World Bank.

2.2. NORWAY AND UNFPA

2.2.1. *Introduction*

In order to understand the present organizational setting and the forms of cooperation between UNFPA and Norway, it is necessary briefly to review the Agreement between UNFPA and Norway and the Norwegian policy for the multi-bilateral assistance to UNFPA as a channel of aid. Previously multi-bilateral aid was administered by the Norwegian Ministry of Foreign Affairs. In June 1983 the Ministry of Development Cooperation was established and multibilateral matters were taken over by the new ministry. The organizational changes led to some changes of the structure and function of multi-bilateral assistance. In the following pages a brief presentation of these changes and the evaluation team's assessment of the present- organizational framework is given.

2.2.2. *The agreement between UNFPA and Norway*

The funds-in-trust agreement between UNFPA and Norway was signed in New York 12 October 1977 and came formally into force when the Norwegian Storting Proposition was signed on 28 October 1977. (St. prp. nr. 35 (1977-78)). In the first year, 1977, UNFPA received NOK 4,550,000 from Norway as funds-in-trust.

The Proposition to the Storting stated that the increase in requests to UNFPA had become higher than the increase of the ordinary fund of the organization. The increase of requests was partly due to the central role of UNFPA in the follow-up of the agreed Plan of Action at the World Population Conference in 1974.

In order to be in a better position to finance these requests UNFPA had taken an initiative to establish funds-in-trust agreements. According to the Proposition Norway responded positively to UNFPA's initiative because this form of cooperation would relieve the administration of Norwegian development cooperation by utilizing the international organization's planning and administrative system. But it is also stated in the Proposition that funds-in-trust assistance was a better means to coordinate the bilateral and multilateral aid.

The argument that multi-bilateral assistance is a channel to increase development financing without a large increase in the Norwegian administration is important, and often repeated in authoritative documents.

The Agreement states that agreements between UNFPA and recipient Governments shall be prepared and construed in accordance with the standard practices and policies of UNFPA. Such agreements shall also include a provision reserving the right of UNFPA and Norway to inspect the programme or project and to obtain relevant reports and documentation.

Articles V and VI of the Agreement contain information of particular relevance to the evaluation. Article V is mainly dealing with the responsibilities of UNFPA during the process of project/-programme identification and planning, while Article VI is related to reporting routines. The following tables give in brief the distribution of responsibilities according to the Agreement.

Table 2.2.2. a.

RESPONSIBILITIES OF UNFPA AND NORWAY DURING PROJECT/PROGRAMME IDENTIFICATION, PLANNING AND IMPLEMENTATION

TIMING	*UNFPA*	*NORWAY*
	Selection and processing of proposals and requests	
Periodically	*Consultation*	
Prep. stage for long term programmes	*May propose preparatory mission*	
Once a year	*Submit to Norway a list of proposals and projects with appropriate supporting documentation*	
	Joint meeting General review of past year and discussion of problems related to reporting and accounting	
		Norway will inform UNFPA as soon as possible of proposed projects likely to be approved
	Formulate detailed proposals or more negotiations. Prepare draft Plans of Operation. Send to Norway for comments	
		Formal approval of proposal
	Finalize agreement. Sign plan of operation. Forward to Norway all relevant documentations including the Description of Purposes and as relevant a copy of the plan of operation	
		Deposit the amounts necessary to finance the activity
	Responsible for supervision and control of the work	

Table 2.2.2.b.

GENERAL COORDINATION BETWEEN UNFPA AND NORWAY ACCORDING TO THE AGREEMENT

TIMING	*UNFPA*	*NORWAY*
Periodically	*The parties shall regularly consult each other all such information and assistance as may reasonably be requested*	
Before May 31 each year	*To submit a statement of accounts showing the use of the funds expended for the activities during the previous year*	
As required	*Periodic Reports to be transmitted to Norway*	
Annually	*To provide Norway with annual progress reports*	
	To provide Norway with information suitable for dissemination to the public at large on activities undertaken under the Agreement	
After the conclusion of each activity	*To provide Norway with final report containing an evaluation of the results*	
In evaluation missions		*Norway entitled to send one or more representatives to participate*
When appropriate	*Programme or project assessment reports to be prepared either with a mission composed of personnel representing Norway, UNFPA and the Recipient Government, or by an independent institution contracted for this purpose jointly by Norway and UNFPA*	

The above tables are direct extracts from the text in the Agreement. As the Agreement is more than 10 years old routines may have changed. But the Agreement is still valid, and constitutes an important set of roles and norms to be taken into account in the evaluation.

The Agreement gives the very clear impression that obligations of the *Norwegian administration* are to be kept at a limited level. However, they are located at critical points in the decision process, and can have large negative consequences for development of the projects/programmes if not presented accurately and on time.

Another conclusion is that responsibilities are described so generally that they allow for different interpretations. For instance, the Norwegian approval of project proposals is to be made "as soon as possible", a very flexible concept depending on what kind of process the project/programme proposal has to undergo in the Norwegian system.

2.2.3. *Cooperation during the Ministry of Foreign Affairs Period (1977-84)*

The Ministry of Foreign Affairs was responsible for administering the Norwegian-UNFPA multi-bilateral cooperation until the Ministry of Development Cooperation was established in 1983. During this period the intention was to keep the Norwegian administration and follow-up of multi-bilateral assistance at a minimum level, i.e. according to the policy of "relieving the Norwegian administration by utilizing the international organization's planning and implementing capacity."

As far as the evaluation team has understood the selection of UN organizations for cooperation was undertaken based on a general opinion about their efficiency and correspondence of their policies with the Norwegian objectives for development assistance. At the project and programme level, the administration by Norway was rather superficial, mainly concerned with budget control.

A single senior officer was responsible not only for UNFPA, but for multi-bilateral programmes under UNICEF, UNESCO, FAO, ILO, IMO and ITC: more than 160 different projects and programmes. In addition to administrative cooperation and follow-up with these organizations the senior officer had many other duties to perform. It should also be mentioned that the administrative routines were earlier more formal and time consuming, for example the main accepted means of communication were formal letters, not as at present when telex and telephone calls constitute important links. Contacts with technical departments in NORAD were limited and particularly so for UNFPA matters.

The Ministry of Foreign Affair's office in charge had its own roster of external experts to participate as consultants in feasibility missions, evaluations etc. However, Norwegian external experts were used only twice to assess UNFPA programmes and projects.

The evaluation team has not made any detailed assessment of the cooperation between UNFPA and Norway during the period 1977 to 1984 as this would only have indirect relevance for present and future administration. In brief one could conclude that the administrative resources at hand during this period would only permit a limited interpretation of Norway's role in project/programme selection, follow-up and evaluation of the cooperation with UNFPA. It is also obvious that since most of the UNFPA multi-bilateral projects financed by Norway today were initiated in this period, they should not be used as the basis for an evaluation of the *present* administration's selection criteria or procedures.

It is on the other hand necessary to mention a few administrative procedures which were established during this period, but *unfortunately not continued* under the next regime in the Multilateral Department: *First*, systematic collection and control of background documents such as assessment and evaluation reports. *Second*, a computerized table for each project, giving the most important data

(for instance budgets, expenditures, list of planned and received reports and a short description of project objectives and main activities). The officer in charge would fill in this table as a routine and would have updated and brief information ready at hand at any time. This system has not been updated since May 1985.

2.2.4. *From Ministry of Foreign Affairs to Ministry of Development Cooperation*

As of June 30 1983 the responsibility of handling most United Nations matters, including UNFPA, was transferred to the new Ministry of Development Cooperation, (MDC), Multilateral Department.

This represented not only a technical administrative shift from one ministry to another, but also a new trend and a marked shift in intentions to follow up the programmes more thoroughly and systematically. The new policy was formulated by the Storting (Stortingsmelding 36) and the political leadership of the Ministry. In order to be in a position to do so the White Paper no 36 indicates a need to reduce the number of recipient multilateral organizations which at that time were about sixty.

The Multilateral Department was split into 3 divisions, and the First Multilateral Division was charged with the handling of multi-bilateral cooperation with UNFPA. This division is also responsible for policy questions and development programmes and funds under UNDP. Administration of multi-bilateral assistance is spread between the Multilateral Department's Divisions and at present 6 executive officers are involved.

2.2.5. *Present Mandate for Multilateral Department.*

Mandate ("instruks") of the Multilateral Department including specific regulations for the multi-bilateral cooperation was approved in February 1987. The evaluation team has observed that there was no formal mandate for the Multilateral Department nor for the multi-bilateral sector of development cooperation during the period 1984-87.

Mandate for multi-bilateral assistance (Chapter 1270) is incorporated as an appendix to the overall mandate for the Multilateral Department. The formulations under the general mandate are relatively general. It is stated that the work shall aim at strengthening the multilateral organizations while at the same time work for the policies spelled out for Norwegian aid.

For the collaboration *within* MDC, it is indicated that MDC's *Juridical Division* is to comment on draft agreements particularly on constitutional and juridical questions. The Juridical Division is also to be invited to participate in negotiations. The Multilateral Department shall assist the other units of MDC, including *Country Representatives* with information about the multilateral organizations and Norwegian cooperation. The Department is supposed actively to collect information from other units in MDC; in particular are mentioned: Cooperation with the *Planning Department* on overall policy questions, frameworks and budgets and cooperation with *NORAD's technical divisions* concerning relevant issues and questions related to cooperation between the multi- and bilateral sectors.

This is not the place to comment in detail on the general mandate for the Multilateral Department. To be of any value such assessment should not only investigate *one* unit's mandate but also how the mandate corresponds and links up to other departments/divisions. Then the totality of the organization could be described as to whether it is logically built up as an instrument to achieve the overall aims of Norway's aid, whether the allocation of administrative resources are matching the work load needed etc.

One could also assess whether the manpower and other resources are sufficient in number and appropriate in qualification for administering the Department according to the mandate. Since MDC/NORAD's administrative structure soon is to be radically changed such analyses would not be of much practical value.

2.2.6. *Mandate for the administration of Multi-bilateral projects.*

These mandates are attached as appendix to the general mandate of the Multilateral Department. Some main points from the text are:

a) Identification and assessment of projects.

General objectives and priorities of Norwegian development assistance and also the extent to which multi-bilateral activities can strengthen ordinary bilateral activities should be considered when assessing project/programme requests. In addition the recipient country's priorities according to development plans, the UNDP country programme, and the organization's capacity to administer the project should be considered. The UNDP's Country Representative shall formally approve the project (not relevant for global and regional projects.) And in the main Norwegian partner countries the MDC/NORAD Country Representative shall assess the proposals.

In addition the Multilateral Department should emphasize that the following aspects are satisfactorily treated within the requesting organization:

- the overall objectives of the project
- technical/economic assessments
- socio-economical analysis
- budgets and systems for financing
- routines for reporting
- planning of project reviews and evaluations
- questions related to operation and maintenance,
- organization in charge of project implementation

Preferably MDC's own staff should undertake the assessment of requests for multi-bilateral projects. However, if this competence is not appropriate, the mandate allows the possibility of utilizing external resources.

b) Meetings

For the organizations with which Norway has a multi-bilateral cooperation there will be two meetings annually to thoroughly discuss ongoing activities and new project proposals. The main meeting is held in the headquarters of the organization, the second meeting in Oslo. During the planning and follow-up of these meetings, Multilateral Department is to consult the other departments in MDC and external institutions if needed.

Reports from the meetings are to be sent to relevant departments in MDC, Ministry of Foreign Affairs, Norwegian Embassies and Consulates as well as MDC Country Representatives.

In the main cooperating countries exchange of information between MDC and the MDC Country Representative is required, and the latter has to be kept informed about the projects.

c) Decision making

In some instances project proposals have to be presented to the Ministry of Foreign Affairs. The reports from the biennial meetings, including program for the coming year should be sent to the Minister of MDC for approval.

d) Evaluation

Norwegian participation in the evaluation of multi-bilateral projects is to be decided in cooperation with the recipient organizations. Norwegian participation in all project reviews within the sector is a priority for the Department.

2.2.7. *Norwegian official policy towards UNFPA.*

The speech made by the Norwegian delegate to the 33rd UNDP Board Meeting in Geneva in June 1986 could be considered one authoritative statement made regarding Norwegian - UNFPA cooperation in particular and of the Norwegian official policies on population activities, family planning and mother and child health in general. The statement included:

- *assurance that assistance for population activities rank high among the priorities for Norway's cooperation with developing countries (with reference to the 10 % of ODA commitment)*
- *that Norway considers UNFPA as the central body through which multilateral activities in this field should be coordinated.*

The lack of resources devoted to population activities during recent years latest years was partly explained by reference to the world economic recession, and because population activities are still a sensitive issue for many donor countries.

Concerning family planning it was found necessary

- *that projects should be an integral part of politically approved population plans*
- *that family planning projects should be closely related to efforts to improve the health situation, especially by the integration of MCH and FP.*
- *to stress the importance of involving the male population in these plans to motivate them to smaller families and child spacing.*

The statement also included the need for increased education for women due to the positive effect on the population structure. Family planning activities are considered an important factor in the advancement of women.

Norway's wish to strengthen assistance to African countries was stressed;

> *"One of the most serious problems of this continent today is the population growth. Within 15 years the population in Africa will grow from 553 million to more than 800 million. Other problems like famine, food production, environment problems and employment must be seen in this connection. The African governments are requesting more assistance to better be able to master the various population problems and several donors, among them Norway, have recently pledged population assistance to Africa."*

The UNFPA intention to distribute increased allocations for activities in Africa was welcomed. The need for sufficient and qualified personnel in Africa and the importance of showing a flexible attitude with regard to the employment of nationals with a thorough knowledge of the local situation was emphasized.

The Norwegian representative stressed the importance of the monitoring and evaluation procedures of UNFPA. UNFPA's Executive Director was supported in the efforts to improve these systems. It was noted, though, that only 17 in-depth evaluations had taken place during 1984-85.

> *"It is with great interest we note that the Fund so openly is willing to put forward and discuss the mistakes and problems these evaluations have brought out. We also take note of the fact that a system for the follow-up of the recommendations of independent evaluation has been established."*

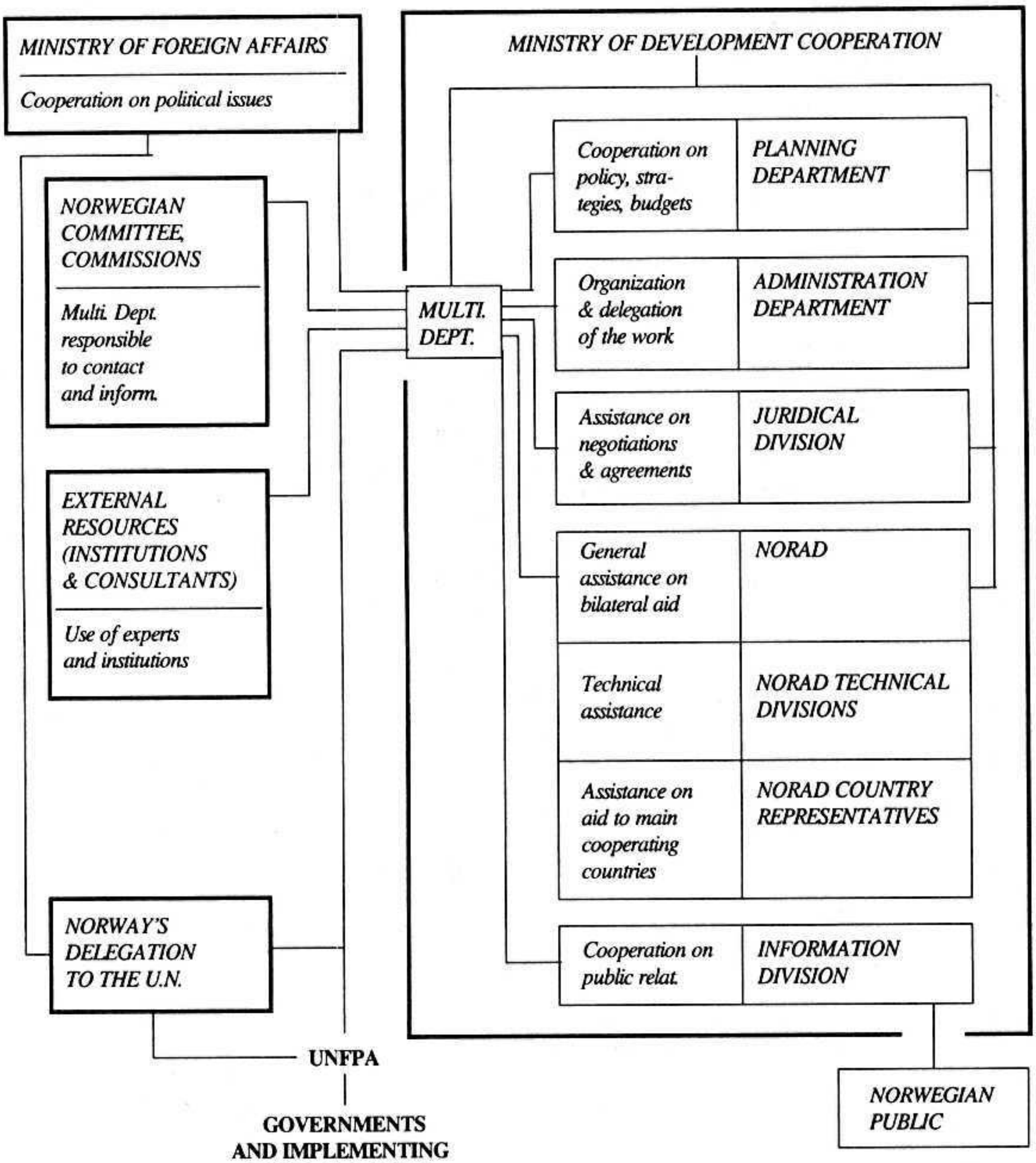
With particular reference to the CIDA "Institutional Appraisal" from October 1985, the Norwegian representative expressed a want to receive some information on how UNFPA is going to respond to the findings of the appraisal and to follow-up these recommendations.

2.2.8. *Discussion*

Some of the lines of communication and authority concerning Norway-UNFPA cooperation according to the mandates and regulations mentioned above are illustrated in the following:

ILLUSTRATION 2.2.8:

SOME OF THE MAIN INSTITUTIONAL COMMUNICATION LINES RELATED TO THE MDC MULTI-BILATERAL ASSISTANCE TO UNFPA ACCORDING TO THE MANDATE OF THE MULTILATERAL DEPARTMENT



At present (November 1987) a reorganization of MDC/NORAD is underway. As a consequence, mandates and roles of the various departments and offices will probably be changed. Hence a *thorough* assessment of the existing administrative system has not been found feasible at present.

However, the evaluation team has made some observations, mainly based on interwievs with "resource people" within the MDC/NORAD system, which will be discussed below.

Illustration 2.2.8. highlights some of the *main* lines of communication. In reality the picture is much more complex and there are a number of external, and internal, administrative and personal factors affecting each communication line.

One relation which seems to have created some conflict and misunderstanding is between the Multilateral Department and the *Planning Department.* According to the mandate Multilateral Department is to cooperate with the Planning Department concerning policy issues, strategy, overall planning and budgets. The Planning Department is also responsible for coordinating aid to countries outside the group of main cooperating countries, for instance Nepal and Nicaragua. The evaluation team was told by representatives from the Multilateral Department that the division of authority and responsibilities between the Planning Department and that of the Ministry of Foreign Affairs was unclear.

From Multilateral Department's point of view the Planning Department does not have the necessary capacity to give this assistance. There is, for instance, limited experience with the work of multilateral organizations. According to the Multilateral Department replies to concrete enquiries in some cases have come too late to be useful.

The Planning Department, on the other hand, has in the mandate been given a superior role over the other departments, but this role has not been sufficiently reflected in the hierarchical structure of MDC/NORAD. The obligations of the Planning Department cover a vide range of activities. Its resources are partly utilized in secretarial functions for the political leaders of the Ministry. The Department is also involved in operational duties in connection with special grant arrangements and programmes that do not fit naturally under other units of MDC/NORAD. In addition the Planning Department is responsible for evaluation, country analysis and research coordination.

As a consequence the Multilateral Department has had a tendency to limit its contacts with the Planning Department and instead approached the Secretary General of MDC directly.

One other important relation is between the Multilateral Department and NORAD. This has been reported to work relatively well, and perhaps best at the level of officers-in-charge. As an example requests for multi-bilateral programmes in the main cooperating countries are sent to NORAD for assessment. The technical office in NORAD in charge of Health, Nutrition and Population matters ("HELSE", previously "HEFA") is often requested to comment on project requests and plans also concerning activities outside the main Norwegian partner countries. Archive files show that such requests are duly replied to. The documentation also gives the impression that HELSE is the only contributor within the MDC/NORAD system on technical issues related to family planning. This fact was reflected clearly during the latest bi-annual meetings with UNFPA, where representatives from HELSE participated; for the first time the Norwegian delegation was in a position to ask questions of a more technical nature.

But HELSE's capacity is also limited. HELSE's primary responsibility is assistance to main cooperating countries, and requests from the Multilateral Department often come as an additional burden to an already overloaded office. One problem raised in this connection was that the requests were not satisfactorily prepared and well detailed, hence making it difficult for HELSE to understand exactly what the problem was. Requests also often related to concrete and isolated projects, and HELSE found them difficult to assess without the necessary knowledge of the overall project framework and context.

The main problems concerning both Multilateral and Planning Departments and HELSE seem to be lack of capacity in terms of personnel with relevant experience. The work stress within the MDC/NORAD offices is extremely heavy. Some senior officers also, by necessity, travel a lot. Due to the fact that responsibilities are only to a small extent divided between officers, work has a tendency to halt when the person concerned is not in office.

The absorptive capacity is limited. There is hardly any chance for the officers to study the activities, programmes and organizations. Some officials also consider their duty as purely administrative, and are not much interested in being more "in touch" with the programmes as such.

We would also point out the seemingly rather arbitrary flow of information within the system. Routines for simple administrative matters, if they are formally established at all, are not known or followed by senior officials. Individuals in the system are playing different roles depending on how central they have become in the "information flow". In general too much of the administration today is depending on personalities and personal relations rather than defined functions, rules and regulations.

It should also be mentioned that there is an evident need of exploring better systems for treatment of documentation: for instance proposals, reviews, assessments and evaluations. Archive IV in MDC/NORAD, which is responsible for UNFPA/Multi-bilateral matters, is at present very incomplete. There seems to be a tendency to defer the sending of documents to Archive IV, and very often reports and papers are kept at the officer's desk. There is reason to believe that many important documents have been lost this way.

From the outset one intention of multi-bilateral assistance was to relieve the Norwegian administration. We have seen how the situation changed with the establishment of the new Ministry of Development Cooperation and the intention to try to improve the follow up capacity. At some point one has to define the extent to which Norwegian control is appropriate: where one has the desired control necessary for ensuring that Norwegian policies are followed.

The evaluation team feels that this point has not yet been reached. But there are some functional and structural limitations in the present channels of information, and other possibilities could have been explored.

RECOMMENDATIONS

Project and country selection

The Multilateral Department should invest more resources and give clearer signals to UNFPA concerning *forms of projects* and kinds of inputs desired from the Norwegian side.

Project proposals should be carefully studied by competent experts in order to assess whether objectives correspond with Norwegian principles and aims and whether projects activities and inputs are feasible for reaching the set objectives. Such experts should have appropriate knowledge on technical matters, the situation in the recipient country and generally on development assistance.

Project follow-up should be kept at a limited level. But Norwegian participation should be ensured at main reviews and assessment missions with reporting back to the Multilateral Department.

Project evaluation. Norwegian participation should be secured.

It is strongly advised that *the same person/institution* follows the project/programme as Norwegian representative over a number of years. This is thought to be the only feasible way to acquire knowledge and systematically establish and maintain Norwegian competence. Previously only 2 Norwegians have participated in UNFPA project assessment missions: an Ambassador and a Senior Officer from NORAD. It is quite clear that although the ideal would be that MDC/NORAD officials participated the capacity of NORAD does not allow for the regular follow-up indicated here. It is recommended that Multilateral Department map and roster relevant external experts available and develop a system allowing the same expert/representative for an institution to follow up each *major* project over time.

For UNFPA such a system would be desirable too. Knowing the qualification of the Norwegian delegates, it will be easier to compose appropriate teams. Presently the tendency has been to invite Norwegian participation too late and UNFPA has had to wait also for its own selection in order eventually to match the qualifications of the Norwegian participant.

The increased use of external resources might become problematic for the work style characterizing the Multilateral Department today. Hiring consultants also presumes new duties such as formulating terms of reference, identifying persons with the best qualifications, follow-up etc. The evaluation team would therefore suggest the establishment of an institutional long-term collaboration instead of hiring single consultants from time to time.

2.3. OTHER MDC SUPPORTED PROJECTS

2.3.1. *The "other" UNFPA Multi-bilateral projects financed by Norway.*

The multi-bi programme supported by Norway 1976 - 1986 consists of the following projects (Norwegian contribution in US$, short assessments):

a) Completed projects:

MAG/79/PO2, Health and Demographic Statistics.

US$ 92,800:- MDC: paper delivery, contract Norsk Data
Final report sent to MDC early summer 1987.
A system of "statistiques sanitaires" seems to work. Difficulties initially with un-trained personnel.

SEY/82/PO2, Family Life Education.

US$ 121,907:- Funded by MDC until 1986. UNFPA financed the remaining period. Mainly concerned with sex education in schools. Progress semi-satisfactory.

URT/79/PO5 Civil Registration

US$ 40,100:- paper and printed forms.
Constant changes in the Tanzanian ad hocracy, the changing of registration forms, slow disbursements administrative bottlenecks and lack of high level and staff commitment are mentioned as a reason for poor performance. However, people with not altogether positive experience of government usually do not want to be counted and registered for no obviously good reason. Evaluation mission beginning 1987, comments not complimentary.

BUR/83/PO1, Burma Census.

US$ 88,000:-, paper and Honeywell computer spare parts delivery. According to plan.

CPR/82/PO3, Printing census results.

US$ 225,639: paper delivery. Census printed 1985

SRL/80/PO3, Hospital based FP services.

US$ 896,889: Personnel costs, equipment, training costs MDC support ended in 1984.

JAM/78/PO3, Primary Health Care FP

US$ 1,006,010:- health education, training of FP/MCH personnel, facilities.
Final payments in 1985.

NIC/84/PO3, MCH/FP programme

US$ 402,280:- Continues as NIC/85/PO3

PER/80/PO3, MCH/FP programme

US$ 495:735:- See below PER/83/PO9

GLO/77/P24, Basic Needs Assessment Missions

US$ 3,499,428:- financing of Needs Assessment Missions
Final expenditure in 1985.
For comments see elsewhere in text.

b) Ongoing projects, (disbursement figures include those planned for 1987):

ETH/81/PO5, Community support to health and MCH programme.

US$ 644,556:-, CAT, Audiovisual material, KAP study
Although executing agency (UNESCO) always reports that "progress is highly satisfactory", the project had difficulties in getting off the ground, also consistently bad financial reporting from executive agency. New and enthusiastic CTA has helped to revive project and steer it through the present bureaucratic maze.

URT/86/PO1 Family Life Education

US$ 210,095:- promised by MDC for 1987.

CPR/82/PO2, China Fertility Surveys

US$ 923,026:- basically paper and Norsk Data professional services. Other donors DANIDA, FINNIDA, CIDA. No implementation problems.

NEP/80/P12 FP/MCH project

US$ 656,642:- and NEP/80/P13 FP/MCH project US$ 5,777,740:-
see elsewhere in text for assessment.

BOL/84/PO2, Extension of integrated MCH care

US$ 1,467,264:- consultants, local salaries medical staff, training, equipment. The project was started to support a new democratic government in Bolivia. It seems to be the only financial support for the Bolivian health service, which is in total disarray, financially and administratively.

It is not known how much of project funds have been distributed outside the project. If MDC wishes to continue support for the Bolivian health services this should probably be done through other and more appropriate channels. PAHO officials stress that other project could not have been carried out (UNICEF etc) if the UNFPA project had not been in place. Bolivia is now to take on the salaries for local medical staff.

NIC/85/PO3, Programme support for MCH/FP in Ministry of Health

US$ 4,221,663:- For comments, see elsewhere in text.

PER/83/PO9, Pilot sex education programme,

US$ 277,108:- Had considerable difficulties to get off the ground. Now change of government and president promises increased support for programme implementation. Studies have indentified project target population. The support for this project could probably be used better somewhere else, for example in Africa.

INT/84/P45 Norway Trust Fund Reserve

at the end of 1986 US$ 31,210:- This is a reserve fund initially for US$ 25,000 to which has been added interest from various projects with underexpenditure.
Should probably be abolished.

INT/85/PO1, Media awareness for women.

US$ 282,240:- women's feature service. A project run with good results by Inter Press Service in Rome, Italy.

2.4 PROJECTS IN NEPAL

2.4.1 *Introduction*

a) Summary of field work

Field work was undertaken in Nepal from Aug. 4th to Aug. 18th, 1987, with the main purpose of reviewing UNFPA projects supported by MDC, and studying the practical implications of UNFPA policies, strategies and procedures at a national level.

The schedule included meetings with senior officials in Ministry of Health (MOH), National Commission on Population (NCP) and National Planning Commission (NPC), participation as observer in a workshop for MOH district level managers, discussions with major donors to the health and population sector and with national and international NGOs involved in MCH/FP activities. A two-day visit to rural health facilities in Chitwan (lowland) and Gorkha (middle hills) districts was also part of the program.

The program was coordinated by UNFPA Senior Program Officer D.B. Lama. S. Møgedal participated throughout the two-week review period and C. Widstrand joined her from aug. 11th.

b) Population and Development in Nepal

Nepal is a landlocked country between China (Tibetan Region) in the north and India in the south, east and west, and covers an area of 145.305 sq. kilometres.

Ecologically it has three broad zones: Mountain region, the Hills and the Terai (lowlands).

The high mountain zone covers 35% of the land area and has 8% of the population. The hills represents 44% of the land area and is the home of 46% of the population. The most fertile area is in the Terai, where almost half of the land is cultivable in a belt that represents 21% of the total land area and is habitated by 46% of the population.

Nepal is still among the poorest countries, with a per capita GNP of $160 (1985). GDP growth has barely kept pace with the growth of population and was estimated to be 2,3% in the period 1965-80 and 3,4% in the period 1980-85. Agricultural production accounts for 62% of GDP, and more than 90% of the labourforce is engaged in this sector.

Whereas previously Nepal has had a history of surplus food grain production, deficits of up to 16% have been registered during the last decade.

Of the total government expenditure, 5% is allocated for health, 12% for education, 6% for defense and 48% for economic services (World Development Report, 1987). The 1981 census data (Central Bureau of Statistics, CBS), calculated an urban growth rate (for towns of 10 000 and more) of 117% between 1971-81. It also documented a sharply increasing man-land ratio, decline in per-capita food availability, growing imbalance in density of population through unplanned migration, pressure on social services and rapid deterioration of the environment.

While according to the 1981 census it was found a rate of immigration of 16 per 1000 population, a demographic sample survey in 1986 found an estimated rate of 28 per 1000 immigrants for the country as a whole, with the highest concentration in the Terai. Most of the immigrants are of Indian origin.

The cencuses show a steady increase in population from 8.2 mill. in the early 1950s to 9.4 mill. in 1961 and 11.6 mill. in 1971. During the period 1971-81 the population grew at a rate of 2.62 per annum and reached approx. 15 mill. in 1981.

POPULATION DATA (NCP 1987)

Population Sizes (000's)	
Total	16.625
Male	8.545
Female	8.080
Land Area (km^2)	147181
Population Density (km^2)	113.0

Population Distribution by Geographic Region (%)	
Mountains	8.3
Hills	45.8
Terai	45.9
Life Expectancy	
Male	50.9
Female	48.1
Both Sexes	49.5

Crude Death Rate/1000	16.6
Crude Birth Rate/1000	41.6
Infant Mortality Rate/1000	111.5
Total Fertility Rate (Live births per woman during 15-49 years)	6.1
Population Growth Rate (%)	2.57

Literacy Rate: (% of persons over 6 years)	
Male	34.0
Female	12.1
Both Sexes	23.2

Continuing Family Planning Acceptors (% of married 15-49 Years)	16.0
Average Household Size	5.8

Planning Documents

From 1956, Nepal has had a series of five year development plans which have addressed the different sectors. The current plan period is covered by the Seventh Plan (1985-90).

The major objective of HMG in population is to reduce the total fertility rate (TFR) from 6.3 in 1981 to 2.5 in year 2000. In order to achieve this, HMG adopted a long-term comprehensive and multisectorial population strategy in 1983, aiming to achieve a TFR of 4.0 by the end of 1990.

Population concerns have received increasing attention in Nepal's development plans. The current strategy places emphasis on:

- fulfillment of unmet demand
- integration of population with broad development efforts
- raising the status of women (education and employment)
- community mobilization through existing community structures and NGO's
- regulation of immigration

Population issues are discussed in several national level policy documents, such as those on ecology and land use, urbanization and habitation, decentralization, regional development and child development. A more specific integration of population concerns with overall development efforts is being increasingly pursued at policy, program and institutional level.

In the field of health and population, such specific strategies include:

- to increasingly institutionalize the delivery of permanent and temporary family planning services as well as MCH services at local hospitals and health facilities
- to place greater emphasis on the delivery of MCH and temporary methods of family planning services
- place increased emphasis on the delivery of services to younger couples and in densely populated areas
- regionalize the family planning and health delivery institutions

While the targets set by the national strategy are ambitious, they are in practice seen as rolling targets and meant to be adjusted periodically based on the performance of the implemented population programs.

Awareness of the urgency of population concerns and acceptance of the need and responsibility for participation in activities and programs has increased significantly among policy makers and program managers over the last years. Yet there is a considerable gap between understanding and verbal commitment on the one side, and the capacity and ability to put policies into practice on the other.

2.4.2. *Health and Population Programmes and Policies*

a) Health Sector Administrative Structure

Health services are mainly provided through three major institutions; Department of Health Services; the Integrated Community Health Services Development Project (ICHSDP) and Family Planning Maternal Child Health Care Project (FP/MCH).

Besides these, there are vertical projects like Expanded programme on Immunization (EPI), Malaria Control Organization, TB Control Project and Leprosy Control Project.

Health services infrastructure include zonal and district hospitals along with a network of rural health posts and some ayurvedic centres.

The Department of Health Services has up to present been responsible for regular development and delivery of services by operation of curative services, management of technical manpower and procurement and distribution of supplies.

A reorganisation of the health services structures was initiated in 1986 with the replacement of Department of Health with 5 Regional Health Directorates. Department of Health functions which were not decentralized were organized as Divisions directly under the Ministry of Health.

The Integrated Community Health Services Development Project was established as a separate project in 1980. It was set up based on experiences with services integration in some pilot districts in the early seventies, organized under an "integration division" in the Department of Health. The policy of integration of vertical projects at both peripheral and central level was clearly laid down at the time of the Fifth Plan (75-80), and was to be extended step by step throughout the country. Integration was to be completed by 1985 with a total of 1052 fully integrated Health Posts in all 75 districts.

Fundamental policy elements in integration were stated to be:

- *integration of all the vertical single purpose projects under a common administrative structure*
- *integration of preventive and curative medicine at the lowest possible cost*

By 1987, only a total of 291 Health Posts in 26 districts are providing integrated services at various stages of integration. The remaining 453 Health Posts continue with more static curative services, supplemented by the different vertical projects.

The reasons for the slow progress in integration have been discussed in a number of reviews and workshops and are commonly understood to be:

- *inability to resolve inter-project rivalries and conflicts;*
- *reluctance by the vertical projects to hand over resources despite acceptance of the policy of integration*
- *weakness in management at district and central level*
- *discrepancy between responsibility and authority*
- *severe strains in central coordinating mechanisms and fragmentation caused by a multiplicity of aid agencies*

From august 1987, the ICHSDP has ceased to be a separate project, and is integrated into a new Public Health Division of the Ministry of Health, as part of the reorganisation of health sevices in the country.

The Nepal Family Planning and Maternal/Child Health Project

(FP/MCH), was established in 1968, Family Planning services were then added to the maternal and child health program operated by Department of Health, and put under the authority of a FP/MCH Board.

Broadly, up to 1975, service delivery followed a static clinical strategy of operations. After the introduction of Panchayat Based Health Workers (PBHW) in 1975, the services were also to some extent given on a door-to-door basis.

The project has a strong organizational base which includes a central office, 5 regional offices, 40 district offices, 258 clinics and approximately 2600 panchayat-(locality)-based centres.

The FP/MCH project has been seen to have a stronger management capacity than ICHSDP, has carried out surveys of internationally acceptable standards and has had ample supply of funds. However, as a development project, staff feel insecure and have no ladder for promotion. The policy of integration has been regarded as a threat and has led to a high attrition rate among the higher level staff.

The project is heavily dependent on foreign aid and most innovations and program changes have been seen as externally induced.

The recent reorganization of health services has in principle cancelled the project with its current organizational structure. The central project capacity will however in the future constitute the family planning technical expertise within the Ministry of Health. Peripheral staff will temporarily be absorbed in an integrated service delivery system, to be gradually refined and developed over the coming three years.

The new organizational structure for Health Services is not yet clear at the time of this review beyond rough indications and a draft organisational chart.

It is however based on extensive management and project reviews, brought together and further developed by a HMG Task Force which submitted its report by the end of 1985.

The aim of the new structure is overall policy and program coordination, decentralization/regionalization and clear lines of responsibility and authority. It is the desire to develop opportunities for flexible approaches with focus at the district level, which is also the level where overall development planning mainly will take place according to the Decentralization Act of 1982.

The reorganization was initiated as a consequence of stated government policies for decentralization, but came equally as a response to considerable external pressure from a number of major donor agencies, who together made this a condition for further support to the health sector.

The problemanalysis and alternatives presented by the national Task Force in 1986 provided the basis for the reorganization. It was expressed as a common view among health officials at the various levels that such a basic structural change was a necessary step at this time, even though it has also created quite a bit of confusion.

It is reason to believe that it will take several years to have an efficient new structure for overall services implementation. Severe management problems may temporarily be compounded by unfamiliar lines of responsibility and uncertainty about future employment opportunities.

Organization charts are included in the appendix.

b) Health Sector Policies and Priorities

Whereas the emphasis in the two first health sector five year plans clearly was on the provision of curative services and communicable disease control, a more comprehensive approach was developed gradually from the mid sixties.

Between 1970 and -75, the strategy changed towards a priority to preventive services and better distribution of sevice delivery points through a system of Health Posts and homebased services. Consistent with this direction and in accordance with the WHO Primary Health Care strategy, the Long Term Health Plan (1976-90) was formulated.

In the current Seventh Plan, all attempts are centered towards meeting the minimum basic needs of the people, primary health care and sanitation being mentioned as two of these needs.

Basic health care services will be expanded in rural areas and family planning programme intensified along with a special thrust upon maternal and child health services and welfare. A multisector approach is adopted to improve nutrition status.

Ayurvedic, homeopathy and unani (traditional healing methods) health care is developed as regular parts of basic health services.

The current plan also encourages private sector participation in health services delivery, and for the first time provides an opening for community financing mechanisms to supplement governmental health care at the various levels.

The recent reorganization of the Ministry of Health and related structures, will in principle open up for a more flexible health care strategy focused on specific needs in each district rather than creating uniform models throughout the country. The District Office will be the main implementing body with overall responsibility for services and utilization of resources.

To what extent one will *actually achieve improvement of service delivery* at the district level and below, is left to be seen. This will take more than structural changes and policy statements, and require a release of creativity and new commitment among staff along with clear delegation of authority for management and coordination.

In most of Nepal there is generally a low utilization of facilities provided, and a low confidence in the health care system as such. In nearly all the health institutions there have been shortages of equipment and drugs and discontinuity in staffing. In the Terai belt, private practitioners and local private drugshops seems to be the preferred option for medical treatment.

Whereas drug prescription in principle is controlled by legislation, drugs can be marketed by whoever wants to open a medical hall or drugshop.

c) MCH and Family Planning Services

- Mother and Child Health Care

More than 14% of Nepal's population is under the age of five. The high mortality among children is regularly stated as being the primary reason for the low practice of family planning in the country.

Women constitute a majority of the workforce in terms of hours worked in agriculture pr. day and in terms of real production. The poor health and high mortality of mothers is increasingly understood to be a serious impediment to the development efforts of the country.

In spite of this realization, FP/MCH services have mainly been concentrated on strict family planning interventions and in particular sterilization programmes.

Whereas targets for MCH services were given in the Sixth Plan, to be provided both through the system of FP/MCH Project clinics and FP workers, and through the ICHSDP's Village Health Workers (education, immunization and referral), no clear strategies and guidelines on MCH services were developed, and these services were thereby given low priority.

Comprehensive MCH care has mainly been practiced by NGO-programmes such as Save the Children, UK and USA, and even more the United Mission to Nepal (UMN), which since the mid-sixties have maintained an extensive decentralized MCH network in its areas of operation.

The onesided emphasis on FP may be seen as a consequence both of internal priorities and the strategies pursued by major donors in selecting projects and activities for external support.

One UNFPA Mid-term Review in 1983, stressing this problem, provided an impetus for the development and acceptance of a strategy paper for MCH in Nepal by the Ministry of Health.

The strategy seeks low cost, practical and simplified interventions, limiting the programme to a short list of priority areas such as;

- oral rehydration
- nutrition
- immunization
- basic and natal care
- child spacing

The strategy is designed to use existing manpower, however with new focus and priority given to the selected MCH activities. The design also includes mobilization of communities for support in various ways as may be found possible in the local context.

Although the strategy formally has been adopted by the MOH, little reference is currently made to it by policymakers and implementors at the various levels of the system. It is however put into practice through UNFPA support in a few districts, where the interest so far seems promising both from health care providers, clients and communities.

One of the main constraints is regarded as the shortage of ANM's actually working in the Health Posts, and the mobility, including allowances, for such staff to provide decentralized services.

- Family Planning

Awareness

Recent surveys reveal a substantial increase in the total awareness and overall knowledge of at least one method of FP during the period 1976-86. However, the largest part of this increase took part in the first five years of the decade.

The fertility and family planning sample survey of 1986 gives the following figures for awareness among currently married women aged 15-50:

	1976	1981	1986
Knowledge of at least one method	22.1%	51.9%	55.9%

According to age groups, the highest knowledge is found among women aged 25-39. The knowledge of contraception increased from 53.5% among illiterate women to 89.3% among women with primary education and above.

Comparison of 1976 data with those of the Demographic Sample Survey (CBS, 1987/87), shows little or no change in fertility during the last decade, except a minor decline in fertility in the age group 35-39. This has been counterbalanced by an increase in fertility in the younger age groups, particularly in the age group 15-19.

The total number of family planning acceptors over the last 20 years is shown in appendix. Accurate data on acceptors, continuation rates and fertility patterns are not readily available, although serious efforts are now beeing made to build up a system for regular demographic monitoring.

Methods and Strategies

For most people in rural Nepal, family planning is equivalent to sterilization. This has also been the main emphasis in IEC activities. Little effort has been placed on promoting temporary methods for child spacing. IUDs gained some acceptance in the early years after introduction, but soon came in discredit among users. In the mid-seventies, vasectomy was the main strategy, whereas the last 8 years female sterilization has become the much preferred choice, where such services can be delivered at a reasonable cost. In the remote hills, vasectomy will continue to be the only permanent method available.

Faced with the problems of topography and the limited number of trained doctors posted in district hospitals, the camp approach has been used for delivery of surgical contraceptive services. The camps have on the whole been successful, but on a long-term basis they are very costly and heavily dependent on foreign aid. Satisfactory follow-up of clients has also been difficult.
The government has decided to increasingly institutionalize surgical contraceptive interventions in district and zonal hospitals. For isolated areas it will however be necessary to continue with the camp approach for some years to come.

Performance

Attempts have been made to estimate birth prevention by various family planning methods. An estimate was made by the FP/MCH Project in 1985 based on the assumption of medium level continuation rates for temporary methods. The findings suggested that the ten year family planning programme had reduced crude birth rate to 42.9 in 1981 compared with 45.4 without the programme. Other figures are suggested in different estimates, but allow a rough conclusion that the current birth rate of just over 40 pr. 1000 would have been higher by 2.4-5 % had there been no family planning programme.

In light of the ambitious targets set for population development in the country and the investment made so far, this is a rather low performance. The emphasis on sterilization has caused a selection of clients who have already completed their desired family size, with an average number of living children of about 4 and average number of sons 2.4.

Yet it is worth noting that FP efforts were started at a time when a woman was respected by her fertility, and FP workers were blamed for being foreign agents. Now attitudes have changed tremendously, and limiting family size is a theme which can be discussed rather freely. This in itself is an important achievement.

Future strategies

In future the family planning programme will increasingly concentrate on temporary methods, on improving continuation rates and on focusing young families in the most heavily populated areas of the kingdom.

This, together with the reorganisation and the institutionalization of permanent methods is expected to cause a temporary decline in overall family planning performance, until new strategies are well established.

Targets set by the Planning Commission may be much to ambitious in this context, and may cause a general resignation rather than act as an incentive for achievement. This situation is

reflected in clear communication gaps between local administration, service providers and policymakers in their preception of what may be realistic and achievable family planning targets.

Private Sector

Besides the regular services under the MOH, the Family Planning Association of Nepal (FPAN) also provides family planning services. This national NGO is recognized specifically for introduction of new methods (such as minilaparotomy and NORPLANT), and for innovative IEC activities.

It seeks to play a supportive and complementary role in the National Population Programme, but as NGO the association also wants to stand on its own in developing strategies and activities. Through coordination of targets and camp-activities with the FP/MCH, care is taken to avoid duplication of services. Yet in the past, such duplication has clearly existed, including competition for sterilization cases at the village level.

A strength is however the opportunities in more integrated small scale community approaches, and the high-level political support that is given because of the links between the association and the palace.

FPAN receives external support from IPPF (US$ 3 mill. for next three year cycle), and from a number of other international agencies. Shortage of funds therefore does not seem to be a constraint.

The Nepal Contraceptive Retail Sales (CRS) Company, also assists in the national FP activities by utilizing the existing retail and wholesale networks for contraceptive social marketing.

The sale of condoms through CRS today represents 47% and of oral pills 22% of total condom/pill distribution in Nepal, both free and selling.

d) Population Activities in Sectors other than Health

Through the last few years, initiatives for the integration of population concerns into overall development efforts have been taken in relation to a number of development programs such as:

- Integrated rural development programs
- Population education and distribution of contraceptives through the cooperative movement
- Resettlement programmes
- Population education in skill development programmes and in the industrial sector

These efforts have however been rather scattered and experimental so far.

In the Sixth Plan, the role of women in national development was emphasized, and some attention given to strengthening the social and economic status of women. Along with this, womens projects were launched in areas of cottage industry, literacy, and agricultural extension. These projects were undertaken mostly as separate initiatives within the overall efforts of various national agencies and have not yet become integrated into the mainstream of development efforts in the country.

Population education and contraceptive distribution have to a varying extent become regular parts of these programmes, but without clearly stipulated goals and generally with limited attention when it comes to actual implementation.

e) National Commission on Population

As population concerns became more evident on the national agenda, a Population Policies Coordination Board was created in 1975, under the chairmanship of the National Planning Commission and with the FP/MCH Project acting as a secretariat.

In order to give stronger authority in policymaking and coordination, the Board gave way to the National Commission on population in 1978 with the Prime Minister as its chairman. The Chief of the FP/MCH Project continued as the member secretary of the commission for the first couple of years.

Two years later, the NCP Secretariat was integrated in the National Planning Commission Secretariat as a Division of Population, but then again reconstituted as a separate body in April 1982.

NCP is governed by a Board with high level membership from Parliament, University, National Planning Commission and key central line ministry officers, as well as Women's organization and Social Services Coordination Council (representing the coordinating body of the NGO's).

The explicit role of the Commission is policy-formulation, program-coordination and evaluation. These responsibilities are to be carried out by the NCP Secretariat through its four main divisions. However, NCP lacks final authority and executive responsibilities in the area of its mandates, serving only as an advisory arm to HMG.

In practice therefore, NCP has had considerable difficulties in fulfilling the expectations of both policymakers and donors interested in supporting population efforts.

Its role has varied through the years of existence, and to a great extent been linked to the personalities filling leadership positions.

The establishment of the Commission in 1978 was given strong support by USAID, at that time the donor agency giving most emphasis to population issues. A strong coordinating and policymaking body was seen as a precondition for successful program intervention. After having a successful start with clear political support in the early years of its existence, it has since 1982 seemingly lost much of the support and also consequently donor interest.

NCP secretariat staff, administrative as well as technical, have had considerable turnover. Among reasons given, highly qualified technical staff felt that work had little scope, and that new ideas were not very well appreciated within the system. Much time was spent with representatives from external agencies, but little meaningful interaction took place within the secretariat as such.

With the low status of the NCP, its role in overall coordination was made impossible. Also the Planning Commission has a separate group of staffmembers working on population concerns, and interaction between NCP and NPC has not been very clear. Whereas there is verbal commitment to integration of population concerns in nationwide development strategies, line agencies and ministries, institutions and policymaking bodies formulate population and development goals separate from each other and with very little mutual interaction and reinforcement.

This weakening of coordination capacity is compounded by donor agencies going directly to implementing agencies in their programming and negotiation, with little involvement or even information to the NCP, thereby undermining the coordinating potential which in spite of all the problems might have been there.

An important achievement of NCP is the formulation of a National Population Strategy in 1983. The implementation of this strategy however, has met with a number of difficulties. Particularly in relation to the MOH, the relationships have been strained, as there is a feeling that the NCP is not rooted in the realities of the sevice delivery system when formulating strategies and setting targets for achievements.

Working groups/committees within NCP have been formed to formulate consistent population programmes in their respective areas. Each working group is chaired by the minister of the respective line agency. Such working groups related to general development are:

- Agriculture and Population
- Forest, Environment and Population
- Panchayat, Class Organizations, Women and Population
- Population Education

The working groups have however not come to a very active life, and it is not clear to what extent the activities of the various ministries do translate policies into active involvment.

Neither does it seem to be an active interchange between the working groups, to make a comprehensive and integrated approach possible. The function of the groups in overall coordination such as discussing priorities and working on potential conflicts is therefore weak. The membership is also such that a deeper level of involvement and problemsolving cannot easily take place, due to a number of competing activities and priorities.

The National Population Strategy calls for a strengthening of the institutional basis of the National Commission on Population, to be achieved by:

- according a definite legal status to NCP
- channelizing the annual programme of individual agencies engaged in population programmes through a process of approval by the Commission
- coordinate all external assistance in population programmes through collaboration between the Commission and Ministry of Finance

It appears that neither the government structure, nor the external agencies have taken these policystatements seriously after the strategy was formulated and adopted in June 83.

2.4.3 *The HMG/UNFPA Country Program*

a) Brief overview of the Country Program

UNFPA assistance to population education programs in Nepal started in 1974. Following a UNFPA Mission on Needs Assessment in 1979, several new projects were identified and the First HMG/UNFPA Country Program (1980-85) formulated.

Based on the guidelines of the Sixth Plan, and in conformity with UNFPA's growing interest in multisectoral approaches to population management at that time, the country program was formulated with inputs into a number of sectors and activities to be undertaken by many different line agencies and institutions.

Main areas of involvement were:

- Basic population data and social, economic and demographic research.
- Population policy and development planning
- Service delivery (MCH/FP)

- Population and development
- Information, education and communication

All together, the program covered 22 projects coordinated and implemented by 20 agencies of HMG. The rationale for this approach was based on the need and urgency for harnessing the resources of many sectors to address the widespread poprehensive and integrated approach the country program has represented a package of many single and to a high extent uncoordinated inputs.

As also other major donors to the health and population sector have used similar multifocal "single project strategies" in search for comprehensiveness of their aid package, this has *contributed to fragmentation in the national system* and increased the urgency for overall coordination.

The UNFPA Midterm Review (MTR), and even more the updated Needs Assessment of 1986 underlines the need for stronger linkages and attention to intersectorial coordination. Also after the MTR, this has continued to be a clear constraint in implementation.

Even within the UNFPA programme office in Kathmandu, little has been done to ensure functional interaction between the various sector inputs. Program Officers attend to their assigned parts of the country program without much discussion together on areas of overlapping concern. There is a regular staffmeeting with the DRSAP, but this is more used for administrative updates and general discussion of bottlenecks in implementation rather than issues relating to functional intersectorial integration.

The regular country program reviews would provide some opportunity for a comprehensive discussion of the total program, both by UNFPA and various involved parties at the national level. Besides the midterm review, this opportunity was however only used in 1985, whereas in 1986 all components of the program were reviewed separately.

A prerequisite for a meaningful comprehensive country program approach must be the presence of sufficient coordination capacity and institutional linkages in the country concerned, along with open communication among major donors in order to assure complementarity in strategies and programming.

In Nepal, an eagerness to be involved in all sectors pertaining to population without due attention to the above constraints may seem to characterize both UNFPA and other major donors. Coordinating mechanisms like NCP have been created for the purpose, but not given sufficient opportunity to develop the capacity to coordinate before being faced with the multiplicity of inputs and initiatives projected as part of the various country and sector programs.

This basic problem affects the country program strategy as a whole, and also many of the aspects relating to absorptive capacity.

In this connection it seems relevant to question to what extent the objectives, strategies and targets of the first country programme were rooted in reality. Already the midterm review pointed out the need to readjust to a more realistic level, many activities of the first phase were carried over to the second and the overall apsorptive capacity has consistently been low.

These experiences should be taken very seriously in the programming for the next cycle.

b) Needs assessment and project cycle

The major needs assessment exercise was done in 1979, and formed the basis for the first country programme. The study identified a number of possible entrypoints for assistance and provided an overview of the whole population scene.

It was however almost entirely done by outside experts, and did not fully succeed in giving the necessary in-depth understanding of institutional and functional constraints for successful implementation of an ambitious population program in the country.

After a rather slow start, the Midterm Review in 1983 provided an extremely useful corrective to the overall program. This review was a combined effort by UNFPA and national professionals, and made some very pertinent observations and recommendations, many of which were subsequently incorporated in the revised program.

Interministerial coordination was stressed, as well as functional linkages between service providing agencies and agencies concerned with population awareness and education. The need for integration of women's programs into the regular and ongoing development efforts of implementing agencies was also pointed out.

Important revisions after the MTR were:

- The Vital Registration Project was phased out due to low performance.
- More emphasis was given to population coordination through the NCP by designing two separate support projects.
- The need for strengthening MCH services was underlined, and a pilot operational research project in community based FP/MCH was initiated. Parallel to this MCH Services Program Intensification strategies were made integral parts of the ongoing service delivery support projects (P12 and P13) in some selected districts.

During the MTR it was also recognized that many of the projects could benefit from technical assistance and backstopping, and a number of executing agencies were brought in to support the national agencies in project implementation.

Separate TPRs for the individual projects were undertaken in 1984, and again in 1985, when these were coordinated in time to constitute an annual country program review. The reviews were chaired by the Secretary of NCP, and attended by representatives from the implementing, donor and executing agency along with others from relevant HMG ministries and agencies.

In 1985, special efforts were made to reduce budget requirements to realistic levels. This has led to some improvement in the overall implementation rates.

Whereas the TPR should have the potential of providing an important forum for interaction on policy issues, progress and constraints, both between UNFPA and the national implementing agencies and between the agencies themselves, *in practice it mainly serves the UNFPA system.*

Reporting is mainly descriptive, giving status according to the work plan, and seems often to avoid problemidentification at a deeper level. Response to TPR recommendations is in general slow and little importance seems to be given to the exercise by the implementing agencies except as a necessary and prescribed routine for UNFPA funded projects.

In 1986 UNFPA Nepal chose to conduct the annual reviews directly with the implementing agencies. The fact that this could be done outside the NCP umbrella, and even separately with the two main implementing agencies in the health sector, says a lot about the overall importance given to the reviews and about the commitment of UNFPA to coordination and integration through NCP.

An update of Needs Assessment was undertaken in autumn 1986, with some continuity in participation from the first exercise in 1979.

The work was again mainly done by outside consultants, and the report submitted to the various national agencies and groups for comments. Apart from the comments compiled and presented by the NCP, the level of national participation in need identification and analysis seems to have been rather low. The consultants were however this time able to utilize the findings and recommendations from a national Task Force on Health Services Delivery, which has given a better depth in the analysis compared with the first assessment.

Project formulation for the next program cycle will take place during november 1987. General recommendations for the new program do not in major ways differ from the overall direction of the current program. With the reorganisation of the health services administrative structure and stronger emphasis at overall integration, it may well be that it is possible to design a country program which has a lower number of individual projects and stronger linkages between implementing agencies. The uncertainty about the future capacity of the new structures may however make it necessary to program for an interim period only, or design a program with a great deal of flexibility and an early country review.

c) Executing and implementing agencies

Slow implementation of planned project activities and use of funds available, were the main reasons for the designation of some of the UN agencies and other external institutions as executing agencies in early 1984, after the MTR.

Along with institutional support and technical backstopping, there was also identified a need for a limited number of external advisers. Many project activities were linked to such support.

Delays in recruitment and financial flow due to the intermediary link between UNFPA and the national implementing agency has caused postponements of project activities and even dependency on the part of several implementing agencies who awaited the expected support and advisory services before project implementation could begin.

UNFPAs role as a fund rather than an agency that can take on project execution does in this context create an important constraint. It may well be that the introduction of intermediaries as executing agencies was a too rushed and generalized approach to a problem which was not sufficiently analyzed, and not a step towards greater overall implementation capacity.

Whereas some of the executing agencies clearly have contributed considerably to progress, others have had less identifyable input and also in some cases had unclear responsibilities in relation to the projects.

Rather than making the use of such executive agencies part of a general strategy, much more attention should be given to identify the needs that can be met by an executive agency along with the likely constraints, and only assign such agencies to the specific projects were there would be a clear net benefit of this kind of technical backstoppping.

d) Role of UNFPA in overall population efforts

Whereas USAID in the seventies was the agency most heavily involved in population, UNFPA is today the leading external agency when it comes to support for population activities in Nepal, both in terms of financial input and when it comes to influence on policies and trends.

This role is acceptsification, institutionalisation of surgical contraceptive services and the concern for integration of population concerns with overall development efforts.

UNFPA has been willing to stand on principle, raise issues and give direction, and is respected for this both by national and international agencies. The UNDP through the office of the Resident Representative has added strength and support to UNFPA in this role.

On the other side, the turn-over of senior staff in the position of DSRAP over the last few years, have created some discontiuity in dialogue and made it difficult to use the role of a lead agency to its full potential.

At times of major events during the program cycle, such as the MTR and now during programming for a new cycle, the senior programme officer has been acting DSRAP, and thereby in effect represented the main continuity in the overall efforts.

As the country programme comprises activities and involvement with a number of ministries and sectors, questions have been raised as to what should be the focal point for interaction with HMG. Or rather, one could ask why NCP has not naturally become such a focal point for coordination of overall UNFPA-support.

The role of a lead agency does carry important consequences and responsibilities. A multisectoral comprehensive approach to population does require strong internal coordination capacity. If this does not exist, or if it is nonfunctional, the risk is that the coordination in actual practice will be taken over by the external agency, and even cause a further weakening of the internal system.

It seems that the UNFPA Needs Assessment Exercises and Reviews do not focus such aspects of assistance like consequences of donor strategies and the interaction between the external agency and the national structures.

In the case of Nepal, and the current status of NCP-UNFPA interaction, this question certainly needs further attention.

It was clearly stated by both NCP and NPC officials that UNFPA is seen to be the agency that can relate to every aspect of population management, and not only single elements like other donor agencies in the sector. UNFPA should be committed to get more involved as a partner in working out country-relevant population and development strategies, with sufficient technical manpower to provide support in the process.

e) Donor coordination, health and population sector

As support to the population sector in Nepal has to a high extent been related to service delivery, coordination of donor inputs to the health and population sector has emerged as a strongly felt need.

Major agencies involved in the sector are UNICEF (MCH), WHO (PHC and overall management) UNFPA and USAID (FP/MCH).

World Bank has fielded a number of missions and expressed interest in the population sector, but so far there has been no clear indication from HMG as to where WB/IDA could have a specific role to play.

The last couple of years a pattern has developed were these agencies have chosen to raise common concerns as a group in relation to HMG agencies. This has mainly been on major policyissues and conditions for support.

Communication between donors have helped to identify potential conflicts between onesided FP strategies backed by strong targets and financial incentives, and other basic health care activities.

As it was put by UNICEF: When FP camps starts, everything stops!

Cooperation has also extended to mutual information on projects under negotiation and seeking to avoid overlap. Yet, each agency has its own constituency and its own organizational needs and priorities, and it is still obvious that there are a number of parallel and at times competing initiatives.

This can be illustrated by the efforts to improve MCH services, where USAID works on their own child survival package, UNICEF are developing new approaches through national workshops and UNFPA claims to have supported the development of a national strategy which mainly is implemented in their own pilot areas for intervention.

It is hard to see the alternatives to these competing approaches. To some extent it may also be enhancing creativity and the search for better models and solutions. Yet a common realization among health care providers in Nepal is that the country now needs overall commitment to make a basic model work, rather than more pilots with priority attention and special funding.

2.4.4. *MDC-supported projects*

a) NEP/80/P12 and NEP/80/P13, position within ICHSDP and FP/MCH Project

Out of the total country program, P13 was selected for Norwegian multi-bilateral support from 1981. This project has had 100% funding from MDC. P12 has been supported by MDC since 1986, and then only drugs and equipment.

The two projects are similar in objectives and scope (see below), but defined in relation to two different implementing agencies, the ICHSDP (P12) and the FP/MCH project (P13). The coordination and communication between the two implementing agencies is minimal.

Both the two implementing agencies or institutions have received support for their total activities also from a number of other donors, and it is difficult to look at the two UNFPA supported projects without looking at the overall activities of the two institutions.

Each donor agency has seemingly defined their own support package within the general framework of the long term plan for the implementing institution. Donor priorities, and concern for comprehensiveness within "own" package has often been a guiding principle. Thereby a number of "mini vertical" projects with separate reporting and funding procedures are created also within each institution.

This also applies to UNFPA P12 and P13. For several of the project components, similar components are supported through agreements with other agencies. These components are not well coordinated, and often supervised by different project officers assigned as responsible for project implementation. *The result is a fragmentation of services and increased demand on the management capacity of the implementing institution.*

P13 has constituted a major input to the FP/MCH project service delivery component, including contraceptive supplies, equipment and infrastructure. MCH services has gradually been given more and more attention.

P12 has similarly included infrastructure, equipment and supplies for service delivery, along with a training and management component.

b) Objectives and components

Objectives and components for the two projects are mostly overlapping, which can be seen from the summary below:

P 13	*P 12*
LONG TERM OBJECTIVES	
Assist in reaching pop.growth targets by strenghtening FP/MCH Project	*Assist in strengthening FP and MCH service activities of ICHSDP*
IMMEDIATE OBJECTIVES/COMPONENTS	
Strengthening steriliz.comp. in static units and camps, est. of infertility unit	*Support and strengthen delivery of permanent methods*
Strengthen prov. of temp. methods Depoprov, IUD	*Support and strengthen deliv. of temp. methods*
Strengthen follow-up care of acceptors, both categories	*Strengthen follow-up care of acceptors both categories*
Strengthen basic MCH serv. in the FP/MCH Project	*Develop and strengthen MCH in the ICHSDP*
Strengthen logistics supply system (contraceptives and MCH essential drugs)	*Strengthen monit. and supervision of service delivery and logistics supply system (coord. also with NEP/80/P14)*
Strengthening operational management im MCH/FP	
Strengthening of training of various levels of pers.	*Improve coordination of service and IEC activities*
Strengthen CP in act. of MCH/FP project through CHLs, local communities and NGO activities	*Strengthen community and NGO particip. in all aspects of MCH and FP of ICHSDP*

Besides the two UNFPA projects specified above, the country program also includes other projects defined in relation to the same implementing agencies.

Between different UNFPA projects with same implementing agency there is stronger coordination than between similar elements supported by different donors.

Both projects have since 1984 been assigned Columbia University as technical backstopping/executing agency. Their role has mainly been in training and the development of MCH intensification strategies. A short term logistics advisor has also been provided.

Several donor agencies have taken an interest in management issues with focus at district and central levels. Logistics is also addressed by a number of different groups. MCH activities are developed in different ways by different donor inputs as also described previously.

The performance of the two projects is difficult to evaluate. A generally expressed opinion is that FP/MCH (P13) is well managed with a reasonable performance in administration of surgical contraceptive services. Yet there is a concern for better integration with permanent health services infrastructure particularly district hospitals and a better balance between temporary and permanent methods. ICHSDP (P12) has had strong managerial problems due to unclear administrative authority and the wide variety of tasks to be integrated within the various levels of the system.

It is clear however, that support through P12 and P13 has been essential for the two implementing institutions in order to make available at least very basic services for FP in most districts of the country, as well as basic primary care and MCH care in more limited areas.

c) Operational planning, monitoring and reporting

Yearly workplans with specified targets and tasks are discussed at the time of the tripartite reviews and agreed upon between the UNFPA and the executing/implementing agencies.

The workplans follow the outlines in the project documents, and are put together by the implementing agency at the time of their regular planning cycle, to ensure that budgets are forwarded and included in the nationally approved budgets.

The TPRs constitute the time when negotiations re reallocations and changes in project components can take place. With the rather centralized decisionmaking of UNFPA, there is limited flexibility during the rest of the year.

PPRs are normally done twice a year by the executing agencies following the standard UNDP format. Monitoring and reporting is done according to the workplan categories and is generally concerned with budget flow and status of project inputs. Functional aspects of the projects in relation to total performance of the implementing agency, interactions and consequences have received little attention.

In projects like P12 and P13, where the support is to elements of a wider program, seing the UNFPA supported projects in isolation does limit the usefulness of the monitoring exercise, particularly from the point of view of the implementing agency.

In-project monitoring is done to meet UNFPA reporting needs, and is seldom used for management purposes within the implementing agency itself.

In general therefore, project monitoring and reporting procedures mainly constitutes a tool for UNFPA to identify status of the projectinputs in relation to the workplan and project document. As such it is useful and does serve to point out major bottlenecks and measure overall absorptive capacity.

d) Financial and Funding Procedures

The contribution of Norway to the two projects is (including the proposed expenditure for 1987):

NEP/80/P12 (since 1986) US$ 501 785:-
NEP/80/P13 (since 1981) US$ 4 502 733:-
(See also annex)

The total UNFPA contribution including UNFPA regular funds multibilateral contributions since 1980 amounts to

US$ 18 502 060:-. (See annex)

There is a considerable underutilization of funds in most projects. Thus, for example, P12 has a balance at the end of 1986 of 43% of the budgetted amount. P13 has a balance of 36%.

It is revealing to study the trend over the past few years of the absorptive capacity of HMG implementing agencies to spend funds locally released:

Percentage of Exp. Against Available Funds for Entire Year

Annual Program	1980	34 %
	1981	54 %
	1982	50 %
	1983	60 %
	1984	60 %
	1985	66 %
	1986	68 %

Such underexpenditure depends mainly on two factors. One is that in projected funds for cars and buildings have not been utilized. Secondly - and related to the above - the procedures of HMG are not very effective. The low implementation capacity of the implementing agency and the cumbersome financial rules of the HMG must thus be taken into account at the future programming exercise.

The financial flowchart in its original form looked somewhat like this.

1. Implementing agency (or executing agency) prepares a request for an advance of funds for the project,
2. the request is sent to the Ministry of Finance for approval,
3. MoF sends the request to the local UNFPA office,
4. the Programme officer and/or the DERSAP decide to release funds (in the case of an executing agency this decision has to come from the executing agency HQs which is a 3-4 months operation),
5. the UNFPA local office releases a cheque to MoF in N.Rs,
6. the MoF sends the cheque to the Comptroller General's office,
7. the implementing agency requests the Comptroller General to issue cheques to the district offices (step 6 and 7 takes about 3 months),

8. the Comptroller General divides UNFPA cheque into appropriate amounts and
9. authorizes the District Officer to disburse the funds,
10. the Project Officer can then collect the funds if he produces records and receipts for past expenditure and a projection of expected expenditure,
11. funds are released.

In 1985 the system was somewhat shortened and step 5 was deleted. UNFPA could then send cheques directly to the Comptroller General's office for further disbursement.

A further streamlining of the system could be achieved if UNFPA could be allowed to prepare the cheques and send them directly to the District Office while informing the MoF and the Comptroller General's office.

The steps outlined above - minus step 5 - takes about 6-9 months.

Equipment is usually requested through the UNFPA office - after the appropriate budget discussions and approvals at TPRs and in the New York HQ. The UNFPA office furthers the request to the UNFPA New York HQ who transmits the requests to, for example, UNIPAC in Copenhagen. The supplies are then delivered by air to the MoH. It has happened that this procedure has takenb 19 months from the ordering of medical supplies to the delivery in Kathmandu.

Purchase of cars has to be agreed upon by the MoF even if there is a budget provision for a vehicle. Vehicles are then ordered through the UNFPA HQ through the usual UNDP procedures and channels. The vehicles are delivered in Calcutta and driven to Kathmandu. 6-9 months delays are not unusual.
To purchase vehicles tax free locally would increase the cost of example a Toyota by US$ 2-3000:-.

Other problems involved are:

- weak reporting systems on expenditures and sloppy recordkeeping especially at the district level,
- the many system delays which prevent the full use of funds within the budget year,
- a peculiar process by which the MoF freezes funds (or uses them for other purposes) and where the MoF is not releasing funds until there is a fresh UNFPA advance in spite of existing balances,
- an unwillingness to return unspent balances at the end of the year.

In 1985 the UNFPA office introduced a variety of controls i.a. deducting exiting surpluses - if they can be determined - from the new advances, and applying specially stringent criteria is also a joint monitoring team consisting of UNFPA and the Comptroller General's office to provide assistance to projects. The introduction of computers has also helped to facilitate monitoring.

e) MDC participation at different stages in the program cycle

The reasons for selection of P13 and later P12 for Norwegian multibilateral support are not alltogether clear from the documents available.

P13 was one of the major service delivery components of the country program and as such well in line with MDC criteria for support. P12 a parallel program with another implementing agency, therefore strengthening the focus on service delivery support.

MDC participated in the main MTR-meetings 18-26 jan.1983, and a brief report was made from the proceedings of the meetings.

TPR reports and PPRs have been received regularly by MDC.

The administrative and professional involvement in the project has therefore been minimal from the norwegian side. One has agreed on a project for funding, and accepted that the administration and implementation was the full responsibility of UNFPA.

One could argue that this level of involvement has left little room for meaningful interaction with UNFPA as a partner, and little opportunity both for influencing policies and for institutional learning within MDC in the complex field of population.

Yet, given the limited capacity of MDC, the arrangement has provided some opportunity for interaction and somehow a norwegian identity in the project.

Looking at the program cycle, it seems that the time of programming and the midterm review would be essential opportunities for participation by the multi-bilateral funding partner. This would provide the opportunity for an overall understanding of UNFPAs countryprogram and the interaction with various agencies.

It would also be the time when policy issues are discussed and conditions laid down for involvement. Only after this kind of participation can a meaningful selection of projects for support take place.

After the projects are identified and formulated, very limited involvement should be necessary in the ongoing monitoring and reporting.

To the extent possible, norwegian participants to main events like programming and MTRs, should be sufficiently familiar with population issues so that professional contribution to the process itself can be made possible, and feed back to MDC can be useful for overall institutional learning.

f) Specific issues

In the review of P12 and P13, some specific issues emerge which in a particular way have implications for ongoing assistance in the area of population and service delivery:

- Incentives

From the early start of external assistance, FP efforts in Nepal were supported by a system of provider and client incentives. Although the motives for the introduction of incentives in a situation of low interest an acceptance are easily understood, the long term negative consequences have become more and more evident.

UNFPA have taken a policy decision not to budget for provider incentives from summer 1988.

The whole strategy for service delivery of permanent contraception have been made dependent on provider incentive payment. It has caused imbalances in overall service delivery, but also ensured a certain emphasis on FP among a number of competing tasks and interests. Withdrawing this extra payment may cause a lot of dissatisfaction among the health professionals involved, and also lead to a drop in performance.

This situation does underline the vulnerability of a national system to changing donor strategies. In principle, the UNFPA decision not to support such payments any more is sound. On the other side, it was the donors who originally introduced the incentives, and it must be a donor responsibility to work out with their national partners a viable alternative strategy.

- Institutionalization

There is currently a deliberate move away from mobile services through camps towards permanent services in district hospitals of an acceptable standard and well integrated with other hospital services.

This concept is well accepted in principle, but progress has been slow in actually ensuring facilities and continuity in staffing at the permanent service delivery points.

There has been structural barriers in the system to an effective institutionalization, as FP services have been administered differently than the regular hospital services. Hospital staff have not easily accepted responsibilities in relation to the FP chain of command, and facilities for FP services have not easily been made available for other purposes, even though present in the same hospital compound.

It seems important that this area be further studied and explored as part of the institutionalization process, so that functional aspects can be properly addressed at the same time as physical facilities are being developed. Even with the new reorganization of health services, these structural and attitudional barriers will not automatically be resolved.

- Targets and service delivery

As previously pointed out, policymakers and service providers find it hard to come to a common stand on targets which are both desirable and achievable. This is an ongoing tension which cannot easily be resolved, but were the aim must be to come sufficiently close together so that targets in themselves do not become destructive.

As one faces a considerable backlog in relation to sterilization targets, a tendency is to shift the "overflow" to temporary methods.

Yet little is done to realistically assess capacity for delivering temporary methods, nor for assuring reasonable continuancy rates.

This will therefore most likely backfire in the years to come, by finding little impact on fertility levels in spite of high input.

FP targets have been receiving much more attention than other service delivery targets. This again has caused some imbalance in overall prioritisation among tasks, and should be considered as part of the discussion of MCH service intensification strategies.

If one believes in a stronger emphasis on MCH this needs to be made visible also in the targets and indicators for achievement and thereby also in recognition of staff performance.

- MCH service delivery

Current UNFPA strategies and planning documents stress the importance of the MCH component. Some promising experience with MCH intensification is also taking place at present in a number of districts. Care must be taken to ensure that these efforts are firmly rooted in the realities of the service delivery system, affordable and flexible enough to be adapted to the different local situations.

The ANM has a key role in the decentralized MCH services strategy on the Terai. The uncertain future of ANMs, the difficulties in posting to a village situation and the problem of mobility must be taken very seriously. It is impressive to see ANMs mobile on bicycle in Terai villages, but hard to see how this can be a solution long term and on a wider scale.

Functional links between ANMs, different types of village health workers and community volunteers should not be taken for granted, but be a matter of constant concern and a focus for team building efforts.

- Decentralization and district level management

Better integration between MCH and FP activities and between district hospital and rural health post services may be achieved through the reorganisation and the proposals for decentralized decisionmaking at the district level. Support to ensure proper function of the referral chain and the district health team should therefore be a key concern for future programming.

2.4.5 *General Assessment*

a) UNFPA assistance in relation to national needs, programmes and policies. Relevance and consequences.

UNFPA is the leading agency on the population scene in Nepal, and has been instrumental in raising awareness, supporting policyformulation and building capacity for a comprehensive population approach in the country.

The HMG/UNFPA Country Program strategy is relevant to national needs and consistent with national policies in that it seeks to combine an expansion of the knowledgebase, awarenessbuilding, demand-creation and service delivery.

Projects are however to a high extent defined outside regular sectoral development activities, which make integration and phasing into the mainstream of national development a problem. Whereas in the health sector this does not apply in the same way, support to selected elements of the service delivery system have caused imbalances and some fragmentation.

Weak national coordination capacity combined with limited practical UNFPA commitment to internal mechanisms for national coordination, makes it difficult to use the integrated country programme strategy to its full potential.

The magnitude of the population problem and the low absorptive capacity for external assistance makes it extremely important to set priorities and plan realistically. Up to present programming has been too ambitious and possibly initiatives too scattered to make the efforts sufficiently rooted in national realities. This has led to some sense of apprehension, vulnerability to changing aid priorities and some activities which are not viable once support is withdrawn.

The main achievement of the support to the health and population sector has been a major attitudinal change in relation to FP interventions and the urgency of population management. Likewise a basic infrastructure for service delivery has been established, and reasonable national capacity for population research and monitoring has been built up.

b) UNFPA administrative performance

UNFPAs role as a fund and not an executing agency has caused some difficulties in project execution. Some delays in program implementation has been caused by the appointment of executing agencies as intermediaries and the arrangements have also not provided the kind of technical advisory capacity as sometimes has been required.

Programming, monitoring and evaluation procedures are well established and serves the UNFPA managerial needs, although they are less useful for management purposes within the implementing agencies and national coordinating bodies.

Discontinuity in staffing of senior posts (DSRAP) have caused some disruptions in relationships and made a heavy demand on the national UNFPA programme officers. In spite of this the UNFPA team in Nepal have been able to ensure a consistency in direction and overall continuity in the program.

Constraints in the financial flow are mainly contributed to factors outside the direct influence of UNFPA.

The centralized decisionmaking within the UNFPA system makes more flexible approaches difficult. This has however not been felt to be a major cause for delay in program implementation.

c) UNFPA and Norwegian Assistance to Nepal

The rewiev of UNFPA as a channel for norwegian support to Nepal's health and population sector affirms that policies and strategies are consistent with norwegian principles and policies for development assistance, and that the agency has an important role to play within the overall population and development sector in the country.

The importance of coordinated strategies in this area of involvement supports the choice of UNFPA as a channel for norwegian assistance.

Clearer MDC criteria for selection of projects within a country program and sufficiently strong Norwegian representation at critical stages during the program cycle such as programming exercises and MTRs, would make the level of cooperation and interaction between MDC and UNFPA more meaningful and give a platform also for participation in policy dialogue and shared learning.

2.5 PROJECTS IN NICARAGUA

2.5.1 *Introduction*

a) Summary of field work

A field tour was undertaken in Nicaragua from July 27th to August 7th 1987 to study the UNFPA supported project *Extension of the Coverage and Improvement of the Quality of Maternal and Child Health and Family Welfare Services.*

The project is a programme support project consisting of key inputs to the national governmental MCH programme of the Ministry of Health (MINSA).

The schedule included a number of meetings and interviews with key administrative and programme directors of the MINSA and agencies involved, notably the Pan American Health Organization (PAHO).

We had the opportunity to review relevant documents. We were able to visit a few hospitals and health centers, but without any careful selection of sites visited, in order to get some impressions only of the health system structure below the central (national) ministry level. Appended is a list of persons we met and sites visited.

Our mission was facilitated by Nicaraguan flexibility, openness and willingness to cooperate and help us to carry out this study. The spirit of self-criticism and the eagerness to point out shortcomings and failures, found among many key MINSA staff members, are attitudes that are of some project development relevance and thus worth while mention.

In this report we have been mainly concerned about performance and achievements in an administrative-organizational context. The project is a not too uncommon *programme support package* consisting of key inputs to a national MCH programme: Personnel, equipment, training and subcontracting. Imported equipment alone takes nearly 63% of the total 4 year project budget of USD 6 million. The two main components of equipment and training total 86% of the budget and are spread out administratively and geographically into the national MCH programme.

Logically, many of the problems in the execution and implementation of the project are those of public administration and not a specific health sector problem. To improve public administration is probably one of the main challenges in the Nicaraguan government's development efforts. Of importance, then, is how external agencies perceive, relate and react to development problems of this nature.

b) Health, Population and Development in Nicaragua

There were significant improvements in health conditions after the 1979 revolution. These improvements are, however, today seriously threatened by deteriorating living conditions for most Nicaraguans. Nutrition is affected by the last years increased poverty. An increasing number of Nicaraguans have not access to what is considered their traditional basic diet.

Nicaraguans of today are living in an uprooted situation where highly unstable and worsening employment opportunities combined with rather strong internal migrations, are perhaps the most visible effects. What was named a survival economy a few years ago is now definitely in crisis if not on the verge on collapse, with very little resources left for development. Several factors together will account for this situation, one of them being the war.

The first years after 1979 were marked by the rather impressive efforts to improve health and education. There were large scale immunization and literacy campaigns, campaigns that were carried out through a good portion of popular (mostly youth) voluntary participation, In health, primary health care was given high priority. By 1979 more than half of the infant population (under five) suffered from some degree of malnutrition, and diarrhea and other preventable infectious diseases were the first cause of death.

The infant mortality rate was reduced from a high of more than 100 (some sources estimate 120) per thousand live births in the 1970's to around 80 (varying estimates from 75 to 85) in 1984/85. Life expectancy at birth increased from 56 (1977) to 60 years (1984), and the general mortality rate is now around 10 per 1000 inhabitants.

The total population numbers today 3.5 million, with a total growth rate of 3.5. The total fertility rate is close to 6. Around half of the population is under 15 years of age. All together, Nicaragua can be characterized as a country with a young population, high fertility, accelerated population growth, high mortality and a very high infant mortality.

The population growth is not in itself considered a serious problem by the country's authorities. Over the last few years, however, there is an increasing concern over the regional biased distribution of population and population growth. But the principal population concern of the government remains that of health: the high levels of morbidity and mortality.

The high fertility constitutes a serious health problem under present circumstances in Nicaragua. A very high portion of pregnancies is considered to be high obstetric risk cases. A large number of pregnant women are under 20 and over 35 years (more than 20% of all mothers are under 20 years of age).

Approximately 60% of the population is urban, and this percentage is increasing. The above mentioned strong internal migrations are changing the urban-rural structure of the country. The migrations are basically from the countryside to the towns and cities, and above all to the Managua capital area. It is, thus, also a migration from agriculture to the informal trade and service sector. There are also, naturally, war displacements, but these, although important enough in the high number of affected, are to a large extent intra-regional and of less importance than those rooted in the economic situation of the peasantry.

The Managua area has now more than 30% of total population, which leaves Nicaragua as one of the most urban biased countries in Latin America. Three Pacific neighboring regions (Managua included) concentrate more than 60% of total population, and more than 70% of total population growth. The fertility rate of those who migrate to urban areas are higher than average (countryside fertility traditionally higher than urban in Nicaragua as most places), they have the poorest living conditions (housing, water hygiene, etc.).

The migrations strongly contribute to the general deteriorating living conditions of Nicaragua posing a serious threat to the health, while resources available for development are shrinking.

2.5.2 *MCH and Nicaraguan Health Programme and Policies.*

a) The Nicaraguan Health Programme and Policies

Few days after the revolution, July 19, 1979, the Sistema Nacional Unificada de Salud (The Unified National Health System, SNUS) was created, or declared. SNUS is not an institution with an administrative structure, - it is a system defining the principles, institutions and functions of health care in Nicaragua. In short, SNUS was the way the health sector was defined.

The 1979 SNUS declaration on the basic principles of health care states that health care is not only for all Nicaraguans (in itself a dramatic change from the past) but also accessible to all. The health care is preventive-curative and should be a planned activity within a non-vertical programme structure. The health care should be performed by multi-professional teams and realised through popular participation.

The popular participation part has, in spite of good intentions, met an inherited hierarchical mentality which has dominated the implementation of health programme activities. Over the last couple of years, however, some changes have been on its way but this takes the form or decentralisation of the previously highly centralised government health structure. The stated policy is to regionalise health authority and implementation.

Since todays effects of development in Nicaragua pose a more serious threat to health than seemed to be the case 3 or 4 years ago, one of the main stated objectives of the 1987 National Health Plan is to prevent the (further) deterioriations of the health situation. Since Nicaragua cannot expect an increase of resources for health development, another specific objective of the 1987 Plan is to find ways to increase the efficiency of existing installations and human resources. There are no realistic plans to increase the number of health institutions (hospitals, health centres and posts). The main challenge is to maintain those they already have. The objective of efficiency in the use of existing resources refers to the tremendous problem of public administration in Nicaragua, which we will return to several times in this report.

When it comes to main target groups, it is worth while noting that soldiers and other army personnel have been a very high priority. This is not only out of the obvious need to take care of the wounded, but is also a political priority. Like most ministerial plans, the MINSA plan clearly states that a general political objective is to increase the capacity of the population to defend the revolution which under present circumstances means participation in the war against the insurgent *contra* forces. This might be seen as nothing but a description of a harse reality, and there is no doubt that the war, including its destructions of health installations, takes too much of the present limited resources available for health. Another warrelated problem is that the population of the war zones receives little health care services due to the inaccessibility of these areas.

Other by MINSA listed target groups are production workers, peasants, Atlantic coast indians and the mother-child population with special reference to children under one year of age.

As already mentioned, mother-child health care is of a very high priority, and most of the resources within primary health care are absorbed by MCH. The MCH policy is clearly preventive orientated.

The preventive health measures of hygiene are given a high priority in the attempts to halt the deterioriation of general health conditions. Drinking water supplies and sanitation are serious problems in Nicaragua. Access to drinking water improved after the 1979 revolution, but is still a largely unsolved problem with serious health implications.

The epidemiological situation is probably worsening. Studies show that the earlier immunization campaign did not have the effects that were hoped for. Although much was achieved before 1984 in the control of polio, tuberculosis and even malaria, there are signs of a slow development towards a pre-1979 situation. This is also the case of several preventable infectious diseases. In this report we have not been able to assess such questions, but the 1987 Health Plan states the need of increased immunization, the only exception being anti-polio and BCG. There are, for example, expectations of an increased number of tuberculosis cases. In general, the present policy is to prevent the (expected) increase of new cases.

The international assistance part of the 1987 Plan presents a budget totalling USD 10.7 million, loans and credits excluded, in which UNFPA and UNICEF assistance to MCH amounts to USD 2.5 million and USD 0.6 million in general PAHO support.

Given the problem of efficiency and public administration, the plan stresses the need to take organisational measures to achieve a better utilisation of external funds.

The 1987 Plan for international assistance of cooperation aims at 55 % in imported equipments and materials, and 35 % for scholarships and training.

The need for imported equipment reflects one of the main economic problems in Nicaragua, the nearly complete lack of foreign currency and the incapacity to produce locally what is needed to survive under present circumstances.

b) The Health Sector Structure

Since the government in principle covers all aspects of health care, and since the private sector *infrastructure* is relatively insignificant, the institution within SNUS of main interest to this study is the MINSA.

Although constantly subject to modifications and even reorganisations, the MINSA at the central government level has a functional structure along the lines of modern governments, reflecting the main priorities in health programmes and the administrative functions.

The structure below the central MINSA is at three levels, geographically classified as *region*, *area* and *sector*. To each level corresponds different health infrastructure units with different health care and treatment capacities.

Nicaragua is divided administratively into 9 geographic regions (e.g. 6 regions and 3 so-called special zones of the Atlantic Coast). Each region has its government where the central government structure is repeated (for instance MINSA regional, region II). The delegates to the regional governments have the rank of minister, and there has been an ongoing process since 1984 to transfer more executing authority to the regional governments. The aim (of interest here) of this regionalisation is autonomy in development planning and budgeting. (Defense, foreign policy and foreign trade including monetary policies are not subject to regionalisation). MINSA intends to regionalise budget control and accounting from 1988. There is already a tendency that international development agencies relate directly to regional governments. In 1986, however, the central government issued a decree stating that all development projects with external financing should be reviewed and approved at central level by MCE.

The MINSA health care institution at the regional level is the *hospital*. There are at present 28 health infrastructure installations classified as hospitals in Nicaragua, 9 of them in the Managua region with more than 30% of the population, and one each in the three special zones.

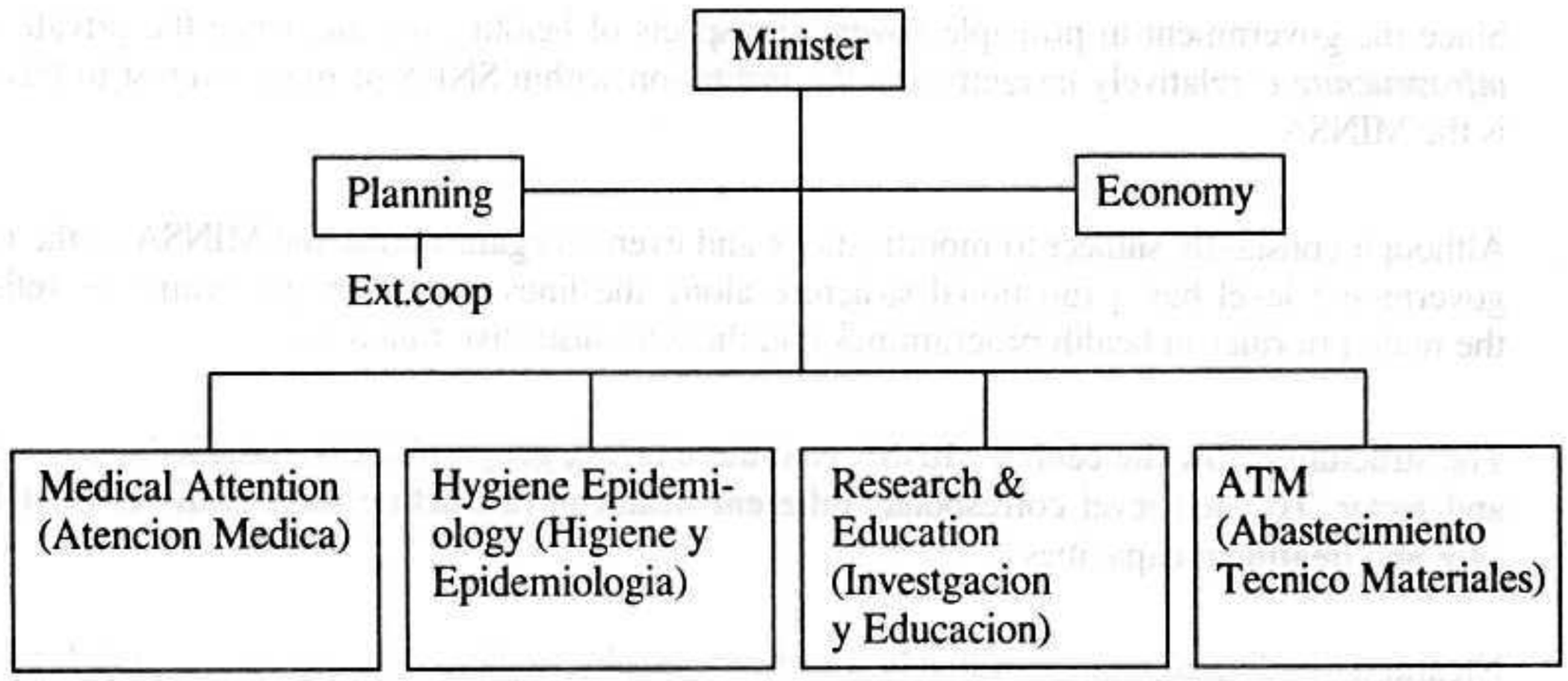
The regions are divided into *areas*, called the local level. The health care unit is the *Health Center*. Each area has its Health Center, and the population in one area vary from 25 to 40.000. A Health Center has its own administrative unit reporting to the regional MINSA representative, and a varying number of MD's, nurses and so-called *brigadistas* (community trained volunteers).

Normally, health centers are without beds. Over the last years, however, MINSA has provided some of the health centers with beds, due to insufficient hospital capacity. Moreover, MINSA has realised that they will not in the foreseeable future have access to the resources to build more hospitals.

There are today 103 health centers in Nicaragua, 22 of them with beds. The two special zones II and III do not have health centers with beds, and Managua region has only one due to better hospital coverage than other regions. All together Managua region has more health centers than other regions, but the distribution is not biased compared with the two other most populated Pacific regions II and IV.

Each area is divided into *sectors* where we find the *Health Posts* (Puestos de Salud). The health posts are administratively related to the corresponding health center. In practice, the health post is an extension of the health center. Equipment and drugs are distributed through the health center. At the sector level, the population shows, logically, strong variation, but an average of 5.000 will provide an idea of the size. The quality and capacity of health posts vary a lot. There are around 400 of them in the country, less in Managua than in other Pacific regions.

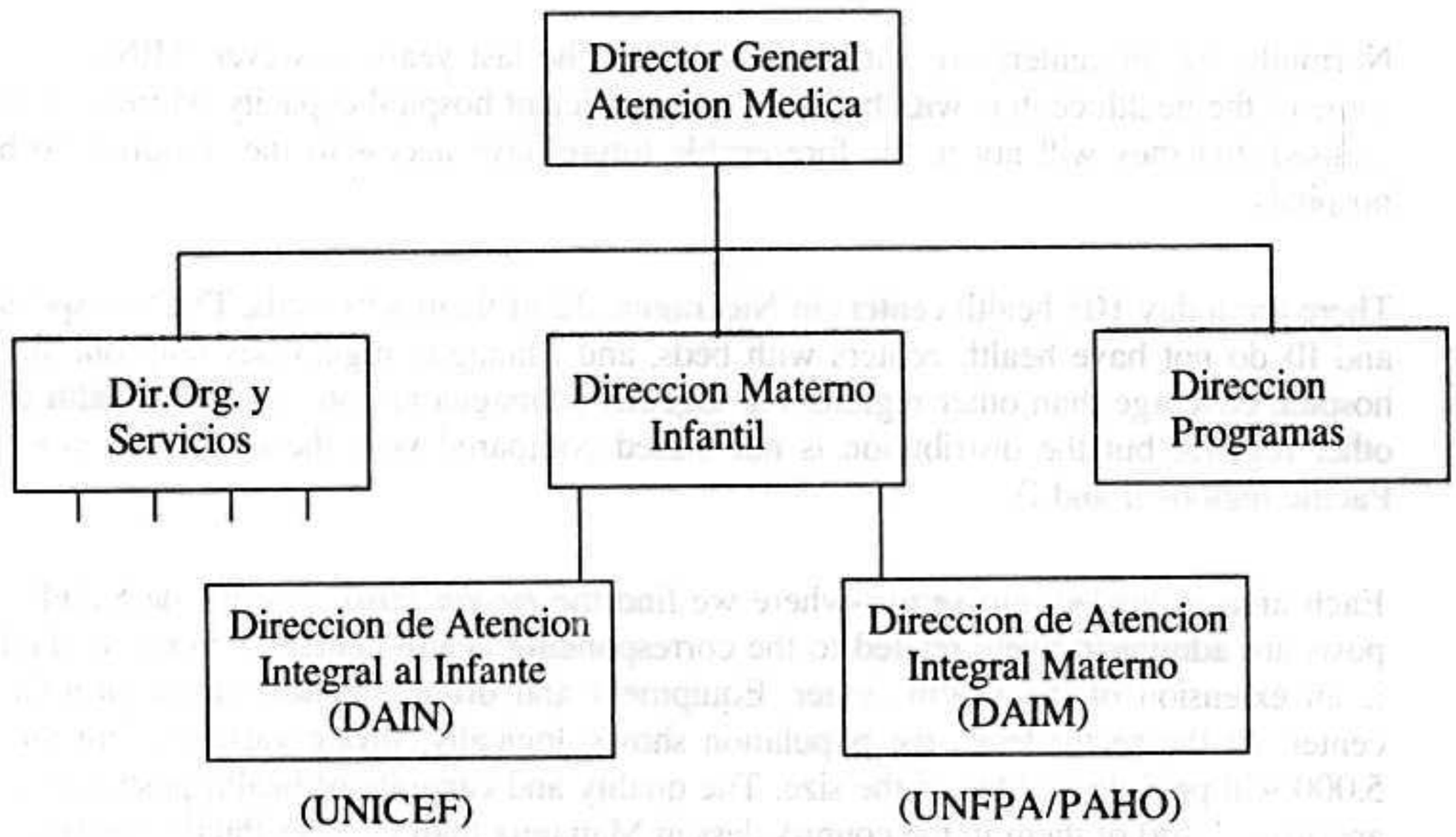
The central MINSA structure is, however, more important to this study:



The planning division is supposed to have an overall coordination function in relation to the programmes of the ministry. The planning division consists of the units of *planning, research and statistics* and *external cooperation*. Especially the unit of external cooperation is of interest here. It is supposed to be the unit in the ministry that presents projects for external funding, and that coordinates the relations of MINSA with international agencies. The latter function should, however, be performed through the Ministry of External Cooperation (MCE) since its mandate is to centralize all coordination with international agencies and organisations. In institutional terms the unit of external cooperation of MINSA is supposed to be a sectorial extension of the MCE. But it does not always work that way. The case of the MCH project is an example of this.

The four divisions of Medical Attention, Hygiene and Epidemiology, Research and Education and the ATM are the main divisions, called *Direcciones Generales*. The first two are the substantial ones and the two latter are support divisions. The Direccion General is headed by a director general with the rank of viceminister.

The director general of Atencion Medica is the responsible director of the MCH project. The structure of the Direccion General de Atencion Medica (DGAM) is as follows:



The first observation is the importance, reflected in the structure, of the MCH programme, - the only programme with its own direccion. Secondly, the functional division of mother and child. (DAIN: Direccion de Atencion Integral al Infante, DAIM: Direccion de Atencion Integral Materno). The division into DAIN and DAIM was the result of a restructuring of DMI (Direccion Materno-Infantil) in 1985-86 in order to, we were told, facilitate administrative procedures. The DAIN programme is supported by UNICEF with mainly Italian funds, and the DAIM programme through UNFPA/PAHO with Norwegian and Finnish funds. Thus, the coordination between UNICEF and UNFPA/PAHO appears to be an important part of the total external support for the MCH programme.

c) The MCH Programme

The MCH programme's *long term objectives* are those of improving the quality of and to extend the maternal and child health and family planning services throughout the country.

The MCH programme is basically a programme concentrating on medical aspects of pregnancy and birth, based on the urgent need to reduce mortality and morbidity of mothers and children. This is clearly reflected in the practices and activities within the programme, as well as in the programme documents.

Improving the quality and extension of services is very often interpreted as *increasing the effectiveness* of both the system of provision of services (the MINSA structure) and the health care activities themselves. Improving the quality, however, faces a problem: the need for systematic knowledge of the health situation and the use of this knowledge. The MCH programme policy of a *Risk Factor Approach* should therefore be considered very important and highly relevant. The use of the Risk Factor Approach will ideally permit an extension of services, since MINSA will not be able to offer the same quality of services to all Nicaraguans all over the country.

The maternal population, women of child-bearing age, is defined as women between the ages of 15 and 49. The child population is of ages between 0 and 6 years, although in some situations this age is extended to 15 years. The latter seems to refer to general long term objectives, while the 0 to 6 years refers to the objectives of the present MCH programme.

Among the *immediate objectives* of the programme, the elaboration of precise diagnosis of the obstetric risks, through the Risk Factor Approach, is of high priority. Closely linked to this is a second objective, which is training of traditional Midwifes (Parteras Empiricas) for the attention of low- or non-risk childbirth. This is an important - and well-thought - part of the MCH programme, and will be explained more in detail below. A third objective is to prevent new pregnancies of women seriously exposed to obstetric risks. There is, as mentioned earlier, no stated policy in Nicaragua to reduce overall birth rate or population growth. *The family planning activities are geared towards those exposed to obstetric risks.* This is how the ongoing activities should be interpreted, although MINSA staff does have a wider social and political view on family planning, extended to the women's right of self-determination. But family planning can hardly find any response among a sufficient number Nicaraguans on this basis.

The MCH programme started in 1979, but it did not become an organized and coordinated programme before 1985. During the years 1979 to 1985 a lot was achieved in the field of health in Nicaragua (for example a notable reduction in infant mortality rate), but through campaigns (like mass vaccinations) and increased activity and concern, rather than attacking the problems in a systematic and organized way based on knowledge and specific diagnosis of target groups. The set of six strategies adopted by the government (MINSA), defining the extension of the MCH programme to the second period, 1985-88, reflects the need to increase efficiency and effectiveness in the utilization of available resources. It is tempting to say that the Nicaraguan

problem is not the lack of medical knowledge, but the organization of this knowledge into efficient methods of implementation. During 1984-85 the MINSA took important steps in this direction, through major reorganization measures in the administrative apparatus.

The most important method towards the development of a efficient programme is the *Risk Factor Approach* (Engoque de Riesgo, RFA). The RFA is based on a simple statistical survey defining the factors and combination of factors producing degrees of obstetric risk. The results of such a survey is considered a necessary tool for pre-natal controls and pregnancy follow-up treatment in health institutions. But it also permits the MINSA to separate high from low obstetric risk cases in order to differentiate treatment and medical attention.

In the present situation 60% of all childbirths are domestic. The problem, however, is that about 70% of domestic childbirths are considered high pre-natal and obstetric risk. Of the 40% hospital childbirths only 40% are high risk. Given the limitations of resources, the strategy of the MINSA is to find ways to channel all high risk cases into the hospitals and all the low risk cases into the domestic sphere.

Most domestic childbirths today are attended by Traditional Midwifes (*Parteras Empiricas*), self-taught-by-experience-midwifes, without any formal training, very often women that have been through a number of childbirths themselves. They are, by the MINSA (and certainly by all hospital MD's), not considered qualified for high risk attention. On the other hand, the midwifes are considered a valuable resource for the Nicaraguan health system.

As of today, the midwifes are not integrated into the health care system. There are as a rough estimate 3 to 5.000 midwifes in Nicaragua, most of them in the countryside. The MINSA has so far been able to get in contact with 500 of them. The midwifes that one manages to "capture", are offered a ten days training course. The objective of integrating them into the system means close contact with the hospital in their district. Cooperation and coordination between hospital and midwifes is what is hoped for. Since it might take some time before the objective of channeling all high risk cases into hospital care, close cooperation with midwifes is seen as the best strategy. It is today not possible to say whether the midwifes will in sufficient numbers respond to the MINSA call for training and cooperation.

There are, however, different opinions among MD's in Nicaragua on the role of the midwifes. MD's, especially in hospitals, are critical to the policy of integrating the midwifes at all, since they are not considered part of a competent and responsible health care system.

The problem of *institutional midwifes* is that *they don't exist* as an MD-independent profession for childbirth attention. There are, although in an insufficient number, *obstetrical nurses* assisting the MD's during hospital childbirths. In Nicaragua the MD's attend *all* childbirths in hospitals, whether high or low risk. It seems to be a waste of resources for MD's to attend normal low risk childbirths.

Education of nurses in general, of different specialties and at different levels, is an important part of the MCH programme. The importance given to training of personnel at this level, is a clear indication of the MINSA priorities in this field. The education of nurses has, however, entered into serious problems over the last couple of years. There are increasing problems of recruitment of students, and a growing tendency that educated nurses leave their work. These problems are due to two well-known reasons: low wages and family problems, the latter because there are no nursery for children in a situation where many of the students and nurses are single mothers. This situation, seriously felt from 1984 and onwards, produces problems of quality of nurses since student entrance requirements has been reduced in order to counteract the tendency of falling recruitment. Nearly all nurses and nurse students are women, and the issue of low wages and nurseries should be considered in the context of the general women issue in the government policy.

The women should play, as *organized women*, a very important part in any MCH programme. This is surprisingly *not* the case in Nicaragua. The MINSA has not consulted organized women, the women's associations in Nicaragua, on the MCH programme. They have never been consulted in the planning and design stages, nor in the formulation and implementation of the programme. The MINSA programme responsible admit that this is contradictory to the general policies of Nicaraguan development and that they should consult women's associations and invite to closer cooperation. The MINSA itself, in documents and elsewhere, gives importance to the role of popular participation in the health programmes. It is, however, given the climate in Nicaragua, no reason to believe that the women issue has not been considered carefully within the MCH programme or other health programmes. The question raised here is on organised women integration in the programme. It is, however, difficult to say whether such integration would have changed anything in the philosophy or strategy of the programme.

The *family planning* part of the MCH programme has showed much less progress than the medical health care part. Family planning has faced some take-off problems since 1979. Before 1984 no attention at all was paid to family planning in Nicaragua. As mentioned above, this is due to several factors: there is no government policy of general population control in Nicaragua and family planning faces obstacles in the attitudes among Nicaraguans due to religion, culture and male domination, *machismo*. The only way to justify family planning in the Nicaraguan religious-cultural context is to refer to obstetric risks.

The main activity within family planning has been the increased accessibility of contraceptives in the health sector institutions including the advice and information offered by health care personnel. The main approach, then, is medical. The MINSA, however, plans to start a more intensive non-medical family planning in some areas of the country. Since they don's consider Nicaragua to be over-populated but characterized by an extreme biased distribution of population, the family planning will be concentrated to the areas of high population density (regions II, III and IV).

Abortion is a very sensitive issue in the very religiously conservative Nicaraguan society. Although many within the MINSA would probably welcome legalized abortion, they don't expect this issue to be discussed seriously for a long time. The way to confront this problem is through education and information hoping to change the attitudes within 10 or 20 years.

Today, provoked abortion services are offered in hospitals on strict medical criteria. The probability that the woman will die must be fairly high. Even in such cases, many hospital doctors refuse to perform the surgery, but they seem to accept that other doctors do it. There are, however, reasons to believe that in some hospitals or among some doctors less strict criteria are applied since many doctors and hospital administrators have a more secular and political-moral attitude towards the problem. An increasing number of women demand abortion in Nicaragua.

Sterilization as a family planning method should be mentioned. In fact, sterilization of women (and a few men) seems to be an important method in Nicaragua and performed in most hospitals where there are at present waiting lists of more than six months. Sterilization is offered, however, according to some relatively strict criteria of age (more than 30) and number of children (3 to 4), and the husbands approval. The latter restriction will be abolished before the end of 1987.

The MCH programme is horizontally organized within central MINSA, reflected in its administrative structure. The *Direccion General de Atenccion Medica* has the overall programme responsibility of planning and implementation, and implements itself the medical part throughout the health sector structure of hospitals, health centers and posts. The *Direccion General de Docencia y Investigaciones* implements the research, training and education part (workshops, training of health personnel, education of nurses, training of brigadistas, and information in general). The *Direccion General de ATM* distributes equipment, drugs and contraceptives to the health institutions according to the programme plan. This means that the whole MINSA central

structure is involved in the implementation of the programme, which also means that the programme performance and achievements depends on the administrative capacity and effectiveness of most MINSA divisions.

The *popular participation* in the MCH programme consists, as of today, basically in training brigadistas and their participation in the health care at the health center and health post level. The brigadistas are ordinary barrio-people working in health care on a voluntary basis in their area. The popular participation is also reflected in the participation in workshops organized by MINSA and in the gradual activisation of health care councils of popular organisations at local levels, the latter being part of the attempt to decentralize governmental implementing responsibility. Until now, popular participation has not been of real importance in the planning and implementation of the programme. The programme has been hierachially organized in the sense that the central MINSA designs and decides, and orders are carried out downwards through the system. The rethinking and reorganization in 1984-85 might lead to a more real popular participation in health programmes, but so far this has not been the case.

2.5.3 *Norway, UNFPA and UN assistance to Nicaragua*

a) Norway and the UN System Assistance

We will try to assess the position of Norwegian funds within the UN System Assistance to Nicaragua. This is somewhat problematic, due to the inconsistency of available information on figures and time periods.

The total assistance approved by the organisations and agencies of the UN System to Nicaragua from July 1979 to May 1986 amounted to approximately USD 285.240.000.

In 1986, Nicaragua received a total of USD 45.017.200 in international technical assistance, of which 53.9% through bilateral cooperation programmes and 35.4% through the UN System. The UN System assistance received amounted to USD 16.388.000, according to MCE sources.

The funds approved (probably including some commitments) by the organisations and agencies of the UN during the period from May 1985 to May 1986, amounted to USD 26.710.000.

Part of the UN System programme is financed through multibilateral arrangements, and a breakdown on funding governments (apparently a 1980-86 aggregate) shows the importance of Norwegian funds:

Norway	*USD*	*9.415.000*	*(UNFPA, FAO, UNCDF, IMO)*
Denmark		*537.000*	*(ILO)*
Finland		*524.000*	*(UNESCO, UNFPA)*
Arab Gulf Fund		*500.000*	*(UNESCO)*
Netherlands		*336.000*	*(UNCHS)*
Canada		*50.000*	*(UNFPA)*
France		*41.000*	*(DTCD)*
China		*28.000*	*(UNIDO)*
Total multi-bi	*USD*	*11.431.000*	

It is difficult exactly to determine the part of multi-bilateral funding within total UN System assistance to Nicaragua on the basis of information available to this mission. Multi-bilateral funding represents however an important part of the total UN System assistance to Nicaragua (excluding WFP), and Norwegian funds (more than 82% of the multi-bilateral as showed in the list above) represent a significant part of the total UN System assistance to Nicaragua.

The Norwegian USD 9.415.000 funds-in-trust support the following projects:

UNFPA	*(the MCH project)*	*USD 5.183.000*
FAO	*(3 projects: Agricultural production/fertilizers, Regional planning and cooperative development, Agricultural information and documentation)*	*USD 3.013.000*
UNCDF	*(School furniture production project)*	*USD 998.000*
IMO	*(Maritime Security project)*	*USD 221.000*
Total		*USD 9.415.000*

The UNFPA is, as far as funds are concerned, the most important agency within the UN System assistance to Nicaragua (again excluding WFP). A list of agencies in order of importance, shows the following, with the MCE figures of received technical assistance in 1986 included:

WFP	*USD 39.480.000*	*(11.286.900)*
UNFPA	*7.545.000*	*(1.502.300)*
UNDP	*6.363.000*	*(888.700)*
UNCDF	*4.553.000*	*(635.700)*
FAO	*3.613.000*	*(173.300)*
UNICEF	*3.380.000*	*(1.565.100)*
WHO	*1.370.000*	*(n.a.)*
UNCHR	*881.000*	*(n.a.)*
UNESCO	*800.000*	*(88.200)*
ILO	*537.000*	*(26.000)*
IAEA	*478.000*	*(51.400)*
UNIDO	*374.000*	*(72.400)*
UNCHS	*336.000*	*(n.a.)*
IMO	*221.000*	*(98.000)*
DTCD	*41.000*	*(n.a.)*
Total (excl. WFP)	*30.262.000*	*(5.101.000)*

Norway finance (given period correspondence) 68.7% of UNFPA, 22% of UNCDF, 83,4% of FAO and 100% of IMO programmes.

The UNFPA is thus the most important UN agency, and Norway is by far the largest contributor to the UNFPA budget.

Furthermore, the MCH project studied in this report is the largest one not only within the UNFPA country programme but also within the UN System assistance to Nicaragua (except from a couple of the WFP food supply programmes). The MCH project takes more than half of all Norwegian multi-bilateral funding in Nicaragua.

b) The UNFPA Country Programme

The present UNFPA 1985-88 programme is not basically different from the previous one (1980-84). The latter was based on a late 1979 *programming mission*. Approved in June 1980, it included projects in the area of MCH, population education, basic data collection and population planning.

The *MCH and Family Welfare* project was initiated in 1979 with PAHO as executing agency from the very beginning. This project has been the biggest and most important within the country programme since 1979/80. The present 1985-88 project is a continuation from the first period, and is the one studied in this report. As will be noted below, it was not until 1985/86 that the project was formulated and specified as a project.

The 4-year *Population Education* project was not initiated until 1983 and therefore included in the present programme cycle. This project is co-executed with UNESCO and integrated into the Ministry of Education (MED) programme of both formal and nonformal education.

The *National Democratic Survey* also started late, in 1984, and apparently with a new 3-year term from February 1987. This project is a support for the work of the *National Institute of Statistics and Census* (INEC) depending on the *Secretaria de Planificacion* of the Presidency. (The Secretariata de Planificacion substituted in 1986 the previous Ministry of Planning.)

Another project is, basically institutional, *support to the national planning authorities* (Secretaria de Planificacion), with the ILO as executing agency. Initiated in 1984 this three-year project is also within the present programme. Linked to the latter two projects is the 1979 initiated *Population and Housing Census* project aimed at strengthening the INEC capacity for undertaking basic data collection.

Highly relevant to the MCH project is the *Sexual Education Seminar* project initiated in 1983, aimed at reaching teenagers and in which the Sandinista Youth Organization, *Juventud Sandinista* plays an important implementing role.

That the UNFPA country programme since 1980 has had MCH as its main project, corresponds well with the Nicaraguan Government's *main population concern:* the high levels of morbidity and mortality.

The MCH project can hardly be compared to the others within the present UNFPA country programme in terms of funds:

MCH project (4 years, 1985-88)	*USD*	*6.000.000*
Population Education and Information (4 years, 1983-)	*USD*	*377.000*
Sexual Education (3 years, 1983-)	*USD*	*36.000*
National Demographic Survey (3 years 1987-89)	*USD*	*506.000*
Population and Development Planning (3 years, 1984-)	*USD*	*626.000*

All the projects of this country programme are without doubt relevant to the Nicaraguan problems. The programme was, however, from its beginning in 1979 not based on a systematic in-depth *needs assessment*, and it seems thus to have been built up a little unsystematic. The projects do not seem to be very closely linked and timed to each other although they are to a large extent part of the same problematic. One example of this can be found in the MCH project's need for democratic knowledge. One of the most successful development components of the MCH project has been the *Risk Factor Approach Study*, a demographic socio-economic health related survey necessary for the implementation and further development of the MCH national programme. This study seems to have been undertaken unrelated to the activities of the national planning authorities or the National Institute of Statistics and Census in particular which receives UNFPA support in the area of social demographic planning and survey.

A more coherent UNFPA country programme could take into account the Nicaraguan public administration and planning problems that result in a very unsystematic and largely non-existent intersectorial coordination. A closer look at this could be useful since population issues cut through all sectors, and a more direct UNFPA presence in Nicaragua should be considered as part of the future country programme.

2.5.4 *The MCH Project*

a) The MCH Programme and Project

As mentioned earlier, the MCH *project* is a programme support package for the MCH *programme*. This is why we in this report relate so closely to the programme.

There has been a problem to separate project from programme. 1986 was the first year in which documents made this for donors important separation. This was partly a result of the November 1985 Tripartite meeting which requested a better organization of project documents. Until this was completed late 1986 (in the revised project document of November 1986, the 1986 report and the 1987 plan), there were problems to identify the external support within the MCH programme. The TPR of 1985 (and 1984) discussed and reviewed the programme without being able to separate project content from the programme.

Before entering into project details, we will specify the immediate objectives of the programme. What follows is a short list outlining the programme objectives as of 1986 (the objectives are presented slightly different in the various documents and there is a confusing relationship between "immediate objectives" and "strategies"):

- *To develop the Risk Factor Approach Study and apply the results to develop strategies to improve quality and extension of MCH and Family Planning services.*

- *To improve the system of referral and counter-referral to increase quality and extension of primary and secondary level MCH health care.*

- *To develop the human fertility component into a programmed plan with the aim of making accessible the Family Planning services to the whole population.*

- *To train and offer continuous education for medical and para-medical personnel in the technical-administrative aspects of the MCH programme.*

- *Improve equipment supplies and its regular distribution to the health sector institutions.*

- *To promote community participation in the MCH and Family Planning programmes and create health preservation habits and responsible parenthood among the population.*

The *activities* of the MCH programme, as outlined in the documents, are divided in its Maternal and Infant parts, in accordance with the organization of the Direccion Materno-Infantil.

The activities of the DAIM (maternal) are:

1. *Pre-natal control, pregnancy attention*

2. *Institutional childbirth attention: promote childbirths in the health sector institutions.*

3. *Postpartum assistance, offer consultations during the first 40 days*

4. *Breastfeeding promotion with the aim of protecting the infant against infections, diseases and malnutrition*

5. *Gynecological attention*

6. *Early detection of cervical and breast cancer with the aim of reducing the risk of developed cancer with efficient treatment.*

7. *Human fecundity study with the aim of providing information about the use of contraceptive methods, and to study the problem of non-fecundity.*

8. *Sexual education with the aim of reducing sexually transmitted diseases, youth pregnancies and provoked abortion mortality.*

The activities of the DAIN (infant) are:

1. *Growth and evolution controls.*

2. *Pediatric morbidity attention pretending to achieve the attention of all children under the age of 15.*

3. *Prevention and immediate treatment of diarrhea and dehydration.*

4. *Prevention, treatment and recovery from nutrition suffering with regular monthly controls of malnutrition among children.*

5. *Prevention, early detection and rehabilitation of (physically and mentalyl) handicapped children, in cooperation with the families and the Ministry of Education.*

b) The project administrative and funding structure

The presentation of project and project reports is the first procedure to be reviewed here, the *elaboration* is a more complex process due to the role of PAHO in its relation to the MINSA.

The DMI presents the document to PAHO through the External Cooperation unit within MINSA. It is then presented to UNDP in Managua as a joint document from MINSA *and* PAHO. UNDP then presents it to UNFPA in New york for approval procedures.

According to MCE all project proposals and reports *should* go from MINSA to them for approval *before* the involvement of any international agency including PAHO, or at least before a document is presented to UNDP. This would have been in accordance with the Nicaraguan "rules of the game", but is not followed in this case. The MCE claims that they are not informed on the MCH project and that they are informed through UNDP and not by MINSA. This might be so due to the deep PAHO involvement *within* the MINSA, a cooperation model that makes it difficult to separate PAHO from MINSA in daily work, which means that an international agency is *already* involved before the presentation of any project document. In this situation the External Cooperation unit of MINSA does not have too much contact with the Multilateral Division of MCE; there are at most a couple of meetings a year.

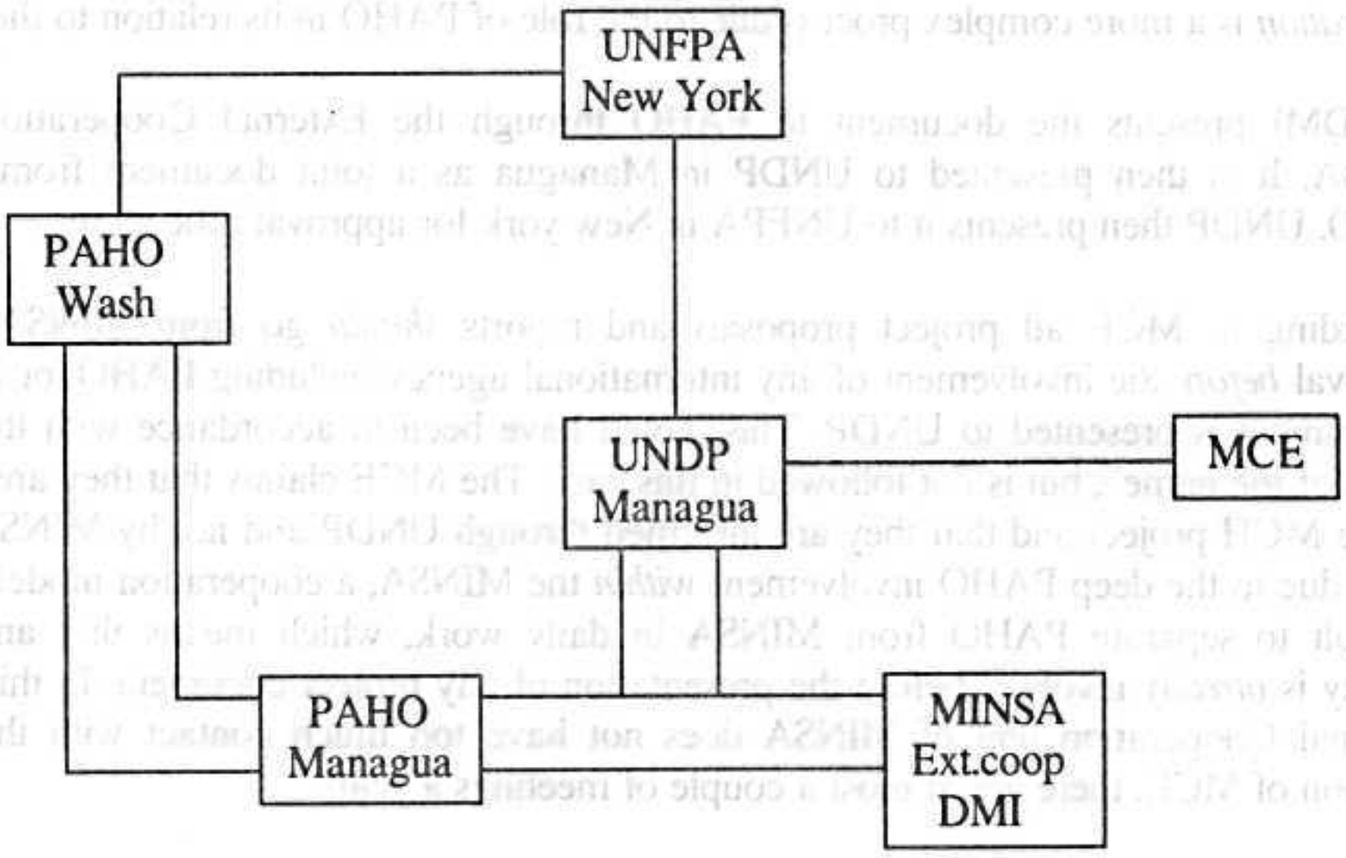
The procedure, then, is that PAHO/MINSA elaborate proposals and reports, pass them to UNDP, and UNDP pass them on to UNFPA. UNDP hold regular meetings with MCE, and this is the main MCE source of information on this particular project.

When it comes to *the funding procedures*, the chain is as follows. The UNFPA deposit funds with PAHO in Washington. All funds for the project, except for vehicles and contraceptives are transferred to PAHO main office in Washington. The contraceptives are purchased and sent to Nicaragua by the UNFPA, received by PAHO in Managua and then handed over to the ATM division of MINSA. The vehicles are purchased by the UNFPA through the UN purchase system and then sent to UNDP in Managua. The vehicles are registered as UNDP property and lent out for project purposes, to PAHO and to DGAM of MINSA.

The rest of the funds are administrated by PAHO in Washington. MINSA or MINSA/PAHO presents equipment specifications to PAHO in Managua which presents the purchase proposals to PAHO in Washington. PAHO in Washington then, often after technical consultancies with PAHO in Managua, makes the purchases, usually through the UNIPAC system in Copenhagen. The funds for local consumption, like scholarships to students in Nicaragua, are administrated by Washington until requested from PAHO in Managua for the project. Funds are then transferred to PAHO in Managua.

The scholarships for Nicaraguans to travel to a foreign country are more or less administrated the same way. It is, however, important to keep in mind that most of the funds for the project arrive Nicaragua in the form of already purchased equipment; 63% of the budget is equipment and most of the personnel and subcontracting is paid directly by PAHO. In fact, MINSA administers very little funds in this project.

The procedures discussed above can be illustrated as follows:



This graph only shows the main flows of information and funds. The relation between UNFPA and PAHO-Washington has not been considered here.

At this stage we should note the important role of PAHO-Managua, both in the presentation of project and reports and as a receiver of project equipment and funds from PAHO-Washington, and as a project budget controller.

It seems that PAHO-Washington is the main technical back-up institution outside Nicaragua. There is apparently a continuous consultancy procedure between PAHO-Washington and PAHO-Managua on technical and medical issues in the project, including the technical specifications for supplies. The UNFPA does not seem to perform any role in this, which is not surprising due to the dominant medical character of the project.

The role of UNDP in Managua is a relatively passive one. This is said to be due to the heavy involvement of PAHO in the project, and not because of lack of interest in the project. Although the UNDP does not have any important role when it comes to the design or operational aspects of the project, we believe that the coordinating role of UNDP is worth mentioning. UNDP takes initiatives for regular programme meetings where MCE participates, and thus provides the missing link to the otherwise left out national international development cooperation authority (MCE).

The fact that the MCE is not really part of the project structure and procedures, is, at least to MCE, a serious problem, and it seems to be closely linked to the way PAHO works in Nicaragua. Unlike other UN agencies, PAHO is practically inside the ministry (MINSA) and does not have a supervisory or operational role from a certain distance like other agencies. This can be explained by the PAHO cooperation policy itself.

What should be pointed out, however, is that PAHO executed projects seem to be implemented and executed without MCE involvement (although MCE involvement normally is not too strong due to MCE's own problems in performing the role it ideally should have had). The *normal* procedure for external funding, according to the Nicaraguan rules, is as follows. The sectorial

ministries (like MINSA) propose a project to MCE where it is approved or not as part of the government total development priorities. Then MCE, on behalf of the actual ministry (or institution), presents the project to foreign donors. If approved, MCE receives the funds and passes them to the Ministry of Finance from there to be authorised to the project ministry according to approved project budgets. This is a procedure that permits the government to control foreign funding in order to, among other things, adjust the government own sector budgets within the development plan for that sector. The MCH project funds, however, do not pass through national financial authorities. It will be recorded later in the MINSA economic reporting to the Ministry of Finance.

A note should be made on the ever-present exchange rate problem. There is a difference between the UN exchange rate and the official donation exchange rate used in Nicaragua. The rate used by UN is lower than the latter, which means that less economic resources are received in Nicaragua for project purposes.

The exchange rate for donation or external funding in Nicaragua is calculated this way: the official bank rate (called state parallel in difference to state foreign trade rate which is much lower) plus the state foreign trade (fixed at 70 Cordobas to USD) divided in two. The official bank rate is constantly increasing (to catch up with the black market), which means that the donation rate also changes. If the bank rate on a given moment in July 1987 was 6.000 Cordobas to 1 USD, the donation rate would be 6.000 + 70/2 = 3.035. At the same time UN used the rate 2.135 Cordobas to 1 USD. PAHO was obliged to use this lower rate until receiving new authorization from UN in New York. This means less money for the project and a potential risk for underfunding.(On the other hand the rising exchange rate, which seems to be stronger than inflation, is likely to reduce such a risk). A dollar account in Managua would allow PAHO to follow the changing exchange rates and thus a better utilization of available funds.

c) The 1985-88 project

The budget summary for the 1985-88 project presented in the November 1986 revised project document is identical to the result of the November 1984 Tripartite budget revision meeting. This budget revision did not result in significant changes of what had been presented earlier the same year. The first Tripartite meeting of the 1985-88 project, held in Managua November 1985, recommended the governments of Norway and Finland to increase their allocation to the project USD 1 million to USD 1.5 million. The 1987 project plan document (presented late 1986) has the same budget as the one approved in November 1984.

The budget summary for 1985-88 (in USD) shows the components of the project:

Component	*1985*	*1986*	*1987*	*1988*	*Total*	*%*
Personnel	*124.040*	*130.720*	*87.880*	*71.000*	*413.640*	*6.9*
Subcontracting	*80.000*	*90.000*	*50.000*	*60.000*	*280.000*	*4.7*
Training	*448.742*	*390.200*	*258.000*	*276.000*	*1.373.936*	*23.2*
Equipment	*1.200.559*	*859.372*	*822.870*	*900.788*	*3.783.589*	*62.7*
Miscellaneous	*50.000*	*40.000*	*39.828*	*18.000*	*147.828*	*2.5*
Total	*1.903.341*	*1.510.292*	*1.258.578*	*1.326.782*	*5.998.993*	
%	*31.7*	*25.2*	*21.0*	*22.1*		*100*

It is difficult to know what portion of the total MCH programme this MCH project budget represents. There is no specified MCH programme budget. In the MINSA there are no budgets per programme but for *areas* and level of activity. There is for instance a budget for primary health care. Approximately 30% of the total health budget (which is 14% of the national budget and amounts to 65 billion cordobas (July 1987) is allocated to primary health care. The maternal-child population is approximately 60% of total population, but represents probably a higher percentage of those attended at the primary health care level. It is difficult to get closer to an estimate of how much the MCH programme takes of the total health sector budget, and of the budget relations between programme and project.

In the 1987 project budget, the *personnel* component consists of salaries to international advisers (CTA and two advisers in Family Planning and Sexual Education; full year for CTA, shortterm consultancies for the two latter) and locally contracted personnel (secretary and administration officer). All personnel is administrated by and integrated in the local PAHO structure. The CTA was contracted from November/December 1985 for two years.

The *subcontracting* component consists of support for the Risk Factor Approach Study and promotion of education of health personnel. In 1986 the Risk Factor Approach Study took most of the Budget for this component, but the study was finished during the first semester of 1987 and therefore occupies only 20% of the 1987 subcontracting budget.

The *training* component consists of scholarships to the exterior (40%), national workshop and courses training (20%) and national scholarships for nurse students (40%).

The *equipment* consists of supplies such as those for immunizations, drugs and materials (books, reviews, logistics) for a total of 31%, non fungible equipment (49%), and contraceptives (20%).

The first report that specifies the project is the 1986 annual report, which contains a budget utilization report of the Norwegian funds. The same report also specifies achievements related to the activities financed through the project.

The objectives of the MCH 1985-88 programme mentioned earlier (section 2.5.4.a) is a reference for the activities supported through the project. The 1987 plan, however, outlines its specific objectives which are:

1) *To improve quality and extension of attention during pregnancy through early integration of the woman into the system of attention.*

2) *To contribute to reduction of pregnancy, delivery and postpartum risk cases.*

3) *To contribute to reduction of the obstetric risk through a strengthening of the Family Planning component giving attention to groups of women identified as most exposed to the risk.*

4) *To implement the programme of early detection of cervical cancer.*

In order to support the achievement of these specific objectives in 1987, the plan document gives priority to the following immediate objectives of the four year programme:

5) *To train and offer continuous education for medical and para-medical personnel in the technical-administrative aspects of the MCH and Family Planning programme.*

6) *To improve equipment supplies and its regular distribution to the health sector institutions.*

7) *To promote community participation in the MCH and Family Planning programme and create health preservation habits and responsible parenthood.*

The 1987 plan further specifies strategies to achieve the above mentioned objectives. In addition to the 1987 plan, there appeared in April-May 1987 an *operational plan* for 1987 which further specifies the *project* components: how to achieve the immediate objectives of the 1987 annual plan. This operational plan presents a rather precise breakdown of the project budget including origins of funds.

1987 was the first project year with elaborated plans, and 1986 was the first with an annual report from which the project development can be traced.

d) Performance and achievements

Above we have presented an overview of the project administrative and funding structures, the main procedures and the routes of information and funds. In this section we will discuss more closely what actually happens, mainly in the performance of the administrative roles of the participating instances.

The organization of information and its elaboration into documents (plans and reports) has been a major project problem. The problems of separating programme from project is already mentioned as part of this problem. Before the end of 1986 the project suffered from a lack of systematically elaborated documents for control and monitoring.

The November 1985 Tripartite meeting discussed this as a serious problem and recommended reorganization of project information into better project documents as a priority for 1986. This request was not repeated by the 1986 Tripartite meeting.

There is no doubt that the elaboration of documents improved considerably during 1986 with the presentation of the 1986 Report and the 1987 Plan. Also the 1987 Operational Plan of April-May 1987 demonstrates a continued improvement, although it was delayed for some months. We believe that these three documents provide a reasonable basis for monitoring and follow-up of the project development. Another document to be mentioned is the strategy document of May 1987 (*"Estrategias de Intervencion"*) based on the findings of the Risk Factor Approach Study. Since we might not expect the problems of public administration (instability, etc.) to be solved within the near future, precise strategy and planning documents are even more important, if not decisive.

The process of elaboration of documents seems to be a complex one, and it is difficult to precisely define the factors behind the 1986 improvement. Of importance is the firm priority decision taken by the MINSA MCH-responsible. The 1985 reorganization of the MCH division probably facilitated the task. Thirdly, the arrival of the CTA at the end of 1985 might have had a positive influence. We should also mention that the Risk Factor Approach Study has contributed to a better systematization of the whole programme.

The elaboration of documents and plans is a joint MINSA-PAHO effort. PAHO seems to participate from the very first step and has taken on a coordinating role (CTA). PAHO also provides shortterm consultants to assist on special subjects. From June 1987 the PAHO staff has been strengthened by the Administrative Assistant who is also involved in the systematization and organization of information, perhaps even more so than the CTA.

This illustrates the role of PAHO in the project. It is difficult in the elaboration process to separate the role of PAHO from the role of MINSA. PAHO is physically established inside the ministry offices at the same time as PAHO claims to have no health strategy or policy different from MINSA. PAHO is an *inside support unit* in the MINSA.

It is then, important to review *what kind of support* PAHO offers the MCH programme. Since PAHO is the "organization of the MD's", the professional medical assistance is dominant if not exclusive. This means that the medical aspects dominate the PAHO work, assistance and consultancies, perhaps leaving the non-medical aspects or considerations of the programme behind. This might, in turn, contribute to a strong "medical" bias in the programme, its strategies, plans and implementation. The MCH programme and project have achieved as of today more in the medical parts than in the components that cannot be fully developed with only professional MD advice. This is not, however, contradictory to the main programme objectives which are of a medical health care nature.

The *Direccion General de Atencion Medica* is responsible for the MCH programme execution. When it comes to the *execution of the project*, PAHO plays an important role. As previously mentioned, all equipment is purchased outside Nicaragua by PAHO and to a lesser extent by UNFPA (vehicles and contraceptives). The personnel component is also handled by PAHO, the employed personnel receiving their salaries from Washington. The only project components that arrive Nicaragua in its monetary form are the funds for local workshop and courses training and the scholarships for nurse students, and the funds to support the Risk Factor Approach Study. These funds are received by PAHO in Managua from PAHO in Washington. The scholarships for the exterior are organized and administrated by PAHO (Washington and Managua).

PAHO administrates the funds received for the project from Washington, perform budget control (these functions now in the hands of the Administration Assistant) and makes the payments to MINSA. In 1987, the funds finally transferred to MINSA constitute approximately 20% of the total project budget.

The equipment is also received by PAHO in Managua, and kept in a special store house for imported donations, before it is handed over to MINSA. Neither equipment nor funds for local activities pass through the national authorities (MCE, Ministry of Finance and the Central Bank) on their way to their final destinations. The system in Nicaragua is normally, and according to government policy, that donations or foreign aid should pass through central authorities before sectorial ministries due to the necessity to adjust sectorial budgets (like the health sector budget). If the activities supported by foreign funds are part of the national programme, the foreign funds should be part of, or included in, the national health budget. It seems that there are difficulties in following such procedures due to the direct link between PAHO and MINSA. The Economic Division in MINSA reports to the Ministry of Finance but, it seems, only after the funds have been spent. This should cause problems to the national budget planning. The MCE does not know much about the PAHO supported projects, and in this PAHO is an exception among international agency performance in Nicaragua.

The administrative role of PAHO could be questioned from a foreign aid policy view. If PAHO to a large extent administers the funds and perform project budget control and monitoring, this is under the present circumstances undoubtedly to the better for the project, but it deprives MINSA from the administrative experience and learning. If the aim of foreign support is to contribute to strengthening the local administration capacity, economic administrative functions should be transferred to the local counterpart. The way this should be done, however, depends on the circumstances including the attitudes of the counterpart itself. In the case of MINSA we believe that this could be done with some advisory assistance from PAHO or UNDP the first year or so. Over the last couple of years the MINSA has established some routines of economic administration and reporting in order to separate foreign funding within programmes, and this will be maintained as the budgets now are in a process of being administratively regionalised.

The general Nicaraguan problem of *public administration* hits MINSA as hard as other ministries. The insufficient administrative capacity is a major factor behind most project or programme problems. It seems that the public administration problem is due to two basic factors. First, the extreme instability of employment. There is in MINSA as in other ministries a rather incredible speed of rotation of staff. This is probably due to the low salaries in the public sector. Many of the most competent, especially in administration, look for jobs in the private sector. Others, we believe many, shift to other ministries for rather small economic benefits. One effect of this situation is that MINSA spends a lot of economic and human resources for on-job-training of new staff. The costs of staff training seem today to be very high. One unconfirmed figure mentioned is that for each cordoba to be spent in programme activities an estimated cost of more than two cordobas is necessary for ministry staff training.

The other basic factors behind the administrative problem is linked to overall Nicaraguan development. There are no traditions in public administration in Nicaragua and the education in this field is insufficient. Furthermore, the present bureaucracy is completely new after 1979, it consists mainly of young people not yet accustomed to the difference between a public bureaucracy and a popular organization. Ministries are chaotic places with numbers of young active people with good ideas and intentions, but without proper bureaucratic routines and procedures that could create an institutional memory (for example by systematically using archives), counteracting the instability of employment and depending less on individuals. This is, of course, a problem all over the world, but it hits Nicaragua hard in its present situation.

If it is easy to discover that the MINSA administration problem exists, it is more difficult to precisely identify the bottlenecks within the MINSA structure, apart from observing that coordination and organization problems seem to be generalised.

It is not the *number* of people that is the problem, but their (administrative) qualifications and the lack of a system to better organize the utilization of limited human resources. In fact, the central MINSA has been reduced in numbers of employed over the last years. The "over-employment" and "over-structuration" of the first years after 1979-80 has partly been overcome supported by the recent strategy of regionalisation of the governmental structures. Previously, MINSA had the high of 310 superior staff (department directors and above), a number that has now been reduced to 160, but still considered too high. From 1980 the central MINSA had an uncontrolled growth in its central structure. With many new immediate tasks in the new situation of 1979-80 and an influx of foreign assistance not previously known to Nicaraguans, new structures were created on an ad-hoc basis in the central ministry for every new (emergency) function, and the numbers of superiors grew. As the MINSA planners put it themselves: the MINSA head was out of proportions to the size of the rest of the body. Slowly, the head has been reduced and the body grown, and today it does not look too bad. But still there are around 800 employed in the central MINSA. The whole health sector has 25.000 on government payroll. (The Ministry of Education has 20.000 out of a total government employment of 150.000).

The DMI (MCH) division of MINSA does not have many staff (although it is often crowded in their offices). The DMI has only six permanent staff: a DMI director, DAIN and DAIM offices a director and a nurse each, and the Risk Factor Approach Study Unit is equipped with one researcher (a nurse).

The DMI division is supposed to run the MCH programme, to follow up all project procedures including intra-ministry coordination. In the latter, they receive a strong support from the Direccion Cooperacion Externa (DCE), a division that plays an important role in the coordination of the various divisions and offices involved in the project. The DCE is a so-called support unit. It centralizes a lot of information from the project and it takes part in the programming of the project implementation without executing. The perhaps most important function of the DCE is that of control through supervision of deadlines set for the various divisions in the MINSA.

The DCE calls for quarterly project monitoring meetings in the MINSA where all divisions participate. The DCE is divided into three offices with a total permanent staff of eleven (directors and officers). It is important to note this role of the DCE since it somehow makes the lack of MCE involvement less dramatic *from a project monitoring and control point of view.*

Formally, it is the *Direccion General de Atencion Medica*, of which DMI is part, that coordinates, approves and presents reports from the project. The CTA approves the reports on behalf of the PAHO before they are jointly (MINSA/PAHO) presented upwards through UNDP.

As mentioned earlier, PAHO participates actively in planning and reporting, especially through the CTA and recently the Administrative Assistant. The PAHO staff seem to take on an intra-MINSA coordinating role as well.

PAHO has four permanent staff, the residential country representative included. This does not include the four *project* employees: CTA, Administrative Assistant, bilingual secretary and driver. The CTA has a two-year assignment (December 1985 to December 1987) and the Administrative Assistant is on a special short term renewable contract (six months) with PAHO. In addition, PAHO uses short term contracted specialists/consultants. To assist in elaborating the 1984 project (i.e. programme) document, PAHO contracted 3-4 consultants. Also in the elaboration of the 1989-92 project plan document (a draft exists, to be presented at the end 1987 Tripartite) PAHO has contracted external consultants.

In general, it seems that PAHO prefers to bring medical specialists to Nicaragua rather than sending Nicaraguans out of the country. According to PAHO itself, technical assistance and training are the most important aspects of their presence. The organization claims to possess (medical) knowledge that each country does not have and that they can play an important role in the exchange of experience between countries.

In the project, however, PAHO has important administrative functions. One of them is *project budget control.* The PAHO approves or refuses proposals from MINSA on budget allocations. It is the project Administrative Assistant that represents PAHO in Managua on this but apparently with limited authority. He will have to seek approval from PAHO Washington or in some cases UNFPA in New York on most budget adjustments and certainly on new allocations. The Administrative Assistant works closely with the PAHO office in Washington, and claims to have nearly all professional backing from there.

Although there might be raised some questions on the extension of the PAHO project administrative role, there is no doubt (even after only a couple of months) that the assignment of the Administrative Assistant has had a positive effect on *project* execution, implementation, monitoring and control. The Administrative Assistant has the role of a project officer. An alternative to the present strengthening of the PAHO project administrative capacity would be to transfer these resources directly to the Direccion General de Atencion Medica.

The CTA was contracted in December 1985 for two years, mainly as a result of the November 1985 Tripartite meeting concern about project documentation. UNFPA and UNDP were among those who strongly recommended a CTA. The CTA was recruited by PAHO with UNFPA regular funds.

The CTA was, however, contracted to assist and advise the MINSA on the MCH *programme* at a professional medical level. But the CTA was also supposed to coordinate the *project* on behalf of the PAHO, with the aim of producing better project documents. The CTA, then, ended up with a double function: as a medical programme advisor and as a (administrative) project coordinator. On the basis of improved reporting, the 1986 TPR could conclude that the CTA was not enough to strengthen the project administration. An administrative assistant was

recommended, with the aim of improving the reporting to funding agencies and governments, and a more efficient distribution of the project equipment and supplies. The Administrative Assistant was contracted from June 1987.

The CTA function is somehow problematic, but it is difficult to make precise assessments on this. Most people interviewed said the assignment has had positive effects on the project. It is a fact that reporting and documentation improved considerable from 1986, but, as mentioned earlier, other factors may well have influenced. This, however, refers to administrative achievements.

While the CTA is a professional medical advisor, it could be questioned whether this is the main MCH programme and project need. It seems that the basic MINSA problem implementing this project is not the lack of sufficient medical knowledge. The MINSA is fairly well equipped with qualified MD's to meet the regular problems of health care. There might be a need for (PAHO) assistance on special issues which could be solved through shortterm consultants or scholarships. Although MINSA received PAHO support to set up and organize an Essential Drugs List, the CTA now does not take part in the present selection of essential drugs since this is considered a national drugs policy issue. (The delay problems here are not that of lack of knowledge but of coordination of knowledge due to the fact that Nicaraguan MD's are educated in many different countries and professional milieus and hence put forward different preferences).

The way the CTA function is defined by the funding agencies and the position given the CTA, appears to be of importance. The CTA is working within the PAHO local structure and seems to hold a position of authority equal to that of the Director General de Atencion Medica (vice-minister and MCH programme responsible), since they both are supposed to approve reports and documents as common PAHO-MINSA products. The CTA will then to a large extent personify both the PAHO and the project relation to the national MINSA authorities.

There is a question of whether a permanent medical advisor is of priority in this case. The project administrative functions now seem to be taken care of by the Administrative Assistant of PAHO. Secondly, if a medical CTA is needed, it is a question of whether this CTA should be completely integrated into the MINSA structure and instructions, and not directly linked to PAHO. Another alternative is not having a medical CTA at all but offering the MCH programme authorities the funds for contracting the resource persons they might need. This alternative seems to fit well into the present MINSA considerations. The MINSA MCH programme authorities has defined the *basic* project problems as those of coordination and administration rather than external medical advise, which means a reconsideration of the CTA function.

A major administrative problem has been the supplies of equipment and drugs. It takes about *a year* from the request until supplies are received in Nicaragua. The MINSA/PAHO make specifications and requests through PAHO Washington. The time needed for equipment to reach Nicaragua means that the project was without supplies during its first year, 1985.

In 1985 the requests were prepared late, however, not until August. Due to the long delay, they prepared the specifications earlier the following year, in March, 1986. Also in 1987 they prepared the request by March and expect to receive the equipment in March 1988.

In the case of drugs, it has happened that MINSA received outdated products that could not be used. MINSA now tries to order drugs that can be used up to two years or more after production, but this is difficult in the case of some highly sensible products. Contraceptives received from UNFPA do not suffer this delay.

The delays are out of MINSA control, but in order to improve the situation requests could be produced earlier. MINSA is actually trying to reduce the time needed to specify products, which

means another organizational challenge within the ministry. It is, however, possible to start the procedures in MINSA earlier since they will know the following years budget time ahead although it is not officially approved until the Tripartite at the end of the year. Again, the MINSA's own delays in producing the specifications of drugs (this is an internal MINSA procedure) is not due to lack of knowledge but rather a problem of organizing the more than 20 MD's that participate in this process that is part of the essential drugs policy making.

e) Comments on project execution

It seems that the PAHO response to MINSA's administration problems (of efficiency and organization) is a tendency to increase the PAHO direct administrative involvement (through for example the Administrative Assistant post) rather than strengthening the MINSA's own capacity.

This is, of course, a development assistance policy issue, where the different options have different short and long term consequences. If the Tripartite meeting (as in 1986) correctly concluded that a considerable administration problem exists, the logic answer is not necessarily to extend the administrative role of the international executing agency, even if this might be the correct *short term* solution to "save" the project. The same is valid for the handling of imported equipment. It is probably in the short run more efficient if PAHO administers and takes care of customs and other import procedures.

Even if the policy of PAHO is to work in close "inside" cooperation with the ministry, it still makes a difference whether the administrative responsibilities are in the hands of the national or the international executing agency. Another cooperation "model" would be to support the MINSA's own administration with personnel (international) combined with on-job training of MINSA officers. The MINSA potential for receiving such support and to absorb it we believe do exists.

The PAHO cooperation "model" in general also deserves a comment. That the project is not very well integrated in the Nicaraguan national foreign aid administration is an effect of this "model". One of the concrete results is that it makes it difficult for the national governmental authorities to include the project foreign funds into the national development budgets, which affects the economic planning for the health sector. This situation could, however, be improved without any drastic change of cooperation model, if the problem is that of information and approval procedures.

f) Inter-agency coordination and cooperation

PAHO and UNICEF have developed the most advanced inter-(UN)-agency coordination programme in Nicaragua. Not by accident however, but rather due to the fact that the two agencies are involved in the same government programmes. The MINSA MCH programme is a good example. In fact, the inter-agency coordination concentrated on this programme from the beginning.

Formally, the PAHO-UNICEF coordination consists of annual meetings (the first one in 1983) and a joint publication of a bulletin, usually after the annual meetings presenting the interventions (report, future plans and other statements). Other UN agencies (such as UNDP, UNESCO, WFP) take part in the annual PAHO-UNICEF meetings together with involved ministries. The latter participation might vary from year to year, but MINSA is always there.

The PAHO-UNICEF coordination covers areas like MCH, diarrhea control, immunization, health education, water supply, nutrition and technical advise. Before 1981 there was no

coordination at all. During 1981-82 there were made attempts to coordinate activities by way of defining common involvement. One important area of work for both agencies is *Primary Health Care*. The first attempts at coordination met problems due to the different approaches or strategies for Primary Health Care. While UNICEF gave priority to *popular participation*, PAHO stressed the development of health *institutions*. Different approaches still exist, but the two agencies found ways to coordinate actions from 1983 and the first coordination meeting took place in May that year. Then the MCH programme was the focus.

The PAHO-UNICEF coordination has without doubt developed since 1983 and covers today the areas mentioned above. In addition the two agencies cooperate in the attempts to promote research in health and to improve health information systems and statistics. Still, it seems that the main area of coordination is that of health, and MCH programme activities in particular.

The PAHO-UNICEF coordination is, however, limited to technical assistance and does not include administration. UNICEF has got their own expert within MINSA central structure as adviser. The PAHO Project Administrative Assistant never (so far) assisted UNICEF on administrative matters. It seems that the two agencies keep their implementation strictly separated from the coordination. This might be due to the fact that the implementation strategies are somehow different: the UNICEF implementation is more directly on a regional level, i.e. UNICEF cooperate directly with the regional MINSA administrations. As is the case with the UNFPA/PAHO-project, a large part (60-70%) of the UNICEF support is equipment (purchased through UNIPAC) while the remaining 3040% supports training and education.

g) Population

The government does not have any specific national population planning policy. *Population concern* is over geographical distribution and growth rather than overall national population growth.

Population statistics and census is not sufficiently developed in Nicaragua. The last national population census is from 1970. The main effort in the field of population statistics was the buildup of the RUC, the national population register, which helped to create an electoral register before the 1984 election.

There is a great need for assistance in the field of population statistics and demographic data, as well as strengthening the institutional framework of the national population planning authorities.

The *Risk Factor Approach* of the MCH provides useful demographic data, and there are plans to create an inter-ministerial coordination in the area of demographic data collection (in which MINSA is supposed to be part).

As has been repeated too often in this report, public development administration is a serious weakness in Nicaragua. Inter-sectorial planning and coordination is spontaneous, unsystematic or most often absent, although very often considered very important and necessary. At the same time Nicaragua is in a process of rather strong internal migrations and occupational changes affecting all social and economic sectors.

2.2.5 *General Assessments*

a) Relevance and position of the MCH project

The relevance and position of the project can be assessed at different levels.

The first question is whether the project, *as a programme support project*, is a relevant support package to the government MCH programme. This is difficult to assess from this evaluation since it has not been an in-depth project analysis of medical aspects. In general, however, we believe the project is relevant to the project simply because it (63% of the four-year budget) provides the programme with *equipment* inaccessible to Nicaragua without international assistance. An assessment of the relevance of the *content* of the imported equipment, from drugs to contraceptives, is beyond reach here (except that we believe Nicaragua needs drugs but that the common habit of using antibiotics to cure everything including bad mood should be changed (MINSA is now restricting the use of antibiotics), and that the population needs contraceptives but that they use to little condoms compared to other devices). The *training* part of the project is without doubt relevant to the programme. The *subcontracting* component having supported the Risk Factor Approach Study has been of vital importance to the continued development of the MCH programme (and a lot has been achieved with small funds). We have, however, raised some doubts about the *personnel* part of the project. Without questioning the need for such support we have made some critical observations on the administrative context (PAHO and CTA).

Secondly, the MCH project and programme is not only relevant to, but of very high priority within the government health programme. As noted earlier, it is, however, difficult to quantify both the importance of the project within the MCH programme, as well as the MCH programme within the total health programme. The MCH programme does not have a specific budget since the budgets are per area of health care. But the MCH programme takes most of the Primary Health Care budget which is approximately 30% of the whole national health budget. In terms of health care strategy, there is no doubt that the maternal-child population (approximately 60% of total population) is of highest priority within Primary Health Care in Nicaragua.

Thirdly, the MCH project is also relevant to *family planning* since family planning activities in Nicaragua are so far mainly geared towards those exposed to obstetric risks. It is, furthermore, relevant to the government *population concern* defined as a problem of high levels of mortality and morbidity.

Fourthly the MCH project is by far the largest within the UNFPA country programme. In fact, it dominates that programme to such a degree that the UNFPA in the Nicaraguan case appears as a MCH support agency. As long as the population problem by the Nicaraguan government is defined as a problem of mortality, the UNFPA programme reflects well the needs. On the other hand, Nicaragua needs more support to build up population statistics in order to run and develop further its MCH programme. Furthermore, the population policy might change and general family planning activities implemented in the regions of high population density.

Finally, it should be repeated that UNFPA is, as far as funds are concerned, the most important agency (excluding the WFP) within the UN System Assistance in Nicaragua. Norway is by far the largest contributor to the UNFPA budget. The MCH project is not only the dominant one in the UNFPA programme but the largest one within the total UN assistance. Finally, the MCH project takes more than half of the Norwegian multi-bilateral funding in Nicaragua.

All this taken together clearly shows that the project studied in this report is highly relevant to the Nicaraguan health and population problems, and that it holds an important position both within the MINSA health programme as well as the UNFPA and UN system programmes.

In a national perspective health and education are given the highest priority when it comes to budget allocations for development. In the present war-and-survival economic policy, where defense takes about 50% of the national government budget, health and education are given 14-15% each.

b) Administrative performance and achievements

When describing the project administrative and funding *structure*, we noted that the direct PAHO involvement within the MINSA institutional framework produces some *"violations" of the formal procedures the government wants to impose on external assistance and funding.* The project documents and reports are elaborated jointly by PAHO and MINSA and then presented directly to UNDP thus avoiding the government external cooperation coordinating authority, the MCE, Ministry of External Cooperation. This results in a procedure that avoids the central government approval and decision making, and it produces a problem of information. The information problem might have the effect that central government authorities are not able to take the MCH project funding properly into consideration in time for economic development planning purposes. This should, of course, be considered an internal government problem (between MINSA and MCE) but given the immense public administration problems in Nicaragua international agencies should be aware of such effects. On the other hand, we do not think the project development has suffered from this. Since what happens is a short-cut in the bureaucratic procedure it is likely that the way it is done is more efficient.

When it comes to *funding procedures and economic administration,* we have found that PAHO plays the important role. Except from the contraceptives and vehicles sent directly from UNFPA, PAHO handles most of the funds, most of them in Washington for purchases of equipment. Most of the funds spent in Nicaragua are administrated by PAHO-Managua, which means that *MINSA is hardly involved in the economic administration of the project.* Furthermore, PAHO in Managua has a direct project *budget control function.* This might be efficient, but in the long run it deprives MINSA from project economic administration experience. It is, however, important to keep in mind that the project is a programme support project in which 63% of the budget is imported equipment and materials.

To spell out these observations we might say that PAHO perhaps takes it to far when project administration is concerned.

We included a note on the ever-present exchange rate problems suggesting that a closer look on this might be appropriate should the differences between the Nicaraguan exchange rate for external funding and the UN rate prevail.

A very important administrative achievement was *the separation of the project from the programme* and the *elaboration of better project documents.* This was achieved during 1986 and has been developed further in 1987 with for example the elaboration of a Project Operation Plan. The improvements seem to coincide with the decision of the TPR to strengthen the administrative part of the project with the assignment of a CTA, and subsequently with a project Administrative Assistant in 1987. On the other hand, it also coincides with the efforts made by the ministry to achieve a better organizational structure, in which the *reorganization of the MCH division* was important. We think that several factors influenced and we do not see the improvements simply as an effect of the arrival of the CTA.

On the other hand, we critically analyzed the role of the CTA. The problems defined by the 1985 TPR were those of administration, the need for a better organization of project documents and information. But the CTA was contracted to assist the MINSA on the MCH *programme* at a professional *medical* level. But since the CTA was also supposed to coordinate the *project* on behalf of PAHO, the CTA ended up with a double function: a medical programme adviser and

an administrative project coordinator. We have questioned, thus, the role of the CTA as it is at present, and suggest a closer look at this problem. Having agreed with the TPR conclusions, we doubt whether a permanent medical adviser should be given priority since the project problems are clearly of an administrative nature.

We furthermore see the CTA problem as part of a more general problematic linked to the nature of PAHO as an "organization of the MDs"'. We find a "*medical bias*" in the technical assistance provided. On the other hand, this might not be too far from the MINSA's own approach to many of the MCH programme problems, although there are quite a few "sociology-minded" among the MINSA (MD)- staff.

A rather serious problem for the project has been the late arrivals of imported equipment. The first project year 1985 was left without equipment, and even if efforts are made in MINSA to shorten the request procedure, the problem largely remains one of purchases and import procedures out of Nicaraguan control.

In a more general perspective the problems of Nicaraguan public administration should be stressed. MINSA as well as all the other ministries suffer from inefficient and badly organized public administration, a very well explainable problem given the government's inherited structure from the pre-1979 period. We have returned to this problem several times in this report, its causes and effects. What is important here, however, is *how external agencies relate to the fact that this is a serious development problem.* The easiest answer is to take over administrative functions, for the well-being of a project in the short run. In the long run, however, this is hardly a well-thought response. We suggest that ways are found to include more *institutional-administrative support* to MINSA as part of the project development, instead of the present solution in which PAHO performs a too extensive administrative role.

APPENDIX I. TERMS OF REFERENCE

EVALUATION OF THE NORWEGIAN MULTI/BILATERAL PROGRAMME UNDER UNFPA.

1.0 BACKGROUND

The Norwegian multi/bilateral programme administered by UNFPA is implemented according to: "The Agreement between the Government and the United Nations fund for population activities on co-operation in the population and family planning field", which was signed 28 October in 1977. (St. prp. nr. 35, 1977-78).

This multi/bilateral agreement gives UNFPA the basic authority as follows: "Subject to the provision of the Agreement, UNFPA is authorized to agree to provide assistance to developing countries for the preparation and implementation of the mutually agreed programmes and projects falling within the scope of the functions assigned to UNFPA under its mandate".

Norway makes available to UNFPA funds-in-trust which the organization shall administer and account for. It is further agreed that: "It is the intention of the Parties that there shall be close cooperation between them for the purpose set forward in their Agreement. To that end they shall regularly consult with each other and shall make available to each other all such information and assistance as may reasonably be requested" (Article V)

Since 1977, 43% of UNFPA multi/bilateral fund has been allocated by Norway. The allocation in 1986 is NOK 18 million (appropriately US$ 2,3 million).

It is now the intention of the Ministry of Development Cooperation to carry out a study of the UNFPA administrative operations.

2.0 OBJECTIVES

The purpose of the Study is to provide a report on the UNFPA project administration, reporting and evaluation systems, and on the application and practicability of such systems through-out all stages of the projects and programmes as relevant to Norwegian supported activities, as well as an evaluation of the efficacy of using the UNFPA as an agency for implementation of Norwegian development policy in the health and population field.

The Report will serve as a basis for an analysis by the MDC of the multi/bilateral development aid cooperation and the use of UNFPA in bilateral country programmes.

3.0 PROJECT DESCRIPTION

3.1 *STRATEGIES*

Desk studies, phase 1 of the evaluation, shall be based on a review of existing general and project documentation, and evaluation reports, together with interviews with UNFPA and MDC staff, including Norwegian participants in project administration/implementation/review/evaluation teams.

The desk studies shall be carried out in MDC and UNFPA headquarters mainly.

An interim report will be submitted to MDC for comments.

Field studies, phase 2, of selected projects/programmes will be planned in more detail in connection with MDC's review of the Interim Report.

3.2 *ASPECTS TO BE ADDRESSED BY THE MISSION*

The Consultant's evaluation team shall carry out the services as outlined below. The MDC reserves the right to amend or extend these services as required after review of the Interim Report.

3.2.1 General review of UNFPA's administrative systems and procedures

The mission shall describe, analyse and assess:

a) UNFPA's procedures for selection of executing agencies, and experience with regard to the employment of other UN organizations, NGOs and national organizations.

b) UNFPA's procedures for selection of recipient countries and projects/programmes, and the subsequent submission of proposals to donor countries for projects to be financed through multi/bilateral cooperation agreements.

c) Procedures for project coordination and follow-up, by UNFPA as well as the Norwegian authorities.

d) Information/interaction between UNFPA and Norwegian authorities as implied in the UNFPA tripartite project reviews and progress reports.

e) The linkages between the UNFPA's policy (policies), project planning, design, implementation and finalization will be discussed in order to evaluate the feed-back systems within the organization and to determine the degree of centralization of management within the UNFPA administration.

f) The policy of the organization regarding the effort to stop the spread of HIV infection, and any changes this has, or should have, in projects and programmes, particularly in the sex/family education.

3.2.2 Specific Review of the Systems and Procedures as applied to Project and Programmes supported by MDC.

The mission shall:

a) Prepare a list of major projects/programmes supported by MDC, with breakdown showing year, amounts allocated by MDC and, if applicable, amounts allocated by other Donors.

b) Describe the UNFPA's criteria for identification, selection, implementation (strategies, time schedule etc) and finalization of the projects/programmes.

c) Assess the Donor's participation or involvement at the different stages of the projects/programmes.

d) Determine to what extent the objectives and the beneficiaries are specified and are in accordance with the objectives of the Norwegian development aid policies.

e) Describe the following aspects of the projects:

   i) The projects' position in UNFPA's country programme and in the recipient countries' development programmes.

   ii) The role played by the UNFPA and/or the executing agency at the different stages of planning and implementation

   iii) The existence, before the project design stage, of baseline information and/or measurable indicators of goal achievements in the recipient countries.

   iv) Project performance, and achievements of the immediate objectives.

   v) Built in monitoring, feed-back and evaluation systems

   vi) Cooperation with other organizations on programmes with similar objectives within the recipient countries

f) Assess to what extent the progress reports and evaluation reports offer the Donor an adequate picture of development of the projects/programmes, and of the actual impact of the projects/programmes in the recipient countries.

3.2.3 Conclusions and recommendations

On the basis of the conclusions on the above points the team shall discuss options for actions by the MDC regarding the reporting/evaluation systems for UNFPA projects supported by Norway, and for possible improvements to the Norwegian administration routines in respect of the multi/bilateral cooperation with the UNFPA.

4.0 CONDITIONS, IMPLEMENTATION

4.1 *IMPLEMENTATION TEAM*

The Study will be undertaken by a team of 2-4 resource persons, together covering the competence areas and experience required for professional execution of the Study. Special requirements are:

- Experience in the field of population project activities in developing countries.
- Knowledge/experience from international cooperation, especially within the UN organizations.

- Experience in project administration.
- Language abilities - English and Spanish.

The team will report to the Ministry of Development Cooperation, 2nd Planning Division.

4.2 *WORK PROGRAMME*

4.2.1 Phase 1 - Desk Studies

The work will comprise:

- collection and processing of available material and information in the MDC and UNFPA headquarters
- preparation of an Interim Report, the contents of which shall include:
- a recommended order of priority of the different problems and activities to be dealt with in the course of completion of the study
- programme for the field studies
- proposal for organisation and outline of the Final Report

4.2.2 Phase 2 - Field Studies

MDC's comments to the Interim Report shall be available before commencement of the field studies. The following list of projects to be studied is provisional only:

NIC/85/PO3 - Extension of the MCH Family Welfare programme, Nicaragua

NEP/80/P12 - Strengthening of FP/MCH in Integrated Community Health Project, Nepal

ETH/81/PO5 - Communication Support to MCH Programme, Ethiopia

The final decision will be undertaken by the MDC after receipt of the Interim Report.

4.2.3 Phase 3 - Preparation of the Final Report

- compilation and analysis of information form the desk- and field studies
- preparation of draft Final Report
- hearing round in MDC and UNFPA
- completion of the Final Report

4.2.4 Time Schedule

The following schedule is based on contract commencement date not later than 15th March 1987, allowance is made for hearing of the Interim Report, and for summer holidays.

Submission of Interim Report	*15th June*	*1987*
Field studies commence	*15th August*	*1987*
Submission of draft Final Report	*1st Dec.*	*1987*

4.3 *THE REPORT AND DOCUMENTATION SHALL BE PRESENTED IN ENGLISH.*

APPENDIX II: LISTS OF MEETINGS AND PEOPLE CONTACTED

OSLO

Tuesday, April 28:

A.M.	Meeting with officers from Ministry of Development Cooperation (Multilateral and Planning Department and NORAD (HEFA))

NEW YORK (Carl Widstrand):

Monday, May 11:

A.M.	Mr. T. Abrams , Deputy Chief Interregional & Multi-Bilateral Branch Ms. K. Trone, Chief, Evaluation branch
P.M.	Ms. Henna Ong, Programme officer, Nepal desk Mr. A. Aquirri, Programme officer, Nicaragua desk Dr. P. Rosenfield, Carnegie Foundation

Tuesday, May 12:

A.M.	Mr. Villareal, Procurement
P.M.	Ms. Elin Ranneberg-Nilsen, Deputy Chief, Africa Branch Mr. T. Abrams

Wednesday, May 13:

A.M.	Documents
P.M.	Ms. K. Trone, Evaluation branch Dr. N. Dodd, Policy Division Mr. J. Saklovski, Chief, Technical and Planning Division Dr. Nafis Sadik, Executive Director Mr. A. Keller, Senior Technical Officer Mr. H. E. Wittrin, Deputy Executive Director

WASHINGTON

Thursday, May 14:

Dr. J. Nellis, The World Bank
Mr. E. Quicke The World Bank
Mr. A. Morgan, Paho

NEW YORK

Ms. M. Dirven UNTCD

Friday, May 15:

A.M. Mr. Lamine N'Diaye, Chief Africa Branch
Ms. Elin Ranneberg-Nilsen, Deputy Chief, Africa Branch
Ms. C. Pierce, Chief, Interregional and Multi-Bilateral Projects Branch
P.M. Ms. N. Perea,Programme officer, Latin America Branch
Mr. J. van Arendonck, Chief Programme Division
Dr. H. Corvalan, Chief, Latin America and Carribbean Branch

Tuesday, May 26

Meeting Norwegian delegation to UNFPA Governing Council

Wednesday, May 27:

A.M. Mr. T. Abrams UNFPA Governing Council
P.M. Dr. H. Corvalan,
Ms. N. Perea
Dr. Judy Harrington, UNFPA DERSAP, Nigeria UNFPA Governing Council
Shorter conversations during reception for UNFPA delegates:
Ms. Ingrid Eide
Canadian delegation
African delegations (Zaire, Tanzania, Kenya, Senegal)

Thursday, May 28:

A.M. Mr. Dh. Gupta, Logistics adviser, consultant on African condome requirements
UNFPA Governing Council
P.M. Dr. John Gerhart, Ford foundation
UNFPA Governing Council

Friday, May 29

A.M. Meeting Norwegian delegation
Semi-annual meeting on multi-bi between UNFPA and Norway
Meeting Ms. Imelda Henkin, Chief, Asia and Pacific Branch
P.M.Official lunch, host Mr. Arendonck
Meeting Ms. K. Trone, Evaluation Branch

NICARAGUA

MANAGUA, Monday, July 27

Delia Rodriquez, Programme Officer, UNDP
Pedro Cabalcante, Technico Administrativo, MCH Project, PAHO
Blanca Hernandes, Directora, Division Cooperacion Externa, MINSA

Tuesday, July 28

Jose Antonio Pages, Coordinator for Planning and Policy, PAHO
Carlos Felipe Martinez, Deputy Res. Rep. UNDP
Benjamin Barreto, Vice-Minister and Director General, Direccion General de Atencion Medica, MINSA
Orlando Perez, Director, Direccion Materno-Infantil, MINSA
Pedro Cabalcante, PAHO

Wednesday, July 29

Visit to Cetro de Salud Silvia Ferufino, Managua
Patricia Ruiz, Directora, Centro de Salud Silvia Ferufino
Visit to Hospital Bertha Calderon, Managua
Victor Mantilla, Sub-Director, Hospital Bertha Calderon
Carmen Maria Lang, Directora, Direccion de Organismos Multilaterales de Cooperacion, MCE
Orlando Perez, MINSA
Pedro Cabalcante, PAHO

Thursday, July 30

Roberto Jimenes, Vice-Minister and Director General, Direccion General de Docencia y Investigaciones, MINSA
Claritza Morales, Officer, Direccion Gen. de Docencia y Investigaciones, MINSA
Gladys Ricarte, Responsable, Departamento Educacion Continua, Dir. Gen. de Docencia y Investigaciones, MINSA
Giacuda Trejos, Responsable, Departamento de Comunicacion, Docencia y Investigaciones, MINSA
Visit to Hospital Comandante Hilaria Sanches, Masaya
Carmen Amanda Solorzano, Directora, Hospital Comandante Hilaria Sanches
Oscar Flores, Director, Direccion Materno Infantil (Responsable Materno), MINSA
Pedro Cabalcante, PAHO

Friday, July 31

Jaime Gonzales, Director General Economica, MINSA Visit to Instituto Pilitecnico de Salud (IPS/POLISAL) Luis Felipe Moncada, Managua
Clara Fonseca, Directora, IPS Luis Felipe Moncada
Claudia Lezama, Sub-Directora Educativa, IPS Luis Felipe Moncada
Oscar Flores, MINSA
Pedro Cabalcante, PAHO
Orlando Perez, MINSA

Monday, August 3

Henry C. Meyer, Res.Rep, UNDP
Carlos Felipe Martinez, UNDP
Antonina Vivas, National Programme Officer, UNDP
Vilma Jimenez, Responsible, Risk Facto Analysis Study, Direccion Materno Infantil, MINSA
Orlando Perez, MINSA
Oscar Florez, MINSA
Pedro Cabalcante, PAHO

Tuesday, August 4

Julio Zapata, Director, Direccion de Organizacion y Servicios, MINSA
Benjamin Barreto, MINSA
Antonina Vivas, UNDP
Lucia Rodriquez, Directora Economica, Direccion General de Abastecimiento Tecnico-Materiales, MINSA
Pedro Cabalcante, PAHO

Wednesday, August 5

Visit to Hospital Regional Santiago, Jinotepe, Carazo
William Chacon, Director, Hospital Santiago
Jose Dolores Gutierrez, Jefe, Dept de Gineco Obstetricia, Hospital Santiago
Visit to Centro de Salud, San Marcos, Carazo
Consuela Espinoza, Directora, Centro de Salud, San Marcos
Vilma Jimenez, MINSA
Benjamin Barreto, MINSA

Thursday, August 6

Pedro Cabalcanto, PAHO
Nicolas Garcia, Res. Rep. UNICEF
Benjamin Barreto, MINSA
Dora Maria Tellez, Minister, MINSA

Friday, August 7

Carlos Lopez, Director, Direccion de Cooperacion Externa, MINSA
Blanca Hernandes, MINSA
Pedro Cabalcanto, PAHO
Benjamin Barreto, MINSA
Miquel Marquez, Res. Rep. PAHO

Wednesday, August 12

Edith Montecinos, Chief Technical Advicer (CTA) PAHO

NEPAL

MAIN CONTACTS

National Planning Commission

Prof. U. M. Malla, Hon. Member

National Commission on Population

Ms C. K. Kiran, Secretary

Ministry of Health

Mr T. B. Prasai, Secretary

Tribhuvan University, Inst. of Medicine

Prof. M. P. Shrestha, Chairman, Dept. of Comm. Medicine
Dr. Indira Singh, Campus Chief
Ms. J. Tamsang, Senior Tutor

Public Health Division/ICHSDP

Dr. D.N. Regmi, Chief
Mr. Sribatsa Shrestha, Deputy Chief
Dr. P. Arora, Project Coordination
Mr. H.L. Rajbans, project Coordinator
Mr. K.P. Acharya, Project Coordinator

Nepal FP/MCH project

Dr. T.B. Khatri, Chief
Dr. J.M. Tuladhar, Chief, Planning and Evaluation Div.
Dr. Pramila Sharma, Deputy Chief
Mr. M.P. Maskey, Project Coordinator
Mr. J.K. Shestha, Project Coordinator

Bir Hospital

Dr. B.R. Pande, Medical Director

Dept. of Coorperative Development

Mr. S.R. Shakya, Principal Training Centre

Family Planning Association of Nepal

Mr. Y. Kharel, Executive Director

United Mission to Nepal, Lalitpur Community Health Program (patan Hospital)

Ms. Meena Sharma, Health Sector in-charge

Save the Children Fund, UK

Mr. I.J. Russel, Field Director

Save the Children Fund, USA

Ms. Mary Taylor

USAID

Dr. David Calder, Chief, Population and Health Section

John Snow Inc.

Dr. N. Daulaire, Party Cheif
Ms. Pat Taylor, Management Consultant

United Nations Children's Fund

Mr. Alan Court, Programme Coordinator
Mr. Alireza Mahallati, Programme Officer, Health

United Nations Fund for Population Activities

Mr. D.B. Lama, Senior Programme Officer
Mr. D.P. Adhikari, Administration Officer

United Nations Development Programme

Ms. Toshiyuki Niwa, Resident Representative

World Health Organization

Dr. P. Micovic, Representative

World Bank

Mr. Richard Woodford, Representative

Participants, Workshop for District Health Managers

Chitwan District Office
FP/MCH Clinic, Bharatpur Hospital health Post staff

Gorkha District
Ms. Lela Gurung, ANM FP/MCH Project

Other
Dr. Vijaya L. Shestha, consultant social scientist
Dr. Y.B. Kharki, sociologist, representative World View, Nepal

APPENDIX III. ST. PRP. AND AGREEMENT

Utenriksdepartementet.

St. prp. nr. 35.
(1977—78)

Om samtykke til godkjenning av Avtale mellom Kongeriket Norges Regjering og De Forente Nasjoners befolkningsfond (UNFPA) om samarbeid på områdene befolkning- og familieplanlegging.

Tilrådding fra Utenriksdepartementet av 28. oktober 1977, godkjent ved kongelig resolusjon samme dag.

(Foredratt av utenriksminister Knut Frydenlund.)

Norge har i flere år ytt store bidrag til De Forente Nasjoners befolkningsfond som uttrykk for erkjennelse av forbindelsen mellom befolkningsvekst og økonomisk og sosial fremgang.

Bistandsanmodningene til UNFPA har imidlertid økt hurtigere enn fondets ressurser bl.a. på bakgrunn av UNFPAs sentrale rolle i oppfølgingen av Handlingsplanen som ble vedtatt på Verdens befolkningskonferanse i 1974.

For å imøtekomme de økte bistandsanmodninger tok UNFPA initiativ til å få utarbeidet multi-bi-samarbeidsavtaler, det vil si samarbeid om prosjekter som hovedsakelig består i at vedkommende land finansierer prosjekter som tilrettelegges og administreres av vedkommende internasjonale organisasjon. Slik bistand klassifiseres i internasjonal sammenheng som bilateral bistand. På norsk hold stilte man seg positiv til initiativet da denne samarbeidsform avlaster den norske bistandsadministrasjon ved å utnytte de internasjonale organisasjoners planleggings- og administrasjonsapparat.

Man har fra norsk side gjennom denne samarbeidsform inngått tilsvarende avtaler med en rekke internasjonale organisasjoner og derved søkt å koordinere den bilaterale og multilaterale bistand til utviklingslandene ved å nyttiggjøre disponible midler på den mest utviklingsfremmende måte.

Etter anmodning fra Utenriksdepartementet utarbeidet UNFPA et avtaleutkast som har vært gjenstand for omfattende drøftinger. På bakgrunn av disse rådslagninger kom man fram til et omforenet avtaleutkast som i hovedsak bygger på tilsvarende rammeavtaler mellom Norge og De Forente Nasjoners Organisasjon for ernæring og landbruk (FAO) og Den internasjonale arbeidsorganisasjon (ILO).

UNFPA er det sentrale multilaterale organ for finansiering av virksomhet på befolkningsområdet og er administrativt underlagt FNs utviklingsprogram (UNDP). Fondet baserer seg på frivillige bidrag fra medlemslandene.

Fondets virksomhet omfatter blant annet folketellinger, opplysningstiltak, opplæring av personell og direkte støtte til familieplanlegging. UNFPA finansierer en vesentlig del av den virksomhet på disse områder som drives av FNs særorganisasjoner. Finansiell bistand ytes også direkte til utviklingsland til gjennomføring av offentlige befolkningsprogrammer.

I 1976 godkjente styret nye retningslinjer for fordeling av ressursene mellom land som har behov for bistand på befolkningsområdet. På grunnlag av slike kriterier som befolkningstilvekst, fruktbarhet, barnedødelighet og folketetthet på dyrkbart areal har UNFPA utarbeidet en liste over ca. 40 land med særlig behov for bistand. Det tas sikte på å kanalisere rundt to tredjeparter av fondets ressurser til disse landene. Det er en forutsetning at listen skal anvendes fleksibelt og kunne revideres i lys av endrede forhold.

Norge har bevilget kr. 4 550 000 til multi-bi-samarbeid med UNFPA for budsjettåret 1977, jfr. St.prp. nr. 1 (1976—77), kapittel 184.

Et avtrykk av avtaleutkastets engelske

Vedlegg: Avtalens tekst på engelsk med oversettelse til norsk.

tekst med oversettelse til norsk følger som trykt vedlegg til denne proposisjon. Til de enkelte bestemmelser i avtaleutkastet skal bemerkes:

Artikkel I fastsetter at UNFPA skal ha kompetanse til å inngå avtaler om bistand til utviklingsland om forberedelse og iverksettelse av programmer og prosjekter som Norge og UNFPA blir enige om og som faller innenfor UNFPAs virkeområde.

Artikkel II forutsetter at Norge skal stille midler til disposisjon for UNFPA — i form av forvaltningsfond — for at organisasjonen kan iverksette avtaler, utføre forberedende oppdrag samt dekke UNFPAs tekniske og administrative kostnader som er nærmere omhandlet i avtalens Artikkel III.

Skulle det finnes overskytende midler etter at et prosjekt er fullført, skal disse tilbakeføres til Norge med mindre Norge bemyndiger UNFPA til helt eller delvis å overføre restbeløpet til andre forvaltningsfond.

UNFPA skal opprette særskilte forvaltningsfond for avtalte formål eller for hvert program eller prosjekt som støttes i henhold til Avtalen. UNFPA skal administrere og føre regnskap over forvaltningsfondene i overensstemmelse med sine egne bestemmelser samt føre særskilte bøker og regnskaper for hvert enkelt forvaltningsfond.

UNFPAs forpliktelser ifølge avtalte formål eller under avtaler som er inngått med en mottakerregjering skal være betinget av de nødvendige norske bidrag.

Artikkel III pålegger Norge å dekke UNFPAs tekniske og administrative kostnader i forbindelse med gjennomføringen av et prosjekt med en viss prosent av de prosjektkostnader som påløper innenfor hvert forvaltningsfond.

Artikkel IV regulerer nærmere innholdet av de avtaler UNFPA inngår med mottakerregjeringer.

Ved inngåelse av slike avtaler skal UNFPA følge sin vanlige fremgangsmåte og sørge for at avtaletekstene blir oversendt til Norge. Disse avtaler skal inneholde bestemmelser om at særlige forpliktelser for UNFPA i henhold til disse avtaler skal kunne overføres til Norge. Norge og UNFPA skal ha rett til å inspisere programmene og prosjektene og få relevante rapporter og dokumentasjon.

Avtalene skal også inneholde bestemmelser om at de forpliktelser som UNFPA påtar seg skal være underlagt beslutninger av UNFPAs styrende organ og dets konstitutive, finansielle og budsjettmessige bestemmelser. De skal dertil være avhengige av at UNFPA mottar de nødvendige bidrag fra Norge.

Artikkel V inneholder nærmere bestemmelser om kompetansefordelingen mellom Norge og UNFPA når det gjelder utvelgelse og administrasjon av projekter.

Det forutsettes et nært samarbeid mellom Partene for de formål som er angitt i Avtalen. UNFPA skal imidlertid ha hovedansvaret for utvelgelse og bearbeidelse av de forslag og prosjekter som kan være egnet til finansiering under Avtalen.

Når det gjelder langtidsprogrammer og større prosjekter, kan UNFPA foreslå at det sendes en forberedende delegasjon til mottakerlandet hvorav minst en deltaker kan være oppnevnt av Norge.

UNFPA skal en gang i året på et tidspunkt som Partene avtaler sende Norge en liste over egnede forslag og prosjekter som foreslås finansiert i det påfølgende kalenderår. Et felles møte skal avholdes mellom Partene for å drøfte disse prosjekter. Etter at Norge har informert UNFPA om hvilke forslag og prosjekter man vurderer å finansiere, skal UNFPA ta kontakt med mottakerregjeringene for å utarbeide arbeidsplaner som skal oversendes Norge. Når Norge har informert UNFPA om hvilke forslag, programmer eller prosjekter som er endelig godkjent, skal de nødvendige midler, som nevnt i Artikkel II, overføres.

UNFPA skal være ansvarlig for tilsyn med og kontroll av prosjektene.

Artikkel VI pålegger UNFPA hvert år å innsende kontoutdrag over de midler som er anvendt samt periodiske fremdriftsrapporter om prosjektene etter behov. Dertil skal UNFPA innsende årlige fremdriftsrapporter.

I opplysningsøyemed skal UNFPA innsende informasjon som egner seg for utsendelse til den almene offentlighet vedrørende virksomhet som utføres under denne Avtale.

UNFPA skal utarbeide sluttrapporter for alle prosjekter inneholdende en vurdering av resultatene. I passende tilfelle vil det også bli foretatt spesielle vurderinger av representanter for Norge, UNFPA og mottakerregjering eller av en uavhengig institusjon.

Artikkel VII forutsetter at Partene kan inngå tilleggsavtaler eller treffe ordninger vedrørende gjennomføringen av Avtalen dersom dette skulle vise seg nødvendig.

Artikkel VIII bestemmer at Avtalen skal bli midlertidig anvendt fra den dato den blir undertegnet og skal tre i kraft når Norge har notifisert UNFPA om at Avtalen er godkjent i samsvar med konstitusjonelle krav.

Avtalen skal forbli i kraft inntil en av Partene finner at samarbeidet ikke lenger kan

fortsette på en hensiktsmessig og effektiv måte. Den kan i så fall bringes til opphør ved gjensidig overenskomst eller ensidig ved seks måneders varsel til den annen Part.

Dersom avtalen bringes til opphør, er det forutsatt at det holdes konsultasjoner mellom Partene for å bli enige om hvilke tiltak som skal iverksettes når det gjelder avvikling av de forpliktelser som UNFPA har påtatt seg i henhold til denne avtale. Eventuelle overskytende beløp skal returneres til Norge.

Ved kongelig resolusjon av 30. september 1977 ble det gitt fullmakt til undertegning av avtalen, med forbehold om Stortingets samtykke. Avtalen ble undertegnet i New York den 12. oktober 1977.

Utenriksdepartementet

tilrår:

At Deres Majestet godkjenner og skriver under et fremlagt utkast til proposisjon til Stortinget om samtykke til godkjenning av en avtale mellom Norge og De Forente Nasjoners befolkningsfond om samarbeid på områdene befolkning- og familieplanlegging.

Vi OLAV, Norges Konge,

gjør vitterlig:

Stortinget blir innbudt til å fatte vedtak om samtykke til godkjenning av en avtale mellom Norge og De Forente Nasjoners befolkningsfond om samarbeid på områdene befolkning- og familieplanlegging

Tilråding fra Utenriksdepartementet ligger ved i avtrykk.

Gitt på Oslo slott 28. oktober 1977.

Under Vår hånd og rikets segl

OLAV
(L. S.)

Odvar Nordli

Dag Berggrav

St. prp. nr. 35. 1977—78
Avtale mellom Norge og de Forente Nasjoners befolkningsfond (UNFPA) om samarbeid på områdene befolkning- og familieplanlegging.

Vedlegg.

Avtale mellom Kongeriket Norges Regjering og De Forente Nasjoners befolkningsfond om samarbeid på områdene befolkning og familieplanlegging.

Da Kongeriket Norges Regjering (heretter kalt «Norge») erkjenner den høye prioritet som må tillegges virksomhet på områdene befolkning- og familieplanlegging for å bistå utviklingslandene med å bedre deres nåværende økonomiske og sosiale vilkår;

Da Norge er klar over den ledende rolle som De Forente Nasjoners befolkningsfond (heretter kalt («UNFPA») spiller i samordningen av denne bistand;

Da Norge ønsker å styrke sitt samarbeid med UNFPA ved å stille midler til rådighet for UNFPA til gjennomføring av omforente programmer og prosjekter;

Da UNFPA med glede hilser denne styrking av samarbeidet med Norge, som vil bidra til å oppfylle de målsettinger som definert i UNFPAs mandat;

Er Norge og UNFPA blitt enige om følgende:

Artikkel I.

UNFPAs grunnleggende myndighet.

I overensstemmelse med bestemmelsene i denne Avtale bemyndiges UNFPA til å inngå avtale om å yte bistand til utviklingsland (heretter kalt «Mottakerregjeringer») for forberedelse og iverksettelse av omforente programmer og prosjekter som faller innenfor rammen av det virkefelt som er tillagt UNFPA i henhold til dets mandat.

Artikkel II.

Forvaltningsfond.

1. (a) Norge skal på forhånd stille til rådighet for UNFPA som forvaltningsfond slike beløp i US dollar og på slike tidspunkt som blir avtalt for å:

(i) iverksette avtaler med Mottakerregjeringer,
(ii) utføre forberedende oppdrag,
(iii) dekke UNFPAs tekniske og administrative omkostninger (se Artikkel III),

(b) Ethvert beløp som gjenstår ubenyttet i et forvaltningsfond etter fullføringen av et bestemt prosjekt eller oppdrag skal tilbakeføres til Norge med mindre sistnevnte bemyndiger UNFPA til helt eller delvis å overføre restbeløpet til andre forvaltningsfond.

2. UNFPA skal opprette et særskilt forvaltningsfond for avtalte formål eller for hvert program eller prosjekt som støttes i henhold til denne Avtale.

3. UNFPA skal administrere og føre regnskap over forvaltningsfondene i henhold til sine egne bestemmelser vedrørende finansielle forhold og andre relevante regler, og skal føre særskilte bøker og regnskaper for hvert enkelt forvaltningsfond.

4. Alle økonomiske forpliktelser og utgifter som UNFPA påtar seg i forbindelse med bistand som ytes i henhold til denne Avtale, skal angis i US dollar.

5. UNFPAs forpliktelse ifølge avtalte formål eller under avtaler som er inngått med en Mottakerregjering skal være betinget av at

1977—78

St. prp. nr. 35

Avtale mellom Norge og de Forente Nasjoners befolkningsfond (UNFPA) om samarbeid på områdene befolkning- og familieplanlegging.

Agreement between The Goverrment of The Kingdom of Norway and The United Nations fund for populations activities on co-operation in the population and family planning fields.

Whereas the Government of the Kingdom of Norway (hereinafter referred to as «Norway») is conscious of the high priority which must be given to activities in the population and family planning fields to assist developing nations in improving their present economic and social conditions;

Whereas Norway is aware of the leading role played by the United Nations Fund For Population Activities (hereinafter referred to as «UNFPA») in coordinating such assistance;

Whereas Norway desires to strengthen its co-operation with UNFPA by making funds available to UNFPA for the implementation of mutually agreed programmes and projects;

Whereas UNFPA welcomes this strengthening of co-operation with Norway which will contribute to the achievement of the objectives as defined in the UNFPA mandate;

Norway and UNFPA have agreed as follows:

Article I.

Basic Authority of UNFPA.

Subject to the provisions of this Agreement, UNFPA is authorized to agree to provide assistance to developing countries (hereinafter referred to as Recipient Governments) for the preparation and implementation of the mutually agreed programmes and projects falling within the scope of the functions assigned to UNFPA under its mandate.

Article II.

Funds-in-Trust.

1. (a) Norway shall make available to UNFPA in advance, as funds-in-trust, such amounts in United States dollars and at such times as may be agreed to:

(i) give effect to agreements with Recipient Governments,
(ii) carry out preparatory missions,
(iii) cover UNFPA's technical and administrative costs (See Article III).

(b) Any balance remaining unspent in any trust fund upon the completion of a given project or mission shall be returned to Norway unless the latter authorizes UNFPA to allocate all or part of such balance to other trust funds.

2. UNFPA shall establish a separate trust fund for agreed purposes or for each programme or project supported under this Agreement.

3. UNFPA shall administer and account for the funds-in-trust in accordance with its own financial regulations and other applicable rules, and shall keep separate records and accounts for each trust fund.

4. All financial commitments and expenditures made by UNFPA with respect to assistance provided under this Agreement shall be expressed in United States dollars.

5. UNFPA's obligation in pursuance of agreed purposes or under any agreement entered into with a Recipient Government shall

Norge yter de nødvendige bidrag. UNFPA påtar seg intet ansvar utover de beløp som er deponert som forvaltningsfond i øyemed av enhver avtale som er inngått med en Mottakerregjering.

Artikkel III.
Tekniske og administrative omkostninger.

For å dekke UNFPAs tekniske og administrative omkostninger skal UNFPA ha krav på godtgjørelse fra Norge med et beløp som svarer til en viss prosent av de prosjektomkostninger som påløper under hvert forvaltningsfond. Det tilsvarende beløp skal angis på utgiftslisten som er vedlagt Formålsbeskrivelsen eller Arbeidsplanen nevnt i Artikkel V, Punkt 7, nedenfor.

Artikkel IV.
Avtaler som UNFPA inngår med Mottakerregjeringer.

1. Avtaler mellom UNFPA og Mottakerregjeringer skal utarbeides og fortolkes i overensstemmelse med UNFPAs vanlige praksis og fremgangsmåte. De vilkår som blir gjort gjeldende for enhver slik avtale skal være nedfelt i en Arbeidsplan eller lignende form for avtale mellom UNFPA og Mottakerregjeringene, hvorav en gjenpart skal oversendes Norge.

2. Avtaler mellom UNFPA og Mottakerregjeringer skal inneholde bestemmelser som tillater at særlige forpliktelser for UNFPA i henhold til disse avtaler overføres til Norge. Avtalene skal også inneholde en bestemmelse som gir UNFPA og Norge rett til å inspisere programmet eller prosjektet og få relevante rapporter og dokumentasjon.

3. Avtaler mellom UNFPA og Mottakerregjeringer skal inneholde en bestemmelse om at UNFPAs forpliktelser i henhold til avtalen skal være betinget av:

(a) beslutningene av dets styrende organ og dets konstitutive, finansielle og budsjettmessige bestemmelser;
(b) mottakelse av de nødvendige bidrag fra Norge.

Artikkel V.
Kompetansefordeling mellom UNFPA og Norge vedrørende utvelgelse og administrasjon av prosjekter.

1. Det er partenes forutsetning at det skal finne sted et nært samarbeid mellom dem for de formål som er angitt i denne Avtale. Med dette for øye skal de regelmessig rådføre seg med hverandre og gjøre tilgjengelig for hverandre alle opplysninger og all bistand som det med rimelighet kan forlanges.

2. UNFPA skal ha hovedansvaret for utvelgelse og bearbeidelse av forslag og prosjektanmodninger som skal vurderes i forbindelse med denne Avtale.

3. Konsultasjoner skal finne sted regelmessig og på et tidlig forberedende stadium når det gjelder slike forslag og prosjektanmodninger som UNFPA anser som egnet til finansiering i henhold til denne Avtales vilkår.

4. Med hensyn til langtidsprogrammer og større prosjekter, kan UNFPA foreslå for Norge at en forberedende delegasjon, som kan inneholde minst en deltaker oppnevnt av Norge, skal sendes til den fremtidige Mottakerregjering.

be contingent upon receipt of the necessary contribution from Norway. UNFPA will not assume any liability in excess of the amounts deposited as funds-in-trust for the purpose of any agreement entered into with a Recipient Government.

Article III.
Technical and administrative costs.

In order to cover UNFPA's technical and administrative costs, UNFPA shall be entitled to compensation from Norway in an amount corresponding to a certain percentage of the project costs incurred in regard to each trust fund. The corresponding amount shall be indicated in the table of expenditure attached to the Description of Purposes or Plan of Operation referred to in Article V, Section 7 below.

Article IV.
Agreements entered into by UNFPA with Recipient Governments.

1. Agreements between UNFPA and Recipient Governments shall be prepared and construed in accordance with the standard practices and policies of UNFPA. The conditions applying to any such agreement shall be embodied in a Plan of Operation or similar form of agreement concluded between UNFPA and Recipient Governments, a copy of which shall be transmitted to Norway.

2. Agreements between UNFPA and Recipient Governments shall contain provisions permitting the transfer of specified UNFPA obligations arising thereunder to Norway. Agreements shall also include a provision reserving the right for UNFPA and Norway to inspect the programme or project and to obtain relevant reports and documentation.

3. Agreements between UNFPA and Recipient Governments shall contain a provision to the effect that UNFPA's obligations specified therein shall be subject:

(a) to the decisions of its governing body and to its constitutional, financial and budgetary rules;
(b) to the receipt of the necessary contribution from Norway.

Article V.
Distribution of functions between UNFPA and Norway with regard to the selection and administration of projects

1. It is the intention of the Parties that there shall be close co-operation between them for the purpose set forth in this Agreement. To that end they shall regularly consult with each other and shall make available to each other all such information and assistance as may reasonably be requested.

2. UNFPA shall have the primary responsibility for selecting and processing proposals and project requests to be considered in the context of this Agreement.

3. Consultations shall take place periodically and at an early preparatory stage with regard to such proposals and project requests as UNFPA considers suitable for financing under the terms of this Agreement.

4. For long-term programmes and major projects, UNFPA may propose to Norway that a preparatory mission, which could include at least one member designated by Norway, be sent to the prospective Recipient Government.

5. UNFPA skal en gang i året på et tidspunkt som Partene avtaler sende Norge en liste over forslag og prosjekter som foreslås finansiert i det påfølgende kalenderår bilagt nødvendig bakgrunnsmateriale. Et felles møte skal avholdes på et tidspunkt som Partene avtaler for å drøfte disse prosjekter og, såfremt påkrevd, for å foreta en generell gjennomgåelse av forutgående års resultater og drøfte problemer forbundet med rapportering og regnskaper. Norge skal så tidlig som mulig orientere UNFPA om hvilke prosjekter som sannsynligvis vil bli godkjent av Norge.

6. UNFPA skal deretter, såfremt påkrevd, utarbeide detaljerte forslag eller innlede nærmere forhandlinger med de aktuelle Mottakerregjeringer og utarbeide utkast til Arbeidsplaner. Disse forslag og utkast skal oversendes Norge til uttalelse.

7. Når Norge har meddelt UNFPA at et forslag, program eller prosjekt er formelt godkjent, skal UNFPA sluttføre avtalen og, når påkrevet, undertegne Arbeidsplanen med Mottakerregjeringen og oversende alle relevante dokumenter, deriblant en Formålsbeskrivelse, og, om relevant, en underskrevet gjenpart av Arbeidsplanen til Norge.

8. Norge skal deretter deponere hos UNFPA de beløp som er nødvendige for å finansiere virksomheten, programmet eller prosjektet som forvaltningsfond i overensstemmelse med Artikkel II i denne Avtale.

9. UNFPA skal være ansvarlig for tilsyn og kontroll med arbeidet som er støttet gjennom forvaltningsfondet, men skal ha adgang til å engasjere under-kontrahenter til å utføre hele eller deler av prosjekter som er finansiert under denne Avtale.

Artikkel VI.
Rapporter.

1. Senest den 31. mai hvert år skal UNFPA oversende Norge et kontoutdrag som viser bruken av de midler som er utbetalt til utføringen av de virksomheter som er finansiert i henhold til denne Avtale i løpet av foregående kalenderår.

2. Periodiske rapporter om de virksomheter som støttes i henhold til denne Avtale skal oversendes Norge etter behov. UNFPA skal gi Norge årlige fremdriftsrapporter.

3. Da det er i partenes felles interesse å opplyse opinionen om utviklingslandenes behov og innsats, skal UNFPA oversende Norge opplysninger som egner seg til utsendelse til den allmenne offentlighet vedrørende virksomhet som utføres under denne Avtale.

4. UNFPA skal etter at hvert enkelt tiltak, program eller prosjekt er fullført oversende Norge en endelig rapport som inneholder en vurdering av resultatene.

5. Norge skal være berettiget til å sende en eller flere representanter til å delta i alle møter som avholdes i UNFPAs hovedkvarter for vurdering av virksomheter som støttes i henhold til denne Avtale.

6. I passende tilfeller skal det etter nærmere avtale mellom Norge og UNFPA utarbeides program- og prosjektvurderingsrapporter enten av en delegasjon sammensatt av personell som representerer Norge, UNFPA og Mottakerregjeringen eller av en uavhengig institusjon som Norge og UNFPA i fellesskap slutter avtale med i dette øyemed.

5. UNFPA will submit to Norway once a year, at a time agreed upon by both Parties, a list of proposals and projects, with appropriate supporting documents proposed for financing during the subsequent calendar year. A joint meeting will be held at a time agreed upon by the Parties to discuss these projects and, as appropriate, to make a general review of performance of the past year and to discuss any problems related to reporting and accounts. Norway will inform UNFPA as soon as possible of the proposals and projects which are likely to be approved by Norway.

6. UNFPA will then as appropriate formulate detailed proposals or enter into more detailed negotiations with the prospective Recipient Governments and prepare draft Plans of Operation. Such detailed proposals and drafts shall be transmitted to Norway for comments.

7. When Norway has informed UNFPA of its formal approval of a proposal, programme or project, UNFPA will finalize the agreement and as appropriate sign the Plan of Operation with the Recipient Government, and forward to Norway all relevant documents including the Description of Purposes and as relevant a signed a copy of the Plan of Operation.

8. Norway will then deposit the amounts necessary to finance the activity, programme or project with UNFPA as funds-in-trust in accordance with Article II of this Agreement.

9. UNFPA shall be responsible for supervision and control of the work supported by the trust fund but shall be free to appoint sub-contractors for the execution of the whole or of any part of projects sponsored under this Agreement.

Article VI.
Reports.

1. UNFPA shall submit to Norway not later than May 31st of each year, a statement of accounts showing the use of the funds expended for the activities financed under this Agreement during the previous calendar year.

2. Periodic reports of the activities supported under this Agreement will be transmitted to Norway as required. UNFPA shall provide Norway with annual progress reports.

3. Since educating public opinion concerning the needs and efforts of the developing countries is of mutual concern to the Parties, UNFPA will provide Norway with information suitable for dissemination to the public at large on activities undertaken under this Agreement.

4. UNFPA shall, after the conclusion of each activity, programme or project, provide Norway with a final report containing an evaluation of the results.

5. Norway shall be entitled to send one or more representatives to participate in any evaluation sessions that may be held at UNFPA Headquarters concerning activities supported under this Agreement.

6. In appropriate cases to be agreed between Norway and UNFPA, programme or project assessment reports will be prepared either by a mission composed of personnel representing Norway, UNFPA and the Recipient Government, or by an independent institution contracted for this purpose jointly by Norway and UNFPA.

Artikkel VII.

Tilleggsavtaler og -ordninger.

Partene kan inngå slike tilleggsavtaler og -ordninger vedrørende gjennomføringen av denne Avtale som anses ønskelige i lys av erfaringene.

Artikkel VIII.

Ikrafttreden og opphør.

1. Denne Avtale skal bli midlertidig anvendt fra den dato den blir undertegnet og skal tre i kraft når Norge har notifisert UNFPA om at Avtalen er godkjent i samsvar med konstitusjonelle krav.

2. Denne Avtale skal forbli i kraft inntil en av Partene finner at det forutsatte samarbeid ikke lenger kan gjennomføres på en hensiktsmessig og effektiv måte. Denne Avtale kan da bringes til opphør ved felles samtykke eller ved den ene Parts avgivelse av seks måneders skriftlig varsel til den annen Part.

3. Dersom varsel om opphør av denne avtale avgis av en av Partene i overensstemmelse med foregående punkt, skal begge Parter straks avholde rådslagninger med henblikk på å treffe de mest hensiktsmessige tiltak for avvikling av den virksomhet som utføres av UNFPA i henhold til avtaler. I ethvert tilfelle skal Norge gi UNFPA fullmakt til å oppfylle alle løpende rettslige forpliktelser som er oppstått forut for opphøret av Avtalen, og som angår personlige og andre kontraktmessige tjenesteytelser, forsyninger, utstyr og reiser. Alle ubrukte midler som gjenstår etter at virksomheten er avviklet, skal tilbakeføres til Norge.

Til bekreftelse herav har de undertegnede, som er behørig bemyndiget til dette, skrevet under nærværende Avtale.

Utferdiget på engelsk i to eksemplarer i den 1977.

For Kongeriket Norges Regjering	For De Forente Nasjoners Befolkningsfond

Article VII.

Supplementary agreements and arrangements.

The Parties may enter into such supplementary agreements and arrangements for the implementation of this Agreement as may be found desirable in the light of experience.

Article VIII.

Entry into force and termination.

1. This Agreement shall be provisionally applied from the date of its signature, and shall enter into force when UNFPA has been notified by Norway that the Agreement has been approved in conformity with constitutional requirements.

2. This Agreement shall remain in force until either Party considers that the co-operation envisaged therein can no longer appropriately or effectively be carried out, at which time this Agreement may be terminated by mutual consent or by either Party serving six months' written notice on the other Party.

3. If notice of termination of this Agreement is given by one of the Parties in accordance with the preceding paragraph, both Parties shall forthwith hold consultations with a view to determining the most appropriate measures to be taken in order to wind up operations being carried out by UNFPA under agreements. In any event Norway shall authorize UNFPA to meet any current legal obligations arising prior to termination of the Agreement and relating to personal and other contractual services, supplies, equipment and travel. Any unused resources remaining after the winding up of operations shall be returned to Norway.

In witness whereof, the undersigned, being duly authorized thereto, have signed the present Agreement.

Done in duplicate in the English language at this day of 1977.

For the Government of the Kingdom of Norway	For the United Nations Fund for Population Activities

APPENDIX IV: NORWEGIAN MULTI-BILATERAL ASSISTANCE TO HEALTH, FP/MCH AND POPULATION PROGRAMMES (Sector 72)

1980

UNFPA	JAMAICA	NOK 2.700.000
UNFPA	SRI LANKA	2.500.000
UNICEF	NICARAGUA	1.725.000
UNFPA	PERU	2.500.000
UNICEF	TCHECKOSLOVAKIA	1.875.000
IDA	THAILAND	5.861.000
TOTAL		17.161.000

1981

UNFPA	BASIC NEEDS ASSESSMENT	NOK 2.970.000
UNFPA	JAMAICA HEALTH	720.000
UNFPA	SRI LANKA FAMILY PLANNING	540.000
UNFPA	NEPAL CHILD HEALTH	3.240.000
UNFPA	PERU CHILD HEALTH	1.530.000
TOTAL		9.000.000

1982

UNFPA	BNA MISSIONS	NOK 1.130.000
UNFPA	JAMAICA PRIM. HEALTH CARE	1.834.000
UNICEF	SRI LANKA ESTATES PROJECT	1.495.000
UNFPA	SRI LANKA FP-SERVICES	137.000
UNICEF	NICARAGUA BASIC SERVICES	2.781.000
UNFPA	NEPAL FP/MCH	5.650.000
UNICEF	SOMALIA SERV. FOR CHILD/MOTHERS	5.980.000
IDA/IBRD	TUNIS POPULATION PROJECT	381.000
TOTAL		19.388.000

1983

UNICEF	BOLIVIA INTEGR.SERV. CHIL	NOK 3.200.000
UNFPA	CHINA FERTILITY SURVEY	2.150.000
UNFPA	CHINA CENSUS PROJECT	5.700.000
UNFPA	ETHIOPIA PRIM. HEALTH CARE	1.000.000
UNICEF	GLOBAL HEALTH EDUC. WOMEN	1.800.000
UNFPA	JAMAICA LITERACY HEALTH PROGR	1.500.000
UNICEF	SRI LANKA ESTATES PROJECT	1.800.000
UNICEF	NICARAGUA SERVICES FOR CHILDREN	3.600.000
UNICEF	NICARAGUA MATERNAL AND HEALTH	315.000
UNFPA	NEPAL FP/CHILD HEALTH	3.900.000
UNFPA	SYC FAMILY LIFE EDUCATION	450.000
TOTAL		25.415.000

1984

UNICEF	BLZ CHILD. HEALTH EDUCATION	NOK	2.349.000
UNICEF	BOLIVIA INTEGR. SERV. FOR CH		4.426.000
UNFPA	BOLIVIA EXTENSION INTEGR. MCH		2.390.000
UNFPA	BURMA CENSUS PROJECT		385.000
UNFPA	CHINA CENSUS PROJECT		1.471.000
UNFPA	ETHIOPIA COM.SUPPORT MCH PROGR.		350.000
UNFPA	JAMAICA PRIM. HC AND FP		30.000
UNICEF	SRI L. SERV. FOR WOMEN AND CH		1.888.000
UNFPA	MADAGASCAR DEMOGRAPH. MCH STAT.		380.000
UNFPA	NICARAGUA MCH/FP PROJECT		2.050.000
UNFPA	NEPAL FP/MCH PROJECT		4.270.000
UNFPA	PERU SEX EDUC. RPOGRAMME		257.000
UNFPA	SYC FAMILY LIFE EDUCATION		182.000
UNFPA	TANZANIA CIVIL REGIST. SYSTEM		220.000
TOTAL			20.648.000

1985

UNICEF	BOL. INFANT MORT. REDUCTION	NOK	2.460.000
UNFPA	BOL. EXTENS. INTEGR. MCH CARE		4.425.000
UNICEF	CRI. URBAN BASIC SERVICES		1.309.000
UNFPA	ETH. COMM. SUPPORT FOR HEALTH		806.000
UNICEF	GTM. URBAN BASIC SERVICES		2.778.000
UNICEF	SRI L. SERV. FOR CHILDR. AND WOMEN		2.587.000
UNICEF	NIC. SERV. FOR CHILDREN AND WOMEN		7.936.000
UNFPA	NIC. MATERNAL AND CH/FP		5.958.000
UNFPA	NEPAL FAMILY PLANNING		5.678.000
UNICEF	PERU INTEGR. BASIC SERVICES		794.000
UNFPA	PERU PILOT SEX EDUC. PROGRAMME		143.000
UNICEF	RAM EARLY CHILDHOOD DEVELOPMENT		1.750.000
UNFPA	SYC FAMILY LIFE EDUCATION		149.000
TOTAL			36.773.000

1986

BOLIVIA CHILD. MORTALITY	NOK	2.284.000
BOLIVIA INTEGR. MCH PROGR		2.753.000
CHINA FERTILITY SURVEY		1.514.000
CRI SERVICES FOR TOWN POPUL.		969.000
ETHIOPIA COMMUNICATION MCH PROG.		946.000
SRI L. SERV. FOR CHILDR. AND WOMEN		2.410.000
NICARAGUA HEALTH SERVICES		7.400.000
NICARAGUA MCH/FP		6.232.000
NEPAL FP		5.424.000
PAN SERV. FOR TOWN POPULATION		788.000
PERU INTEGR. BASIC SERVICES		473.000
PERU SEX EDUCATION		420.000
UGANDA HEALTH/WATER SERVICES		4.726.000
TOTAL		36.339.000

APPENDIX V. NORWEGIAN BILATERAL ASSISTANCS TO NICARAGUA AND NEPAL 1984 - 86

NORWEGIAN BILATERAL ASSISTANCE TO NICARAGUA 1986

NIC	0143.70.01	FLYKTNINGAR MENNESKERETTIGH RØDE KORS	2	2	1.975.000
NIC	1211.72.02	KUNSTGJØDSEL	30	3	28.477.000
NIC	1211.72.02	MELKESPANN	32	3	0.005.000
NIC	1211.72.02	PAPIR	19	3	3.709.000
NIC	1211.72.02	FISKERIUTSTYR	35	3	2.136.000
NIC	1220.70.02	IIED MILJØFORSKN	92	1	0.136.000
NIC	1220.72.01	KULTURMANIFESTASJONER I NORGE	83	1	0.220.000
NIC	1220.72.01	INTERNASJONALE KULTURKONFERANSER	83	4	0.026.000
NIC	1221.70	MOBILT SAGBRUK ARB RØRSLAS INT STØTTE K	40	1	1.530.000
NIC	1221.70	HELSEPROSJEKT BLUEFIELDS AOF	70	1	0.814.000
NIC	1221.70	UTD SENTER UTSTYR AUF	63	1	0.206.000
NIC	1221.70	KUNSTGJØDSEL SMÅBØNDER CARE NORGE	30	1	1.596.000
NIC	1221.70	JORDBRUKSKOOP MATFORSYNING FIVH	30	1	0.043.000
NIC	1221.70	SKOLE PROD JORDBR REDSKAP FIVH	39	1	0.020.000
NIC	1221.70	PROD AV LÆREBØKER LEON FIVH	63	1	0.116.000
NIC	1221.70	OVNSPROD FIVH	39	1	0.149.000
NIC	1221.70	KJØP AV PAPIR FIVH	30	1	0.100.000
NIC	1221.70	DISTRIKTSUTV PROSJ KIRKENS NØDHJELP	90	1	2.800.000
NIC	1221.70	SKOLEBYGGING LAG	63	1	0.477.000
NIC	1221.70	MEKANISK YRKESSKOLE MANAGUA LAG	63	4	1.204.000
NIC	1221.70	STØTTE LANDARB ORG LO	33	1	1.000.000
NIC	1221.70	TUB PROSJ NASJ FOR FOR FOLKEHELSE	73	1	0.850.000
NIC	1221.70	FORPROSJ BLINDES HUS NORGES BLINDEFORB	63	1	0.050.000
NIC	1221.70	FISKERIUTV NORSK FOLKEHJELP	35	1	0.135.000
NIC	1221.70	PERSONELLBISTAND NORSK FOLKEHJELP	72	4	0.340.000
NIC	1221.70	VANNFORSYNINGSANLEGG FISKERI N FOLKEHJ	21	1	1.614.000
NIC	1221.70	ENSILERINGSPROSJ FISKERI N FOLKEHJ	35	1	0.142.000
NIC	1221.70	INTERNT FLYKTNINGEPROGR N FOLKEHJ	81	4	0.173.000
NIC	1221.70	HANDVERKSKOOP ESTELI N FOLKEHJ	40	1	0.730.000
NIC	1221.70	KOOP SENTER OG OPPL NORSK FOLKEHJ	35	1	0.225.000
NIC	1221.70	KJØLETEKNIKERBISTAND FISKERI N FOLKEHJ	35	4	0.705.000
NIC	1221.70	PRØVEPROD SISALTAKSTEIN N FOLKEHJELP	80	1	1.161.000
NIC	1221.70	INTERNT FLYKTNINGEPROGR N FOLKEHJ	81	1	0.240.000
NIC	1221.70	ENSILERINGSPROSJ FISKERI N FOLKEHJ	35	1	0.124.000
NIC	1221.70	REP SJARKER OG OPPLÆRING N FOLKEHJ	36	4	0.384.000
NIC	1221.70	HELSEPROSJ ZELAYA SAIH	74	4	1.143.000
NIC	1221.70	PROSJEKTKOORDINATOR SAIH	91	4	0.165.000
NIC	1221.70	SJUKEPLEIARSKOLE SAIH	70	1	1.111.000
NIC	1221.70	PROD LÆREMIDLAR FØRSKOLER SAIH	63	1	0.409.000
NIC	1240.72.28	NIC501 TNI	99	4	0.100.000
NIC	1250.01.50	JORDFAG	30	4	0.077.000
NIC	1250.01.50	FISKERITEKNOLOGI	36	4	0.099.000
NIC	1250.01.50	OPPLÆRING I 3 LAND	39	4	0.016.000
NIC	1250.01.50	OPPLÆRING I 3 LAND	99	4	0.005.000
NIC	1250.11.61	FISKERIUTVIKLING	35	4	0.145.000
NIC	1270.72	HELSETENESTER	72	1	7.400.000
NIC	1270.73	MOR BARN HELSE FAMILIEPLANLEGGING	72	1	6.232.000
NIC	1270.74	OPPLERING DISTRIKTSUTV JORDBR PLANL	39	1	2.692.000
NIC	1270.74	DISTRIKTSUTV GJ SJØLVBERGINGSPROGR	90	1	0.647.000
NIC	1270.74	KUNSTGJØDSEL PROD AUKE	30	1	2.273.000
NIC	1270.79	MARITIM TRYGGLEIK ADMINISTRASJON	24	1	0.699.000
NIC	1270.82	SKOLEMØBELPRODUKSJON	40	1	5.890.000
NIC	1280.70.01	NØDHJ DIV RIO ABAJO KIRKENS NØDHJELP	2	2	1.000.000
NIC	1280.70.01	NØDHJ DIV TV-AKSJ KIRKENS NØDHJELP	2	2	1.000.000
		I ALT :			84.715.000

(Appendix V: Norwegian Bilateral Assistance to Nicaragua and Nepal)

NORWEGIAN BILATERAL ASSISTANCE TO NICARAGUA 1985

LAND	NIC				
NIC	0143.70.01	FLYKTN HJELP NF AMBULANSE	2	2	0.199.000
NIC	1211.72.02	VAREBISTAND KUNSTGJØDSEL	30	3	19.430.000
NIC	1211.72.02	VAREBISTAND MELKESPANN	32	3	0.322.000
NIC	1220.72	KULTUR STIPEND	83	4	0.004.000
NIC	1221.70	UTRUSTNING AV UTDANN SENTER	63	1	0.562.000
NIC	1221.70	KUNSTGJØDSEL TIL SMÅBØNDER	30	3	1.782.000
NIC	1221.70	JORDBR KOOP MATFORSYNING	30	1	0.658.000
NIC	1221.70	DISTRIKTSUTVIKLINGSPROSJEKT	90	1	2.460.000
NIC	1221.70	SKOLEBYGG NIC	63	1	0.123.000
NIC	1221.70	FORUND MEKANISK YRKESSKOLE	63	4	0.022.000
NIC	1221.70	TUBERKULOSEPROSJEKT I NIC	73	1	0.022.000
NIC	1221.70	ETABLERINGSSTØTTE PROSJ KOORD	39	4	0.091.000
NIC	1221.70	HELSEPROSJ NIC	74	4	0.595.000
NIC	1221.70	FORUND HELSE	71	4	0.050.000
NIC	1250.15	STIP I NORGE > 3 MND	39	4	0.086.000
NIC	1250.15	STIP I NORGE > 3 MND	79	4	0.164.000
NIC	1250.15	STIP I NORGE < 3 MND	39	4	0.006.000
NIC	1270.72	UNICEF SERVICES FOR CHILDREN AND WOMEN	72	1	7.936.000
NIC	1270.73	UNFPA MATERNAL AND CHILD HEALTH AND FAM	72	1	5.958.000
NIC	1270.79	IMO MARITIME SAFETY ADMINISTRATION	24	1	0.687.000
NIC	1270.82	UNDP/UNCDF SKOLEMØBELPRODUKSJON	63	1	1.732.000
			I ALT :		42.889.000

NORWEGIAN BILATERAL ASSISTANCE TO NICARAGUA 1984

LAND	NIC				
NIC	0143.70.01	NØDHJELP DIV	2	2	1.500.000
NIC	0165.01.05	OPPL NORGE > 3 MND	39	4	0.052.000
NIC	0166.74.01	VAREBISTAND KUNSTGJØDSEL	30	3	7.645.000
NIC	0166.74.01	VAREBISTAND PAPIR	49	3	3.930.000
NIC	0166.74.01	VAREBISTAND MEDISINER	79	3	2.004.000
NIC	0166.74.01	VAREBISTAND FRAKT DIV	9	3	3.376.000
NIC	0170.70	SKOLE FOR PROD. AV JORDBR. REDSKAP	39	1	0.124.000
NIC	0170.70	DISTRIKTSUTVIKLINGSPROSJEKT	90	1	2.460.000
NIC	0170.70	INTEGRERT NØDHJELP	90	1	2.500.000
NIC	0170.70	NØDHJELP	90	1	2.289.000
NIC	0170.70	STUDIE OM NORSK BISTAND	99	4	0.080.000
NIC	0170.70	FORPROSJEKTERING FISKEFOREDLING	35	1	0.091.000
NIC	0170.70	MISKITOUNDERSØKELSE	64	4	0.107.000
NIC	0170.70	MISKITO GRAMMATIKK	69	1	0.161.000
NIC	0170.70	FISKERIUTVIKLING	35	1	4.232.000
NIC	0170.70	HELSEPROSJEKT	74	4	0.498.000
NIC	0184.72	UNICEF HEALTH SERVICES	71	1	4.909.000
NIC	0184.72	UNICEF PRIMARY EDUCATION	63	1	2.644.000
NIC	0184.73	UNFPA FP/MCH PROJECT	72	1	2.050.000
NIC	0184.74	FAO MISCELLANEOUS PROJECTS	99	1	6.000.000
			I ALT :		46.652.000

(Appendix V: Norwegian Bilateral Assistance to Nicaragua and Nepal)

NORWEGIAN BILATERAL ASSISTANCE TO NEPAL 1986

NPL	1221.70	KRAFTVERKPROSJ DEN NORSKE TIBETMISJ	20	1	1.400.000
NPL	1221.70	STILLINGSSTØTTE D N TIBETMISJ	79	4	0.611.000
NPL	1221.70	IRRIGASJONSPROSJ D N TIBETMISJ	30	1	0.180.000
NPL	1221.70	YRKESSKOLE JUMLA D N TIBETMISJ	63	1	0.080.000
NPL	1221.70	SMÅKRAFTVERK D N TIBETMISJ	20	1	3.996.000
NPL	1221.70	VID UTD LOK PERS D N TIBETMISJ	20	4	0.015.000
NPL	1221.70	SJUKEPLEIARSKOLE EIGEDOM TIBETMISJ	79	1	2.400.000
NPL	1221.70	ØYEHELSETENESTE HAMAR ROTARY KLUBB	73	1	0.080.000
NPL	1221.70	FOREB OG BEHANDL AV BLINDHET KRK NØDHJ	73	1	2.301.000
NPL	1221.70	LWS PROGR KIRKENS NØDHJELP	90	1	0.400.000
NPL	1221.70	DISTRIKTSUTV KIRKENS NØDHJELP	90	1	0.400.000
NPL	1221.70	TUB PROSJ LANDSF HJERTE OG LUNGESJUKE	73	1	0.890.000
NPL	1221.70	FORUNDERS NFPU	82	4	0.006.000
NPL	1221.70	HANDIKAPPROSJ RÅDGIVINGSTJ NFPU	69	1	0.477.000
NPL	1230.70.02	KRAFTVERK TURBINPROD. SØRUMSAND V. ETC.	20	1	1.875.000
NPL	1240.72.37	NPL502 BJØNNES, NTH	80	4	0.044.000
NPL	1250.01.36	JUNIOREKSPERTAR UTGIFTER	69	4	0.395.000
NPL	1250.01.50	VANNKRAFTUTBYGGING	20	4	0.197.000
NPL	1250.01.50	NATURRESSURS MILJØ	92	4	0.091.000
NPL	1250.01.50	JORDFAG	30	4	0.115.000
NPL	1250.01.50	HUSDYRBRUK	32	4	0.115.000
NPL	1250.01.50	KURS EL-KRAFT	20	4	0.091.000
NPL	1250.01.50	PETROLIUMSEXPLORATION KURS	41	4	0.144.000
NPL	1250.01.50	OPPLÆRING NORGE MINDRE ENN 3MND	99	4	0.020.000
NPL	1250.01.50	OPPLÆRING I 3 LAND	99	4	0.141.000
NPL	1270.72	VAKSINASJONSKAMPANJE	73	1	2.950.000
NPL	1270.73	FAMILIEPLANLEGGING	72	1	5.424.000
NPL	1270.74	BRENSELVED PLANTING VATNFORS LEIING	31	1	1.575.000
NPL	1270.76	UTDANNING FOR JENTER OG KVINNER	91	1	1.652.000
NPL	1280.70.01	NØDHJ KATASTROFEBEREDSKAP RØDE KORS	2	2	0.882.000
		I ALT :			28.947.000

NORWEGIAN BILATERAL ASSISTANCE TO NEPAL 1985

LAND	NPL				
NPL	1221.70	HENGEBROER I NEPAL	23	1	1.555.000
NPL	1221.70	STILLINGSSTØTTE	79	4	0.800.000
NPL	1221.70	HIMAL HYDRO AND GEN CONSTR PVT LTD	20	1	1.500.000
NPL	1221.70	PROSJ GJENN GANG KVINNER OG ALFABETISERI	91	4	0.042.000
NPL	1221.70	FOREBYGG OG BEH AV BLINDHET	73	1	1.879.000
NPL	1221.70	DISTRIKTSUTV	90	1	0.400.000
NPL	1221.70	KN LWS PROGRAMMET	90	1	0.400.000
NPL	1240.11	NPL 401 EVAL MODELL BISTAND	99	4	0.008.000
NPL	1240.72.24	FORSKNING VANNKRAFTUTBYGGING	20	4	0.036.000
NPL	1250.01.36	JUNIOREKSPERTER UTGIFTER	69	4	0.549.000
NPL	1250.15	STIP I NORGE > 3 MND	29	4	0.257.000
NPL	1250.15	STIP I NORGE > 3 MND	39	4	0.114.000
NPL	1250.15	STIP I 3. LAND	99	4	0.100.000
NPL	1270.72	UNICEF FORMAL EDUCATION	63	1	2.976.000
NPL	1270.73	UNFPA FAMILY PLANNING	72	1	5.678.000
NPL	1270.76	UNESCO ACCESS OF WOMEN AND GIRLS TO ED	91	1	0.558.000
		I ALT :			16.852.000

(Appendix V: Norwegian Bilateral Assistance to Nicaragua and Nepal)

NORWEGIAN BILATERAL ASSISTANCE TO NEPAL 1984

LAND NPL

NPL 0165.01.05	OPPL NORGE > 3 MND	29	4	0.052.000
NPL 0165.01.05	OPPL NORGE < 3 MND	19	4	0.003.000
NPL 0165.01.05	OPPL 3.LAND	99	4	0.057.000
NPL 0165.01.01	LØNN JR EKSPERTER	69	4	0.397.000
NPL 0165.11.05	REKR EKSP JR EKSP	69	4	0.136.000
NPL 0170.70	KURS I TROPEMEDISIN	70	4	0.006.000
NPL 0170.70	STILLINGSSTØTTE	79	4	0.825.000
NPL 0170.70	IRRIGASJONSPROSJEKT	30	1	1.748.000
NPL 0170.70	BEKJEMPELSE AV BLINDHET	70	1	0.127.000
NPL 0170.70	TUBERKULOSEBEKJEMPELSE	73	1	0.755.000
NPL 0170.70	FORUNDERSØKELSE KVINNEPROGRAM MEDIA	69	4	0.119.000
NPL 0179.79.24	(501) EFFEKTER AV HYDROPROSJEKTER	20	4	0.023.000
NPL 0179.79.37	(502) BYGGFORSKNING	80	4	0.030.000
NPL 0184.72	UNICEF FORMAL EDUCATION	63	1	1.511.000
NPL 0184.73	UNFPA FP/MCH PROJECT	72	1	4.270.000
NPL 0184.76	UNESCO ACCESS OF WOMEN AND GIRLS EDUCATI	91	1	1.500.000
	I ALT :			11.559.000

(Appendix V: Norwegian Bilateral Assistance to Nicaragua and Nepal)

APPENDIX VI. UNFPA MULTI-BILATERAL PROGRAMME

Table 1

UNFPA MULTI-BILATERAL PROGRAMME: ONGOING PROJECTS As of April 1987

Region/ Project	Title	Donor	Workplan Category	Duration of Project	Total Cost (US$)
Interregional					
INT/84/P45	Norwegian Trust Fund Reserve	Norway	814	1984-	$ 31,210
INT/85/P01	Media Awareness for Women	Norway	611	1985-1987	282,240
INT/86/P13	Micro-computer Data Base (Aust, Canada,	Neth,Unif)	214	1987	123,361
INT/86/P28	Louvain-la-Neuve	Belgium	331	1987-1990	1,090,518
Total					1,527,329
Africa					
ETH/81/P05	Comm. Support to Health MCH Programme	Norway	633	1984-1987	644,556
ETH/81/P06	Comm. Support to Health MCH Programme	Italy	633	1984-1986	311,385
RAF/84/P30	Pop. IEC Regional Training Programme	Canada	600	1987-1989	709,194
RAF/87/P03	Training Prog. Sub-Saharan Africa Reg.	Canada	600	1987-1991	2,147,000
Total					3,812,135
Asia and Pacific					
BGD/85/P02	Strengthening Integ. MCH/FP	Belgium	514	1987-1990	945,946
BGD/85/P04	Supply and Distribution Monitoring Unit for the Bangladesh Population Prog.	Canada	514	1985-1987	289,102
BGD/85/P10	Family Welfare Education	Netherlands	634	1985-1987	289,675
BGD/85/P12	Improv. of NGO's Manag. Capabilities	Netherlands	540	1986-1987	162,557
CPR/82/P02	China Fertility Survey	Norway	124	1984-1988	923,026
NEP/80/P09	PopEd through Agriculture Extension	Netherlands	714	1982-1987	127,439
NEP/80/P10	SFDP Women's Group	Netherlands	711	1982-1987	272,351
NEP/80/P12	Strengthening FP/MCH in Integrated Community Health Project	Norway	514	1986-1987	656,642
NEP/80/P13	FP/MCH Project	Norway	514	1981-1988	5,777,740
NEP/80/P14	Health Manpower Training	Netherlands	521	1981-1986	510,787
NEP/83/P06	Pilot Operational Research in Comm. Based MCH/FP Activities	U.K.	522	1985-1987	73,743
PAK/82/P07	Family Welfare Centres	OPEC	514	1982-1986	1,567,105
RAS/85/P09	South Asia Management Programme	Netherlands	544	1986-1987	1,146,172
VIE/84/P02	FP Activities in Selected Prov & Distr.	Australia	500	1987-1988	175,136
Total					12,917,421
Latin America and Caribbean					
BOL/84/P02	Extension Integrated MCH Care	Norway	514	1984-1987	1,467,624
COL/79/P06	MCH/FP Programme	Italy	534	1983-1986	2,118,466
NIC/85/P02	MCH/Family Welfare	Finland	514	1985-1987	946,981
NIC/85/P03	MCH/FP Programme	Norway	514	1985-1989	4,221,663
PER/79/P03	MCH and Population	Italy	514	1983-1986	1,324,119
PER/83/P09	Pilot Sex Education Programme	Norway	634	1985-1987	277,108
RLA/83/P01	Population Information Network	Italy	611	1985-1987	1,102,500
Total					11,458,461
Middle East and Mediterranean					
SOM/80/P02	Preparatory Work 1985 Census	Italy	114	1985-1986	793,825
Total					793,825
GRAND TOTAL					$ 30,509,171

13 April 1987

Table 2

UNFPA MULTI-BILATERAL PROGRAMME: CUMULATIVE LIST OF COMPLETED AND ONGOING PROJECTS, 1976 - 1991

Region/ Project	Title	Donor	Workplan Category	Duration of Project	Total Cost (US$)
Interregional					
INT/84/P45	Norwegian Trust Fund Reserve	Norway	814	1984-	$ 31,210
INT/85/P01	Media Awareness for Women	Norway	611	1985-1987	282,240
INT/86/P13	Micro-computer Data Base (Australia,Can,Neth,Unifem)		214	1987	123,361
INT/86/P28	Louvain-la-Neuve	Belgium	331	1987-1990	1,090,518
GLO/77/P24	BNA Missions	Norway	822	1977-1985	3,499,428
Total					5,026,757
Africa					
ETH/81/P05	Comm. Support to Health MCH Programme	Norway	633	1984-1987	644,556
ETH/81/P06	Comm. Support to Health MCH Programme	Italy	633	1984-1986	311,385
MAG/79/P02	Health and Demographic Statistics	Norway	211	1984-1986	92,800
MAR/81/P01	MCH/FP on Rodrigues Island	U.K.	514	1983	103,205
RAF/81/P01	African Information Network	Italy	513	1981-1984	750,000
RAF/84/P30	Pop. IEC Regional Training Programme	Canada	600	1987-1989	709,194
RAF/87/P03	Training Prog.Sub-Saharan Africa Region	Canada	600	1987-1991	2,147,000
SEY/82/P02	Family Life Education	Norway	634	1983-1985	121,907
URT/79/P05	Civil Registration	Norway	130	1984	40,100
Total					4,920,147
Asia and Pacific					
BGD/79/P04	Integrated MCH/FP	Denmark	514	1981-1985	4,386,675
BGD/79/P07	Contraceptive Production Assistance	Netherlands	532	1981	52,500
BGD/79/P20	Population Manpower Development	Netherlands	511	1981-1985	1,216,582
BGD/85/P02	Strengthening Integrated MCH/FP	Belgium	514	1987-1990	945,946
BGD/85/P04	Supply and Distribution Monitoring Unit for the Bangladesh Population Prog.	Canada	514	1985-1987	289,102
BGD/85/P10	Family Welfare Education	Netherlands	634	1985-1987	289,675
BGD/85/P12	Improv. of NGO's Manag. Capabilities	Netherlands	540	1986-1987	162,557
BUR/83/P01	Burma Census	Norway	100	1984	88,000
CPR/82/P02	China Fertility Survey	Norway	124	1984-1988	923,026
CPR/82/P03	Printing Census Results	Norway	114	1983-1984	225,639
IND/80/P09	Supply of CuT200 IUDs	Finland	534	1984-1985	404,237
NEP/80/P09	PopEd through Agriculture Extension	Netherlands	714	1982-1987	127,439
NEP/80/P10	SFDP Women's Group	Netherlands	711	1982-1987	272,351
NEP/80/P12	Strengthening FP/MCH in Integrated Community Health Project	Norway	514	1986-1987	656,642
NEP/80/P13	FP/MCH Project	Norway	514	1981-1988	5,777,740
NEP/80/P14	Health Manpower Training	Netherlands	521	1981-1986	510,787
NEP/83/P06	Pilot Operational Research in Comm. Based MCH/FP Activities	U.K.	522	1985-1987	73,743
PAK/82/P07	Family Welfare Centres	OPEC	514	1982-1986	1,567,105
RAS/85/P09	South Asia Management Programme	Netherlands	544	1986-1987	1,146,172
SRL/80/P03	Hospital Based FP Services	Norway	514	1977-1984	896,889
VIE/84/P02	FP Activities in Selected Prov.& Distr.	Australia	500	1987-1988	175,136
Total					$ 20,177,943

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Table 2 (cont'd)

Region/ Project	Title	Donor	Workplan Category	Duration of Project	Total Cost (US$)
Latin America and Caribbean					
BOL/84/P02	Extension Integrated MCH Care	Norway	514	1984-1987	$ 1,467,624
COL/79/P06	MCH/FP Programme	Italy	534	1983-1986	2,118,466
JAM/78/P03	Primary Health Care FP	Norway	514	1980-1984	1,006,010
MEX/75/P02	Sex Education	Sweden	631	1976-1984	2,099,002
NIC/79/P01	MCH/Family Welfare	Finland	514	1980-1985	866,456
NIC/79/P02	Population Housing Census	Finland	114	1980-1984	90,273
NIC/83/P02	Expansion MCH/FP	Italy	514	1983-1985	516,656
NIC/84/P03	MCH/FP Programme	Norway	514	1984-1985	402,280
NIC/85/P02	MCH/Family Welfare	Finland	514	1985-1987	946,981
NIC/85/P03	MCH/FP Programme	Norway	514	1985-1989	4,221,663
PER/79/P03	MCH and Population	Italy	514	1983-1986	1,324,119
PER/80/P03	MCH/FP Population	Norway	514	1981	495,735
PER/83/P09	Pilot Sex Education Programme	Norway	634	1985-1987	277,108
RLA/83/P01	Population Information Network	Italy	611	1985-1987	1,102,500
Total					16,934,873
Middle East and Mediterranean					
EGY/81/P12	Population and Development Project	Netherlands	524	1982-1985	564,946
SOM/80/P02	Preparatory Work 1985 Census	Italy	114	1985-1986	793,825
Total					1,358,771
GRAND TOTAL					$ 48,418,491

13 April 1987

(Appendix VI: UNFPA Multi-bi Programme)

Table 3

UNFPA Multi-bilateral Programme - Proposed Allocations by Region for 1987*

Region/ Project	Proposed Allocation 1987 in US$
Interregional	
INT/84/P45	$ 26,352
INT/85/P01	94,080
INT/86/P13	123,361
INT/86/P28	305,428
Total Region	549,221
Africa	
ETH/81/P05	407,262
ETH/81/P06	71,547
RAF/84/P30	312,931
RAF/87/P03	458,780
Total Region	1,250,520
Asia and Pacific	
BGD/85/P02	236,486
BGD/85/P04	157,340
BGD/85/P10	134,605
BGD/85/P12	114,853
CPR/82/P02	200,000**
NEP/80/P09	49,911
NEP/80/P10	82,313
NEP/80/P12	455,334
NEP/80/P13	899,298
NEP/80/P14	153,289
NEP/83/P06	36,160
PAK/82/P07	57,952
RAS/85/P09	895,143
VIE/84/P02	116,757
Total Region	3,589,441
Latin America and Caribbean	
BOL/84/P02	230,285
NIC/85/P02	225,444
NIC/85/P03	1,002,847
PER/79/P03	757,894
PER/83/P09	166,554
RLA/83/P01	315,000
Total Region	2,698,024
Middle East and Mediterranean	
SOM/80/P02	25,851
Total Region	25,851
Total	$8,113,057

* Proposed Allocations include carry-overs from previous year, originally approved requirements for the year and administrative support costs.
** Represents in-kind-contribution.

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(Appendix VI: UNFPA Multi-bi Programme)

Table 4

1987 Multi-bilateral Planned Allocations by Donor

Australia	$ 143,277
Belgium	541,914
Canada	969,051
Finland	225,444
Italy	1,170,292
Netherlands	1,471,955
Norway	3,482,012
OPEC	57,952
United Kingdom	36,160
Unifem	15,000
Total	$8,113,057

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(Appendix VI: UNFPA Multi-bi Programme)

APPENDIX VII. NORWAY/UNFPA MULTI-BILATERAL PROGRAMME 1977-1989

NORWAY/UNFPA Multi-bilateral Programme 1977-1989

Region/ Project	Title	Expenditures Cumulative 1977 - 1983	1984	1985	1986	Planned Allocations 1987	1988	1989	Total
Interregional									
INT/84/P45	Norway Trust Fund Reserve	-	4,858	-	-	26,352	-	-	31,210
INT/85/P01	Media Awareness for Women	-	-	94,080	94,080	94,080	-	-	282,240
GLO/77/P24	BNA Missions*	3,458,086	45,976	8,995	(13,6297	-	-	-	3,499,428
Africa									
ETH/81/P05	Comm.Support to health MCH Prog.	-	36,774	115,119	85,401	407,262	-	-	644,556
MAG/79/P02	Health and Demog. Statistics*	-	46,900	30,900	15,000	-	-	-	92,800
SEY/82/P02	Family Life Education*	66,539	35,538	19,830	-	-	-	-	121,907
URT/79/P05	Civil Registration*	-	40,100	-	-	-	-	-	40,100
Asia and Pacific									
BUR/83/P01	Burma Census*	-	88,000	-	-	-	-	-	88,000
CPR/82/P02	China Fertility Surveys	-	205,922	32,472	241,632 1/	200,000 2/	243,000 3/	-	923,026
CPR/82/P03	Printing Census Results*	159,330	66,309	-	-	-	-	-	225,639
NEP/80/P12	FP/MCH in Integ.Comm.Health Proj.	-	-	-	201,308	455,334	-	-	656,642
NEP/80/P13	FP/MCH Project	2,062,844	957,241	759,989	313,386	899,298	784,982	-	5,777,740
SRL/80/P03	Hospital Based FP Services*	888,239	8,650	-	-	-		-	896,889
Latin America and Caribbean									
BOL/84/P02	Extension Integ. MCH Care	-	254,031	544,061	439,247	230,285	-	-	1,467,624
JAM/78/P03	Primary Health Care FP*	745,779	314,173	21	(53,963)	-	-	-	1,006,010
NIC/84/P03	MCH/FP Programme*	-	391,570	10,710	-	-	-	-	402,280
NIC/85/P03	MCH/FP Programme	-	-	750,831	985,745	1,002,847	1,000,000	482,240	4,221,663
PER/80/P03	MCH/FP Population*	495,735	-	-	-	-	-	-	495,735
PER/83/P09	Pilot Sex EducationProgramme	-	-	12,977	53,144	166,554	44,433	-	277,108
	Total	7,876,552	2,496,042	2,379,985	2,361,351	3,482,012	2,072,415	482,240	21,150,597

* Completed projects.
1/ $85,000 was retained in Oslo for in-kind contribution.
2/ To be retained in Oslo for in-kind contribution.
3/ Tentative amount to be retained in Oslo for in-kind contribution.

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APPENDIX VIII. NEPAL - INFORMATION

1. Organogram of the Ministry og Health

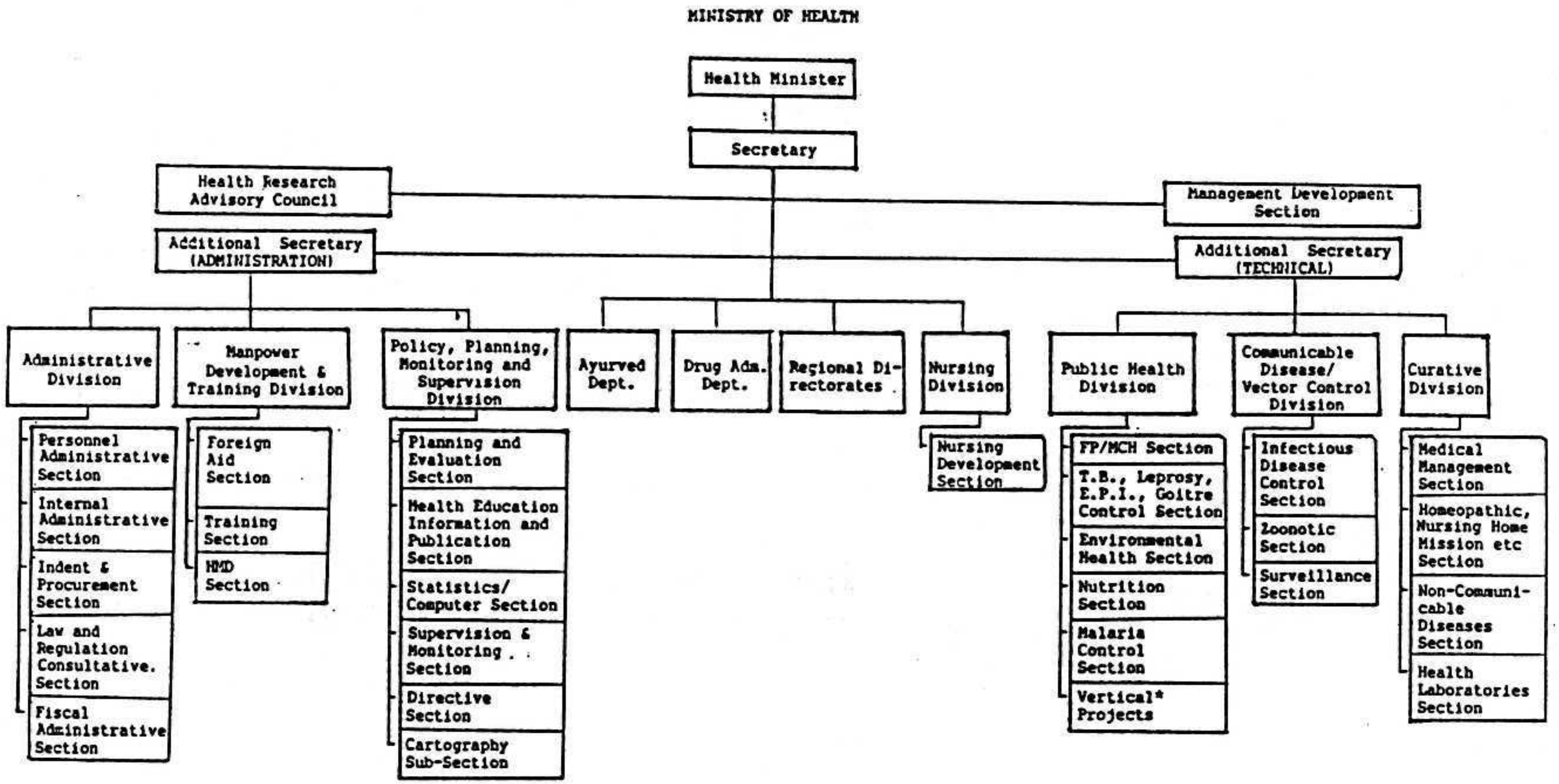
2. FP/MCH Project Organization Chart

3. NEP/80/P13 Status of Expenditures and Budget
   Norwegian Government Funds

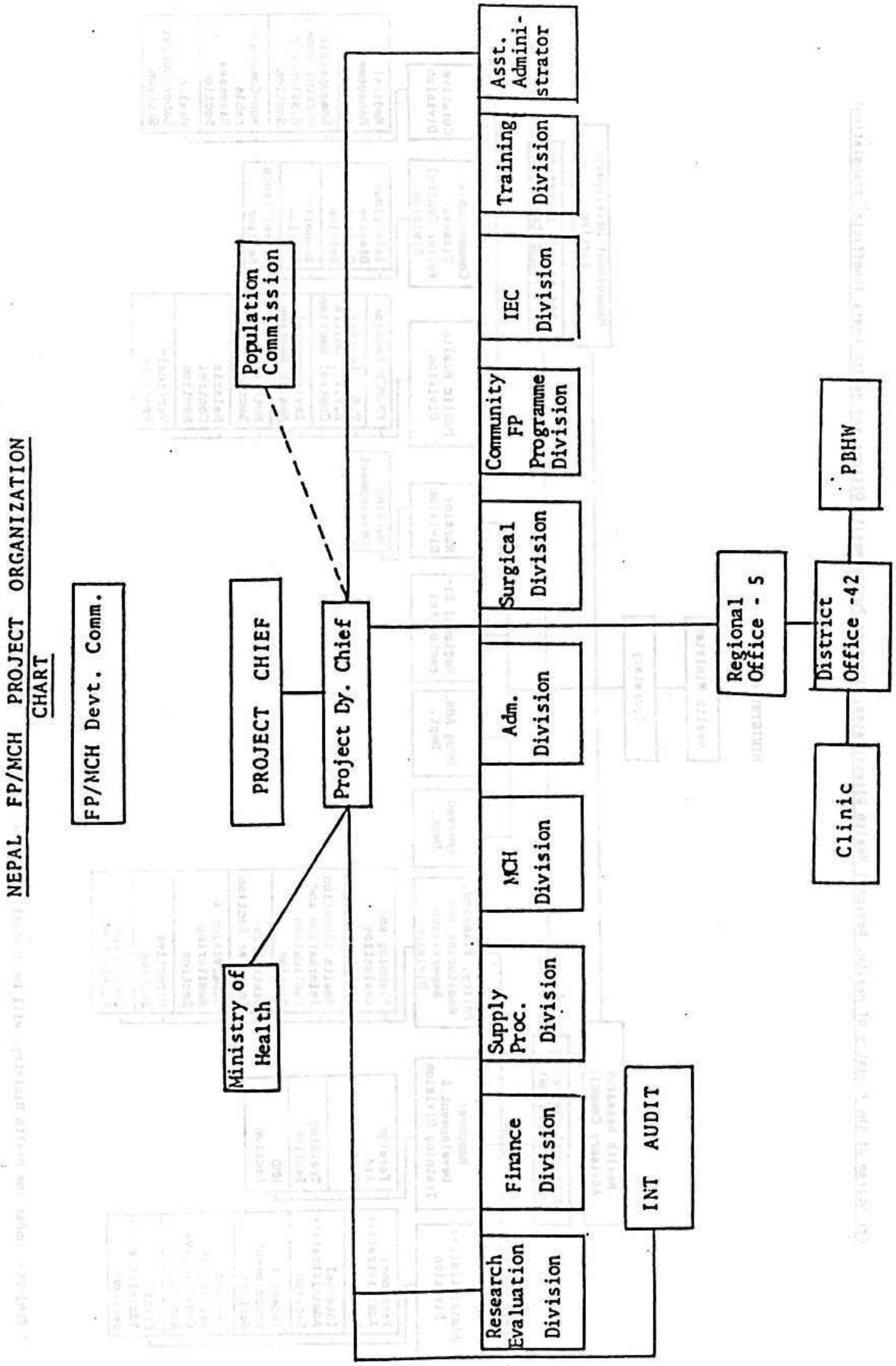
4. UNFPA Programmes in Nepal
   Financial Summary as of June 1987

5. Family Planning Acceptors by Method and Year

Organogram of the Ministry of Health, Regional Health Directorates, District Public Health Offices and Health Posts (Unofficial translation)



* Projects, under the Health Ministry, will be gradually integrated.



(Appendix VIII: NEPAL - Information)

STATUS OF EXPENDITURES AND BUDGET

Funds: Norwegian Government

Period: 1980 - 1987

Project: NEP/80/P13 - Assistance to FP/MCH Project

(In US Dollars)

Components	1981 Expenditure	1982 Expenditure	1983 Expenditure	1984 Expenditure	1985 Expenditure	1986 Expenditure	1987 Budget (Estimated)	TOTAL
Personnel	27,474	34,970	182,583	630,342	391,088	9,525	1,000	1,276,982
Training	9,775	31,418	44,834	50,160	81,027	38,676	59,475	315,365
Equipment	279,263	383,615	330,216	273,244	285,156	264,339	568,738	2,384,571
Miscellaneous	205,419	306,819	226,458	3,495	2,718	846	3,902	749,657
GRAND TOTAL	521,931	756,822	784,091	957,241	759,989	313,386	633,115	4,726,575

Note: Executing/Implementing Agencies:

Government
UNICEF
WHO

FINANCIAL SUMMARY - UNFPA FUNDED PROGRAMME

(As of June 1987)

(Figures in US Dollars)

(1) Project Number and Title	(2) Executing Agency(ies)	(3) 1980 Actual	(4) 1981 Actual	(5) 1982 Actual	(6) 1983 Actual	(7) 1984 Actual	(8) 1985 Actual	(9) 1986 Actual	(10) 1987	(11) Total (3 to 10)
I. UNFPA REGULAR FUNDS/ONGOING PROJECTS										
1. NEP/80/P02 - Improvement of Vital Events	UNFPA	37,850	72,467	102,930	38,933	6,916	-	-	-	259,096
	UNDP	-	17,756	27,384	369	243	16,560	4,613	-	67,525
										0
2. NEP/80/P04 - Improvement of Mgmt. Coordinating Capability of MSDC	UNFPA	20	26,106	17,508	8,343	10,186	13,730	23,425	22,147	121,565
										0
3. NEP/80/P07 - Introduction of Pop.Ed. through Cottage Industry for Women	UNFPA	-	38,926	138,751	176,083	-	-	-	-	353,760
	ILO	-	10,719	(36)	7,355	1,209	10,525	36,682	-	66,454
										0
4. NEP/80/P08 - Population Education Programe	UNFPA	16,780	65,903	42,351	25,212	2,407	-	-	-	152,653
	UNESCO	-	76,790	23,194	2,199	336	51,794	68,344	42,613	265,270
										0
5. NEP/80/P09 - Pop.Ed. for Farmers through the Ministry of Agriculture	UNFPA	20	48,851	47,472	25,469	11,100	3,239	-	-	136,151
	FAO	-	-	-	-	57,045	67,177	7,323	-	131,545
	UNICEF	-	-	770	10	-	-	-	-	780
										0
6. NEP/80/P10 - Pop.Ed. through SFDP	UNFPA	-	49,001	22,493	45,338	-	-	-	-	116,832
	FAO	-	-	-	-	46,951	(6,565)	333	-	40,719
										0
7. NEP/80/P11 - Strengthening the IDHSDP in the MCH at the Central Level	UNFPA	500,014	21,340	18,018	(260,430)	(29,736)	319,834	131,661	517,492	1,218,193
	WHO	-	-	11,740	21,841	31,220	7,439	-	-	72,240
										0
8. NEP/80/P12 - Strengthening the FP Service Delivery System for the IDHSDP	UNFPA	18,954	134,742	204,935	381,988	400,318	348,717	269,794	167,638	1,927,086
	UNICEF	-	33,486	90,782	3,849	131,586	133,811	33,773	2,492	429,779
	CPE	-	-	-	-	-	46,614	-	-	46,614
										0
9. NEP/80/P13 - Assistance to FP/MCH Project in Nepal	UNFPA	159,772	2,612	13,550	(101)	-	146,326	379,224	422,794	1,124,177
	UNICEF	-	-	-	-	-	446	25,757	-	26,203
										0
10. NEP/80/P14 - Strengthening the FP Personnel in the IDHSDP	UNFPA	39,714	55,298	129,419	81,408	101,086	84,830	44,290	297,761	833,806
	CPE	-	-	-	-	-	23,803	21,054	17,946	62,803
										0
11. NEP/80/P15 - Improvement of Teaching in Pop.Dy. Human Reproduction and FP at IOM.	UNFPA	28,150	122,604	66,992	36,915	34,771	35,623	39,934	38,103	403,092
	WHO	-	40,980	83,618	27,970	7,265	9,411	6,934	-	176,178
	UNICEF	-	2,486	-	-	-	1,330	-	-	3,816
										0
12. NEP/80/P18 - Introduction of FP through Day Care Centre for Women Factory Workers										0
	UNFPA	-	16,446	8,176	9,359	-	-	-	-	33,981
	ILO	-	-	-	-	4,162	10,678	28,707	12,800	56,347
13. NEP/82/P01 - Panchayat Village Level Pop./Fam. Welfare Education through MOPLD	UNFPA	-	-	11,582	39,982	8,707	4,220	8,835	18,942	92,268
	ILO	-	-	-	-	27,173	22,402	16,512	49,500	115,587
					-				-	0
14. NEP/82/P02 - Pop.Fam. Welfare Education through Cooperatives	UNFPA	-	-	21,359	43,583	32,334	30,451	15,190	44,146	187,063
	ILO	-	-	-	-	4,305	11,461	11,500	10,000	37,266
15. NEP/83/P01 - Support to NCP	UNFPA	-	-	-	1,560	109,801	10,494	11,746	13,605	147,206
16. NEP/83/P02 - Training of Planners and Programme Personnel	ILO	-	-	-	-	53,078	50,314	27,788	35,868	167,048
17. NEP/83/P03 - FP/MCH Services and Pop.Ed. Integrated with Development Projects - Pilot Study	UNFPA	-	-	-	-	8,617	47,544	14,341	50,243	120,745
	CPE	-	-	-	-	-	13,507	-	-	13,507
	UNICEF	-	-	-	-	-	-	10,358	-	10,358
18. NEP/83/P06 - Pilot Operational Research in Community-Based FP/MCH Activities	UNFPA	-	-	-	6,035	25,170	2,573	3,179	37,174	74,131
	UNICEF	-	-	-	-	3,425	7,069	2,639	2,595	15,728
19. NEP/83/P07 - FP and Fertility Survey	UNDP	-	-	-	-	-	42,481	47,412	20,193	110,086
20. NEP/83/P10 - Information Education and Communication Support for POP/FP Programmes	UNFPA	-	-	-	14,987	9,974	25,810	20,447	56,108	128,326
	CPE	-	-	-	-	-	18,794	18,965	6,241	44,000
21. NEP/83/P11 - Strengthening National Capability for Demographic Analysis and Demographic Survey	UNDP	-	-	-	-	252,400	219,070	102,442	212,890	786,802
	CPE	-	-	-	-	-	3,301	2,714	10,485	16,500
22. NEP/83/P12 - Pop.Ed. Programme through Adult Ed. Division (MOEC)	UNFPA	-	-	-	6,113	-	-	-	-	6,113
	UNESCO	-	-	-	-	15,298	25,602	21,011	42,439	104,350
SUB - TOTAL		801,274	836,453	1,083,688	744,370	1,367,347	1,861,475	1,466,927	2,152,215	10,303,749

(1) Project Number and Title	(2) Executing Agency(ies)	(3) 1980 Actual	(4) 1981 Actual	(5) 1982 Actual	(6) 1983 Actual	(7) 1984 Actual	(8) 1985 Actual	(9) 1986 Actual	(10) 1987	(11) Total (3 to 10)
II. UNFPA REGULAR FUNDS/CLOSED PROJECTS*										
1. NEP/74/P01 - Population Education in the Organized Sector	ILO	4,433	17,207							21,640
2. NEP/77/P02 - Pop.Ed. Through Panchayats/Cooperatives	UNFPA ILO	10,482 67,458	47,014 40,729	14,730 1,486	(5,852) 824					66,374 110,497
3. NEP/77/P03 - Innovative Communication Approaches	UNFPA	9,032	206,524	55,132	86,933					357,621
4. NEP/78/P03 - Support to Population Census - 1981	UNFPA UNTCD	93,220 30,462	627,120 149,969	1,542 140,563	241 111,661					722,123 432,655
5. NEP/78/P04 - Support to Data Processing for the Population Census	UNTCD	198,390	222,725							421,115
6. NEP/78/P05 - Support to Cartographic for Population Census - 1981	UNTCD	65,986	73,250	83						139,319
7. NEP/79/P03 - Communication Support to Population Census	UNFPA	20,888	35,654							56,542
8. NEP/80/P06 - Pop.Ed. Through Agr.Ext. Women merged into NEP/80/P09	UNFPA	6	3,937							3,943
SUB - TOTAL		500,357	1,424,129	213,536	193,807					2,331,829
A. TOTAL UNFPA REGULAR FUNDED PROGRAMME (I + II)		1,301,631	2,260,582	1,297,224	938,177	1,367,347	1,861,475	1,456,927	2,152,215	12,635,578
III. UNFPA TRUST FUNDS Ongoing Projects										
1. NEP/80/P09 - Pop.Ed. Through MOA (The Netherlands)	FAO						9,810	52,951	42,210	104,971
2. NEP/80/P10 - Pop.Ed. through SFDP (The Netherlands)	FAO						20,406	38,962	67,727	127,095
3. NEP/80/P12 - Strengthening the FP/MCH Service for ICDSDP	UNICEF							201,308	60,265	261,573
4. NEP/80/P13 - Assistance to FP/MCH Project (Norway)	UNFPA UNICEF WHO		422,469 78,052 20,400	499,303 160,217 97,302	632,960 106,736 44,395	843,741 113,667 (167)	545,768 169,902 44,319	200,026 113,360	563,975 69,140	3,709,242 811,084 206,249
5. NEP/80/P14 - Strengthening the FP Personnel in the ICDSDP (The Netherlands)	UNFPA WHO OPE		41,871	92,526 25,576	34,014 26,872	39,681 29,841	12,210 24,744	11,671 18,492	40,004 63,000	271,977 125,525 63,000
6. NEP/83/P06 - Pilot Operational Research in Community-Based FP/MCH Activities (UK)	UNFPA						37,585	-	2,744	40,329
SUB - TOTAL			563,802	874,924	844,977	1,026,763	864,744	636,770	909,065	5,721,045
IV. UNFPA TRUST FUNDS/Closed Projects										
1. NEP/80/P05 - SFDP Women's Group (The Netherlands)	UNFPA			29,393	101,287					130,670
2. NEP/80/P05 - Pop.Ed. Through Agriculture Ext./Women (The Netherlands)	UNFPA			10,041	4,726					14,767
SUB - TOTAL				39,434	106,013					145,437
B. TOTAL UNFPA MULTI-BILATERAL FUNDED PROGRAMME (III + IV)			563,802	914,358	950,990	1,026,763	864,744	636,770	909,065	5,866,482
C. TOTAL UNFPA PROGRAMME (Regular + Multibilateral = A+B)		1,301,631	2,824,384	2,211,572	1,889,167	2,394,110	2,726,219	2,093,697	3,061,280	18,502,060

* The UNFPA funded programme started per 1 July 1980. Therefore, the table shows for those projects which were started before that date (see Section II of the table) an amount equal to 0% of

FAMILY PLANNING ACCEPTORS BY METHOD AND YEAR

Year/ Methods	Vasec-tomy	Lapros-copy	Prop. of Sterili-zation to Total Acceptors	IUD	Depo-provera	Pills	Condom	Total Accep-tors (New)
1966/67	N.A.	-	-	1806	-	13	33	1852
1967/68	1052	-	20.5	2614	-	200	1256	5122
1968/69	3292	-	42.3	1183	-	1355	1944	7774
1969/70	3888	-	13.1	1109	-	10263	14480	29740
1970/71	4441	-	12.9	711	-	10496	18785	34433
1971/72	3900	-	8.9	1162	-	15868	22908	43838
1972/73	4161	558	7.2	607	-	24056	35713	65095
1973/74	5166	810	6.9	662	25	27141	52075	66079
1974/75	3702	662	4.4	1110	61	26943	65814	98312
1975/76	9169	2162	8.2	1636	152	37640	87876	138634
1976/77	10953	5422	12.9	1149	976	32250	74782	166532
1977/78	12171	7923	11.5	863	1690	44346	107112	174106
1978/79	7009	11208	11.0	1231	1549	37896	106891	166774
1979/80	4277	11130	7.8	1036	1722	44270	134099	196534
1980/81	4802	18040	10.6	1304	2119	49079	140666	216010
1981/82	10398	20167	13.7	1204	3109	48752	139585	223215
1982/83	16493	18507	15.8	1557	4939	66815	166261	284572
1983/84	26311	41426	22.4	1050	5705	63453	164737	302684
Total	131186	148017		22193	22067	541836	1336007	2200306

Source: Nepal FP/MCH Project.

APPENDIX IX. LIST OF PUBLICATIONS

BERGSTRØM, S. "Overpopulation and childlessness - two aspects of reproductive health in the third world conference on population, health and development"
DERAP, CMI,
Bergen, October 1986

BERGSTRØM, S. "Den svenska resursbasen inom forskningsområdet internationell mødrahelsovård; erfarenheter och framtidsperspektiv"
SIDA, SAREC,
Stockholm, September 1986

BERGSTRØM, S. "Inventering av forskningsinsatser for reproduktiv helsa",
SIDA, SAREC, Stockholm, Juli 1986

BONDESTAM, L., BERGSTRØM, S. Poverty and Population Control
Academic Press London 1980

CIDA "UNFPA - Institutional Appraisal" ROBINSON, W., GOBEIL, L., WIDSTRAND, C.
Hull, Canada July-October 1985
(Field visits: Bangladesh, Thailand, India, Kenya, Zimbabwe, Ethiopia)

ELLEFSEN, E.S., OTTERSTAD, H.K., TASSERUD, R., WATHNE K,. "A study of possible Norwegian assistance to health and family planning programs in Kenya"
Nairobi, December 12, 1985

ELLEFSEN, E.S., OTTERSTAD, H.K., TASSERUD, R., WATHNE K,. "Agreed Assistance to the health and family planning sector in Bungoma District in Kenya"
May 1986

GOMEZ DE LEON, J., PEDERSEN, J. "Research on population and health in developing countries"
Norsk Utenrikspolitisk Institutt,
Oslo, Norway, undated

GOVERNMENT OF NEPAL
The Secretariat to the HMG Task Force
"Review of the Delivery of Health Services for Improving Integrated Services Including Family Planning and Maternal Child Health"
Katmandu, July 15 1985

Programme Review and Allocation Committee
"Second Country Programme for UNFPA Assistance,

1988-1992"
Katmandu, February 6, 1987

MINISTRY OF HEALTH, PLANNING, RESEARCH AND EVALUATION SECTION
"Nepal - Fertility and Family Planning, Survey Report 1986"

NATIONAL PLANNING COMMISSION SECRETARIAT, CENTRAL BUREAU OF STATISTICS
"Demographic Sample Survey 1986/87, First Report"
Katmandu 1987

GOVERNMENT OF NICARAGUA

AMPES - a CTA Report
"Informe I a VII-87, Salud Madre y Nino"
Managua, undated

DMI/MINSA
"Estrategias de Intervencion basadas en el Estudio de Enfoque de Riesgo"
Managua, May 1987

MINSA
"Plan Nacional de Salud 1987"
Managua, December 1986

"Plan Anual 1987"
Managua, undated/unsigned

"Plan Anual 1987" (MCH Project)
Managua, undated

"Operativizacion del Plan Anual 1987"
Managua, undated

"Priority Health Need Plan in Central America and Panama"
Managua, November 1985

"Antecedentes y Logros del Projecto Extension de la Cobertura y Aumento de la Calidad de la Atencion Materno Infantil en Nicaragua" Director MCH Programme
July 1987,

"Informe sobre Reunion Tripartita de Fencha 21-22 de Noviembre de 1985 sobre Proyecto "Extension de la Cobertura y Aumento de la Calidad de la Atencion Materno Infantil y Bienestar Familiar 1985-86"
Unsigned and undated

MINSA/MCE/UNFPA/PAHO
"Acta de la 1ra Reunion Tripartita"

(Appendix IX: List of Publications)

Managua, November 21, 1985

"Acta de la 2da Reunion Tripartita"
Managua, December 11, 1986

MINSA/PAHO:
"Extension de la Cobertura y Aumento de la Calidad de la Atencion Materno Infantil y Bienestar Familiar" (Revised version of Project Document (application to UNFPA))
November 1986

"Extension of the coverage and Improvement of the Quality of Maternal and Child Health Care and Family Welfare Services" (Project request to UNFPA),
1984

"Informe Anual 1986" (MCH Project)
Managua, undated

MINSA, UNFPA, PAHO and MCE
"Acta de la 1ra Reunion Tripartita"
Managua, November 21, 1985

GOVERNMENT OF NORWAY

MINISTRY OF DEVELOPMENT COOPERATION
Stortingsmelding nr. 36 (1984-85) "Om enkelte hovedspørmål i norsk utviklingshjelp",
Oslo, October 26, 1984

Stortingsmelding nr. 34 (1985-86) "Om Norges samarbeid med utviklingslandene i 1985",
Oslo, April 4, 1986

Stortingsmelding nr. 34 (1986-87) "Om hovedspørsmål i norsk utviklingshjelp"
Tilleggsmelding til St.meld.nr. 36 (1984-85)
Oslo, February 27, 1987

"Travel Report from Nicaragua, November 1985" (in Norwegian)
Oslo, undated

MINISTRY OF FOREIGN AFFAIRS, Norway
Stortingsproposisjon nr. 35 (1977-78)
"Om samtykke til godkjenning av Avtale mellom Kongeriket Norges Regjering og de Forente Nasjoners befolkningsfond (UNFPA) om samarbeid på områdene befolkning- og familieplanlegging."
Oslo, October 1977

MIRANDA, A. "Utredning om norsk bistand til det indiske familievelferdsprogrammet"
DERAP Working Papers A303

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