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International Planned Parenthood Federation – Policy and effectiveness at country and regional levels

Synthesis Report

Prepared by Options Consultancy Services on behalf of

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Performance assessment of IPPF: Policy and effectiveness at country and regional levels

Synthesis Report

Based on the Six Country
and the Two Regional Case Studies

by
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Prepared by Options Consultancy Services
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Royal Ministry of Foreign Affairs, Norway
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A Report submitted to the Norwegian Ministry of Foreign Affairs
by Options Consultancy Services

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AR(O)	Africa Region (Office)
AVSC	Access to Voluntary and Safe Contraception
CBD	Community Based Distribution/Distributor
CSW	Commercial Sex Worker
CYP	Couple Year of Protection
DFID	(UK) Department for International Development
FGM	Female Genital Mutilation
FPA	Family Planning Association
HIV	Human Immunodeficiency Virus
HQ	Headquarters
ICPD	International Conference on Population and Development (Cairo, 1994)
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
MIS	Management Information System
NGO	Non Governmental Organisation
PPBR	Programme Planning, Budgeting and Reporting
QoC	Quality of Care
RO	Regional Office
RTI	Reproductive Tract Infection
SAR(O)	South Asia Region (Office)
Sida	Swedish International Development Co-operation Agency
SRH(S)	Sexual and Reproductive Health (Services)
STD(I)	Sexually Transmitted Disease (Infection)
TOR	Terms of Reference
USAID	United States Agency for International Development
V2000	Vision 2000
V2F	Vision 2000 Fund

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The core group of consultants is grateful to their donor country colleagues who served as consultants with the three teams, and to the national consultants for their hard work and invaluable contributions. Pal Jareg contributed to the design and content of this synthesis report. Ann-Karin Valle provided Box 8.

Options Consultancy Services (London), who managed the assignment, undertook a massive logistic exercise at short notice and provided the arrangements and back up which is so essential to the success of such a demanding enterprise as this assessment proved to be. Sue Billington took the lead in this, assisted by David Ranger.

Finally, we thank the three donors for giving us such a challenging but fascinating task, and making the assessment possible. We trust our efforts prove of assistance.

A NOTE ON EXTERNAL VALIDITY

A purposive sample of six family planning associations (FPAs) and two regional offices (RO) was made by the sponsors of this study. The sample was composed of the FPAs in Ethiopia (Family Guidance Association of Ethiopia - FGAE), Bangladesh (FPAB), India (FPAI), Nepal (FPAN), Uganda (FPAU) and Zambia (the Planned Parenthood Association of Zambia - PPAZ), and the Africa Region Office (ARO) and South Asia Region Office (SARO). Obviously the findings from these countries cannot be generalised to all FPAs. However, in the opinion of the study teams it is likely that the FPAs studied are typical of a fairly large number of FPAs of medium to high capacity in low-income countries in the two regions concerned. No generalisations can be made to other regions.

Among the three African FPAs studied, Ethiopia was characterised as being high capacity (one of the best in the region), Zambia as medium capacity, and Uganda on its way upwards from a problem situation a few years ago. In the South Asia region, Bangladesh and India represented large and well established FPAs, and Nepal an FPA working under difficult circumstances.

Rather than qualifying all general statements in this report the authors would like to note that generalised statements in the body of this report refer to the six countries and FPAs studied. When only one or some of the countries are referred to this has been indicated in the text.

1. INTRODUCTION

The Ministry of Foreign Affairs of Norway and the government aid agencies of Sweden, and the UK - namely, Sida, and DFID - have jointly commissioned Options Consultancy Services to organise an assessment of the International Planned Parenthood Federation (IPPF) at the country level (Terms of Reference in Appendix 2). This is a follow-up to the Swedish study of IPPF at the central level, which was carried out in 1997 (Stenson and Andersson-Brolin, 1997). All three governments make contributions to the core grant of IPPF and have broadly supported the IPPF Vision 2000 initiative which since 1992 has emphasised the `six challenges': unmet family planning need, sexual and reproductive health (SRH), unsafe abortion, women's empowerment, youth SRH, and SRH quality of care.

Six country FPAs and two regional offices were selected for the assessment. They were: Bangladesh, Ethiopia, India, Nepal, Uganda, and Zambia; and Africa (regional office in Nairobi), and South Asia (London). Data collection took place from September to November 1998. Three teams each comprising two international and one national consultant have visited these countries (a list of team members and a summary itinerary is given in Appendix 3). The two regional offices were visited by the team leaders who constituted a core group for the exercise. There is a report for each country visited, and one for the two regional offices. This brief synthesis completes the reporting for the assessment. A summary of the key findings of the regional and country studies can be found at Appendices 4 and 5 respectively.

During the 1990s there have been major changes in thinking about sexual and reproductive health, and about population and development. IPPF has played a significant role in this process. In 1992 IPPF adopted the Vision 2000 aims and challenges. This set a new agenda for the Federation and its member associations. The implications and implementation of which are still being worked out today. More immediately it provided a platform for the contribution IPPF made to the Programme of Action of the International Conference on Population and Development (Cairo, 1994).

The aims and objectives of Vision 2000 and the ICPD Plan of Action are broadly consistent (IPPF, 1995), but the interpretation of these aims and finding ways to realise them in varied cultural, political and economic settings has proved difficult. Of course, if this were not the case there would have been no real challenge to be met.

2. PURPOSE OF THE ASSESSMENT AND APPROACH TAKEN

When commissioning the present assessment, the three donors asked for comment on three aspects. First, the extent to which the Federation at all levels - headquarters, regional offices, and associations (though with emphasis on the last two) - has produced policies, programmes and services which are relevant to the needs of the member countries. Second, if performance is satisfactory. Finally, if IPPF is effective in meeting the challenges as they manifest themselves in each country and region. The regions and countries chosen for the assessment reflect the donors' interest in directing their development assistance to low income countries, and to the poor and disadvantaged in those countries.

The purpose of the assessment, as set out in the terms of reference (TORs), is:

> *`.. to help Sweden, Norway and the UK make informed judgements about the effectiveness, performance and relevance of IPPF in promoting policy development, increasing access to and the quality of reproductive health services, and responding to the needs of those most disadvantaged in developing countries.'*

This purpose identifies four dimensions - policy, access, quality, and the disadvantaged - and for each applies three assessment criteria. The study methodology identified components of each dimension and established a framework for applying the selected criteria (see Box 1).

BOX 1: RELEVANCE, PERFORMANCE AND EFFECTIVENESS: THE CASE OF IMAM'S IN BANGLADESH

The Family Planning Association of Bangladesh in 1984 created an Islamic Research Cell (IRC) to initiate a project to inform and influence religious leaders in Bangladesh some of whom were opposing FPAB's work. The IRC organises seminars and obtains the explicit support of imams who agree to have their names recorded in a publication which discusses the role of family planning in Islam, including quotes from the Holy Quran and Hadith, and lists religious leaders who accept the importance of family planning and endorse the work of FPAB.

The project is ***relevant*** to the aspirations of IPPF and to the needs of Bangladesh, whose government adopted a strong family planning policy in 1976. The seminar format has permitted introduction of new ideas and aspirations over the years so that the project has been able to adapt to the aims encapsulated in Vision 2000 and the ICPD Plan of Action. Seminars, which are attended by female religious leaders as well as imams, now include discussion on many aspects of sexuality, the respective roles of females and males, and reproductive health care.

In the 14 years since the inception of the project, 35,000 religious and other local opinion leaders have received training and 100,000 booklets have been distributed. Thus, the ***performance*** of the project has been sustained and its coverage extended over the years.

Opposition from religious leaders to the family planning movement and FPAB in particular, which on occasions in the past has been strong, is now all but absent, and open support and advocacy by imams is not uncommon. The project has been ***effective***. Such is the success of the programme that in 1998 the South-South Partners for Population and Development invited FPAB to formulate with them a project proposal to share their experience with eight other Islamic states or countries with substantial Islamic communities.

Key themes and issues are also identified in the TORs. These cover the subject areas:

1. Policy and Advocacy
2. Relevance, Strategy and Priorities
3. Information, Services and Care: what the FPA does and for whom
4. Management, Systems and Resources
5. Volunteers and Staff
6. Effectiveness, Impact and Sustainability
7. External Environment and Wider Policy Context

This synthesis report sets out the findings on each of the seven themes (Section 3). Each study (six countries and the regional offices report) identified key

issues and a summary of these is given in Section 4. The case studies highlight many achievements and a wide range of problems; a few of these have been selected for brief presentation in nine illustrative boxes. Finally, there is a short overall conclusion and a set of recommendations to the sponsoring donors (Section 5).

3. SUMMARY - MAJOR STUDY THEMES

This section organises the study team observations by the seven themes identified in the assessment terms of reference.

3.1 Policy and Advocacy

Almost all national governments are responding to the ICPD initiatives on sexual and reproductive health care. The response is more enthusiastic and energetic in some, of course, than in others. National FPAs find themselves positioned strategically to carry the forward-looking objectives of Vision 2000 into the national arena, but they have to be sensitive to the stage reached in the reorientation of national policy and practice.

Family Planning

The FPAs in all countries studied had a history of being pioneers in family planning, having been established and starting their advocacy in times when conditions were more or less adverse to the concept and practice of family planning. In all six cases, the FPAs were instrumental in bringing family planning on to government agendas.

Family planning is today an accepted activity with strong government support in these countries. This has led to a reduced need for general advocacy for family planning. With a basis in IPPF's V2000 strategy, advocacy for the broader SRH concept including, for instance, safe motherhood, action against sexually transmitted diseases (STDs) including HIV/AIDS, for infertility and cancer screening services, and for women's empowerment have been initiated by all FPAs, although in some countries, Nepal for example (see Nepal report 3.4), only in the last few years.

From FP to SRH: Slow Progress

IPPF aims, as expressed in the six challenges, are highly relevant to the conditions found in the countries visited in sub-Saharan Africa and South Asia. Each of the case study reports starts with a chronicle of relative deprivation and acute SRH care needs. The strategies adopted by each national FPA are generally consistent with programmes, which serve the needy and remove disadvantages, but their application does not always produce the desired result. For example, many older clinics are located in major cities and not always in the poorest areas even there. A further problem relates to the long term nature of many of the Programme Planning, Budgeting and Reporting (PPBR) Strategic Plans and the perpetuation within them of projects dating back many years, some to the early 1970s. The 1990s have been a time of rapid enlargement of consciousness about the range of SRH problems, which need to be addressed. This means that many current projects and activities are being presented within a conceptual framework, which is no longer as relevant as it once was, and does not match the six challenges as directly and as clearly as is desirable.

One result is that FPAs are often still more closely associated with advocacy of and service delivery for family planning, than for the wider range of SRH issues and health care delivery. The Vision 2000 activities and broader ICPD programme are not sufficiently reflected in strategic plans.

FPAs as SRH Pioneers

Despite this general impression, FPAs are frequently at the forefront of new SRH developments as with efforts to change abortion legislation in Nepal (see Box 2), female genital mutilation (FGM) practices in Ethiopia (Ethiopia report, 4.2.6) and Uganda (Uganda report 5.4.5), women's empowerment in India (see Box 3), and awareness of sexuality and the needs of youths in both South Asia and eastern Africa.

Regional Offices have also played a role in sponsoring conferences and workshops at which these issues are drawn to the attention of government representatives and other decision-makers. The pre- and post-meeting publications have often reinforced the effectiveness of these efforts, and senior volunteers clearly are helping to keep Vision 2000 concerns and aspirations in the minds of policy makers.

BOX 2: ADVOCACY FOR LEGAL AND SAFE ABORTION IN NEPAL

Nepal is characterised by traditional social norms and an archaic legal framework as it relates to women's rights. Abortion is an area where strict laws are applied. Abortion is always illegal and in later gestational stages even considered as infanticide. However, wealthy women can easily access abortion services in-country while poor women are exposed to the dangers of unsafe abortion and the risk of being reported and jailed. Two thirds of women in prisons are incarcerated because of abortion with terms of up to twenty years. Providers are not punished.

BOX 2: ADVOCACY FOR LEGAL AND SAFE ABORTION IN NEPAL (con'd)

The Family Planning Association of Nepal decided that this was an important area for advocacy and has, through its president who is a parliamentarian, proposed a bill to legalise abortion under certain circumstances. IPPF has provided a legal consultant to help draft the bill. FPAN has been active in promoting the bill through different activities including seminars for members of parliament and journalists.

The issue has received considerable attention and is the subject of controversy. Fundamentalist right to life groups from the United States have appeared in the country and have been trying to raise opposition to the bill. This advocacy effort is highly relevant although the ultimate outcome is still uncertain.

BOX 3: VISION OF SMALL FAMILY BY CHOICE: WOMEN'S EMPOWERMENT IN INDIA

In 1995 the Indian Family Planning Association was the first recipient of a grant from the Vision 2000 Fund (V2F). This scheme (formerly the Partnership Challenges Fund) offers funding on a competitive basis for innovative projects designed in accordance with IPPF's Strategic Plan *Vision 2000*. The FPAI V2F grant is by far the largest to date.

The Small Family by Choice Project received US$10.8 million for five years to promote family planning in areas of high need and low performance by placing it in the context of overall development. The project is located in three districts (Bhopal, Sagar, and Vidisha) of the northern state of Madhya Pradesh which are characterised by high population density, low female literacy, low mean age at marriage, and high infant mortality and fertility.

The project has helped to create local volunteer groups and women's clubs, co-operated with local non-governmental organisations (NGOs), initiated youth centres, developed training programmes, and established community-based distribution (CBD) outlets. New clinics and outreach programmes have started. In Bhopal, for example, the project has started 13 special male clinics as men do not normally wish to attend standard FPAI clinics. Family planning (FP) acceptor numbers have increased steadily, but a wide range of other services including child immunisation have also developed successfully. Assessments of quality and client satisfaction have given very positive results. A mid-term evaluation noted many achievements but suggested more syndromic management of STDs and acute obstetric care; improvements in infection control, IUD (inter-uterine device) training, traditional birth attendant (TBA) follow-up; the removal of FP incentives; and redressing the existing bias towards male CBD agents.

The project has assisted individual and community development in many diverse ways not easy to capture in statistics. An example from Shaista Khedi village is typical. Project support has assisted Rakhi Sharma - a young literate woman practising family planning herself but with a love of children - to open a nursery school which gives education to children of the community. This also provides release for mothers to pursue new income generating activities for which the project provides training.

Older siblings formerly kept at home to look after younger children are also free to pursue education or training offered at the youth centres. The youth group in turn collects funds to pay Rakhi and her assistant.

Advancing the frontiers of acceptability is still a difficult process. Advocacy for safe abortion is important although constrained by restrictive abortion laws in five of the six case study countries, the exception being India. In Ethiopia and Uganda, the FPAs are actively advocating against FGM. General advocacy for greater openness about sexuality and related issues is being carried out at regional as well as at country level e.g through the Sex Wise radio programme in the South Asia region (see Regional report, Appendix 3.2, P13), and through the hot line for youth in Ethiopia.

Thus, overall, we believe that IPPF is making a useful contribution to policy discussion and evolution at the country level, paradoxically, in part because it has established a reputation among governments and even donors for reliability and steadfastness in its advocacy and service delivery of family planning. As an organisation that over many decades has demonstrated commitment and success in providing good quality family planning services, and has enlarged the scope of constructive debate about SRH requirements without wholesale alienation of important stakeholders, it continues to be included in

national policy-making activities and is able to promote further the Vision 2000 goals.

3.2 Relevance, Strategy and Priorities

The relevance of FPA activities in relation to global policies, such as those agreed upon in Cairo and Beijing, is very high as judged from IPPF policy documents. However, these policies are not yet implemented fully although well underway in all the countries studied. Often FPAs play a leading role in their respective countries in encouraging and co-ordinating NGO activities in SRH. Bangladesh (see report 9.4), Ethiopia (see report 2.3), Nepal (see report 8.4) and Zambia (see report 9.4) are countries where FPAs have taken particular initiatives in this respect. They frequently work closely with government on policy development as discussed above, but also as a complement to public sector services.

Identifying effective strategies and setting priorities presents a particular problem in very poor countries where SRH needs are enormous, resources severely limited, and international and national contexts change rapidly. Quite clearly, FPAs cannot engage in all types of activities for which there is a need. The Federation may, and has, chosen broad priorities (the six challenges) and established strategic frameworks (IPPF, 1993; IPPF, 1995), but their application to national circumstances requires many adjustments, and in the face of severe resource constraints FPAs have to be very selective. Regional Offices play an important role in assisting selection and adjustment (see Appendix 4). The Federation has used the device of the Vision 2000 Fund to re-focus FPA efforts - enlarging the scope of services offered, improving management information systems, and directing projects to the disadvantaged - but this has often not been carefully or fully integrated into the existing FPA strategic plans (see Box 4). In the six years from 1992, and more particularly in the post-Cairo period, in our opinion, the FPAs would have benefited from stronger guidance in addressing these difficult issues. It needs to be borne in mind, however, that FPAs are largely autonomous bodies and there is a tension between overtly directive intervention from the Federation and supporting local and participatory project initiatives.

BOX 4: VISION 2000 FUND: PROS AND CONS

Both regions visited have obtained V2F funding for proposals submitted in this competitive bidding system. For instance in South Asia: India has a *Small Family by Choice* project (US$10.8m) which has reached the stage of mid-term evaluation (MTE); Pakistan has an *FP and Reproductive Health Services at the Doorstep* project ($1.92m) about to undergo an MTE in December 1998; Nepal has *The Challenges for Change* project ($2.53m) also evaluated in 1998; and Bangladesh has a *Community Ownership of Reproductive Health Initiative* project ($2.5m) which started in 1998. In Africa region, 21 countries are at various stages of implementing projects.

These V2F projects are intended to serve as a catalyst to help FPAs respond to the challenges of Vision 2000, and elaborate some its strategies in their own programmes. They have resulted in close collaboration between the V2F unit at HQ, the regional offices, and the FPAs during the processes of needs assessment, proposal design, and implementation. They have brought additional funds into the region and to the recipient countries; in the case of SARO an additional US$18 million. The projects have permitted experimentation, improvements in quality of care, extension of services to disadvantaged groups, and underserved areas, and introduction of a wider range of SRH services. They often have improved management information system (MIS), and have received increased levels of evaluation.

On the other hand, those countries which have not been successful have watched a part of unrestricted core funding (9% initially, now closer to 5%) being siphoned to a few. Pressure has resulted in inclusion in the bidding process of regions other than the original deprived Africa and S. Asia regions, which perhaps defeats the original intention. There are concerns about the impact of such large projects on the balance of national programmes, on their replicability, and on their sustainability and on the extent to which they are generating lessons about meeting the six challenges.

Finding an Appropriate Role

A major issue concerns the role of FPAs in relation to governments and other actors. One option which often presents itself is for an FPA to yield to government wishes and extend its SRH services as much as possible thereby replacing the government who may not have the capacity to carry out these services. All of the FPAs studied are seriously involved in the business of providing SRH services: India reporting in 1997 over 220 thousand new FP acceptors and 1.6 million

Mother and Child Health (MCH) clients, and Uganda reporting a total client load of nearly 350,000 of whom 47% received non-contraceptive RH services.

Another option for an FPA would be to focus on innovative activities, continuously trying to be on the frontline, challenging their government to do more and better rather than seeing itself as a service provider.

These are hard choices. The study indicates that FPAs are not making explicit choices between these options. Perhaps it can be said that the innovative aspects appear to be a major issue at the verbal level while in practice FP service provision continues to be the major activity.

Responsiveness to the Needs of the Most Needy

IPPF HQ, the ROs and FPAs all have a strong commitment to services for the disadvantaged - geographically (remoteness), socially (minority and low status groups), culturally (women), and economically (the poor). This is a continuing strength of the organisation. It is an explicit part of the mission of FPAs, and their programmes and projects demonstrate ways in which they seek to realise these ideals through projects located in slum areas, for commercial sex workers (CSWs) and truckers, in remote and undeserved areas, for women's empowerment, against FGM, etc.

This targeting of activities is an important issue for the Federation as is the consequences of any selected focus. The main target groups of IPPF, according to Federation policies, are the poor and vulnerable. However, a clear strategy for determining priorities with respect to the provision of services for the poor is generally absent from IPPF, Regional and FPA documents. Associations have limited resources and this must always severely constrain large-scale service provision for the poorest.

Serving the poor also comes into conflict with the ambition to achieve a higher degree of financial sustainability. The poor cannot pay for the services and thus reaching the main target groups makes complete financial sustainability impossible. FPAs in most countries have provision for waiving registration and other charges for those considered too poor to pay, and registers show that this is done for about 10% of clients. What they do not show is the number of the poor deterred from visiting the clinics and outreaches.

Every poor person who is turned down or who wishes to but does not request FPA services is a missed target, while everyone who is given services free but who has the ability and willingness to pay is a lost opportunity.

3.3 Information, Services and Care: What the FPAs Do and For Whom

The activities of different FPAs are heavily dependent upon national environmental, cultural, social, and political factors including the modalities and opportunities for NGOs to work independently.

Emphasis and Range of FPA Activities

In all the countries studied the focus of FPA activities was still on family planning (see Box 5). This emphasis was still strong, for example in Nepal, or obvious but mixed with other types of activities as in Ethiopia. All countries had adopted and were committed to broad SRH policies in accordance with the V2000 strategy but the extent to which policies had penetrated differed. With limited resources, broadening the focus implies less emphasis on traditional activities. All FPAs visited maintained IEC (Information, Education and Communication) services, which showed some enlargement of focus but were still predominantly concerned with family planning.

BOX 5: CONTINUING FOCUS ON FAMILY PLANNING

Vision 2000 was intended to alert every person in the Federation and all those who took an interest in its activities to the broader range of needs it encompassed. Family planning took its place as only one component among six. In the ensuing six years there have been many discussions and publications elaborating the original vision. The Vision 2000 Fund has provided extra resources for projects designed to address specifically one or more of the six challenges. Most FPAs, certainly the ones visited during this assessment, have extended the scope of their work to provide a wider range of clinical services and to engage in advocacy and IEC directed at SRH requirements.

Yet Work Programmes and Budgets, and Annual Reports, and regional office reviews of Three Year and Annual plans and performance still focus on family planning. Tables and formats concentrate on FP: contraceptive stocks, receipts and issues; new FP acceptors, FP acceptor visits, and contraceptives distributed to acceptors; FP acceptors by type of outlet; number of outlets by type supplied with contraceptives; and couple years of protection by contraceptive method and type of outlet. Only one short table gives data on non-contraceptive services provided through FPA clinics, non-clinical outlets and referrals, and even this includes information on FP counselling and FP referrals.

BOX 5: CONTINUING FOCUS ON FAMILY PLANNING (con'd)

The origin of this emphasis is understandable given the history and early purpose of the organisation. However, if the Federation is serious about promoting a broader conception, it has the means through the pre-set formats and tables contained in the Annual Reports to require FPAs to give greater attention to non-contraceptive elements of the clinical services, and to non-clinical activities many of which are essential to the promotion of better sexual and reproductive health.

Traditionally FPAs have included some elements of MCH in their clinic and outreach services. This continues, is reported in a somewhat desultory fashion, and still occupies a secondary role subservient to family planning.

Examples of new activities in line with V2000 Strategy were found such as strong youth activities in Bangladesh (Bangladesh report, 3.1.3), Ethiopia (Ethiopia report, 4.6) and Uganda (Uganda report, 5.4.4); promotion of female condoms in Zambia as an empowerment and HIV preventative measure, and infertility counselling in Ethiopia (Ethiopia report, 4.2.7). The Indian FPA has initiated programmes to combat the threat of AIDS: a national network of specialised counselling and treatment centres for sexually transmitted and reproductive tract infections mainly for youths; services for commercial sex workers and drug users in several large cities; and peer education projects for youths (see also Box 3 on women's empowerment in India).

Increasing Access to Reproductive Health Services

This is a more complicated issue. Vision 2000 aims to increase access, and this in and of itself seems highly relevant. FPAs maintain clinics - usually in urban settings - and in most countries have outreach and CBD activities, which take services to remoter communities. The Associations engage in a whole range of promotional and motivational programmes which are designed to inform and change attitudes and behaviour, break down psychological and social barriers, and thereby increase accessibility and use of the services available from FPA and other providers.

Yet, donors, the Federation and FPAs are all trying simultaneously to increase both sustainability and quality of care. Strengthening financial sustainability usually involves introducing and raising costs to users. The assessment team has seen cases where re-directing resources to improve quality of care has meant also closing clinics and reducing staff. These features are not necessarily irreconcilable, but at both regional and national level, the team found officers and volunteers who seem to find them so. HQ and Regional Offices have run workshops on sustainability. Nevertheless, there still appears to be a need to explore with FPAs practical approaches for organising a mix of project types, and the creation of clear arguments to justify each type. Some projects might be highly subsidised and directed at serving the needs of the disadvantaged; others would be more self-sufficient or even provide income-generating services. Examples show, however, (e.g. the paying clinic in Nepal) that it is difficult to organise such profitable services in a competitive environment. This second type could increase overall FPA financial sustainability and permit general improvements in service quality. They would continue to be accessible and attractive to the better off, but are less likely to be accessible economically (and possibly psychologically) to the poor.

Again, the overall judgement is that IPPF, through the ROs and FPAs in sub-Saharan Africa and South Asia, is contributing to increased accessibility to SRH services. This is more to family planning than to other elements of SRH. Nonetheless, these other elements appear to be given more emphasis over time. This is more often through advocacy and IEC activities which reach wide audiences (broadcasting of the SexWise programmes produced thousands of appreciative letters to SARO) than through clinical services. Resource constraints have meant that the relatively expensive clinics and their related outreach and CBD services are rather limited in their coverage. Evidence of cost-effectiveness of FPA services is mixed. Whilst in Bangladesh the FPA was more cost-effective than the equivalent government service by a factor of 9 or 10 for family planning services, it was claimed that in Nepal FPA clinics were generally much more costly than those of the government.

Increasing the Quality of Reproductive Health Services

There are well-developed quality of care (QoC) frameworks for family planning services, but whereas general health service QoC criteria exist, there are no such universally applied frameworks for SRH QoC. SARO began to develop a checklist as part of its resource allocation model in 1992, and the draft IPPF Vision 2000 Monitoring and Evaluation Guidelines have begun, albeit in a rather limited way, to set out criteria. But the assessments so far have been partial and piecemeal. In Bangladesh the FPA has been assisted by the Quality Improvement Programme of AVSC/USAID to

develop a clinical quality assessment instrument which, so far, has been applied to four of the FPAB clinics. The Vision 2000 Fund projects, examples of which have been developed - if not yet fully implemented - in five of the case study countries, have been encouraged to include more specific attention to quality of care issues, but these projects are also very high cost (judged by expenditure per client) at present and have yet to demonstrate that with maturity they will become more cost-effective.

There is evidence to suggest that even on the established FP criteria, and in countries where services have been developed over many decades, they may still fall short on basic QoC criteria (see Box 6).

BOX 6: METHOD MIX AND STERILISATION - INDIA

India had an estimated population of 950 million in 1997, with the average annual population growth rate still close to 2.0%. The 1993 National Family Health Survey reported that 20% of women in India had unmet need for family planning: 11% for spacing births, and 9% for limiting births. Among family planning users there is a high proportion who have been sterilised, and this has been of some concern to outside observers. It is an accepted tenet of good FP quality of care that clients are offered and counselled on a range of contraceptive methods so that they may make an informed choice. It was reported that the FPA India stresses contraceptive choice through its counselling and service delivery programme, but many of its new acceptors continue to select female sterilisation.

The assessment team met young, low parity mothers who were accepting sterilisation as a means of limiting family size, and the team expressed general concern about the apparent continuing emphasis being given to sterilisation. The FPAI statistics demonstrate the importance of female sterilisation as a method for new acceptors:

New Acceptors by Method, FPA Clinics 1993-1997 (thousands)

Year	OCP	IUD	Condoms	F.Steril.	M.Steril.	Other[a]
1993	24	36	80	52	1.4	1
1994	27	34	83	50	1.2	<1
1995	28	34	82	50	1.0	<1
1996	25	34	86	50	1.0	<1
1997	25	34	78	51	0.5	1

Source: SARO Annual Report Reviews 1997

[a] Injectables and Spermicides

With cumulative users, sterilisation will increase as a percentage because of the permanence of the method, but the figures for FPAI new acceptors suggests the position appears not to have improved even in recent years.

By contrast, paramedics in some areas are performing very effectively and demonstrating skills not normally expected of their counterparts in more affluent countries (see Box 7). Quality of care varies considerably from country to country, but also among outlets within countries, as has been demonstrated recently by the new quality assurance unit in Bangladesh (Bangladesh report 6.3).

BOX 7: NURSE/MIDWIFE SKILLS IN ZAMBIA

Zambian nurses were found to be empowered, skilled and self confident. Many of them were accustomed to working with emergency cases without a doctor in attendance.

The assessment team in Zambia observed a PPAZ nurse treating a seriously ill young woman, who had been carried by her family to a small clinic in a village in a tribal area. The nurse received the patient and family with dignity and calm. In a small dark room, the patient was laid on a bench, which took up nearly half the space in the room. In a matter of minutes, the nurse had started intravenous infusion with modern sterile equipment. When team members asked another nurse what they would do with retained placenta she stated that they had been instructed to remove it themselves, and would do so if necessary. The gynaecologist on the assessment team endorsed this assessment since a bleeding mother would not survive transport on the bad roads of the area, with - quite probably - no suitable vehicle at the disposal of the dispensary. The nurses met by the team had successfully removed placenta on several occasions.

One indication of the relevance of Federation strategy is that quality of care is one of the original IPPF Vision 2000 six challenges. Another indication is that quality of care has been given emphasis in Vision 2000 Fund projects. Performance has varied. Training on quality of care has made some progress, but rigorous QoC assessments are only just being introduced. It is too early to judge the use-effectiveness of improved QoC procedures, and the cost-effectiveness of V2F projects is often poor relative to standard branch clinic performance. The country case studies attempted to summarise QoC experience (see Box 8) to demonstrate areas of activity and areas of weakness.

BOX 8: QUALITY OF CARE IN ETHIOPIA

There is an emphasis by Family Guidance Association of Ethiopia on counselling and quality of care in all training materials demonstrated for health providers. Training on quality of care in counselling and provision of contraceptives has been systematic for several years.

The HQ research and evaluation office generally performs a baseline study for new initiatives, which, in respect of FP quality of care and counselling are generally very good. There was a large 1994 study of quality of family planning services and a client satisfaction study, and in 1997 a quality and client perspective study at the headquarters clinic. Both studies documented high client satisfaction, and usage by clients from all socio-economic backgrounds. This assessment included 25 client interviews that supported these findings.

At the core of quality of care is the recognition of clients' rights to make informed choices. Such recognition is visible at FGAE. An important emphasis is placed on counselling services, privacy and confidentiality, in addition to technical competence and adequate supplies and facilities. A tool for continuous quality improvement for client-oriented, provider efficient services, (AVSC's COPE), has been established in the clinics at HQ, Bazir Das and Awassa. The system includes self-assessment checklists of clients' rights and provider needs, client interviews, client flow analysis and plan of action. The system has limitations regarding an assessment of integration of a more comprehensive SRH approach than FP. Nevertheless, it is a focused beginning with potential, if developed, for improving quality on a greater scale.

Family Planning *contraceptive counselling and services* is the best functioning part of FGAE. The professional and compassionate attitudes towards clients demonstrated among staff, in addition to high level of technical competence in FP methodology gives FGAE a good base from which to enhance its range of SRH services. This potential is already demonstrated in infertility counselling, the increased attention to Sexually Transmitted Diseases (STD) and FP integration in youth services and the fact that more clients keep coming for their services. Access to all is ensured by policies, which aim not to exclude any clients, regardless of paying capacity.

With an increased attention to STD/HIV-counselling and treatment, gender sensitivity and female involvement at all decision-making levels, the organisation has great potential for quality SRH services on a broader scale.

Other Service Concerns

FPAs are major health care information and service providers, in the latter case often second only to government for family planning. They employ many staff, mobilise considerable numbers of volunteer workers, engage in a great variety of activities, and provide services of one sort or another to millions of people. The Annual Reports attest to the scale and variety; to capture this in a few simple measures is a problem the Federation has not yet resolved, and it has found no easy way to demonstrate the impact of its activities. Many are described in the country and regional reports of this Assessment and their relevance and effectiveness gauged.

Services for youths is a case in point; the standard FP outcome measures are only partly applicable to SRH services for youths (in Uganda contraceptive counselling and supply among students in tertiary education has reduced unwanted pregnancies) as much of the work with teenagers and young adults is educational and preventative. In Ethiopia, for example, efforts to reach youth is part of the association's strategic plan and since 1990 five youth centres have been opened in urban areas and out-reach through peer educators has taken SRH messages to in- and out-of-school students. In Nepal where the government does not provide any SRH services for youth, the FPA has organised youth groups in every district where it is active.

Each of the countries examined had similar projects all reflecting implementation of the Federation's concern to raise awareness of the SRH needs of young people and to provide them with services. Experimentation with dedicated services for youths has begun and could be increased; strong support from local members is again proving a key factor in countering residual resistance.

In addition to the above summary remarks on emphasis, access and quality, we note four other service-related issues.

- As already noted, activities related to abortion are difficult, and circumstances vary depending on the legal situation. FPAs have to work within the constraints of the law and have to limit themselves mostly to post-abortion care and/or advocacy for more liberal abortion laws (such as in Nepal), though menstrual regulation is permitted in Bangladesh, and the law is more liberal in India.

- In general FPAs do not have sufficient knowledge about who their clients are. Much more information is required for the FPAs to be able to target their services to the most vulnerable groups and to gear their services more to customer demands.

- Some FPAs have started to charge for training given to government staff or those from other NGOs. This has happened in Ethiopia (see Ethiopia report, 8.6) and India (India report, 5.3) although not yet in Zambia (Zambia report, 9.6).

- A general problem appeared to be the distribution of IEC materials in countries even if available at central level.

A more comprehensive review might demonstrate that these are issues on which the Federation should seek to develop more general service strategies.

3.4 Management, Systems and Resources

On paper, IPPF is a federation made up of independent national associations who govern themselves as well as their global organisation. However, this fact hides two important aspects. First, a number of member associations are in reality immature, and others pass through periods of weakness or decline. Second, the Secretariat (i.e the HQ and the regional level) is wholly donor financed without any contribution from the member associations. Furthermore most unrestricted donor funds pass through the Secretariat on their way to the national associations thus giving the Secretariat the power of the purse.

As a result the grant-receiving associations are strongly dependent upon the Secretariat. By and large they are also appreciative for the support they receive, especially from the regional level which is the level with which they generally meet and interact. The regional level has a number of main functions:

- Regional activities;

- Supporting the FPAs;

- Upholding Federation principles and ensuring compliance from the FPAs.

All of these functions are important and constitute the rationale for the regional level of IPPF. An absolutely essential function at the present stage in the two regions studied is for the Secretariat to monitor the work of the FPAs and take action whenever required (see Box 9). This is what gives the Federation credibility in the eyes of the donors and thereby access to continued donor financing for the grant-receiving FPAs (who constitute the vast majority of FPAs). The essential value and functions of the regional offices as discerned by the assessment team, and some shared concerns are listed in Appendix 4.

BOX 9: REGIONAL OFFICE SUPERVISORY AND SUPPORT FUNCTIONS IN UGANDA

The regional offices of IPPF have a range of functions most of which are judged by the assessment team to be essential for the efficiency and effectiveness of the Federation and the benefit of those it serves. Most of these are in one sense routine, but occasionally special intervention is required.

The Family Planning Association of Uganda, like all other FPAs in the region, has received general support from the Africa Region Office with the preparation of strategic and five year plans, and in planning and budgeting annual work programmes. It has also benefited from participation in workshops and seminars arranged by the specialist units of ARO.

BOX 9: REGIONAL OFFICE SUPERVISORY AND SUPPORT FUNCTIONS IN UGANDA (con'd)

In 1994/95 FPAU faced special problems when two senior officials were deemed not to have complied with all IPPF procedural requirements. Local associations are autonomous bodies, but the fact that IPPF core funding constitutes a significant part of the revenue for most FPAs gives the Secretariat considerable persuasive power; as a last resort the regional council can withhold funding. In the case of Uganda, ARO and national senior volunteers collaborated closely and the senior personnel were removed. The regional office put in an Administrator and was instrumental in arranging consultancy inputs (from another East African FPA, and one from Northern New England). In 1995 a thorough, wide-ranging and participatory Needs Assessment was conducted, and a new Strategic Plan formulated. A series of workshops were conducted for national and branch volunteers. ARO provided advice and resource persons for these. The strength of the Association was re-built. The new senior management and the ARO country advisor worked closely together on the preparation of a Vision 2000 Fund proposal, which was successful and ready for implementation in 1998.

Unfortunately, early in 1998, such had been the success of the replacement senior staff that they were both offered and accepted prestigious and more lucrative jobs with international agencies. Under these very different circumstances, ARO once again felt it prudent to suspend funding, this time for the V2F project. It is anticipated that once the newly appointed Executive Director and Finance Officer have completed their induction, V2F support will be reinstated, probably in January 1999.

At the country level obviously the management capacity varies between associations and over time. In all FPAs studied the management capacity at present could be described as medium to high (although two of the FPAs had gone through periods of weakness during the last few years).

Among the weaknesses noted in several FPAs were traditional authoritarian types of leadership, in some countries strong centralist tendencies, little observation of gender aspects in practice, and isolation of projects from the mainstream FPA work.

The latter aspect is compounded by donor influences requiring the creation of specific projects with specific monitoring systems and accountability separate from the regular activities. This is also something that was noted as regards V2000 Fund projects where emphasis so far has been more on project development than on integration of experiences into the regular FPA work.

The PPBR system as it is now applied has certain weaknesses e.g. cementing the long-term strategic plan as a straight jacket rather than as a vision and imposing the three year plans as an intermediary planning period which may be redundant. A new system is being developed for introduction from the beginning of the year 2000.

Evaluation is often a weak point with the emphasis still being on family planning rather than on broad SRH activities and on quantitative data rather than on a mixture of quantitative and qualitative information. Overall programme and project evaluations are conducted, but IPPF has not modified its annual reporting format since the introduction of the broad SRH strategies though this is to be done in 1999 (training) and 2000 (reporting). Annual reports still have several pages of detailed quantitative information on family planning methods, Couple Years of Protection (CYPs) etc and only a small section for everything else including MCH, STD activities, cancer screening, infertility and general health services. Similarly procurement is geared towards contraceptives and logistic support while, for example, HIV test kits are not provided routinely within the system; individual FPAs are left to make their own decision about the inclusion of non-contraceptive services and supplies.

3.5 Volunteers and Staff

From a purely technocratic point of view, the membership structure of IPPF may seem not only superfluous but also costly. Relationships between volunteers and staff are sometimes problematic and give rise to conflicts and delays.

However, the membership functions are what gives IPPF its NGO character, it is the essence and soul of the Federation. They provide a form of widespread stakeholder participation, and associated responsiveness to local concerns as well as local influence, which many other agencies lack. Without it IPPF would be like any other agency or company that provides services. The membership structure is also essential for advocacy and it gives FPAs a particular strength, for example, in relation to donor agency NGOs and in relation to governments. FPA activities have to be assessed against this background.

Even if there may be a tendency for policy volunteers to be more traditional than staff this is not always the case and appears to vary between countries. In some countries, certain life members have been campaigning for many years, for example, for changes to abortion legislation, for sex education in schools, for better STD and emergency obstetric care (EOC) services, etc. Although these volunteers are more senior in years now the issues they support are still at the forefront of battles for SRH rights and improved SRH services.

3.6 Effectiveness, Impact and Sustainability

It is impossible to establish the effectiveness of FPAs solely in quantitative terms. In all six countries studied the FPAs have had a clear impact in terms of influencing governments and through the family planning services provided. In new areas such as STD prevention, youth activities, cancer screening and infertility clinics positive developments can be seen although it is often still too early to establish impact. The proposed Vision 2000 monitoring and evaluation system should partly redress this deficiency, but it behoves IPPF to find imaginative ways of reporting to its supporters the less quantifiable achievements of it programmes.

The question of financial sustainability is an insoluble problem in poor societies; it becomes an issue of balancing between targeting the poor and cost-recovery. In none of the countries studied was the percentage of self-generated funds over five percent. Membership fees tended to yield minimal amounts while local revenue was mostly derived from sale of medicines and to some extent from user fees from clinical and laboratory services. In some countries, for example, Bangladesh (Bangladesh report, 7.3.3.) and Nepal (Nepal report, 6.3.4), the FPA is actively trying to institute schemes for cost-recovery. It is surprising that this has not been done until now on a larger scale in India, a country where it is obvious that there are tens of millions, maybe hundreds of millions of people who would be able to pay for services rendered (India report, 7.3.3).

As regards institutional sustainability, the outlook for FPAs is brighter. In spite of relying heavily on external funding, FPAs were always considered as indigenous organisations. Functioning administrative systems and a fair continuity of staff also helped to achieve sustainability in this sense. However, there was some evidence that the commitment of staff was being strained by what sometimes seemed to them less favourable conditions of service.

3.7 External Environment and Wider Policy Context

The socio-economic, cultural and political environment for effective work in SRH varies widely between regions and countries as well as over time. Therefore, the achievements of each FPA have to be judged in context and any comparison across countries has to be done with great care.

In some countries, Nepal for example, the conditions for women are particularly detrimental. In other countries, such as Ethiopia, governments are unwilling or unable to co-operate effectively with NGOs. Unstable governments may make conditions for NGO work difficult as happened in Uganda in the 1970s and early 1980s. Health reforms may change the context for interventions as in Bangladesh at present.

In all countries, HIV/AIDS poses a threat, which will impact on the sexual and reproductive health of people. This threat does not appear to be taken seriously enough, though in several countries (notably India and Uganda) there are STD/HIV projects. There is scope and an apparent need for a more developed policy for the Federation; at present it is not part of IPPF policy, for instance, for FPAs to provide systematic HIV testing. The prevalence and risk of HIV/AIDs is also a factor, which should have consequences for contraceptive procurement, promotion, counselling and choice. Of the countries studied it was only in Zambia that this was apparent.

4. KEY ISSUES IDENTIFIED

The assessment team has not seen it as its task to make sets of recommendations as such. Rather each country study and the regional report picked out key issues and concerns. Here, we provide only an overview of these key issues and concerns. The selected issues have been grouped by four topics: role of FPAs, activities of FPAs, management, and relation to donors. These issues generally relate to FPA activities although not necessarily each issue for each country FPA.

4.1 Role of FPAs.

There are six issues relating to the role of FPAs:

a) Getting the balance right between service for the disadvantaged versus self-sufficiency;

b) Need to collaborate more fully in government SRH programmes, especially in the maintenance of standards;

c) Choice of emphasis/perceived role: risk-taking enlargement of scope and provision of frontline services (testing the limits of acceptability); service to the underserved/disadvantaged; provision of a stable service delivery system and/or efficient and reliable IEC advocacy effort;

d) IPPF need to be able to articulate and defend their choice, and encourage FPAs to do likewise, on the role in each country of FPA with respect to scaling up (increasing their own coverage, influencing other service providers including government, NGOs, communities, etc. to adopt replicable models, etc.);

e) Preservation of the NGO character of the FPAs, and protecting FPAs from becoming solely vehicles for government and donor funding;

f) Retaining the value of voluntarism while using opportunities to reduce expenditure.

4.2 Activities of FPAs

There are seven issues related to the activities of FPAs:

a) Need to prioritise, and produce phased plans for implementation taking account of resource constraints and availability of services from other suppliers;

b) QoC - apparent lack of a general SRH QoC framework for service improvement and reporting;

c) Continuing need to promote and publicise FPA achievements and capability - especially beyond FP awareness and contraceptive supply;

d) How to develop an affordable package of SRH clinical care while managing to retain provision for the poor (and make waivers on fees, etc.). IPPF should provide guidelines on elements of SRH services which are relevant for FPAs to provide (e.g. infertility screening but not treatment; HIV testing if other providers are not there, otherwise screening and referral; cervical cancer/reproductive tract infection (RTI) screening when carrying out pelvic examinations, etc.) together with back-up for equipment and drug procurement, quality assurance and reporting;

e) To plan services, and differentiate markets, FPAs/IPPF need to collect information on client profiles. The new MIS intends to do this, but it is not being done widely and systematically at present as far as the team could tell;

f) Paediatric care (as part of MCH) is neglected; position on cervical and breast cancer services requires clarification;

g) Male involvement: treating youths as one category has disadvantages (boys require different approaches and services from girls; adolescent boys and married youths have different requirements); separate SRH service centres or designated times at FPA clinics are needed for all males. FPA management often links gender and youth: perhaps this alienates young males?

4.3 Management

There are five main management issues to emphasise:

a) The inflexibility of the current PPRB system is believed to be a constraint;

b) The reporting of activities and performance has yet to be streamlined and modified to reflect more clearly the Vision 2000 priorities;

c) The full implications of initiating large scale but limited duration projects under the Vision 2000 funding are not adequately addressed;

d) Role of IPPF HQ and ROs in ensuring compliance with standards and procedures is essential, is gen-

erally done successfully by IPPF, and therefore needs continued support;

e) The relative value to FPAs of various RO services is not easily gauged when all are supplied free, efficiency might be increased by some demand analysis and - possibly - a charging system.

4.4 Financing/Relation to Donors

Finally, the team identified two key issues related to financing and donors:

a) Core Funding versus Restricted Funding. It is clear that continued core funding is essential to ensure that essential central and regional functions are maintained. However, we believe that FPAs should be encouraged to be more realistic about who is paying their overhead costs. They need advice on charging for services provided: including on projects using IPPF earmarked funds, or funded by other donors;

b) IPPF needs to review its new resource allocation formula, and assess its effect when applied precipitately, as it has been in the case of India;

5. CONCLUSIONS AND RECOMMENDATIONS

In conclusion we give a summary of strengths and concerns:

a) All FPAs studied had fulfilled an important role in advocacy for family planning and are trusted partners to governments often with a role as advisors in policy matters;

b) Service provision by FPAs is important in all countries, and FPA quality of care is generally better than government services;

c) Family planning is still by far the main component of service provision. However, all FPAs have started to transform their activities to a broad SRH approach;

d) In some FPAs important new advocacy issues, such as legalising abortion or against FGM, are now being developed. However, often FPAs could still do more to challenge governments e.g. in emphasising STD/HIV/AIDS prevention, and being explicit about the sexuality and reproductive health care needs of youths;

e) Management including monitoring, reporting and procurement has not yet been fully adapted to the V2000 policies, which were introduced six years ago, and gender awareness requires reinforcement;

f) V2000 Fund projects are innovative and offer broad high quality services. They also tend to require more resources, sometimes disproportionate to the regular FPA activities, and have not yet been integrated fully into the national programme;

g) The volunteer structure is an essential component in ensuring the NGO character of the Federation. Even if problems arising from the relationship between volunteers and staff occasionally do occur (as in all NGOs) this structure must be considered as an overall positive aspect;

h) The role of the Secretariat at central and regional levels is essential, not least for protecting and promoting Federation values and principles.

In our view, core support to FPAs via the IPPF system tends to reinforce institutional autonomy and strength, and is more valuable than project support. Donor support directly to FPAs is important to extend services but without adequate provision for overheads may weaken the Associations, making demands on their resources and re-channelling effort away from their own priorities. In addition, the Secretariat relies for its existence on core funding.

Our recommendations are to the sponsoring donors rather than to IPPF directly:

1. Continue to provide core grant to IPPF;

2. Clarify and make explicit IPPF reporting requirements upon which annual grants are conditional. For example, if national FPA programme impact, proportional contribution to national SRH services, and value for money are of major concern to the donors, then IPPF should be asked to develop schemes for reporting on these and be asked to produce a regime for regular reporting to which they should adhere;

3. Major core grant donors should have more frequent review meetings with IPPF senior management. For example key donors might establish a small donor task force which has bi-annual meetings with IPPF HQ and selected regional office staff at which matters of general concern are discussed and mutual requirements exchanged. A timetable should be agreed and circulated to all current and potential donors, and minutes should be produced and circulated;

4. Jointly ask IPPF formally to undertake actions and produce policy and strategy documents, implementation timetables, and reports as identified below -

a) Bring revision of PPBR system to a conclusion as rapidly as is consistent with maintaining quality of the reform. Provide donors with a time frame (milestones) for implementation, and report regularly on progress;

b) Accelerate the introduction of the Vision 2000 Monitoring and Evaluation Guidelines, including revision of the annual reporting formats (narrative descriptions and annexes). Produce national, regional and federation summary reporting templates and give donors a timetable for the production of these reports;

c) In particular, produce clear guidelines for the reporting of association impact on SRH, contribution to national SRH service delivery, and cost-effectiveness and cost recovery;

d) Produce a policy and strategy document on sustainability. This should include advice to associa-

tions on setting overall cost-recovery targets, taking account of and setting out a justification for poverty-focused components of the national FPA programme. Regional offices should be included in this overview with suggestions as to how they may raise revenue, and use market mechanisms to gauge the relative value to associations of RO activities;

e) Develop for the Federation and its members, and provide to donors, a clear strategy for integrating V2F projects into national FPA programmes. Report on the implementation of this plan giving timetables for each project showing the scale of V2F project employment, current and projected recurrent expenditure, service delivery, and current and projected income;

f) Develop, produce and disseminate regular profiles on the contribution of volunteers to the activities and achievements of the movement.

5. Offer strong support to IPPF secretariat in its attempt to fulfil its functions:

a) Seeking to maintain the current vibrancy of the Federation and its memberassociations as a movement seeking to enhance reproductive and sexual health throughout the world;

b) Continuing to elaborate the six challenges of Vision 2000 and find ways to ensure that their implications are fully understood by officers and volunteers throughout the Federation;

c) Assisting financially and with technical advice directly and through the regional offices each national association to identify SRH needs and the best way in which it may contribute to the appropriate enlargement and fulfilment of national SRH aspirations;

d) Assisting each association to design, and implement effectively and efficiently an appropriate SRH programme;

e) Collaborating closely with the associations and regional offices to generate information on the achievements of each and how they contribute to the attainment of SRH goals. Then ensure that this is reported succinctly yet comprehensively.

Appendix 1: Key References

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Appendix 2: Assessment Terms of Reference

Background
The IPPF, through the affiliated membership of more than 150 family planning associations, is the largest international NGO working in reproductive health in the world. Donor funding of IPPF accounts for roughly one third of total income to all FPAs. Most of this is channelled through the London based international secretariat and regional offices direct to FPAs for a range of strategies and activities aimed to promote better reproductive health. Whilst IPPF has embarked on a process to overhaul and improve its systems for monitoring and evaluation, many of IPPF's major donors have expressed a desire to learn more about how well the Federation serves as a mechanism that makes a real difference to people's reproductive health.

Further to a study of the international secretariat commissioned by the Swedish government in 1997 (Andersson Brolin L. and Stenson B: IPPF, A consultancy study for Sida, October 1997), Sweden (Sida), Norway (Ministry of Foreign Affairs) and UK (DFID) have agreed to collaborate in a co-sponsored assessment of IPPF's impact at country level. In particular, it is felt that there is a need to examine how policy is translated into action at country level and to assess the effectiveness of FPAs in promoting reproductive health. This, together with the secretariat study, will provide a more complete picture of the role of the IPPF system in contributing to better reproductive health. IPPF has pledged its full cooperation in the conduct of this assessment.

These terms of reference aim to serve as a common framework for the assessment in order that key issues and lessons can be synthesised and distilled for a set of core themes. But they are not intended to preclude consideration of issues of particular interest to the co-sponsoring agencies. It is also intended that they be shared with IPPF for information and comment.

Purpose
The purpose of this assessment is to help Sweden, Norway and the UK make informed judgements about the effectiveness, performance and relevance of IPPF in promoting policy development, increasing access to and the quality of reproductive health services, and responding to the needs of those most disadvantaged in developing countries.

Approach
Six FPA country studies will be undertaken: in Ethiopia, Zambia, Uganda, Bangladesh, India (one to two states) and Vietnam. All receive significant financial support from IPPF. These country studies will be supplemented by an assessment of the role of IPPF regional offices in supporting and adding value to the work of FPAs. Two regional offices will be included: the Africa and South Asia regional offices.

Three teams of three consultants will each conduct two country studies. Each team will have a team leader responsible for overseeing the preparation of reports on each of the country studies (max. 30 pages) and an executive summary covering both country assessments (max. 10 pages). The team leaders will be responsible for preparing a synthesis report covering all of the country studies which will highlight key lessons and issues (max. 20 pages). The intention is that highlights from the synthesis study will be presented during the 1998 IPPF annual Donor's meeting (in December).

Subsequent to completion of the country studies, the team leaders will undertake the review of the IPPF Africa and South Asia regional offices and prepare a report and executive summary of their findings (max. 30 pages).

The consultant teams will need to represent a range of skills and expertise, but perhaps most notably in the field of programme management and evaluation in reproductive health, strategic planning for NGOs and gender issues. The teams should to the extent possible reflect a gender balance. Each of the co-sponsoring agencies will nominate and/or approve candidates for each of the teams and team leaders.

Options, a reproductive health consulting group based in London, will be contracted to handle logistical, administrative and consultant recruitment aspects of this assessment, in liaison with IPPF and relevant FPAs wherever appropriate, for example to arrange details for country visits. Options may also be asked to nominate candidates for this assignment. Options will keep the co-sponsoring agencies informed of progress in carrying out this work, and be responsible for presentation of the reports (but will not be required to make a direct technical contribution to the studies).

Responsibilities: the core group
The team leaders, serving as the "core group", will be responsible for developing and refining a common methodology for the country studies that addresses - and enables the group to form a view on - each of the thematic questions and issues outlined below. They will be expected to work in a collegiate manner. It is likely that this will involve the development of proto-

cols and checklists to guide interviews with key staff and volunteers. It should include design of the format for reporting. It should also include, to the extent possible, identification of the information IPPF and FPAs will be requested to furnish to the core group in advance of the country visits (annual workplans, reports and evaluations and other relevant material available). The methodology should be approved by representatives from the co-sponsoring agencies. It will be shared with IPPF for information and comment (this work is not intended as a "joint" assessment with IPPF).

Subsequent to the country studies, a methodology for the review of the regional office will need to be prepared. This will be the responsibility of the team leader, in consultation with the co-sponsoring agencies.

The core group, as team leaders, will oversee the country-based studies and be responsible for delegating and organising the work of the team as appropriate. (The services of Options will be available to provided administrative and logistical support that is not available from IPPF/FPAs. Options will also be asked to coordinate any briefing between the team leaders and co-sponsoring agencies). The team leaders may be asked to present the synthesis findings at the 1998 Donor's meeting.

Scope of work: key themes and issues

To fulfil the purpose of this performance assessment, and to guide development of the study methodology (and structure of written reports), the following themes, issues and questions will need to be examined in each of the country studies:

Policy and advocacy

- The extent to which policy is communicated to and throughout FPAs (e.g. at HQ, branch, volunteer and staff levels);
- The relevance of, and perceptions to, IPPF policies at FPA level, especially relating to "Vision 2000", and the extent to which this is reflected in FPA policy and advocacy;
- The extent to which FPAs are effective in initiating and promoting policy dialogue with government and other groups;
- The extent to which the FPA is playing a useful advocacy role around key and emerging reproductive health issues;

Relevance, strategy and priorities

- The extent to which the FPA has identified a strategic role that is relevant to priority reproductive health needs and maximises its comparative advantage;
- The extent to which the sexual and reproductive health agenda defined in Vision 2000 is appropriately reflected in FPA plans and priorities; the extent to which Vision 2000 is serving as an effective mechanism for change;
- The extent to which the FPA has clearly defined priorities (and target groups) that serve as the basis for guiding resources and action;

Information, services and care: what the FPA does and for whom

- What is the range of information, care and services (including commodities and products) provided by the FPA and who benefits?
- Who are the clients by age, sex, employment, income, marital status, location (urban/rural). Are there strategies for reaching various target groups?
- Do client profiles correspond to target groups defined at policy level, e.g. adolescents, the poor;
- Are services designed and monitored to be gender sensitive?
- The quality of FPA services and care and the extent to which the FPA is helping to drive up overall quality in reproductive health;
- The extent to which the FPA is contributing to greater accountability in the delivery and quality of reproductive health services.

Management, systems and resources

- The extent to which the FPA has robust and effective systems for planning, managing, monitoring and evaluating what it does, with clear indicators and benchmarks for assessing progress and identifying beneficiaries;
- The extent to which budgetary and resource allocation processes (i) are congruent to and support established priorities (ii) take account of performance;
- The effectiveness of institutional arrangements - including availability and use of written guidance - for financial and technical support and management;

- The extent to which FPAs are making the best use of resources, both external and internal. Are user fee structures appropriate to the setting? Is the relationship between pricing policy and ability to pay right? (see sustainability below);

- Is the policy, management and staffing structure appropriate to strategies and priorities of the FPA?

Volunteers and staff

- Is there an appropriate gender and age balance in volunteers and staff?

- The extent to which volunteer and staff roles and functions are clearly and suitably delineated;

- The role and effectiveness of volunteers in shaping and guiding strategy, and as advocates in influencing government, civil society organisations, community groups and others.

Effectiveness, impact and sustainability

- The difference FPAs are making to people's reproductive health and results achieved; how important are FPAs?

- The extent to which FPAs are still relevant, effective and responsive to local needs in reproductive health, and remain an efficient means of subsidising people's access to care and services;

- The degree of financial dependency on external resources (from IPPF and elsewhere) and extent to which FPAs have been able to achieve financial and institutional sustainability.

External environment and wider policy context

- How is FPA action evolving in response to the external policy environment and changing emphases in global/national population policy, planning and practice - international conferences, emerging health sector investment agenda, new concepts in family planning;

- How do FPAs define their role in relation to other actors, e.g. government health provision, other service providers, partnerships with other actors.

Whilst it is not the purpose of this assignment to make any comparisons with other organisations concerned with reproductive health, the assessment - for example, of advocacy, strategic relevance and success in increasing people's access to services and essential commodities - will need to take account of the role and contribution of other groups, and the extent to which the FPA has and is responding to changing circumstances.

In the light of the above, the teams are invited to offer a judgement about whether it right for IPPF to continue to fund only its FPA members and not other NGOs.

Many of the issues identified above involve interactions between FPAs and their respective regional offices of IPPF (for example, in relation to resource allocation). It may therefore be the case that additional information to complete the country level studies will require discussions with regionally based staff. However, the study focusing on the role of the regional offices should pay particular attention to the following issues:

- The extent to which regional systems and support "add value" to the work of IPPF centrally and to FPAs (e.g. quality of technical support);

- How lessons and best practice are shared and promoted (including with other regions and IPPF);

- Effectiveness of systems and procedures for allocating resources and monitoring outcomes;

- The extent to which regions play a "challenging" role for FPAs;

- Effectiveness, and timeliness, of communication between the regional office and FPAs;

- The role of regional volunteers in policy, advocacy, governance and in ensuring accountability.

Interlocutors

Much of the information for this work will be obtained from interviews with FPA personnel (staff and volunteers) at country and regional levels. Key health or reproductive health staff within other relevant groups, including government departments, donor agencies (especially those that provide bilateral support to FPAs) and other local NGOs and women's groups, should also be contacted wherever possible.

Timing

It is estimated that development of the methodology and study tools will take 4 person weeks from commencement. During this time, Options will seek to finalise logistical arrangements with IPPF for each of the country visits.

It is intended that the country visits will take place from end August/early September 1998. It is anticipated that about 8 to 10 working days will be required for each of the country visits. Preparatory work of about 5 to 8 days per country will be needed in advance of the country visits. One to two days per

country study will be allowed for report writing, together with an additional 4 to 6 days for completion of the synthesis report.

The final reports will be shared for information with IPPF (who will be responsible for dissemination to relevant regional offices and FPAs). The core group may also be asked to present and discuss their findings in a workshop for IPPF staff and representatives from the co-sponsoring agencies (in addition possibly to a summary presentation at the Donor's meeting).

It is intended that the synthesis report from each of the country studies should be completed - at least in draft - by the end of November 1998 at the latest.

Budget
Based on this TOR, Options will be invited to submit a costing for this work, which specifies team composition, to each of the co-sponsoring agencies by 10 July 1998. Each of the co-sponsoring agencies will reimburse Options one-third of the total cost.

June 1998

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Norwegian Ministry of Foreign Affairs
DFID

Appendix 3: Team Members and Summary Itinerary

A: Team Members

Core Group

Julie Skjaeraasen (Norway)
Bo Stenson (Sweden)
Ian Thomas (UK) – Co-ordinating Editor of Joint Reports

Donor Country Consultants

Lillemor Andersson-Brolin (Sweden)
Pal Jareg (Norway)
Elise Schanke (Norway)
Miriam Temin (UK)
Ann-Karin Valle (Norway)

National Consultants

Peggy Chibuye (Zambia)
Genet Mengistu (Ethiopia)
Florence Mirembe (Uganda)
Madhavi Mittal (India)
Mahboob Aminur Rahman (Bangladesh)
Prabha Thacker (Nepal)

Options Project Staff

Sue Billington, Project Manager
David Ranger, Project Assistant

B: Timetable of Visits

Ethiopia:	12 - 25 September
Zambia:	14 - 25 September
Bangladesh:	30 September - 14 October
Nepal:	5 - 16 October
Uganda:	21 - 30 October
India:	24 October – 4 November
Africa Region Office (Nairobi):	2 - 4 November
South Asia Region Office (London):	10 - 12 November

Appendix 4: Regional Offices: Essential Functions and Concerns

Some of the **essential functions** of the regional offices are:

- Allocating Africa/South Asia resources taking account of national needs and association strengths and weaknesses;
- Interpreting Federation aims in a fashion which is sensitive to cultural, economic and political realities of the region;
- Providing technical assistance attuned to needs of African/South Asian associations;
- Keeping in touch with regional volunteers to ensure that they are kept well informed on IPPF/FPA affairs, and that their views are respected at FPA, regional and HQ levels;
- Providing a ready response to and a means of resolving FPA problems as they arise;
- Helping FPAs to develop new projects and to find additional sources of funding; and
- Ensuring compliance with Federation aims, principles and management rules.

Some of the **concerns**, discussed in more detail in the Regional Office Report (sections 3 and 4), are:

- Such a rapid review of two sophisticated branches of a very large organisation does not allow the assessment team to discern adequately the tensions that almost certainly exist among the interest groups and stakeholders: the struggle by different national FPAs to obtain a share of the Federal funding coming to a region, and their efforts to acquire access to the expertise of the RO personnel; the dynamics of volunteer-staff interaction at all levels and the extent to which ROs foster enterprise or suppress expressions of local initiative; the role of political groups, etc.;
- The assessment team's impression that the balance seemingly achieved by ROs between directive intervention and supervision (in part to ensure compliance and good governance, and in part to maintain the momentum of the PPBR system) on the one hand, and support and assistance to autonomous associations on the other may be superficial and unduly influenced by the good impression that both FPAs and ROs, understandably, wish to make;
- There has been insufficient effort to demonstrate the reality and strength of demand for RO functions;
- Certain elements of the PPBR system - particularly continued adherence to the framework of long-out-of-date Strategic Plans - place constraints on the creativity of FPAs and their ability to respond imaginatively and explicitly to the challenges of Vision 2000;
- This is reinforced by the apparent failure of HQ and ROs to assist FPAs to report on key indicators closer to aims and activities believed to be essential to demonstrate response to the six challenges (in fact this is a case where HQ/RO might usefully be more directive, and have the mechanism to hand in the required reporting formats in the Annual Reports);
- And clearly relates to the delay that has occurred in the wholesale modification of the MIS system employed at all levels;
- But that this needs to be accompanied, after the elapse of some six years, by a reappraisal of the relevance to each region of each of the six challenges - asking has there been adequate and appropriate focus/prioritising, and has this included realistic assessment of the comparative advantage as well as limitations of FPAs in the region;
- The Vision 2000 Fund arrangements may lead to imbalance in national FPA programmes and increase inequalities among FPAs as more regions have been permitted access to the fund and as a consequence those countries in the poorest regions which did not obtain V2F funding find it increasingly difficult to do so;
- Insufficient attention has been devoted to identifying the ways in which the regions and FPAs may reconcile the apparently conflicting objectives of increasing financial sustainability and quality of care on the one hand, with the continued commitment on the other hand to serve the disadvantaged and take services to the underserved areas;
- A more rigorous evaluation of the purpose and impact of some of the RO publications might reveal they are not good value for money;
- Workshops might more systematically be designed to assist FPAs (staff and volunteers) to achieve the

paradigm shift (as it was described in ARO) required by Vision 2000;

- From a core grant donor perspective we question the validity of using core grant funding to underwrite proposal preparation and project overheads thereby in effect giving subsidies to other donors and apparently enhancing the cost-effectiveness of their assistance.

Appendix 5: Key Findings of Country Studies

A purposive sample of six family planning associations was made by the sponsors of this study. The sample was composed of the FPAs in Ethiopia (Family Guidance Association of Ethiopia - FGAE), Bangladesh (FPAB), India (FPAI), Nepal (FPAN), Uganda (FPAU) and Zambia (the Planned Parenthood Association of Zambia - PPAZ). Obviously the findings from these countries cannot be generalised to all FPAs. However, in the opinion of the study teams it is likely that the FPAs studied are typical of a fairly large number of FPAs of medium to high capacity in low-income countries in the two regions concerned. No generalisations can be made to other regions.

Full reports on each of the FPAs studies are available. There follows a summary of key findings of each of the country studies.

Bangladesh

Bangladesh has a population of 122 million. The average population density is very high, and the per capita income low (849 persons per sq.km, and US$240 per annum). The literacy rate remains low especially for females, and infant, under five and maternal mortality are all high. Contraceptive prevalence has increased in recent years reaching 45% in 1997, and the total fertility rate has reduced to 3.2 children. Population growth at 1.6% per annum if continued would double the population in 43 years.

The Family Planning Association of Bangladesh was formed in 1953 and is now a large organisation with 31 clinics and 36 outreach sites throughout the country, and many educational and service provider projects. In the 1990s it is estimated that FPAB is responsible for approximately 10% of the national family planning achievement, or about one million active users of contraception. The Association has a staff of 764 (56% female), and over four thousand volunteers (again over 50% female). It is a key stakeholder in national family planning services, and has increased its involvement in sexual and reproductive health advocacy and service provision.

Notable achievements:-

a) Providing a cost-effective family planning service, including successful collaboration with other major NGOs.
b) Effectively overcoming the resistance of religious leaders first to family planning and more recently to broader aspects of reproductive health.
c) Initiating youth programmes in both rural and urban settings, and increasing awareness of the SRH needs of youths through the medium of television and radio.
d) Obtained Vision 2000 Funds for a major SRH initiative amongst the disadvantaged populations of the eastern borderlands.
e) Setting up a quality assurance unit to improve clinical quality of care.

Challenges:-

a) Increasing gender awareness within the association and among the communities in which it works, and promoting more female staff and volunteers to senior posts.
b) Promoting reproductive rights as well as meeting reproductive needs.
c) Ensuring a secure place for the Association and other NGOs in the emerging national SRH programme, which is increasingly emphasising one-stop primary health care services.
d) With the Regional Office, revising the Strategic Plan framework to make it more transparently related to the Six Challenges, and to streamline the reporting so that SRH performance and impact are more readily apparent.
e) Integrating the V2F project more fully into the national FPA programme.
f) Refining sustainability strategies - especially financial sustainability - and strengthening the viability of the association.

Ethiopia

Ethiopia has a population of 58 million. Fully 86% of the population is rural, and the per capita income is very low (US$120 per annum). The literacy rate remains low especially for females, and infant, under five and maternal mortality are all high. In 1997 HIV prevalence was 7.2% for adults countrywide, female genital mutilation is ubiquitous, and abortion though illegal is widespread. Contraceptive prevalence in 1997 was estimated to be 9.8%, and the total fertility rate is as high as 6.7 children. Population growth at 2.9% per annum if continued would double the population in 24 years.

The Family Guidance Association of Ethiopia was founded in 1966 and had to work for many years in an environment negative about family planning and reproductive health. It is now a trusted partner of a government which is only slowly increasing its commitment to expanding RH services. The association now provides an estimated 15-20% of RH services countrywide, and the technical quality of the services is generally high. It has 227 staff and 3,300 volunteers

who run 13 clinics, 54 outreach sites, and a community service programme, as well as extensive informational, educational and training activities.

Notable achievements:-
a) Has clearly been instrumental in promoting family planning in Ethiopia, and as a trusted partner of the government has the opportunity to promote SRH.
b) Carries out quality RH services characterised by broad and adequate counselling, respect for privacy and high technical quality.
c) Has trained government health workers, including medical doctors, in RH since 1975.
d) More recently initiated youth activities which in their scope and in providing access to special youth clinical services are a model for others. As yet they are limited in coverage.

Challenges:-
a) The integration of STD/HIV/AIDS aspects into counselling and service provision. Extending access to HIV testing.
b) Improving access to safe delivery.
c) Refocusing the advocacy role in favour of safe abortion, women's rights and youth.
d) Greater involvement of women in decision-making, including in the affairs of the association.
e) Balancing collaboration with the government as a means of influencing the expansion of SRH services, with the need to maintain its autonomy and independent voice.

India

India has a population of some 1000 million, 75% of which is still rural. Over a third live below the poverty line, and the overall per capita income is US$340. The female literacy rate is 40%, and infant, under five and maternal mortality are all high. The status of women is generally low and son preference continues. Contraceptive prevalence has increased only slowly and is now 43%. The total fertility rate is still 3.4 children. Population growth at 2.1% per annum if continued would double the population in 32 years.

The Family Planning Association of India was founded in 1949 and has been an important pioneer in promoting family planning, and latterly SRH, in India as well as elsewhere in the world. It is now a large NGO with 40 branches throughout India, 24 integrated rural projects and three area projects. It runs 78 static clinics and an extensive FP/MCH outreach programme through 189 clinics and mobile education-cum-service units. The Small Family by Choice Vision 2000 Fund project is IPPF's largest. There are approximately 3,500 policy volunteers active in advocacy, governance, resource mobilisation, service provision, technical direction and community involvement, and 1015 staff 56% of whom are female. In 1997 17 male clinics were started.

Notable achievements:-
a) One of the founder nations for IPPF - a pioneer both within IPPF and in India.
b) Largescale RH service provider.
c) Substantial refocusing to encompass Vision 2000 challenges - especially women's empowerment (including very large V2 Fund project), youth, men's involvement, MCH, and services for sex workers.

Challenges:-
a) HIV/AIDS in India.
b) Continuing to inform and promote contraceptive choice, avoiding undue reliance on sterilisation.
c) Clinical services for youths, and encouraging more young people into the association.
d) Addressing violence against women.
e) Responding effectively to government encouragement to work in remote and disadvantaged areas in the face of severely reduced core funding.
f) Improving monitoring and supervision, and strengthening research and evaluation capabilities.
g) Financial sustainability, including phasing out of the large V2F funding.

Nepal

Nepal has a population of 23 million, and is one of the poorest countries in the world (per capita income of US$234 per annum). The female literacy rate is 38%. Infant, and under five mortality are high. Maternal mortality is particularly high and female life expectancy is lower than that for men. Contraceptive prevalence is estimated at 28%, and the total fertility rate, though reduced, is still 4.6 children. Population growth at 2.3% per annum if continued would double the population in 30 years.

The Family Planning Association of Nepal was established in 1959 and has been the pioneer FP organisation in the country. It influenced the government to adopt family planning activities. FPAN is now the largest NGO in SRH in Nepal working in 33 of the 75 districts, and providing services for approximately 5 million people (25% of married women) through 7 static clinics, 31 outreach sites and special projects. The Association has a remarkable 5422 volunteers (84% male), and 312 staff (16% female).

Notable achievements:-
a) In an uncertain environment maintaining its influence on government to promote FP and latterly a broader concept of SRH.

b) Raising project funds from other donors and reducing reliance on IPPF.
c) Mounting advocacy campaigns to increase awareness and knowledge and to press for legislative liberalisation (e.g. on abortion)
d) Offering a higher quality service than the government, including greater individual choice.

Challenges:-
a) Further improving quality of care.
b) Integrating special projects and core activities, avoiding projectization (often resulting from donor pressure).
c) Increasing staff training and alertness to client SRH needs, and enhancing capability to provide broader services.
d) Addressing gender issues: staffing and volunteer representation; gender sensitivity of programme activities.
e) Providing special clinical services for youths.
f) Sharpening focus on STD/HIV/AIDS prevention.

Uganda

Uganda has a population of 21 million. Despite its rich agricultural resources the country remains poor (annual per capita income US$280) and still faces many political, social and economic problems. There is a high prevalence of HIV/AIDS, high teenage pregnancy, high maternal mortality, and low contraceptive prevalence. Female literacy has been raised to 67% but infant and child mortality remain high. The total fertility rate is 6.9 children, and the population growth rate at 2.6% per annum if continued would double the population in 27 years.

The Family Planning Association of Uganda was founded in 1963. It went through a management crisis in 1994/95 but with support from the Africa Region Office, other FPAs and national volunteers it overcame these problems and has maintained service provision and advocacy activities. The association has 23 static clinics, 47 outreach sites and an extensive community based distribution and care network. It employs 133 staff (66% female), and there are over 4000 volunteers (30% female). FPAU has advocated FP for many years and has now extended this vigorously to the sexual and reproductive needs of youths, and to a lesser extent to those of women. Many agencies are concerned with HIV/AIDS in Uganda, but the association participates with the government and other NGOs in prevention campaigns, and provides STD treatment at its clinics.

Notable achievements:-
a) Youth programme, including IEC, counselling and contraceptive supply by peers among tertiary level students.
b) Initiating and achieving success with its anti-female genital mutilation campaign.
c) Collaborating with government and NGOs in the development of national population policy, and national plans for maternal and child health.
d) Raising the number of non-contraceptive clinic visits above FP visits in 1997 while doubling the latter during the last three years.

Challenges:-
a) Balancing quality of care improvements and maintaining services for the poorest, both of which demand resources, against the desire to extend coverage and range of services in the face of reduced core funding.
b) Consolidating and strengthening links with organisations promoting women's rights.
c) Combatting residual negative images of the association among influential aid agencies, and continuing to increase non-IPPF revenue.
d) Demonstrating sufficient management capability to warrant reinstatement of the Vision 2000 Fund award suspended early in 1998, and vigorous implementation of this project.

Zambia

Zambia has a population of 9.5 million. Annual per capita income is US$400. Population growth at 3.2% per annum if continued would double the population in 22 years. But it is estimated that HIV prevalence is 20% of the adult population, and infant, under five and maternal mortality are also high and have risen over the last five years. The literacy rate among females is 75%, yet the use of modern contraceptives is a low 14.4%, and the total fertility rate is still 6.1 children. Although abortion is legal, safe abortion services are scarce and it is estimated that about 30% of maternal deaths are due to complications from abortion. An additional 27% of maternal mortality is related to obstetric emergencies.

The Planned Parenthood Association of Zambia was established in 1972. It was a pioneer of family planning and is now the largest NGO working in the field of sexual and reproductive health in Zambia. PPAZ has 38 branches and an extensive network of community based workers who provide information, counselling and services. It has two static clinics. There is a staff of 72, and volunteers play a major role in policy, local organisation and community level services.

Notable achievements:-

a) Pioneered FP in Zambia and seen by government and other agencies as a major provider. Receives government funding.
b) Advocacy activities have played an important role in promoting and maintaining national attention on SRH.
c) Developed FP/SRH training for its own CBD agents and for those of other NGOs.
d) Extensive community based programme and thus good geographical coverage.

Challenges:-

a) Improvement of monitoring and evaluation of advocacy activities.
b) Evaluation of services, including client satisfaction and extent to which disadvantaged are provided for.
c) Implement Gender Mainstreaming Policy, with increased attention to human rights aspects of women's empowerment.
d) Develop services for special needs groups, e.g commercial sex workers, and enlarge scope of SRH services at clinics.
e) Strengthening capacity to generate extra revenue, and increase financial sustainability of the association.
f) Build on decentralised management successes of the two large regional projects and apply lessons learned to the branches.

EVALUATION REPORTS

1.87 The Water Supply Programme in Western Province, Zambia
2.87 Sosio-kulturelle forhold i bistanden
3.87 Summary Findings of 23 Evaluation Reports
4.87 NORAD's Provisions for Investment Support
5.87 Multilateral bistand gjennom FN-systemet
6.87 Promoting Imports from Developing Countries

1.88 UNIFEM - United Nations Development Fund for Women
2.88 The Norwegian Multi-Bilateral Programme under UNFPA
3.88 Rural Roads Maintenance, Mbeya and Tanga Regions, Tanzania
4.88 Import Support, Tanzania
5.88 Nordic Technical Assistance Personnel to Eastern Africa
6.88 Good Aid for Women?
7.88 Soil Science Fellowship Course in Norway

1.89 Parallel Financing and Mixed Credits
2.89 The Women's Grant. Desk Study Review
3.89 The Norwegian Volunteer Service
4.89 Fisheries Research Vessel - "Dr. Fridtjof Nansen"
5.89 Institute of Development Management, Tanzania
6.89 DUHs forskningsprogrammer
7.89 Rural Water Supply, Zimbabwe
8.89 Commodity Import Programme, Zimbabwe
9.89 Dairy Sector Support, Zimbabwe

1.90 Mini-Hydropower Plants, Lesotho
2.90 Operation and Maintenance in Development Assistance
3.90 Telecommunications in SADCC Countries
4.90 Energy support in SADCC Countries
5.90 International Research and Training Institue for Advancement of Women (INSTRAW)
6.90 Socio-cultural Conditions in Development Assistance
7.90 Non-Project Financial Assistance to Mozambique

1.91 Hjelp til selvhjelp og levedyktig utvikling
2.91 Diploma Courses at the Norwegian Institute of Technology
3.91 The Women's Grant in Bilateral Assistance
4.91 Hambantota Integrated Rural Development Programme, Sri Lanka
5.91 The Special Grant for Environment and Development

1.92 NGOs as partners in health care, Zambia
2.92 The Sahel-Sudan-Ethiopia Programme
3.92 De private organisasjonene som kanal for norsk bistand, Fase1

1.93 Internal learning from evaluation and reviews
2.93 Macroeconomic impacts of import support to Tanzania
3.93 Garantiordning for investeringer i og eksport til utviklingsland
4.93 Capacity-Building in Development Cooperation Towards integration and recipient responsibility

1.94 Evaluation of World Food Programme
2.94 Evaluation of the Norwegian Junior Expert Programme with UN Organisations

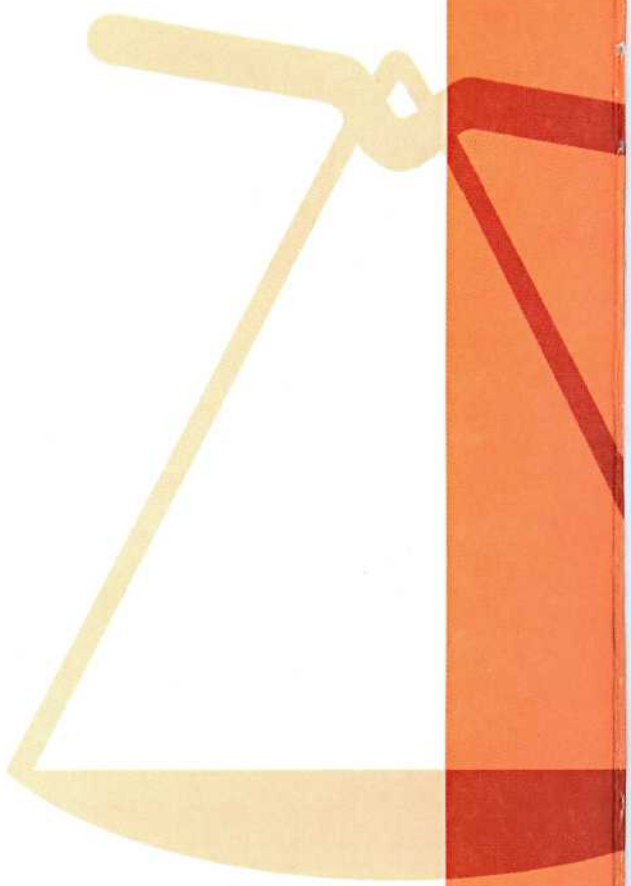
1.95 Technical Cooperation in Transition
2.95 Evaluering av FN-sambandet i Norge
3.95 NGOs as a channel in development aid
3A.95 Rapport fra presentasjonsmøte av "Evalueringen av de frivillige organisasjoner"
4.95 Rural Development and Local Government in Tanzania
5.95 Integration of Environmental Concerns into Norwegian Bilateral Development Assistance: Policies and Performance

1.96 NORAD's Support of the Remote Area Development Programme (RADP) in Botswana
2.96 Norwegian Development Aid Experiences. A Review of Evaluation Studies 1986-92
3.96 The Norwegian People´s Aid Mine Clearance Project in Cambodia
4.96 Democratic Global Civil Governance Report of the 1995 Benchmark Survey of NGOs
5.96 Evaluation of the Yearbook Human Rights in Developing Countries

1.97 Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS
2.97 «Kultursjokk og korrektiv» – Evaluering av UD/NORADs studiereiser for lærere
3.97 Evaluation of decentralisation and development
4.97 Evaluation of Norwegian Assistance to Peace, Reconciliation and Rehabilitation in Mozambique
5.97 Aid to Basic Education in Africa – Opportunities and Constraints
6.97 Norwegian Church Aid's Humanitarian and Peace-making Work in Mali
7.97 Aid as a tool for promotion of human rights and democracy: What can Norway do?
8.97 Evaluation of the Nordic Africa Institute, Uppsala
9.97 Evaluation of Norwegian Assistance to Worldview International Foundation
10.97 Review of Norwegian Assistance to IPS
11.97 Evaluation of Norwegian Humanitarian Assistance to the Sudan
12.97 Cooperation for Health Development WHO's support to programmes at country level

1.98 «Twinning for Development» Institutional Cooperation between Public Institutions in Norway and the South
2.98 Institutional Cooperation between Sokoine and Norwegian Agricultural Universities
3.98 Development through Institutions? Institutional Development promoted by Norwegian Private Companies and Consulting Firms
4.98 Development through Institutions? Institutional Development promoted by Norwegian Non-Governmental Organisations
5.98 Development through Institutions? Institutional Development in Norwegian Bilateral Assistence. Synthesis Report
6.98 Managing good fortune – Macroeconomic management and the role of aid in Botswana
7.98 The World Bank and Poverty in Africa
8.98 Evaluation of the Norwegian Program for Indigenous Peoples
9.98 Evaluering av informasjonsstøtten til RORGene
10.98 Strategy for Assistance to Children in Norwegian Development Cooperation
11.98 Norwegian Assistance to Countries in Conflict
12.98 Evaluation of the Development Cooperation between Norway and Nicaragua
13.98 UNICEF-komiteen i Norge
14.98 Relief in Complex Emergencies

1.99 WID/Gender Units and the Experience of Gender Mainstreaming in Multilateral Organisations
2.99 International Planned Parenthood Federation – Policy and effectiveness at country and regional levels



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